BREATH ONE, BREATH TWO, BREATH THREE:
UTILIZING NARRATIVE CONSULTATION FOR HEALTHCARE CULTURE TRANSFORMATION

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Suzanne J. Milkiewicz-Bryjak

Drew University

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Advisor: Merel Visse PhD

Committee Member: Liana Piehler PhD

ABSTRACT

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Suzanne J. Milkiewicz-Bryjak

The intensity of the interactions in Neonatal Intensive Care Unit (NICU) take an emotional toll on the staff, and stress scales of NICU staff rank consistently high in the profession. Due to the nature of this highly specialized form of nursing, NICU nurses experience high levels of psychological and physical stress. Compassion fatigue, the precursor to burnout, is defined as emotional distress leading to apathy brought on by the trauma of constant care for others and will be experienced by almost all healthcare workers at some point in their profession. Current literature in a meta-narrative review of 90 studies in nursing and other healthcare professionals calls for a new discourse that looks at the distinguishing characteristics, motivators, and outcome responses of occupational stress and burnout of healthcare providers. Recommendations include encouraging new models that honor the healthcare providers' lived clinical experiences. In the current healthcare climate, caring for the healthcare providers who dedicate their lives to caring for the public is no longer optional. It is essential. Narrative Consultation is a reflective support construct designed to meet this need and to be utilized with frontline clinicians. Narrative Consultation's theoretical underpinning is based on the intersecting fields of Infant Mental Health, Medical Humanities and Holistic Practice. The practice affirms the voices and lived experiences of our healthcare staff and utilizes their combined expertise as evidence which manifests as the

centralized mechanism for co-constructed learning in order to better serve the public and each other as providers.

The results of a mixed methodology study at The Valley Hospital in Ridgewood New Jersey report on NICU staff (N=49) exposed to Narrative Consultation. Outcomes of statistical significance included decreased emotional exhaustion and increased teamwork on the Masloch Burnout Inventory and Team Development Scale respectively. Qualitative data, including ethnographic field notes and videos, as well as semi-structured interviews and observation over a period of 27 months, present a descriptive analysis of the mechanisms of change, revealing a healthcare staff who embraced vulnerability and honored differing perspectives in order to embed needed change and improve the way they provided healthcare. NICU staff co-created a space of shared values surrounding their work and professional identities that resulted in the recognition of the intersection of self and others within the environment. These coregulating and reciprocal relationships with patient, family and team resulted in better clinical outcomes and improved staff health and satisfaction outcomes. Narrative Consultation gives participants a platform to be heard and examine their own belief systems in order to develop trusting relationships and embrace systems change necessary to improve quality of care.

Key Words: burnout, reflective practice, narrative, compassion fatigue, emotional exhaustion, staff, stress, team coregulation, vulnerability, teamwork, perspective, quality improvement, change theory, neonatal

Dedication

This dissertation is in loving dedication to my husband and my beautiful boys, who by now I should refer to as, young men. Frank, you are the rock on which all of this is built. Thank you for every word of encouragement. You never made me feel like I was abandoning our family to my studies rather, you created the best cheerleading section I could ever imagine. Zach, you are my inspiration and continue to teach us what heroes are made of. Jeremy, you strengthen all of us with your heart and depth of character. I can't imagine my world without you... and you… and you

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Part One - Knowing know·ing | \ ˈnō-iŋg \: (noun) The state of being aware or informed by facts, education and skills acquired by experience and education.

Introduction- *The Knowing of Self*

Dissertation introductions historically do not begin this way for scholarly writers, but I identify strongly with being a storyteller. Renowned qualitative researcher, Brene Brown, tells the story of her dislike of being listed as a storyteller in a conference bio, and I smile at my juxtaposed reaction, the dislike of being called a researcher. I am a storyteller who has utilized research to examine the things that the keenly observant know to be true. This feels better for me personally; however, this project has required me to jump into the deep end of inquiry, and subsequently my identity is now forever enmeshed with research. I see this introduction almost as a personal story and a prayer of sorts that can set the stage of this story with accuracy and limited ego. Grounding in my story helps me sort through this writing process that has become harder than I ever realized it would or could be. Yes, I admit that as part of an opening statement. As a reader you may be wondering why you care? Writing is rarely easy and dissertation writing even less so. Sharing that statement is central to embodiment of the lessons learned through this project. Sharing that statement, and positioning myself as a researcher in this text, is also in line with developments in qualitative inquiry where self-reflexivity has become an important quality procedure to foster rigor in research (Van Wijngaarden et al. 2017, Finlay, 2008). Since I will conclude with the essential need for embedding opportunity for explorations of vulnerabilities within healthcare practice, I will begin by introducing the vulnerabilities of this author.

I am overcome by the beauty and the sadness of all this project has captured. I want to do it justice and I know that I am just one human who is flawed and moderately educated. I know

that I stand on the shoulders of giants who studied most of their lives when I pat myself on the back for dedicating a mere 10 years or so to my studies. I also know the thing that brought me to today and this is that I have an extraordinary tale to tell. I have had extraordinary life experience that has led me to where I am. To a place where I can climb on the backs of giants and tell the story of the people living inside the walls of this place that is forgotten by most. That place for me is called the ICU. I concentrate on Neonatal Intensive Care Unit (NICU), but it could easily be a Pediatric Intensive Care Unit (PICU), and I think it would ring true for most intensive care units within the hospital environment. The world of pediatrics and neonatal care resonates closest to home. After all, that is where I spent months with my son. And where I spent decades of practice, learning, failing and eventually growing, all while recovering from the personal traumas inflicted by this world. I know that there are others whose feelings are similar, their work is similar, their struggles are similar, and importantly this world is a reality in which countless families have lived. It is where they have had their defining moments in life. In raw vulnerability, I share the following creative writing piece that will serve as a personal narrative of my commitment to the practice of healthcare for the betterment of patients, families, and staff as one whole entity and all equal parts of the stories that unfold.

I Remember…

I remember Evie, our favorite nurse in the ICU, her two braids flailing about and hitting me in the face as she dragged me down the hallway by my forearm…me screaming, her thick Irish brogue soft yet stern, beckoning me not to watch as they pumped on my baby's chest, blood pouring from his mouth.

I remember having visions of his stretcher being wheeled out, his beautiful face covered in the dark bag that surrounded him, zipped up by a stranger who would be the last one to see him. He would be the sixth child in the unit to lose their battle in recent months. I could feel his turn was coming soon. I pictured it many sleepless nights. I imagined the cold chill as I would embrace his frigid lifeless body.

I remember picturing Louisa, his primary nurse as she heard the news in the morning…her questions, her face. Telling my parents, my friends and enduring their sadness and pity. Walking out of the hospital alone…without our baby… for the last time… to his empty crib, my empty home, my empty life, my empty dreams.

I remember that one moment when I thought he was gone. I replay it in my mind every time I watch one of my babies struggle. They call me a passionate nurse now, some call me crazy for ever returning to work in the world that I lived in with my son, the world in which we've experienced so much pain. I've become driven…almost obsessed with doing all I can do to help other families avoid that chaos and despair that I remember.

I remember thinking that next day about what lead to this…One moment…one brief lapse in judgement that can cause a spiral into an indescribable abyss. But believing it happened in one moment is inaccurate. I've spent years examining the many links in the chain that lead to that moment.

I remember Katie, the new nurse coming in that next day. She was thrust into this complex, volatile environment just like Zach was… both of them ill equipped to navigate its harshness. She had darkness shadowing her red eyes. She was in plain clothes and not a uniform. I knew her night was as unbearable as ours, maybe even more so. Frank glared in her direction. My sweet, unassuming, low key husband was exploding with

judgement. But I stood up and went to her. I was pulled by an unstoppable force. I held her tight as she cried. "I'm sorry. I almost killed him. I'm so sorry." She choked.

"You don't need to say anymore." I whispered shaking my head to quiet her thoughts. With compassion I pulled her hair back so that I could look in her eyes and sternly I continued... "I know how and why this happened." She nodded through tears of gratitude as I shared my sacred promise with her… "I know…and for Zach and for you, I will remember."

Decades later, I breathe in the life changing realities of my story and all of the little-known stories of families within the healthcare system. An even lesser-known story is that of the countless staff who have lived with family after family, dedicated to their practice for most of their lives. They've lived days, nights, weekends, and holidays within the walls of these units, performing the extraordinary miracles that some may think they are familiar with through unrealistic television dramas that both over inflate and underestimate our work at the same time. I want to bring you the reality of these interconnected worlds, but in order to see the reality, you have to accept the parts that are ugly. The parts that are heartbreaking. The parts that are mundane and routine. The parts that are broken. So much of this healthcare system is broken, and we in healthcare must look at it closely every day. We can't turn the news channel off or step out to the water cooler on the worst days. We on the frontlines of healthcare must stay in it and face it head on. In order to do that successfully, we must be in touch with becoming vulnerable and what it means to do so. Allowing space for vulnerability and empathy without compassion fatigue and burnout setting in is pivotal. Protecting ourselves from the trauma by engaging in numbing has become a norm in healthcare. The goal of this work is to create a space where we can engage in our shared humanity

and leave feeling lighter, so that numbing is no longer the go-to, as we have found in our qualitative study. There has been a strong focus on burnout in recent years, as evidenced by workplace burnout now being a diagnosable mental health condition according to the World Health Organization IDP 11th edition (https://icd.who.int/en/). The recently unparalleled strain, secondary to the COVID-19 pandemic, laced into an already taxed healthcare system, can make this seem like a grim time to propose supportive systems for frontline healthcare workers. But here is the good news: in all my searching throughout my career, there is nothing more beautiful than the humans inside the machine of a hospital. A hospital, where the sheer determination and selflessness and the raw cracked pieces of humanity abound, is the place where the human spirit can overcome all odds. It is a place where even at the end of physiological care, there is always the ability to heal the spirit. I want to share that beauty in all its reality. Now is the time for policy makers to add a focus on supportive systems of care for those on the frontlines that utilize evidence-based practices. This is a universal priority.

I approach this knowing that there may be personal bias and perspective involved, but that is unavoidable. My research is aligned with a view on evidence being contextual and bound to my personal and professional history. In line with Polklinghorne (1986) "The traditional notions of validity and reliability in research design imply a system of concepts that is stable, context free, and clearly delineated from one another, yet human existence points toward a conceptual system that changes, is context-dependent and is organized around prototypical instances. (p. 129). Because the core of my research on Narrative Consultation is qualitative, " (…) it aims to embrace complexities, existential matters, and lived experience. Indeed, qualitative research is significant because it addresses issues and problems that might otherwise be declared nonresearchable. Qualitative researchers should make a conscious effort to bring these strengths to the fore" (Van

Wijngaarden et al. 2017, p. 2). Acknowledgement of and reflection on possible bias in such research creates a vulnerability within me that is often paralyzing since the nature of what I do and how I have done it makes me cognizant of the increased risk of potential critics. Despite this, recent realizations on the essential nature of vulnerability have given me the drive to push forth, finally, moving toward this conclusion that has immense impact both professionally and personally.

I am a product of all of those who have touched me, including families, colleagues, and mentors, and I have absorbed their words as part of my being. I will try to give credit where credit is due, but honestly in an effort to radically listen to each participant in interviews, consultations, and in practice, I didn't write everything down, but rather absorbed it as I gave them my full presence. I am much like a sponge that has soaked up knowledge and emotion and is now saturated. All that I have heard and learned is flowing out of my pores and is finally ready to be squeezed out to hydrate the workers of this parched profession, whose mouths are wide open and waiting for it. I know this instinctively, as much as I know that there is so much I have left to discover. This urgency to allow the waters of reflection to spring forth will empower me to swallow my fear of inadequacy that has been embedded deep within my mind. I will let go of the obstacles that have stopped me in the past, the critique of past projects. I know that I have tried to think of everything in my power at this time and to cover as much theoretical and research ground as possible. Some may even say I have perhaps thought a bit too much about this. Regardless of this under or overthought, I will write. The most difficult part of beginning this process is letting go of the concept of "I". "I" have lived all of this, and all that "I" have seen and heard matters. In the world of quantitative, and even in some qualitative evidence-based theoretical knowledge, this work of narrative is circumstantial and anecdotal. It is not evidence as perceived in traditional

approaches to social science research. However, it may be seen as lifeworld evidence, "(…) more likely to not lose sight of the fact that human living is an unfolding narrative in which meaning rather than measurement is appropriate currency of understanding" (Todres, 2002, p. 3). I know that the words I write will ring true for many who have lived these truths as well. Seeing it all on paper may help us heal the broken parts and peel back the layers of the machine that healthcare has become in order to see the oasis of hope at the core. May God be with me and keep me and guide my hand and heart to share as accurately and as eloquently as their stories deserve.

Rita Charon speaks in a Tedx talk on November 4, 2011 on "Honoring the Stories of Illness". Depicted within the talk is 18 minutes and 17 seconds of raw emotion regarding the practice of healthcare. Her words, first geared to physicians, have quickly found their way to various healthcare professions including nursing. This seminal work is used as the prompt for Session Nine of Narrative Consultation.

This concept of honoring the stories of illness is something that has been innate in the profession of nursing for centuries, but this profession built on caring has evolved in recent years to be reminiscent of the hard sciences of medicine. Evidence-based medicine is a necessary and constructive approach that is meant to maximize the usage of proven data in order to minimize risk in healthcare. Florence Nightingale knew the importance of this as the pioneer of nursing data, graphically presenting data of soldiers' mortality rates within certain conditions (MacDonald, 2001). Despite this desire for facts, Nightingale also knew the importance of advocacy and narrative which was evident in her many journals. She recognized the power of observation and its ability to influence practice and outcomes in her writing, "Observation tells us the fact, reflection shows what is to be done (the meaning of that fact)" (Nightingale 1882, p.1038, 1049). The words of Nightingale serve as the guiding principle for Narrative Consultation and as a case

for the importance of the utilization of a mixed methodology in nursing research. Quantitative statistics may provide the measurable results that are appreciated by the medical community we strive to be equal with, and qualitative results provide the descriptive analysis that allow for reflections which discern the meaning of the facts, the experiential knowledge of those whose lives are impacted. This is the essence of *Narrative Co-constructed Learning* and *Narrative Consultation* which are new paradigms that have been both designed and studied within the Neonatal Intensive Care Unit. Through these narrative learning processes, we seek to reflect on the everyday practices and the meaning that is created by the sum of these studied parts. Going into this process, there was a strong hypothesis that looked somewhat like this:

Evidence-based practice + human condition/relations + reflective learning + mindful responses = Results in Real Time

To be clearer about what this equation may look like, we must understand that the patient- centered results are dependent on qualitative variables that are quite different from the results achieved in a Randomized Control Trial where variables are *controlled* in many ways. For example, countless studies on sterile line changes impacting central line infections have proven evidence-based practice methods. To demonstrate the difference in the equation that this study proposes, let's analyze this random, but potentially real, equation:

Sterile Line Change + Performed by a team of Colleagues who do not have trust + Colleagues who may be on third shift in a row with emerging illness + Colleagues who have been taught the principles of practice incorrectly and have not reflected on the proper principles of the practice + Colleagues who are inundated by processes that do not allow for mindful presence= Results that may not be in accordance with the evidence-based practice in question

The descriptive analysis of a qualitative study through interview and observation may provide the necessary details on why a unit which has adopted an evidence-based practice may still have incidence of central line infection. The descriptors of qualitative work provide the "how to" where quantitative evidence has historically provided the "what to do" with its statistical analysis. In the above example, we can learn about "what to do" in the statistical meta-analysis supporting sterile line changes, but we do not get information about the human variables that need to be addressed in order to see the practice implemented successfully in an institution. Looking at the lived experiences of the staff could provide insight into factors that statistical analysis cannot address.

Narrative Co-constructed Learning and Narrative Consultation (NC) are designed to look at various processes in an indirect way that allows the additional aspects of the personal narratives and human interactions within the practices to be visible, and to create shared awareness so we can examine them collectively in order to create common goals for learning and change that can improve processes and have positive impacts for patients, families, and staff.

Summary of Narrative Consultation

The construct of Narrative Consultation was developed in the interest of incorporating a practice that utilized information from several fields that employ the use of reflective practice and storytelling with frontline healthcare workers. The study of this construct is nested within a convenience sample of interdisciplinary staff who are already involved in the study of the operationalization of Family Nurture Care. It is hypothesized that this construct of Narrative Consultation, which is built on the concentric circles of Reflective Practice, Medical Humanities and Holistic Nursing, will further augment results seen in Narrative Consultation and give voice

to the frontline staff, especially in times of stressful change. At the core of each practice session is the story or the narrative which is discovered through a group process. It is further hypothesized that co-constructed learning through this reflective process could assist in hardwiring change processes by examining the potential barriers to the desired change.

The evolution of this group process within the Narrative Consultation is essential to the development of the group and to building an environment of trust. Years of life experience with trusting relationships, as well as years of experience in the healthcare profession, have been shown to impact the amount of time it takes to "norm" into the group. Another factor shown to impact the time it takes for a group to "norm" is mixing of hierarchical balance. A significantly shifted hierarchical balance among participants can impact members' willingness to share narratives openly, which adversely affects the co-constructed learning process.

Why Narrative Consultation?

The circle of Reflective Practice comes primarily from the area of relationship-based learning that is foundational to the field of social work and psychology, especially from age zero to three (Brandt, 2014, p.293). These areas have created a formative organization called the World Association for Infant Mental Health whose foundations include reflective practice for parent facing professionals as a best practice (Bernstein, 2012, p.297). The practice of reflective supervision is a regular collaborative between a service provider (clinical or other) and a supervisor that builds on the supervisee's use of their thoughts, feelings, and values within an encounter. Reflective supervision has been proven effective in the area of trauma informed practice within women's and children's services. Although these practices are evidence based and well used in the social work and home visiting fields, a regular collaborative of reflective work has not been

standardized in hospital-based healthcare environments in the United States. Reflective-based practices have been explored on the pedagogical level in education and as an optional means of continuing education for current practitioners. This limited exposure on the frontlines of healthcare risks excluding those who may benefit the most from these practices, the clinicians who have sparse or no knowledge of the practice benefits, and those who may be in the danger zone of burnout and are reluctant to seek reflective services. In this study, Narrative Consultation seeks to target those groups and explore what engaging in the practice brings to their individual practice.

Ethnographic field notes are collected throughout a period of 24 months in both a control and intervention stage of delivery of standard care (pre and post Family Nurture Care (FNC) training utilizing the Narrative Co-constructed learning model) and pre and post Narrative Consultation sessions. Interviews take place with over 90 percent of frontline staff, clinical and administrative leaders, physicians, and colleagues at the follow-up center, prior to rollout of both FNC and NC. Post interviews take place approximately nine to 12 months after FNC rollout and post NC. The addition of Narrative Consultation in Phase Two serves a twofold purpose. The first is to demonstrate benefits of NC to clinical staff and the impact on both collegial relationships and relationships with patients and families. The second is to roll out NC sequentially to the rollout of this new standard of care, called Family Nurture Care, which requires innovative and open ways of thinking by staff. The study of NC suggests that if the staff are given a safe space in which to explore the impact of this new FNC program on both their practice and their interpersonal relationships, the adoption and integration of the program will be met with less resistance. Therefore, adding NC with staff as an augmentation to the introduction of a paradigm where major shifts in thinking and practicing are proposed, may lead to a smoother transition and increased

probability of long-term success of the program, thereby protecting any financial investment and avoiding any financial risk that the hospital may incur through any programmatic investment.

This dissertation is divided into the three developmental levels of education and leadership that can transform didactic knowledge into practice through illuminating identity and purpose. These levels of *knowing, doing, and being* are widely utilized in both education and leadership circles and were adopted and described in a 2011 text by Harvard professors, Snook, Nohria, and Khurana, entitled *Pedagogy of Practice. Handbook for teaching leadership: knowing, doing, and being*. Learning how, when, and where to use—or innovate—new skills requires an understanding of their purpose, clarity as to conditions under which they are useful, and the imagination to adapt them to novel contexts and contents (Snook et.al, 2011 p.356). This paper describes the didactic and experiential learning, "the Knowing", that led to the design of Narrative Consultation, the circumstances or the act of "Doing" the work and description of the process and the measurable achievements, and finally ethnographic and phenomenological description geared toward making meaning out of the process in its entirety, or "the Being".

You will experience voice change as the author (I), shift from multiple roles of parent, clinician, student, teacher, researcher, and ultimately as a human in relationship with self and others. You will experience slight changes in my style of writing as I shift within these roles while always keeping in mind that my holistic being encompasses all of them.

I invite you to join me for the next 150 pages, as we go through the journey of exploring personal and professional experience, didactic learning, research, and relationship, and how they intersect to form a pedagogy rooted in both art and science.

Chapter One: History of Research and Methodological Approach

(*The Knowing of Past Work in the Field)*

Historical and Contemporary Use of Narrative in Medicine

Narrative, in its basic form, is the art of storytelling. Narrative uses thick description of lived experiences in order to illustrate, teach, and examine parts of our lives. Storytelling can be traced back to the earliest of days through archaeological findings such as ancient cave drawings. Researchers hypothesize that these drawings may tell stories about early man's existence, and more particularly, may have been used to share knowledge of practices such as hunting. Storytelling continued through the ages as a construct in which to learn and entertain, and as a way to capture histories. Through shared understanding of experiences, people created meaning together. Across different cultures, sharing stories is one of the common threads of humanity. This shared communication is what makes humans distinct as a species.

One of the earliest philosophers credited with describing what we today know as narrative was Aristotle, the ancient Greek philosopher and scientist who is still considered one of the greatest thinkers in logic, literature, psychology and ethics**.** Aristotle described the rules of storytelling and the purpose of story to include the art of persuasion, engagement and learning (Sullivan-Tarazi 2016, sec 1, para 3, sec 4, para 1). In this way, narrative as a theoretical and pedagogical concept has been accepted and relevant for thousands of years.

Medical Humanities, as we know it today, came into focus in the late 1960s and 1970s through the influence of Edmund Pellegrino, a physician dedicated to the reformation of medical education. Pellegrino argued that medicine had become dehumanized through overspecialization, technical emphasis, over professionalism, insensitivity to the personal and sociocultural values, over medicalization and poor communication. He took the position that medical students' views

were narrowed by too much science and insufficient liberal arts in their education (Cole 2015, p. 44-45). An increasing interest in the ethics of healthcare and the need to incorporate the patient's story as central in medical practice was growing. Innovators such as Elizabeth Kubler-Ross used story to humanize the dying patient, and went as far as to bring patients in to tell their stories at Grand Rounds, which was not a common practice in the context of 1970s healthcare.

Medical Humanities became more widely spread in the 1980s and 1990s. The journal, *Literature and Medicine,* began its publication in 1982 and encouraged the blending of literary practices into medicine. The breakthrough fifth volume was published in 1986 when Rita Charon, a physician and literary scholar, encouraged medical residents to write about their patients. These emerging methods began to encourage clinicians to think about approaching medicine in new ways (EM Jones 2013, p. 15).

History of Modern Narrative Medicine

Rita Charon began teaching at Columbia University in 1982 and became a full professor in 2001, holding both a medical degree and a doctorate in English. She founded the Program in Narrative Medicine at Columbia University in 2000 and began the Masters in Science in Narrative Medicine program, which was the first of its kind (www.columbia.edu, 2019). Narrative Medicine fortifies clinical practice with the narrative competence to recognize, absorb, metabolize, interpret, and be moved by the stories of illness. Through narrative training, Narrative Medicine helps not only physicians, but also nurses, social workers, mental health professionals, chaplains, social workers, academics, and all those interested in the intersection between narrative and medicine to improve the effectiveness of care by developing these skills with patients and colleagues (www.narrativemedicine.org, 2019).

In recent years, medical narrative has evolved from stories about patients and their illnesses to stories that weave the patient's narrative with the narrative of the clinicians. This practice led to the creation or defining of narrative-based medicine. The term was coined deliberately to mark a distinction from evidence-based medicine and was propagated to counteract the shortcomings of evidence-based medicine. Narrative based medicine or narrative practices can be considered specific therapeutic tools, a special form of communication, a qualitative research tool, and a particular attitude a clinician meets a patient with, or a form of reflection, depending on the approach (Kalitzkus and Matthiessen, 2009, p.85-86).

As Charon states, the theories and practices of narrative medicine propose that a disciplined and rigorous understanding of how stories work and what narrative actions reveal about their participants, can help comprehension of clinical care. Considering clinical work through narrative frameworks clarifies what might help the clinician achieve attention, respect, affiliation, trustworthiness, and even empathy toward their patient. Narrative practices lend tested methods of teaching and learning to clinical encounters. They develop skills in the socio-cultural, interpersonal, and inner dimensions of clinical work. Framing healthcare as an undertaking requiring narrative competence helps us to formulate answers to long-standing questions about how to teach and practice professionalism, therapeutic relationships, self-awareness, and reflective practice (Charon 2012, p.343).

Despite the praises and extensive acknowledgment of benefits in using narrative in healthcare, there is strong resistance and inevitable criticisms by skeptics. One of the disparagements for the uses of narrative medicine, is presumed inability to utilize this practice in real time. A study by Morris in 2008 shares commentary by physicians to a non-physician writer-scholar affiliated with the program. When questioned about narrative practice, the physician

answered: “What you say about narrative is very interesting, but I have seven minutes per patient. End of story.” (Morris, 2008, p.89, para 3).

After the 2009 publication of Charon’s *Honoring the Stories of Illness,* a critic had the following critisicms,

> “Though the book is resolutely earnest and enthusiastic in tone, refreshingly encouraging and wishing and willing to better the practice of the profession, the amount of time spent circumnavigating — or validating — narrative medicine through the pertinent theorists is best suited to the academic physician charged with teaching students and is of little relevance to the most obvious audience, namely family physicians.”

He further commented that the practice was not novel nor new,

> “To the average clinician, the main message is the simple (and not necessarily new) idea that in writing about what one knows (one’s own experience) one discovers what one actually knows, and in writing the approximation of a patient’s experience and moving emphatically closer to the patient, one cannot help but improve the relationships of one’s practice.”

Lastly, he discussed Charon’s denouncement of detachment as a means of self-preservation in the statement,

> “The book outright dismisses detachment as a strategy of self-preservation. Yet I believe there is a place for detachment in medicine; there is such a thing as the catharsis of burnout, and by using a one-size-fits-all approach the authors fail to recognize that self-preservation is sometimes saying, I am not of this, it is not me.”(Neilson 2009, p.182)

Concern about time restrictions is a frequently shared sentiment among clinicians in the face of managed care and insurance-based medicine practices. In addition, detachment often becomes a protective device against the moral injury incurred when practices are incongruent with the value systems that our clinicians possess internally. Proponents of narrative practice would argue that these are the precise reasons why we need to assure that the patient/clinician stories of narrative practices be embraced and heard.

At its best, narratives can repair the predominant theme of the patient and family as the "other" which disconnects clinicians from the stories of our patients. In an account of appreciative inquiry and self-disclosure practices by Inui and Frankel, narratives are discussed "as a way to develop a robust appreciation of patient interactions and understanding of self that fosters the practice of medicine". It is suggested that practicing physicians and trainees alike must confront the challenge of acknowledging and connecting to otherness or difference in patients and in themselves, and practice in a way that can help to bridge the gaps between self and other (Inui & Frankel 2006, p.416).

Within the world of narrative medicine, use of the practice is currently expanding beyond medicine alone, and has been embraced by many healthcare professions, including nursing. Nursing has long been known as the caring profession in healthcare. The nurse's notes or nurse's narratives have been used for generations as a way to tell the story of the patient and to promote healing. In the last decade, there has been a loss of the nurse's narrative with the upsurge of the Electronic Medical Record (EMR). Our stories have become lost in a sea of checked boxes that does not allow for individualization or personalization of the patient, nor the acknowledgement of clinicians as an integral part of the patient's story. In light of this epidemic, it is pivotal that we return to a practice that embraces story as a way of reflecting and learning.

Reflective Practice and Narrative Pedagogy in Nursing Education

"Narrative pedagogy has been developed in nursing over the last decade as a means to complement conventional content and to evaluate competency. It focuses attention on the human experience of healthcare by deriving shared meanings from interpretation of stories. This allows students to explore the different perspectives of those involved. The emotional experiences of participants can be understood, conventional wisdom challenged, and new knowledge emerge, as students work together to construct their learning. Individual stories are embedded within the narrative, and teachers have successfully used literature and film as narratives to help them explore the meaning of healthcare with their students" (Walsh, 2011, p 216).

"Reflective supervision is a specialized approach to supervision that is essential to infant mental health (IMH) practice, a relationship-based approach to working with infant and toddlers and their families. This unique approach is rooted in reflective practice, which has been cited as an important component of social work and practice education (CSWE in Educational policy and accreditation standards," (Shea 2019 p. 61). This construct serves as part of the theoretical framework in Narrative Consultation. The field of Infant Mental Health (IMH) that flourished out of Michigan, was based on a parallel process; where the relationship of the facilitator with their supervisee or consultee works in tandem with the work that the supervisee does with the family they are working with. In this context, these learnings from the IMH world are instrumental to any practice being brought forth to the frontlines of healthcare where clinicians work directly with infants and families, especially in times of great stress and trauma.

The centrality of reflective practice encompasses the idea that attention to all relationships is required to understand how they may be impacting how we care for others (our patients). Rebecca Shamoon-Shanok states, "When reflective practice is going well, we are creating a

holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences" (Shamoon-Shanok, 1992, pg 37-41). Facilitators place emphasis on the ability to listen and wait for the participants to express thought and feeling. Opportunities are needed for professionals to increase self-awareness by identifying and addressing personal biases in the context of a safe "relationship for learning." This increased self-awareness is critical for providing culturally responsive services and affects how we may be intentionally or unintentionally affecting the families we care for. (Michigan Association for Infant Mental Health Guidelines, rev. 2018, https://mi-aimh.org/)

Through ethnography, interview, and lived-experience, a picture of how occupational stress impacts the ability to effectively care for families, and the need for reflection, begins to emerge.

History of Occupational Stress and Disruptions in Teamwork on Clinical Frontlines

Narrative Example

An excerpt from a narrative written in a Narrative Medicine Workshop/2016: by Suzanne Milkiewicz-Bryjak. Taken from journals and memories.

I Remember… the Breaking of a Nurse

Panic. Shame. Who do I go to for help? I watched the blood pulse back slowly through the umbilical catheter and I flushed it back into the abyss of the baby again. My mind raced to the critical eyes all around me whenever I asked for help. The sharp sting of their comments and eye

rolling swarmed through my mind. I thought back and remembered the time my preceptor (nurse trainer) had me call the doctor for a baby I observed breathing fast with some pauses. She said "If you think this is a problem, then call." She was testing her new nurse orientee. It was 3am and I woke the doctor who screamed at me that "periodic breathing" was normal at this stage for a preemie. I cringed as she screamed "look it up!" and my nurse preceptor laughed in the background with other nurses.

I was tired. Working nights was clouding my mind, but I was not unlike most new grads that had to work nights. I was physically tired and mentally exhausted. My mind swarmed to all of the tasks and charting I still had to do. I couldn't keep up, much less read about anything. I hadn't had a didactic course, it wasn't offered by this hospital and I only have two weeks orientation on day shift so I was too tired from working full time nights to read or comprehend anything during the day. I looked down and the blood pulsed back through the line… again. I knew I had to fix this but how? I didn't know where to start. I watched the vitals on the monitor fluctuate and the quickening beat of his heart matched my own terrified pulsations that were pounding through my entire body. Sweat beaded on my brow as I looked through the room for a friendly face. It was a very busy night so even some of the kinder nurses all had twisted faces tonight. I flushed the blood back in to the abyss…into the baby…oh, my God, this is a baby! This is a person. Be brave, I told myself, be brave for him. I called out "Can anyone help over here?" Either they pretended to ignore me or really didn't hear me. I was new to the NICU, without a friend or teacher in sight. If I was honest with myself, I would realize that I was a failure as a nurse. I didn't know anything and never would. Why did I have to ask so many questions? My curiosity and quest for knowledge put me in the place of ridicule. I didn't realize that my questions were so stupid until they came out of my mouth. One time in report I was told that a baby had

TTN. "What is that?" I asked. "What is that?" If you don't know just go home!" I was told by a nurse. "Transient Tachypnea of the Newborn" she laughed. They often played jokes on me and because everyone in the room laughed so hard, I wasn't sure if this was one too. "Is that a made up name?" I asked innocently. "Are you joking?" They weren't joking, I thought. I was the joke.

The monitor alarms shook me back into the present. The blood was back again. Where was this leak coming from? I checked all connections, traced the lines. "I need help." I yelled out louder. One nurse glanced my way. "I can't get there right now. Clamp the line if you have to." I wanted to run away screaming. My head was pounding. "Oh my God please help me." I prayed inside my head as a seasoned NICU nurse arrived and thrust me aside. She shut off the alarms, and surveyed the bed. I did as well and saw this tiny life, born with only 24 weeks in the womb, only one pound, with more wires and tubes than you had enough fingers to count. He was dependent on an exhausted, panicked, untrained nurse. The real nurse to my left furiously worked to change the tubing on the baby. Now, as an experienced nurse, I know that the transducer was cracked and the line would continue to back up until changed, but she didn't explain what she was doing, just tossed the other line in the trash and talked under her breath, "I don't have time for this shit!" I replied "Thank you" and she spat, "You better call the doctor and get some antibiotics and tell them what you did!" Problem was, I didn't know what I did. I only knew that I felt trapped. Trapped in this world of pain. Pain for my patients, pain for me and I was so afraid. Why didn't I know what to do? I was so ashamed. From now on I won't sleep at all. That is the answer. I will read everything I can get my hands on but right now I have to get through the night. I have to continue on through the glares and eyes that narrowed at me. The whispers I heard when I tilted my ears toward the corners of the room. I stared at the small baby in my care. "I'm so sorry", I mouthed silently, a lump in my throat that would have subsided to tears if I hadn't been

dehydrated from being on my third 12 hour shift without breaks. How could I come back for a fourth tomorrow? I thought about the baby's chance of survival at 24 weeks and hoped I hadn't done anything to add to those terrible odds. I silently mouthed, "If I could die in place of you right now I would. Death seems so much less painful than being here." I looked at the small boy's furrowed brow and asked him, "Do you feel that way too my little friend?"

Occupational Stressors in Nursing

The effects of occupational stress in nursing have been the topic of focus in many professional organizations and governing bodies within the profession in recent years. The narrative above allows the reader to step into the world of a novice nurse in charge of a neonatal intensive care patient. It provides a phenomenological picture of what her experience looked and felt like while enduring multiple occupational stressors.

In July of 2016, the Critical Care Societies Collaborative released a call to action to promote research, understanding, and advocacy related to burnout, compassion fatigue, and the associated and causative factors and consequences (Kelly, 2017 p.439). In healthcare settings, the consequences of these occupational stressors have been found not only to be detrimental to the individual, but to the hospital systems in general. According to the PRC marketing Nursing Engagement Report of 2019, 15.6% of all nurses reported feelings of burnout, with the percentage rising to 41% of "unengaged" nurses (https://nurse.org/articles/nurse-burnout-statistics/). Burnout is defined as a person's inability to relieve the physical and mental symptoms associated with unrelenting stress. It can manifest as poor job performance, impersonality with patients, and lack of motivation. Health problems such as high blood pressure, insomnia, depression, or addiction can also be signs of burnout. Compassion fatigue, the precursor to burnout, is defined as emotional

distress leading to apathy, brought on by the trauma of constant care for others, and it will be experienced by almost all healthcare workers at some point in their career. It has been called "the cost of caring" (Mathieu, Francoise, 2005, p.110-11).

High levels of absenteeism, low morale, mental fatigue, and exhaustion can be seen due to the nature of the hospital environment, particularly intensive care, secondary to the emotional labor of the lived experiences staff bear witness to, combined with the highly specialized care that is needed for both the patients and their loved ones.

In the NJ State NICU collaborative meetings of 2014-16, research was cited comparing the stress and index for error in Neonatal Intensive Care Unit staff to that of nuclear submarine barge personnel and air traffic control. Hospital organizations have moved to use similar frameworks as these industries, known as high reliability organizations (HRO). Within this framework, it is contended that safety, patient experience outcomes and quality are all directly related to the mindful work engagement of the staff (Veazie, 2019). It is pivotal to understand the correlation between nurses' experiences and the prevalence of occupation stressors in the workplace and our patient outcomes. Job satisfaction, emotional support, and self-care are known in the literature to combat these occupation stressors faced globally by nurses, especially in certain specialties, including NICU. Factors observed in NICU that continue to impact nurse self-care include long work hours, decreased staffing, increased workload and responsibility, ineffective grieving processes, and inability to process the emotional components of their work environment.

Lateral Violence or Workplace Bullying as an Occupational Stressor

Lateral violence (LV) is characterized as destructive acts, either intentional or unintentional, that are meant to harm, humiliate, and intimidate another group or individual. They are usually repeated behaviors that have the effect of creating an environment of hostility (Sincox

& Fitzpatrick, 2008, p. 8). When left unrecognized or allowed to continue in our units, the severity and prevalence of these behaviors often increase. The effects of these behaviors in Neonatal Intensive Care Units compromise the health, well-being, and safety of all staff, families, and patients. Consequences of lateral violence have been demonstrated in literature to include absenteeism, low self-esteem, high staff turnover, negative patient outcomes, and a toxic work environment (Embree, 2010, page 1-2).

Effects on the Victim

For years, lateral violence was an entity thought to only affect the staff and was treated as a "rite of passage". But more recent focuses on this topic in nursing literature have proved otherwise. The list of physical and psychological effects stress caused by LV can foster on the victim is impressive. It includes headaches, stomach disorders, weight changes, hypertension, cardiovascular disease, anxiety, panic, anger, embarrassment, depression, insomnia, fatigue, and rumination, possibly leading to PTSD (Post Traumatic Stress Disorder) (Sincox & Fitzpatrick, 2008, p. 9). As seen in the narrative on page 19, many of these effects were present during the incident of "delayed response" to assisting a new coworker, which is a frequent form of LV. In addition, Maslow's hierarchy of needs assumes that basic needs must be met before learning, which makes learning most achievable when threats to self are minimized (Reed, 2013, para 6). In this way, it takes much longer for victims of LV to learn new skills which are essential to new nurses.

The numbers of those touched by LV from a nursing standpoint are staggering. It is impossible to pinpoint the cascade of effects on patients and families. The Institute for Safe Medication Practices conducted a study in 2004 which cited 2095 healthcare workers. 48% reported being subject to verbal abuse, 43% reported threatening body language and 4% reported

physical abuse (Hughes, 2009, p. 182). Another study done with 26 new registered nurses in the Boston area followed them throughout their first year of practice and discovered the following: 96% had witnessed LV in the unit, 46% said it was directed at them. Four out of the 26 nurses had considered leaving the profession due to LV. (Reed, 2013, para 9)

As evidenced in the nurse's narrative on page 26, the stress of her perceived workplace bullying, whether intentional or imagined, affected her ability to develop trusting relationships, and impacted her ability to effectively care for her patients. This theme was reoccurring in the interviews conducted with frontline staff. A nurse in a 2016 qualitative study on lateral violence in the Valley Hospital reported the following (Milkiewicz-Bryjak 2016):

> "When I was trained I was trained as a nurse 40 years ago. I went to a hospital school and lots of punishment was inflicted on the nurse, on the student nurses and we had high attrition rates. We started out with a 100 students and graduated 35, and it was brutal. I then went to work at a Catholic Hospital where they followed a very similar type of – I felt like I was joining a bad sorority, there were clicks, there was name calling, there was all kinds of lateral violence that was – it was pathologic- I was floored. I grew up in a big family where everybody fought and if you weren't on top you were on the bottom, so that just worked really well in the nursing setting in that particular hospital. I see it in the hospital that I am working at now, it's more subtle than it was there, but I see it nonetheless and it's hard not to slide into those behaviors yourself, because there is a visceral when you feel that you are under threat it's only human nature to -- it's human nature to want to protect yourself. So that's just -- it's a skill that I am still working on."

The nurse describes the development of her career in nursing with a consistent theme of workplace bullying that occurred throughout her practice. She discusses its origins in relation to her familial life and ends with controlling the behavior as a "skill she is still working on." An awareness is reached through the dialogue of the interview that may be a parallel in narrative practice.

Narrative practices may be a way that we can look at the phenomenon that occurs in clinical practice, such a bullying or the perceptions of bullying, through a more neutral lens. Utilizing works in the humanities, (literature, poetry, art) as a guide to opening up conversations and issues such as these, may increase awareness and perspective.

The Effects of Occupational Stressors on Nursing

It is estimated by the American Association of Nursing Colleges that a nursing shortage crisis will be approaching within the next 15 years that will be twice as serious as the shortage of the 1960s. During that time, baby boomers will retire, and healthcare needs will increase. The patients in our hospitals are sicker now more than ever before. Anyone who has ever had a loved one in the hospital will testify to the value of having a good nurse. They will likely also attest to the workload that they have observed as nurses struggle to care for their patients. The public know these truths through research and practical observation. They also know of the importance of the impending nursing shortage. The fact that may not be as evident, is that many of our frontline hospital staff are leaving the bedside due to burnout and fatigue, and our new nurses are at highest risk. The literature on compassion fatigue and occupational stressors in nursing has shown that nearly 20% of nurses leave their positions in their very first year, and many recent graduates leave nursing altogether (Kelly, 2017, p443).

Nurses who lack the space to process trauma often succumb to compassion fatigue as a form of self-defense. National data on divorce in professions, collected by the Psychological Institute of Police and Criminology in 2009, reported nursing as one of the top professions with marriages ending in divorce. Ethnographic notes share a nurse to nurse communication:

"After a 12 hour shift caring for others, you just don't have anything left to give"

Practicing fulfilling family relationships was cited as one of the top ways to reduce stress in nursing according to The Birchtree Center for Healthcare Transformation (Andrus, 2014, p 20-21). This reality of divorce in nursing can make it challenging to practice in fulfilling family relationships. Other known problems within the profession include chronic fatigue syndrome and chronic pain issues with the potential for substance abuse. These outcomes need to be examined in relation to occupational stressors, and tools for examination of our familial relationships and reactions to stress could be helpful in understanding correlations.

Emphasis on the need for emotional support and wellbeing is essential, especially in high stress areas such as NICU. Programs such as "We Grieve Too", given by the NJ Maternal and Child Health Consortium, address the grief and trauma that often goes undetected in perinatal and neonatal loss. Hospital run debriefs are often procedural and rarely address, or skim the top of, the emotional labor and trauma experienced by NICU staff when a death or adverse event occurs. Regular practices of supportive circles where staff can be heard, such as "Reflective Supervision", are practical ways to address work trauma in critical care areas, but they are not common practice in nursing, particularly in the United States. These types of circles are common practice in other caring professions such as social services, but are widely unavailable to frontline nursing and clinical staff. The need for additional counseling to avoid progression to Compassion Fatigue or Burnout can be assessed regularly at such sessions. The basis of this Infant Mental Health Model

and reflective work with staff, is a key component to the construct of narrative practice utilized with staff in our study. The sensitizing framework and its core elements are looked at in depth in future chapters.

In order to ensure the sustainability and success of any intervention, there must be investment in the follow up and continuation of the instituted practices. In the ethnographies and Phase One interviews a nurse reports having seen various models of practice focused on self-care of nursing. She refers to self-care as:

"trendy practice that goes in and out of fashion. With budget cuts and staffing cuts, breaks are no longer the priority".

Embracing the practices of nurturing the staff will demonstrate the value that an institution places on their nurses, and the return on investment can far exceed what is put out in efforts to sustain these nurse centered programs.

Research has demonstrated that inexperienced and younger nurses can be at increased risk for occupational stressors and may experience the secondary traumatic stress of caring for patients and families who are directly experiencing traumatic stress themselves. Secondary traumatic stress is an occupational hazard for healthcare providers who care for patients who have been traumatized. In a study with a sample of 175 NICU nurses, 49% of the nurses' scores on the Secondary Traumatic Stress Scale (STSS) indicated moderate to severe secondary traumatic stress (Beck, et al 2017, p.488).

As referenced in the nurse's narrative on page 26, there is a time of realization in a novice nurse that one's action or inaction creates a stream of consequence for the patient in one's care. This realization and responsibility can be traumatizing if the skills to handle these situations are

not offered either by the employer or other venue. Care of the emotional and physical needs of staff is pivotal in our patient outcomes. As mentioned above, the public may know the importance of a nurse but may not realize that there are many other reasons to care about the physical and emotional state of our nurses, like the care cascades or ripple effect that result from a nurse who is negatively impacted.

It is likely that most NICU patients have been in the care of a nurse who has worked three or more 12 hours shifts in a row, an overnight shift where the nurse had less than four hours sleep, or had some form of emotional work-related distress on their shift.

In the opening nurse's narrative, the repeated long shifts, lack of sleep, and perception of her co-workers were looming factors in her feelings of ineffectiveness. Seen through exit interviews with NICU families, the predominant memories parents have of nurses in NICU are of the importance of the nurse being compassionate and intuitive over being skilled. The overall attitude is one of reverence for the profession of NICU nursing. Many feel that nursing made the greatest impact on their child's wellbeing in NICU. Despite the feeling that nurses made the greatest contributions, there are also stories of the things that nurses had the potential to do better. There are stories of a knowing that torticollis or neck muscle stiffening, which requires months or years of therapy, could have been prevented by simple positioning. They know that patience and time with a baby's feeding could have made days or weeks of difference in length of stay. That emotional support and compassion could have eased emotional distress of the family and possibly prevented many traumatic memories. These examples have all been recounted as memories of "issues with nurses" in the NICU. These are the potential results and cascades of the care that wasn't received, but these effects aren't always recognizable as directly related to nursing occupational stress issues. When we ask a nurse to work four 12 hour shifts back-to-back, ask for

excessive overtime, and for them to work overnights without nap breaks, and especially to work in an emotionally charged area without appropriate supports, we are allowing trauma to take root in our staff. This directly impacts our patient and family outcomes. We must examine these issues and their root causes in relation to our outcomes data. Nursing has looked at studies of medication errors, cognition of exhaustion, and even studies on potential for Motor Vehicle Accidents (MVAs) in exhausted nurses. But it is the indirect cascades of care that happen every day that are a reason to address this problem with urgency. Examining stories may be a way to both give voice to our frontline staff, and to examine the narrative through many lenses, including patient experience, safety, quality, and how this relates to the caregivers work experience.

Narrative as a Construct to Address Compassion Fatigue

The article, "Compassion Fatigue: A meta-narrative review of the healthcare literatu*re",* by Sinclair et al. in *The International Journal of Nursing Studies* from January 2017, is a compilation of 90 studies in nursing and healthcare on the subject of Compassion Fatigue. Recommendations include encouraging new models that "honor healthcare providers lived clinical experiences" and look at an "interaction of factors that affect a provider's ability to give compassionate care". Its conclusion is the need for "a new discourse on healthcare occupational stress and burnout".

Nurses report in pre- narrative consultation interviews in a 2016 study at The Valley Hospital that Compassion Fatigue is one of the challenges that they recognized in their workplace. Below are two examples.

> "I would say one of my biggest challenges is compassion fatigue that comes especially after working several days in a row, sometimes dealing with difficult parents, and maybe the first day is all hunky-dory but then as they kind of wear on you, you start to get compassion fatigue. It's frustrating for the nurse because you know that you should be kinder, and these parents are suffering really greatly with this experience having their baby here in the NICU. But meanwhile, the pressure on your time and your patience can kind of cause you to not have the kindness that you really should have."
>
> and
>
> "I find that compassion fatigue happens not just after working several days in a row but also when the nurse is overwhelmed and has a lot of demands on their attention at that moment so that's when they can sometimes become snappy with parents. And parents can pick up everything, and even as a fellow nurse I can pick up that this person is really stressed and it's because they might have three patients and they all have IVs, all the IVs need restarting, things like that. It's just -- you know, I think that it's more than just the number of patients, you need to factor in the acuity, things that all take your time and attention so that the nurse can properly give their time and not be overwhelmed and therefore lose their patience say with the families." (N001)

Both of these examples discuss the awareness of the need to support patients and families in a compassionate way. The nurses also discuss the factors that can lead to behaviors that may be signs of compassion fatigue, such as "pressures on your time and patience" related to workload and feeling overwhelmed.

Throughout the literature, there is mention of a potential cause of compassion fatigue being the fear that we cannot relieve human suffering. This has prompted a new way of conceptualizing

my inquiry regarding examining narrative and the benefits of a story that honors both the patient and clinician.

Current Recognition of the Problem and Remaining Gaps

Amongst nursing leadership circles, a movement to stress self-care is becoming dominant. Organizations that include a holistic nursing component are leading the way in practices such as "quiet rooms" for nurses and are stressing the importance of self-care practices, such as proper nutrition and exercise, as well as offering practices like mediation and yoga. However, large gaps remain in the practical application of these modalities when nurses aren't given the tools to apply this self-care. The historical emphasis in nursing had remained on the "other", whether it is the patient, family, coworker, hospital, or the public interest in general. We are motivated as nurses to put the "other" first, and that becomes who we are. It is part of our personhood. An examination of our narrative in relation to caring for self and others could give voice to the importance that we place on our self-care practices.

Jean Watson's Caring Caritas and Current Methods of Healthcare Resilience Training

In the 1990s The Valley Hospital adopted Jean Watson's nursing theory known as The Theory of Human Caring or the Theory of Transpersonal Caring as the foundation for their nursing practice. This aligned with the philosophy of the hospital that was moving toward a nursing excellence designation (The Magnet Nursing Excellence Award) and the concurrent adoption of a holistic nursing collaboration with The Birchtree Center for Healthcare Transformation. The

principles and ideals of the programs and the theoretical underpinnings align to the principles of caring for patient and caring for self, being intertwined.

According to Watson (1997, p.50), the core of the Theory of Caring is that "humans cannot be treated as objects and that humans cannot be separated from self, other, nature, and the larger workforce." Her theory encompasses the whole world of nursing; with the emphasis placed on the interpersonal process between the care giver and care recipient. The theory is focused on "the centrality of human caring and on the caring-to-caring transpersonal relationship and its healing potential for both the one who is caring and the one who is being cared for" (Watson, 1996, p.148).

Watson's patient/nurse centric theory focalized on the interconnection between the quality of patient outcomes in relation to the art of caring. She centralizes the work of Florence Nightingale in many of her writings and brought an age of nursing autonomy and empowerment while connecting to our core caring values. Despite the acknowledgement of these ideals by many leading healthcare institutions throughout the late 1990s and the subsequent decades in the 2000s, there was often a disconnect between theory and practice written into hospital guidelines and award documents and the practices as seen by clinicians on the front lines. Despite these gaps in care for our staff, the centralized message of importance of self gave way for policy directed toward nurse-patient ratios and professional autonomy. The work of Watson was central in nurse empowerment, however, burnout was an entity that was just emerging in prevalence in the literature.

In the most recent decade, an emphasis on resilience as a form of protection from burnout had abundance in clinical journals. A study by Cameron and Brownie identified eight themes that impacted nurse resilience including experience, satisfaction, attitude, faith, feeling of making a difference, leadership, mentors, insights, and work-life balance (2010, p.69-70) and programs concentrating on these areas began to emerge. In 2019, The World Health organization's 11th

edition International Classification of Diseases (ICD), characterized “burnout syndrome” as a diagnosis for healthcare professionals and described care that would be covered by health insurers (https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281). This classification gave way for increased interest in the prevalence of burnout as a whole in the healthcare profession. Just as light began to be shed on ways to bring effective programs to the frontlines, the global pandemic of COVID emerged in early 2020. The recognition of the problem of burnout continues to evolve, and an emphasis on creating programs to address the themes discussed by Cameron and Brownie continue at the forefront. In recent publications that highlight the COVID pandemic, the strain it has put upon the healthcare clinicians has been described. Basic needs such as sleep, work-life balance and acknowledgement of both positive and negative emotions have been identified as the needs to be prioritized in order to begin to address the issues (Bozdag 2020, p.14-15). Many institutions have added resilience training to their online education for clinicians and some have offered webinars. Programs that focus attention on hospital based programs that provide longitudinal support and connection to one another while emphasizing patient/practitioner intersections, may potentially surpass the current model of technology based lectures centered on how the clinician should include the self on their long list of items to care for as they arrive home for the day.

Narrative Consultation, designed and studied at The Valley Hospital, is outlined and described in the next chapter.

Methodological Approaches Studied

A mixed methods approach was followed, consisting of a quantitative and qualitative part. Qualitative research is research that involves analyzing and interpreting texts and interviews in order to discover meaningful patterns descriptive of a particular phenomenon (Auerbach 2003, p.3.). In other words, it is the research on the lived experieince of a person or persons that in turn describes the nature or essence of said person or people. It seeks to dive into *their being* individually and collectively in connection with others in a specific space and time, examining what lies within one culture or setting or in various cultures and settings. Furthermore, there are many variables in qualitative research, and they are not as controllable as they may be in quantitative research. The objectivity of quantitative research makes it desirable to hard and fast scientists and clinicians, but as soon as we study something, it has already begun changing, so there is subjectivity in everything. I would also argue that there is truth in the lived experiences, the stories, and the testimonies of those who share what they know in the name of qualitative research.

Again, as this section opens, *I* must insert myself as the primary researcher and disclose the fact that *I* have come into this project as a keen observer of the NICU environment for over twenty years. Observations are made and biased by my nature or essence, which includes my being as a mother, clinician (who worked all shifts for many years), administrator, researcher, colleague, family support advocate, employee of Columbia University, student of Drew University, and lifelong lover of both reading and writing stories. In the study of Narrative Consultation at The Valley Hospital NICU during a period of change to a new standard of care called Family Nurture Care, which takes place from 2017 to 2020, the research team seeks to

consider and describe the experience of working in the unit before this change in care (including the Narrative Consultation support service), and then seeks to describe the salience of what is said about the experiences afterward. We seek to identify theoretical constructs and frameworks within the experiences that describe what is helpful and what "needs further study". This practice has been developed over twenty years of lived experience and didactic education, including almost a decade of graduate study. The practice is personal as it is born out of promise "to remember" the experiences of having a son in the ICU, and how that intersects with the experiences of the staff.

An intern working on data reports her bias as being informed by disclosures of some of the focuses of the researcher. She names those foci as burnout, work engagement, teamwork, and empathy. In the quantitative study, we use validated scales designed for these unique purposes, however that is not qualified as bias. Although qualitative research is part of my being, my vulnerabilities (and the vulnerabilities of others) keep me defending its rigor and meaning. In a meeting at Columbia University, a renowned social scientist dismissed qualitative research, saying that "it was just a less rigorous way to look at things that ends up quantifying results in percentages in the end." My interns looked at me in dismay.

Sandelowski, Foils, and Knafl posit that the theoretical appeal of numbers – their cultural association with scientific rigor and precision- has served to reinforce the necessity of converting qualitative data into quantitative data (2009 p. 208). Qualitative studies typically seek to answer questions about the 'what', 'how', and 'why' of phenomena. This is in contrast to the questions of 'how many' or 'how much' that are sought to be answered by quantitative research, including epidemiologic studies and clinical trials. A common distinguishing feature of qualitative research is that studies often aim to explore and understand, rather than measure, phenomena and behaviors (Green & Thorogood, 2004, https://www.qualitativeresearch.net, sec 2 para 2). The goal of *this*

researcher is to describe an experience while inserting my being as both bias and part of the knowledge and asset of this study. The team seeks to collect descriptive knowledge utilizing several approaches.

The first, Ethnography, is described in Chapters Four and Five, and inserts the researchers into the culture of the NICU with the purpose of collecting field notes and videos. The two approaches that are discussed in the analysis section are the utilization of Grounded Theory hypothesis coding and a phenomenological lens.

Ethnography

Ethnography is a research strategy that allows the researcher to explore and examine cultures, a fundamental part of the human experience. Unlike other scientific research strategies, ethnography collects data from firsthand participant observation, and has direct involvement with the relevant community, which can take the form of personal conversations, interviews, and emotional experiences (Murchinson, 2010, p. 4). Anthropological ethnography emerged in the late 19th and early 20th centuries as expanding territories preempted the study of foreign cultures. Anthropologists such as the American Clifford Geertz, who studied symbolic anthropology, and Polish ethnographer, Bronislaw Malinowski, who is credited with "open-air" ethnography (Van Maanen, 1992, p.16) paved the way for the field where their work, in which they lived side by side and participated in a culture in order to learn more about them, created a new form of research. Sociologists soon took up ethnographic practices in America, and The Chicago School of Urban Ethnography was the main force behind this form of study just prior to and during and in the post-depression era.

Medical ethnography is still relatively young, having been around for just over 50 years. Landmark studies include Fox's *The Student Physician* in 1967, and Pugsley's *Boys in White* in 1961, which both examine medical school experiences. Van der Geest and Finkler suggested the use of ethnography in the hospital setting in their 2004 article in *Social Science Medicine*, and state that hospitals are unique communities that reflect dominant cultures and belief systems that are not always clear to the naked eye (Goodson, Vassar 2011, sec 3, para 5). The ethnographer is required to have a deep understanding of the questions at hand, and the ability to "live" or "work" in the field along with the subjects in order to become part of the environment.

The fundamental idea of ethnography is to create meaning by giving context and process to the lived experiences that are observable within a culture. Part of the work of the ethnographer is to study the social construction of place and space within a structure. Understanding the different conceptions of patients, families, and various staff within the hospital setting can further the understanding the different perspectives of place and space within the hospital environment. A working definition of social construction of place and space includes the transformations and contestations that occur through people's social interactions, memories, feelings, imaginings, and their use of the meaning that they give to one particular place or space (Low, 2017, p.8)

An interesting example of this in the Neonatal Intensive Care is bed space that may be assigned to an infant. The meaning of the space takes on a different life to each individual. To the family of the infant, the stories that are heard from staff shape and mold their experience as much as their individualized experience does. Staff may have had positive or negative experiences in that bed space that impacts the meaning that they assign the space. In most units, there is one or more spaces assigned to the sickest baby in the unit. In an interview with a NICU mother, she states that her baby was put in this space because it was closest to the doctor's on call room, and

the “sickest” babies went there. This helped shape her understanding of the illness of her infant. In a separate observation, a nurse is observed telling a colleague that she refused to move a baby to another space in the unit because it is isolated and she “never gets help” in that spot. Weeks later, another nurse is observed stating that she refused to move her assigned infant to a space because “all of the chronically ill babies go into this spot and they all end up with long-term feeding tubes”. She further states that she “would not be responsible for adding to the chances of that outcome for this infant by moving him to this space”. Unit superstitions and folklore, as well as historical known truths play a large part of the daily operations within a unit, and an understanding of space and place is an important tool in the ethnographer’s toolbox.

Phenomenology

Max van Manen, considered by many to be *the modern Father of Phenomenological Research* writes, “Phenomenology, if practiced well, enthralls us with insights into the enigma of life as we experience it—the world as it gives and reveals itself to the wondering gaze—thus asking us to be forever attentive to the fascinating varieties and subtleties of primal lived experience and consciousness in all its remarkable complexities, fathomless depths, rich details, startling disturbances, and luring charms. Genuine phenomenological inquiry is challenging and satisfying precisely because its meaningful revelations must be originary and existentially compelling to the soul.” (van Manen, 2017, p.779). A common accepted definition of the practice comes from the Stanford Encyclopedia of Philosophy, “The discipline of phenomenology may be defined initially as the study of structures of experience, or consciousness. Phenomenology is the study of ‘phenomena’: appearances of things, or things as they appear in our experience, or the ways we experience things, thus looks at the meanings things have in our experience. Phenomenology

studies conscious experience as experienced from the subjective or first person point of view" (Smith, 2018, p 8).

The final theoretical analyses are interpreted in the context of Phenomenlogy due to the nature of this work, and the conclusion that in the end, the mechanism reveals itself within the experience. Martin Heidegger's famous definition of phenomenology is "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heideggar, 1962, p. 58). Heidegger's approach is not inconsistent with the fundamental idea that phenomenology is concerned with what gives itself. Leading phenomenologist, Jean-Luc Marion (2002) stresses again that phenomenology is the study of how things show or give themselves. He points out that things do not show themselves because we turn to them—When things show themselves, they can only do so because they have already given themselves to us (vanManen, 2017, p. 810-811).

Through the construct of Narrative Consultation, vulnerability shows itself. Vulnerability emerges as a point of communication with self and others, explored to manifest co-constructed learning based upon shared values and shared challenges. Over and over in theoretical saturation it emerges and shows itself and is seen and felt as itself and gives of itself to the participants.

Chapter Two: The Construct of Narrative Consultation in the Neonatal Intensive Care Unit and the Study Design-(The Construction and Approval of the Research Protocol)

As part of preparation for the research study, an Institutional Review Board (IRB) protocol was drafted and submitted for approval at two individual instituions. The first was through the Western Institutional Review Board at The Valley Hospital where the procedures would take place. The second protocol was approved through Columbia University's RASCAL who served in sponsorship and analysis. WIRB Approval Protocol #20173010 and RASCAL IRB Approval Protocol IRB-AAAR7432 were given prior to commencement of any study procedures. The following outlines the comprehensive protocol that was written and approved for both institutions.

Background

The Neonatal Intensive Care Unit (NICU) is a stressful work environment in which staff may experience burnout and compassion fatigue. Its fast paced nature, changing workload, need for critical thinking in intense situations, and the continual demands for expert communication, empathic responses, and emotional intelligence during interactions with both patients' families and co-workers, all contribute to this stressful environment. In addition, technological, administrative, and policy driven changes are occurring rapidly and simultaneously around the aforementioned stressors without an outlet for clinicians to process their daily interactions and reflect upon their meanings within their professional and personal verves. During times of transition and change, it is especially important to incorporate the use of a systematic support for clinicians in order to successfully incorporate the change and assist with adoption of new programming or policies.

Burnout is a response to workplace stress that results in emotional and mental exhaustion, depersonalization, and decreased sense of personal accomplishment. Nurses account for up to 80 percent of hospital frontline staff. Burnout rates are reported to be near 83 percent for ICU nurses

after five years of practice, and this burnout has been proven to have a significant effect on patient outcomes and safety initiatives such as infection prevention (Cimiotti, 2012, p.487, 490).

The effects of nurse burnout and stress are reported to be prevalent in the Neonatal Intensive Care Unit (NICU). These include elevated levels of absenteeism, low morale, mental fatigue, and exhaustion, which all can have detrimental effects on neonatal care. Electronic health record use was also shown to be associated with higher burnout prevalence in NICU (Tawfik et al, 2017, p.4). The nature of this highly specialized form of nursing may cause NICU nurses to experience high levels of psychological and physical stress (Braithwaite, 2008, p. 343). Compassion fatigue, the precursor to burnout, is defined as emotional distress leading to apathy brought on by the trauma of constant care for others and will be experienced by almost all healthcare workers at some point in their profession (Mathieu, 2014, para 3). The intensity of the interactions in NICU take an emotional toll on the staff in NICU and stress scales of NICU staff rank consistently high in the profession (Braithwaite, 2008, p. 343). Current literature in a meta-narrative review of 90 studies in nursing and other healthcare professionals, calls for a new discourse that looks at the distinguishing characteristics, motivators and outcome responses of occupational stress and burnout of healthcare providers. Recommendations included encouraging new models that honor the healthcare providers lived clinical experiences. (Sinclair et al., 2017, p. 21). Narrative Consultation is a construct designed to meet this need and to be utilized with frontline clinicians.

Hypothesis: Narrative Consultation as a Construct to Address Occupational Stressors and Facilitate Change

Narrative Consultation is a process that can be used to support employees and facilitate successful uptake of change by giving voice to those on the frontlines. Narrative pedagogy is grounded in story and is known as community interpretive scholarship or community reflective scholarship (Diekelmann, 2001; Diekelmann & Ironside, 2002, p.380) Although interpretive storytelling goes back to the roots of mankind and is located centrally in the histories of both medicine and nursing practices, it is currently considered an innovative form of learning in both medical school and nursing program curriculum. The emergence of the medical humanities and narrative has been embraced in scholarship as a means for students to gain insight and perspective into future clinical practice. Currently, however, frontline clinicians have limited (or no) exposure to this pedagogical construct/tool through which they – and subsequently, their patients and families - may derive many benefits. A consistent narrative practice would strengthen this concept, as well as potentially address occupational stressors such as burnout; narrative consultation is hypothesized to be a construct that fills these needs.

Narrative Consultation engages perspective through reflection to build a phenomenological picture of experiences in the unit. The consultation sessions utilize medical humanities, holistic nursing theory, and reflective practice, which all focus on the theme of narrative practice and the patient's story. In an era in which the electronic medical record has reduced our stories to a narrative of checked boxes, it is imperative to return our frontline staff to the practice of examining patients' stories and embracing our role as a pivotal part of their narrative. In addition, this practice of giving voice to our frontline staff and hearing the challenges and triumphs of clinical practice has been utilized to aid in safety and quality improvement in our hospital units. Safety stories have been discussed in frameworks such as the high reliability organization (HRO) (Hayes & Maslen, 2014, p. 714).

Narrative Consultation gives participants a platform to be heard and to examine their own belief systems, in order to develop trusting relationships and improve care. It can also give nurses the tools to deal with the ethical dilemmas that occur within the unit. We also hypothesize that it may be used as a tool to include staff in the implementation of structural change. Goals of the sessions revolve around what health and healthcare may mean to the individuals and families that clinicians are trying to serve. In order to provide holistic care, they must be attentive to the patient's story as well as their own narratives within their story. The ability to connect with this understanding of perspective can be accomplished within the field of Narrative Medicine, and it is gaining strong evidence of its utility within the medical fields (Charon, 2006; 2016).

Research Design: The Narrative Consultation Study at the Valley Hospital

A unit-wide change in the standard of care has been implemented in the Neonatal Intensive Care Unit in The Valley Hospital in Ridgewood, NJ. While encouraging results have generally been demonstrated with this approach, a change of this magnitude unit wide dissemination may be stressful for staff. Nurses must constantly adapt to a variety of radical and incremental changes in the way they work, but their emotional responses can inhibit changes from being sustained in practice. "Implementing sustainable and meaningful change means supporting each individual to find value in new ways of working" (Bowers, 2011, p.19). Changes in the workplace naturally create uncertainty and can be emotionally challenging for employees. Change, particularly when it is unexpected, can undermine confidence and threaten sense of purpose (Holbeche, 2006, p. 71). Staff participation in constructing change is pivotal to decreasing the resistance an organization is met with (Curtis and White, 2002, p.20).

It was hypothesized that the transition to a new NICU-wide standard of care, Family Nurture Intervention (FNI) at The Valley Hospital as part of an effectiveness study (AAAR4899), may alter the work environment. Designed to facilitate emotional connection between mothers and preterm infants, FNI has been demonstrated to improve outcomes for dyads receiving individualized care. However, the impact of unit-wide implementation on NICU staff has not previously been evaluated. Staff may need support to transition from long-established protocols to the revised FNI approach. Narrative Consultation, a practice grounded in holistic nursing, medical humanities and reflective practice, could be a suitable means of providing support for front-line clinicians, during the transition to the new standard of care.

Research Question

The overarching goal of the study is thus to characterize the effect on perceived workplace environment among NICU staff during the transition to Family Nurture Intervention, a new standard of care while utilizing Narrative Consultation as a support construct for clinicians during this time of transition.

Objectives

The study has two related objectives:

a) to describe the effect of the transition to Family Nurture Intervention on the perceived workplace environment among staff in the NICU

b) to assess the effect of Narrative Consultation, experienced during the transition to Family Nurture Intervention, on perceived workplace environment among NICU staff.

Methods

A cohort study has been conducted among nurses and support staff employed at The Valley Hospital NICU during the associated FNI effectiveness study. Participants are assessed both prior to and following the first six months of FNI implementation. Those who self-select to receive the Narrative Consultation intervention constitute the 'exposed' group, while those who opt out serving as the 'unexposed' (control) group. Workplace environment is assessed quantitatively with standardized instruments measuring burnout, empathy, interpersonal functioning, and teamwork, as well as qualitatively via semi-structured participant interviews, and ethnographic observation and video recordings of the unit. Feedback from participants in the intervention group is used to assess the utility of the Narrative Consultation method in this setting. Staff and family in the unit are approached for consent for videography, photography and audio prior to initiation of ethnographic video. All staff and family are notified of the uses of the video, and should they choose not to participate, their images and audio are skewed to protect their identity.

Background

Specific hypothesis related to the aforementioned objectives are listed below:

Objective One: To describe the effect of the transition to Family Nurture Intervention on the perceived workplace environment among staff in the NICU

Hypothesis One: Perceptions of the workplace environment among NICU staff will improve after six months of implementation of the new standard of care, Family Nurture Intervention

Objective Two: To assess the effect of Narrative Consultation, experienced during the transition to Family Nurture Intervention, on perceived workplace environment among NICU staff

Hypothesis Two: Compared with those who opt out, NICU staff who attend Narrative Consultation sessions will demonstrate greater workplace satisfaction after six months of FNI implementation

Study Design

A prospective cohort study has been conducted among nurses and other staff employed in the NICU at The Valley Hospital prior to, and concurrent to, the implementation of Family Nurture Intervention, a new protocol for preterm infant care in the NICU that is being tested in an effectiveness study (See protocol number AAAR4899). In the context of the effectiveness study, participants self-select into (exposed) or opt out of (unexposed) Narrative Consultation group sessions offered concurrently with the first six months of FNI implementation. A mixed methods approach is employed to assess participants' experience of the workplace from baseline through end-line.

Sample

Participants: The Neonatal Intensive Care Unit at The Valley Hospital in Ridgewood, NJ, provides the sampling frame. Fulltime, part-time, and per diem nurses and support staff who have been continuously employed in the NICU for at least six months prior to the introduction of FNI and plan to remain at TVH for at least six months following the introduction of FNI are eligible. While

NICU nurses are the primary target, all staff, including physicians, social workers, therapists (occupational, physical, speech), lactation consultants, technicians, environmental and administrative staff may be included. In addition, volunteers trained by Nurture Specialists and Family Support Specialists to provide support to families in the unit, who spend an average of four hours per week in the NICU, are included. Staff who are not contracted for the entire duration of the study (+/- 18 months), such as agency or travel nurses, and staff working fewer than four hours per week in the NICU, are not ineligible.

Recruitment: Eligible staff are invited to join the study during the six months prior to the anticipated FNI implementation start date. Recruitment ceases once the control phase of the concurrent effectiveness study concludes and implementation of FNI has begun.

Participants are followed prospectively from baseline, i.e., prior to the introduction of FNI in the companion study, through six months following the FNI implementation start date. At enrollment, participants are provided with information about planned narrative consultation sessions and given the option of joining or not joining. Participants who initially opt out are able to opt in at any time prior to the start of the last six-session Narrative Consultation group.

The Intervention Procedure

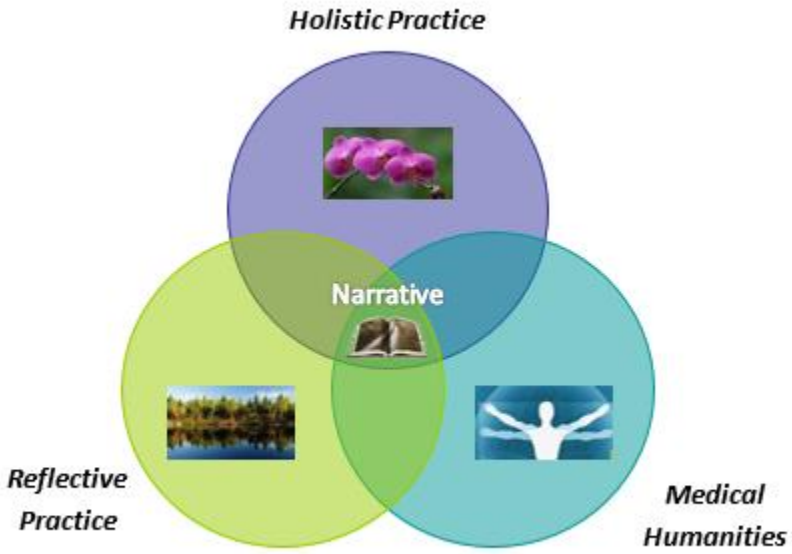
Narrative Consultation sessions are informed by the Narrative Medicine method pioneered by Rita Charon (2006; 2017). Every alternate week for a period of three months, for a total of six facilitated sessions, closed groups of five to six participants engage with a piece of art, such as a poem, painting, or musical item, about which they are prompted to write a response. Writing is followed by discussion of reactions to, and associations with, the object. Links to experiences in the workplace are interpreted where applicable. Participants control the degree to which they share

their reflections. The development of attention, reflection and mindfulness techniques is encouraged. Sessions are conducted by the local PI who serves as the facilitator during times that are convenient for staff (e.g. Saturdays).

Sensitizing and Theoretical Framework of Narrative Consultation

Narrative consultation engages perspective through reflection to build a phenomenological picture of experiences in the unit. The consultation sessions utilize medical humanities, holistic nursing theory, and reflective practice, which all center on the theme of narrative practice, and subsequently, the patient's story.

Figure 1.0



Informed by the work of Charon (2006, 2018), Watson (2009), the Michigan Infant Mental Health Initiatives for Reflective Practice, and other specialists in the sensitizing fields listed below,

the theory blends mindfulness, reflection, close reading, and humanism in practice which all intersect centrally on the narrative of the participants written or described story. Within the clinical practice, there is the story of the patient. Parallel to the story of the patient it is pivotal to understand the narrative from different participants whose perspectives and influences in the conclusions are not often noticed. These other participants may include those who are of influential in the patient's life, including family, the environment, and the clinicians caring for them. As clinicians, we examine who our own narratives which include our values and beliefs, which can impact how we care for our patients. The narrative also allows us to reflect upon practices we engage in which may be outside of our own value and belief systems but are present due to systems or circumstances which cause us to behave or communicate in a fashion incongruent with our true selves. This is where moral injury is born. Examining a multi perspective viewpoint allows for the reflective practice that is pivotal to learning, growing, and processing.

Narrative Consultation Sessions are conducted as follows:

1. Setting the Intention (Holistic Nursing Theory, Watson, 1999; 2009)

   Step one is derived from the Watson Caring Science Center whose goals include advancing the art and science of human caring knowledge, ethics, and clinical practice in the fields of nursing and health sciences. It offers authentic, mindful, Caring Science educational programs and workshops to help nurses, care providers, and health care systems transform from the inside out. This transformation involves a step back to the core values, knowledge, purpose, skill and meaning that honor our commitment to care for our patients and ourselves.

2. Checking in with Participants: Reflections (Reflective Practice Theory, Weatherston, Shea, Goldberg, 2016)

   The Michigan Association for Infant Mental Health (IMH), the leading authority on infant mental health practices, has identified a need for reflective supervision training for infant mental health specialists providing services to highly vulnerable infants and their families. Findings indicate that a pilot of an IMH community mental health professional development model was successful, as measured by the participants' increased capacity to apply reflective practice and supervisory knowledge and skills. Furthermore, IMH clinicians demonstrated an increase in the frequency of their use of reflective practice skills, and their supervisors demonstrated an increase in their sense of self-efficacy regarding reflective guiding tasks. Their evaluation included a successful pilot of new measures designed to measure reflective practice, contributing to the growing body of research in the area of reflective supervision. When facilitating the cohorts, knowledge from reflective practice was drawn upon greatly.

3. The Spark: Sharing of a work obtained from the Humanities. This may be in direct relation to the medical field or taken from literature, poetry, music, or art. In order to open work up to a multi-generational and multi contextual audience, we are incorporating pieces from contemporary media as well.

4. A "close reading". (Medical Humanities, Pellegrino, 2008); Narrative Medicine, Charon, 2006; 2016)

   Medical Humanities is an examination of the use of formal fine arts training in clinical curriculum to enhance diagnostic skills. A great deal can be discerned about pathology and pathophysiology using visual cues. Conventional medical education stresses the

importance of physical diagnostic skills, but often omits explicit teaching on how to methodically observe for information that could be useful for diagnosis. The current curriculum could be greatly complimented by the study of fine arts, which deals directly with the careful observation, description, and interpretation of the visual world. The work of Edmund Pellegrino, commonly referred to as the father of Medical Humanities, is referenced, as is the work of Rita Charon, whose Narrative Medicine program at Columbia University is principal in the field of utilizing narrative in clinical practice education. Dr. Charon coined the term "close reading", which allows for "abstract thought, textual argument, psychological insight and a surrender of being carried away by a piece" (Charon, 207 p.181)

5. The Prompt: A writing prompt which allows intersection of the reflection, the humanities "spark", and the writers' and readers' professional and personal worlds. (Five minutes)
6. The Share/Reflections: Participants are encouraged to share writing with short explorations by the group. The share incorporates elements of reflective supervision, mindfulness, and humanism.

   The facilitator would lead the group away from conflict and toward a spirit of wondering. Groups are flexible and the facilitator may decide to give more time to one element of the framework if the work of the group is meeting the intended goal.

***Please see Appendix 1 through 6 for Narrative Consultation session content.

Data Collection and Analysis

Exposure/Intervention: Exposure to Narrative Consultation (the intervention) is reflected by a binary indicator of participation (ever vs. never), and an ordinal measure of the number of sessions

attended. Participants also provide feedback about their experiences of this intervention method during the semi-structured interview conducted at end-line.

Outcome: Staff experience of the workplace are assessed qualitatively through semi-structured interviews and observation, and quantitatively by means of standardized questionnaires.

Semi-structured Interviews: Two interviews are conducted with each participant, one prior to (baseline), and one six months after (end-line) the initiation of Family Nurture Intervention. Interviews are conducted in a private setting within the hospital, recorded and transcribed prior to analysis.

The interview schedule includes the following questions/topics:

- What is your role in the NICU and how many years have you been working here?
- What is your impression of the NICU environment?
- What has been your experience while working in the NICU and how does it impact your personhood (you as a person)?
- Please share a recent or memorable experience while working with families in the NICU.
- Describe communication with families and teamwork in the NICU unit first with colleagues and then in relation to the patient and families.
- Tell me about the challenges of working in NICU. On the harder days in NICU, how do you take care of yourself?
- Did you participate in the Narrative Consultation sessions? If so, what was your experience during these sessions? What did you take from it?

- Do you have any overall comments or anything that you think we should know about the NICU in general?

Ethnography and Observation: Activity in the NICU is documented with ethnographic field notes, photography, audio recording and on film. Ethnography is experientially driven, as the writers immerse themselves in the culture they are studying and draw conclusions directly from their fieldwork. Drawing conclusions is an interpretive act that occurs within the writing of notes and text (van Maanen, 1990, p vvi ; 2011). We believe that the information analyzed in the qualitative methodologies can enrich the hypothesized quantitative findings of increases in teamwork, engagement, and empathy, as well as decreased burnout. We also may find augmentation to the institutional quality markers (patient and staff satisfaction, safety markers, retention, and absenteeism) through phenomenology. Lastly, we look for additional emerging themes related to the hypothesis that Narrative Consultation and/or FNI may address occupational stressors and improve work environment.

Members of the study team will observe in the unit for a minimum of five hours and a maximum of 50 collective hours per week and will take field notes on the proceedings for three months minimum during each phase. Field notes will not be identifiable by name. Initial analysis will utilize NVIVO and/or ATLAS I technology. Video ethnography will be taken at the times of field observations when possible in order to augment what the researcher's eye can see.

Qualitative Analysis

Qualitative data is collected and analyzed utilizing Glaser and Strauss's Grounded Theory method and interpreted utilizing both these processes and Heideggerian Hermeneutics. In addition, ethnographic methodologies as described by John Van Maanen and Madeline Leininger are incorporated. In this methodology, the researcher functions as co-participant with informants to discover how people experience and practice care in their daily lives. Observation, participation, and reflection with participants happen throughout the research process (McFarland, et al., 2012, p. 265). "Heidegerrian Hermeneutics reflects the process of doing hermeneutic phenomenology and is represented as a journey of 'thinking' in which researchers are caught up in a cycle of reading-writing-dialogue- which spirals onwards (Diekelmann, 2001, method para 5). Through such disciplined and committed engagement come insights. The researcher is always open to questions, and to following a felt sense of what needs to happen next. However, it is not a process of 'do whatever you like', but rather a very attentive attunement to 'thinking' and listening to how the notes and texts speak to the hypothesis" (Smythe et al., 2008, p. 1389).

Grounded Theory Hypothesis Coding

Grounded theory involves the collection and analysis of data. The theory is "grounded" in actual data, which means the analysis and development of theories happens after having collected the data. It was introduced by Glaser & Strauss in 1967 to legitimize qualitative research. Though it can be used in different types of research, grounded theory is often adopted to formulate hypotheses or theories based on existing phenomena, or to discover the participants' main concern and how they continually try to resolve it (Glaser, 1992). In accordance with the stages of analysis, the coding team utilizes the method to code relevant text and repeating ideas in order to create themes, and finally to describe theoretical constructs. Theoretical saturation is the phase of

qualitative data analysis in which the researcher has continued sampling and analyzing data until no new data appear, and all concepts in the theory are well-developed. Benefits of this practice include being able to describe extensive data and provide explanations of complex occurrences (Pope and Mays, 1995, p.110).

In the study of Narrative Consultation, the extensive data set, which includes ethnographic field notes (over 150 pages of notes taken by clinical and non-clinical interns) and videos, as well as 146 semi-structured interviews of staff, and 42 interviews of NICU families, all ranging in length from five to 45 minutes in length, and collected over a period of 27 months (Jan 2018-March 2020), are coded utilizing Grounded Theory methodology. Staff semi-structured interviews provide the foundation of the results presented in this section. The interviews are double coded in each phase, utilizing Grounded Theory Hypothesis coding. In Phase One, undergraduate research interns coded utilizing a combination of hand coding and an excel program coding chart designed by the research team. NVIVO software was utilized by the author to cross code data however, this program became costly and time consuming, and codes were transferred to hand and excel methods for ease of analysis. In Phase Two, a graduate intern from the School of Public Health coded concurrently with the author (myself), both utilizing excel programming. The author then analyzed the codes and seperated them into thematic categories and cross compared them with codes from the ethnographic field notes. A descriptive picture of the lived-experience of a practitioner exposed to Narrative Consultation in the The Valley Hospital during the timeframe studied then emerges through saturation of themes and their concordance with theoretical underpinnings of the practice.

Due to the nature of the study and its central theme of examining not only the benefits, challenges, and central mechanisms of Narrative Consultation, but to understand the lived-experience of participants, a phenomenological lens is incorporated in the final analysis.

Quantitative Measures and Analysis

Staff workplace experience is operationalized as burnout, capacity for empathy, interpersonal functioning and teamwork, quantified using the following standardized self-report instruments:

1. Maslach Burnout Inventory (MBI)

MBI-Human Services Survey (MBI-HSS) (Maslach, Jackson & Leiter, 1996) is the original and most widely used version of the MBI, the leading measure of burnout. Designed for professionals in the human services, it is appropriate for respondents working in a diverse array of service occupations, including nurses, physicians, health aides, social workers, health counselors, therapists, and other fields focused on helping people live better lives. The MBI measures three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment. This survey helps identify the level of burnout and compassion fatigue in the NICU staff. It is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

2. Utrecht Work Engagement Scale (UWES)

The Utrecht Work Engagement Scale (Schaufeli & Bakker, 2003) is a nine-item scale devised to measure work engagement that includes a two-factor model with burnout (including exhaustion and cynicism) and engagement (including vigor, dedication, absorption, and professional efficacy) (Kulikowski, 2017). This measure is used to determine whether work engagement changes with the implementation of narrative consultation; increased work engagement would indicate an alleviation of burnout. This scale is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

3. Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index (Davis, 1980) is a multi-dimensional measure of empathy and its relationships with measures of social functioning, self-esteem, emotionality, and sensitivity to others. Each of the four subscales (perspective taking, fantasy, empathetic concern, and personal distress) displays a distinctive and predictable pattern of relationships with these measures. The IRI is a 28-item assessment on a five-point Likert scale, and is used to determine if burnout is reduced. This scale will be administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

4. The Team Development Measure (TDM)

The Team Development Measure (Stock, 2013) is a 31-item questionnaire constructed using the Rasch rating scale measurement model used to study how team functioning affects clinical outcomes, and as a quality improvement tool for team functioning. This scale is used to assess teamwork in the NICU and see how it changes with the implementation of narrative consultation. This scale is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

Institutional Quality Measures

In addition to the mixed methods research data, the study team has gathered relevant institutional data related to safety markers, patient and staff satisfaction scores, and retention and absenteeism. These are obtained using several programs databases including SPSS, Qualtrics, Press Gainey, Survey Monkey, Meditech, and Qlik programming. Institutional consent has been obtained.

Sample Size /Power

A difference between groups of effect size = 0.5 on the Emotional Exhaustion subscale from the Maslach Burnout Inventory is considered clinically meaningful. Studies in similar settings (Aytekin et al., 2010; Rushton et al., 2015) have reported mean scores between 13.0 and 16.3 with standard deviation of 3.74 and 5.46 respectively. Therefore, with a total sample of 120 staff members, and a significance level of alpha= .05, we would have power (1-beta) = .91 to detect an effect size of 0.5. At N=120, we would have power= .80 to detect an effect size of 0.36 on the Emotional Exhaustion scale. Alternately, we would need a sample of only N=66 to have power= .80 to detect an effect size = 0.5.

Confidentiality

At recruitment, participants are assigned a unique study number which is used on all study forms and records. Once information is transferred, any information entering the database is also identified by study number only. Access to the coding information in relation to the institutional quality markers is limited to the study coordinators, investigators, and the person assigned to building and maintaining the study database. Information provided to the data analyst is coded with the unique study number. The data is stored in securely certified environments and on encrypted, password protected endpoint devices. At CUMC, data is uploaded to certified environment #4069. At TVH, data is stored in a secure, locked location. Only members of the research team have access to the data. All identifying information is kept separate from the data collected.

As part of the study, participants are asked to consent to photography and video and audio recording. In addition, a subset of participants are approached to consent to the use of photographs or video images in journal articles, reports, conferences or lecture presentations generated by the study team. This consent is optional and does not affect study participation.

Compensation

Participants are compensated $25.00 upon the completion of questionnaires and interview for two sessions. One session is during Phase One for questionnaires and interview (approximately one hour), and a second session takes place during Phase Two for questionnaires and interview (approximately one hour). Participants who opt into the six sessions of Narrative Consultation (one hour each) are compensated an additional $150.00 at the completion of these sessions. Participants

are required to attend a minimum of five of the six sessions in order to receive full compensation. Further absences lead to prorated compensation at a deduction of $25 per session missed.

Potential Risks (disclosed to participants)

Some clinicians may find the questions to be personal. Potential for emotional distress is monitored and a referral to the hospital Care EAP (Employee Assistance program) is made if deemed necessary.

Potential Benefits (disclosed to participants)

Potential benefits may include positive contribution to the work environment, including increased patient satisfaction, improved clinical outcomes, enhanced safety practices, and increased clinician productivity. Impact on participants may include, but is not limited to, increased job satisfaction, increased emotional intelligence, improved empathic response, improved teamwork, and overall wellbeing.

Part Two: Doing: /ˈd$\bar{o}$oiNG/ (noun) The activities in which a particular person engages.

Chapter Three: Narrative Co-constructed Learning Model and Ethnographic Observation with Preliminary Analysis in Phase One

Narrative Co-constructed learning utilizes the strength of group learning processes, where story helps construct the need for change. Through collective stories, the participants co-participate in the curriculum by sharing both aligning and opposing beliefs through their professional experience in order to co-construct lessons and needed systems change. From this, they are able to co-create solutions, including breaking down barriers to implementing evidence based practices. Co-construction requires radical listening and an openness to perspective sharing, in order to hear solutions and potential detriments to practice in real time narratives. Co-construction requires tapping into our vulnerabilities and the reality that we may be facing and recognition that we do not have all of the answers we seek at this time. This is an incredible shift in thinking from the views of learning through realism, which was the predominant theory of knowledge in medicine, proposing that knowledge and reality are separate, and that knowledge is a representation of reality.

Constructivism theorizes that "knowledge cannot be given from one mind to the other, it must be constructed or created from an individual's experience" (Hendry et al, 1999, p.369). These methods of problems-based learning have been proven in studies to improve achievement of medical students (Sungar 2010, Schmidt et al 2009, p. 160), and were intriguing to the researchers who sought to create a learning paradigm utilizing stories where the learners could self-identify and problem solve, thus constructing knowledge from their experiences. These theories of co-

constructed learning were developed in the Social Development Theory of Jean Piaget and Vygotsky surrounding social learning.

The research team collected over 100 analyzed pages of field notes and filled over 10 composition/notebooks with handwritten notes over a period of 27 months. Description of how participants historically learned in the environment prior to Narrative Consultation, and the effectiveness (and ineffectiveness) of these methods lend themselves to the theory that knowledge that is co-constructed relationally is more likely to become part of the cultural norm, and is more likely to impact outcomes regardless of policy and procedure. With this in mind, we sought to embed co-constructed relational learning through small group sharing of narratives. The learnings obtained thematically in the Phase One analysis informed the structure of the sessions and the decisions regarding the prompts and "Sparks" for Phase Two of the study.

Ethnography in the Neonatal Intensive Care and Learnings Co-constructed in Phase One

In interviews, staff were asked about their observations of the Neonatal Intensive Care Unit (NICU) environment. Most commonly used phrases include intense, busy, overwhelming, stressful, and miraculous. The NICU is essentially foreign to anyone who has not worked in the unit or been a parent of a baby in a NICU. The routines and culture vary somewhat from unit to unit, but there are commonalities that have been found. Jessica Mesman's book on ethnographic fieldwork documented two NICUs in the 1990s through the mid 2000s, one in America and one in the Netherlands. Similar themes were found throughout, which document a culture that is "risky, uncertain, morally and emotionally challenging, socially intense, and technologically complex". Her book is a reminder of the "complex, evolving and multidimensional phenomena" of NICU,

and the need for better ways to understand the implications for healthcare and society in the broader context (Falkner, 2011, p.32).

Additionally, some ethnographic studies have focused on "finding happiness" within the walls of NICU as a staff member in Iceland. The findings conclude that focusing on the families, the infants, doing well, and pride in your profession were key to finding happiness in your work. The interviews in the NJ study find similar themes in answers to the interview question, "What is the part of your work which is most important to you?" A deep and universal acknowledgement that *working with and helping families was the core source of enjoyment and value in their work* is present and saturated throughout. However, we find actions that are juxtaposed to this universally stated value set in the ethnographic content of the day to day workings of the unit, which function on a much more task oriented, time conscious and methodical level. The majority of time spent was not observed to be at the bedside with patients or families, but rather at the computer reading histories, orders and charting. An emphasis on the instrumental care (feeding, procedures, and medications) is also noted in observations. We posit that this misalignment of stated core value/source of job enjoyment to actual observed time spent with the patient and family in practice, could contribute to increased staff stressors.

A 2013 article in Physical and Occupational Pediatrics focused on the ethnography of team dynamics including mutual respect, professional competence, accountability, effective blame, and collaboration. The author discusses roles within the unit and the modes of service delivery. The article" highlights the unique contribution of every member", as well as the challenges and tremendous opportunity to improve the experience for families by increasing a collaborative approach emphasizing shared responsibility, effective communication, and respect and recognition

for the fact that we cannot function independently, in order to promote the best possible outcomes (Barbosa, 2013, p.5).

The NJ NICU culture study seeks to learn more about what creates cohesive teams that in turn create better outcomes for infants and families. Further, we seek to find if a new construct called Narrative Consultation, based on the theoretical framework of narrative within the medical humanities, holistic nursing, and infant mental health principles impacts these outcomes.

Communication and Collaboration in the NICU

Communication is central to what NICU babies need for quality care and is integrated in every aspect of Neonatal Intensive Care. The NICU experience for families can hinge on positive or negative communications, more so than the actual outcomes or experiences. This is reported repeatedly in interviews that were conducted with NICU mothers through the qualitative interview process. One mother states, "I could handle whatever they were telling me but needed them to make sure they explained it and that they were patient when they talked to me". Communication can be the catalyst for strong or weak relationships. Staff-family communication, staff-staff communication, and even communication with self as a practitioner, has a tremendous impact upon the outcomes of our hospital's smallest, most fragile patients in the NICU. It impacts the emotional stability and preparedness of the families they will go home to and the emotional and clinical capabilities of the staff that are caring for them.

One NICU RN interviewed observes the following:

"I would say that it (miscommunication) mostly happen when there is a chaotic situation or something happen, there's a blaming part in there…and then people (families) or nurses alike are trying to blame each other for not doing the right thing" (N005).

Effective communication methods of self-reflection are needed to avoid these situations leading to further disruptions in workplace communications. Narrative strategies fostering open communication in small group cohorts will be utilized in Phase Two as a standard in NICU. We posit that this will encourage staff to work together as they engage in close readings and explore themes that they encounter within the unit. We hypothesize that this could foster more effective and therapeutic communication when practiced routinely.

Honest and open communication is the key for a parent's thorough understanding of the infant's condition in a NICU. It leads to a more prepared family at discharge that is aware and ready for the challenges that lie ahead. When consistent and frequent updates are coupled with sincere concern and recognition of infants' as well as the families' needs, true family-centered care is practiced and is reflected in the infant's ultimate outcomes.

In order for NICU culture to fully embrace developmentally appropriate care and family centered care, the foundation of communication techniques in the NICU must be addressed. An article in the *Journal of Maternal, Fetal and Neonatal Medicine* by Orzalesi and Aite in October of 2011 states that "lapses in communication in the NICU are often responsible for increases in medico-litigation and increased burnout of staff" (Orzalesi, 2011, p.135). They further go on to say that training in communication is imperative as a foundation of Neonatal ICU training. Liza Cooper, LMSW, who started the March of Dimes NICU Family Support Program in 2004, is cited in *Medscape Medical News* in September 2010 stating that "staff-family conversations are crucial", and "words or actions of a healthcare professional are forever etched in the families' memories, because the words were either so tender and caring or because they were so hurtful and cold" (McGann, 2010, https://www.staging.medscape.com/viewarticle/729514).

As a means of studying this, the research group observes communication with families in order to better understand the concepts of mindful communication. It was immediately noticed that those who clearly and compassionately communicated were the staff with which both families and other staff desired to regularly work. A common example of this is the avoidant healthcare worker who works diligently but appears not to be impacted by anything going on in the environment around them. This is the staff member who has a one track, task oriented mind who tries not to look up and be distracted by noticing other things that may be going on in the environment. There were multiple notes on parents who would arrive in the unit and sit at their baby's bedside in an open bay unit with their eyes darting all around, and breathing quickening while looking for someone to make eye contact with so they could ask for help. If that parent's nurse was out of the room for some external reason, the staff who communicated kindly, were sought after by the parent repeatedly. Other staff who approached the situation by yelling across the room, "we will get there as soon as we can" or those who did not respond at all were avoided by parents and coworkers alike. These same staff members were likely to avoid asking a team member if they needed help and, despite the signs of a co-worker seeming distressed, would avoid eye contact.

There were opposite examples of team members who engaged in the environment regardless of their own tasks. They possess certain qualities in common, including the innate ability to be present and truly participate in the act of listening to the other party or parties. This was seen in the tone of voice used and the proximity to the other that they engaged in such as pulling up a chair to speak to a parent or putting a hand on a co-worker's shoulder when asking if they needed help. This communication style translates in both staff-patient communication and in staff-staff communications.

Communication lapses are observed in field notes occurring almost every day both in routine communications as well as when the situation was critical. The quality implications of this observation will be a topic of this study.

Effective care for babies in NICU is dependent upon effective clinical communication. When conducting interviews, the nurses noted bedside shift report most often in reference to observations on communication in the NICU. Nurses discuss the need for effective communication skills during report handoff, and they reference tools given, such as the SBAR (Situation, Background, Assessment, Recommendation). Nurses found tools helpful, but they stress that communication styles and the differences in how one communicates can be a barrier to effective communication. One nurse comments that the key is "to recognize that there are different styles however we all have to keep the same goal in mind." (N007)

The challenge is navigating these cultural, educational, and experiential differences among staff when tools given for bedside shift report do not include ways to navigate the common barriers. This is an area for improvement within our study.

Other areas of concern are communication from administration to staff, interdepartmental communication, and physician to nurse communication. One nurse makes the observation that the overload of information on the computer, including flashing notices, internet information, and emails during charting create "visual noise" which make effective communication of these needed messages from administration virtually impossible to digest. With the prioritization of multitasking and communication being put into hyper drive with the checked boxes of the electronic medical record (EMR), there is ethnographic evidence that much of the patient's narrative is lost in translation.

Unequal distribution of power in nurse-physician relationships also appears to have an effect on communication with bedside NICU nurses. In observations, Neonatologists are cited as making statements such as, “what did you do to the baby?”, when called by a nurse regarding a physical change in the infant, igniting a sense of blame and guilt on the part of the nurse, making her reluctant to call the neonatologist freely in the future. Awareness of these toxic communication styles is pivotal to optimal care for infants in NICU.

Team Co-regulation and its Impact on Quality Care as an Emerging Hypothesis

Co-regulation is a term that refers to the autonomic state through which people help one another regulate or come to a state of homeostasis. Other expert definitions include the ability to respond to one another and adapt to what another is saying or doing in order to maintain a regulated state (McKnight, 2016, para 1-3). Neuroscience shows that humans have the ability for emotional and physical regulation through reliable caregivers, and they call this co-regulation. The field of neuroscience has also shown that co-regulation can impact one’s vagal tone, oxytocin surge, and can regulate blood pressure and vital signs (Welch, 2017, p.531). The education field has embarked on studies to utilize this phenomenon of co-regulation in the classroom for improved cognition and overall improved education outcomes (Bath, 2008, p. 44-45, McKnight, 2016, para 1-3) Although many studies have been conducted and multiple models on teamwork within healthcare teams have been in place, co-regulation has not been introduced as a mechanism of improving the functionality of the healthcare team. There has been a link to the concept of Daniel Goleman’s emotional intelligence; however, co-regulation is considered an autonomic and visceral response as opposed to an intellectual response (Goleman, 1995).

Preliminary field note and interview analysis in the NJ study lend evidence to the idea that when members of the healthcare teamwork in a co-regulatory fashion, desired outcomes are evident for both patients/families and staff. We posit that evidence may be found to support that there is increased learning, communication, teamwork, and job satisfaction when there is evidence of co-regulation among the team on any given day/shift. We also look through data to discern the components that make up a co-regulated team, as well as the components of a dysregulated team.

In order to understand the ability of a team to co-regulate with one another, the ideas of group norms, roles, cohesiveness, and the phenomenon of groupthink are important to understand. In the NICU ethnography, group norm is a valued concept in the unit. When group norms are violated on any given day, there is an observable impact on the cohesiveness of the group. These group norms may be a clinical or ethical belief that is shared and socially constructed by the given group of the day. In morally or ethically challenging situations, it is observed to be even more important that one conforms to group norms, subsequently creating groupthink, defined as being a strong concurrence seeking tendency among a group that leads to a deterioration in independent decision making (Harris, 2008, p.56). This concept of groupthink appears in field notes to occur more prevalently when a questionable concept is enforced by an authoritative figure, such as an attending physician or nurse in charge. Exploration of morally or ethically ambiguous topics is necessary in order to decrease moral residue and burnout, as well as create to a sense of well-being and satisfaction. Group norms, the occurrence of groupthink, cohesiveness, and the hierarchy of roles, all present a challenge when groups work together (Harris, 2008, p.65). Understanding these concepts can help the ethnographer identify challenges in the environment and factors that may prevent the group from achieving team co-regulation.

Chapter Four: Operationalization and Description of Narrative Consultation Sessions

Operationalization of the Narrative Consultation Groups

In Rita Charon's *Narrative Medicine Honoring the Stories of Illness*, she discusses the need for a narrative practice in healthcare. Her words create the clearing for the logical connections between narrative practice and healthcare: "The divides in healthcare need to be bridged in order for effective treatment to proceed. I have proposed that narrative means might help bridge these chasms because narrative ways of knowing and experiencing the world and self are held in common by health care professionals and patients." (Charon, 2006, p. 39)

The Narrative Consultation concept is built upon these ideals of shared experience within a healthcare team cohort, prompted by a discussion of relevant work within the humanities. In many ways, this practice is built upon the work of Dr. Charon and her team, who host Narrative Medicine workshops, certification, and degree programs at Columbia University. However, there are a few distinct differences as well as several principles which have rationality with the sentinel work done in Narrative Medicine.

The first and obvious commonality is the introduction of a piece of art, music, literature, etc. from the field of the humanities, and the close reading of these pieces. Dissimilarities along this point are the introduction of contemporary media and contemporary musical pieces. The prompts were chosen carefully and tested in a convenience sample pilot group with research team members who worked in NICU or Pediatrics in New York, New Jersey, Texas, and Connecticut. Moreover, the expansion into contemporary works is important because of the diversity and broad range of ages, educational levels, and interests within the study population. We wanted to choose

pieces that were relatable and spoke to issues with which NICU personnel can connect with. We also surveyed the pilot group and chose pieces that would prompt interaction in a meaningful way.

Another commonality is the insertion of reflective and mindfulness practices. However, we have taken the core practice related to these theoretical foundations from areas within the healthcare system, nursing, and infant mental health fields specifically. The prompts begin as broad based with close reading, but then focus in on commonalities found within the group, and further place a lens on issues about which the staff wanted to talk. However, the practice is based on reflection and mindful approach with a focus on self-reflection as well as discussion of empathic responses for the "other", both professionally (patient, family or coworker) and personally (relatives, friends). As the groups began the precedent was set that prompts are open to interpretation and discussion can include both personal or professional accounts, as both are components of the self that we bring to our practice daily, and it is crucial to recognize how our personal lives intersect with our professional roles is pivotal.

Ground rules were also set at the beginning of Session One of each individual group, and disclosure that anyone exhibiting signs of emotional "triggering" within the practice may want to opt out and that appropriate referrals could be made, including a Care Employee Assistance program consisting of mental health professionals. It was explained that any long standing or newly discovered emotions that surface in a concerning way were beyond the scope of the goals of Narrative Consultation. This was also discussed and noted in the informed consent process.

In order to first understand the work of Narrative Consultation, we must explore the three concentric circles that make up the theoretical and sensitizing framework. These are the areas of practice where knowledge is drawn from in order to formulate the ingredients that make up the "recipe" of Narrative Consultation. See figure 1.a.

These areas consist of the Medical Humanities, Holistic Nursing Practice and Infant Mental Health, specifically reflective practice such as Reflective Supervision practiced as a matter of course by mental health professionals and those in social services.

The area of Medical Humanities grounds the utilization of external works from the humanities and media as catalysts for explorative writing and dialogue. The second area, Holistic Nursing Practice connects the mind-body-spirit approach that proposes that the insertion of self-care, self-responsibility, spirituality, and reflection into practice helps maintain a proper balance of mind, body, and spirit (www.registerednursing.org/specialty/holistic-nurse/). The third area of reflective practice comes from the human services fields of social work and is further described by the Association for Infant Mental Health both nationally and on an international level. Reflective practice proposes that one must possess the ability to consistently pause for insights that can be found in examining actions in our practice and lives that help us engage in the process of constant learning and growth.

Upon consideration of the attributes that each of these concentric circles brings to the new construct of Narrative Consultation, the intersecting factor or common denominator is within the story, where the healthcare providers, their peers, and the patient and family all come together. To recount and paraphrase the words of Dr. Charon and relate them to this project, it is where the chasms are bridged by the experiences that patients, coworkers, and families all share. It connects us in our struggles and in our joys, and it creates relatability. The hypothesis that this bridge would be built between healthcare worker and family/patient is always present. However, the poignant accounts of self, both personally and professionally, also create an atmosphere of rationality among the healthcare team, as evidenced by quantitative markers and deep qualitative reports of their

lived experiences within and outside of the Narrative Consultation group. The extension of benefits described by participants is discussed in future chapters.

Operationalization of NC Sessions: The Research Timeline

Narrative Consultation sessions were held every two weeks over a period of three months during the Fall of 2019. The sessions started seven months after the introduction of a new standard of care in the Neonatal Intensive Care Unit. As previously mentioned, the standard of care was augmented with a new evidence-based paradigm and way of caring for Neonatal Intensive Care Unit (NICU) families and infants, called the Family Nurture Intervention (FNI), which is described by the Nurture Science Program at Columbia University. This shift in care led to a distinctly different view and challenge the belief systems and historical practices of some frontline clinicians. In order to ascertain the effect of Narrative Consultation from the effect of the introduction of FNI, the qualitative scales were collected at three time points. T1 was Enrollment which was 18-12 months prior to the introduction of FNI, immediately prior to the NC session (which was seven months after the introduction of FNI) and T2 which was one to two months after the completion of NC (which in total was 11-12 months after the introduction of FNI). We hypothesize that NC could help with integration and adoption of this new care paradigm and give voice and a platform for processing and reflecting upon the value and challenges of the new practice. In addition, the research team continued ethnographic field notes throughout the timeline and conducted semi structured interviews with participants at enrollment and Timepoint Two. Through the qualitative forms of research, the team seeks out emerging themes, as well as has immersed themselves within the culture ethnographically, and has conducted interviews in order to understand the lived

experience of the NICU healthcare team in this particular unit. This allows us to examine the evolution of their experiences, both positive and negative, consider factors that may impede or assist in the flow of the unit, and examine and describe the experiences of the staff both prior to and after NC.

Operationalization of NC Sessions: Developing the Cohorts

Hierarchy describes the organization of a group with clearly defined tasks, structure, or relationship (Sherman, 2020). It is reported that companies that utilize this type of management, focus on control and emphasize accountability with a typically downward form of communication, without allowances for employees to participate in decision making (https://smallbusiness.chron.com/hierarchy-within-group-31481.html). Healthcare systems largely participate in hierarchical structures that are further perpetuated by the historically paternalistic relationship between physician and nurse in healthcare. A staff nurse shares this observation in Phase One:

> "I think communication between the nurses and doctors could be better, and sometimes there's a little bit of a undermining, or just the way we speak to each other could be better. I know that we or the doctors because they're above us, but should be an equal playing field and not be talked down sometimes." (N013)

Organizations such as the Magnet Model, developed by the American Nurses Credentialing Center (ANCC), have sought to create structural empowerment, transformational leadership, and valued innovation by nurses and other interdisciplinary staff. The Valley Hospital has a baseline advantage as a magnet certified organization. However, the pervasiveness of power dynamic based on hierarchical structure and clinical role remains visible and has been reported to be present in

everyday interactions during Phase One. Moving beyond the mistrust of people in positions of power in a group setting is challenging for those accustomed to being marginalized, and the first step may be placing the empowered people consciously at the margins of group process, permitting members they consider to have "less expertise" to take the reins and allow themselves to be heard in order to gain valuable insight and expand knowledge (Harris and Sherblom, 2008, p.96). For this reason, groups are structured in the following way: One group is comprised of administrators (most with clinical background) considered to be "leadership", another group is comprised of physicians and advanced practice nurses, and the remaining seven groups' participants, mainly nurses and therapists, have self-selected into for their convenience. A consideration of randomization of groups was made, but based upon discussion with consented individuals, a preference is clear to self-organize date and time and group selection. In a first attempt to co-construct the design, this model has been implemented.

As groups begin to meet, a drop-in model, where participants can move in and out of groups as an additional convenience factor, has been created. The drop in model and its utility is explored further within the notes of the sessions and within the analysis. Of note, the administrative group remains exclusive, and no members choose to "drop in" to other groups, the physicians group has quickly dissolved and has visible impact on the groups they drop into, the impacts varying greatly depending upon their abilities to "place themselves at the margins of the groups" or their assertions to maintain a position of power within the group. Clinical staff at the frontline level tend to move in and out of groups due to scheduling changes, and support staff with a "Monday through Friday" schedule appear to find it easier to maintain a particular day and time and maintain consistency of group members.

Description and Observations of Sessions

"Life is a succession of lessons that must be lived to be understood." Ralph Waldo Emerson

The National Center for Health Statistics reports that nearly 4,000,000 babies are born in the US annually. Ten to fifteen percent of those babies will go to a Neonatal Intensive Care Unit (NICU) to be cared for by the dedicated staff of doctors, nurses, therapists, and countless other professions within the hospital environment. The babies, their families, and the NICU staff are placed together in intersection by this turn of fate that a new parent never wants to experience. As a result, this is a microcosmic world that most people are unfamiliar with and never give significant thought to that is unless they are propelled into this world by their child's medical outcome or are one of the healthcare providers called to dedicate their lives in service in the NICU. These professionals spend many of their days and nights living in shared space with families in crisis and small fragile lives that are at the precipice of being. The stresses and experiences of everyday life in the NICU are what most staff would describe as normal for them when others from the outside may find it anything but, and in fact, extraordinary.

The lived experiences of healthcare workers is a field relatively unexplored, but immensely important. The impact staff have on the baby and family have been well described in the literature, and studies have shown that the healthcare experience extends far beyond safety and quality outcomes, but having profound impact on parental anxiety, depression, and coping abilities that extend far into the child's life (Cooper et al, 2007, p. s32-s33). The impact of the families' time in NICU can have ripple effects that extend into their finances and their subsequent abilities as consumers in our communities. Extended family relationships and their mental health are also impacted. A child's long term needs flow into the educational systems and healthcare systems. The relatively short time a family spends in NICU can ultimately impact their participation and

functionality in their communities for years to come. These impacts are not limited to the core family alone, but extend to siblings, grandparents, and others. The experiences our families are having are shaped and molded by the caregivers in NICU.

Our infants in NICU will spend more potential time in the healthcare system than any other patients in the hospital. Therefore, it is imperative that we take the time to understand the world where they are beginning their days. It is within the honest examination of this world that we can find the keys to improvement. It is within this examination and reflection of NICU that we can find great meaning in the experiences at the intersection of two lived perspectives which are considered "normal" (to staff) and "extraordinary" (to patients and family).

The conception of Narrative Consultation is the product of years of study and observation of each of these perspectives, and an eventual conclusion that examining our perspective and understanding that it is just that, one perspective and not an only perspective, was pivotal to creating a shared space for families and staff to thrive. It is based on the need for clinicians and support staff to share their voice and hear the voices of others. It incorporates reflection and mindful presence in the form of radical listening and observation in order to navigate a shared space. Within this space, several perspectives or several storylines can meet at an intersection that puts the whole patient, the whole infant, whose family is inevitably and rightfully connected to, at the center of the narrative. The sessions build upon each other and incorporate knowledge and insights gained from participants, which in this way incorporates a co-construction of learning where power dynamics with the facilitator are leveled and all can feel empowered.

Session One- Introduction-Honoring the Stories of Illness

"Knowing yourself is the beginning of all wisdom"- Aristotle

An opening question that I asked in facilitation of learning was, "*How can we know how to care for our patients and families, if we are not in touch with who we are within this lived space of Neonatal Intensive Care?"* Session One centered on examining our own beliefs, understanding the meanings behind reflective practices, and the utilization of close readings in order to look deeper below the surface. The prompts brought up different themes for each individual cohort, and by reflecting on each group's message, a picture of the rationality of the team started to emerge.

Session One was different than others, in that it was used as an introductory session to set ground rules, review format, and allow participants to glimpse into the world of narrative and the humanities through a short video excerpt by Dr. Rita Charon, called "Honoring the Stories of Illness". This was distinctly different than the plans for the next five sessions, which would put a work from the humanities or contemporary media at the center for examination and relational exploration. The differentiation of the design of Session One was calculated and purposeful. Our main goal was to allow for an immediate immersion into narrative as a form of learning through a leading field expert in order to ground the practice and create legitimacy. There was a suggestion to participants to explore other texts and resources however, but this first session needed to accomplish this goal singularly as it was unlikely that most participants would do outside work as it was not required. A second goal was to introduce a strong thought-provoking topic that instantly immersed us into the depth of discussions that we could be expected to have over the next few weeks. Dr. Charon's topic was instrumental in accomplishing this goal.

Each session consisted of five components:

1. Setting the intention and grounding (Holistic Nursing Theory)

2. Reflective quote ((Reflective Practice Theory, Infant Mental Health)

3. The spark (Sharing of a work pulled from the Humanities. This may be in direct relation to the medical field or taken from literature, poetry, music or art. A "close reading" would follow. (Medical Humanities, Narrative Medicine).

4. The prompt: A writing prompt

5. The share and reflection: Participants are encouraged to share writing with short explorations by the group. (Narrative Practice, Reflective Practice Theory, Infant Mental Health)

Session One:

1. Setting the Intention/Grounding

Participants started by being led in the practice of taking three cleansing breaths with the intention of dedicating this time to being mindfully present. We dedicated this time with the following intentions: **Breath One**- to better serve our babies and their families, **Breath Two**- to better serve each other (our colleagues), and **Breath Three**- to better serve our own lives (ourselves both personally and professionally as well as serving our loved ones). There was an understanding that all are inevitably connected. Many hours are spent in our work lives which impacts all aspects of our lives, as there will be crossover regardless of the practice of boundaries. For this reason, a regular practice of reflection, expression and release was foundational to addressing workplace stress.

Ground rules were shared before any participants engaged in discussion and writing. These included the following: a. No self-deprecating remarks, b. Share only what makes you comfortable, c. Take time to digest and closely read what others have written, d. Respond in the context of their

story, e. Writing style is not up for critique, f. Maintain the confidentiality and honor, this is a sacred space.

A discussion on appropriate contexts in which to share our experiences here were reviewed. We discussed that a direct conversation with a participant was acceptable such as: Person A. Has had a positive response to something Person B wrote/said and would like to approach the person outside to discuss. This is acceptable, however Person B. may wish to say that they prefer not to talk about it outside of the session. It was also acceptable to speak with each other or other colleagues regarding the "spark". Discussion of the piece of art, music, film, etc. was acceptable entirely.

Alternatively, we discussed violations of this space which include:

Person A. and Person B. discuss Person C.'s responses. This was inappropriate. We should not be sharing anyone else's responses with anyone else. Person A. discusses disagreement and negativity toward a writing/discussion with Person B. This was not treating this space as confidential and safe. We are meant to create a safety net here for one another to wonder and explore. Within this context, the above example would be deemed inappropriate. The participants all verbalized agreement and understanding without difficulty. In two groups, a comedic element was introduced by a member who would humorously give their own example of inappropriate behavior. The improved ability of some shone through throughout the sessions and became part of that group norm.

2. The Reflection Quote

A quote was introduced that would speak directly to the sessions theme. In this introductory session we used a quote by education researcher, John Dewey.

"We do not learn by experience, we learn from reflecting on our experiences."

A short exploration into reactions to the quote was shared, and we moved into explaining the format for this first session and the pieces that would be used for "the spark" over the next five sessions. It was a "teaser" of sorts to excite and encourage future participation with the goal of potentiating enthusiasm.

In Session One we had an additional didactic component where we explored the term "Close Reading" as coined by Rita Charon. This was integral to the participants understanding the purposes for engaging with and reflecting on the "Spark" pieces that we would share in each session. In her 2017 book *Honoring the Stories of Illness,* Charon talks about how attentive listening in healthcare is like reading a novel closely. "Close reading," she says, "develops the capacity for attentive listening" (p. 166), including "the close reader's attention to metaphor and figural language, to tone, to mood" (p. 169).

This sequence in healthcare is not unlike a sequence of close reading," she explains. "The same alert creative presence is needed by the reader or the listener; the same attention to all features of the narrating are awakened; the same intimacy between creator and receiver of the narrative is achieved" (p. 167). We also explored Charon's passage, "narrative medicine is committed to developing deep and accurate attention to the accounts of self that are told and heard in the contexts of healthcare" (p. 157).

3. The Spark

As noted previously, this week's spark included engaging in a small piece of Charon's Ted Talk, "Honoring the Stories of Illness" that brings the participants directly into a narrative shared on an experience Charon had with one of her patients. The total time of the Ted Talk was 18

minutes and 16 seconds, however, the listening time chosen was three minutes and 48 seconds with a suggestion to watch additional footage on their own if they were interested. These nearly four short minutes created a catalyst for immediate immersion into the depth of conversation we would share, and it created an immediate communion with the intensity of our profession and acknowledgement of the extent to which it intersects with our personhood. The following is the pivotal dialogue that evoked this experience from her talk:

See Appendix 1 for transcription of talk or view

You-Tube Rita Charon Honoring the Stories of Illness TedX (Time Stamp 11:07-15:10)

https://www.youtube.com/watch?v=24kHX2HtU3o

The groups' reactions to Dr. Charon's words ranged from thoughtfulness to tears, but everyone was engaged on some level. The words that stayed with most were the following:

> *"**we had made contact through the glare of death that was in the room with us, as it always is and we could accept it and more than that, we could sit with it. It helped me and this woman to understand what medicine is for and even more than that in excess of the medicine, what ordinary living is for. It is for the making of contact**"*

Through conversation we began to unpack those powerful words. They touched some through their personal lives. They wanted to reflect on what it might be like to be cared for by practitioners who could see medicine in the way Dr. Charon described. Many participants noted that they themselves and their loved ones have not had these kinds of experiences. The conversation turned to placing ourselves as the provider and whether we feel the ability to be "exposed and down to the floor of who are on the presence of the illness and make contact", Dr. Charon went on to say in the end that "it is possible all of the time". We explored how we felt about that idea. Was it

actually possible all of the time from where we stand in the NICU? The answers were varied but honest and thoughtful.

The prompt:

In Cohort One we used a "getting to know you" prompt which came from Dr. Charon's workshop directly. The prompt was simply "Please write a story of your name". It was designed to get the participants comfortable writing, and to share and expose some personal aspects of themselves. What was not realized in the design phase was that after going to the depths of the relational oceans as a group, this prompt was like treading back to the shallow surface. They were thrown into the deep end and were floating around in the reflective waters of Dr. Charon's words when they were yanked back by the prompt of their name.

In reflection, the group was able to accomplish the originally intended goals of sharing pieces of themselves and gaining comfort with writing, especially for those who had not practiced this for some time. However, I was aware that the prompt needed to be changed for the next eight cohorts. The subsequent cohorts two to nine would receive the writing prompt of "Tell the story of a time that you were down to the floor in the presence of illness and were able to make contact. As a clinician, describe how you are able to get back up after those experiences and return to your outside world."

The Share and Reflection:

Dr. Charon's words gave us permission to go to these places. Stories emerged. Despite the prompt, which was designed to lead participants toward their clinical experiences, participants asked if they could transpose the prompt and talk about personal experiences that they had where they were down to the floor and how they had to come back to the world of NICU. Either way

the prompt was interpreted, it worked as participants were talking about their vulnerabilities and how they related to the manner in which they showed up for clinical practice and for their own lives. Therefore, either version, the original or the one created by the participants, was welcomed. This was the first of many examples of co-construction as we progressed. In groups that shared expressively, we could see the rationality and cohesion of the group increasing at greater speed.

The session closed with a preview of the spark to come, the next date, and a message for all to be safe, well, and to take care of each other and themselves.

Reactions to Session One

The facilitator (My reaction):

As a facilitator, I made ethnographic notes on both my experience and observations that were made from the group. The first words in the notes were an acknowledgement as a facilitator that I was unprepared for the vulnerability that this would evoke in me. Vulnerability not through sharing intimate space and holding that space for others, which was a practice I was trained in, but rather vulnerability in sharing this project designed, constructed, and facilitated by myself. I had been prepared by training as a holistic nurse, in infant mental health during reflective practice, in multiple medical humanities programs and Columbia University's narrative medicine workshops, but this was not the sharing of another's work but rather opening a window into my work and having to accept both the good and bad that comes with that. The participant reactions to the practice, were deeply important to me and I had invested much of my studies in support of constructing this practice which was now not just a concept but an actual practice. It was no longer just an idea but a reality that my colleagues were experiencing, and that came with a great responsibility.

Every participant here was a colleague, and every participant spoke about the world of NICU, a world that was so personal to me. The sessions were designed with a positive intent of helpfulness that would now be put to the test. This practice was not something from any of the aforementioned constructs, and therefore lacked the safety net that came with it. Rather, I was "down to the floor of who I was", not in the presence of illness, but in the presence of the vulnerability of sharing my work. This was the first time I would study this construct with a staff including those who were my peers, colleagues, mentors, and administrators. I was laying all of my work out in front of everyone, and it was deeply personal. I did not realize this until well after I had begun the first session. Up until that point, I was so consumed with IRB, consents, design, finding acceptable cohorts and times, and many other actual preparations that went into the making of this moment, and I neglected to embrace my vulnerability until that first session. I was so caught up in the getting to this moment that I did engage with my own feelings toward it.

Another observation was that I could not predict that the practice would be embraced by the staff so wholly and honestly right from the start. I hypothesized that we would grow into norming as a group, and certainly some cohorts would appear more connected right from the start, but I expected to have more resistance. The overarching takeaway was that there was some form of interest and honesty in each cohort. The positive response of the participant and accessibility of the program was evident by participants.

The group that was comprised of the doctors and the group that was comprised of the administrators brought up issues of my hierarchical vulnerability for myself, which came out in the physician group when I shared a bit about my training. The Director of Neonatal Medicine asked me why I felt the need to qualify my training for them when they were not asking me to do so. As jarring as this question actually was for me, I smiled professionally and answered her

question unwaveringly with the simple answer, “this was a standard format of disclosure of my background in order to gain the participants confidence in me as I accompanied them in this practice”. It seemed to answer her question, but it stayed with me throughout my sessions and the subsequent analysis process. This was the first gateway into the central thesis of vulnerability. I had nine cohorts every two weeks for six sessions, which meant that there were nine sessions down and 45 more to go. There would be a need for me to dig deep in order to continue to facilitate or accompany with the degree of accessibility but unwavering professionalism that I knew was required. And yes, there was a need for me to get in touch with my vulnerabilities as well. As with the question posed by the Director, who was both a mentor and a boss to me at one time or another, I would be left vulnerable and exposed, but the behavior that I modeled would allow for shared vulnerability to be either a strength or a weakness within this study. This was an emerging responsibility and certainly contained more reflective and personal work than I had initially imagined. Despite these reflective findings, due to the shift that I already felt happening within the unit, I knew it was worth it.

Observations on the cohorts:

I immediately noticed that there was a generational difference in one group in particular. The millennial participants in this particular group seemed the least likely to access themselves and share with the group. There was a nurse with over 40 years’ experience who often attempted to monopolize conversations, often requiring redirection. The older and more experienced nurses talked about generational differences openly. Both groups of nurses seemed to have vulnerability issues that were apparent when it came to the generational differences, but I began to realize that neither group was aware of the other’s vulnerabilities, only their own. I was interested to see if this could change through our sessions.

One third of the participants spoke about personal situations that they were going through with personal illness, with a sick loved one at home, or a recent loss in their personal life. Some participants were brought to tears. As per the IRB protocol, I offered CARE EAP (the hospital's employee assistance program for staff seeking counseling) and the opportunity to drop out of the sessions to anyone who shared deep personal situations. There was an overwhelming enthusiasm to continue in the majority of these cases. During all sessions, two of 49 of the participants dropped after the first session due to acknowledgement that participation was difficult due to a recent loss. One was the very recent loss of a grandmother and the other was the loss of a family pet.

Narrative writings often surrounded appreciation of accompaniment of others when you were "down to the floor in the presence of illness". Personal stories of accompaniment were shared much more often than professional stories. When shift to self as the clinician emerged, some barriers to "accompaniment as a norm" that emerged were inability to be present because of the enormity of responsibilities that clinicians carry, including procedures, instrumental care giving tasks and charting. Wondering emerged around what accompaniment might look like within these contexts.

In the physician group, one participant stated she "very rarely speaks of her personal stories but does so on occasion by choosing carefully when looking for appropriate moments." She shares that her personal story of having a daughter with autism could often leave families with hope in the face of an incurable diagnosis. She discussed what that transformative process felt like.

A nurse with over 40 years of experience admittedly "does not get touchy, feely with families often". She notes that it was part of her cultural upbringing in a Scandinavian country. Despite this disclosure, she goes on in the group to be one of the most expressive, stating, "When we are with our patients and families, we are only touching the surface of what they are going

through and feeling. Sometimes we only skim the surface when in 'the glare' because it takes a while for us to come back and we have a job to do. But then, we end up back in the glare when we go home, and we have to figure out a way to process all that has happened."

A counselor for bereavement shared that her role gives her the space to be totally present because that is her job however, it remains a challenge to maintain the professional separation in order to protect ourselves from guilt that is inherent in the scope of responsibility of that work. We shifted to the idea of using this as a point of contact in order to meet families where they are without getting lost in it. We reflected on times when we were able to accomplish that successfully and times when we couldn't and examined the differences.

The group of administrators held the most interesting dynamic, as there were multiple layers of hierarchy present. In this first session, there was a palpable carefulness secondary to sharing. The Vice President spoke up courageously as if to offer a gateway for others to join. He reconstructed the story of walking down the halls of the ER with patients on stretchers in vulnerable states and he there in his three piece suit trying not to make contact through eyes or otherwise because he assumed that people did not want to be seen in the presence of illness. At least, not by someone who was in his role. He discussed his rationale of not wanting to make anyone feel uncomfortable and wanting to honor privacy. He also recounted a time when it was so busy that he had to help give out warm blankets and recalled the patient who asked him his role. When he told her who he was, she commented, "Well I see why you have the role. Thank you." He said her smile was warm and her comment genuine. It made him question if avoiding making contact with patients as regular practice was the right one, even if he could only offer a smile.

In preparation for the groups, Bruce Tuckman's group dynamic theory of "Forming-Storming-Norming and Performing" (Harris and Sherblom, 2008, p.65-66) was studied. We

anticipated that we may see some of this phenomena in action. In addition, study of the concept of autonomic coregulation as described by Stephen Porges and Martha Welch was also considered. According to Polyvagal Theory, coregulation lies at the heart of all relationships and is the reciprocal sending and receiving of signals of safety. It is not merely the absence of danger, but connection between two nervous systems, each nourishing and regulating the other in the process (https://khironclinics.com/blog/polyvagal-theory-coregulation/).

In the article "Coregulating with Students at Risk" (McKnight, 2016), the author describes this autonomic process within the classroom. Throughout the course of these sessions, there was ethnographic evidence that the groups who openly expressed through their stories, showed outward signs of improved autonomic coregulation, including decreases in fidgeting and nervous movement, such as pen tapping or foot tapping. There was also an ease of breath that was often visible. Ease in kinesthetic communication or body language was also appreciated, such as nodding, leaning in, and even putting a supportive hand on the lap of a participant next to them as they spoke, conveying radical listening. It encouraged other participants to go on and the typical stages of group norming as described by Tuckman were not appreciated fully and rather a coregulation on an autonomic level of performance seemed to emerge quickly in these particular groups.

One example of this coregulation appeared within the share between a groups of nurses who were immersed in a participant's story of a colleague who had passed away suddenly. She wrote about how that tragedy brought the staff into contact with illness in a profound way. Each participant added to this theme and connected it to their clinical work by adding commentary to the written narrative and using the space to honor all this nurse did to create contact with the families with which she worked.

In another group, a social worker shared the story of accompanying her brother on his journey with cancer. She eloquently told the tale with tears and bravery and talked of what it felt like to be on the other side of the caregiving paradigm as the family member of a patient. She related her feelings to feelings she shared with families of her patients. Her colleagues encouraged her story with mutual tears and reassuring smiles as appropriate.

In each of these two groups there were shared hugs and sincere thanks offered in closure. Participants expressed excitement at returning in two weeks' time. The intense content and expression of emotion appeared to both connect the group and calm them as they created a safety net for expression and reflection.

Session Two: Three Men Walking II

"In art we see what we need to see"- Alberto Giacometti

With the start of Session Two, the groups began to form a "drop in model" of participation. As the interview testimonies would later prove, the most difficult component of Narrative Consultation was for participants to actually find the time to attend. At the request of multiple participants, all dates and times were left open to "drop in" to a group, in the case that a participant was unable to attend their regular cohort. Preliminary concern over the constant reforming of group norms, due to new participants coming in, and others stepping out, raised caution for me as facilitator. Initially, the belief was that group formation was a key part of establishing trust and facilitating expression and reflection. Soon we would see that this proved not to be the case, and multiple participants successfully moved in and out of groups. Other participants stayed in their scheduled cohort. It was clear early on that administrators, physical, occupational and speech therapists, social workers, and other participants who worked a Monday-Friday set schedule found it easier to stay within their fixed cohort. Physicians, nurses, respiratory therapists, and patient

care techs who all had varying schedules week to week, needed the drop in model in order to navigate their sessions. There was an overt desire to participate that was shining through, as the groups came up with creative solutions to find ways to participate. In addition to the "drop in" model, a virtual attendance via ZOOM was also used. Throughout the time of the study there were groups who routinely used the ZOOM platform and others who preferred to not use it and in fact never did at all. This virtual model was introduced in a pre-COVID world, where some groups who did not have fluency with technology, seemed resistant despite instructions and tutorials offered. As virtual platforms have become a necessity in a post-COVID society, the findings on participants' comfortability with utilizing ZOOM may be very different.

1. Setting the Intention/Grounding

Participants arrived in the room with the energies that they brought with them from the day. Small talk and shop talk ensued until all were gathered. As we began with our three breaths and intentions, there was a palpable calm that settled over the group as they engaged in this exercise. Discussion of "letting go" of all else for this small piece of time helped the participants mentally and mindfully "arrive" in the space together.

2. The Refection Quote

The quote by novelist Anne Lamott served as a gateway into our topic for this session. The groups considered the words, "We are not here to see through one another, but to see each other through." The participants considered how often in their daily lives they look right through situations that are unfolding directly in front of them. After a few thoughts were shared, we moved to the Spark.

The Spark- Three Men Walking II (1949 Giacometti, A.)

Figure 2.0

An introduction to the piece included a background on the artist, Alberto Giacometti (1901-1966), who was born in Switzerland and was a famous as a sculptor, painter, draughtsman, and printmaker. Three Men Walking II, a painted bronze sculpture located at the Metropolitan Museum of Art, was finished in 1949. A conversation on the consideration of the piece within the context of the time in history in which it was created ensued. This sculpture was one of a series of similar pieces that Giacometti created during the immediate post World War II era. Participants studied the piece on the screen and were given some background as to what the live viewing felt like from the facilitator, in order to bring context to some features that were hard to grasp from mere photos despite utilizing several camera angles. Word or phrases came forth from participants as the "close reading" went underway. These included: "*one foot forward", "looking through each other", "heels lifted in propulsion", "walking with purpose", "bigger figures knocking over smaller figures", "no eye contact", "inevitable collision".* Participants mused over the meanings of the

piece within the discussion, and a sense of wondering entered the group. The invisibility of humanity during WWII came into conversation. Participants discussed the time period of the art and how nations in war time could not truly see one another and still harm one another. There was discussion of soldiers in holocaust camps and the depersonalization of humanity as a necessity to further their regime. These discussions set the stage for the prompt that followed.

4. The Prompt

Consider what the piece, *Three Men Walking II*, brought up for us either personally or professionally. Write the story of how we can be so close in proximity but unable to see what may be right in front of us in the NICU or in our lives.

5. The Share

Stories emerged that created space for discussion of topics that directly impacted the way we work within the space of the NICU. Writing pieces on the difficulty of "really seeing our patients" or "working in silo" were prevalent. *Three Men Walking II* was a look into why and how we may cut ourselves off from one another in society. It was an artistic exploration of connection and disconnection, which was directly related to the Family Nurture Care goals of embedding emotional connection between parent and child as a priority in the NICU. By taking this closer look, we began to see the barriers we put up both with and without purpose.

Reactions to Session Two

The Facilitator (my reactions):

This prompt was forged from a learning experience in "The Art of Medicine" course at Drew University, where I was introduced to *Three Men Walking II*. It profoundly impacted me, and multiple writings emerged from the piece. I shared parts of them in certain groups that seemed to need more prompting, and alternatively I shared in groups where the conversion was rich and in close proximity to my thoughts, which left a perfect opening for me to share. There were some groups where I did not share because there was such enthusiasm and I did not want to take time from others, or where I thought my writing might turn the conversation in another direction without enough time to explore it. I began to see the piece through the eyes of others and find new ways of wondering within their stories but every evening when I left, I would come back to mine…

> *"Beep…beep…beep…hummm…ring ,Ring, RING, RING". My breath was shallow and quick, my eyes darting furiously as I was jarred awake by the alarm of the monitor. Vent settings maxed still, color pale but not blue, monitor silent for now. A quick assessment showed that it was not Zach but the child across the ward, Adolpho. I saw his mother sitting next to his bed as she watched with intent eyes as members of the team tried to oxygenate and calm the beast that was the monitor. But my eyes stayed on Adolpho's mother. Everyday I watched as her eyes waited with anticipation for the moment when a staff member may come in with news that would bring joy to their faces instead sorrow as they waited for a kidney donor to bring Adolpho back to them. I watched her intently, both of us here for months, but mere strangers passing in the hallways. I wanted to reach out to her, but I knew she did not speak English. Her gaze was always averting mine or cast downward as I tried to make eye contact. She and I lived here in this space together but we were separated by curtains and rules. Yet I knew so much about her by watching. I knew how many pairs of sneakers she owned, the dusty white adidas, the black keds and*

the sparkly pink ones that seemed so comfy. I knew how she tied her hair back with one quick twist when she became nervous as if she were clearing her sight and getting ready for battle. And I knew how she looked when she gazed at her son in devout prayer. I knew it and I felt it and I prayed with her.

I prayed for this stranger who was so unforgettable but yet so unreachable from where I was on my side of the curtain. I put my head back and breathed deep. Both of our children were fighting for their lives and in this moment hers was losing. When would it be our turn to lose this game? Tears streamed down my face and it was at this moment when I heard the voices in the background.

The laughter of the staff at the nurses' station. The chatter about their upcoming plans, the movies they watched last night, the snacks they would share, the latest gossip that was going around. I envied their joyful lives, I knew it was necessary for them to keep coming back and still I felt anger at their indifference to us in this moment. Did they see me crying? Did they see Adolpho's Mom praying? Were we invisible? Were we just so ordinary in our pain? I shifted my focus across the room again. Did Adolpho's mother see me or was it just too hard for some to see all of this pain? Why did I see everything? Why do I feel like I hear everything? I was so close to everyone who was surrounding me but yet I was utterly alone.

Within this practice of Narrative Consultation, we were seeing each other and the families that were living inside our walls. We were turning our gaze upward to make eye contact and nodding at the person next to us. There was connection that was real, and it was seen both within the groups and increasingly in the unit as the weeks progressed.

Observations within the cohorts:

An early group provided a co-constructive element that I included in the exploration of this week's theme. As a response to the writing prompt, a participant shared one word…Sonder. The Webster dictionary definition of sonder is "the realization that each random passerby is living a life as vivid and complex as your own-populated with their own ambitions, friends, routines, and worries." The word lent itself to rich conversation, and with permission, I reintroduced it to the rest of the groups. Through the act of wondering, participants explored the one-dimensional view that we often use when viewing others. We discussed ourselves as the main character in our story and everyone else as taking a supporting role or being mere ensemble. We discussed what it might be like to look at our roles in different ways. We explored the idea of boundaries, and if through boundaries we refuse to see ourselves as an important character in the stories of our patients' and families' lives. We questioned the responsibility that comes with being written into their lives through this twist of NICU fate. We discussed how we could embrace this idea and keep our eyes open for opportunities for connection while still maintaining boundaries.

A cohort of frontline staff shared stories related to disconnection in practice and an observation was made by a nurse who noted, "Somewhere along the line in practice it became OK to just walk over the bodies around us in order to get where we are going." Observations such as this one created intimate space where we could share our experiences and thoughts on topics with which many identified.

The cohort of administrators discussed the idea of the interdisciplinary team, and how teams often work "on their own" like the figures in the statue. A narrative of disconnection between, physician, nurse, and therapist emerged. It seemed comfortable for the administrative group to use examples where they did not identify as one of the figures in the *Three Walking Men*

image. I asked them to create a scenario where they may inhabit one of the figures and the discussion of differences between management and frontline viewpoints emerged. We discussed what it might look like if we do not look up to see "what is right in front of us". The words "pop off" appeared in similarity to the earlier group's discussion of collision. The participant shared, "Most days I just want to stay in my own lane as protection. It's like, you stay in your lane and I'll stay in mine, that way neither of us gets to *Pop-Off* on one another." These remarks spoke to the perceived issue of protection given by "staying in your lane" or not seeing what may be right in front of you through avoidance. The potentiality of becoming vulnerable by meeting together in shared space was seen through these examples as the administrator described a pattern of avoiding contact with others who may complain or have a need to discuss issues. This was described as "popping off". The discussion of issues without the ability to find immediate solutions may perpetuate this feeling of vulnerability on the administrator's part. The group eventually came to a discussion of how practicing without a mindful awareness of the team could end in a "collision" where the patient is harmed. The administrator who candidly shared their need for avoidance, looked down to the floor when others discussed the necessity of mindful awareness.

In Session Two, an overall picture of the importance of connection between those who are sharing space in NICU was painted. Learnings were constructed from personal and professional story, and from exploration of post war art and new vocabulary such as in the musings on "Sonder". We parted with a preview of the next spark which would come from the world of music.

Session Three: The Sound of Silence

"And in the naked light I saw, 10,000 people maybe more, People talking without speaking, people hearing without listening, people writing songs that voices never share. No dare disturb the sound of silence."- Paul Simon and Art Garfunkel

1. Setting the Intention/Grounding

The groups had a cadence as we went into Session Three. Once the door was closed as a signal that we were about to begin, participants shifted in their chairs, put their feet on the ground, and prepared for the breath. It was routine now, and the practice of the breath opened the space and somehow protected us within it.

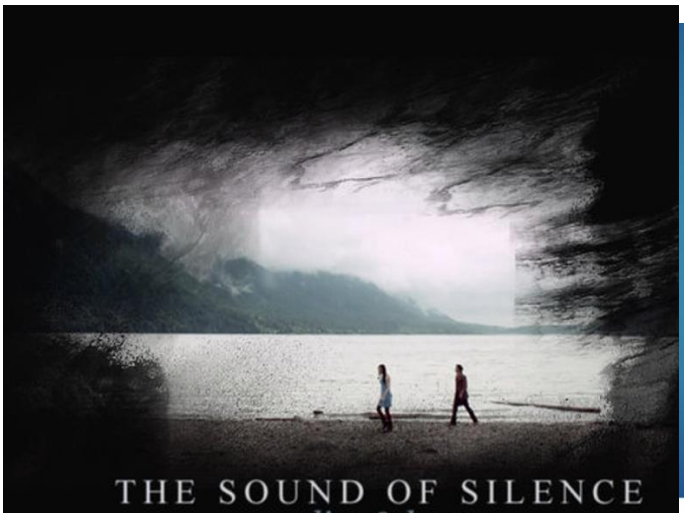
2. The Reflective Quote

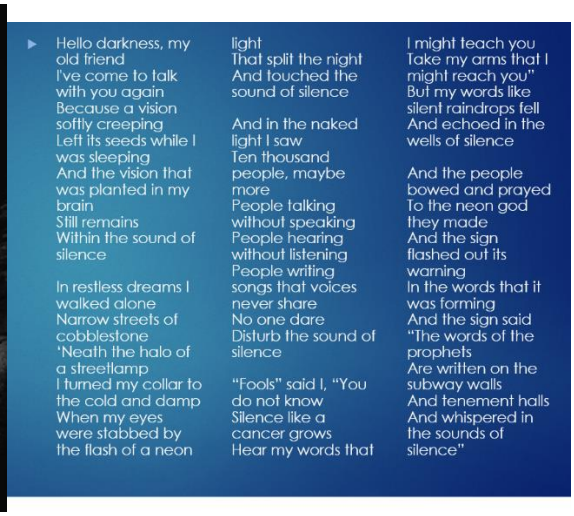
The late 19th century, French composer Claude Debussy provided the quote for Session Three, which read, "Music is the silence between the notes". In many of the cohorts we could have used the entire duration of the session on these words alone. Exploring the potential meaning of these words ranged from participants sharing that "the pauses in music makes room for you to enjoy the rest of the notes", and the idea that "it isn't only the crescendo of the music (or the crescendo in life) that makes it extraordinary, but also the quieter or even silent moments that are meaningful". The groups would reflect on times when that was true in life. One nurse, whose father recently passed, recounted the days prior to his death where she spent most of her time rushing through the day. She recounted going to the food store, driving the children to their activities, rushing home to bathe them, cleaning the house and doing tasks. She offered her thoughts on the importance of slowing down and how during loss we can learn that lesson. She offered closure by stating, "I

cannot change the past, but I can change how I am going forward in the future. I look forward to more silent times."

2. The Spark- *The Sound of Silence* – written by Paul Simon performed by Simon and Garfunkel or Disturbed

   Figure 3.0 and 3.1





Each cohort was given the choice of which version of the song that they would listen to. The folk classic by Simon and Garfunkel was chosen about one third of the time, and the contemporary rock version by the band Disturbed was chosen by the remaining groups. All groups seemed open to both options. Both were offered with the desire to expose listeners to the idea that the way we expressed, listened to, and interpreted music was all perspective. Despite this individuality, within the space of the experience, we could find commonality.

As the final notes played, each group visibly drew in breaths as if to ground before responding. These mindful pauses became a practice for most, but for those who continued to dive

right into response, the group seemed to hold the pause for them in their return responses. To begin the close reading, we first explored lines that "jumped out at us". These included:

"Hello darkness my old friend, I've come to talk with you again"

"The vision that was planted in my brain"

"People talking without speaking, People hearing without listening"

"Writing songs that voices never share"

"Silence like a cancer grows"

"Take my arms that I might reach you"

We explored some of these thoughts within the context of the NICU. Discussions included the hierarchical silencing of voice. Frontline staff explored ethical dilemmas and the rationality of feeling silenced when questioning a course of care for a patient. They further explored how it feels to be on the receiving end of silencing. In some cohorts, the group spoke of silence as calming, while others associated it with a death in the unit. In some groups, the conversation turned to the silencing of the voice of the baby. We explored who might really have the voice of the baby closest to heart, and we arrived at the parent voice in NICU. This opened the door to explore if we felt comfortable with parents speaking openly as advocates for their babies. We considered what outlets we were giving parents to share their stories that were unfolding within the NICU walls, and how present we were when those opportunities arise.

4. The Prompt-

Consider what the element of silence means to you in relationship to the world of the Neonatal ICU. Silence can be interpreted to be a calming and necessary strength in NICU that promotes healing and encourages concentration. In juxtaposition, silence at times can be a force for

disruption in communication or perceived as an element of sadness. Write a story of silence in NICU and what it means/meant for you and those around you.

5. The Share-

A shared writing titled, "Accompanied Silence" created another opportunity for co-constructed knowledge. The opportunity to wonder about the juxtaposition of "Accompanied Silence" VS "Abandonment" was proposed within a powerful piece on how we support families in NICU. From this emerged the vision of closing the curtain or door to them to provide "privacy" in moments of sadness, versus the idea of not trying to "fill up space" with conversation but not abandoning them in their moments of sadness by sitting together in silence.

Reactions to Session Three

The Facilitator (My reaction)

"Hello Darkness my old friend…vision that was planted in my brain." Words that were so meaningful to me were now taking new shape through the learnings that were being co-created during these sessions. I found the visions shifting from the old paradigm of practice, where vulnerability was liability, to this emergent world where allowing space for vulnerability could potentially shed light on some of the darkness and allow for a new vision. The seeds planted did not have to contain trauma, but they could contain understanding and connection. There was evidence to this happening during this time in real time practice.

> *The family had just received this worst news that they would ever get. It was what one imagined as the worst moment of their life and we were witness to it. Their baby was here but forever changed and forever disabled. Mom fled with her hands over her ears,*

screaming as the social worker followed her down the hallway. The nurse went to Dad who had just laid his head on the table in front of him in defeat. Many moments passed and she just sat with him. She put her hand on his and his eyelids fluttered allowing for the stream of tears to flow without a sound. She asked if he would rather be alone and his grip on her hand tightened ever so slightly as he said, "Please Stay." She stayed. In accompanied silence she stayed for 15 lifesaving minutes that Dad would recount over and over to family and friends through the years.

Observations within the cohorts:

In an evening group where participants preferred the zoom option, several experienced nurses, a lactation consultant and a respiratory therapist gathered together virtually. Session after session the free-word association writing of a well experienced nurse captured the attention of all participants. It wasn't the words themselves, but the expression and emphasis put into reading them each week. There was an anger covered in hope, strength and resilience that were mixing right below the surface, and in each phrase, it could appear in either form, depending on what was provoked. A sample of her words are as follows, but the passion and purposeful cadence cannot be conveyed on the page:

ALONE-SADNESS-DISCONNECTION----CLOSE IN PROXIMITY BUT SO ALONE----MOVEMENT-PURPOSEFUL MOVEMENT----SIMILAR BUT NOT OBVIOUSLY SO----DETACHED-SIMILARLY DETACHED----ETHICAL HEALTHCARE?-NO!-COLLISION INEVITABLE!-LOOK UP AND SEE

The entry into the topic of silence was explored in multiple ways, and the groups were able to see many perspectives and meanings behind the silence. Participants discussed that the unit was

usually very loud despite the recommendations of decreased decibel level for babies to thrive developmentally. They acknowledged that silence should mean healing in the NICU but more often is unattainable, especially during the day shift. They also described that when they enter the NICU and it is very quiet, there is a feeling that something must be wrong because it was unusual. The uncomfortable silence usually accompanies a critical baby or a dying baby. Every group explored multiple aspects but usually the conversations landed equally in either the camp of silence as healing or silence as sadness. An exploration into how the context of silence has changed in the NICU, secondary to a new standard of care, Family Nurture Care, was pursued with participants.

Within the context of Family Nurture Care, the new standard that was introduced six months ago, parents were encouraged to emotionally express to their babies. They were asked to tell their babies their personal stories and speak with prosody and emotion. The evidence-based benefits proven to support the intervention included improvement in mothers' psychological outcomes at four months post NICU, and improved baby developmental outcomes up to five years (Welch, et al 2015, 2020). Despite the evidence, this practice interrupted the therapeutic silence that was the goal clinicians strived for with the adoption of developmental care in the 1990s. As a result of this move to a more developmentally appropriate environment, open bay units were converted to extremely costly single-family rooms, and sound monitoring devices were utilized in many units that remained as open bay. Despite the therapeutic intentions of sound reduction, studies conducted on babies who were hospitalized in single family rooms showed lower language scores at two years of age (Pineda et al. 2017, p.66). Although, toxic noise was limited, overall language seemed to be limited as well. More recent studies link underlying deficits in language and cognition to potential language integration deficits and lack of language exposure (Horwitz-

Krauss et al. 2016, 2013 p. 2651, 2662). This paradigm of Family Nurture Care sought to add language nutrition to the infant's daily routine while fostering emotional connection by encouraging mom to share her personal stories with the most captive listener, her child. However, this was a new context for the clinical staff. The following question was posed as we explored therapeutic silence…How has the context of silence in NICU changed since Family Nurture Care? The responses were candid and variable. Staff expressed how often they found themselves filling the silence when a parent was at the bedside, by engaging in "friendly chatter" before Family Nurture Care was implemented. Clinicians utilized their time to educate and update parents, but then expressed feelings of guilt or emptiness when the parent sat silently at the bedside. They interpreted the silence as sadness. A sense of discomfort was discussed by most nurses as they recounted the first few weeks of Family Nurture Care. Some clinicians admitted that it still seemed strange to hear the sounds of mothers and fathers talking expressively to their babies behind the screens. However, a seasoned NICU nurse agreed that it was "the right approach as long as the baby tolerated it and parents could modulate". Others in the group nodded in agreement. There was commentary by a patient tech that "we can no longer act as if complete silence is a shield. We understand the place of silence when it comes to concentration and when it comes to HIPAA (confidentiality) but there is a downside to silence as well and we have to admit that."

The overall takeaway from Session Three was a general sense that was captured by one of the physicians when she stated that "Silence comes with a duality". Silence can be calming or confusing, lonely or guided, disagreeable or trusting, comfortable or challenging. We could not and would not seek to concretely define silence in the walls of the NICU, but there was a new found awareness of its mindful presence that was palpable amongst the participants.

Session Four: At the Beginning of Each Shift by Alyson Kennedy

"I look up to the night sky and trace the pattern of the stars I know…forming a design that saves me." Alyson Kennedy

Session Four centered on the epidemic of burnout and resilience within the powerful poetry of nurse/writer Alyson Kennedy. Her piece, "At the Beginning of Each Shift", was included in a collection called *Intensive Care, More Poetry and Prose by Nurses.* This book was introduced during a study in a Narrative course at Drew University taught by Sean Nevin. This impassioned collection, written entirely by nurses in various settings, is filled with narrative testimony that brings the lived experiences of those on the front lines of healthcare to life through vivid accounts. After thoughtful consideration, Alyson Kennedy's piece was chosen to highlight the issues of the fatiguing demands and hope-filled strength of those who dedicate their lives to the art of caring for others, despite the difficult conditions imposed within the healthcare system.

1. Setting the Intention/Grounding

Breath One- to better serve our babies and their families, Breath Two- to better serve each other (our colleagues), and Breath Three- to better serve our own lives (ourselves both personally and professionally as well as serving our loved ones). A silent prayer was said in the mind of the facilitator at the start of each group, "Dear Lord, let me get this one right for them. Please give me the words and wisdom."

2. The Reflective Quote

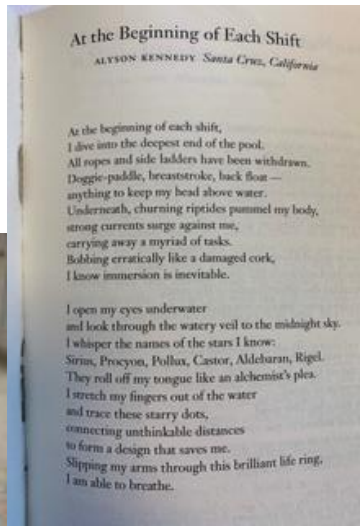
Mindfully selected, the shared reflection for Session Four was the words of Nobel Peace Prize recipient, Nelson Mandela. The upcoming poem would take us to the deep oceans of the work done in the hospital setting, and in order to keep us readily abled to find the bubbles to get back up to the surface, Mandela offered the life ring with the image of resilience that rang in his shared words.

"The greatest glory in living lies not in never falling, but rising every time we fall."- Nelson Mandela

We discussed resilience, which had become a buzz word in healthcare, and recounted what the word meant to each of us. Resilience resonated with many people, and they wanted to embody what they interpreted the meaning to be. It was certainly considered a compliment in the circles of leadership in healthcare. Others felt the term was "overused" and somewhat insulting. Observation that somehow, the clinician was entirely responsible for their own ability to overcome all adversity and be resilient was discussed. The groups wondered if some of the responsibility for developing resilient clinicians should lie within the healthcare system itself. One nurse noted, "The movement to make us all find our resilience in the face of impossible expectations perpetuates the culture of culpability that has become frontline healthcare." These remarks further demonstrate the reluctance to enter into a state of vulnerability within a profession where solutions and answers must always be found. Creating a state of wondering and embracing the potentiality of a clinician who may not have all of the answers was pivotal to our understanding and acceptance of self and other.

3. The Spark

Figure 4.0 and 4.1



At the Beginning of Each Shift

ALYSON KENNEDY *Santa Cruz, California*

At the beginning of each shift,
I dive into the deepest end of the pool.
All ropes and side ladders have been withdrawn.
Doggie-paddle, breaststroke, back float —
anything to keep my head above water.
Underneath, churning riptides pummel my body,
strong currents surge against me,
carrying away a myriad of tasks.
Bobbing erratically like a damaged cork,
I know immersion is inevitable.

I open my eyes underwater
and look through the watery veil to the midnight sky.
I whisper the names of the stars I know:
Sirius, Procyon, Pollux, Castor, Aldebaran, Rigel.
They roll off my tongue like an alchemist's plea.
I stretch my fingers out of the water
and trace these starry dots,
connecting unthinkable distances
to form a design that saves me.
Slipping my arms through this brilliant life ring,
I am able to breathe.

Participants were asked to describe a feeling that they had while the poem was read. The words used were variable including, "Sad", "Hopeful", "Dream-like", "Wistful", and "Heavy". The close reading continued with an exploration into the author's biography as compared with others at the end of the text. Nurse Kennedy's read, "Alyson Kennedy worked on a medical-surgical floor as a staff RN for nearly eighteen years when she left nursing in 2001 to pursue other career options. This is Alyson Kennedy's first publication." A close reading into where inspiration for this poetry may have come from ensued. The first notable description was the floor that this nurse worked on. Medical-Surgical floors were known to have the heaviest caseloads and highest patient to staff ratios. Participants recounted their days on the med-surg floors with humor and nostalgia. A common feeling was relief to be in intensive care, where situations were more extreme but ratios more controlled. In connection, a discussion on the home state of the author and the context of time when she reportedly ended her nursing career was reflected on. Multiple nurses instantly connected the timeframe to the well-known strikes and subsequent 2004 passing of the sentinel law mandating nurse-patient ratios. As a result of the laws passed, it was reported in 2015's *Economic Policy Institute* that nurse employment rose over 15 percent and nurse injuries were

reduced by over 30 percent (Leigh, 2015, para 2). Once more connecting to the feelings of empowerment rather than despair, groups proceeded into the prompt.

4. The Prompt

Burnout and resilience are well described in healthcare today. Write a story or your thoughts on their intersection considering what your life ring may look like…

5. The Share

The participants in most groups were so moved by the imagery in the poem that they continued the metaphors of drowning in work and the life ring appearing in various forms. A group of nurses, respiratory therapists, and patient care techs shared in a story of the staff communication phone that we all carry now, as a source of burnout. The imagery of trying to eat lunch but the phone rings, trying to be present with a patient while being called by lab, trying to concentrate on drawing up medication and a patient's family calling in, trying to use the bathroom and the doctor is calling… drowning in a sea of phone calls and then you arrive at your home doorway and your child puts their arms out as the life ring.

Family was a strong life ring, but a close second, when recounting stories, was the team you work with on any given day. An administrator recalled their days in staff, and the life ring being "a coworker who reaches out and asks if you need help, a patient who turned the corner and started to do well, the ability to talk about what is going on at the end of the day".

Reactions to Session Three

The Facilitator (My Reaction)-

There is was! The recognition that we need to express and reflect in some productive way. Recognition that we can find our life ring in one another. If we are left without a way to process

all that each day holds, it may be unlikely that we as humans are able to fully engage and be present in the face of illness on a daily basis. The following is part of a poetry collection written for Sean Nevin's class. The collection was titled, "Looking for Light in Dark Places".

Empty Holes

They show us gratitude
with Donuts.
The gelatinous kinds that are lipid filled and ooze
onto our swollen crooked hands.
Harsh hands that are raw and cracked from the constant struggle
trying to abrade them
from all they have touched, all they have seen.

They show us gratitude
with Donuts.
The kind with empty holes inside but sprinkled
with the spectrum of the rainbow.
The ones they never dare eat themselves,
Intended as payment for the light that goes missing.

Gazing through the hole,
searching for the light
We long to see.

By Suzanne Milkiewicz-Bryjak-2016

Observations within the cohorts:

Several cohorts wrote about metaphorical images and wanted to explore the feeling of jumping into the deep end at the beginning of each shift. Some described the beginning of each day being like "going into battle". There were various mechanisms of embracing this theme. Some participants used the jumping off point within the poetic nature of the work and provided specific descriptors. One such example was knowing at the beginning of a shift that you were going to take care of a sick or dying baby and that all of your efforts may not matter. They discussed how you had to conciously make the choice to jump into a day filled with misery despite challenges that

may be going on in your own life. They described the feeling of overwhelm when you know you are short staffed and how it feels like you are literally drowning as it takes your breath away. Some participants had difficulty embracing the serious nature of the work and used more humorous tones. One nurse described how it felt to have to put on all of your armor as you engaged in the battle of the day, and humorously recalled the phrase a colleague would use to indicate that feeling of jumping into the deep end or going into battle. The group erupted in needed laughter as she shared the bellowing of a beloved colleague who would say "Get ready everyone and get your bedpan helmets today!" Shared story and laughter such as this served to bind the group together through yet another mechanism and build a team atmosphere. Discussion continued on what that armor looks like, and what it consists of when you take it off. There was acknowledgement that part of what is left behind is the sadness and loss that families endure, because you shouldn't take it with you. A social worker shared that it was sometimes hard to separate from it when you go home and it "plays over and over in your mind." A nurse in another group affirmed that "when something goes wrong, I think about it all night and wonder what I could have done better. When I am so busy, I wonder if I could have missed something and it makes me disappointed because I was not the nurse that I wanted to be."

This theme of "busyness" as a condition that causes burnout and fatigue was prevalent across the cohorts. A seasoned nurse with over 30 years of experience noted, "I remember the time when patient ratios were what we were drowning in, but times have changed. With the addition of technology and the electronic medical record (EMR), we are drowning in processes. Every day there is a new process. It is understandable that many of them are safety driven and considered advancements, but by the time I go to the computer, check my orders, go to the lab computer and pull out my labels, scan the milk, go to the pyxis computer to get my medication and go back to the computer to scan it again, getting to the patient is the absolutely last thing on

my list and I am out of time. I spent my whole day drowning in processes that I can't possibly keep up with because there is always a new advancement. Something new to learn that sets us all back as a novice in some way every day." Her eyes were cast downward as she finished her reading.

An overall feeling that clinicians are hungry for human contact was pervasive. The life ring was almost always a description of human contact. It was that moment that Rita Charon described in her TedX where she professes, "it was within the story that we made contact. It is possible all of the time."

Session Five- The Affair

"What you see depends not only on what you look at, but also, on where you look from"-
James Deacon

Session Five was an attempt at including contemporary media within the collection of pieces that we would study. Several clips from the Showtime channel's American television drama, *The Affair*, were used. *The Affair* was created by Sarah Treem and Hagai Levi and ran for five seasons from 2014-2019. Episodes were separated into two or more parts, with each piece being told from different character's perspective. Often exact scenes would be shown but would appear in variations according to whose viewpoint we were experiencing.

Many participants immediately recognized the series and initially wanted to digress into discussion, but we redirected back to the theme that was masterfully highlighted by the series- Perspective.

Setting the Intention/Grounding-

The Buddist Monk Thich Knat Hahn reminds us that, “Feelings come and go like clouds in the windy sky. Conscious breathing is the anchor to the soul.” With each passing group it became more evident that this simple exercise of the breath could bring us all together in shared space. Moments ago, sitting in the same chairs, our minds raced from different places moving onto the next activities in our minds, hardly able to be present in this moment as our minds and feelings moved as quickly as that metaphor of clouds in a windy sky. The breath settled the wind. It allowed us to arrive in this moment, and although we would engage in reflections, stories and feelings, the awareness that we were all together and present in this actual moment and space was clear.

2. The Reflective Quote-

“Everything we hear is an opinion, not a fact, everything we see is perspective not the truth.”- Marcus Aurelius.

Marcus Aurelius, who was known as the last of the Five Good Roman Emperors, reigned from 161-180 CE. He was known for his philosophy and views in Stoicism that centered upon our responsibility toward one another as humans. His series of meditations were writings throughout his life, composed mostly during experiences of wartime that concentrated on the importance of analyzing one's judgment of self and others, and developing a cosmic perspective (Piazza, Needleman, Aurelius 2008)

We began with an exploration into what truth is and what perspective means. Concessions to some universal truths were acknowledged however, further reflection into what perspective means within the context of story was discussed. The quote served as a jumping off point to shift from the wisdom of ancient history to the contemporary media drama that detailed the ripple effects of what our actions (or inaction) do to one another, and how our decisions affect the

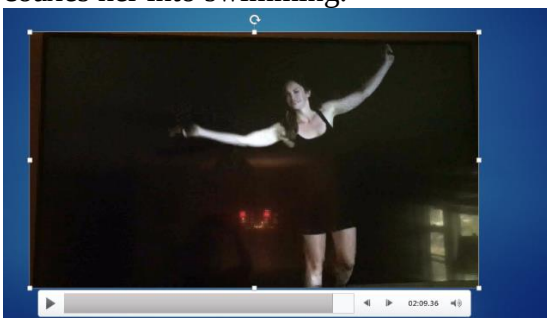
multitudes around us, even across generations (Feldman, podcast https://admin.salesforce.com/blog/2018/the-ripple-effect-with-cheryl-feldman).

3. The Spark-

The cohorts watched two to three minute clips from Season One Episode Two that depicted a party scene where a man and woman first embark on a series of meetings that would change their lives. The first clip depicted the same moments in time as the second clip, only each segments was from a different perspective, memory, and viewpoint. The following series of images from the clips depict the highlighted differences.

Figure 5.0 and 5.1 First Meeting Close Reading- Perspective One was presented from "His" point of view, noting that the first time they saw each other at the party was when she glanced his way seductively from across the room as he danced intimately with his wife. The second clip, "Her" perspective shows their first meeting at the table where he aggressively grabs her attention while his wife is distracted.

Figure 5.2 and 5.3 The Water Close Reading- Perspective One "His" perspective shows her splashing in the ocean and inviting him to join her, while Perspective Two "her" perspective, noting them walking parellel on the beach while she explains that she does not like the water as he coaxes her into swimming.



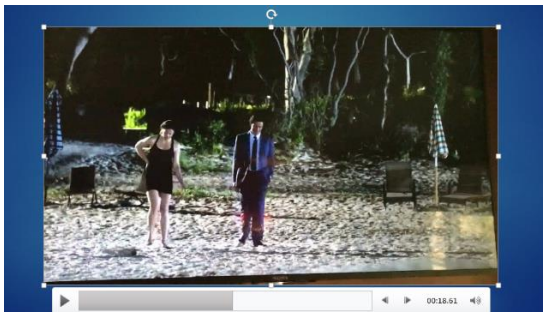
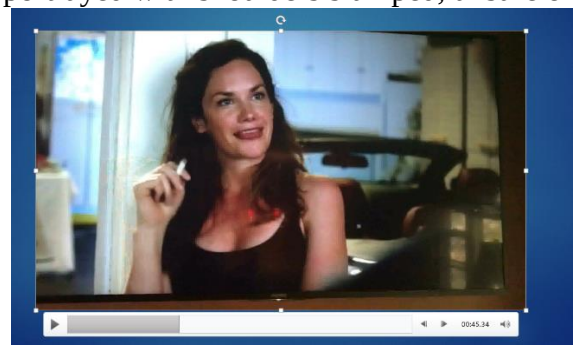
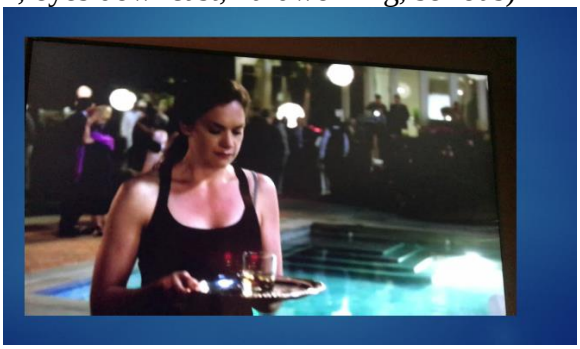


Figure 5.4 and 5.5 Appearance and Body language Close Reading – Discussion of the differences in hair style (Down and flowing in P1, Up and back in P2) Shoes (Heels in P1, Flats in P2) and Body Language (Confident, Upright, Eye Contact, Smoking, Laughing in P1 while in P2 she is portrayed with shoulders slumped, unsure of self, eyes downcast, hardworking, serious)





5. The Prompt

Everyone has their own predispositions, tendencies, and inclinations that influence their points of view. Understanding the perspectives of each person involved in any given situation (including your own) can help draw a clearer picture of the reality of the situation. Often NICU parents, nurses, and physicians can see the patients' stories and needs from different perspectives. Other scenarios that include the need for perspective study can be how we view each other's roles, (management, clinicians, techs) and how departments work together (Labor and Delivery, Mother Baby, NICU, Pediatrics, X-Ray, Laboratory, etc.).

Understanding the perspective of the other is essential to our communications.

Think about a time where another's perspective differed from your perspective.

The Twist: Now write the story from the perspective of the other person.

6. The Share

Many participants shared that this was “the most difficult writing that they have done so far”. We discussed the challenge in taking ourselves out of our comfort zone of what we think that we know about a situation and shift our way of thinking in order to see things from another view. We engaged in conversation that even where we are placed in a room can change perspective of any given situation. We may be able to see things or hear things that we may not appreciate from another view. We discussed the perspective of a parent in NICU when a clinician sits with them as opposed to the perspective they take when a clinician speaks to them as they stand over them. Stories began to emerge, and participants shared from their page, minds, and hearts.

Reactions to Session Five

The Facilitator (My Reactions):

In order to create a safe space where one could readily share an imagined piece where truths held dear may now be discovered to not be absolute truths, raw vulnerability needed to be displayed and I embodied that in my writings.

Within my piece, I became the nurses who cared for my son and honestly believed that they were helping him by limiting my ability to touch him, hold him, talk to him and sing to him. I was no longer the mother who relied on her knowledge as a nurse and her sheer determination in order to assure that her child would survive. I wasn’t that mother whose lived experience with her family included a serious and prolonged ICU course that not only left physiological scars strewn all over my son’s body, but also so many psychological and emotional scars that would last for decades and forever shape my family.

I was not that person. I am the nurse who worked in an extremely busy ICU where infants and children lie critically ill and often did not survive. I am the nurse who saw six out of eight

long-term pediatric patients die over the course of a few months and could not risk another child's instability at the hands of his mother, who, although well meaning, was overbearing, emotional and unrealistic, this mother, who refuses to ever leave the bedside and inserts herself in medical care all of the time at the detriment of her son. An example of that was last night when she insisted he needed to be suctioned. I wanted to wait for respiratory, but she was impatiently pacing as the monitor showed some slight desaturations. So I gave in. I knew I should have waited for respiratory because of course, his breathing tube came out. Of course, she started screaming as he turned blue and made every lifesaving move we had to make even harder through her drama and judgement. And now we are here and he is resting, and she wants to read to him. I just don't believe he is stable enough. He's about to drift off to sleep. He doesn't want or need to be read to. He is stable enough. Well, maybe he is, but honestly who knows what she will want next if I entertain this? If I give into this, she may want to hold him next and that not only can that take much more time than I possibly have with my other patient going to surgery, but let's face it, it can also be so dangerous. I am sorry, I really am but I am looking out for these children. I am looking out for my patients and I really know what is best here. No other tragedies are happening on my watch.

Observations within the Cohorts:

Most often, personal stories of differing viewpoints with a loved one were examined in the writings. An atmosphere of openness and exploration was apparent, where brave readers took the first person view of sister, a parent, a spouse, or their child. In some groups, we turned the conversation toward the clinical and wondered if there was room to examine other team members' perspectives.

Within the physician's group, the honesty and eloquence of one participant continued to shine through. This particular physician was able to display her thoughts about the physician/nurse relationship bravely and vividly on the page. In this group and in others, once one participant in a cohort displayed vulnerability that landed in a safe space, others shared thoughts, both from their page and newfound thoughts in relation to a workplace topic.

An example of this was in a mixed group with nurses and therapists. A physical therapist had written a story of perspective from her home life, but after a colleague bravely explored a piece where she took the role of a challenging parent in follow up feeding clinic, the physical therapist acknowledged,

> "My story was about a situation with my husband but I want to take this time to respond to what we just heard because it is so important. When we are seeing families we are only seeing this small piece, this perspective from where we are viewing things but there is so much more involved. Like we just heard, there may be reasons why that parent may be reluctant to certain therapies that we propose but it's not always apparent. This is such important conversation."

Important conversations were turning up in the administrators group as well. A manager and an educator wrote from their staff perspective. The manager made observations on her feelings toward middle management at the conclusion of her short piece. It is important to note that the cohort member who was the highest ranking administrator in the group, was absent from this session perhaps allowing for increased honestly within this session.

> "I feel like it's hardest in middle management. I need to see everyone's perspective and I feel like I am the stuffing in between the two cookies in the Oreo. I feel like I am always getting squashed."

These observations were acknowledged, and we turned the conversation to imagine each side of the Oreo. Were the two hard cookie sides as strong and unbreakable as they seemed? Were they vulnerable as well? Could we acknowledge and appreciate each of the parts of our Oreo in healthcare?

Session Six Juniper-The girl who was born too soon by Kelley and Thomas French

"Perhaps if we made her long to hear what happens next, she would stay with us until morning."-Tom and Kelley French

Our final session was on the 2016 novel, *Juniper The girl who was born too soon*, by Kelley and Thomas French. This masterfully crafted biography and memoir had direct relevance to the participants due to its primary setting of the Neonatal Intensive Care Unit. It chronicles the experiences of Kelley and Thomas French and their daughter Juniper, born at one pound four ounces and 23 weeks' gestation, as they navigate a long and complicated NICU stay. Google Books calls it "an extraordinary and gorgeously told story of survival by two award winning journalists". The fact that Tom French was a Pulitzer prize winner and Kelley French was an accomplished journalist prior to their experience as parents in NICU brought a level of literary beauty to the writing. Their abilities to artistically portray their experience with authenticity and brilliance allowed this close examination of "their world", which was in fact "our world". This extraordinary perspective was offered through their unique lens.

1. Setting the Intention/Grounding

A feeling of finality accompanied us as we engaged in the breath this week. Participants were invited to use this practice whenever they felt a need to focus in on what was central in their practice and in their lives. Holistic practice is something that was embedded within the culture of The Valley Hospital through a 15 year partnership with the Birchtree Center for Healthcare Transformation. It was a yearlong training and certification program that I experienced in 2013-2014. The partnership is described in Nursing Management journal as "fundamentally changing organizational culture using principles of holism, nurse resilience, presence, integrative therapies, and compassionate care" (Shanahan et al, 2018, p.24). I was both enlightened and discouraged by this subculture of holism within the workplace, as I could see its integration, but also saw the disconnect in practice because of the limited amount of reach the program had to those on the frontlines. Management chose a small number of participants per unit to attend yearly, and a new stream of transactional management style was embedding the organization that was overshadowing the holistic framework, and it was increasingly visible. There were critics and "nay sayers", and less time and money dedicated for those invested. A sentinel moment was when our holistic birth program was moved out of the hospital to an offsite location, and our digital screen with empowering birth quotes was removed from the lobby, and a gaping hole was left in its place, which stood as a reminder each day, of the ground we were losing. NC was created, in part, to reach those on the frontlines in hopes of an environmental transformation that would cast a wide net, but I knew that it would not have been possible without the vision of those who planted seeds throughout the organization that allowed me to study this work. It is true that we tend to see the challenges, but on these particular days, in this shared space, I honored the progress. As we engaged in breathing this final time together as cohorts, we spent extra time reflecting on the

intentions and I dedicated my breath to the visionaries who allowed this practice to be realized and those who may be emerging through this shared space to continue the work.

Breath One- to better serve our babies and their families,
Breath Two- to better serve each other (our colleagues)
Breath Three- to better serve our own lives (ourselves both personally and professionally as well as serving our loved ones).

2. The Reflective Quote

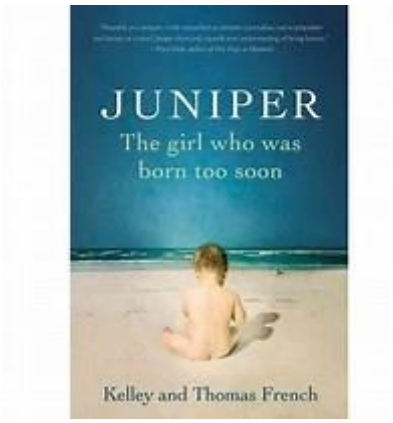
"I alone cannot change the world, but I can cast a stone across the waters that forms many ripples."- Mother Theresa

Our final reflective quote was provided by 1979, Nobel Peace Prize winner and well-known Catholic humanitarian, Mother Theresa of Calcutta. We acknowledged that even if one did not share in Mother Theresa's religious beliefs, most regard her as a symbol of peace and altruism, dedicating her life to providing relief to those who were suffering all over the globe including those impacted by catastrophe and illness. We reflected on connections to her beliefs and our work as clinicians, as we accompany the sick and suffering in the hospital environment. We reflected on the ripples that are formed by each and every stone that we cast; ripples not only for our patients and their families, but ripples that impact each other as co-workers, the community, our own families, and healthcare as a whole. What form did we want those ripples to take? Did we believe that we could make a difference within our practice? The overwhelming answer was yes.

3. The Spark-

Prologue from *Juniper, The girl that was born too soon* by Kelley and Thomas French

Figure 6.0 and 6.1



Prologue- The Tunnel

She arrived at the edge of what is possible and what is right, the shadowland between life and death, hubris and hope. Her eyes were fused shut. The plates of her skull were half formed, leaving her head more squishy than solid. Her skin was so translucent that just below the surface we could see the shuddering fist of her heart. The doctors and nurses ringed her plastic box, summoning all of their arts and deploying all of their machines, working at the limit of human capability to keep her with us. We soon forgot what day it was, what we had been doing before we arrived in this place—our jobs, our plans, the vanities that had defined us. We'd been dropped inside a tunnel and were down so deep there was no way back. She was perpetually dying, then not dying, then dying again. Slowly, we discovered that the only escape was to create a world *for her beyond the box. So we filled her endless night with possibilities and sang her songs about the sun and read her books in which children could fly. We shared the story of how we had fought to make*

her ours. If we made her long to know what happened next, maybe we could keep her with us until dawn (2016 French).

A close reading of the prologue began. Passages such as "*The doctors and nurses ringed her plastic box, summoning all of their arts and deploying all of their machines, working at the limit of human capability to keep her with us."* were examined. This was a line that had exceptional meaning to the participants who shared their stories of that moment in time that happens routinely, but felt, as one nurse said, "otherworldly", in the words of this author. We examined again how what was a depiction of daily interdisciplinary rounds, was transformed into a scene from Harry Potter, with us, the clinicians as the magical wizards. Many participants shared that when they were given the list of "sparks", they purchased the novel and read it in its entirety. Many participants encouraged others in the NICU to read it as well, including clinicians who were not participants in Narrative Consultation.

The close reading continued to the final lines of the prologue, "*Slowly, we discovered that the only escape was to create a* world *for her beyond the box. So we filled her endless night with possibilities and sang her songs about the sun and read her books in which children could fly. We shared the story of how we had fought to make her ours. If we made her long to know what happened next, maybe we could keep her with us until dawn"(2016 French).* We discussed how this way of interacting with their infant in NICU, sharing stories, songs, emotions, and truly connecting to their child was quite similar to the new standard of care, Family Nurture Care, that the unit embarked on at the beginning of the year. We discussed if the French's were able to give us a new insight into what this practice looked like and felt like for families. A therapist shared, "that although parents may see us as the magicians in the NICU, it is actually them, as parents, that have the central role." The role of the family was shifted from a supporting character in NICU

to the leading role, and this was significant. Would clinicians still find innate value and joy if their role was in the supporting actor category? Could they embrace their magic while embracing its vulnerability?

4. The Prompt

Write the prologue to your unique NICU story. Consider some of the following…Who are you when you enter the NICU? How does it change who you are when you leave? What do you want written down and what should be left unwritten? How do we perceive ourselves and each other in NICU? How does the public perceive us and what should they know? What do you want to change most and what makes you most proud?

5. The Share

This piece was being written uniquely for the self. In this last session, we wouldn't do a public share, but rather engage in a discussion on some of our thoughts so all participants could have space to share something about what they received out of participation in these sessions. Participants were encouraged to hold onto their prologues and perhaps continue in the practice of writing if they found it helpful. Participants were encouraged to make it their song, make it their sculpture, make it their story, but always have room in that story to see others within it.

This week's final share started with gratitude within the groups. Perhaps it was because the dates of the last groups coincided with Thanksgiving week, or perhaps it was genuinely the emotion with which we were left with, but there was an overwhelming message of gratitude.

Reactions to Session Six

The Facilitator (My Reactions):

"If we want to make meaning, we need to make art. As long as we are creating, we are cultivating meaning."- Brene Brown

Relief was certainly an emotion that was present. Anticipation for the work of evaluation that was to come was another overarching feeling. However, what I saw and felt, what was truly embodied during that final session, could be summed up in one word: Connection; connection to one another, connection to our work, connection to ourselves which allowed space for one to create meaning. There was a brief moment where we were not divided into shifts, roles, races, income brackets, or generational labels, but a place in time where we were a team, and on that team we had the same goals. The goals saw the patient and families as central, not as an "other" but also a part of this team. The goals were not ultimately or singularly to "cure", but to make meaning within this space of NICU and learn from one another, if not for the betterment of this present situation, for the betterment of those that come next. The stories of our patients, our families, and our future clinicians are all bound by a common interest and shared ties to this most magical space where trauma can be transformed.

That was my reaction, and most assuredly it is with bias I write those words. That was my personal story of taking the most traumatic year of my life, one that transcended into a decade or so of secondary trauma and another subsequent decade dedicated to doing a close reading on the experiences in order to make meaning and connection. A dedication to equalizing the art of clinical practice in balance with the science in order to assure that we can connect back to reason why we are here. In the words of Dr. Rita Charon, *"**to understand what medicine is for and even more than that in excess of the medicine, what ordinary living is for**."* (Charon TedX, 2011)

Observations within the cohorts:

The making of meaning and the need for that as a regular practice, was verbalized. In a group a nurses, there was commentary about how the doctors get to follow patients in their clinics, but there is not a way for the nurses, who put their hearts into caring for these patients to be connected to their stories. Nurses discussed how relationships on social media are discouraged, yet it had changed the paradigm so that there was a way that they could stay in contact. Discussion of events like the "NICU Reunion" and the annual "NICU Fashion Show" event that had been started in this particular hospital ensued and participants felt that these were "some ways" that they could connect to the long term impacts of their work. Nurses suggested that the unit begin a practice of physicians giving weekly or monthly updates from clinical follow up visits as a way for nursing staff to see the impact directly and to connect their work to the long term outcomes. There was evidence in this thinking that problem solving was at the forefront as opposed to the disconnect being centered.

Several participants asked if there would be opportunities to continue this practice of coming together in Narrative Consultation, and thoughts around what that practice would look like were explored, lending to the co-construction of possibilities. In the groups, multiple participants who were in the midst of personal or family health issues expressed gratitude for this practice and its impact on their coping abilities. One participant expressed that it seemed as if it would be "difficult at first, but it actually helped me see where the rest of my family was coming from, and maybe where the patient was coming from too."

A reference to the underpinnings of art was made by an administrator who shared these honest and well thought-out words,

> "Often when I come into the unit, I have a goal or purpose in mind. I come in, do what has to be done and rush out to get to my next meeting. We all rush so much. (she looked

around the room at the group and nodded to each and there was reciprocal nodding in validation) What I realized here is that you cannot view a piece of art in the museum from the street. You have to go into the museum and get close to it. You have to get personal in order to do a close reading."

The room was silent for many moments afterward, and there was a glistening of tears in the eyes of the participants. Leadership and administration in healthcare is a particularly difficult business. The opening of one's eyes to what lies within "the museum" has the potential to change the way that we run its operations. There was power in that statement and the co-constructed knowledge that came out of it.

In its most basic form, the messages that were being sent by the group on the days of this last session were that there was gratitude for participation, meaning in participation, and connection in participation. The close readings helped participants closely read work and personal situations and examine perspectives that would otherwise have gone unnoticed or misrepresented. The questions that remained were daunting. Would we see a lasting difference? Would it be internalized? Was this representative of most or only few? Were these few perhaps most vocal and leading?

The ethnographic evidence within the groups was powerful, but what remained was to see if there was a significant difference quantitatively in the scientific and statistical conclusion. Additionally, there was the question of if we would we see lasting evidence and saturation of these themes in the interview and analysis process that would follow in the next months.

Chapter 5- The Statistical Analysis and Quantitative Findings

Aliaga and Gunderson describe quantitative research with the following, "Quantitative research is 'explaining phenomena by collecting numerical data that are analyzed using mathematically based methods and statistics. Further, quantitative data is the collection of numerical data that supplies specificity to explain a phenomenon by answering a direct question" (Aliaga et al 2000, http://valmikiacademy.com/module-two-qualitative-research-methods/, para 3). Discussions on the contrast and paradigm wars of Quantitative data vs Qualitative data continue to be pervasive in the research world. For the purposes of this study, a mixed methodology approach is used in order to quantify questions central to our research. This first step provides breadth with numerical analysis, and act as leads to thematic coding in the qualitative data. The concurrent step is to utilize various qualitative approaches, providing depth in order to provide a descriptive analysis to facilitate a better understanding of what the numbers reached (or not reached) mean in regard to current and future practice. The Qualitative analysis is discussed in the next chapter.

The program Statistical Package for the Social Sciences (SPSS) was used in the analysis run by Columbia University's Department of Public Health statistician, Judy Austin PhD. Utilization of SPSS provides ways to interpret survey data in order to identify trends, develop predictive models and draw informed conclusions (www.alchemer.com). The statistical tools used incorporate Analysis of Variance (ANOVA) and Multiple Regression Analysis to analyze the data and interpret the results.

A brief review of the elements of the study as described in the initial protocol in Chapter 3 precede the results below. Please refer to Chapter 3 for a more thorough description of the background, design, and methods.

Design

A prospective cohort study design is used examining the longitudinal effects of the intervention of Narrative Consultation.

Methods

Data on four validated surveys (see below for description) are analyzed at three time points over a two-year period. Timepoint One (T1) assesses the unit culture at a time before Family Nurture Care or Narrative Consultation is implemented in the NICU at The Valley Hospital in Ridgewood, NJ. This period spans from January, 2018 to January, 2019. Timepoint Two (T2) is taken at least six months after the introduction of Family Nurture Care as the new standard of neonatal care, but prior to the initiation of Narrative Consultation. Timepoint Three (T3) is taken after the completion of Narrative Consultation and six to 12 months after the start of Family Nurture Care as the new standard of care in The Valley Hospital Neonatal Intensive Care Unit.

A comparison of T1 to T2 was run in order to assess differences in culture secondary to Family Nurture Intervention without the addition of Narrative Consultation. A comparison of T1 to T3 was run to assess differences in culture secondary to Family Nurture Intervention with an augmentation of Narrative Consultation as a support structure for staff.

The Emotional Exhaustion subscale in the Maslach Burnout Inventory is marked as the primary outcome and powered against similar studies. Studies in similar settings (Aytekin et al., 2010; Rushton et al., 2015) have reported mean scores between 13.0 and 16.3 with standard deviation of 3.74 and 5.46 respectively. Therefore, with a total sample of 120 staff members, and a significance

level of alpha= .05, we would have power (1-beta) = .91 to detect an effect size of 0.5. At N=120, we would have power= .80 to detect an effect size of 0.36 on the Emotional Exhaustion scale. Alternately, we would need a sample of only N=66 to have power= .80 to detect an effect size = 0.5.

With a final sample size of N=47 we are able to detect a significant effect in Emotional Exhaustion which is described below.

Surveys

1. Maslach Burnout Inventory (MBI)

MBI-Human Services Survey (MBI-HSS) (Maslach, Jackson & Leiter, 1996) is the original and most widely used version of the MBI, the leading measure of burnout. Designed for professionals in the human services, it is appropriate for respondents working in a diverse array of service occupations, including nurses, physicians, health aides, social workers, health counselors, therapists, and other fields focused on helping people live better lives. The MBI measures three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment. This survey helps identify the level of burnout and compassion fatigue in the NICU staff. It is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

2. Utrecht Work Engagement Scale (UWES)

The Utrecht Work Engagement Scale (Schaufeli & Bakker, 2003) is a nine-item scale devised to measure work engagement that includes a two-factor model with burnout (including exhaustion and cynicism) and engagement (including vigor, dedication, absorption, and professional efficacy) (Kulikowski, 2017). This measure is used to determine whether work engagement changes with the implementation of narrative consultation; increased work engagement would indicate an alleviation of burnout. This scale is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

3. Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index (Davis, 1980) is a multi-dimensional measure of empathy and its relationships with measures of social functioning, self-esteem, emotionality, and sensitivity to others. Each of the four subscales (perspective taking, fantasy, empathetic concern, and personal distress) displays a distinctive and predictable pattern of relationships with these measures. The IRI is a 28-item assessment on a five-point Likert scale, and is used to determine if burnout is reduced. This scale is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

4. The Team Development Measure (TDM)

The Team Development Measure (Stock, 2013) is a 31-item questionnaire constructed using the Rasch rating scale measurement model used to study how team functioning affects clinical outcomes and as a quality improvement tool for team functioning. This scale is used to assess teamwork in the NICU and see how it changes with the implementation of narrative consultation. This scale is administered once before the introduction of narrative consultation, and once after completion of the narrative consultation sessions to determine if there has been a change over time.

Demographic Data

A convenience sampling frame is provided by The Valley Hospital Neonatal Intensive Care Unit in Ridgewood, NJ, who are employed before, during, and after the timeframe of implementation of both Family Nurture Care, a new standard of caring for families in the NICU, and Narrative Consultation, a new construct for supporting staff. While NICU nurses make up the majority of participants, all staff, including physicians, social workers, therapists (occupational, physical, speech), lactation consultants, technicians, environmental staff, and administrative staff are included.

Staff are identified by role (job title and category), employment status (full time vs part time), years within the role and years of service within their profession. Stratifications by each of these descriptors is considered when examining the data.

The following table offers descriptors for the demographics of the data set.

Demographics:

1. Title and Employment

Graph 1.0

Role * Employed Full-time Crosstabulation

			Employed Full-time?		
			Full-time	Part-time/PD	Total
Role	Nurses	Count	20	4	24
		% within Role	83.3%	16.7%	100.0%
		% within Employed Full-time?	55.6%	36.4%	51.1%
	Doctors	Count	2	1	3
		% within Role	66.7%	33.3%	100.0%
		% within Employed Full-time?	5.6%	9.1%	6.4%
	Therapists	Count	5	3	8
		% within Role	62.5%	37.5%	100.0%
		% within Employed Full-time?	13.9%	27.3%	17.0%
	Family Support/Social Work	Count	5	3	8
		% within Role	62.5%	37.5%	100.0%
		% within Employed Full-time?	13.9%	27.3%	17.0%
	Management	Count	4	0	4
		% within Role	100.0%	0.0%	100.0%
		% within Employed Full-time?	11.1%	0.0%	8.5%
Total		Count	36	11	47
		% within Role	76.6%	23.4%	100.0%
		% within Employed Full-time?	100.0%	100.0%	100.0%

2. Length of Service i) at Valley, and 2 Total career by Staff type (Nurse/Not Nurse)

Graph 2.0
Statistics

Nurse			Years at Valley	Total Years of Service
Nurses	N	Valid	24	24
		Missing	0	0
	Mean		9.8854	13.8333
	Median		6.5000	9.5000
	Std. Deviation		9.84664	11.76183
	Minimum		1.00	1.00
	Maximum		35.00	45.00
Staff	N	Valid	23	23
		Missing	0	0
	Mean		9.0435	14.0652
	Median		5.0000	12.0000
	Std. Deviation		8.60353	11.55452
	Minimum		.50	.50
	Maximum		32.00	36.00

Maslach Burnout Inventory (MBI)

The summary scores at T1 and T3 (stated as Phase 2 for the analysis) reflect the change from Pre-NC to post FNC and NC implementation for the 3 subscales.

The table below allows you to compare the median scale score at each time point and then see how the 'Change" score reflects this. In Emotional Exhaustion, the median is 18 at Pre-NC and 15 at Phase 2, and the median change score is negative two (-2). While the mean change score = difference between mean Pre-NC and mean Phase2, the median change score does not in this case. That's because the distribution is skew. A non-parametric test was used as a distribution free test, due to the absence of a normal distribution.

Graph 3.0
Statistics

		MBI Pre-NC Emotional Exhaustion	MBI Phase 2 Emotional Exhaustion	EE: Change from Pre-NC to Phase 2	MBI Pre-NC Depersonalization	MBI Phase 2 Depersonalization	DP: Change from Pre-NC to Phase 2	MBI Pre-NC Personal Accomplishment		PA: Change from Pre-NC to Phase 2
N	Valid	47	47	47	47	47	47	47	47	47
	Missing	0	0	0	0	0	0	0	0	0
Mean		19.30	17.28	-2.02	3.09	3.04	-.04	38.70	39.26	.55
Median		18.00	15.00	-2.00	2.00	2.00	.00	39.00	41.00	2.00
Std. Deviation		11.980	10.794	6.088	4.112	3.021	2.476	6.440	6.901	5.797
Minimum		0	1	-18	0	0	-9	19	23	-20
Maximum		48	44	20	17	16	5	48	48	10

MBI Subscale: Emotional Exhaustion

Graph 4.0
Nonparametric Tests
Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distributions of MBI Pre-NC Emotional Exhaustion and MBI Phase 2 Emotional Exhaustion are the same.	Related-Samples Friedman's Two-Way Analysis of Variance by Ranks	.009	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .050.

Graph 5.0

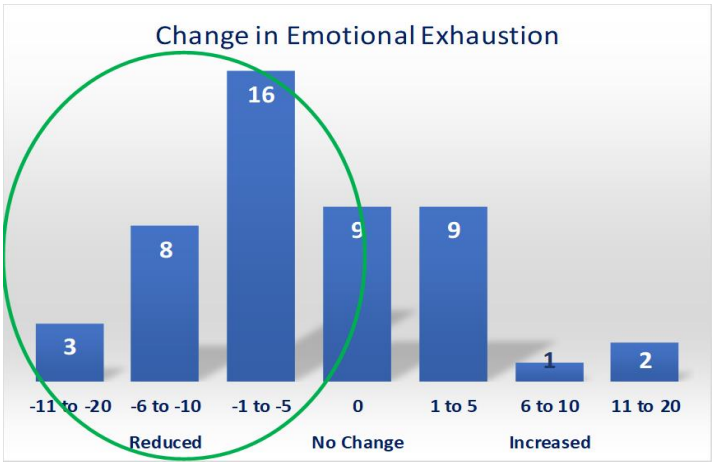
Related-Samples Friedman's Two-Way Analysis of Variance by Ranks Summary

Total N	47
Test Statistic	6.737[a]
Degree Of Freedom	1
Asymptotic Sig.(2-sided test)	.009

a. Multiple comparisons are not performed because there are less than three test fields.

The following graph represents the degree of change from T1 to T3. The numbers within the bars correlate N=number of staff in each category. Q=6.74 with a p value of .009 making it statistically significant.

Graph 6.0



MBI Subscale: Personal Accomplishment

Graph 7.0

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distributions of MBI Pre-NC Personal Accomplishment and MBI Phase 2 Personal Accomplishment are the same.	Related-Samples Friedman's Two-Way Analysis of Variance by Ranks	.064	Retain the null hypothesis

Asymptotic significances are displayed. The significance level is .050.

Graph 8.0

Related-Samples Friedman's Two-Way Analysis of Variance by Ranks Summary

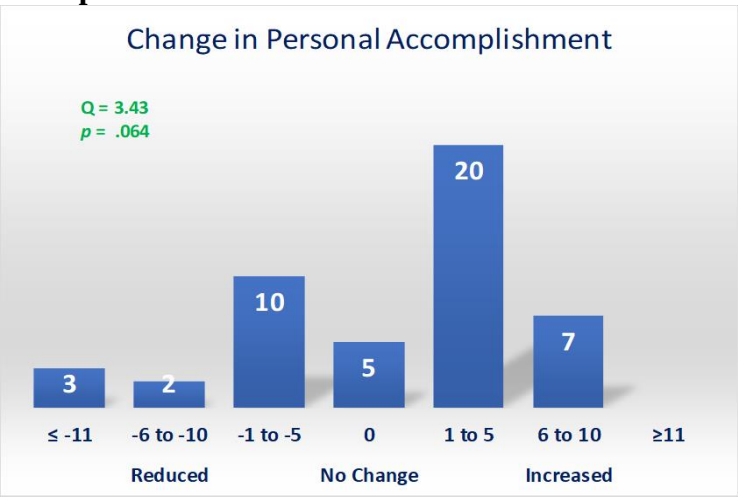
Total N	47
Test Statistic	3.429[a]
Degree Of Freedom	1
Asymptotic Sig.(2-sided test)	.064

a. Multiple comparisons are not performed because the overall test retained the null hypothesis of no differences.

In the subscale of Personal Accomplishment Q=3.43 with a p value of .064 which **does not** lend to statistical significance. The small sample size may contribute to this finding. It is of interest to examine the distribution of change in the bar graph where it becomes clearer that the results were **very near significance.** Secondary to the degree of change, we looked further into the stratification of those who had a decrease in Personal Accomplishment and found a uniform decrease in the cohort labeled the "administrative group". The heavy focus on clinical practice combined with the administrative group's feelings of being disassociated with front line clinical

practice and direct patient care may explain this difference. This is an area to be explored in further studies.

Graph 9.0



MBI Subscale: Depersonalization

Depersonalization as defined in the manual for the MBI says that this scale "measures an unfeeling and impersonal response toward recipients of one's service, care treatment or instruction". In this subscale, a reduction in depersonalization was the desired effect. Results in this category were not found to be significant until stratified by role. A comparison was done looking at nurses in one role and all remaining staff in a second category. As seen in the tables below, changes in depersonalization scores varied significantly in nurses vs staff. Nurses saw a significant effect p=.036 where staff scores went in the opposite direction showing an increase in depersonalization.

Graph 10.0
Descriptive Statistics

Nurse	ExpCat		N	Minimum	Maximum	Mean	Std. Deviation
Nurses	10 yrs or less	DP: Change from Pre-NC to Phase 2	13	-9	3	-.69	3.146
		Valid N (listwise)	13				
	More than 10 Years	DP: Change from Pre-NC to Phase 2	11	-8	3	-.91	2.700
		Valid N (listwise)	11				
Staff	10 yrs or less	DP: Change from Pre-NC to Phase 2	11	-2	5	.73	1.794
		Valid N (listwise)	11				
	More than 10 Years	DP: Change from Pre-NC to Phase 2	12	-3	4	.75	1.658
		Valid N (listwise)	12				

Graph 11.0
Tests of Between-Subjects Effects

Dependent Variable: DP: Change from Pre-NC to Phase 2

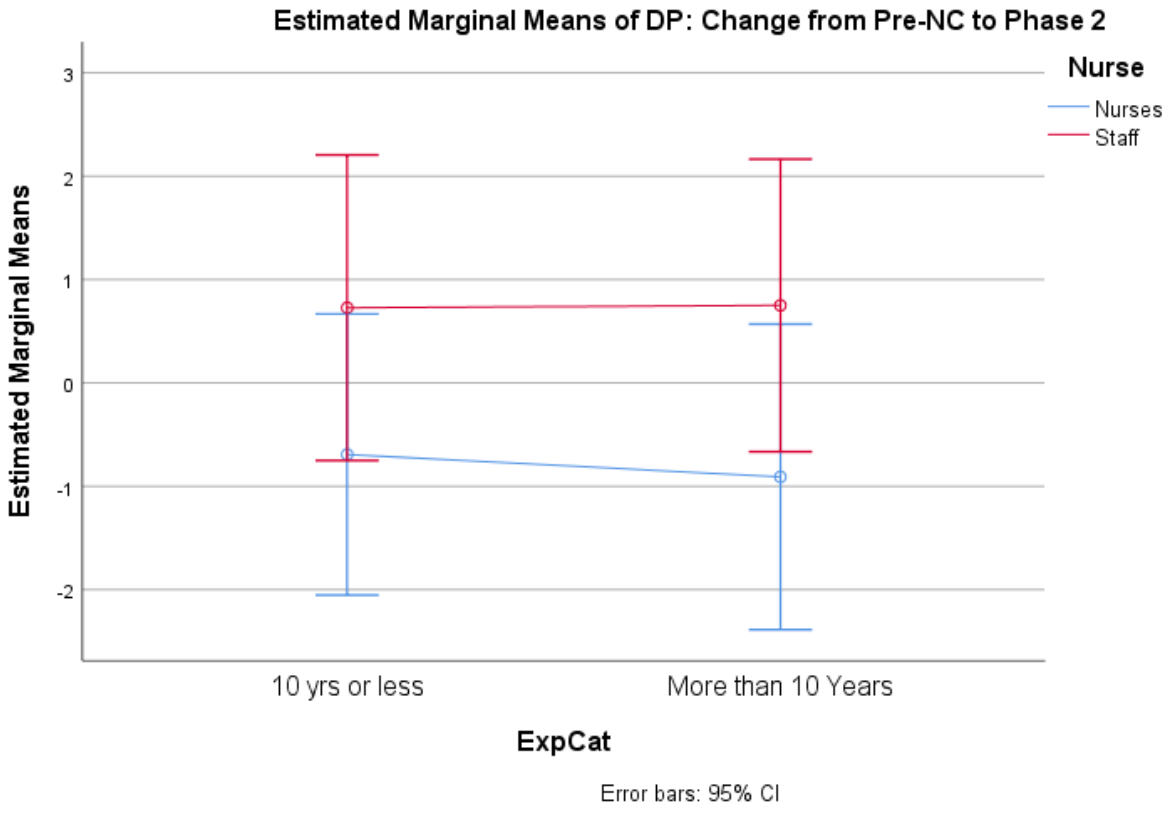
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	27.805[a]	3	9.268	1.568	.211
Intercept	.045	1	.045	.008	.931
Nurse	27.708	1	27.708	4.689	.036
ExpCat	.110	1	.110	.019	.892
Nurse * ExpCat	.168	1	.168	.028	.867
Error	254.110	43	5.910		
Total	282.000	47			
Corrected Total	281.915	46			

a. R Squared = .099 (Adjusted R Squared = .036)

Staff depersonalization increased, irrespective of number of years of working while nurses saw a greater change in the group who had more than 10 years' experience. A correlation of these results with generational differences within the qualitative codes/themes in both phase one and two are examined in the next chapter.

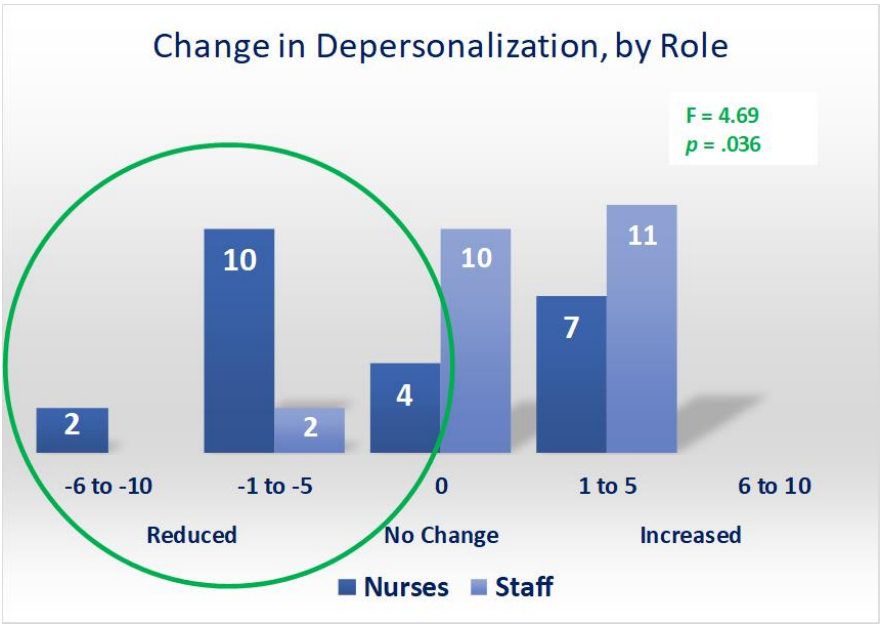
Graph 12.0

Change in DP scores differed significantly for Nurses vs other staff.



The change in DP scores differed significantly between nurses and other staff. The identification of participants with the profession of the facilitator is hypothesized to potentially have influenced this result. Attention to co-facilitators of varying professions may be needed.

Graph 13.0



Team Development Measure

The following table displays results on the Team Development Measure and categorized by subscale including Communication, Roles/Goals, Team Primacy and overall Team Score. Significance or near significance was found in the area of Communication and overall Team Score.

Graph 14.0

Statistics

		TDM Phase 1 Communication, Range 14-56	TDM Phase 2 Communication, Range 14-56	CM: Change from Phase 1 to Phase 2	TDM Phase 1 Roles & Goals, Range 4-16	TDM Phase 2 Roles & Goals, Range 4-16	RG: Change from Phase 1 to Phase 2	TDM Phase 1 Cohesion, Range 4-16	TDM Phase 2 Cohesion, Range 4-16	HS: Change from Phase 1 to Phase 2	TDM Phase 1 Team Primacy, Range 2-8	TDM Phase 2 Team Primacy, Range 2-8	TP: Change from Phase 1 to Phase 2	TDM Phase 1 Total Scale Score Range 31-124	TDM Phase 2 Total Scale Score Range 31-124	TEAM: Change from Phase 1 to Phase 2
N	Valid	44	47	44	44	47	44	44	47	44	44	47	44	44	47	44
	Missing	3	0	3	3	0	3	3	0	3	3	0	3	3	0	3
Mean		37.82	39.68	1.64	11.18	11.68	.39	12.23	12.62	.34	5.27	5.55	.30	86.05	89.77	3.27
Median		40.00	41.00	1.00	12.00	12.00	.00	12.00	12.00	.00	6.00	6.00	.00	90.00	91.00	1.50
Std. Deviation		7.403	5.619	6.405	1.896	1.843	2.082	1.987	1.906	2.272	1.086	1.119	1.472	14.183	11.097	13.241
Minimum		17	26	-16	6	8	-4	4	8	-6	3	2	-4	46	60	-35
Maximum		52	56	21	14	16	5	16	16	8	8	8	3	114	120	43

Roles and Goals

Comparison of change in RG (from Pre-NC to Phase 2) in all N=47, by Total work experience (up to 5 years vs. 5+ years).

One-way ANOVA

Graph 15.0

Descriptive

RG: Change from Pre-NC to Phase 2

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
5 yrs or less	24	1.21	1.641	.335	.52	1.90	-1	6
More than 10 Years	23	-.26	2.005	.418	-1.13	.61	-4	4
Total	47	.49	1.955	.285	-.08	1.06	-4	6

Graph 16.0

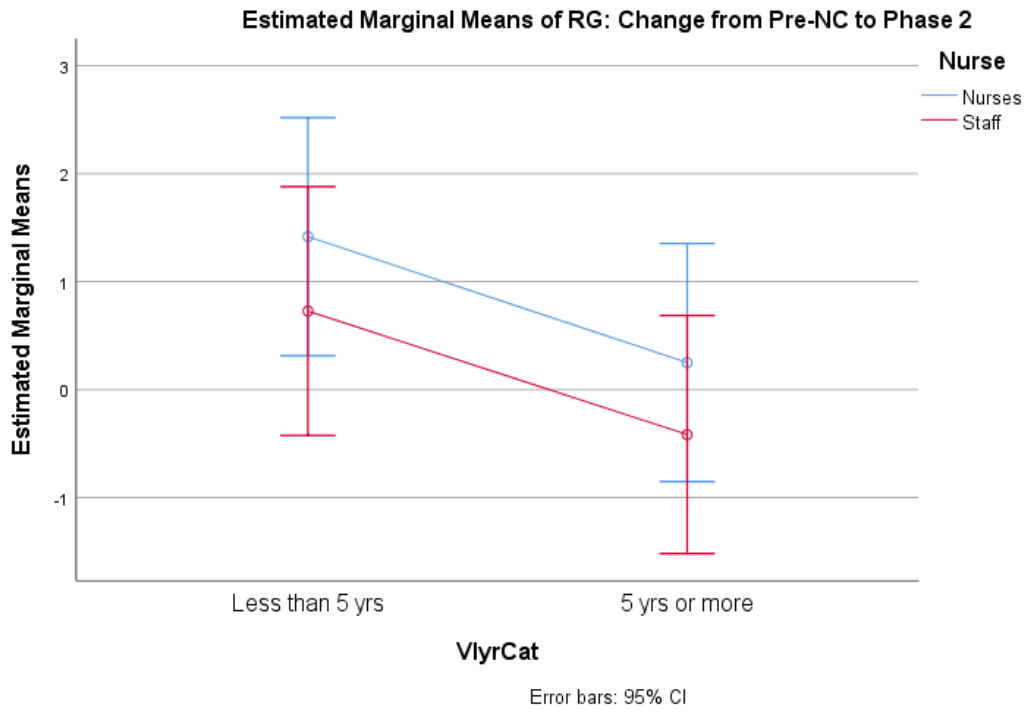
ANOVA

RG: Change from Pre-NC to Phase 2

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	25.352	1	25.352	7.586	.008
Within Groups	150.393	45	3.342		
Total	175.745	46			

We found that the less experienced people improved on average (+1.21), while the more experienced (older) people actually got slightly worse, on average (-.26). It can be hypothesized that understanding of self-role was challenged within the groups and may have created a challenge of role for staff who had over ten years of practice. This correlated with finding within the Personal Accomplishment data further warranting future study.

Graph 17.0



Nurses consistently had higher RG change scores than staff (blue line always higher than red line) We can hypothesize that NC potentially had improved effect of role and goals on nurses potentially due to the association with content and facilitator. Nurses with <5 years at Valley improved more with respect to Roles and Goals than those with longer service.

TDM: Total Team Scores

Nonparametric Tests

Graph 18.0

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
	The distributions of TDM Pre-NC Total Scale Score Range 31-124 and TDM Phase 2 Total Scale Score Range 31-124 are the same.	Related-Samples Friedman's Two-Way Analysis of Variance by Ranks	.018	Reject the null hypothesis

Asymptotic significances are displayed. The significance level is .050.

Related-Samples Friedman's Two-Way Analysis of Variance by Ranks

TDM Pre-NC Total Scale Score Range 31-124, TDM Phase 2 Total Scale Score Range 31-124

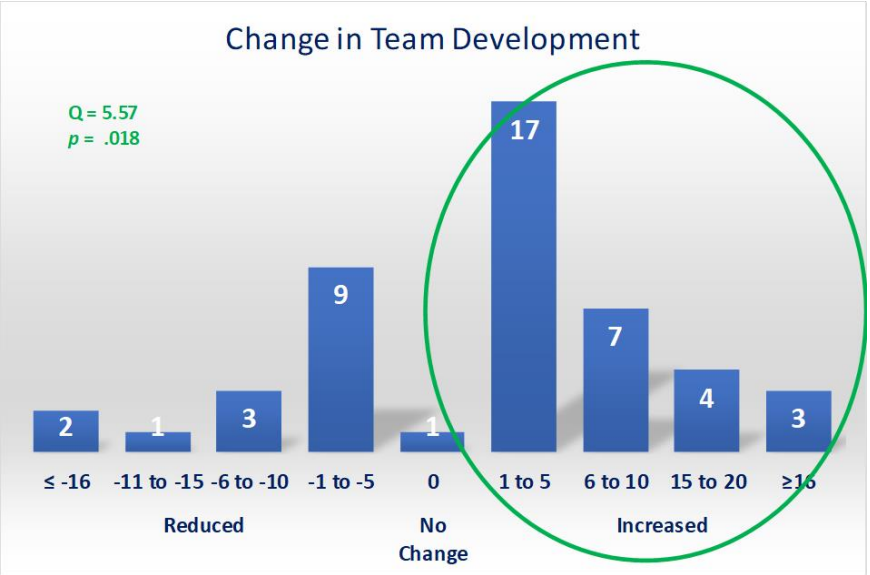
Graph 19.0

Related-Samples Friedman's Two-Way Analysis of Variance by Ranks Summary

Total N	47
Test Statistic	5.565[a]
Degree Of Freedom	1
Asymptotic Sig.(2-sided test)	.018

a. Multiple comparisons are not performed because there are less than three test fields.

Graph 20.0
For the whole group (all 47), Total TDM Scores Increased significantly between Pre-NC and Phase 2.



Overall the Total Team Development score improved significantly showing overall impact of Narrative Consultation on Communication, Cohesiveness, Roles/Goals and Team Primacy. The team development scale has been utilized by leaders to create plans for improvement.

Secondary to this study, we believe that Narrative Consultation may be an effective tool to promote communication and cohesiveness amongst interdisciplinary teams and decrease emotional exhaustion in the workplace. Further studies may want to be done, exploring a co-facilitation with other disciplines and incorporation of works by additional healthcare providers creating an increasingly interdisciplinary approach to further impact roles/goals and improve depersonalization within the workplace.

Further exploration and descriptive analysis of generational differences will be examined in the next section.

Part Three Being /ˈbēiNG (noun) The nature or essence of a person.

Chapter Six: Descriptive Analysis and Qualitative Findings

Emergent themes Graph 21.0

The qualitative data analysis resulted in eight thematic findings:

Themes
1. Narrative Consultation assists with the uptake of unit **cultural change** by providing voice and exploration of voice by clinicians.
2. Narrative Consultation increases **understanding of perspective**, providing improved relationships (and potentially improved outcomes) for patients and families.
3. Narrative Consultation improves **teamwork** through evidence of increased understanding of co-worker perspective, improving communication among the team.
4. Narrative Consultation improves **understanding of self and other** through exploration, mindfulness and reflection.
5. Narrative Consultation appears as a way to **decrease emotional exhaustion** through embracing shared vulnerability through shared expression.
6. Narrative Consultation fosters **Shared Vulnerability** and expression and appears as a way to promote identification of self and other, trust of self and other and value of self and other.
7. Narrative Consultation fosters **co-regulation**: Value of self and other can be appreciated, seen, and felt in teams and appears as co-regulation and connection in the team.
8. Narrative Consultation may evoke **challenges such as self-doubt.**

1. Narrative Consultation assists with the uptake of unit **cultural change** (new programming) by providing voice and exploration of voice by clinicians (Saturation of alignment of change paradigm to value set of clinicians)

In both phases of the study, participants are asked what their favorite part of their work is, what they "love" about their work, and what is most valued. Saturation is achieved readily with phrases that speak to this theme. In Phase One, we see this in form of "helping babies and teaching parents"

as a source of joy and alignment to care values. References are made to clinical outcomes and instrumental care such as learning to feed, bathe, and discharge teaching.

> "I always go back to my first baby that I had who was very sick when he was born. And it was nice because we really had the continuity of care with him and I was with him until she was discharged and it did really show me the importance of family and teaching and them being involved when he was very small, the importance of skin-to-skin and as he got bigger, the importance of including them in bathing and feeding and just so that they felt when they went home that they were going to ready." (N001)

> "I feel like just today, a mom was like, "You changed (the baby's) course. You changed the game. You changed the nipple. Since Wednesday, he is eating so much better and now I don't feel like …we are going by chance. I feel like I have something to work on during feeding." I think that's really positive. I think that those are the little tidbits that make it all worth it." (NO21)

Caring for patients and families is also explicitly stated as a priority in the majority of the interviews.

> "It is my passion. I love the babies. I love the families. I love how much we do for them and how much (inaudible)… but the special relationships that we build and the impact that we all have on the families is most important." (N039)

> "Helping the babies and families is it. It's a rewarding job. When you're going home, you feel like you really did something." (NO52)

In Phase Two of the study, there continues to be an explicit naming of caring for babies and families as the core value of staff in the NICU. However, there is a distinct reference to change, accompaniment, and connection over the importance of instrumental care and teaching as the main way to measure the impact of their work.

> "...it's rewarding working with, especially the small babies and sick babies and to see them grow and get well and how the parents change over time." (N008)

> "Connecting with patients. Definitely, connecting with patients and seeing results, and making that connection." (N020)

> "I think it's very important for us to look at the whole family when they are in the NICU, because they are very stressed out and it's easy when you're in the NICU, taking care of the baby to compartmentalize things and look at all the technical aspects, but we really need to look at what that family is going through, or they perceive the NICU as we perceive it to look like they are two very different things. So, we have to help raise back up and make them feel like they are more involved with the care of their baby. So, having this whole program I think has put a human touch on what's going on in the NICU and the fact that taking care of the patients and family needs are also important and that's part of the task that you need to do, not something optional and people are looking at more as what they are obliged to do, and responsible for." (N075)

This last example, by participant N075, segues from the saturation of the core value of staff being "caring for babies and families" and the transition of how they define or view the meaning of "Caring", to the central nature of the unit cultural transformation in Phase Two and how this relates to practice changes. An environment was created anew, not solely based on procedural and instrumental care, but rather an environment where one could see beyond the illness or condition in order to recognize the place where human connection is needed in order to heal and support systems that go beyond physical care.

> "I think it's been good for the parents and for the nurses. I feel like either it brings awareness to some of us that didn't know about things, and about the type of care that we could give to babies, how babies can benefit. How parents can benefit and bond together, and grow together. For those of us that did know but we got so busy in the job and the day-to-day, and we forgot, it brought me awareness so that we were able to focus, again, on the whole family" (N072)

> " I think everyone has changed. I think they take the time to not just be work-oriented, where they are seeing the parent as a part of the patient, the whole family." (N041)

Although the interviewer did not utilize the word "change", but rather asked about what the "journey" has looked like, the theme of embraced change was embedded throughout interviews. Descriptors of what it felt like to change and how it was perceived as growth and given positive

attributes rather than seen as a challenging or given negative attributes was prevalent.

> "So, it's been just eye-opening. It's just been like a time for change. It's like, "Let's change. Let's be comfortable with the change: and like having the support system to go through that change. So, it's been eye-opening in that sense because I've always been one to hate change and always been one to not like certain things." (N016)

> "That it's a growth. That it doesn't happen overnight. That you have to constantly be reminding yourself, reminding each other that it's not you do it once, it's not one and done. It's continuous. It's a continuum that you're growing on the journey. That you're not there, it's not the end. You have to continue doing. Really, I feel like that. It's a great thing." (N020)

The next participant speaks to the connection to role identity and expresses a recognition that all members of the team are responsible for, and have the ability to, impact the lived experience of our patients and families. The core values of participants (caring for families and babies) become clearer and more present when spoken aloud through the exploration of Narrative Consultation.

> "The unit has changed in a great way, because people are, meaning the nurses, the staff, I feel that they are given allowance to approach the parents. Even for myself, I was scared to approach the parents, because I felt like I didn't know what to say to them in a time of struggle and hard time, their baby is very sick. Even if you don't know, it's okay not to know. Put your hand on their shoulder and say, if there is anything I could do to help you, and that was enough. So, I held back and now, I feel myself reaching out. it is [wonderful]. I appreciate it, because I felt like I didn't have that ability to talk to a parent, because I wasn't a nurse or a doctor, or anything like that, but I feel like I can now.(NO41)- Patient Care Tech

The act of honoring staff voices in shared story illuminates the alignment of their core values and correlates them to this new standard of care. Further, it creates an increased awareness of the need for change and unites the team through increased perspective.

2. Narrative Consultation increases **understanding of perspective,** providing improved relationships (and potentially improved outcomes) for patients and families.

Perspective is deeply embedded in the construction of the NC sessions and is prevalent in Session *Two-Three Men Walking,* and Session Five-*The Affair*. In some form perspective was present throughout all of the sessions in the form of shared narrative and exploration of all themes, such as Session Three- The Sound of Silence, where we could connect to the various ways in which we viewed each topic. This increase in perspective serves multiple purposes and proves to be the most identifiable element and "takeaway" that participants discuss in the series of interviews as well as in practice. This element of increased perspective is augmented by the final Spark that chronicled a family's journey in the NICU, Juniper, The Girl Who Was Born Too Soon. The perspective work that led up to the exploration of this piece of literature set the stage for the participants to place themselves in the role of each of the parents as individuals, and not exclusively in their respective roles in life or in their relatable professional counterpart within the book. It opened up dialogue outside of the unit that otherwise would not occur and crossed professional, cultural, generational, and gender barriers, allowing participants to "see" one another and those they serve through a new lens.

> "I really enjoyed … perspective, and understanding that from where you're standing, the perspective is going to be different. So, to understand the parents' perspective, other nurses' perspective, the physician's perspective. To not just be in my own head. That was a really good one." (NO20)

> "It made me think of things differently. I saw different perspectives, and I was able to see things from different point of views. Sometimes I don't always—I do see, but now I see from a different perspective, makes you think a little bit differently." (N015)

Healthcare staff are thrust into a multi-generational, cross-cultural and diverse work place where patients, families and staff intersect during times of stress and trauma. A picture of a workforce who could constructively adapt to differences was emerging.

> "I think the biggest thing was perspective. One understanding getting into the parents shoes, and even staff, colleagues, knowing that everyone sees things in a different way and not getting frustrated because you clearly know you're right. And you might think you're right, but somehow communication has to insure that everyone sees the same path which is difficult." (N024)

> "We really had to write in different perspectives and I feel like life is about being able to take people's perspective. So, I think it's a refresher, always thinking about the other side. That parent who is ungodly afraid to move their kid's neck is, in our head, you're like, oh my god, you knew you were having a baby. You had months to think about holding a baby. Your baby is only two pounds smaller than a normal baby, but you think you're going to break the baby's neck. That seems an unreasonable thought, but then you put it in perspective and you realize, to them , if you just show them…, that's what's going to help them get through at the end of the day. So, I think that was it " (N021)

Discussion of the utility of entering the intimate space of the "other" in practice was shared as both a challenge but also as necessary.

> "forced us to really just look at what we do and really just kind of analyzing everything that we do and writing about it not sort of just going through the motions but really looking at everything. I think the hardest was one of the ones on like just perspective where like we had to rate the piece from the opposite perspective of what we had. Because that's not something that you would normally force yourself to do, but when you actually sat down and did it, you realized kind of how worthwhile it was. But it was difficult to kind of reframe your thinking, but necessary I think to do".(NO29)

> "The perspectives from the affair I think was good. I think it really made you look at two different people's views of the same situation. When you approach something from a care-provider perspective or from the family's perspective, they're both dealing with the same event but they both look at it very differently. I think it makes you more conscious of when you're dealing with patients, don't just look at them from your perspective; put yourself in the patients shoes and see what they're seeing from their end and seeing." (NO68)

A comparative analysis was done between Phase One, and interestingly, there is no mention of "perspective" in a direct sense, but indirect references to a lack of perspective in the form of a lack of communication are prevalent.

> "I think that it (communication) needs improvement. I see families [inaudible 00:02:27] feel we are lost. I feel like sometimes the nurse is too busy with another baby and non-intentionally trying to ignore them, but just because the workload sometimes could be a little more strained than other days that they might not get the initial attention that they need. I think, honestly, there should be a person dedicated to cradle them more and just condition them in, because they feel scared." (N041)

> "Again, I think I am going to have to say it's fragmented. It really depends on where the communication is coming from. There are some people that will sit down with the parents and have conversations, and there are other people, whether it be just their personality, their culture or whatever, they don't open up to them, don't give them a lot of information, they don't nurture them at the bedside. Again, is it personality? Is it the environment? I don't know. It's kind of hard." (NO47)

The prevalence of strained communications in Phase One extends to references of communications among the team on multiple levels and across multiple disciplines and shifts.

> "It's that everybody is giving their opinions… they are their own chef and they are giving their own piece, but there is some times that many chefs spoil the broth. I think that sometimes not being on the same page happens and it could be avoidable. There could be better communication. Too many cooks in the kitchen. (N021)

> "Communication is okay. (Defeated tone) There are certain people that it's harder to communicate with. Everybody's different though. There's different personalities, people feel differently every day, but with any work environment there's always those one or two outliers that are always hard to communicate with." (NO14)

Additional data centers on communication gaps in general and strained relationships among the interdisciplinary care team in Phase One.

> "I think it [the environment] can be a bit tense… We need to just take a minute to sit down and talk. I think communication-wise that's what I see." (N005)

> "the work relationship I'd think between respiratory and nursing, hopefully it will be better, more trustworthy, a relationship on letting us do our job. And the communication between respiratory nursing maybe has to be improved on what they want from us, what nursing wants from us and what we communicate to the nurse. If there's a good communication between the two teams, then I think it would be a more healthy environment". (NO71)

> "I still think there is a lack of communication between doctors and nurses, the DR and the NICU…, I still feel, is a missing link." (NO21)

The last participant describes communication as a "missing link". Carl Rogers, founder of human-centered psychotherapy, described "labeling and judging as one of the major blocks to communication." He describes this "judging" of others as a defensive and natural tendency for gaining control of our emotions and creating mental order (Firstein 2010, para 4). The commonality of this judging, which is rooted in a lack of perspective, can serve as a block to radical listening and mindful presence. The theme of communication being impacted by blocked perspectives was prevalent within Phase One.

> "I guess it depends on the mood of which nurse, because there are nurses are really like, when they come in, they bring their attitude when they're not in the mood. And doctors, if you do something they don't like, they will really like push you down. They don't support you if they don't like what you've done…" (N011)

> "if I were to change or improve anything at Valley right now, I would definitely improve communication skills… There is just a lot of haywire going on and I feel like it doesn't benefit anybody. You have that certain amount when things are busy, but there is a lot of verbal outburst here… I would say that's true in physicians and nursing." (N056)

In contrast, as in the next example, we see a less strained atmosphere within the unit in Phase Two that was credited to the practices shared within the context of Narrative Consultation. There was some direct association to the ideology of judgement and the narrative practice being a "way to deal with it" in a helpful way.

> "I think they offered like a good way to look at stuff in a different way and to look at some of the issues and how to deal with it. And you know, about judging other people. You don't know what they're going through. So, you know, making assumptions. I thought it was really, really helpful." (N085)

Reference to workplace bullying primarily takes place in relation to generational gaps in Phase One, and is notably not present in the Phase Two interviews. Other references to generational issues among the staff include description of how different ages and levels of expertise view their role and speak of the self exclusively. Of note in Phase One, there is no show of evidence that a

consideration of the viewpoint of the (younger generation) staff is represented in the (older generation). Strong viewpoint with emphasis based upon their own experience exclusively is pervasive, exhibiting lack of perspective.

> "I also think that some of the teamwork could be better. This is the first time I've ever worked in a place where there's a big gap in age, like a lot of old -- there are nurses that have been here and a lot of newbie nurses, not a lot of in between. I feel like that is a flaw in a sense, I think that's not the most cohesive because I feel like there's, I don't like the word bias or like bullying, but there's a lot of -- I guess bullying would be the best word." (NO16)

> "I am afraid that in the next five or 10 years, the older generation will retire and we'll end up with a new generation, which really, I guess, I can feel that they don't have the maturity or the experience to have to take care of a 23, 24 or 25-weeker… Us, the older generation, we tend to be ... they (the younger generation) are dependent on us as a general rule." (NO44)

> "Today, I find that (communication is hard) … I don't know if it's the way the generations are growing up, the way the younger generation comes in and they have a different way of communicating, I think that sometimes it's hard to find that common denominator where everybody communicates the same way to make sure that everybody gets the message right." (N019)

Participant N019 displays a distinctly different tone in the Phase Two interview. She spoke with a disapproving tone when discussing "the younger" generation with a clear sense that the differences were a challenge, where in phase two she spoke about the generational differences again with a recognition of "change and evolution" which were discussed in a more wistful tone with a sense of exploration.

> "The environment is compiled of different generations, different skill levels…I think we have gone through a lot of changes with the delivery of care changes with the years also. Also, as far as the doctors go, there has been quite a few changes in my 20 years here. New doctors have come on and new ideas have been brought forth. So, we have seen an evolution on many different aspects." (N019)

The next observation is made regarding NC by the same participant (N019), with emphasis on incorporating perspective with embraced vulnerability of what could have benefitted her (younger) self. This recognition and identification with her younger self and what "would have benefitted" her, seemed to put the nurse in a place of intersection with the younger generation that she often seemed to be at odds with as we observed her ethnographically and in interview in Phase One.

> "I think it's a great way to be able to share the thoughts and to be able to communicate with people that live through this the way I live through this every day. I think that's very important and I think, I would recommend a program like this, like I said, to go on indefinitely, if there was enough resources for this. It might be because I've been doing this so long. I think if I had this opportunity when I started off in NICU, when I was much, much younger, I think it would have benefited me a lot." (N019)

In ethnographic notes, pervasive styles of toxic communication that does not centralize the baby, is prevalent in Phase One observations of medical rounds. It is important to note that in these examples, interns are used to take field notes so there is no clinical bias.

Phase One- Rounds observation:

When MD 3 clarifies her plan to them, MD 1 states that MD 3 will be "addicting the baby" to Fentanyl to which MD 3 responds with "the baby is already addicted". MD 2 offers a suggestion as well on how to better wean the baby, using Morphine as an option. MD 3 repeats two more times that this was her plan for the day and MD 4 who is sitting next to the case manager states "this is not a discharge discussion". At that point, the case manager moves onto the next baby, who is also in the care of MD 3. MD 3 holds her notes with shaky hands and with a shaky voice gives an update on the next baby. MD 1 stands up and as she walks out, quietly says "bye" to MD 3. MD 3 with a shaky voice and seemingly under her breath replies "I'm just going to do whatever you guys want me to do." The remainder of the meeting proceeds without open arguments.
During the open, sometimes heated arguments between the various doctors, I could not help but feel as if I was bearing witness to discussions that should have been occurring behind closed doors. Later on in the day, a nurse notes to me the erratic behavior of MD 3 and I explain what had happened in the rounds meeting. It was the first time I had witnessed the "origin" so to speak, of a doctor's bad day, and I felt for the first time a little bit of understanding.

Phase Two-Rounds observation:

The robust teamwork of the NICU really shined during rounds today. When Physical Therapist #1 consulted Neonatologist #1 and the charge nurse for validation of her diagnosis of Erb's palsy, they immediately came over to take a look at the baby. The nurses were also always ready and helpful whenever Neonatologist #1 wished to begin rounding on one of their patients. Because everyone in the NICU loves caring for the babies and shares the same goal of providing the babies with the highest level of care for the infants, they are motivated to act cohesively.
The unit functioned like a well-oiled machine, which I view as a degree of coregulation. While Physical Therapist #1 was assessing a patient, Neonatologist #1 rounded on another patient, and a lactation consulting was teaching a mom how to effectively bottle feed her baby. There are countless interactions transpiring constantly in the NICU, so effective teamwork, communication and connection must be present for this intense unit to thrive (which it looks like to me).

Phase Two-Rounds observation:

The tone of NICU rounds is casual and low-stress. Everyone present …seems genuinely interested in the well-being of former patients and asks questions about their progress, even though they are no longer in charge of their care. This sustained interest in the wellness of NICU graduates reveals the authentic nature of medical staff in the NICU. They all truly care about the babies and their outcomes, and do not merely view them as numbers on a page like some other professionals might.

The NICU team appears to be somewhat in tune with each other. One nurse in particular can sense when a case is trailing off so she'll announce the next patient name on the census list. She undertakes this role during every NICU rounds meeting, and people clearly expect her to.

In the Phase Two observations, the reader is able to draw a picture of a staff that is better abled to anticipate each other's needs, communicate fluidly and centralize the patient. An emerging pattern of improved teamwork was being revealed. The Phase Two interviews would begin to lend themselves to the description of the mechanisms through which these changes occurred.

3. Narrative Consultation improves **teamwork** through evidence of increased understanding of co-worker perspective, improving communication among the team.

Staff experiences cited in Phase Two show a correlation of increased perspective sharing and improvements in communication. One common definition of communication is "saying what you mean and understanding what is said." The use of perspective appears to give participants pause as they mindfully reflected to better understand "what was being said" and where it may be coming

from, in order to avoid judgements when dealing with parents and team members both in the NICU and in other departments. A 2016 meta-analysis on team communication by Malow et al. that included 150 studies and over 9,000 team's main findings confirms that communication may be related to the results the team achieves. Further, they suggest a factor that can be related to the characteristics of team's communication as being the context in which they receive the communication and encourage creating opportunities for knowledge sharing and encouraging people on teams to learn from each other (Marlow et al, 2016, p. 145, 170). A prevalent theme in Phase Two interviews is an increased awareness that the understanding of perspective is a powerful tool.

> "I feel very comfortable about tapping (asking help of) anyone in the unit. Having been a relatively newer nurse, starting my day, I usually pick a nurse or two that I am going to go up to, if I had a question, but now I feel across the board, I could probably go up to anyone and without a question, they would come over and help me. So, I think that's something that we do very well in our NICU. Narrative Consultation made me aware that people whom I may not talk to outside of work or know them more than just colleagues that they are living the same experiences, working in the NICU, and do feel the same ways working in the NICU, and have the same concerns." (N012)

> "Perspective is so important and everybody coming into something has their own demons, and their own baggage, and that jades their perspective, and sometimes, people are not going to see eye to eye, and you may or may not convince them to see eye to eye, but at the end of the day, it came from somewhere. There is no reason to harbor it in a bad way, it's just something that can ... it's something that can be worked through with good communication." (N021)

The next participant moves beyond the boundaries of the unit itself and discusses the interdisciplinary and inter-unit impact of the practice of perspective and its role in strengthening and potentially unifying goals. There is also a recognition to its context in the broader world which is essential to true cultural competence and diversity training.

> "working in a big hospital, even in different units, you don't

> realize we're there, but we're in one unit, and sometimes, it's hard to recognize everyone's individual take…, and it allows us to be more aware of the need for being cohesive in our care. So, that was a visual for me. NC was very helpful just in terms of-- First of all getting to be in the consultation with other disciplines, interdisciplinary roles. I think just, it really like forced us to look at just different things that go on in the NICU, in the outside world, all the difference between the songs and the readings. All of it was just so interesting and really kind of just putting life experience back into sort of the NICU and the roles and takeaways from the NICU." (N029)

> "perspective is fun because it's like--Actually the last one too, it's that the one where you fill up someone's cup... I don't talk about it when we're at work, but then I'm like, oh, I think about it like what we talk about it at the Narrative. I'm like, oh, that's what's Suzanne is talking about, or like, oh, okay this is my perspective. Now if I get a phone call from L and D (Labor and Delivery) and stuff, I'm like, okay, let me see what they're thinking over there when they're calling, you know what I mean? I get to use it, which is fun." (N035)

This last example is a practical look at perspective training in action. This nurse reflects on her thoughts and tells herself, "okay this is my perspective", acknowledging that not all beliefs are absolute truths. Upon realizing this, she shares the account of trying to see the perspective in interdepartmental communication with Labor and Delivery (which is cited multiple times as a barrier to communication in Phase One). Lastly, she describes the use of perspective as "fun" and expresses an appreciation of its utility in practice. This appreciation of reflecting on differences in practice, thought, and style, is prevalent throughout Phase Two and appears in various contexts (interdepartmentally, hierarchy and power, shift to shift, and clinician to patient/family). References to the impact on relationships paint a picture of the lived experience of working in the NICU during this timeframe.

> "I think that the groups that we have been doing have been really good because we're seeing each other in a different atmosphere. We're outside of the unit, and we have a topic that we're talking about and it's interesting to hear everybody's perspectives. You kind of get a sense as to like how they view things and the fact that we're all working towards the same goal. It's interesting to see everybody with a little bit of time separate from the unit and able to talk about our experiences and reflect on some of the families, and maybe we saw things differently or the

same. That's been good, I like it a lot." (N030)

"They (NC) were a great time to just talk and with peers and also with you guys and share our stories. And, you know, it was nice because I was in a couple different groups. So I got to hear from different people and even one of the neonatologist was in one of my groups. So I got to hear just her perspective with all of this. So it was nice to hear other people's perspectives." (N001)

"I saw a softer side to some hard ones (colleagues)." (N002)

A descriptive pattern of reconizing positive attributes across roles, shifts and professions was emerging within the staff. Acknowledgement of both differences and similarities appeared to create an environment with increasing acceptance and understanding.

"I think we had a nice group and we kind of talked about our different experiences, buts some were really similar. Whether you were a respiratory therapist, a tech, or a nurse, it was similar feelings. So that'd be one thing and I think just understanding how you're dealing with stress and everything, it gives you a better understanding of everyone's issues and work ethics, or whatever." (N007)

"What I liked most is that we are different, I mean there was a nurse in, there were social work, there was all different people in my section so that was good. We were coming from all different aspects and we weren't **just** (emphasized) frontline people caring for the patient, the babies and the moms and stuff and dads." (N031)

A deeper appreciation of roles and goals among the team was prevalent and a conscious search for the unifying factors in the context of their chosen professions that all centralize "caring" was valued.

"I really enjoyed them a lot. I think it really pushed me to think about certain situations and I really enjoyed hearing what the other members of the team had to say. I did a floating one, so I wasn't always with the same people. It initially started off just the doctors, but I mean, it worked out great, because just because of our time constraints, I did others so it was really great hearing what other, I mean, I was with all different people. I was with respiratory nurses, with different people, secretaries. So it was great hearing what everyone had to say." (N046)

"I was actually with all of the upper echelon we should say. It was interesting to sit in a room with directors, and AVPs, and having conversations, and talking about life

> experiences and what that brings to the table and how we can look at situations in that same way. Yeah, it was eye-opening" (N047)

Beyond these findings within the coding of interviews, ethnographic field notes paint a picture of an environment transforming in the way they relate to their patient, families and one another in everyday interactions.

Phase One- Unit Observation:
The unit appears busy this morning, two nurses are bringing infant back from the operating room. Parents are in the hallway pacing. Nursing staff in a huddle around infant discussing concerns regarding the patient's case. Nurses consisted of educator, <u>new orientee</u> and senior nurse preceptor, charge nurse, and another RN. Discussion became loud at times and disagreements in regard to care decisions were made publicly.

The infant was showing signs of pain and dysregulation including increased BP, HR and desaturations as the team spoke around him. The respiratory therapist attended to the ventilator but voices were not lowered. No one on the team spoke to the infant or diverted attention from the discussion.

Members of the staff proceeded to disagree and have discussions in smaller groups talking loudly "negatively "about one another within close proximity to each other. When the parents came in the majority of this conversation stopped and the one group that remained to talk at the desk lowered their voices.

During this two hour block of time other parents were in and out of the room and within proximity to hear some of what was being said. Two sets of parents were in kangaroo care and their eyes kept fixing on the chaotic environment in the corner.

On the intermediate side there were only one set of parents who were quiet. The atmosphere was more controlled and noise level was minimal. Staff kept going to the other side and making statements like, "I need to stay here to think for a bit."

Phase Two-Unit Observation:

The baby's nurse was <u>a new nurse orientee</u> working with a preceptor and she comes by to marvel at the baby in his costume. She asks her preceptor to come by to also see the baby and they both exclaim over the baby. The next baby's parents are at the bedside and had brought in their own costume – a little witch costume from Build-A-Bear complete with a tiny hat and broomstick accessories. These parents had just gotten news the day before that their baby's brain had periventricular leukomalacia, a neurological condition that affects the motor capabilities. I think of the day before when the mom was sobbing in the neonatologist's office when the doctor told her

she didn't know when or even if the baby would ever walk but also that the mom was strong enough to handle whatever she was faced with. We helped mom put the costume on her little girl and took photos of her with her mom and then with both her parents. I could still see the sadness behind mom's smile and when I asked how she was, she answered "I've been better but I'm okay. I'll get there." I assured her that she would and that we were here for her to support her, she thanked me. We walked over to the intensive side of the NICU where the parents of the baby in Bed 1 were waiting for their photo opportunity. They chose the hula girl costume and huge smiles broke out over both their faces when they put the costume on her and posed the baby for photos. They thanked us and said how happy they were to partake in the holiday and that they were excited the baby was in a crib and getting ready to go home to them soon. The other staff nurses gathered around the hula girl baby and couldn't contain their giggles as they marveled and exclaimed over the dressed baby.

Within these notes, distinct differences in the way a "new nurse orientee" is indoctrinated into the unit emerge. Being a graduate nurse and transitioning from a novice to beginner in the first year of clinical practice is stressful, challenging, and overwhelming, due to steep learning curves and adjusting to working in professional environments. How graduate nurses socially adapt and fit into ward cultures is a hurdle to successful transition, and can be difficult. Facilitating and enhancing graduate nurse adaptation is the precursor to creating more resilient nurses ready to face the challenges that exist in today's work environments (Feltrin et al, 2018, p.616). The nurse orientee in Phase One is thrust into a chaotic environment where core values are not being met, whereas in the Phase Two note, this new nurse orientee's experieince not only aligns to care for the family and child, but places her as part of the whole when the *"nurses gathered around the hula girl baby and couldn't contain their giggles as they marveled and exclaimed over the dressed baby".*

The baby and parent are recognized for their "personhood" in example two, and despite the noted neurological condition, the staff create a space where they can normalize the environment of the NICU and centralize the mother and baby's needs while aligning to their core care values.

In the example of Phase One, a picture of a fragmented team who *"loudly disagreed and spoke negatively about one another"* emerges for the new orientee, creating an environment of mistrust. Additionally, the baby and parent appeared in separate spaces and are unrecognized. Thus, a misalignment is created with what staff report as their central values of caring for the family.

The phrase, "eye-opening", as well as the reference to "making less judgements and assumptions" appears multiple times in interviews in Phase Two. A connection to the embodiment of an increasingly holistic environment is being unveiled through self-reflection.

4. Narrative Consultation improves **understanding of self and other** through exploration, mindfulness and reflection.

Jean Watson, notable holistic nursing theorist on the Human Caring Theory asks the questions… what does it mean to be human? What does it mean to care? What does it mean to heal? What does it mean to develop knowledge and practices about life phenomena and subjective human experiences? What is a living philosophical context for exploring nursing and life meaning in health and illness? (Watson, 2006, p. 49-50). These questions that explore meaning are central to our human experience and our choice to work in healthcare, where we accompany patients through sentinel events in their lives that parallel experiences of our own. These experiences may be a birth and welcoming of a new life, the illness of self or a loved one, and reconciliations and awareness that come in many forms, as we come to an understanding that our physical bodies are not a permanent thing. Reflecting and creating mindful awareness in order to "develop knowledge and practices about life phenomena" was prevalent in the NC sessions.

> "I liked the idea of reflecting, because I don't feel like I have time in my day to ever sit down. I mean, that's not totally true, but to ever actually devote time. When I'm doing

> this, I'm always thinking or reflecting, but it was nice to reflect, because time was given to reflect." (NO21)
>
> "The importance of care, not only for the moms and the babies, but also for ourselves as a person and as a team. Sometimes, you are so busy giving, when you're at work, whether it be your time, attention, the efforts, that sometimes you neglect yourself, or the other members of your team, and how if you have nothing, if you don't save anything for yourself, then you don't have anything to give. So, the idea that you have to take of yourself, as well". (NO33)
>
> "It's very in line with my training anyway. Maybe if you were just trying to medical model wise, it would be a real difference, but for me, it was really very much in line with the holistic approach that I'd been trained in and that I implement anyway but it was fun. It was enjoyable. I liked it." (N032)

An atmosphere of cultural self-understanding was emerging, where one could spend time prioritizing the relationship with self as a priority in order to care for others.

> "It seems like we're a little bit closer with...ourselves ...When you're exposed to something, you're more aware." (N062)
>
> "I learned a lot about myself, I really did. To appreciate more of what I do and to think more positive. Even certain nurses don't want to do this, but I'm still going to do it.
> I thought it was pretty cathartic, to be honest. I felt like I said things that I didn't realize that were in my little noggin there. And I felt pretty good after it."(N014)
>
> "We have to celebrate the small victories and we don't always do that. A lot of times, we pat ourselves on the back when the kids go home who are really small and we think we did a great job, but what we're sending them home to is not always the best outcome or the best life. So, when we realize that and we see a poor outcome and the family is devastated, the marriage falters, we have to remember that we did the best that we could, and what portion of that worked. Not only just, has "This really sucked that this happened to this kid." Where was the good in it? Where can we see the good in it? Where can we see what was done right? Not necessarily that we failed. We need to reflect. We need to do a dissection on those kinds of things, and say, should we have done something differently, but also, where did we excel? Not just we got the kid home and it was a 24-weeker, but it has to be a little more nuanced. We have to be a little more self-aware. I liked NC, because I heard different people say different things. There were people who reflected in ways that were unexpected. People said stuff that I didn't expect those particular people to share." (NO18)

Reference was made to the creation of safe space where one could express reflections and co-construct meaning with others in the groups. An appreciation of the value of spending time in community was prevalent.

> "They were great! It's funny because I always have a busy schedule and it's like another meeting but once you went to it you were thankful that you went. They really gave you time to take a deep breath and reflect on what was important that day and things throughout the course of the week. It gave you time to offload some things that may be bothering you, things that you may be struggling with, bumping by the other people that were in the group too. It was creating a nice safe environment too". (NO68)

A mindful, less reactive approach to the challenges and difficulties faced by healthcare professionals was prevalent in Phase Two that unfolded as a theme throughout the responses.

> "I always try to tell myself that this has an end. (In reference to hard days) It's not forever, but I just try to stay calm and be mindful, and it's hard…you have to try ". (NO26)

During each phase, staff are asked about what the hard days in NICU looked like and how they take care of themselves and/or what helped on the hard days. During Phase One, hard days are often described as days of dealing with emotions of the families in various ways, difficult days with coworkers, and heavy patient load or low staffing days. In Phase Two, there is a continuation of the element of heavy patient load, low staffing, and a shift to talking about the difficulty of a "patient taking a turn for the worse", rather than directing the difficulty at the parent's emotions. A stark contrast in the data around how staff care for themselves and what helps, appears in the phase-to-phase analysis. During Phase One, a prevalence of quick-witted answers surrounding "numbing techniques" is present. Interaction with team members has a strong presence in Phase Two but is referenced overwhelmingly as "what helps on the hard days."

Phase One responses to “what a hard day looks like?”:

> “the harder days are [when] you can't be enough… I think it's a consistent theme, especially with some interpersonal difficulties when you get closer… like going on with the physician staff.” (N003)
>
> “There are many hard days in NICU. Many. Multiple. Sometimes it's the patients, sometimes it your co-workers, and sometimes it's your manager.” (N019)
>
> “Hard days is when you don’t see eye to eye with somebody and sometimes it gets blown out of proportion. I know it's tough, we are all females.” (N035)
>
> “Absolutely, because I feel that we are not always supported and I feel that lactation is just yes, there is the lactation queen… but our job is important and I don’t think people realize that as much as I wish they would.” (N051)
>
> “The hard days working in the NICU is any day shift where Dr. “X” is on, and that's it.” (N061)
>
> “I guess the hardest days is when an infant doesn’t make it out of the NICU. That’s detrimental to me and I myself have two kids so I know how it feels when a baby is very sick and you get to go home and look at your own kids and they’re nice and healthy.” (N063)

Descriptions of feeling that “you can’t be enough”, internalizing loss and interpersonal and relational challenges with communication were pervasive. Staff talked about the phenomena of replaying all that “went wrong” in their minds over and over in non-constructive ways as a need to process the stress of the workplace. In Phase One we see descriptives of some of the ways that staff approached caring for themselves.

> Question: “How do you care for yourself on the hard days?”
>
> “Are you looking for an answer other than alcohol?… I prefer a Prosecco, Riondo [phonetic 00:09:29] with the green label… And I will go home and put my pajamas on and get directly into bed and I put on *The Office* because I've seen it 150,000 times and I just needed to exit… Everything I do after I'm here is utterly benign because I am not good for anything else. (N003)
>
> “Just try to work, get home, and then de stress at home [with] a glass of wine. (N014)

> "Maybe I'll have a cocktail or maybe I'll go straight to sleep, but the next day I have off, I'm going to go and try to like exercise and try to get my mind off of it." (N080)

> "I take a nap, [laughter] if I can, if my kids will let me. I have small kids, so there's not a lot of time-- or wine. [Laughter] That helps." (N016)

> "It is hard not to [take the hard days in NICU home with you]." (N050)

> "I love taking care of the babies and I just happen to be the type of person that holds onto things. So, lately, the patient I've been caring for has been a very stressful patient for me and unfortunately, I take that home with me. For the most part, it's a good thing but sometimes, it can be a negative for me because I'll go home and I can't separate work from my home life. I won't sleep at night, worrying about the patient and did I do everything I could do for the patient?... I need to learn how to separate the two and leave it at the door when I go home, but I still have a hard time doing that." (N055)

Descriptives of the emotional exhaustion and the impact of the hard days on the energy level that you have left for self and family, created a visual picture of the far reaching cascades of unprocessed work related concerns.

> "Sometimes I go home and I'm just exhausted and I watch Jeopardy and I go to bed and that's good enough. It's really no escape though." (N006)

> "They're exhausting. When you get home you're dead tired… Really, just hope that the next day is better." (N015)

> "That's hard, because I live with my husband, my daughter, her husband and her kids. So it is … there is not much. I try and cut it off at 8 pm. I've got to watch my nonsense shows and stuff like that because I am leaving here to my next job. So it is hard." (N031)

> "I go home and after a 12-hour day, I don't do much taking care of myself. I probably do a few things, like putting the dishes away and go to bed." (N041)

> "Yes, I probably just go to sleep and don't process anything [on days where I don't take care of myself]." (N050)

> "On the hard day, I know I don't do nothing at home." (N070)

Phase Two responses to the question "What helps you on the hard days?"

> "I think just like if you just, like, step back and reflect and just think like, it's not a bad day, it's not a bad career is just a bad day, basically." (NO14)

> "And I just have to stay focused, calm and do what I need to do, and give the best care for the baby that I need to give. So, it's really just myself, prepping myself and keeping myself put together and calm." (NO72)

> "I sometimes just have to go in my office and just take a deep breath. Have a sip of my coffee and know that I'm doing the best I can do." (NO67)

> "Reflecting on how you're feeling about working and stuff, when you usually don't think about it. When I go home, I just think about everything that happened, trying to process everything...So, it helps you look inward, reflect and be mindful, as the day goes on, trying to think of these things and what you could do differently to change... not it (changes) a bad day, but it'll change your thinking about it." (N026)

References to mindful, reflective approaches and the recognition of the ways these practices helped participants to redefine "bad days" or "hard days" was threaded throughout Phase Two. A strong reference to the roles that team members played in processing and assisting in various ways to help on the hard days was also prevalent.

> "I think that the teamwork with my Social Workers (helps on hard days) because they are – we would share an office and so we're able to help each other out." (NO31)

> "I think knowing that your coworkers are there to provide the support and that you kind of remind each other to kind of take a break and offering help-- Anticipating that my coworker would need this specific-- Help them with a specific task to lighten the work and the stress of that day." (N049)

> "I think they (the team) help, (on the hard days) because even though something isn't your specific job, it's just like you do this, go get that, can you take care of this, and I think everybody pulls whatever they need to do to get done, and it just works smoothly." (N062)

> "What helps you get through the day is sometimes, even just supporting each other, helping each other out, and knowing that you're working with a team that cares, which most of the nurses do care for each other, they really do." (NO04)

> "If you (staff) have someone to talk to, if they have someone to talk to (parents), we kind of settle them down, so… Yes, just having somebody, I think, to help, would be, my position (on what helps)." (N005)

Of note, there is a prevalent mindful pause before participants answer the question of "how do you take care of yourself" and "what helps on the hard days" in Phase Two. It is possible that the question, in combination with discussion of Family Nurture Care and Narrative Consultation, influences responses, but it is notable that there is heavy reference to the team and family helping on hard days, and just one sole reference to alcohol and no references to TV in Phase Two.

Within the Grounded Theory Model, we find significant descriptors of a team that is functioning at a higher level, which is translating into improved communication and work relationships. Reflective practice and attending to the perspective of others is well recognized as an intervention by staff, and an increasingly mindful approach in communicating is observed. As previously discussed, reflection and mindfulness are practices that must be embraced in order for it to have impact in professional practice and in our lives. In a systematic review of Reflective Practice, it appears that across all settings and methods, the most influential elements in enabling the development of Reflective Practice are authentic context, accommodations for individual differences, learning style, mentoring, and group support, and free expression of opinions. Other factors noted included perceptions of relevance, positive experiences, organizational climate, respect between professionals and time for reflection (Mann, 2009, p. 608). These findings assist in giving context to what may be happening through Narrative Consultation.

Additionally, these practices in Narrative Consultation appear to have an impact on the uptake of Family Nurture Care and lend themselves to a recognition that its central goal of connecting families with their babies in NICU is in direct alignment with the NICU staff's core values of caring for families and providing improved outcomes. Staff appear to become reunited with their core values within the space of Reflective Practice.

For administrators considering implementing new practices, these testimonies of lived experience may be powerful and could arguably translate into increased staff and patient satisfaction scores without performance improvement and quality of care being sacrificed. Participants discuss the visible changes that they observed in the quality of care and outcomes in passages such as the following,

> "I see that the patients are going home a little earlier. I feel that there's more success in feeding or having less difficulty with feeding. Reflux, residuals-- just not that we see them-- We really look for them—but just overall. No stopping and starting feedings, and I think it has to do with the parents holding their baby." (N026)

Noteworthy and of interest, quality outcomes are explored through a program that interfaced with the electronic medical record called QLIK, which looks at a list of clinical outcomes including days on respiratory support, length of stay, breastfeeding rates, days to full feed (line days), days to skin to skin hold, and major morbidities, among others during both Phase One and Phase Two of this study. These indicators correlate to both Family Nurture Care and the support construct of Narrative Consultation. The Phase Two data show no indication of decreases in quality and safety, and in fact show significant improvements across multiple domains, especially in our smallest and sickest infants. Particular statistical significance is found in the area of feeding (decreased days to full feedings which correlates to a decrease in days where the infant has a central IV line). This is noted anecdotally in observation by the physician in the prior interview, who hypothesizes how the prioritization of values (parents coming together with their babies in holding) may serve to impact this quality outcome known to lead to decreased length of stay and decreased potential for infection.

> "Some sort of quality of life long-term outcomes, you know, devastated children are children who are left devastated. I think the study shows just the change in the way we think about these kids that they're more than just a pulse in a set of vital signs that you guys are really trying to change the infants in the parents' experiences, in ways that are going to impact where the child develops forever, which is so powerful. That is part of it is the way

> the mom bonds with the child. You're almost alleviating this inevitable PTSD by making beautiful, instead of a NICU. Taking the ICU out of it and making it just I guess more palatable or maybe more humane or it makes it more human, I think. I think it elevates care—It elevates the entire thought of what a premature baby could be and what a premature mother could be because it used to just be survival. Now I really think you're making it beautiful, I think it's important." (N084)

One of the final ethnographic entries in Phase Two of the study gives an unexpected example of the impacts that may have been seen. It may be classified according to the ripple effect, which is defined as an initial disturbance to a system that propagates outward to disturb an increasingly larger portion of the system, like ripples expanding across the water when an object is dropped into it. In sociology, the ripple effect can be observed in how social interactions can affect situations not directly related to the initial interaction (Long, 2001, p.45).

…They (staff) mention that they have a feeling there will be a lot of NICU staff going (to the holiday party) this year, as opposed to the more sparse attendance they had seen the previous years. One of the seasoned nurses going actually states she had not gone in 30 years. Later that night when the night staff came in, each one of them also said they were going to the holiday party and that they were looking forward to it. They also mentioned they felt like this year would have a record number of NICU staff attending the party. The difference in the attendance this year at the hospital-wide holiday party made me think of how coworkers were willing to spend off-unit hours together when they didn't have to, and when they already worked with each other, most of them for 40 hours a week. I hoped that this was an indicator of how their feelings about their coworkers had improved from previous years.

This indirect impact, observed by a member of the research staff, propogates a sense of wondering as we begin the process of drawing conclusions. Questions surrounding how to describe this lived experience during Phase Two of the study, and an exploration into the elements that may reveal themselves as the catalysts of change within the space we created, and moved findings beyond Grounded Theory and into an embodied way of experiencing the data. That is demonstrated in the next few themes on vulnerability.

5. Narrative Consultation appears as a way to **decrease emotional exhaustion** through embracing shared vulnerability through shared expression

The choice to dedicate one's life to a profession in healthcare comes with a promise to accompany others through what are likely the most significant days of their lives, often including sentinel events such as birth, illness, trauma and death. There is an innate vulnerability that is created by the potential identification and recognition of the patient and family within the self of the healthcare worker. The intersection of that identification and the recognition of our own clinical and relational vulnerabilities as "helping" professionals appeared throughout phase two. Researcher Brene Brown speaks of the cost of numbing feelings that may put us in touch with vulnerabilities. The cost of numbing the hard feelings is also numbing the feelings of joy, fulfillment and connection (Brown 2013). A deep sense of acceptance of feelings that may evoke vulnerability was emerging within the interviews in phase two and staff showed an appreciation of the space to engage in shared expression.

> "I felt like because generally I don't like to show emotion. Like I'm not like—I—I currently have a lot of emotion, but I don't like to show emotion. And my takeaway there was like it's okay to have these feelings. Like all these feelings that I have, it's okay to have them. It's okay to express them. It's okay to not only express them, but not be judged by them." (N016)

> "There were definitely stories or topics that were hard to share. And so that was hard. But it helped to have peers who, you know, even if you didn't want to share, a lot of them would talk to the same topics. So you felt like you weren't alone, that we were all kind of experiencing the same hard, hard times and challenges." (N001)

A recognition of the feelings of connection and meaning within the challenges was present in the text of the responses. The terms "safety" and "courage" were used synonomously with feelings that were interpreted as vulnerability. This potentially redefined what it meant to be vulnerable with self and other for the healthcare participants. A space where vulnerability was not only allowed, but encouraged emerged.

> "I brought my mind to that place—like a place where like prior to that, I never wanted to go to. So, the fact that like this is like, "Okay. This is—I'm going to think about this. How do I feel with this?" So, I thought about all these things even though I felt like I didn't have the courage to." (NO16)

> "That's not a topic at work that we talk about and it gave us a pause to just stop and see something differently, and be able to be like, "Oh, okay." Writing my thoughts was … I am a writer, so I am good with that, but having that dialog and actually having somebody be vulnerable in my circle, and then knowing that we had a safe space for the vulnerability, and you could be angry, happy, sad, confused, frustrated, or whatever you wanted in a safe space. It was like free therapy that we never give each other."(NO69)

In *Love's Labor* by Eva Kattay, the author creates a clearing for discussing the vulnerabilities of what she names dependency workers (including healthcare workers). She asks,

> "What about the obligations owed to the dependency worker? Who is to care for the caregiver? How are her needs to be recognized? To the extent that the dependency worker is vulnerable to her charge, the charge is obliged to behave in ways that address those vulnerabilities." (Kittay, 1998, p.65)

The questions posed address the obligations of those in receipt of healthcare (everyone) to the healthcare professional, whose vulnerabilities or feelings toward their work often become a detriment if gone unaddressed. van Heijst asserts in *Professional Loving Care* that those who give care are also vulnerable and precious and applications of "loving care" applies just as much to the people looking after others. The text goes on to discuss historical perspectives of caregivers who were encouraged to pay little respect and value to their own needs vs. a contemporary view of examining the authenticity of caring (van Heijst, p. 181). The narrative exploration in this study allows space for the examination of what caring means to participants and gives permission to not only feel variations of emotions in regard to their findings, but to readily express them and share them in communion with others so as to not feel alone.

6. Narrative Consultation fosters **Shared Vulnerability** and expression which appear as a way to promote identification of self and other, trust of self and other and value of self and other.

Culpability is defined as the degree to which an individual can be held morally or legally responsible for actions or inactions. The culture of culpability is well defined and ingrained in healthcare education and may indeed have some place within its construct, however the need to operate with control and predictive accuracy at all costs, may preclude the naming of vulnerability as necessary in healthcare. As participants engaged in shared expression within Narrative Consultation, a picture of self and other was emerging to create an shared understanding that within the context of shared vulnerabilities, stories could be dissected in order to co-construct meaningful solutions without judgement and blame. Moreover, it created a culture where finding one absolute answer to a given challenge wasn't the goal, but rather finding shared meaning and value within the context of caring for self and other including patient, family and coworker.

> "These narratives; I don't think people knew how impactful they would be to them in terms of just everyday care. I didn't even know that this would be part of it. I really felt that this would be something that you gave to the parents. To know that you gave us something, is pretty amazing. Kudos to you and your group. I think that that's made a difference. Maybe, maybe we've altered some of our behavior, because it's a real isolated, windowless place where you could have a lot of problems. I have seen less…problems." (NO24)

> "(NC) was amazing, both personally, as well as professionally. I wrote down each quote that she gave. I wrote down in my little journal... It helped me personally and helped me professionally. It was organizing, it was thought- provoking. It was integrating and speaking with certain people on the team that I haven't been able to sit and look in their eyes, and talk to. So, it was very, very productive." (N030)

> "I think it's the sharing every other week that we share each other's experiences and how we can promote (each other) and be successful…" (NO49)

The recognition of the utility of the humanities as a gateway into topics that evoke expression and emotion was recognized by some participants. The connection of themes in the arts and their place

in facilitating the expression of emotion within the practice of healthcare was appreciated and verbalized.

> "So, when we brought artwork and when we brought music, and when there was a painting. It allowed you to use that as a talking piece that led you down another road. Who knew that we could use that sort of stuff to stimulate a conversation and have a deep one? Again, people cried. We're looking at a piece of art and it wasn't pretty. It wasn't touching, but at the end, people brought out this emotion and this deep feeling that was like I never knew she felt that way. Now, I get her. That piece was there. Even reading back on what you wrote was easy to see that stuff. I think it was interesting that you got that something so simple as a song, an artwork, a story or a poem could take you down in a medical conversation, which we don't usually do." (NO69)

7. Narrative Consultation fosters **co-regulation**: Value of self and other can be appreciated, seen, and felt in teams and appears as co-regulation and connection in the team.

The relevance of "not feeling alone" repeats in phase two. A space of vulnerability is created where participants could co-construct meaning but are not required to have all of the answers. Researcher Kristina Orfali's assertion that health care professionals' expression of medical certainty may control or even "erase the very ethical nature of uncertainty", speaks to this phenomenon (Orfali, 2004, p. 2018). Clinicians in healthcare are trained to assess and treat with evidence and certainty. The litigious sector has made certain that there is little room for vulnerabilities, which in turn creates a closed door to expressions that may foster new ways to learn and grow through the practice of vulnerability. The lived experiences of NICU staff expressed in Narrative Consultation speak to the need to create this space where vulnerabilities are acceptable and encouraged. The sharing of these experiences created an environment that could not only be seen but also felt by the members of the team. These findings are illustrated by the following quotes:

> "it's changed a lot in a good way. I find that, first of all, it just seems the group and team is…more cohesive. I feel like people are more on the same page

about what we're trying to do for the parents" (NO29)

> "I feel that the nurses are calmer. I'm not sure if the workload has changed but there's a collaborative sense between you so that way the workload has changed. I think that's probably what's happened." (N024)

> "I think it helps just to keep everything calm." (NO41)

> "I rationalize (now). I keep calm, you know. I rationalize." (NO44)

An environment where coworkers reach out to one another through various mechanisms to "check in" on one another was appreciated and recognized. A team who could anticipate one another's needs and create a cohesive support system was valued. Testimony of coworkers reaching out to one another in positive ways was increasingly prevalent in phase two versus commentary on divides and dysregulation that was seen in phase one.

> "Again, I think that the people around me help me. When people notice that I'm stressed, people tend to give me peanut M&M's or a cold soda. Some of the people have even come and given me a neck massage. I think people are sort of aware when, at least for me, when the stress level is getting high" (NO46)

> "a respiratory therapist found me crying in the corner, just came over and hugged me, and I (previously) didn't have any rapport with this. Just working with this person and not really engaging much outside of work, just her coming over and just putting her arms around me." (NO12)

> "I think what helps is to know that there's a whole team of people, of nurses, the doctors and everybody working together to try to support the family. You're not doing any of it alone."(NO30)

A deep recognition that the team were connected and the sense of "not being alone" prevailed and was verbalized consistently throughout Phase Two. Examples of this comfort found within one another and the connection to the ability to give better care was seen.

> "I feel like it lets me… I am looking for the right word… I don't feel alone in trying to give them (parents) difficult messages. I feel that I am supported and its okay for me to, in a sense, grieve with the family, because the support is there. It's like any caregiver needs support in order to give care to somebody. So that's why we should rely on each other and I think it has really made a big difference, I think, for the NICU." (NO19)

8. Narrative Consultation may evoke **challenges such as self-doubt.**

Within the data analysis we also explore areas that may be difficult in regard to participating in Narrative Consultation. Challenges identified include the idea that some content may be unrelatable for all participants and has the potential to discourage participants and create feelings of self-doubt.

> "Some of it was over my head. Some of it was just too fluffy for me. I was like, maybe I'm just not bright enough for this." (NO20)

> "having to speak elegantly after given five minutes to journal and I have to speak like a professional graduate prepared student, and many times, I didn't. I would just say that it's not enough time or I am exhausted, because that was the truth, but sometimes, that pressure of coming up with something spectacular to say, I did not have every time. Sometimes I felt like I had to deliver something worth Suzanne writing down, or something like that." (NO14)

These examples speak to the concept of "knowing the audience" and creating relatable content that translates to all participants. In addition, careful attention needs to be paid by the facilitator to create a safe space for sharing and encouraging all levels of participation, perhaps by inserting their own vulnerabilities within this work. These participants also speak to the primary challenge of embraced vulnerability that seems to be successfully overcome in most participants, but not in all, as is seen below.

> "I think sometimes I held back a little. Same reason that I liked it, it was the reason that it was a little hard, because some of my friends were actually in there. So, people I hang out with out of work too. So, I'm like, I don't know if I want to open up because this is something that they won't get out of their head, really, and if you say... I wouldn't say I had anything crazy to share, but something that... I don't know, like I am going out to eat sushi with them later."(NO26)

> Interviewer: "What was the hardest thing about participating?" Respondent: "Sharing." (N020)

> "I think like worrying that what you said would be judged by your peers in the room. Interviewer: Do you think that could be fixed with a different group? Respondent: No. I think I personally probably would have been still anxious to say how I like truly felt with anybody." (NO14)

In Barbara Mitsztal's *The Challenges of Vulnerability* (2011, p.2), she discusses the concepts, public perceptions and definitions of vulnerability in the context of being an "undesirable emotional" state. In order to overcome challenges of vulnerability as a practice in healthcare, we must begin to understand the positive aspects of vulnerability and embrace how we learn and grow from all aspects of our being, both personal and professional. Mitszal goes on to share that some of the "remedies" to the negative feelings associated with vulnerability are caring for each other (p. 135), supporting and trusting relationships (p. 167) and forgiving painful memories (p. 197). Mitzal's stance on vulnerability creates a paradigm where the historical perspective of vulnerability requires a reduction in the challenges related to how we feel about vulnerability. Her conclusion includes studying the construct as a multidimensional concept. A cultural shift toward embracing the contributions of vulnerability was evidencd within the study of Narrative Consultation.

General Discussion and Conclusion

Researcher and vulnerability expert, Brene Brown, shared

> "Yes, we are completely exposed when we are vulnerable. We are in the torture chamber that we call uncertainty. We are taking huge emotional risks when we allow vulnerability in, but there is no equation where taking risks and braving uncertainty and opening ourselves up to emotional exposure equals weakness." (Brown, 2013, p.37)

The concept of vulnerability as a strength is a new paradigm within the scientific and scrupulous world of healthcare. Within the sessions of NC and in clinical practice, the participants are able to feel a connection with others and this only comes with experiencing a certain degree of vulnerability. This is shown within the text, "speaking with certain people on the team that I haven't (talked to before), I have been able to sit and look in their eyes, and talk to (them)". Participants value this intimate space for conversation, leading to co-created meanings of what it is like to work in shared practice in accompaniment of others within the unit. These intimate spaces often lead to co-constructed learning. Participants engage in trusting relationships with one another through the experience of sharing without judgement. Brene Brown shares this definition of connection in her podcast *The Gifts of Imperfection*- "I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship" (Brown, 2011). The idea of deriving sustenance and strength from relationship is relational to the concepts of connection being directly related to the phenomena of team co-regulation.

Team Coregulatory Theory as an Emergent Insight to Reduce Occupational Stress

The Nurture Science Program at Columbia University describes the Calming Cycle Theory that proposes two new constructs, emotional connection and autonomic co-regulation (Welch, 2016, p.1266). These constructs are based off of Stephen Porges' work on Polyvagal Theory, describing a parasympathetic tone (vagal tone) that is related to the regulation of emotion (Porges, 1994, 2011 p.167). Put simply, good relationships control physiological responses and create a calming reflex. The belief that mother and child could have a physiological calming reflex that impacts one another when emotionally connected may extend beyond the mother/child dyad and have the potential to exist between teams. This study is a first step in looking at a *team co-regulatory theory* and understanding its utility. The concept of team coregulation has been described in classroom settings. This describes a conscious state of "brain to brain" coregulation, where emotions are contagious. When a teacher is able to model a calm presence through their tone, facial expression, and posture, students are less likely to react defensively. When the teacher listens to what is beneath the behavior, focusing on the student's feelings, this type of validation says to the child that the teacher sees them and is trying to understand. When the teacher takes deep breaths, gets a drink of water, and creates space for reflection for a minute or two, they are modeling the regulation skills they want to see from students (Desautels. 2019, https://www.edutopia.org/article/role-emotion-co-regulation-discipline).

The Nurture Science Program describes a more "body to body" co-regulation that may have physiological benefits as well. More studies are needed to describe the effects and mechanisms of coregulation among teams. Within the accounts of the lived experiences of staff during NC, the word "calm" permeates team descriptors during Phase Two. Accounts of

cohesion, connection, and descriptors of a responsive staff that was likely to make eye contact with another, place a hand on another's shoulder, or offer a reassuring hug, are omnipresent. This phenomenon of calm among the participants is felt within the cohorts and appears to extend into the unit and permeate beyond the border of the session, beyond the participants themselves. The "brain to brain" modeling of calm is in effect visibly, however one who studies the account of the felt experience in the unit during this timeframe may argue that there could be a "body to body" impact as well, where the autonomic nervous systems of the staff are being co-conditioned to expect less stress in the environment. This presence of comfortability with embraced vulnerability may have created a safe space where one can share, reflect, trust, and learn in a way that creates connection and co-regulation that is both visible and measurable.

The history of the pursuit of a superhuman, perfectionistic healthcare system has lended itself to

the belief that vulnerability is liability in healthcare. This culture based on a system that does not value or acknowledge the stories of the day to day contributions of the healthcare staff can prevent the creation of a community of trust that can engage with one another and actively learn, grow and problem solve.

The "courage to be imperfect" as described by Brene Brown (Brown, 2013) may actually translate to improved cognitive and coregulatory processes that let the flaws within ourselves and the system be seen in order to come into contact with them. It is only when we face and come into contact with the challenges before us, that we can begin to embrace the change needed to create a more dynamic and mutually beneficial healthcare system.

Utility of Narrative Consultation

A reported universal barrier to participation is time. Participants express the feelings of being "happy to be there" but having difficulty making it a priority. These feelings echo research on other health initiatives promoted by the workplace. A recent 2020 study by the Mayo Clinic examined the keys to "Fitting in Time for Fitness". The key is found to be convenience. Familiarity with a virtual model utilizing platforms such as Zoom could address these convenience factors. Additionally, reflective programs such as NC could be added as health promotion programs in healthcare systems. The Centers for Disease Control (CDC) reports that on average, Americans working full-time spend more than one-third of their day, five days per week, at the workplace. The use of effective workplace programs and policies can reduce health risks and improve the quality of life for American workers. Their website provides workplace health promotion programs, including how to design, implement, and evaluate effective programs. Promoting prioritization of emotional and relational health of the staff, and applying incentives similar to those given for physiological health could have great impact.

Areas for Future Study

The extensive data set provided by this study has allowed for exploration of many additional experiences within the Neonatal Intensive Care Unit and has created considerations for future research. In the area of Narrative Consultation itself, this research represents one hospital's NICU, within one demographic area, during one particular moment in time in a pre-COVID society. Other areas for study include replicating results in different healthcare systems that may

have different demographics. Consideration for utilizing this program to embed other forms of quality change in various units throughout the hospital should also be considered.

Within the text, emerging patterns reveal provocative domains of concern for NICU staff that may adversely impact the experiences one has in the workplace. Consideration on how generational differences, gender, and hierarchical power impact the workplace are concerns taking priority in today's workplace. *Forbes* magazine reported on generational differences, stating that "it is vital that all five generations understand the unique perspectives and needs of each to more fully leverage the potential of every company's most valuable asset: its people" (https://www.forbes.com/sites/workday/2019/09/12/generational-differences-and-the-shifting-workplace). This report focuses on the area of perspective, which was a strength within the Narrative Consultation construct, suggesting that NC may be a way to address these priority areas within the contemporary workplace.

Importantly, it is pivotal to note that this study took place in a pre-COVID world with the study officially ending in February 2020, just as COVID was emerging. The healthcare system has been altered dramatically since. In our current reality, we are dealing with a healthcare system that has been strained and shaken to its core. In the world of NICU, babies and parents have been separated at a level that has not been seen for decades. Healthcare staff have given new meaning to the bravery that is necessary to be a frontline essential worker. Vulnerabilities have been illuminated, perspectives (clinical and political) have been challenged, creating opposition among teams, and core value alignment within the healthcare system for healthcare workers has been called into question. The need to address Sinclair's call to action and address occupational stress in healthcare by "encouraging new models that honor the healthcare providers lived clinical

experiences" is more urgent now than it ever was. For me, this author, the end of this dissertation is a closing of one door, with the door of a post-COVID world swinging open before me.

Closing the Door

Katie,

I've reimagined and remembered over and over. I see your face as if you were before me right now. I wonder if my memory is accurate through all of my wonderings. Do you know how that fateful night has impacted my life in so many directions, I couldn't begin to name them? I can still feel your panic as the new nurse who couldn't find a friendly face or someone to help. I feel in my body the emotional exhaustion of the entire staff as we watched yet another child die in the ICU that week. Yes, we watched it together. My fear growing that my baby was next but your fear growing that you could not prevent it. Your fear that your clinical skills were not infallible and feeling the heavy implications of that as you searched for value and meaning in this new career you had dedicated yourself to. The stress of a mother, permeating into your being and the stress of doctors and nurses, permeating into mine. Did Zach feel it too? Did both of our physiological and psychological states permeate my baby that night when we almost lost him? Possibly they did.

Katie, where are you now? I want to hear the lessons you have learned. I want to share stories and co-create meaning from the paths each of our careers have taken. I want to share Zach's essence with you. Did you know he will be graduating with a degree in Fine Arts this year? Did you know I (God willing) will be graduating with a doctorate? Did you know that I have you to thank for both?

Your memory reminds me every day of the value of this crazy, broken, beautiful, exquisite world where we universally place caring above all. I am reminded of it in the memory of your embrace.

The healing that occurred in that moment of shear vulnerability and shared expression based on an experience that we could not, and should not, keep bottled up inside of us. Thank you for allowing me to access it, to place a lens on it. Thank you for forcing me to examine all of the parts of the healthcare machine.

Katie, I want to share the power of the machine with you. It was articulated by Dr. Rita Charon and I believe her words to be true so I want to share them. You, Katie, helped me realize what healthcare was for and in excess of healthcare, what life is for. ***It is for the making of contact.*** *We made enduring, life sustaining contact and all that I have learned gives evidence that Dr. Charon is correct when she assures us that* ***this is always possible, all of the time****.*

With a heart full of gratitude,

In Connection with your spirit,

Suzanne

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VITA

Name: Suzanne Milkiewicz Bryjak

Place and date of birth: Hackensack, New Jersey- August 5, 1971

Parents Name: Barbara and Frank Milkiewicz

Educational Institutions:

School	Place	Degree/Date
Garfield High School	Garfield, NJ	Diploma, June 1989
Bergen Community College	Paramus, NJ	AAS Nursing, 1995
College of Saint Elizabeth	Morristown, NJ	BSN Nursing, 2013
Goddard College	Plainfield, Vermont	MA, Health Arts & Sciences 2016
Drew University	Madison, NJ	Doctorate Medical Humanities 2021