

“Facing–Coping–Transformation” Traumatic Experiences to Growth Among Chinese Nursing Students During Clinical Internship: A Qualitative Descriptive Study

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Abstract: Clinical internship is a core component in nursing education, during which students are often exposed to high emotional stress and potentially traumatic events. Although the adverse psychological effects of these experiences have been widely recognized, it remains unclear whether and how such traumatic experiences can foster personal and professional growth among Chinese nursing students. This qualitative descriptive study aimed to explore the traumatic experiences of nursing students during an internship conducted at a college in eastern China. Purposive sampling techniques were used to recruit 15 undergraduate nursing students who were engaged in their pre-graduation clinical practicum. Data were collected through in-depth, semi-structured interviews and supplemented by their original drawings. Following each interview, participants were invited to depict their traumatic experiences or reflections using colored pencils on A4 paper, without restrictions on time or artistic skill. The Braun and Clarke topic analysis method was employed.

Three main themes emerged: 1) confronting painful experiences during practicum, encompassing unprepared exposure to death and suffering, hidden harm within power structures, and activation of personal unfinished business; 2) coping with emotional pain, including emotional labor overload, feelings of empathy but powerlessness, and defensive emotional isolation; and 3) transformation from pain to personal and professional growth, involving pulling strength from supportive resources to develop coping strategies, reshaping personal views on life, nursing, and boundaries, and reaffirmation of professional identity and personal growth.

This study reveals a unique experience of trauma-to-growth trajectory among nursing students, “Facing–Coping–Transformation.” It identifies the core mechanisms underlying this positive transformation: using internal and external supportive resources as the foundation, internal cognitive restructuring as the core driving force, and reaffirmation of professional values and meaning as a key link, ultimately leading to dual growth in personal maturity and professional advancement. It is suggested that trauma-informed growth experiences be integrated into undergraduate nursing curricula to cultivate such adaptive capacities and transformative skills in clinical practice, with adequate support.

Keywords: Clinical internship, Education, Nursing students, Psychological trauma, Qualitative research

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Introduction

In China, undergraduate nursing education typically includes an 8–10-month pre-graduation clinical internship, which is a critical transitional stage for students moving from systematic education

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to clinical practice.¹ According to the regulations on nurses in China, nursing students are required to complete more than eight months of clinical internship in a comprehensive teaching hospital, a necessary condition for their nurse registration.² However, this transitional period is also widely regarded as a high-risk phase filled with stress, uncertainty, and potential psychological trauma. This transition means that students need to transform from learners into expectant registered nurses,³ facing multiple challenges in role identification, skill adaptation, and emotional management, as well as various pressures such as internship evaluations, the nursing licensure examination, and job searches.⁴ High-intensity clinical rotations, inadequate student-preceptor ratios, and cultural constraints on the expression of trauma may exacerbate students' vulnerability.

Regarding the nursing education system in China, undergraduate nursing education adopts a two-stage model of school study (3 years) and centralized clinical internship (1 year). Students are taught a range of knowledge and skills to prepare for clinical practice during the first three years. Pre-graduation clinical internships adopt a “school-hospital” cooperation model, in which students are assigned by the university to affiliated or cooperative teaching hospitals. Students rotate through core clinical departments, including the emergency department, operating room, intensive care unit (ICU), obstetrics and gynecology, pediatrics, surgery, and internal medicine, under the supervision of clinical instructors.⁵

Most instructors are frontline nurses who shoulder simultaneous responsibilities for patient care and student instruction, often leaving limited capacity to provide timely, structured psychological support for interns.^{6,7} Formal and systematic psychological support resources for nursing interns remain scarce, with support largely limited to informal mentoring and peer assistance.⁶ In addition, cultural values in Chinese society emphasize endurance and emotional restraint, leading students to remain silent or independently

process distressing events.⁸ This mismatch between heightened psychological demands and insufficient supportive resources renders the internship a high-risk period for psychological trauma. It therefore highlights the urgent need to explore adaptive coping mechanisms and pathways of positive transformation.

During an internship, nursing students not only have to cope with heavy academic and clinical tasks but are also frequently exposed to patient suffering, death, reanimation, or serious injuries, structural stress within the healthcare system, and workplace violence.^{9,10} Research indicates that baccalaureate nursing students have encountered trauma while participating in clinical practice, and 56% report experiencing moderate to severe levels of secondary traumatic stress (STS).¹¹ An estimated 45% of Chinese nursing interns have experienced at least one incidence of psychological workplace violence.¹² Recent qualitative studies also support this view, showing that Chinese nursing students commonly suffer verbal abuse from patients, family members, and even clinical mentors and nurses during their internships, which poses a serious threat to their professional identity.^{8,13} Collectively, these findings indicate that traumatic experiences among nursing interns are not isolated incidents, but rather a common and diverse occupational risk.

Previous studies have confirmed the negative impact of traumatic experiences, including anxiety, depression, burnout, and potentially developing into more severe STS.^{14,15} It may cause them to doubt their own abilities and drop out of the nursing profession.^{16,17} The reason may be that nursing students lack proper preparation and mechanisms to cope with trauma.¹⁸ Compared to guidance during trauma and reflection after trauma, pre-traumatic education is receiving increasing attention. A rapid review study supports this and emphasizes the need for school curricula to ensure that students are made aware of trauma and the personal and professional strategies that can aid them in coping with such experiences.¹⁷

Given the urgent need for a structured framework to guide pre-traumatic education for nursing students, trauma-informed care (TIC) provides a valuable conceptual foundation. TIC emphasizes understanding the pervasive impacts of trauma and integrating such understanding into service delivery. The core principles include safety, trust, peer support, and empowerment, aiming to protect the safety of healthcare providers and patients and prevent re-traumatization.¹⁹ Trauma-informed care training and education has been strongly advocated for nursing students to help them better prepare for exposure to trauma in clinical settings.^{20,21}

In China, the concept of trauma is only mentioned sporadically in courses such as nursing psychology, and there is no specialized, structured trauma psychological preparation education or TIC training. Students often have limited knowledge of trauma and coping strategies before entering clinical practice. To develop a trauma-informed care curriculum tailored for Chinese nursing students, the primary prerequisite is a deep understanding of the nature of their traumatic experiences.

Therefore, this qualitative descriptive study aimed to explore the traumatic experiences and coping strategies that Chinese undergraduate nursing students learned during clinical internships. Findings from this study could provide empirical evidence to support the development of a culturally tailored, targeted trauma-informed care in nursing education.

Review of Literature

Nursing students represent a high-risk population for trauma-related consequences due to both personal vulnerabilities and exposure to stressful clinical environments. Studies show that nursing students encounter more significant levels of adverse childhood experiences (ACEs) compared to the general population,²² which increases their vulnerability to depression, anxiety, and post-traumatic stress disorder

(PTSD).²³ Moreover, nursing students may have suffer psychological impacts even greater than those experienced by nurses.¹⁶ The experience of “reality shock” may lead to moral distress particularly when students know what is ethically correct but are unable to act due to institutional constraints, power imbalances, or insufficient capacity. They experience profound guilt, anger, and professional doubt.²⁴ If this anguish is left unaddressed for a long time, it can not only damage mental health but may also lead to career withdrawal intentions.²⁵

The impact of traumatic experiences on nursing students is not a one-way negative path, but also those experiences may be transformed into an opportunity for career growth. A previous study described positive transformation in practice by nursing students from challenges to “experience of meaningfulness.”²⁶ This shift does not happen automatically, but depends on a series of mediating conditions. Another qualitative study among students also reaffirmed their professional commitment and developed professional resilience through supportive relationships.²⁷ Similarly, a grounded theory study proposed the “Pushing Through” theory, which describes the process “distress, identity shift, and moving forward” by which nursing students experience after encountering critical clinical events.²⁸ Reflection through journaling, counseling, or self-reflection provides students with opportunities to process their experiences over time, ultimately leading to identity transformation.²⁸ However, this process and the mechanisms of transformation among Chinese nursing students is rarely described.

To cope with trauma, nursing students often employ strategies such as emotion regulation, social interactions, or religious/spiritual support.²⁹ Some studies have found that instructors’ support^{26,27} and peer support²⁸ are very important. However, this support often relies on informal, sporadic interpersonal interactions and lacks institutional guarantees, especially in the Chinese clinical environment;

psychological support resources are generally scarce. Furthermore, existing curricula in the Chinese context rarely cover trauma coping, boundary setting, or self-care, leaving students unprepared and helpless in traumatic events.

In summary, most studies focus on single sources of trauma (such as workplace violence or bullying), lacking a comprehensive qualitative exploration of the complex and diverse traumatic experiences of nursing interns. Although previous studies have addressed the negative impacts of trauma, the simultaneous coping with multiple sources of trauma during internships within the context of Chinese culture is undiscovered.

This study used the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of trauma as a broad guide. According to SAMHSA's 3E model—Event(s), Experience, and Effect, whether an event is experienced as traumatic depends on the individual's subjective interpretation—including their comprehension of the event's significance, emotional response, and the power dynamics involved—rather than on the objective severity of the event alone.¹⁹ This emphasis on subjective experience aligns with the qualitative descriptive design, which prioritizes participants' own perspectives and remains open to emergent data without imposing predetermined theoretical constructs.

Study Aim

This study aimed to describe the traumatic experiences and coping processes encountered by Chinese undergraduate nursing students during their clinical internships. The ways they learned from traumatic experiences to develop their own growth were also explored.

Methods

Design: A qualitative descriptive study was employed. This design is suitable for direct and

detailed descriptions of specific phenomena, aiming to present participants' experiences and perspectives without theoretical constructions. It focuses on the who, what, and where of complex experiences,³⁰ emphasizing how individuals make meaning of lived experiences, particularly relevant to nursing education and psychological trauma.³¹ The Consolidated Criteria for Reporting Qualitative Research (COREQ)³² was adhered to in this paper.

Participants and Setting: Purposive sampling with maximum variation was used to recruit 15 undergraduate nursing students at different clinical internship stages from a university in eastern China, with consideration of gender, department, and internship hospital diversity. All participants included in the study provided voluntary consent. No dropouts occurred.

Recruitment was conducted in three phases (May, July, and September 2024). May: students from the first cohort who had completed the full internship (late stage, 10 months); July: students from the second cohort in early internship (≥ 2 months); September: the same second cohort in mid-internship (5 months). The " ≥ 2 months internship" requirement ensures that participants have sufficient clinical experience for effective reflection. This range covered nursing interns at different stages of internship, early (at least 2 months), middle (5 months), and late (10 months). Recruitment was conducted through the nursing teaching office. With the assistance of the administrative staff, recruitment announcements containing the study information and contact details of the primary investigator (PI) were disseminated to undergraduate nursing student cohorts via official WeChat groups. Interested students were invited to contact the PI directly.

Inclusion criteria were: a) aged ≥ 18 years; b) completed all professional courses; c) completed ≥ 2 months of clinical internship; d) stated he or she had a traumatic experience in the hospital during internship; and (e) willing to participate. Nursing

students with mental disorders or serious psychological problems who were receiving medication were excluded. The exclusion was determined based on participants' self-reports and sick leave records obtained from the clinical internship management office.

In this study, a traumatic experience was defined as a subjective encounter occurring during formal clinical placements that the student described as extremely challenging, deeply distressing, unforgettable, or identity-shaking in interactions with patients, family members, clinical instructors, nursing staff, or institutional policies. The sample size was determined by the principle of data saturation; recruitment ceased when newly collected data yielded no additional themes.

Ethical Considerations: This study was approved by the Institutional Review Board of Suzhou Vocational Health College in China (No. SWYXLL202408, May 2024 to October 2025). All participants provided written informed consent after being fully informed of the study's purpose, procedures, and potential risks. To mitigate potential power imbalances, the PI, though a lecturer, was not the direct instructor or clinical supervisor for any of the participants, nor was the PI involved in their academic or internship evaluations. Participants retained the right to withdraw at any time. Strict confidentiality was maintained throughout the research process; all interview recordings and transcripts were stored anonymously on encrypted devices. The interview was conducted in a private, undisturbed space.

The PI holds a nationally certified Level-2 Psychological Counselor qualification in China. This professional training enabled the researcher to maintain emotional sensitivity during interviews. If participants experienced emotional distress, the researcher was prepared to pause the session and provide immediate emotional support without probing

further. To prevent participants from ending the session in a state of distress, a 'cool-down' period was incorporated into the final 10 minutes to provide reassurance and grounding. Furthermore, all participants received a resource list containing school counseling center contacts and local psychological hotlines. Upon observing signs of severe distress or upon a participant's request, the researcher would initiate a referral process to either on-campus free counseling services or third-party psychological institutions, subject to the participant's consent. In this study, no participants experienced emotional breakdowns and were referred to other institutions.

Data Collection: Data were collected from May to September 2024 using a combination of semi-structured face-to-face interviews and drawing. Interviews were conducted by the PI in a private room at the university's mental health center (a confidential and comfortable environment with soft lighting to reduce participant anxiety), with the research assistant arranging the venue.

The PI was trained both in class and research practice in conducting qualitative methods under the methodological guidance of the second author, who possesses extensive experience in qualitative inquiry in trauma and nursing education. Each interview was conducted after rapport and trust were established and lasted approximately 45–60 minutes. All interviews were audio-recorded, and field notes were taken to capture non-verbal cues.

A semi-structured interview guide was developed based on the study aims and reviewed by three experts in nursing education and trauma to ensure content validity. The questions were designed to be open-ended, progressing from non-threatening topics such as "Which hospital did you intern at? How long did you intern at? Which departments did you rotate through?" to sensitive, core questions, such as 1) "Please recall: what events occurred during your internship that left you feeling deeply

traumatized, distressed, shocked, helpless, or unable to let go?" 2) "What were your emotions at that time? What thoughts went through your mind?" 3) "What did you do to help you get through that period?" and 4) "Looking back, how has this experience influenced your personal development or your identity as a future nurse?"

During the interviews, the PI maintained a non-judgmental stance to build rapport and ensure a safe environment for disclosure. Specific techniques employed included active listening, probing, clarifying, empathic paraphrasing, and silence. When participants became emotionally distressed, the PI provided companionship and immediate emotional support (e.g., offering tissues, water, using grounding techniques) and waited for them to decide whether to continue the interview.

Following each interview, participants were invited to create a drawing that represented or expressed their traumatic experience or reflection. They were provided with one sheet of A4 paper, a set of 12 colored pencils, a graphite pencil, and an eraser. No time limit or artistic skill was required; the focus was on spontaneous representation. After the drawing was completed, the PI fully respected the participant, invited him or her to name it, briefly described its content and explained how it related to their recounted experience. The PI used non-directive questioning techniques (e.g., "What is this drawing trying to say?") to facilitate the full expression of their inner thoughts.

After the interviews, all recorded data were transcribed verbatim in Mandarin Chinese. Two of the transcripts were unclear, so the PI conducted phone calls and WeChat to clarify meanings and ensure understanding. Prior to formal analysis, transcripts were anonymized by replacing participants' names with identification numbers (P1–P15) and returned to the respective participants for member checking—allowing them to review, comment on, or correct the content to enhance accuracy and credibility.

Data Analysis: An inductive thematic analysis was conducted following the six-step procedure outlined by Braun and Clarke:³³ 1) familiarization with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; (5) defining and naming themes; and 6) producing the report. The analysis was conducted independently by two authors. Each read all transcripts multiple times to achieve data immersion. Following initial coding, codes were collated into potential sub-themes and overarching themes based on conceptual similarity and relevance to the research questions. These preliminary themes were iteratively reviewed against the full dataset to assess coherence and internal homogeneity, refined through discussion, and finally named to reflect their core essences. Throughout this process, participants' drawings served as supplementary data sources: visual elements were interpreted alongside verbal narratives to triangulate emotional tones and validate thematic interpretations.

Trustworthiness: The criteria of trustworthiness set forth by Lincoln and Guba were rigorously applied.³⁴ Regarding the research background of the PI and second author, any discrepancies in coding or theme interpretation were resolved through iterative discussion and mutual reflection until a consensus was reached. To strengthen dependability, the interview guide was pilot-tested and refined through consultation with an ethics expert and the full research team prior to implementation. Confirmability was ensured through an audit trail and data-source triangulation. The triangulation method used two different data sources. The participants' verbal narratives from interviews were cross-validated with their self-generated drawings. Preliminary themes and interpretations of the drawings were presented to participants for validation. Any discrepancies were discussed and resolved, ensuring that the final analysis accurately reflected the participants' perspectives rather than the researcher's bias. In addition, confirmability was achieved by the researcher being aware of subjectivity through member checking and peer review.

Findings

The findings were divided into demographic characteristics and traumatic experiences of nursing students.

Demographic characteristics of the participants

This study recruited 15 undergraduate nursing students. Participants were between 21 and 23 years old. There were 5 males and 10 females. All participants

were Han Chinese, and had no religious affiliation. Internships were at tertiary hospitals in Jiangsu Province (n = 13) and Shanghai (n = 2). Five participants interned for two months, three for five months, and seven for ten months.

Traumatic experience in clinical internship

Three main themes and nine sub-themes of traumatic experiences in clinical internship among nursing students emerged (see **Table 1**).

Table 1. Themes and sub-themes of traumatic experiences by nursing students in clinical internship

Themes	Sub-themes
1. Confronting painful experiences during practicum	1.1 Unprepared exposure to death and suffering 1.2 Hidden harms within power structures 1.3 Activation of personal unfinished business
2. Coping with emotional pain	2.1 Emotional labor overload 2.2 Feelings of empathy but powerlessness 2.3 Defensive emotional isolation
3. Transformation from pain to personal and professional growth	3.1 Pulling strength from supportive resources to develop coping strategies 3.2 Reshaping personal views on life, nursing, and boundaries 3.3 Reaffirmation of professional identity and personal growth

Theme 1: Confronting painful experiences during practicum

The trauma faced by nursing students during their clinical internships was not an isolated event, but a complex predicament formed by the interplay of multiple challenges, including facing life-or-death situations, enduring structural power oppression, and the activation of personal traumatic memories. It has three sub-themes.

Sub-theme 1.1: Unprepared exposure to death and suffering

This is a common source of trauma mentioned by nursing students. Students described the profound shock of first encountering patients in extreme suffering, dying, and failing resuscitation attempts. This study found that students interning in high-risk departments such as the intensive care unit, emergency department, oncology department, and

infectious diseases department are exposed to death, dying experiences, and severe illness more frequently, and their trauma responses are more intense. One participant who interned in the emergency department experienced the suddenness of facing death for the first time.

“In the emergency department, an elderly woman in a deep coma suddenly began foaming at the mouth. I tried to resuscitate her, but ultimately couldn’t save her. The first time I performed CPR on a person, the feeling was very different from the sensation of pressing on a model. I was terrified, and even now, I’m still shaken.” (P4)

Another participant in the infectious disease department also described suddenly learning of the death of a young patient.

"The patient was a young man with liver cancer. He lay in bed, constantly groaning in pain. One day during rounds, I saw the ward attendant packing his things and asked if he had been discharged. She said he had passed away. That was the first patient I encountered at my internship who passed away. I was deeply moved and couldn't calm down for a long time. He was still so young." (P6)

Sub-theme 1.2: Hidden harms within power structures

The students described traumatic interactions stemming from multi-layered power structures. Within the hospital hierarchical system, students occupied a structurally vulnerable position. Their identity as "learners" is sometimes overlooked by clinical nurses and instead is instrumentalized as "labor" to fill staff shortages. This results in the deprivation of professional growth opportunities and exposure to unwarranted accusations, humiliation, and even harassment from some patients or their family, causing a double blow to both their professional and personal dignity. The lack of support systems within the organization exacerbates this experience of being instrumentalized.

"In my first department, I had to do 20 to 30 electrocardiograms a day. My back was always hunched over, and I was extremely tired [emphasis added]. I was so tired that my back would ache as soon as I lay down, and I felt uncomfortable all over. Even for the smallest things, they would call you over, and when you finally got a break, they would make you do this and that—tidy up, sweep, clean—you had no free time at all, and you were constantly working all day long." (P2)

"During the evening shift handover, I waited until they finished before leaving, thinking I'd observe the handover process. The head nurse

said, 'Go to the nurses' station and keep an eye out for anyone else who needs a nurse.' Actually, I was thinking, you don't even let me observe the ward rounds? What can I learn sitting at the nurses' station? This made me very uncomfortable [angry]." (P2)

"On my first day in the department, the clinical instructor asked me to run errands and pick up takeout for them, which made me feel very uncomfortable." (P3)

"While I was taking an old man's blood pressure and putting on the cuff in the ward, he started saying he liked me and knew so-and-so important people. I felt disgusted and quickly left....I don't understand Suzhou dialect. A patient called to me in Suzhou dialect, but I didn't reply. Then she mocked me." (P8)

There is a drawing titled "Understanding and respect," which describes a scene where a patient berates an intern nurse. *"A patient rang the bell to change her IV fluids, but I was too busy and arrived late. The patient became very angry, smashed a cup, and yelled at me. I felt wronged and sad, and I silently wept as I cleaned up the broken cup. I think she dared to yell at me like that just because I was a nursing intern."* (P5)

Sub-theme 1.3: Activation of personal unfinished business

This study found that students' traumatic experiences did not all stem from entirely new terrifying events. Some were triggered by personal historical traumas reactivated by specific situations encountered in clinical work. These situations could unexpectedly activate and amplify pre-existing painful memories or fearful images from their personal lives, creating a strong "resonance" effect that made their current professional experience unbearable. As a participant from an oncology internship, she reflected on her traumatic experiences when interacting with cancer patients, reminding her of her own family's suffering.

The oncology environment itself became a powerful trigger, directly connecting the patients' pain with her own deep-seated grief for her family.

"When I saw the suffering of patients with advanced cancer, it was as if I saw my grandfather again, as if he had never left me. My heart felt heavy." (P1)

Another participant described a profound clinical situation: when a terminally ill cancer patient beckoned to her, she felt intense guilt for turning away. This event resonated strongly with her past unfinished grief at not being able to see her aunt one last time, creating traumatic emotional stacking, leading to persistent guilt and intrusive rumination.

"She [a patient with end-stage breast cancer] was unable to speak and was bedridden. She waved for me to come over, and at that moment I froze, I was scared and didn't go over. I thought of my beloved aunt, who also had breast cancer and had passed away. But because of exams, I couldn't see her one last time. I have let down my aunt, and I have also failed my patients." (P6)

This "resonance" reveals that students enter clinical practice carrying their complete personal histories.

Theme 2: Coping with emotional pain

All participants were more likely to have emotional distress upon learning about their traumatic experiences during clinical internship. Three sub-themes were described.

Sub-theme 2.1 Emotional labor overload

This study found that participants internalized the patients' suffering through deep empathy, resulting in a certain degree of emotional overload.

"One of my patients passed away, and I didn't know how to cope or adjust psychologically... The patient passed away quickly, and it took

me a long time to process it...I feel I can deeply empathize with him; I am caught in his negative emotions." (P6)

"The most memorable patient was a newly diagnosed one. He initially seemed very healthy; however, less than a month later, he looked like a withered leaf. I felt a chill run down my spine, a cold, icy sensation." (P3)

Sub-theme 2.2 Feelings of empathy but powerlessness

Some participants experienced a complex emotional predicament when their moral instincts encountered real-world limitations (insufficient ability, limited resources), manifesting as three intertwined emotional experiences: feelings of powerlessness due to inadequate knowledge, and the fear of making mistakes. Feelings of powerlessness were the most common, as described by participants.

"This is a fact [he has passed away]. I really wanted to help, but there was nothing I could do." (P6)

"I don't yet know how to help him process his emotions, given his psychological reaction." (P1)

When the feeling of powerlessness persisted, participants began to attribute the predicament to themselves, developing profound feelings of inadequacy and fear. Participants not only feared their inability to help patients but also feared "doing more harm than good," as stated by P3 on his drawing.

There is a drawing titled "Striving to run," which depicts a young patient who lost an arm and a lower leg in an explosion.

"I wanted to encourage him, but I didn't try to say it. I felt it was a heavy topic, and my own experience is limited. I didn't know how to communicate, and I was afraid of doing something wrong and upsetting him." (P3)

Almost all participants described their empathy, particularly when witnessing patients or their families break down in tears, as having a far more direct and emotional impact than words. They often felt deep empathy but felt powerless when they were unable to help.

"That day, when I opened the door, I saw her and her husband crying. I felt I might have been touched too. I didn't know what to say or do." (P4)

"His mother was breaking down in tears, and it was incredibly impactful for me. I wanted to comfort her, but I had no idea how." (P6)

The impact of crying is even stronger when it occurs against a backdrop of loneliness and helplessness. As one participant said:

"I heard an elderly patient crying late at night. He had no family with him, only an employed caregiver. The employed caregiver was very irritable, impatient, and arrogant. I tried to ask him why he was crying, but he wouldn't answer me." (P5)

One participant's drawing, he interpreted as follows:

"The patient is crying, the machines are operating, the disease, appearance, pain, and inner feelings are complex colors, the environment is a single color, and there is bright light outside the ward." (P4)

Sub-theme 2.3: Defensive emotional isolation

This study also revealed a dynamic of bidirectional emotional isolation in traumatic clinical situations. Patients exhibited withdrawal, numbness, and isolation due to pain or fear; while nursing students developed defensive professional behaviors to cope

with their overwhelming emotional burden, manifested as silences or defensive avoidance from the scene. When the system failed to teach students how to be "present" in pain and survive, avoidance became their familiar survival skill. This was an immediate protective mechanism triggered to preserve their psychological functioning in the absence of a supportive system. As a participant wrote in the painting "Isolation."

"The emaciated tortoise in this drawing represents an elderly man in my ward suffering from a terminal illness. He is isolated from the outside world. Outside, the sky is azure, the clouds are fluffy, birds are singing, and flowers are in full bloom. The sunlight reaching out is me. I desperately reach out, wanting to comfort his pain and warm the lonely heart beneath his shell. But he remains hidden within the walls he has built for himself, imagining the coldness of death, curling up, and even trying to escape the warmth of the sunlight." (P9)

"Seeing this [the patient and her family were crying], I quietly left, closing the door behind me, not wanting to disturb them." (P4)

Theme 3: Transformation from pain to personal and professional growth

This theme reveals a dynamic trajectory from initial vulnerability to the construction of positive transformation. Both internal and external supportive resources were described as the foundation for developing coping strategies, internal cognitive restructuring as the core driving force, and reaffirmation of professional values and meaning as a key link. These experiences ultimately lead to dual growth in personal maturity and professional advancement.

Sub-theme 3.1: Pulling strength from supportive resources to develop coping strategies

Nursing students' capacity to navigate traumatic experiences is profoundly shaped by their engagement with diverse support resources and

the coping strategies they cultivate. When faced with trauma, nursing students may develop multi-layered, progressive coping strategies, ranging from immediate physical regulation and attention shifting to observational learning and independent cognitive reflection.

Meditation and breathing relaxation are more effective for me. (P14)

I like to play mobile or computer games to release emotions and temporarily escape reality. (P3)

I observed and learned how the clinical instructor handled these situations. (P12)

When I feel distressed, I might talk to friends, but most of the time I bear it alone and frequently reflect on my experiences. (P1)

In this process, nursing students have various sources of support, ranging from interpersonal support to professional assistance, including clinical instructors, parents, friends, and mental health professionals. When self-adjustment and general support failed, seeking professional help became a crucial step.

“A patient started touching my hand inappropriately, and I couldn’t stand it anymore, so I told my clinical instructors. She said I handled it well and have no conflict with the patient. She comforted me, telling me not to worry about it and that she would take over.” (P8)

“It has been bothering me for a long time. When I heard what she [a psychological counselor in school] said, my eyes lit up. Suddenly, a new path opened up in my mind. It wasn’t like 1 and 1.1; it was like 0 and 1. When she helped me change my perspective on the situation, I felt much better.” (P6)

In addition, in a few hospitals, a supportive organizational culture served as an important protective environment for students. As one participant described:

“This hospital places special emphasis on mental health. Every day during nursing handover, the head nurse would ask, ‘Do you know the patient’s personality? What about the personality of the patient’s family? What are their psychological needs?’ It makes us naturally pay attention to mental well-being.” (P13)

Besides, cultural or spiritual aspects were being considered. A few participants turned to cultural and spiritual resources as a unique way to cope with trauma. Faced with the fear and depression brought about by exposure to death, some students sought psychological refuge through folk beliefs. As a participant who described herself as “physically weak and susceptible to negative influences,” she specifically sought out an amulet to wear in hopes of obtaining supernatural protection and peace. She reflected:

“A long time passed, but I still seemed to be able to see the people who had passed away. Later, I got a talisman from a shaman and wore it.” (P1)

Sub-theme 3.2: Reshaping personal views on life, nursing, and boundaries

Traumatic experiences do not merely change students’ perceptions; they trigger a gradual, reflective process that dynamically reshapes their understanding of life, nursing, and professional boundaries. Through repeated emotional shocks, self-examination, and key moments of insight, students experience turning points that lead to lasting cognitive transformation.

First, their view of life matures and is more valued.

“In the past, when faced with a serious setback, I often thought, ‘The worst that can happen is that I’ll just die.’ After witnessing

some patients' deaths during my internship and seeing the impact on their families, I couldn't help thinking: what would happen to my parents if I died?... Now I feel that living is wonderful, and as long as I am alive, I can definitely find a solution." (P15)

In addition, facing death also shakes some students' original perceptions, evolving step-by-step from initial fear and avoidance to a calm acceptance of the finiteness of life, and a more meaningful commitment to caring for patients.

"I was very scared and wanted to run away when a patient passed away suddenly. After repeated experiences, I now accept that death is a natural part of life.... I can face death more calmly. ...I will do my best to serve patients in their final stage." (P5)

Second, interning nurses' perspectives underwent a paradigm shift from a technology-centric to a relationship-centric approach. Interns deeply understand that nursing is a combination of "skills plus caring" (P10), and that patients crave closeness, not just treatment (P12). They distilled the wisdom of relational care from practice, including the power of a smile (P10), listening (P12), patiently answering questions (P11), and humor (P9).

"Listening and patiently answering questions are very important." (P2)

A drawing titled "Synergy protection" was described as follows: a nurse (blue) and a family member (orange) together protect a patient with trauma, forming two large hearts that surround the patient (P6). Another drawing, titled "Embrace," depicts me (a nursing intern) approaching and preparing to embrace a patient suffering from psychological trauma (P11).

Finally, from "over-empathy" to "bounded care"—the rational construction of professional boundaries.

Through mentorship and self-reflection, they learned to balance empathy with exhaustion (P10 and P13), transforming emotional investment into sustainable, strategic care and establishing professional boundaries.

"We empathize with him, but that doesn't mean his misfortune was caused by us, and we shouldn't be forced to bear so much self-blame." (P10)

Sub-theme 3.3: Reaffirmation of professional identity and personal growth

Traumatic events often trigger a temporary shake in professional identity, with students potentially questioning their suitability for the nursing profession. However, through the integrated process of coping, support, and cognitive restructuring, this shaking often leads to a more resilient and profound professional identity. This transformation not only strengthens professional identity but also fosters holistic personal growth in emotional resilience, coping capacity, and life orientation.

"I couldn't get over it for a long time after that young patient died suddenly. I once doubted whether my nursing care was worthwhile. ... This doubt lingered until near the end of my internship, when I mustered the courage to consult an experienced clinical nurse educator. She explained that nursing value has two dimensions: lifespan extension and life experience. Later, I realized the meaning of nursing work when I shifted my focus from measuring the value of care by the length of life to relieving the patient's suffering." (P6)

"When I first encountered a patient with a hostile attitude during my internship, the first thought that popped into my head was 'stay away from nursing work.' Thinking back to my internship, although patients sometimes distrusted, misunderstood, and were verbally

aggressive towards intern nurses, this was a minority. The patients recovered, their pain lessened, and their families were laughing and talking. I felt a great sense of accomplishment, and I still really enjoy nursing.” (P4)

Drawings also symbolize the students’ personal and professional growth. The drawing by P15 titled “Thousands of lights shine in every home as my journey” depicts the happiest scene for nursing students after a day’s work, lights shining in every home, families rejoicing; lights guiding the way ahead, signifying an increasingly bright future.

Discussion

This study explored how Chinese nursing students navigated and transformed traumatic experiences. Three main themes emerged: 1) Confronting painful experiences during practicum; 2) Coping with emotional pain; and 3) Transformation from pain to personal and professional growth. It presents the dynamic process of nursing students from experiencing trauma and enduring pain to reconstructing meaning and regenerating personal and professional growth.

The first theme, “*Confronting painful experiences during practicum*,” revealed that nursing students’ trauma is not an isolated event, but a complex interwoven with the impact of death and suffering, power oppression, and the activation of personal trauma.

For nursing students in China, clinical internships are an essential step towards becoming registered nurses. For hospitals, interns are a vital resource for alleviating the shortage of clinical nurses and supplementing the clinical nursing workforce. Although they are nursing students, both clinical instructors and patients often expect them to act as nearly independent caregivers.⁵ Additionally, as required, all undergraduate nursing students must complete internships and rotations in high-risk departments such as the ICU, emergency

department, and operating room. Before they have developed mature psychological coping mechanisms, they are required to face death and suffering. The unprepared exposure to death and suffering aligns with a previous study, which identified “unprepared exposure to critical events” as a core stressor for nursing students globally.¹⁷

Secondly, structured harms may stem from power imbalances within the clinical education setting. Students are individually assigned to staff nurses.⁷ In some high-pressure departments, students are treated as “cheap labor.” As students occupy the lowest position in the clinical power hierarchy, they become vulnerable to subtle mistreatment, which is often normalized by some clinical instructors. Furthermore, nursing students are often excluded from formal support systems due to their informal staff status.³⁵ Some may also become targets of verbal abuse or harassment, displaced by patients or their families.

Some events in clinical practice become “traumatic” not only because of their inherent impact but also because they trigger unresolved personal experiences from participants’ past—“unfinished business.” This phenomenon has received little attention in previous literature on nursing students’ internship experiences. Students internalize the patient’s suffering as their own, blurring the lines between self and others; they may experience emotional reactions beyond what is expected of the current event, leading to intensified emotional reactions. In the context of Chinese nursing education, students often enter clinical training with a range of prior life experiences, including personal adversities such as family conflicts, academic pressure, or loss. However, these experiences are rarely systematically addressed or processed within the educational curriculum due to cultural norms that discourage open discussion of personal distress and an educational system that prioritizes clinical skills acquisition over emotional preparation. Consequently, when these students encounter suffering patients in

clinical settings—particularly those whose circumstances resonate with their own unresolved past experiences—they may exhibit heightened emotional responses that extend beyond empathic engagement. Moreover, “activation of personal unfinished business” transcends the traditional “vicarious trauma” and “secondary traumatic stress” paradigm, by showing how past trauma can be reactivated. As Oakley et al. emphasized, nursing students’ trauma sensitivity is highly dependent on their personal history.¹⁵ It is important for nurse educators to recognize the trauma students faced prior to entering nursing programs.¹⁵

The second theme “*Coping with emotional pain*” includes pain emotion overload, powerlessness, inadequacy, and fear in ethical dilemmas, as well as coping deficit, and instinctive responses. It highlights the direct emotional impact of traumatic experience on students and the potential impact on career commitment.

In all descriptions, students express a range of negative emotions, including exhaustion, suppression, helplessness, powerlessness, fear, self-doubt, grief/sadness, shame, anxiety, anger, frustration and guilt, and so on. These unbuffered emotional responses represent the immediate affective reaction to traumatic experiences, which can be summarized as emotional labor overload. Similar findings from Harvey also reported that nursing students often “push through” traumatic events by suppressing emotions until they rupture, and even questioned whether they were competent for the role of nurse.²⁸

This study found that trauma is not only caused by external events but also results from the conflict between internal moral demands and realistic limitations. Feelings of powerlessness do not exist in isolation; they reinforce one another. When students’ desire to help others cannot be fulfilled, they not only feel distressed but also begin to question their own value and abilities. These negative consequences may be related to students’ lack of tools and knowledge to understand and cope with traumatic events.²⁷

A previous survey found that 94.0% of undergraduate nursing students in China had a low level of TIC practice.¹⁸

Another key manifestation of unskilled coping is the grief process. Within Chinese cultural contexts, the crying of patients may foreshadow the outward manifestation of trauma after long-term emotional repression.³⁶ When nursing students witness patients crying, they often feel deep empathy yet remain silent, withdrawn, and bewildered. This response reveals not only their limited knowledge and strategies for supporting grieving patients but also their insufficient awareness and regulation of their own emotions.

Over time, persistent high empathy and unregulated emotional burden may lead to emotional exhaustion. As an instinctive self-protective response, some students adopt defensive emotional isolation to avoid overwhelming pain. Therefore, some students instinctively adopt a defensive, emotionally isolating strategy to protect themselves. This adaptive but maladaptive strategy is consistent with a previous study.³⁷ Defensive emotional isolation acts as an immediate psychological survival mechanism for students in acute distress and also serves as a logical precursor to the later transformation, cognitive restructuring, and growth processes described in the third theme.

The third theme, “*Transformation from pain to personal and professional growth*,” aligns closely with the post-traumatic growth (PTG) process after experiencing trauma. PTG theory posits that individual growth does not stem directly from the traumatic event itself, but rather arises from the struggle against adversity.³⁸ This study found that a multi-layered support system as a foundation to enable students’ adaptive coping. Specifically, students not only engage in self-regulation through reflection or video games, but more importantly, they actively seek external resources, such as help from clinical instructors,^{26,27} family and friends or peers,^{26,28} professional psychological support,²⁷ and even religious/spiritual support.²⁹ Beyond interpersonal and professional support, organizational

cultures and cultural-spiritual beliefs further alleviate death-related anxiety and emotional distress. The finding extends existing literature by highlighting the unique role of non-traditional support in trauma recovery. It is this proactive interaction and resource exchange with the environment (social support networks, cultural beliefs) that provides crucial nourishment for cognitive reshaping and the awakening of professional commitment, thereby promoting PTG.

Furthermore, this study revealed significant shifts in nursing students' perceptions of life, nursing, and professional boundaries after traumatic experiences. Some participants initially had a strong fear and avoidance of death. For participant P5, the dynamic mechanism underlying the turning point involves three sequential steps. First, choosing to confront fear rather than suppress it; second, reconstructing the meaning of death through repeated clinical exposure, redefining it from a "horrible event" to "the natural end of life"; and finally, translating this cognitive acceptance into concrete actions in end-of-life care. Among other participants, like participant P15, death was initially viewed as an escape from suffering. A critical turning point emerged when they linked patients' deaths to their own family and personal fate. It triggers deep reflection on the meaning of life and a gradual shift from casual disregard to sincere appreciation of life's value. The maturation of life perspective developed dynamically through a growing sense of responsibility toward life. Secondly, the shift in nursing perspectives was dynamically triggered when students realized that technical skills alone cannot alleviate patients' suffering. The mechanism driving this change lies in ongoing reflection and experiential learning in clinical practice. The students learned that "caring is effective not from the classroom, but from observing real patient responses in authentic clinical situations. Thirdly, the critical turning point occurs under the professional boundaries when nursing students recognize the risks of unregulated emotional engagement. The know-how underlying this shift is the ability to

distinguish empathy from self-blame: students may empathize with patients' suffering without attributing it to their own incompetence. This cognitive demarcation enables them to transcend emotional overload and engage in bounded, sustainable care. The post-traumatic growth theory posits that individuals who cope with major crises may experience positive transformations in their relationships with others, personal strength, philosophy of life, new possibilities, and spirituality.³⁸ Similarly, a previous study reported that nursing students used "meaningful experiences" to promote growth.²⁶

A reaffirming process of professional identity during traumatic experiences was shown. The findings were consistent with a previous survey⁶ that highlighted the severity of compassion fatigue and over-shock during the later stages of nursing internships, significantly impacting their career choices after graduation. Traumatic events may temporarily disrupt one's original identity, but through reflection and meaning-making, individuals can build a more resilient and complex new professional identity.³⁹ A study of midwifery students also reported similar career-affirming shifts among participants, from self-doubt to career identity.²⁷ A key growth point is that students gradually realize that traumatic challenge is part of the profession, and that unpleasant patients or traumatic events are only a minority of nursing internships. The transformative insights may arise either from long-term retrospective reflection and sudden realization or from seeking guidance from experienced mentors, thereby enabling students to view the value and meaning of nursing. This cognitive shift is an important sign of professional maturity. In parallel, such professional reconstruction was accompanied by profound personal growth. Just like one participant (P15), when students are able to connect nursing by drawing a picture of "the lights of countless homes," professional identity ceases to be a job and becomes a mission, and reconstructing a more resilient and mature self. This dual transformation strongly supports post traumatic growth theory by illustrating how clinical adversity fosters synchronized growth in

self-concept, life philosophy, and professional commitment.

In addition, if nursing students obtain professional support pre-traumatic events (education), during (guidance), and post-traumatic events (debriefing), they can alleviate the biopsychosocial impacts.¹⁷ However, for the majority of participants in this study, resulting from their long-time self-directed developing strategies, involving a prolonged period of exploration and suffering, sometimes lasting months or even a year. Therefore, relevant courses, especially trauma-informed care, should be established before nursing students' clinical internships to inform them, enhance their trauma sensitivity, equip them with coping and career strategies, and reduce the degree and duration of trauma-induced suffering.

Limitations

This study has the following limitations: First, all participants were recruited from a single college in eastern China and were exclusively Han Chinese. This may limit the transferability of the findings to nursing students from other cultural, ethnic, or regional backgrounds. Second, participants took their clinical internships in tertiary hospitals or higher-level medical institutions. The results may therefore not be readily applicable to nursing students placed in primary healthcare settings, community hospitals, or other less specialized clinical environments. Third, the retrospective nature of the interviews may introduce recall bias, as participants' memories of traumatic experiences could have been shaped by subsequent events or ongoing reflection.

Implications for Practice

The results of this research carry significant practical implications for nursing education and people-centered nursing. First, nursing schools should formally incorporate trauma-informed care into their

curricula, especially during pre-internship preparation. Case development should cover the core scenarios identified in this study, such as facing patients with advanced cancer, facing death, and ethical dilemmas. The curriculum must include practical self-compassion strategies and practical skills packages. Furthermore, clinical instructors should receive training in psychological trauma, as well as a comprehensive psychological support system.

Conclusion and Recommendation

This study reveals a three-stage trauma-to-growth trajectory experienced by nursing students: "Facing-Coping-Transformation." It identifies the core mechanisms underlying this positive transformation using internal and external supportive resources, reaffirmation of professional values and meaning, which lead to dual growth in personal maturity and professional advancement. The findings could be further used to design a culturally appropriate course in nursing education and evaluate long-term outcomes. Future research needs to include students from multiple colleges of nursing and examine the implementation of a trauma-informed care program to enhance students' future professional growth and development.

Author Contributions:

Conceptualization, Method and design: P.S., D.Z.
Data collection, Drafting the manuscript: D.Z.
Data analysis and interpretation: P.S., D.Z.
Editing the manuscript: P.S., R.V.
Revising the manuscript: P.S., D.Z.
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“การเผชิญหน้า-การเผชิญปัญหา-การเปลี่ยนผ่าน”: ประสบการณ์กระทบกระเทือนทางจิตใจสู่การเติบโตของนักศึกษาพยาบาลจีนระหว่างการฝึกปฏิบัติทางคลินิก : การศึกษาเชิงคุณภาพ

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บทคัดย่อ: การฝึกปฏิบัติทางคลินิกเป็นองค์ประกอบสำคัญของการศึกษาพยาบาล ซึ่งในระหว่างการฝึกดังกล่าว นักศึกษามักเผชิญกับความเครียดทางอารมณ์ในระดับสูงและเหตุการณ์ที่อาจก่อให้เกิดบาดแผลทางจิตใจ แม้ว่าผลกระทบด้านลบทางจิตใจจากประสบการณ์เหล่านี้จะเป็นที่รู้จักหรือยอมรับอย่างกว้างขวางว่าเกิดขึ้นจริง แต่ยังคงขาดความชัดเจนว่าประสบการณ์กระทบกระเทือนทางจิตใจดังกล่าวสามารถส่งเสริมหรือนำไปสู่การเติบโตทั้งในระดับบุคคลและวิชาชีพในกลุ่มนักศึกษาพยาบาลจีนได้อย่างไร การศึกษาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่อค้นหาประสบการณ์กระทบกระเทือนทางจิตใจของนักศึกษาพยาบาลระหว่างการฝึกปฏิบัติ ณ วิทยาลัยแห่งหนึ่งในภาคตะวันออกเฉียงเหนือของประเทศไทย ผู้ให้ข้อมูลคือนักศึกษาพยาบาลระดับปริญญาตรีที่ได้รับการคัดเลือกแบบเฉพาะเจาะจง จำนวน 15 คน ซึ่งกำลังอยู่ระหว่างการฝึกปฏิบัติทางคลินิกก่อนสำเร็จการศึกษา เก็บรวบรวมข้อมูลโดยใช้การสัมภาษณ์เชิงลึกตามแนวคำถามแบบกึ่งโครงสร้าง และเสริมการบรรยายด้วยภาพวาดภายหลังการสัมภาษณ์แต่ละครั้ง เปิดโอกาสให้ผู้ให้ข้อมูลมีการถ่ายทอดประสบการณ์กระทบกระเทือนทางจิตใจหรือการสะท้อนคิดของตนเองผ่านภาพวาดด้วยดินสอสีบนกระดาษ โดยไม่มีข้อจำกัดด้านเวลาและทักษะทางศิลปะ การวิเคราะห์ข้อมูลใช้วิธีการวิเคราะห์ประเด็นเชิงเนื้อหาของ Braun และ Clarke

ผลการศึกษาพบ 3 ประเด็นหลัก ได้แก่ 1) การเผชิญกับประสบการณ์ที่เจ็บปวดระหว่างการฝึกปฏิบัติ ประกอบด้วย การเผชิญความตายและความทุกข์ทรมานโดยไม่ทันเตรียมตัว เผชิญภัยอันตราย แอบแฝงภายใต้โครงสร้างอำนาจ และการถูกกระตุ้นให้เผชิญกับปัญหาที่ยังไม่ได้รับการคลี่คลายในชีวิตส่วนตัว 2) การเผชิญปัญหาจากความเจ็บปวดทางอารมณ์ ประกอบด้วย ภาระหนักจากการจัดการอารมณ์ความรู้สึกร่วมเห็นอกเห็นใจแต่ไร้อำนาจในการช่วยเหลือ และการแยกตัวทางอารมณ์เพื่อป้องกันตนเอง และ 3) การเปลี่ยนผ่านจากความเจ็บปวดสู่การเติบโตทั้งส่วนบุคคลและวิชาชีพ ประกอบด้วย การดึงพลังจากแหล่งสนับสนุนเพื่อพัฒนาวิธีการเผชิญปัญหา การปรับมุมมองต่อชีวิต วิชาชีพพยาบาล และขอบเขตของตนเองใหม่ รวมถึงการยืนยันอัตลักษณ์วิชาชีพและการเติบโตของตนเอง

การศึกษานี้แสดงให้เห็นเส้นทางเฉพาะของ “บาดแผลทางใจสู่การเติบโต” ในกลุ่มนักศึกษาพยาบาล ซึ่งประกอบด้วยกระบวนการ “การเผชิญหน้า-การเผชิญปัญหา-การเปลี่ยนผ่าน” โดยชี้ให้เห็นกลไกสำคัญที่อยู่เบื้องหลังการเปลี่ยนผ่านในเชิงบวกนี้ ได้แก่ การใช้ทรัพยากรสนับสนุนทั้งภายในและภายนอกเป็นพื้นฐาน การปรับโครงสร้างทางความคิดภายในเป็นแรงขับเคลื่อนหลัก และการยืนยันคุณค่าและความหมายของวิชาชีพเพื่อเป็นจุดเชื่อมต่อสำคัญ ซึ่งท้ายที่สุดนำไปสู่การเติบโตควบคู่กันทั้งด้านวุฒิภาวะส่วนบุคคลและความก้าวหน้าทางวิชาชีพ ทั้งนี้ ควรบูรณาการแนวคิดจากประสบการณ์การเติบโตบนความตระหนักรู้ต่อบาดแผลทางจิตใจ เข้าไว้ในหลักสูตรพยาบาลระดับปริญญาตรี โดยมีระบบสนับสนุนที่เพียงพอเพื่อบ่มเพาะศักยภาพในการปรับตัวและทักษะการเปลี่ยนผ่านตนเองในการปฏิบัติทางคลินิก

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