Challenged by Compassion:
An Exploration of the Lived Experience of Compassion Fatigue Among Canadian Nurses Who Worked During COVID-19

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Dedication

To the most vulnerable forms of existence on this earth that instill faith in the incredible force of compassion around us.

To every nurse and health care professional who compassionately cared for patients during the COVID-19 pandemic.

To my beloved parents who taught me to be compassionate.

A special dedication of this work
to my beloved wife, Vinu, who steadfastly stood by me through the thick and thin,
and to our daughter, Amelia who cheered me through the final lap of this dissertation as she turned three this July and our fifteen-month-old son, Abel whose nurturing gestures continues to inspire me.

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Abstract

The experience of compassion fatigue is a serious challenge within caregiving professions. Scholars agree that although the symptoms of compassion fatigue are similar to burnout and secondary stress disorder, there is no agreement on what distinguishes compassion fatigue from similar experiences. The terms compassion fatigue, secondary traumatic stress disorder, and burnout have been used interchangeably in the literature. The aim of this research was to develop a theoretical understanding of compassion fatigue, its process, and its relationship with compassion, which can inform nursing research and education.

This research is a grounded theory investigation into the relationship between lived experience of compassion fatigue, patient engagement styles, and their knowledge of and attitude towards compassion among direct care nurses who worked during the COVID-19 pandemic in Canada. As part of this study, an anonymous survey among direct care nursing professionals from different parts of Canada functioned as the participant recruitment platform for the subsequent grounded theory interviews. The main inclusion criteria were specified as the nurses' who experienced of compassion fatigue any time during their career and who worked or are working during COVID-19. The principal methodology of this is the grounded theory approach of Gioia et al. (2013), located within the constructivist paradigm of Charmaz (2006). As the main part of the data collection process, in-depth interviews were done with 27 direct care nurses from different parts of the country; the majority came from the provinces of Ontario, Alberta, and British Columbia. The preliminary literature review and anonymous survey data indirectly informed the formulation of the research problem and questions and contributed towards cross checking of the emergent grounded theory model and other findings.

The research addresses the significant gap in the literature around understanding compassion fatigue within the context of the practice of compassion. Specifically, the study contributes a comprehensive understanding of the process of nurse compassion fatigue within an emergent grounded theory. Findings emerging from the data indicate the understanding of nurse compassion fatigue as an outcome of a relational process within the context of the practice of self-referential compassion, rather than a reactive process experienced within empathic interaction between the nurse and patient. While the former experience can be called compassion fatigue, the latter can be termed general nurse fatigue. The study considered both pandemic and non-pandemic experiences related to compassion fatigue. While COVID-19 was an acute

stressor in relation to compassion fatigue, the pandemic and non-pandemic factors of compassion fatigue appeared to be similar. The emergent grounded theory of the multi-phased compassion fatigue process among nursing professionals highlights the formative opportunities in dealing with compassion fatigue and the central role of the work environment as an attachment system which has a potentially high mediatory role in the experience of compassionate care and compassion fatigue. This research connects the philosophical understanding of compassion with nurses' everyday lived experience of compassionate care of patients, and it convincingly argues for a place for compassion fatigue within the compassion literature.

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List of Acronyms Employed

BO:	Burnout
CF:	Compassion Fatigue
COVID-19:	Corona Virus Disease-2019
DSM:	Diagnostic and Statistical Manual of Mental Disorders
ICU:	Intensive Care Unit
LPN:	Licensed Practical Nurse
NICU:	Neonatal Intensive Care Unit
PPE:	Personal Protective Equipment
ProQOL:	Professional Quality of Life scale
PTSD:	Post Traumatic Stress Disorder
RN:	Registered Nurse
STS:	Secondary Traumatic Stress
STSD:	Secondary Traumatic Stress Disorder:

CHAPTER I

OVERVIEW AND ORIENTATION OF THE STUDY

1. Background

Over the last three decades, scholars and researchers have studied stress-related fatigue and burnout of caregiving professionals at their work. Joinson (1992) is credited with introducing the term compassion fatigue into nursing literature, but Figley (1995, 2002) brought it into the scholarly conversation by replacing his concept of secondary traumatic stress disorder (STSD) with compassion fatigue. Though over two decades of compassion fatigue research suffers significantly from a lack of both conceptual clarity and adequate measurement criteria (Boyle, 2011; Bride et al., 2007; Figley 1995, 2002; Sabo, 2011; Sinclair et al., 2017; Steinheiser, 2018), the relevance of the issue of compassion fatigue has never been contested. Compassion fatigue continues to be a regularly discussed subject in healthcare and mental health contexts. Canadian Nursing Association accepted it as a concern, reporting 80% of the 7000 nurses polled as feeling fatigued after work and 55% of the 7000 nurses always felt fatigued during their work, and asked for a collaborative effort in dealing with it (Canadian Nursing Association, 2010).

Joinson (1992) used the term compassion fatigue to mean the “loss of ability to nurture” (p.119) in her studies on emergency nursing. She suggested it as a unique kind of burnout affecting caregiving professionals like nurses, counsellors, and ministers. Figley (1995) adopted the term to describe the "cost of caring" (p.7) when therapists and counsellors worked with clients who were physically and/or psychologically traumatized. He used the term compassion fatigue interchangeably with secondary traumatic stress disorder (STSD), which emerged from his work on Post-Traumatic Stress Disorder (PTSD). According to Figley (1995), the symptoms were very similar to PTSD, except that STSD was caused by indirect trauma. Ever since Figley defined compassion fatigue as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), there has been a surge of research in the field mostly using the Professional Quality of Life (ProQOL) scale. However, ProQOL has been reported as non-representative of compassionate care (Ledoux, 2015; Sinclair et al., 2017) and not being a valid statistical measurement tool (Bride et al., 2007; Sinclair et al., 2017; Steinheiser, 2018). The issues of conceptual clarity and lack of adequate measurement

tools regarding compassion fatigue will be discussed in detail within the literature review portion of this dissertation.

The unique use of compassion as a resource (sometimes limited) in a relational process is found in Joinson (1992), in contrast to the use of it as a stress regulator with all characteristics of empathy as explained by Figley (1995) in his account of compassion fatigue. This insight of compassion as a potentially limited resource affecting relational processes resonates with the broader issue of limited, conditional compassion found in both Western philosophical systems and in the early stages of training of Buddhist compassion (Parattukudi & Melville, 2019). Self-referential compassion refers to the various expressions of limited exercise of compassion (Ekman, 2012: Halifax, 2011), which depends on either the perception of the compassionate and/or the condition of the object of compassion. In the context of self-referential compassion, we can explain the issues of compassion fade, fatigue, grades of compassion, conditional and limited compassion.

Dealing with a pandemic like the COVID-19 brings unimaginable stress for both the health care system and health care professionals. It also becomes a challenging time for the practice of compassionate care as it confronts indefinite demand for human connection by patients who undergo intense and unavoidable suffering (Joinson, 1992) due to both their illness and the pandemic. The pandemic continues to hit different parts of the world with its different waves and diverse mutated virus variants even today as I am writing this. There are no recent comparable events to COVID-19, even after considering that the 9/11 terrorist attacks, 2003 SARS and 2014 Ebola virus diseases affected a considerable part of the world. The effects of these events were limited by geography and did not pose the need for quarantines or isolation and the ongoing risk of life-threatening illnesses (Holmes et al., 2021). COVID-19 has resulted in a global surge of depression, anxiety, and escalation of existing mental health conditions. It has explicitly affected the health care workers with physical and emotional challenges to varying degrees. Of particular importance to our study is the emotional breakdown of direct health care workers who are challenged with the "added pressure to choose between family responsibilities and their inner sense of duty toward patients" (Sasangohar et al., 2020, p. 2), not to mention their need for a livelihood. They are further challenged with the overloaded demand on the health care system to respond to a disaster like this. They also are faced with the prospects of being exposed to the virus and taking it home to the vulnerable population at home. The frontline health care

workers also seem to experience the paradox of having to be in direct contact with the infected persons while the public is advised to stay at home and avoid social contact (Ruiz-Fernández et al., 2020). The nurses often care during a pandemic with limited resources and scarcity of personal protective equipment (PPE). Thus, witnessing the suffering of these patients impacts the frontline health care workers with a "perceived inability to alleviate the suffering of those in their care" (Alharbi et al., 2020), even though there is a lot of fear and anxiety and lack of support.

The term "shared trauma" (Holmes et al., 202l, p. 2), which emerged in response to the 9/11 experience, appears to be the appropriate term to explain a pandemic like COVID-19. Secondary trauma, though a similar term, refers to the sufferer communicating their trauma to a therapist or the caregiver, and they are being affected through the experience of empathy (Figley, 1995). In shared trauma, both the sufferer and the caregiver experience the trauma directly through its multidimensional effects, both in their social and personal lives. A few among the study participants who lost their close family members to COVID-19 had to work with the COVID-19 patients.

This grounded theory research into the relationship between direct care nursing professionals' lived experience of compassion fatigue, patient engagement styles and their knowledge of and attitude towards compassion during the COVID-19 pandemic is aimed at finding a theoretical understanding of compassion fatigue, its process and relationship to compassion. It may also present specific insights related to the experience of compassion fatigue unique to a pandemic context. In order to attain the above-stated goals, this dissertation will explore the foundational literature on compassion, compassion fatigue and explore and analyze the data collected from the in-depth interviews to build a grounded theory of compassion fatigue.

2. Linking the Personal and the Research

Growing up in a rural village of an Asian country, with close connected neighbourhoods, are my earliest childhood memories. The people were of varied creeds and classes who established a dynamic relationship through many altruistic emotions like love, hate, pity, and compassion. Even though I had witnessed hatred and pity during my childhood to some extent, the overwhelming experience was of love and compassion. Even when my family struggled with ruptures and disturbances, I experienced the community as a safe haven and secure base (Bowlby, 1969). After my tenth grade, I started exploring beyond the frontiers of my village and province to distant and different geographical, cultural, spiritual, and socio-political spaces. My

adult life was a period of exposure to complex human realities of conflicts in societies related to class, gender, haves and have nots, majority and minority, and different faiths ranging from theistic to atheistic. They valued compassion more as a remedy to human suffering than a problem to be avoided. Compassionate care, both in natural and formal care settings, though it involved challenges, sacrifices, and fatigue, was never construed as a problem in the society rather a highly regarded virtue. I tried to critique the concept with my philosophical, psychological, religious studies and academic exposure. However, the contemplative, religious experiences and spiritual/religious interactions with people reinforced the value of compassion in me. Somewhere along the way, I had accepted the importance of compassion beyond any reasonable doubt into my personal and professional life to define me and my relationship with others around me.

Several years ago, when I came to Canada as a student, I had not expected that altruistic emotions would capture my attention once again. In the initial year in a new country without family or friends to depend on, the journey took me from loneliness and insecurity to strangers who would become friends and family. Though the Western society portion of my experience was marked with its individualistic philosophy and had unleashed a philosophical presumption of compassion as weak, often going against justice and morality, I witnessed the worth of compassion by being mentored by a few very compassionate individuals and through the practice of compassion in therapeutic spaces. By this time, I had more questions than answers that I grappled with regarding compassion triggered by existential stories of people.

As I began pursuing higher education, my focus was doubtlessly on altruistic emotions, specifically compassion. Soon it came to my awareness that my Eastern upbringing and Western exposure, the philosophical training, the opportunity to work with the real-life situations of people in therapeutic spaces as well as a questioning mind interested in finding answers and solutions to the worries of the world, will keep the passion in me during the doctoral program.

The decision to research compassion fatigue for my doctoral dissertation was not a spontaneous choice. It emerged out of a pragmatic philosophical bend of my mind, which later alone I came to know was congruent with the philosophical undercurrents of pragmatism in constructivist grounded theory. After having done an extensive literature exploration on compassion, I was able to get a journal article published in *Asian Philosophy*, titled, "Understanding the phenomenon: A comparative study of compassion of the West and karuna of

the East" (some parts of this work is integrated into the literature review chapter); another journal article in *Journal of the International Society for Teacher Education* titled, "Enacting the educational world in compassion: A reflection and positioning of how to teach and learn the art of compassion"; and a conference paper titled, "A case for the language of the first-person plural in classroom activities for the sake of community and compassion."

As the time approached to determine the subject of research, my clinical background in health care prompted me to work on something related to healthcare. Researching on compassionate care was a natural choice. However, the issue that came up in literature was not so much the experience of compassionate care but the inability to care compassionately because of related fatigue and stress. This issues in compassionate care challenged my reflections on it from an experiential point of view. Having worked as a health care professional who is interested in the formative experiences of care professionals, the choice of researching on compassion fatigue appeared the right choice.

3. Introduction to the Study

This grounded theory investigation made use of a nation-wide anonymous survey for participant recruitment which followed by in-depth interviews for data collection. Initially, I collected responses from 305 nurses from different parts of Canada about their experience of compassion fatigue through an anonymous survey and around 80 of the survey participants agreed to share their experiences in the subsequent research interviews. Finally, I was able to do in-depth interviews with 27 direct care nurses from different parts of the country as part of the data collection process of this research. Direct care nursing was chosen as the research context, assuming that the phenomenon under study may be more prevalent in this nursing population as they are in direct contact with human suffering and trauma. According to *Nursing Interventions Classification* (NIC), nursing interventions are divided into direct and indirect care activities. Direct care intervention is a treatment performed through direct interaction with patients, and the indirect care interventions are done away from the patients but on behalf of patients or a group of patients, which supports the effectiveness of the direct care intervention (Butcher et al., 2018). The following section speaks of the purpose, rationale, significance, and challenges of this research.

3.1 Statement of Problem

There is a non-negotiable place in health care for the caring of suffering individuals. While alleviating physical, mental, and emotional suffering is the essential aim of health care services, it is most often facilitated in relational care. It is imperative for health care personnel in direct client care to be repeatedly exposed to unpredictable and varying degrees of suffering of the individuals in their care. Repeated exposure to suffering evokes compassion fatigue (Figley, 1995) and related experiences like secondary traumatic stress and burnout. Just as caring for the suffering individuals ever remain the focus of health care practice, learning about the formative and non-formative experiences of direct caregiving professionals which influence the practise of compassionate care and experience of compassion fatigue is taken up in this dissertation as part of the scope of health care educational research. Clarifying the concept of compassion fatigue and its relationship with compassion will remain the central focus of this research as compassionate care is of great value in health care, however, is also much misunderstood as causing fatigue.

3.2 Rationale for Research

Kirby et al. (2019) speaks about positive attitudes to compassion resulting in positive outcomes related to compassionate care. In building on the current literature, I examine the role of compassion within the experience of compassion fatigue among direct care nurses most of whom experienced it during COVID-19 in Canada. Joinson (1992) speaks of the nature of suffering as largely unavoidable and sometimes intense, leaving very high emotional demand on health care professionals. A situation like the COVID-19 pandemic stands out as a unique kind of unavoidable and intense suffering for both the patient and the health care professionals. The patient engagement styles adopted by health care professionals during patient care are discussed in compassion fatigue literature by Figley (1995) and Joinson (1992) with contradicting implications. Porr et al. (2010) observed that the socially connecting engagement style in fatigue is beneficial to its management. As the research questions are theoretical and clinical, and contextualized in a pandemic situation, the emergent grounded theory may contribute to developing educational interventions related to compassion fatigue management in general and specific to COVID-19 like pandemic situations.

3.3 Purpose of the Study and Research Questions.

The threefold purposes of this study in investigating the experience of compassion fatigue among direct care nursing professionals who worked during COVID-19 are,

- To examine the experience of compassion fatigue, including the reasons, processes, and effects.
- To examine the role of compassion within the experience of compassion fatigue.
- To develop a theoretical model of the process of compassion fatigue by employing the grounded theory research methodology.

In order to address these purposes, a primary research question, and a subsidiary question have been developed. The primary research question is:

1. What is the etiology and processes of compassion fatigue among direct care nursing professionals who worked during COVID-19 in Canada?

Flowing from the answer to this primary question, the subsidiary question is:

2. Can we model the nurse's formative experiences of compassion and how that impacts their experiences of compassion fatigue?

3.4 The Scope of the Study

All participants of this research have been educated, and most of their nursing formation happened in Canada. This research employed a comprehensive approach in investigating the issue of compassion fatigue which took into consideration the personal, developmental, work-related, and social factors of the participants within the study. The study also encapsulated diverse ages, duration of experience, specialties, and education. The study does not represent gender diversity, as only one participant of the study was male, although that is informative as it may reflect the profession as a whole. The study was limited to direct care nurses who were either Registered Nurses (RN) or Licensed Practical Nurses (LPN)/ Registered Practical Nurses in Ontario (RPN).

3.5 Theoretical Approach

The conceptual framework for this proposed research explores the whole person, their lived experience and environment regarding compassion fatigue and compassion. Some of the recent qualitative studies on compassion fatigue (Austin et al., 2009; Perry et al., 2011) have endorsed this view of understanding compassion fatigue in the context of the whole person, lived experience and environment. To explore compassion, I will be using the theoretical model of

Fernando and Consedine (2014) who speak of the transactional model of physician compassion, which considers the dynamic interplay between person and environmental changes in the experience of compassion. Halifax's (2012) model of enactive compassion is very similar as she explains it as an emergent process that comes about in the interplay of "interrelated attentional, somatosensory, and cognitive processes that are embedded in and responsive to the context" (p. 2). Similarly, I have elaborated a theoretical model of compassion as enaction following the theory of enaction proposed by Varela et al. (2016) in one of my works (Parattukudi, 2019). The theoretical orientation to study the whole person will be complemented with the study of the developmental experiences of the study participants. The studies on compassion as an attachment system involving the interplay between attachment behaviour and caregiving behaviour (Mikulincer & Shaver, 2017) is used in this study to understand and interpret participant experiences related to compassionate care.

The theoretical approach of studying the whole person is also reflected in the methodology for this study, namely the constructivist paradigm of Charmaz (2006) specifically using the grounded theory approach of Gioia et al. (2013). While constructivist grounded theory examines participant experiences in the light of an emerging theory that may explain some sense of causality and pattern, the Gioia approach takes into consideration the lived experience of the participants throughout the data collection, analysis and articulation of the grounded theory process, which deepens the awareness of the nature of the issues that the participants face.

3.6 Place of Literature Review and Anonymous Survey Data in this Study

In most research approaches, literature review prior to data collection and analysis helps the researcher to contextualize the research within the existing body of knowledge. However, in grounded theory, in general, conducting a literature review prior to collection and analysis of data is understood to be a constraining approach (Glaser & Strauss, 1967, Strauss & Corbin, 1994). Though all traditions of grounded theory espouse the idea that the theory developed through grounded theory should be grounded on the participant data and not on literature, they have varied approaches to the use of literature informing the researcher. While Glaser (1967) recommends avoiding contaminating data by researcher's prior knowledge, Strauss and Corbin (1994) advocates for maintaining "an attitude of skepticism" (p. 45) regarding prior literature or knowledge. However, Charmaz (2014) following the tradition of qualitative research suggested that avoiding the influence of the researcher on the research is an impossible task. The grounded-

ness in constructivist grounded theory is not the result of the removal of the researcher from the research process rather through "researcher's commitment to analyse what they actually observe in the field or in their data" (Charmaz, 1990, p. 1162).

Regarding the use of literature within grounded theory, Gioia et al. (2013) upholds a stand of "semi-ignorance or enforced ignorance" (p. 21). Accordingly, over dependence on the literature early on the research blinds the researcher and it causes "prior hypothesis bias" (p. 21) in the researcher. So, they suggest for a balanced approach in using the literature just to facilitate the discovery of new concepts without re-inventing the wheel. The "semi-ignorance" of the literature is also helpful during the writing phase to be creative, and not being pre-occupied to disprove or contest the literature that has gone before. The purpose of the literature review in this dissertation has been similarly not to re-invent the wheel (Charmaz, 2006, Gioia et al., 2013) but to focus on the phenomenon as experienced by the participants in the study.

Similarly, the study initiated an anonymous survey mainly for the purpose of participant recruitment. The survey also collected demographic data and inquired into the prevalence and nature of compassion fatigue experience among the survey participants (Appendix x). It has indirectly informed choices in developing the research problem and questions and was used to cross check the theoretical model and its projected implications. The data for the study, however, solely consists of the in-depth interview data collected from the 27 research participants.

4. Significance and Limitations of the Study

The significance of this study lies in the approach to understanding compassion fatigue in connection with compassion in the lived experiences of nurses. The study explores compassion fatigue experience in the lives of nurses by identifying the reasons, effects, and processes. There is currently limited research in this area, and the COVID-19 pandemic has highlighted the gap in the literature. The study addresses the need to honour the nurturing ability of healthcare professionals in nursing profession, also expressed in a wide variety of caregiving contexts. In doing so, the experiences and expertise of these caregiving professionals, including their struggles and insights are highlighted. This research would facilitate a discussion on potential growth opportunities for nursing professionals without abandoning what brought them to the caregiving profession in the first place, namely compassion (Joinson, 1992).

The study is about compassion and compassionate care and the limiting or depleting of that ability in individuals. The study approaches the experience with an open mind and a desire to

describe the problem in a conceptually organized language. The methodology used for this study, namely, grounded theory (Charmaz, 2006; Gioia et al., 2013), is unique as this approach to grounded theory seriously accounts the exploration of the lived experience of participants in every step of the study to understand the phenomenon and maintains a constructivist paradigm in building the theoretical model. As the study considers the various social actors within this experience, it will have direct implication to nursing practice and their work environment. The study approaches compassion fatigue as a confused and ambiguous subject in nursing literature. It will call for a relational approach to compassion fatigue research. The study also puts the issue of compassion fatigue within the scope of compassion research. The research may also have insights into a pandemic related compassion fatigue experience as it considers both pandemic and non-pandemic experiences of compassion fatigue.

The study is limited in its ability to be generalized as the research may contribute a conceptual and clinical understanding only suitable for a similar situation under consideration. However, understanding and distinguishing the lived experience compared to other related constructs could be a step towards a broader generalization effort. The rich data that may be arrived at by the phenomenological focus can strengthen the theory to reflect what it is supposed to understand and theorize. The limited number of samples used in the study can affect the strength of data, even though theoretical saturation is appropriately used as part of the grounded theory approach.

5. Organization of the Dissertation

The dissertation is arranged into nine chapters. Each chapter is arranged according to the natural progression of the research process, which started with the preliminary conceptualization of the subject, in-depth review of related literature, assessment of research methodology, the process of data collection and analysis, exploration of data, discussion, the discovery of grounded theory, discussion on value and implication of the study and ended with a reflection on the research journey. The first chapter is titled "An Overview and Orientation of the Study" which introduces the research context, research questions and significance of the study. Chapter two “Compassion Fatigue: Historical and Theoretical Debates” is a detailed and critical overview of the concept of compassion fatigue, including the role of empathy and compassion within it. Chapter three “Research Methodology” deals with the choice and rationale behind the chosen methodology and description of the flow of work using the methodology. Chapter four is titled as

"Data Analysis and Results". As clear from the title, this chapter describes various steps used for data collection and analysis.

Chapter five and six deal with the findings within this dissertation. Chapter five "Findings: The Main Themes and the Emergence of a Grounded Model" explores the main themes within the study to evidence the saturated data which is followed by a short presentation of the constructivist grounded theory model of multi-phased nurse compassion fatigue process. The chapter six "Findings: Explicating Grounded Model Through Case Vignettes" is where the grounded theory model is tested against participant data. This is achieved by formulating representative participant narratives into a separate case vignette which go through the various phases within the grounded theory model. Chapter Seven, "Discussion on the Grounded Theory Model of Multi-phased Nurse Compassion Fatigue Process" is devoted into the discussion of the grounded theory model by exploring various elements of the grounded theory, checking it against literature and participant data. Chapter eight "Emergent Grounded Theory: Conclusions and Implications" gives a summary of the research, its value and implications to the scholarly community. Chapter nine is titled "Challenged by Compassion: Researcher's Reflections on the Research", which is my retrospection into this research journey, what I learned as a researcher and the challenges I encountered. The overall arrangement of the dissertation into the nine chapters is meant for a logical progression of the thought process. The inclusion of case vignettes in this grounded theory study enhances its phenomenological focus in studying human behaviour regarding care and fatigue within the context of empathy and compassion.

6. Concluding Remarks

This chapter was aimed at helping the reader to be oriented about the study background, research questions and purposes, researcher location and theoretical approach. It also gives a pre-taste of researcher's philosophical and methodological approaches in investigating the subject. The following literature review chapter will consider the concept of compassion fatigue, its origin, foundational thoughts, arguments, and contemporary debates related to empathy, compassion, and compassion fatigue.

CHAPTER II

COMPASSION FATIGUE: THE HISTORICAL AND THEORETICAL DEBATES

At the beginning of my doctoral program, one of the foundational readings recommended by my dissertation supervisor was Boote and Beile (2005), which speaks about the centrality of literature review within a doctoral work. I was fascinated by the term used in their title, "scholars before researchers," and ever since tried to have a good grasp of the foundational literature in my research interest. As a result, I engaged in a rather extensive literature exploration in the fields of empathy, compassion, and compassion fatigue. This section produces the results of those explorations on content and contexts, which ignited the initial curiosity and understanding to take up the constructivist grounded theory research on the subject.

The essence of this chapter is a review of the related literature to understand the nature and extent of compassion and the nature and extent of fatigue experienced during intentional caregiving contexts between human persons. This chapter has a detailed overview of the literature on the concept of compassion fatigue and its relationship to empathy and compassion. As demanded by the literature on compassion fatigue, I also undertook a comprehensive historical/etymological/philosophical investigation into the nature and structure of the phenomenon of compassion comparing the Western and the Eastern expressions of it. This work has been published as a journal article in *Asian Philosophy* under the title: “Understanding the phenomenon: A comparative study of compassion of the West and karuna of the East (Parattukudi & Melville, 2019). A summary of this study is incorporated into this section to explicate the potential relationship of compassion to compassion fatigue.

Unlike most of the existing literature on compassion fatigue, my final speculation is to consider compassion fatigue as resulting from a relational process rather than a reactive process evidenced by a close analysis of some of the recent literature. The discussion also implies that compassion fatigue may not be empathic distress fatigue or a secondary traumatic stress disorder. This position would mean that the study on compassion fatigue can be situated within compassion research as the self-referential experience of the phenomenon of compassion which can be subject to fatigue or depletion.

This chapter analyses the historical development, interpretation, and use of the term compassion fatigue with the help of an integrative review of the literature. It explores the issue of mistaken use of the term and proposes a cross correction with a relational model to explain compassion fatigue by exploring the concepts of empathy and compassion as related to compassion fatigue.

1. Background

In September 2018, Dr. Nadia Hitchen from the Auckland City hospital wrote a letter to the editor of the *Journal of Internal Medicine* narrating her personal experience with compassion fatigue and calling it an epidemic to the medical profession (Hitchen, 2019). Hitchen was personalising a concern about the connection between compassion fatigue and health professionals' health. This link had been highlighted by Lee et al. (2003). Their study of nurse's health, which had 54412 participants, followed over four years, reported an increase in the risk of heart diseases in nurses who cared for disabled or chronically ill patients for nine or more hours per week. This research can be understood in the context of burnout, vicarious trauma, compassion fatigue (CF) and secondary traumatic stress disorder (STSD) experienced by persons in various caring professions. Compassionate care is an integral part of the health care profession, and it is explicitly mentioned by various nursing bodies (Durkin et al., 2016). Though compassionate care is encouraged continuously by health care professionals, there are also questions about its impacts on health care professionals due to the prevalence of the experience of compassion fatigue and similar experiences. Indeed, Austin et al. (2009 question whether the caring space is a "dangerous place?" (p. 196). They report compassion fatigue as one of the main factors in the overall absence of nurses at work and in issues related to employee retention in the health care field.

Just as compassionate care for suffering individuals remains as a focus of health care, it is imperative to find ways to understand the problem of compassion fatigue and related experiences which disrupt care. There is a need for us to differentiate compassion fatigue from other similar concepts and experiences. Such clarity will help in finding an effective way to deal with the problem of compassion fatigue. The relationship of compassion fatigue, conceptually and experientially, to compassion needs to be established as compassionate care is of great value in health care and is much misunderstood as a cause for compassion fatigue and related distress (Ledoux, 2015; Sinclair et al., 2017). This integrated review aims at reviewing the historical and

theoretical progression of the concept at various points in the literature. This will inform and enrich the study in its efforts to clarify the concept of compassion fatigue and its relationship with other related concepts.

2. Method of Review and Selection of Literature

For this study, the integrative literature review method was selected as outlined in (Russell 2005). An integrative review asks four questions: namely, "(1) What is known? (2) What is the quality of what is known? (3) What should be known? Moreover, (4) what the next step for research or practice?" (p. 1) is? In such a review, all available relevant material connected to the topic can be considered. This literature can then be segregated in the data collection phase by considering the historical period of the emergence of the concept. This will ensure the validity of research at the data collection stage by addressing the issue of "inadequate sampling" (p. 4). During the data evaluation phase, to counter the temptation to evaluate data all positively, the study mixed different kinds of data, including methodology, in tabulating associated ideas and concepts. An integrative review is considered an excellent tool to "identify central issues in an area … identifying a theoretical or conceptual framework" (p. 5) to support further research of the concept.

The initial inclusion criteria gave preference to health care literature. I selected a few pieces of literature outside of this area due to their presence in the reference list of the seminal or prominent works. 199 individual works were chosen as relevant to the topic. Most of them were quantitative or qualitative studies, which evaluated at least one of three major concepts other than compassion fatigue: burnout, secondary traumatic stress disorder, and compassion satisfaction. The search narrowed down to 51 works due to redundancy and relevance of ideas, including five book chapters, one doctoral thesis, and 44 journal articles. The 51 works had 26 pieces of literature, which were considered seminal and theoretical in content, and others included 11-literature reviews, eight concept analyses and six exploratory qualitative works. The literature was all published in the period 1982 to 2020. The choice of this period reflects the earliest found literature on compassion fatigue.

The guiding question to help this review is, what is compassion fatigue? Moreover, what makes it different from the related concepts of burnout, secondary traumatic stress disorder, vicarious trauma, and transference?

3. Historical and Theoretical Debates

3.1. Compassion Fatigue: A Historical Overview

Maslach (1982) identified burnout symptoms as the experience of fatigue, tiredness, resistance, and eventual withdrawal from patients (Austin et al., 2009). The earliest use of the term compassion fatigue is found in the studies of Maslach (1982), related to job burnout in helping professionals (Kinnick et al., 1996). Maslach (1982) considers burnout is not limited to helping professions alone rather experienced in any occupation. She explicated that burnout occurs when there is no sufficient acknowledgement of the human person, and there is a conflict between the nature of the person and the nature of the job; by a "pattern of emotional overload and subsequent emotional exhaustion" (p. 3). In helping the caring professions, a person gets overly involved emotionally with the client and feels overwhelmed by the emotional demand. Maslach (1982) describes the first component of burnout as the emotional exhaustion that is experienced when the helping professional's emotional resources are depleted. She says that in such a situation, "people feel that they are no longer able to give themselves to others. It's not that I don't want to help, but that I can't, I seem to have a "compassion fatigue" (p. 3). According to Maslach, to avoid such a predicament, professionals try to emotionally detach from their clients to the extent of being cold and even despising the presence of people, which she calls "depersonalization" (p. 5), the second aspect of burnout. Being overwhelmed by the inability to care, the experience of depersonalization, and the conflict of being not a caring, compassionate person, individuals start to experience a "feeling of reduced personal accomplishment" (p.7), which Maslach labels as the third aspect of burnout. Issues of low self-esteem and depression are some of the symptoms that may follow such a deterioration of health. Maslach states that when emotional detachment is combined with genuine care, which she calls "detached concern" (p. 4) a professional can deal with the potential for emotional exhaustion and subsequent burnout. She proposed that the situational influences of a stressful environment contributed more to burnout than the caregiver's personality.

Before 1990, the term compassion fatigue was used to address a lack of empathy towards social problems (Austin et al., 2009). The term developed a negative connotation in the context of its usage for the popular American response to refugee problems (Baizerman, 1990; LeMaster & Zall, 1983; Riddle, 1988). The words compassion fatigue described the hesitation to resettle refugees (Riddle, 1988); it reflected the resentment of American people over the perceived

uncontrolled refugee inflow (LeMaster & Zall, 1983). Baizerman (1990), reacting to the killing of students the Tiananmen Square by the Chinese authorities and the apathy towards the incident by the public, described compassion fatigue as a "condition of caring without concomitant action" (p. 68). In the earliest known empirical study on the media-related compassion fatigue phenomenon, Kinnick et al. (1996) used Hoffman's (1981) over-arousal hypothesis related to the empathy/altruism literature, which is supported by the experience of health care professional's burnout, particularly through compassion fatigue. Hoffman (1981) speaks about a spectrum of empathic arousal where the optimum empathic arousal leads to helping behaviour, and over-arousal may cause avoidance behaviour to alleviate the distress attached to the experience of empathy. Less than optimum arousal may make the person indifferent to the suffering of the other.

By 1990 compassion fatigue started being used in the health professions to express a lack of empathy towards patients (Austin et al., 2009). Though Joinson (1992) is often quoted as having originally introduced the term compassion fatigue in health care settings, a 1989 *Los Angeles Times'* article speaks of Dr. Edward Poliandro of Mt. Sinai Medical School in New York and Dr. Lyle H. Miller, head of the Biobehavioral Institute in Boston publishing a paper with the title; *Doctors, social workers and therapists are giving a new name to a syndrome they say is draining their ranks: "compassion fatigue"* (J. Puch, 1989). Poliandro calls compassion fatigue a kind of burnout, which is a resultant feeling of energy depletion by giving it away (Berkmoes, 1990). Berkmoes (1990) terms compassion fatigue as compassion-related burnout in his article, and he directly connects it with compassion, which, according to him, is an essential part of medicine. He says, "From compassion burns the fire of hope and inspiration. However, that same fire can be all-consuming. If a person gives and gives without pausing to replenish themselves, that person may end up with nothing left to give" (p. 23).

Joinson (1992) introduced the terminology of compassion fatigue with her observation of the nurses in an emergency department who had gradually become unable to nurture. She referred to compassion fatigue as a kind of burnout affecting caregiving professionals and spoke about two case examples. The first case involved Jackie, who grieved the death of her patient and finally approached a pastor to deal with her feelings around it, and secondly, Marian, a surgical unit nurse who stopped crying over her patients as a way of dealing with it. Joinson speaks of Marian as the nurse with compassion fatigue. Further, Joinson (1992) gives four characteristics

to compassion fatigue: it is emotionally destructive, the caregiver's personality is part of the issue, the outside sources that cause it are unavoidable, and it's difficult to recognize without proper awareness. She says that the very nature of compassion, which attracts a caregiving professional to their profession, works to their detriment. She quotes Rev. Steven Wende, who speaks to the use of self in the nursing profession and the infinity of human need regarding caring, together with the multiple roles of the nurses, can be a problem. Joinson speaks of nurses who "completely forget how to turn off that nurturing mindset" (p. 117) as the reason for compassion fatigue.

According to Joinson, by disengaging the caring nature of a caring professional, they are taking away their nurturing element, which can cause conflict in their psyche. Rather, Joinson advocates for engaging with the emotion of compassion as the right way to deal with compassion fatigue. One of the most difficult things is to recognize compassion fatigue early enough, as people generally lack proper awareness and training for it. However, she believed that it could be taught. Joinson concludes in her work that the real way to work through compassion fatigue is to care for oneself and care for others, not to disengage or withdraw. However, she agrees with the suggestion that the care professional should get away from the stressful situation, find time for oneself, and know that they don't need to solve problems by themselves.

Figley (1995) adopted the term compassion fatigue to replace secondary traumatic stress disorder (STSD) in his 1995 seminal work. He also acknowledged the first use of the term by Joinson (1992). Figley re-contextualized the caring professional's concept of compassion fatigue to a more therapeutic setting of working with the traumatic suffering of clients. According to him, "the most effective therapists are most vulnerable to this mirroring or contagion effect. Those who have an enormous capacity for feeling and expressing empathy tend to be more at risk of compassion distress" (p. 1). He defined compassion fatigue as "The natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). In his psychotraumatology explication, influenced by the 1980 publication of the American Psychiatric Association's DSM-111, with its introduction of Post Traumatic Disorder (PTSD) and its subsequent revisions, Figley argued that people are traumatized both directly and indirectly. Figley was influenced by some of his colleagues who abandoned clinical work and research with traumatized individuals, as they found their inability to deal with the pain of

others. Figley (1995) was concerned about the under-representation of trauma experienced by people who care for trauma victims and thus introduced the terms Secondary Traumatic Stress (STS) and Secondary Traumatic Stress Disorder (STSD) (p. 7). In this connection, he preferred to call PTSD Primary Traumatic Stress Disorder compared to STSD.

Accordingly, Figley (1995), even though STS and STSD represent most accurately the experience of secondary trauma, preferred to use the term compassion fatigue, as in his informal research he found that nurses, emergency workers, and other trauma workers preferred the term compassion fatigue over STSD. Another argument for this shift was that STS and STSD were derogatory labels, and the word compassion better expressed the nature of the job by nurses and therapists. Therefore, he suggested, that the terms compassion fatigue and STSD can be “used interchangeably by those who feel uncomfortable with STS and STSD" (p. 15). Though Joinson (1992) described compassion fatigue in the nursing literature for the first time, Figley took over the concept in his seminal work (1995) on compassion fatigue and later Stamm (2005) developed the Professional Quality of Life scale (ProQOL), which is a revised version of the compassion fatigue Self-Test (Figley, 1995). Stamm described compassion fatigue and compassion satisfaction as the negative and positive experiences of helping professionals. Since then, ProQOL has been widely used both for clinical evaluation and research on compassion fatigue.

Gentry (2002) finds the origins of compassion fatigue as the cost of caring in the writings of Carl Jung on countertransference, and he goes on to accept the turn of the term with Figley’s (1995) STSD without mentioning anything about Joinson (1992) and the burnout literature. Collins and Long (2003) hold the view that compassion fatigue has "its root in the abstract notion of compassion" (p. 421); however, they accepted the conceptualization of Figley. One of the unique observations regarding Joinson's (1992) take on compassion fatigue is that it doesn't speak of trauma or traumatic experience between the caregiver and the patient. The use of self is explained not in any other way but only in the context of care, which places infinite demand on the caregiver.

3.2. Empathy or Compassion? Contemporary Debates on Etiology

Starting from Sabo (2006), researchers have questioned the veracity of the usage of the term compassion fatigue, as it expresses a lessening of compassion (Ledoux, 2015, Fernando and Consedine, 2014). Sabo (2006) argued that compassion fatigue in health care is a negative approach, which focuses on pathology, should shift to the protective factors for caregiving

professionals who are caring for the sick and suffering. He asks, by focusing on the pathology of compassion fatigue, "do we run the risk of pathologizing a quality of nursing that forms its foundation?" (p. 136). Fernando & Consedine (2014) similarly states that although compassion fatigue is a "very real phenomenon, the focus on compassion fatigue appears to have led to paradoxical neglect of compassion itself" (p. 290). Ledoux (2015) speaks about the lack of clarity regarding the etiology of compassion fatigue.

Empathy is understood as the ability of a person to experience another's emotions. But compassion is understood as a response to suffering, and it involves a concern for the sufferer and a desire to alleviate suffering (Price & Caouette, 2018). Empathy has its etymological root in the 19th-century German word *einfühlung*, meaning "in feeling" (Soto-Rubio & Sinclair, 2018, p. 2) attributed to German psychologist Vischer in 1873 in the context of appreciating art with the ability to project self into the art. The term's usage was introduced in psychology by 20th-century translation of the psychoanalytic literature of Freud, followed by the use of it by object relation theorists. According to Kohut (1981), empathy is considered an informer for an accurate understanding of the other, where the purpose of understanding the inner experience of the other "can be of kindness or…of utter hostility" (p. 126). In their experiments on empathy, Batson et al. (1995) found that empathy-induced altruism can work against the principle of justice as empathy and sense of justice are independent of each other. The modern scientific consensus is a distinction between empathy and compassion, where empathy is useful in communicating feelings (any feeling), not necessarily leading to action, and compassion entails an essential motive towards alleviating suffering (Soto-Rubio & Sinclair, 2018).

The following section is an exploration into the role of empathy and compassion within compassion fatigue experience with the purpose of gaining clarity regarding etiology.

3.2.1 Empathy and Compassion Fatigue

One of the most challenging criticisms of the term compassion fatigue has come from the neurological research article of Klimecki and Singer (2011). Drawing from social psychology and neuroscience research on empathy, they proposed that the word compassion fatigue needs to be replaced by the term empathic distress fatigue as the experience of compassion fatigue is similar to empathic distress. Their suggestion also pre-supposed the belief that compassion cannot be subject to fatigue and empathy is the cause of the experience which often called as compassion fatigue.

Klimecki and Singer (2011) unpacked the experience of burnout and secondary stress disorder with the conclusion that empathy was contributing to the experience of compassion fatigue. They used the term compassion fatigue interchangeably with burnout and secondary stress disorder. They have not considered the description of compassion fatigue as the inability to nurture (Joinson, 1992). This is important as both burnout, and secondary stress disorder speaks of empathic reactive response to situations or people's trauma and suffering, but compassion as the "inability to nurture" (Joinson, 1992) speaks of a relational process.

Klimecki and Singer's idea of empathy producing empathic concern (compassion) and empathic distress is not proved in their research. They adopted the idea that empathy is the first step in line with feelings of compassion, empathic concern, or sympathy. Accordingly, there are two ways of responding to suffering: empathic concern or personal distress/empathic distress. This conceptualization was majorly influenced by Batson et al. (1981), who put into experiment some of Hoffman's (1981) hypotheses on empathy creating altruistic action. Though Klimecki and Singer (2011) hypothesized empathy to grow into compassion, their later research (Klimecki et al. (2013) revealed that both empathy and compassion represented non-overlapping brain regions which establishes the fact that these two are different experiences. However, compassion training can override the empathic distress experience by introducing positive affect and making changes in areas related to compassion feeling (medial orbitofrontal cortex (mOFC), subgenual anterior cingulate cortex (sgACC) and the ventral striatum/nucleus accumbens (VS, NAcc). In their experiment, an increase of empathy increased pain and negative affect in the corresponding brain regions but did not transform into compassion, disproving the claim they made in their 2011 paper that "physicians and caregivers, in general, should aim at maintaining high levels of empathy and how to transform empathy into compassion and loving-kindness before being trapped by empathic distress" (p. 378).

The most important observation from Klimecki et al.'s (2013) experiments regarding compassion fatigue indicates that probably what we are witnessing in compassionate care and compassion fatigue is something like mother-child caregiving and the potential of fatigue. Their 2013 research suggests social connectedness is represented in the compassion-activated brain areas. Disconnection is presented in the empathy activated areas: "social connectedness is typically associated with activations in brain regions that comprise ventromedial prefrontal cortex and ventral striatum, whereas social disconnection is rather associated with activations in

AI and dorsal ACC" (p. 877). They also suggested that the brain area involved with compassion also represents maternal affiliations: "positive affect and reward, activations in the prefrontal cortex and ventral striatum have been related more specifically to maternal affiliation" (p. 878). These are the brain regions that are activated with compassion training in their experiment.

It is also hard to assume that the altruistic helping behaviours of individuals who experience compassion fatigue are propelled by the stress regulatory needs arising from empathic distress. The discovery of distinct neural pathways for empathy and compassion (Klimecki & Singer, 2013) may challenge the empathy-induced altruistic action hypothesis (Batson et al., 1981) through the empathic concern and personal distress routes as "empathy and compassion indeed rely on antagonistic affective systems" (Klimecki et al., 2014, p. 878). This may be an argument for empathy's inability to produce helping action through a direct mechanism other than the stress regulatory function.

3.2.2 Compassion and Compassion Fatigue

Gu et al. (2017) have developed a five-factor description of compassion which includes different phases of awareness of suffering, awareness of the universality of suffering, emotional connection to the sufferer, ability to tolerate negative emotion in the experience and motivation to alleviate suffering. Referring to the practice of compassion in nursing literature and its history, Bivins et al. (2017) speak of complex historical shifts through, before concluding that most definitions surveyed in the nursing literature include a cognitive element: understanding the other's perspective; a volitional element: choosing to alleviate other's suffering; an altruistic element of responding to others selflessly; and a moral element saying that to not show compassion to others may compound further distress to the suffering patient.

Berzoff and Kita (2010) write that while compassion sometimes leads to fatigue; it helps one to enter the suffering of others. They reported that some who attended an end-of-life certificate program reported great satisfaction in entering an intimate space with the dying persons. They define compassion fatigue as the result of constant caring, and what prevents compassion fatigue is the practice of compassion. For them, compassion fatigue is not a reactive process; rather, it speaks about the inability to reduce suffering, "...compassion fatigue is not an enactment. Rather, it is a response to the cumulative experience of caring for people who are suffering, and the personal experience of the persistent excess of suffering despite one's best efforts at ameliorating it" (p. 343). Austin et al. (2009) say that compassion fatigue refers to a

state prior to when the person had compassion, and which is diminished now. They describe compassion fatigue following an understanding of compassion where compassion has two inevitable components; recognizing the suffering and the motivation to alleviate suffering. They suggest, "compassion fatigue may be the bifurcation of these necessary emotive constituents, where a person, unable to alleviate the suffering of another actively withdraws from similar emotive stimuli" (p. 200). Sinclair et al. (2017) argued that compassion fatigue, if essentially linked to the construct of compassion, can be problematic as it implies "something inherently tiring about compassionate feelings and behaviours" (p. 13). Ledoux (2015) challenges the idea that caring itself is the cause of compassion fatigue and that there is a cost to caring. Instead, he says that to understand compassion fatigue, we need to study compassion. Similarly, Sinclair et al. (2017) suggest that the term compassion needs to be empirically studied in order to understand compassion fatigue.

It is clear from the given literature that there are for and against opinions regarding the possibility of compassionate care becoming subject of fatigue. The literature clearly states the need for investigating the concept of compassion to understand compassion fatigue and its etiology. Following this gap in literature in understanding compassion fatigue, I undertook a historical, etymological, and philosophical exploration of the concepts of compassion and karuna-an Eastern equivalent for compassion which has been published in *Asian Philosophy Journal* (Parattukudi & Melville, 2019). The central focus of this literature investigation was to understand the phenomenon of compassion by exploring the similarity and difference between the Western concept of compassion and the Eastern concept of *Karuna*. There were two main sources used for this study representing the West: 1) the philosophical thoughts on Pity (the word pity refers to the phenomenon of compassion in Classic Greek and Latin literature, including its exposition in the works of Aristotle) in Homeric poems (c. 800BCE-600BCE), in Aristotelian tradition (Aristotle's *The Rhetoric*-c. 384-322BCE) culminating in the most recent exposition in Martha Nussbaum (2001, 2008, 2013), 2) the account of pity developed during the Hellenistic period (323 BCE-31BCE) of Western philosophy in the Judeo-Hellenistic tradition (300 BCE-200 BCE), followed by the 1st Century philosopher Philo. The sources used in the study representing the East was the teaching and practice of *karuna* in Buddhism. The study compared the nature and structure of the phenomenon of compassion within these various traditions.

The comparison between the expressions of this phenomenon of compassion in the East and West, revealed that the Aristotelian tradition, despite its influence in philosophy and the Western worldview, falls short of the essential elements of similarity as compared with the Judeo-Hellenistic exposition of the phenomenon of compassion and that in Buddhism. In the Western presentation of compassion, the Judeo-Hellenistic concept of compassion is more comparable with the Buddhist karuna as both show a structural completion in the process of the emotion, and both show love as one of the motivating principles of the experience. These traditions also show a strong forward move towards action to remove affliction from the sufferer. In our exploration of the phenomenon of compassion, the most challenging and unique difference, even when the Judeo-Hellenistic view representing the West is well considered as a close ally to Buddhism, is the self-centeredness of compassion and the non-self-centeredness of karuna.

Kupperman (1995), in his exploration of emotions in the West and East, observes that the "limited altruism" of the West has deep roots in its philosophical construct of "individualized self" (p. 131). In contrast, Buddhism insists that the relationships (the five aggregates – *khanda*) that make personhood and reality are empty, and the perception of it is something that one must escape for attaining nirvana. The main difference is based on understanding the individual self within the Western and Eastern systems, which introduces the concepts of self-referential and non-self-referential expressions of compassion.

While self-referential compassion is subject to individual conditions and interpretations, non-self-referential compassion can transcend those limiting factors. Halifax (2011) speaks of self-referential compassion in the Buddhist tradition. According to her, self-referential compassion always has an object and may be subject to fatigue, whereas non-self-referential compassion has no object and is universal. Halifax divides self-referential compassion into various categories, "biologically based compassion" which implies instinctual bond, "unripened compassion", implying a kind of compromised one, "attached compassion" like that experienced in a sexual relationship, "compassion through identification" experienced through identifying with the suffering of others, and "reasoned compassion" which is further divided into compassion as a moral principle and compassion through the deep insight of reality (p. 151). Ekman (2012) spoke of four types of compassion: familiar compassion, familial compassion, compassion to strangers and compassion to all sentient beings. The first two reflect self-

referential compassion, and the latter represents non-self-referential compassion. Self-referential compassion, when understood through the prism of the universal human experience of suffering, can be vulnerable to fatigue or fade and, however, is amenable to change towards the direction of non-self-referential experience with its positive benefits as compassion training is treated in Buddhist tradition (Analayo, 2015; Halifax, 2011).

The following tabulation (Table: 1) places empathy, self-referential compassion, and non-self-referential compassion in their respective processes related to altruistic action, the reason, and results.

Empathy/compassion	Different types	Reason for altruistic action	Result of altruistic action
Empathy (Ability to experience any emotion, ability to distinguish the feeling in self or other, no natural action oriented-ness, Reactive)	Cognitive empathy Emotional empathy	Through distress regulation	Fatigue is experienced due to the depletion of the dopaminergic system (Dowling, 2018)
		Emotional arousal theory (Hoffman,1981)	
		Empathic distress, Pathological altruism (Klimecki & Singer, 2011) (Batson et al., 1987)	Negative feelings, poor health, burnout, withdrawal Empathic distress fatigue
Compassion (Self-referential) Concern for suffering and action to alleviate suffering (Virtuous action, most times guided by love and pleasant affect, Moral/spiritual motivation Relational, Subject-Object divide).	Familial compassion (Ekman, 2012) Biologically based compassion-(Halifax,2011) "Attached compassion-(Halifax, 2011)	Attachment-based (Gilbert, 2017)	Perception of depletion in the ability to care/nurture due to the perception of excess need and lack of resources (Compassion fatigue) (Genuine altruistic action and yet vulnerable to fatigue)
Analayo (2015) speaks of Buddhist compassion focusing on a particular object in the basic stage and is objectless in the advanced stage.	Familiar compassion (Ekman, 2012) compassion through identification-(Halifax,2011), (Nussbaum,2001) .	Guided by the fear of a similar thing happening to me Guided by the subjective state of the compassionate or condition of the object (Aristotelian view, Nussbaum, 2001)	Distress regulation.
Compassion (Non-self-referential/transcending self) Universal, Relational, No subject-object divide, Pleasant affect, Guided by the awareness of the nature of suffering and interdependence of all beings	Compassion to all sentient beings-(Ekman, 2012) Reasoned compassion-Halifax (2011)	Guided by awareness of suffering, common humanity, and interdependence of sentient beings, Guided by wisdom (Buddhist tradition) Neurological research by (Klimecki & Singer, 2013)	No fatigue It can prevent fatigue
Guided by the unconditional law of love-nature of God	Compassion to strangers-(Ekman,2012)	Judeo Hellenistic tradition (Mirguet, 2017) (parattukudi & Melville, 2019)	

Table 1: Empathy, compassion, and altruistic action

It is possible that most times, what we call empathy or compassion in the health care experience is the self-referential compassion which can be limited, conditional and respond to the nature, size and intensity of the suffering object, the personality of the sufferer or the compassionate caregiver. While acknowledging that non-self-referential compassion is the ideal,

it is hard to believe that such universal compassion is common experience among caregivers. We need to account for the instances of self-referential compassion found in Buddhist literature (Ekman, 2012; Halifax, 2011) and in Western philosophical tradition (Parattukudi & Melville, 2019), which may also be present in the health care related compassionate caregiving spaces and the biological, attachment-based informal caregiving systems like parenting. That is to say, when we refer to compassion in general terms, we may be looking at a spectrum of experiences within compassion, most of it resulting in fade and fatigue. Therefor the recent euphemism around compassionate workplaces, if not accepting all expressions of compassion as legitimate, may end up in a context of compassion becoming a "mode of power" (Simpson et al., 2014) viewed through a Foucauldian analysis.

4. Current Status of Compassion Fatigue Research

The term compassion fatigue originated in the context of nursing (Joinson, 1992) and burnout literature, mainly supported by the burnout theory of Maslach (1982). However, the majority of the literature follows the conceptualization of Figley (1995, 2002), which sees compassion fatigue as a secondary traumatic stress disorder (STSD), which he argued as parallel in traumatology and symptoms to Post Traumatic Stress Disorder (PTSD) which appeared in DSM III. Beginning with Figley (1995), scholars started exploring the experience of therapeutic exposure to trauma and suffering within the compassion fatigue /secondary traumatic stress disorder (CF/STSD) model. In this review, and in the following sections of this dissertation, CF/STSD refers specifically to the interpretation of compassion fatigue by Figley (1995).

Most studies have mapped overlapping experiences of compassion fatigue, secondary traumatic stress disorder and burn out. Several studies (Abendroth, 2005; Craig & Sprang, 2010; Drury et al., 2014; Hegney et al., 2014; Kelly et al., 2015) reported trauma, anxiety, life demands and excessive empathy as contributory factors for CF/STSD. The factors that predicted CF/STSD and burnout were young age, lack of work experience and reduced recognition at work. Meaningful recognition, higher job satisfaction, older age, more years of experience, self-care, and evidence-based practice were found as having some preventive effects on CF/STSD and burnout in some studies (Craig & Sprang, 2010; Hegney et al., 2014; Kelly et al., 2015; Sansó et al., 2015).

A study including hospice nurses in Florida by Abendroth (2005) revealed that 78% of the nurses interviewed had moderate to severe CF/STSD, and 26% were considered at high-risk.

Significant factors influencing CF/STSD were trauma, anxiety, life demands and excessive empathy. These factors accounted for 91% of the incidence of CF/STSD, and hospice organization and others accounted for the rest. Hegney et al. (2014) studied 132 nurses regarding CF/STSD and compassion satisfaction and the contributory factors of depression, anxiety, and stress. Compassion fatigue, burnout, secondary stresses were positively correlated to anxiety and depression. Younger populations of nurses with less experience had a higher incidence of compassion fatigue. Kelly et al. (2015) surveyed 491 direct care nurses in critical care regarding compassion satisfaction, burnout, and secondary trauma. The factors connected to higher compassion satisfaction with receiving meaningful recognition, higher job satisfaction, older age, and fewer years of experience. Conversely, the factors linked to burnout were lack of meaningful recognition, membership of the age group 21-33years, and more years of experience.

Mental health professionals tend to have chronic and intense exposure to traumatic clients and their stories. From Figley (1995), scholars started exploring the experience of therapeutic exposure to trauma within the framework of CF/STSD. Sprang et al. (2007) examined the relationship between CF/STSD, compassion satisfaction and burnout in 1121 mental health professionals. Female gender was associated with higher compassion fatigue, with psychiatrists reporting more compassion fatigue compared to non-medical professionals. Craig and Sprang (2010) surveyed a random sample of 532 self-identified trauma specialists in the United States on the impact of evidence-based practices to deal with CF/STSD and burnout. The results indicated higher levels of burnout in younger professionals compared to higher levels of compassion satisfaction in experienced professionals. Use of evidence-based practices reported a decrease in CF/STSD in this study. Kraus (2005) investigated self-care, CF/STSD, and burnout and compassion satisfaction among 90 mental health clinicians who worked with adult sex offenders. The study found that self-care strategies had no influence on compassion fatigue and burnout but had some relationship to compassion satisfaction. They suggest that compassion satisfaction may be useful in decreasing burnout, not compassion fatigue.

It appears that there is some difference between direct, critical nursing to oncology, hospice palliative care nursing regarding CF/STSD. Hooper et al. (2010) compared emergency nurses with other specialties like oncology and nephrology and intensive care. There was no statistically significant difference in CF/STSD, intensive care nurses had higher burnout, and oncology nurses showed high levels of compassion fatigue. Martins Pereira et al. (2011)

in their literature review of burnout in palliative care concluded that the burnout experienced by palliative care professionals was not higher than professionals experienced in similar health care settings. The study by Sansó et al. (2015) on palliative care nurses to understand the impact of CF/STSD found that self-awareness was a significant component in promoting compassion satisfaction and a decrease in CF/STSD.

There are several studies which look at the personality factors of caring professionals its relationship to CF/STSD and burnout. Craigie et al. (2016) studied the relationship of the trait-negative affect (disposition to experience negative state of mind) of nurses in 273 samples to compassion fatigue and other related experiences. The negative trait affect contributed to a relationship to both compassion fatigue and secondary traumatic stress and burn out. However, compassion satisfaction showed only protective factors regarding burnout, not secondary traumatic stress. Kim et al. (2014) conducted a study in 172 nurses to understand how Type D personality (a personality type who usually suppress negative emotions) was related to CF/STSD, burnout, compassion satisfaction and job stress. In this study, 79.7% of nurses were of Type D personality, and Type D personality had a statistically significant positive relationship with CF/STSD, burnout and job stress. Pardess et al. (2014) studied volunteers from several trauma-related organizations in a series of three studies on attachment insecurities and CF/STSD. The result indicated a significant positive relationship of attachment insecurities with compassion fatigue.

Some of the following approaches are found in the reviewed literature as preventative strategies for CF/STSD. Figley (1995, 2002) suggested developing methods for compassion satisfaction and physical and emotional separation from their work to allow workers to renew their energy to deal with compassion fatigue/STSD. Drury et al. (2014) in a study of Australian nurses which involved two phases, regarding CF/STSD, compassion satisfaction, anxiety and stress proposed a model of resilience as effective against CF/STSD. Hevezi (2016) did a nonrandomized pre-post study on 15 registered oncology nurses by introducing a short meditation (less than ten mints) to deal with CF/STSD. The study revealed a statistically significant increase in compassion satisfaction, decrease in burnout and secondary trauma. Way and Tracy (2012), using qualitative data from hospice employees, studied the communication of compassion at work. The authors proposed a model of "recognizing, relating, and (re) acting" (p. 292) for communicating compassion at work. A literature review by Canfield (2005) revealed

some of the coping strategies by therapists included "affective distancing; putting collegial support systems in place; drawing on a sense of altruism or a higher purpose in life; regular exercise; and having a supportive and empathic supervisor to whom therapist could reach out" (p. 98). Schwam (1998) suggested self-awareness and self-care as an intervention for compassion fatigue. Valent (2002) suggested a holistic approach, which included debriefing and psychotherapy mainly to deal with the survival strategies. Dev et a. (2019) surveyed 801 nurses, 516 physicians, and 383 medical students regarding barriers to compassion in work. Nurses in this study reported more work environment-related barriers to compassion such as pages, phone call or other interruptions during consult, and less patient family related barriers such as the worry that the patient/family may complain or sue.

5. Compassion Fatigue Research: Methodological Problems

Figley (1995) designed the first test for measuring CF/STSD, the *Compassion Fatigue Self-Test.* It was a 40 item self-report measure combining compassion fatigue/STSD (23 items) and burnout (17 items). Gentry et al. (2002) adapted it to a 30-item scale called the *Compassion Fatigue Scale.* Recently Stamm (2005) incorporated positive items on compassion satisfaction onto the scale and designed the ProQOL with 30 items, three sub-items with ten items each on compassion fatigue, STSD, and compassion satisfaction. Stamm (2005) described compassion fatigue and compassion satisfaction as the negative and positive experiences of helping professionals. Since the introduction of the tool, the ProQOL scale has been widely used both for clinical evaluation and research on compassion fatigue. Stamm states that the ProQOL scale contains three distinct scales, and they have not succeeded in getting all three into a single composite scale. In his conceptualization of compassion fatigue, he defines it as the result of "work-related, secondary exposure to extremely stressful events" (p.5) and compassion satisfaction as "the pleasure an individual derives from being able to do their work" (p. 5). This definition indicates that the scale does not consider caring relationships and compassion sources in such a process. Despite this, the ProQOL scale continues as the most prominent compassion fatigue measure (Sinclair et al., 2017) in recent healthcare research. Ledoux (2015) says that though nursing research has always used the ProQOLscale and other compassion fatigue tools following the theory of Figley (1995), they do not seem to measure the construct of compassion. Sinclair et al. (2017) hold a similar opinion in their meta-narrative review on compassion fatigue.

Within the literature, the accepted view on compassion fatigue's measurement is that it is challenging due to the lack of clarity of the concept and lack of classification compared to other related experiences (Najjar et al., 2009). The various compassion fatigue measures are not considered diagnostic but are instead screening tools to help the individual and the organization. Bride et al. (2007) state that the score of the ProQOL scale needs to be interpreted with caution, as the individual who reports high in the measure may not, in fact, experience compassion fatigue. As Stamm (2005) clarifies: "It is possible for people to report high scores on compassion satisfaction combined with high scores on compassion fatigue" (p. 5), and he argues that highly altruistic people may find themselves in the most challenging places and experience both compassion satisfaction and compassion fatigue. This explanation clarifies the lack of any direct relationship between the different parts of the scale. However, in the general perception, as we find in current literature, compassion satisfaction appears to be the opposite of compassion fatigue (Gribben et al., 2019).

Some of the recent qualitative exploratory studies (Austin et al., 2009; Perry, 2008; Perry et al., 2011; Steinheiser, 2018) have departed from using measures like the ProQOL scale in studying compassion fatigue. Steinheiser (2018) reviewed the experience of compassion fatigue in Skilled Nursing Facilities (SNF), where they cared for older adults who faced multiple losses and end-of-life concerns. He used the interpretive phenomenological approach in understanding the phenomenon of compassion fatigue, which primarily reflected it as caring relationships and the inability to nurture it coupled with traumatic incidents like death. He compared the potential use of the ProQOL scale for nursing research and reported that many nurses reflected their symptoms to the items in the scale related to burnout; however, they did not support the symptoms associated with compassion fatigue in the scale.

The ambiguities in defining the concept led to a lack of focus and clarity in the literature regarding compassion fatigue. Measurements and interventions are based on the foundational conceptualization of the concept. Without having such a clear conceptual foundation, further research on compassion fatigue will not measure what it is supposed to measure and intervene what it needs to intervene. In the earliest works on compassion fatigue, Valent (2002) stands out as someone who proposed a heuristic distinction between the terms STSD, compassion fatigue and burnout through his survival strategies approach. He suggested burnout as the failure of assertiveness-goal achievement strategy, compassion fatigue as rescue-care taking strategy. He

acknowledged the general term of STSD perpetuated by Figley (1995,2002) and others while holding on to the idea of rescue-caretaking trauma in compassion fatigue.

Kanter (2007) has an intuitive suggestion regarding confusion in conceptualizing compassion fatigue. Given that the consequent physiological symptoms of compassion fatigue, secondary traumatic stress disorder and burnout are very similar, what is needed is a differential diagnosis approach. Critiquing Figley's work, he argues that "reducing all stress to traumatic origins" (p. 289) is wrong and that there is chronic suffering experienced by many without a trauma component. He says that all suffering is inherently stressful, and it is the individual's response that makes it manageable or not and that not all suffering leads to trauma.

6. Compassion Fatigue and Other Related Experiences

Kanter (2007) writes a critique of Figley's ideas on compassion fatigue and explores other experiences like countertransference and burnout. According to him, we need a clear etiology to study compassion fatigue, and such a thing is missing in the literature. Collins and Long (2003), in a literature review on the after-effects of exposure to the traumatic narratives of patients by care professionals, elaborate at length on a synthetic view of secondary stress, burnout, vicarious trauma, countertransference and compassion fatigue. The distinction between burnout and secondary stress disorder is that burnout does not include work-related fear, but STS includes the experience of fear related to work trauma. Burnout is also related to the workplace environment, but STS is related to patient-related episodes (Ames et al., 2017).

In the following sections these related experiences will be briefly discussed in order to better understand the relationships between compassion fatigue and these related experiences.

6.1 Compassion Fatigue and Secondary Traumatic Stress

Meadors et al. (2010) suggested that compassion fatigue and secondary traumatic stress are different even though they have overlapping elements that warrants further research. Leone et al. (1999) suggested that Figley (1995) combined the experience of burnout and PTSD symptoms experienced by individuals who were associated with or treating trauma victims to conceptualize compassion fatigue/STSD. They suggested that if it was not treated, it might become PTSD. According to Stamm (2005), the symptoms of compassion fatigue/STSD can have a sudden onset related to a particular event and can manifest difficulty in sleeping, triggering disturbing memories and evoking avoidance response. Though the term compassion fatigue was initially used in the nursing context, it was later defined in another context. The common risk factor for

both is contact with clients. However, STSD presents with trauma and exhaustion, while compassion fatigue more commonly presents with exhaustion (Coetzee & Klopper, 2010).

6.2 Compassion Fatigue and Burnout

According to Gallagher (2013), burnout results from the caring professional's interaction with their working environment not being supportive of their health. However, compassion fatigue results from the relationship between the patient and the professional. Ledoux (2015) suggests that burnout speaks about the breakdown of the relationship between the employer and the employee, while compassion fatigue refers to the nurse-patient relationship. According to McHolm (2006), while the nurse who experiences burnout eventually becomes less caring and empathetic, nurses with compassion fatigue "give themselves fully to their patients, finding it difficult to maintain a healthy balance of empathy and objectivity" (p. 14). The same experience is reported by Boyle (2011), who found nurses suffering from compassion fatigue made desperate attempts to connect with their patients compared to the nurses who experienced burnout who practiced distancing from patients. For Boyle, the difference between burnout and compassion fatigue is in their etiology: burnout is a reaction experience, and compassion fatigue is a relational experience. Ledoux (2015), analyzing the work of Joinson (1992), suggests that Joinson was not trying to make a "causal relation between burnout and compassion fatigue" (p. 2045). Figley (1995) suggested that burnout emerges gradually while CF/STSD can happen suddenly, and there is a faster recovery for it than burnout. Keidel (2002) conceived compassion fatigue and burnout as mutually overlapping concepts. Valent (2002) made a clear distinction between compassion fatigue and burnout by suggesting that compassion fatigue resulted from the failure of rescue-care taking strategy and burnout resulted from the failure of an assertiveness strategy. Collins and Long (2003) are of the opinion that compassion fatigue and burnout have a dynamic relationship, with burnout sometimes causing compassion fatigue and vice-versa.

6.3 Compassion Fatigue and Counter Transference

In psychoanalytic theory counter transference is understood as the “result of the analyst's unconscious reaction to the patient” (Tosone, 2012, p. 3) where the therapist projects to the client their unresolved conflicts. Accordingly, many of the patients instead of remembering traumatic issues of the past, unconsciously involves the therapist in “traumatic enactments as a form of communication and recollection” (P. 7). If not managed well, this can be extremely emotionally draining for the therapist. Figley (1995) argued that countertransference could be incorporated

into CF/STSD, but not limited to it as it can also occur in non-therapeutic situations. Berzoff and Kita (2010) state that countertransference and compassion fatigue are different experiences and need different interventions. Countertransference happens as part of therapeutic enactment. However, compassion fatigue is the result of repeated exposure to suffering. Gentry (2002) suggested that CF/STSD had roots in transference experience and that it works as a "catalyst for positive change, transformation, maturation, and resiliency" (p. 37), together with its disruptive role in the lives of people who care for the traumatized. Kanter (2007) says that the scholars of compassion fatigue have taken an "ahistorical approach" (p. 289) in not considering countertransference experience in the conceptualization of CF/STSD. He argues that the example of Jane with compassion fatigue in Figley (2002) is really an example of how countertransference affects an individual. He argues for transference as the cause of compassion fatigue/STSD. Berzoff and Kita (2010) suggest in response to Kanter (2007) that compassion fatigue is based on caring for those suffering, and countertransference depends on the client and clinician interaction and the intersubjective unconscious worlds. For Berzoff and Kita, compassion fatigue is accumulated over time through caregiving, but transference can be experienced suddenly, even by a well-trained professional.

6.4 Compassion Fatigue and Vicarious Trauma

The term vicarious trauma is often used interchangeably with compassion fatigue, even though some authors do not support such usage (Jenkins & Warren, 2012). Kadambi and Ennis (2004) define vicarious trauma as “the process and mechanism by which the inner experience of the therapist is profoundly and permanently changed through an empathic bonding with the client’s traumatic experiences" (p. 3). According to Figley (1995) vicarious trauma happens when a person is out of contact with the other members of their group (e.g., in war, coal mine accidents, hostage situations, distant disasters) who may be suffering. Stamm (2005) speaks of CF/STSD as related to vicarious trauma, and Bride et al. (2007) refer to CF/STSD as vicarious trauma in their work. Sabo (2011) believes that compassion fatigue can be treated, but vicarious trauma may be permanent. The symptoms attached to CF/STSD are very similar to vicarious trauma (Kadambi & Ennis, 2004). However, vicarious trauma leaves a person with irreversible effects of working with trauma survivors, unlike CF/STSD.

7. Defining Compassion Fatigue: Towards a Relational Model

We saw in the history and evolution of the concept of compassion fatigue that Figley (1995) had taken the term compassion fatigue to be interchangeably used with secondary traumatic stress disorder, more for pragmatic reasons of common acceptance than anything else. However, this historical adaptation of the term and the generalized contextual use, crossing over from nursing to other helping professions and vice versa, has confused conceptual clarity, research, and academic applications today. My effort in this section is to tie this historical context of compassion fatigue with the theoretical analyses in literature by essentially dividing them into two broad sections, which is achieved by operationalizing the concept of empathy and compassion. Lee et al. (2015) asks a very pertinent question regarding the causation of compassion fatigue: is it caused by overexposure to suffering or the fatigue of compassion?

Figley's (1995) justification of considering compassion fatigue as secondary traumatic disorder, is his idea of "traumatized by concern" (p. 5). He quotes from Figley, 1983b,

> "Sometimes… we become emotionally drained by (caring so much); we are adversely affected by our efforts. Indeed, simply being a family member and caring deeply about its members makes us emotionally vulnerable to the catastrophes that impact them. We, too, become "victims" because of our emotional connection with the victimized family member." (p. 2)" (cited in p. 5).

The emotional connection made possible using empathy in an interpersonal space becomes the carrier of trauma. Accordingly, to him, empathy and exposure to trauma explain the process of individuals experiencing compassion fatigue. Empathy works as the medium of "induction of traumatic material from the primary to the secondary victim" (p. 15) and empathizing with others causes one to be traumatized. If we extrapolate Figley's (1995) conceptualization further, empathy can cause trauma in the simplest act of caring, even in the absence of any traumatic event or enactment.

Joinson (1992) speaks of compassion fatigue as a "unique form of burnout" (p. 116) and the loss of the "ability to nurture" (p.119). According to her, the nursing profession sets up a professional for compassion fatigue due to the demand for nurturing (compassion) embedded in the job, and they are to experience it at some point in their career. Caregiving professionals are faced with the infinite need for human connection and exposure to suffering, which is essentially unavoidable and not always bad. In this context, Joinson (1992) speaks of the nurse who

experienced compassion fatigue: "When Marian Wilson stopped crying over patients long ago, she stepped into compassion fatigue and lost her ability to nurture. The pain she denies leaves her ineffective as a caregiver" (p. 119). In this context, compassion fatigue is understood as caused by the depletion or loss of ability to nurture (compassion) and the denial of the pain of suffering.

The following are two models. One holds the view of compassion sometimes as a limited resource to address suffering and therefore causing fatigue. The other speaks about empathy, which is causative of secondary trauma in the caregiver or therapist. Table (Table 2) illustrates the two models of compassion fatigue as extrapolated from Joinson (1992) and Figley (1995).

The relational model of Compassion Fatigue (Joinson, 1992)	**Reactive model of Secondary traumatic stress disorder/Compassion Fatigue (Figley, 1995)**
Context of care	Any context, including the context of care
Exposure to suffering	Exposure to trauma
Chronic, intense exposure	Chronic, intense exposure
Nature of suffering/stress-unavoidable, not always bad	It doesn't speak of the nature of suffering/stress
Focus on the alleviation of suffering	Not focused on the alleviation of suffering but served as stress regulatory function
Direct exposure to suffering	Indirect exposure to trauma
Promotes engagement as an intervention	Promotes disengagement as an intervention
Loss, obstruction in the ability to nurture	Excessive use of empathy is causative; the Absence of empathy leads to the Absence of compassion fatigue.
Use of self to care	Use of self-in trauma
Gradual in nature	Sudden in nature
Etiologically relational	Etiologically related to trauma
Confronted with infinite need and limited resources of compassion	Nature of suffering and the nature of compassion is not a subject matter
Speaks of compassion	Speaks of empathy

Table 2 The relational model and the reactive model of compassion fatigue

7.1 Figley's Reactive/Empathy Model of CF/STSD

Figley's (1995, 2002) model suggested that the prolonged indirect exposure to the traumatic client evokes an empathic response in the therapist. The emotional impact brings in compassion stress in the therapist and, if not addressed, can develop into compassion fatigue /secondary traumatic stress disorder. Accordingly, empathy and exposure to trauma explain the process of individuals experiencing compassion fatigue /secondary traumatic stress disorder. Further, Figley (1995) argues: "If we are not empathic or exposed to the traumatized, there should be little concern for compassion fatigue" (p. 15).

Kinnick et al. (1996), in the first-ever experimental media study on compassion fatigue, described the process of empathy as advocated by Hoffman (1981), where when one is faced with a distressing situation, empathy brings in emotional distress, and as a response to it, the individual is motivated to reduce it through altruism or avoidance. Accordingly, optimum empathic arousal is needed for helping behaviour, and an over-arousal can cause an individual to avoid it. Under arousal may make individuals indifferent to the stimuli and prompt no helping or avoiding action. According to Kinnick et al. (1996), this process is parallel to the process of emotional exhaustion in burnout literature, especially by Maslach (1982), "in which subjects become increasingly desensitized to those they are supposed to help" (p. 688).

Valent (2002) speaks of the eight survival strategies: rescuing or caretaking, attaching, asserting or goal achievement, adapting or goal surrender, fighting, fleeing, competing, and cooperating. According to him, the helpers activate the adaptive rescue-caretaking response in the face of stress using empathy. Accordingly, when the situation of helplessness by the caregiver in saving or helping the sufferer amounts to be in traumatic proportions going beyond compassion stress, it becomes compassion fatigue. Vachon et al. (2015) spoke of compassion fatigue as resulting from empathic strain between the caregiver and the patient. In this model, intrusive empathic strain results in overidentification and excessive bonding between the caregiver and the patient, resulting in the caregiver distancing and avoiding the patient.

7.2 Joinson's (1992) Relational/Compassion Model of Compassion Fatigue

Joinson (1992) doesn't use the word empathy anywhere in her article except when explaining the compassionate nurse Jackie Kemp who withstood compassion fatigue. "She was compassionate and acted as a caregiver by empathizing and bonding with her patient. She then nurtured and comforted the woman, grieved at her death, and made use of her support system" (p.119). Two aspects stand out in this narrative of what helped nurse Jackie avoid compassion fatigue: bonding and nurturing. Bonding and nurturing in relationships or caregiving reflect the secure attachment experience, as elaborated by Bowlby (1999) which is a sign of healthy. attachment experience (Gilbert, 2017). Ekman (2012) and Halifax (2011) talk about biologically based compassion reflected in an attachment-related processes in relationship or caregiving, which they also include in the category of self-referential compassion.

Several recent qualitative exploratory studies (Austin et al., 2009; Cross, 2019; Harris & Griffins, 2015; Lynch & Lobo, 2012; Peters, 2018; Perry et al., 2011; Sacco & Copel, 2018)

have described compassion fatigue within the framework of a relational process. The interpretive phenomenological study by Steinheiser (2018) described compassion fatigue as a relational process that reflected the caregivers" perception of an inability to nurture. Harris and Griffins (2015) described compassion fatigue experience as "unable to love, nurture, care for, or empathize with another's suffering" (p. 82). Cross (2019) spoke of the experience of compassion fatigue as the loss of compassion, and Austin et al. (2009) explained it as the caregiver's distress of not being able to care for the patient. The phenomenological study of Perry (2008) with exemplary, compassionate caregivers indicated the theme of connection as the most potent indicator which protects from compassion fatigue. Gallagher (2013) and Ledoux (2015) described compassion fatigue as precisely the result of the patient-caregiver relationship. McHolm (2006) and Boyle (2011) observed that nurses who experienced compassion fatigue desperately attempted to give themselves more fully to the patients who eventually faced balance and boundary issues. Boyle (2011) called compassion fatigue etiologically a relational process.

The following table (Table 3) shows how empathy or compassion is found in compassion fatigue literature, mainly in concept analyses and qualitative interpretive works. One common observation is that most of the authors who conceptualized compassion as a resource in caregiving and compassion fatigue as a disturbance or depletion of that resource in a relational space have not accepted the definition of Figley (1995, 2002) rather have come up with their definitions. The following table (table 3) gives a better understanding of the uniqueness of compassion fatigue revealed in a relational context of care/compassion and its use as a precious resource as opposed to it being a vehicle of trauma or stress regulatory component in the interaction with the patient and caregiver.

Use of relational or reactive models in selected compassion fatigue literature					
Author, Year & type	Definition of compassion fatigue	Antecedents/Attributes	Relational	Reactive	Comments
Coetzee and Klopper (2010) Concept Analysis (First ever)	"Compassion fatigue is the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress. It evolves from a state of compassion discomfort, which if not effaced through adequate rest, leads to	Risk factors Contact with patient Use of self Stress Cause-Prolonged, Continuous, intense exposure		Yes	Purpose: To define compassion fatigue in nursing context Influence of Figley's def.

	compassion stress that exceeds nurses" endurance levels and ultimately results in compassion fatigue" (p. 237)				
Jenkins and Warren (2012) Concept Analysis	Repeats Figley's (1995) definition-It's the consequence of caring between two individuals, one who has been traumatized and the other who is affected by the first's trauma experience.	Exposure to suffering Continuous and intense contact High-stress exposure High use of self in work		Yes	Purpose: An analysis of compassion fatigue to inform critical care nurses that compassion fatigue used method of Walker and Avant (2011) Influence of Figley" s def.
Lynch and Lobo (2012) Concept Analysis	"Compassion fatigue in family caregivers is a resultant condition experienced by caregivers who provide daily care to seriously ill or dying family members and are simultaneously exposed to the patient's pain while experiencing their own emotional pain" (p. 2128)	Relationship between caregiver and patient Empathy Stress Shared experiences and their psychological and physical response	Yes		Purpose: An analysis of the concept in family caregivers Used Wilsonian concept analysis strategy Own definition of compassion fatigue
Harris and Griffins (2015) Concept Analysis	"Compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice and /or prolonged exposure to difficult situations that renders a person unable to love, nurture, care for, or empathize with another's suffering" (p. 82)	Minimal spiritual commitment Degree of emotional investment Lack of support system Lack of inner conviction and resiliency	Yes		Purpose: To analyze and define compassion fatigue to develop potential protective mechanisms. A theoretical paper The author- assistant prof. in nursing Own definition of compassion fatigue
Peters (2018) Concept Analysis	"Compassion fatigue is a preventable state of holistic exhaustion that manifests as a physical decline in energy and endurance, and emotional decline in empathetic ability and emotional exhaustion, and a spiritual decline as one feels hopeless or helpless to recover those results from chronic exposure to others" suffering, compassion, high-stress exposure, and high occupational use of self in the Absence of boundary setting and self-care measures" (p. 470).	Chronic exposure to suffering Compassion Inability to maintain a boundary. High use of self High-stress exposure Lack of self-care measures	Yes		Purpose: To clarify the concept of compassion fatigue for developing prevention for compassion fatigue, used method of Walker and Avant (2011) Own definition of compassion fatigue
Cross (2019) Concept Analysis	"It is the state where compassion and empathy are lost, demonstrated by emotional and psychological, intellectual and professional, physical, social, and spiritual	Ability to experience compassion and empathy Exposure to suffering Repeated exposure to stressors	Yes		Purpose: To define compassion fatigue in the context of palliative care nursing, used method of Walker and Avant (2011)

	characteristics that, if left unattended, result in disinterest, moral distress, burnout, and breakdown" (p.26).				Own definition of compassion fatigue
Austin et al. (2009) Interpretive Description study	It speaks about the inability of the care professional to care- a kind of practitioner distress. Relationship is the protective factor. Lack of genuine engagement is the problem. A shift from conceiving compassion fatigue as an individual psychological phenomenon to a systemic nature.	Themes: Running on empty Shielding myself Being impotent as a nurse Losing balance: it overwhelms everything. The kind of nurse I was. Trying to survive	Yes		A Canadian study on registered nurses and registered psychiatric nurses using Interpretive Description asked, what is the experience of compassion fatigue like?
Perry et al. (2011) Descriptive Exploratory Qualitative	"I just don't have the energy to keep going." "I just had an overwhelming fatigue." "The feeling of hypervigilance"	Being unable to ease suffering. Coexisting physical and emotional stresses Excessive emotional attachment Lack of time/ability to give quality care	Yes		A Canadian Descriptive Exploratory Qualitative study with 19 oncology nurses on compassion fatigue
Sacco and Copel (2018) Concept Analysis on Compassion Satisfaction	Def: Compassion Satisfaction "The pleasure, purpose, and gratification received by professional caregivers through their contributions to the well-being of patients and their families" (p. 78).	Caregiving as a calling Empathetic caregiving relationship Continuous exposure to stress but collegial support Development of resilience Developing coping skills Practice of self-care Adequate social support	Yes		A review of social work and nursing literature to investigate compassion satisfaction as it is experienced in the nursing profession Own definition of CS
Perry (2008) Phenomenol ogical study On exemplary nurse & compassion fatigue	Used definition of compassion fatigue "a heavy heart, a debilitating weariness brought about by repetitive, empathic responses to pain and suffering others" (LaRowe, 2005, p. 21).	Themes: Moments of connection Making moments matter Energizing moments	Yes		A Phenomenological Study of 7oncology exemplary nurses on what helped them to avoid compassion fatigue

Table 3: Use of empathy/ compassion in compassion fatigue literature

7.3 Operational Definition

The following is an operational definition of compassion fatigue, incorporating some of the underlying assumptions by various authors in this review.

> *Compassion fatigue is the physical, psychological, emotional, and spiritual response characterized mainly by the experience of exhaustion and its individually unique pathological presentations, caused by the perception of extreme inability to sustain a nurturing relationship between the caregiver and the patient in the context of a long and ongoing exposure to the chronic, intense, often unavoidable and traumatic nature of suffering and an unsupportive environment.*

This operational definition captures a relational model between the patient and the caregiver in the process of compassion fatigue. Accordingly, the relational process between the patient and caregiver can be strained by different factors including traumatic experiences and unsupportive environment. The caregiver is left with the perception of the "extreme inability" to sustain a nurturing relationship which results in experience of exhaustion and fatigue.

8. Concluding Remarks

This review began by exploring the possible earliest connections in history to the concept of compassion fatigue. It became clear that burnout literature was already present, and compassion fatigue started as a negative concept outside of healthcare but found its way into health care. Compassion fatigue, an expression of unwillingness, became an expression of vulnerability and pathology in caregiving professionals instead. Further, the concept found its way to the mainstream through the efforts of Figley (1995, 2002). Though the word compassion fatigue was initially used in relation to the concept of compassion (Joinson,1992), the historical journey of compassion fatigue appeared to be disconnected from the concept of compassion. However, in recent years, the authors (Austin et al., 2009; Cross, 2019; Harris & Griffins, 2015; Lynch & Lobo, 2012; Peters, 2018; Perry et al., 2011; Sacco & Copel, 2018) have started noticing this aberration and are advocating for the rightful place of compassion in health care.

The word empathy, which had an 18th-century origin in the appreciation of art, has been used interchangeably with compassion in the Western world. Empathy as a carrier of trauma and regulating stress in the presence of trauma and suffering has become the core of discussion in the work of Figley's traumatology. Recognizing the role of empathy and its probably misplaced usage with compassion fatigue has been this review's subject matter. The central theme of the

relational process appears to be the unique factor that can help us make a differential diagnosis (Kanter, 2007) because the consequence of compassion fatigue reflects symptoms of burnout, secondary traumatic stress disorder, countertransference, and vicarious trauma.

The next chapter elaborates on the research methodology employed in the current study, including the methods of data collection and the various steps of the research process. The methodological choices of this study is informed by the literature on the subject within a constructivist paradigm of grounded theory investigation.

CHAPTER III

RESEARCH METHODOLOGY

This chapter deals with the study's methodological choices and data collection methods. This is usually a traditional part of a dissertation for the reader to clearly understand the "how" of the research, which justifies the choices in the research process and the results the dissertation arrives at.

1. Introduction

Understanding the researchers' fundamental assumptions about the world can be a good starting point in discussing research methodology in a doctoral dissertation. Leavy (2017) speaks about a "qualitative philosophical statement" (p. 128) which may provide sufficient information about the researcher's worldview guiding a particular project. Lincoln and Denzin (2005) consider qualitative researchers as philosophers who explore ontology, epistemology, congruent methodology and methods in a research endeavour. While ontology investigates the nature of reality, epistemology looks at ways of knowing and the relationship between the knower and the known. An appropriate methodology follows the ontological and epistemological path in devising a suitable approach to gain knowledge. Methods are techniques or procedures that the researcher uses to investigate a research question, including participant recruitment, data collection, data analysis, and reporting. This study uses the grounded theory approach of Gioia et al. (2013) within the constructivist paradigm (Charmaz, 2006) as the principal methodology of choice.

2. Ontological and Epistemological Starting Points

Corbin and Strauss (1990) speak of the two principles that guide the development of a grounded theory. The first is that reality is not static. Instead, it is continuously changing "in response to evolving conditions" (p. 5). The second is that "strict determinism is rejected, as is nondeterminism" (p. 5), giving freedom to the individual players to choose some time to move against their destiny by responding to the conditions that are present. Thus, there is an essential interplay of these two principles that can be revealed through grounded theory: it "seeks not only to uncover relevant conditions but also to determine how the actors respond to changing conditions and to the consequences of their actions" (p. 5). These two principles are reflected in both pragmatist philosophy and symbolic interactionist sociology. Pragmatism and symbolic

interactionism constitute grounded theory's ontological and epistemological framework (Chamberlain-Salaun et al., 2013).

Pragmatism is a humanistic philosophy that speaks about the worthlessness of mere knowing if it does not bring social progress (Berger et al., 2015). American pragmatism progressed after World War II in the 1940s when the economic and social progress based on materialistic gains and philosophical undertakings were challenged to prove its worth in practice. Accordingly, the "unification of knowledge and action, and applying theory to practice distinguished pragmatist philosophy from other philosophical positions" (Chamberlain-Salaun et al., 2013, p. 2).

Symbolic interactionism emerged in American society with the primary influence of American pragmatist philosopher George Herbert Mead (1934), opposing the positivist model and proposing a bottom-up approach in the operation of society (Carter & Fuller, 2015). The three fundamental premises of symbolic interactionism are,

> "Human beings act towards things based on the meanings that the things have for them … the meaning of such things is derived from or arises out of, the social interaction that one has with one's fellows … [and] these meanings are handled in and modified through, an interpretative process used by the person dealing with the things he encounters" (Blumer, 1969, p. 1).

Further, Blumer explains symbolic interactionism as something that makes a person's meaning-making process central to any study of behaviour. Grounded theory reflects the basic tenets of symbolic interactionism when the researcher is trying to understand the symbolic meanings of the appearance and interaction of the participants with groups of other people. The individuals are conceived as active participants in a meaning-making process within the given context of research (Cutcliffe, 2000). The grounded theorists try to discover the patterns, processes and life experiences and create categories and theories of the observed and experienced data.

Following the relativist ontological standpoint, an epistemological structure of the interrelationship between the knower and the known/researcher and the participant, the co-production of meaning is established in constructivism. The interpretive, or constructivist, paradigm explores "how people engage in processes of constructing and reconstructing meanings through daily interactions" (Leavy, 2017, p. 129). Symbolic interactionism and phenomenology are two primary schools of thought within the constructivist paradigm.

Though symbolic interactionism is at the root of all grounded theory approaches, in the constructivist grounded theory approach of Charmaz (2006), we find the ontological and epistemological threads leading to a methodology of theory building in a more congruent fashion (Mills et al., 2006). As phenomenology falls within the constructive paradigm, it is also methodologically congruent to conceive of an integration of constructivist grounded theory with case study approach. Following this line of thought, this study integrates some elements of phenomenological case study approach with the constructivist grounded theory by engaging the grounded theory approach of Gioa et al. (2013) within the constructivist paradigm of Charmaz (2006) in collection, analysis, and interpretation of the research data.

3. Methodological Choices

Methodological self-consciousness (Charmaz, 2006) refers to the awareness in a researcher regarding various choices that they are making, including the that of ontological or epistemological assumptions, and the choice of methodology and methods. Sufficient knowledge on the specific methodology and methods that the researcher utilizes becomes essential for a successful research project. A researcher is also expected to give an honest description of their various research choices regarding participant recruitment, data collection, and strategy of analysis.

The methodological choice of this research is informed by some of the recent qualitative studies on compassion fatigue (Austin et al., 2009; Perry et al., 2011) which encourage the view of understanding compassion fatigue in the context of the whole person, their lived experience and environment. Even though the phenomenological lens got me interested regarding my work with nurses' compassion fatigue, I felt that it could achieve only a part of the research purpose, namely creating rich description of nurse experience regarding compassion fatigue. The purposes of comparing experiences from a large population of participants and developing a theoretical understanding of the etiology and process of compassion fatigue could not be achieved in it. After having reviewed various other qualitative methodologies, I concluded that the research on nurse compassion fatigue with a desired purposes is most appropriately conducted in a grounded theory approach within the constructivist paradigm. The constructivist paradigm encourages the researcher to study the "meanings, intentions and actions of the research participants" (Charmaz, 1996, p. 32) whether the data is collected through direct observation, in-depth interview or learning through clinical histories. It recognizes multiple realities and the human construction of

meaning. It allows both the researcher and the participant to co-construct meaning as the "interpretation of the studied phenomenon itself a construction" (Charmaz, 2006, p. 187). The pragmatic bend of the constructivist paradigm which uses usefulness as a core criterion for quality also appealed me as I didn't want to keep the research a mere academic exercise. After having found a methodological base in Charmaz's (2006) constructivist grounded theory, I looked into various authors who have integrated a phenomenological lens within grounded theory to achieve strength of both approaches.

Many authors have tried to combine both case studies and grounded theory, mainly using grounded theory for data analysis (Adwan, 2017; Bonner & Adams, 2012; Dubois & Gadde, 2002; Edward, 1998; Floersch et al., 2010; Halaweh et al., 2008; Krueger et al., 2014; Lawrence & Tar, 2013; Tierney et al., 2017). Though data collection is similar, the goal and methodology of formulating questions are different in both methodologies. The purpose of a phenomenological case study is to "describe the meaning of the lived experience of a phenomenon" (Starks & Brown Trinidad, 2007, p. 1373), and the goal of grounded theory is to "develop an explanatory theory" (p. 1373). Undoubtedly using grounded theory to analyze rich data within the case study can lead to a better outcome in theory making from cases. However, integrating some important elements of a phenomenological case study approach within grounded theory can bring forth a well explained phenomenon and a well-developed theoretical model which explains the underlying social and psychological process. Such a potential is present in the grounded theory approach of Gioia et al. (2013) as elaborated in the following sections.

The methodological choice of using the Gioia approach (Gioia et. al, 2013) to grounded theory within the constructivist paradigm (Charmaz, 2006, 2014) proved to be beneficial in this study as it facilitated rich exploration, systematic comparison, analysis, and interpretation of the data without losing the participant voice in abstraction. While constructivist grounded theory encouraged a relational and pragmatic approach to research, the Gioia approach clearly laid out plans within the grounded theory data collection, analysis, and interpretation to make "conscious effort to adequately give voice to informants' understandings in the research" (Gioia, 2021, p. 22) without losing the rigour or credible interpretation of data (Gioia et. al, 2013). The decision to present the findings with snapshots of nurse experiences and explicate the emergent grounded theory model with nurse vignettes appropriate to different phases was influenced by this

methodological plan. As each time I re-read the dissertation, the balanced appearance of theoretical insights and rich description allows me to further engage with the experience of nurse compassion fatigue more meaningfully.

The above methodological decisions also helped me to collect, analyse and present the data and its outcome in congruent manner. I engaged phenomenological interviewing methods in conjunction with constructivist grounded theory guidelines in the conduct of the in-depth interviews. Similarly, comparison tables and data structure were used together with coding and analysing of the grounded data as suggested by Gioia et. al. (2013). The research culminated in the formulation of emergent grounded theory, its explication and discussion which was further enriched by appropriate nurse vignettes. The above methodological preferences helped me to collect, describe, analyse and interpret the data keeping all the four quality criteria of a constructivist grounded theory, namely, credibility, originality, resonance and usefulness (Charmaz & Thornberg, 2020, Charmaz, 2006).

3.1 The Constructivist Grounded Theory

Grounded theory evolved in the 1960s through the sociological research program of Glaser and Strauss regarding death and dying in hospitals (Charmaz, 1990; Corbin & Strauss, 1990). They proposed generating a theory, which is "too intimately linked to data" (Glaser & Strauss, 1967, p. 4) as opposed to logical deduction approaches. The Straussian and the Glaserian models of grounded theory came to be used to introduce the *Basics of Qualitative Research* (Strauss & Corbin, 1990). The subsequent development and use of grounded theory evolved into the constructivist grounded theory model of Charmaz in 1990, which her 2016 book *Constructing Grounded Theory* elaborated. Walker and Myrick (2006) think that the two significant differences between the Straussian and Glaserian models are "the issue of forcing versus emerging about the coding procedures … [and the] … issue of verification" (p. 550) in grounded theory. Both are alike in the coding steps, constant comparison, theoretical sampling, saturation and use of memos. They also follow a similar process of gathering data, coding, comparing, categorizing, and generating theory; however, the difference is how it is done (Walker & Myrick, 2006).

Taking liberty from Glaser and Strauss's (1967) original advice for researchers to use grounded theory flexibly in their work Charmaz (2006) created an approach to use rich data in socially constructed spaces through her constructivist grounded theory. In social constructivist

grounded theory, the researcher becomes an active observer whose interactions and decisions regarding the processes become part of the social construction. The "research report is also a social construction of the social construction found and explicated in the data" (Charmaz, 1990, p. 1165). As the philosophical approach, methodological strategies, experience, and values of the researcher influence the process of building grounded theory (Charmaz, 1990), researcher reflexivity is given a very significant place in the constructivist grounded theory. The constructivist grounded theory goes through similar steps as of other versions of grounded theories like opening research questions, gathering rich data, coding process, memo writing, theoretical sampling, saturation, sorting of categories, constructive theory, and writing the initial draft (Charmaz's (2006). The various aspects of the constructivist paradigm as suggested by Charmaz (2006) are interwoven into the following sections of methodology and analysis along with the elaboration and application of Gioia et. al's (2013) approach to grounded theory.

3.2 Gioia's Approach to Grounded Theory

Gioia et al. (2013) introduced their version of grounded theory which is sometime is called as the "Gioia method" stated two purposes for their approach. The first was to bring "qualitative rigor" (p. 15) while remaining creative and retaining some characteristics of case study approach in generating new concepts and ideas. The second is to apply "systematic conceptual and analytical discipline that leads to credible interpretation of data" (p. 15) within qualitative studies. This organizational research approach for them shifted the attention from the measurable frequent occurrences of variables to understanding how the organizational members constructed the meaning of their experiences. Gioia et al. (2013) predicated an interpretive constructive paradigm (Chandra & Shang, 2019) for their approach with two basic assumptions that the "organizational world is socially constructed" and that people are able to describe their experiences, their intentions, thoughts, and actions as "knowledgeable agents" (Gioia et al., 2013, p. 17). These basic assumptions propel the researcher to make "extraordinary efforts to give voice to the informants in the early stages of data gathering and analysis and also to represent their voices prominently in the reporting of the research" (p. 17). This special attention to the voice of the participant, to me is the hallmark of Gioia method compared to other grounded theory approaches. The approach also empowers the researcher to be an active player within research by co-constructing the meaning of participant's experience and figuring out the

concepts and patterns of their relationship that may escape the awareness of the research participants as clearly expressed in Charmaz's (2006) constructivist grounded theory.

In the original work of Gioia and Chittipeddi (1991) which later emerged as the first example of the application of their method, they engaged an ethnographic case study approach which had multiple data sources. In a later work using the same approach (Corley & Gioia, 2004) the researchers used a multiple case study approach in studying the concept of change in a Fortune 100 company. Langley and Abdallah (2011) while referring to Gioia's approach compared it with the Eisenhardt method (Eisenhardt, 2007) of building theories from multiple cases. They suggest that even though the in-depth contextual detail of a case may allow the reader to understand the theoretical formulation, cases, or mergers of cases of a single phenomenon, may have some "generic qualities" (p.121) that could positively affect the transferability and relevance of the research. Chandra and Shang (2019) also agree that though Gioia's grounded theory approach has been predominantly single case focused, it can be equally useful within multiple case study approach. A few examples of the studies that articulated the Gioia approach in grounded theory are Corley and Gioia (2004); Gioia and Thomas (1996); Hiemer and Andresen (2019); Nag et al. (2007); and Patvardhan et al. (2015). Below is a tabulated presentation (Figure 1) of the grounded theory approach of Gioia et al., (2013).

Features of the Methodology That Enhance Grounded Theory Development.

Step[a]	Key Features
Research Design	• Articulate a well-defined phenomenon of interest and research question(s) (research question[s] framed in "how" terms aimed at surfacing concepts and their inter-relationships) • Initially consult with existing literature, with suspension of judgment about its conclusions to allow discovery of new insights
Data Collection	• Give extraordinary voice to informants, who are treated as knowledgeable agents • Preserve flexibility to adjust interview protocol based on informant responses • "Backtrack" to prior informants to ask questions that arise from subsequent interviews
Data Analysis	• Perform initial data coding, maintaining the integrity of 1st-order (informant-centric) terms • Develop a comprehensive compendium of 1st-order terms • Organize 1st-order codes into 2nd-order (theory-centric) themes • Distill 2nd-order themes into overarching theoretical dimensions (if appropriate) • Assemble terms, themes, and dimensions into a "data structure"
Grounded Theory Articulation	• Formulate dynamic relationships among the 2nd-order concepts in data structure • Transform static data structure into dynamic grounded theory model • Conduct additional consultations with the literature to refine articulation of emergent concepts and relationships

[a]The Research Design and Data Collection steps are moderate variations on traditional grounded theory approaches. The Data Analysis and Grounded Theory Articulation steps constitute the main distinctive features of the approach.

Figure 1:Gioia's grounded theory approach (Gioia et al., 2013, p. 26)

Gioia et al. (2013) suggested that their approach is not a "cookbook", or a strict method, but a methodology of theorizing in qualitative research. If Gioia's approach to grounded theory may be accepted as a methodology (Gehman et al., 2018) then researchers have to move beyond the mere application of the qualitative template in it into "the systematic perusal and problematization of the template's underlying paradigmatic and methodological suggestions to suit the research situation" (Balachandran Nair, 2021, p. 412). Accordingly, I will be using Gioia's methodological approach in conjunction with the insights from the constructivist grounded theory described by Charmaz (1990,1996, 2006) to develop a comprehensive integration of the grounded theory methodology with important elements of a case study approach.

3.3 The Working Flow of the Gioia Method of Grounded Theory as Applied in this Study.

The Gioia approach (Gioia et al., 2013) of grounded theory starts with the "get in there and get your hands dirty" (p. 19) approach in data collection. It refers to staying close to the language of the participant(s), purposefully using their language to understand their lived experience. Whether approaching from a single case or multiple case approach, the most pre-dominant data collecting method is in-depth interviews (Gioia et al. 2013). In this study a clearly

articulated phenomenological lens (Seidman, 2006) was followed in the preparation and conduct of the in-depth interviews, along the guidelines proposed by Charmaz (2006) for conducting grounded theory data collection. At least two hours were allocated for each interview and open-ended questions were posed to each participant encouraging them to share their story without being interrupted.

The transcribed interview data evolve into a large number of terms, concepts and codes and the researcher tries to be fully loyal to the participant terms in organizing them. In order to ensure that the data maintained loyalty to the participant stories, all the participants were offered the opportunity to undertake a member check of the transcribed data. Any suggested changes and corrections were then incorporated into the text. Gioia's approach calls the first order analysis similar to Strauss and Corbin's (1990) idea of open coding. Simultaneously with the initial data gathering and coding we also begin the cyclical process of constant comparison between the emerging data, themes, and concepts with the purpose of finding new themes towards theoretical sampling and data saturation. This phase is enriched by a serious commitment to the grounded data even to the extent of a "willful suspension of belief concerning previous theorizing" (Gehman et al., 2018, p. 291). As Gioia states in Gehman (2018), "Anyway, my opening stance is one of well-intended ignorance. I really don't pretend to know what my informants are experiencing, and I don't presume to have some silver-bullet theory that might explain their experience" (p. 291). The first order findings bring forth the rich narrative of participant experience, disclosing their meaning systems and their insight into the process. I have used in-vivo and incident-to-incident coding methods in my first order analysis (open coding) phase to reproduce as closely as possible the participant voices which later emerged as snapshots of participant experiences and case vignettes.

Moving from a descriptive process in "open coding" or "first order analysis" to a more theoretical analysis process in evolving second order themes and categories which entails a high level of abstraction. This is same as the notion of "axial coding" (Strauss & Corbin, 1990). This process will bring down the codes and categories into a manageable number of categories. This study pooled the codes and categories into manageable themes, reflecting both positive and negative sides of them (see Table 7-Data Structure). Continuing with the initial data gathering and analysing phase, the theoretical level of analysis through themes, and narratives with a theoretical wondering of "what is going on here?" would shed light on themes and their tentative

connections. In the subsequent interviews the researcher would be looking for these themes and connections through a process of "theoretical sampling" (Glaser & Strauss, 1967). Continuing through various interviews, the researcher would find a convincing set of concepts and themes which appears to repeat in different cases and doesn't produce any new concepts or themes. This stage would mean that "theoretical saturation" (Glaser & Strauss, 1967) had been reached. The comparison table (Figure 4), together with memos for each participant, helped me to visualise the categories and themes that were being repeated, ensuring saturation in the process. It is at this stage that the researcher may stop interviewing any new participant and starts to see if the second order themes/ categories can be further distilled into core categories or "second order aggregate dimensions" (Gioia et al., 2013, p. 20).

The third step in Gioia's grounded theory approach is building data structure. Once we have completed the interviews and data collection, finalised the transcription and coding of all and developed the first order terms (open coding), second order themes or categories (axial coding) and aggregate dimensions (core categories) we have everything needed for building the data structure. Gioia (2013) considers a data structure which shows the progression from the raw data to first order codes and second order themes and aggregate dimensions as indispensable in this approach: "you got no data structure, you got nothing" (Gehman et al., 2018, p. 286). However, the data structure is the "static picture of a dynamic phenomenon" (Gioia et al., 2013, p. 22) which doesn't yet explore the process. Table 7 shows the data structure arrived at in this study, and it was this, in conjunction with the theoretical memos that helped develop the study's grounded theory model.

The building of a dynamic model of grounded theory which is grounded in the participant experiences and theoretical patterns is possible by making this static picture into a dynamic motion picture (Gioia et al. 2013). This is achieved by building the model which represents not only the concepts, themes and dimensions as presented in the data structure but also demonstrating the dynamic relationship between these different emerging concepts enriched by the guiding theoretical insights which are not obvious in the data structure. Accordingly, the grounded theory can illustrate the "data-to-theory connections" (Gehman et al., 2018, p. 286) for the readers and reviewers of a research. Thus, the grounded theory model would not only exhibit deep structure, deep processes and but also their interconnections (Gioia et al, 2013). The

transition from the data structure to the theoretical model in this study appeared as a very useful process.

Within the Gioia et al. (2013) approach to grounded theory, the writing of the findings and discussion has a significant story telling nature. The writing should be "intellectually compelling-and sometimes emotionally compelling-story on the basis of transparent evidence" (p. 23). In order to achieve the above stated goal, the findings are "suffused with informant quotes-quotes that align with the exemplars shown in the data structure" (p. 23). Gioia (2021) places the priority on informant voice in every step of the research:

> Researchers need to make a conscious effort to adequately give voice to informants' understandings in the research and also to adequately represent informant voices prominently in the reporting of the research (by directly quoting your informants throughout your reporting of findings. (p. 22)

Following the above understanding of Gioia's approach in integrating the participant voice in a rich and meaningful way, I have made the methodological choice of integrating the use of snap shots of participant experiences, participant direct quotes and appropriate use of representative case vignettes into this study. Though this can be challenging to a traditional application of grounded theory, is within the ontological and epistemological possibilities as explained at the beginning of this chapter. The findings' section will devote space to each emergent dimension by highlighting the emergent concepts and themes within them using snapshots of participant experiences and representative case vignettes. This section will show the progression from the static picture to the dynamic process in the grounded theory work. Integrating case vignettes in this dissertation is also an effort to honour the participant stories (Gioia et al., 2013), which otherwise may be lost into codes and categories.

The role of the discussion section is to bring meaning into the model. This is achieved through discussing the implication of the dynamic process, comparing the concepts and the process with existing ideas, concepts and theories found in literature and other sources. Even at this stage, this study incorporates some of the participant experiences in order to enumerate the discussion points. While highlighting the participant's voices throughout the study, a more systematic approach to analysis and writing is adopted using Gioia's approach to show the reader the connection between raw data to emergent theory in a more convincing manner. The

following figure (Figure 2) shows the application of Gioia et al. (2013) approach within the constructivist paradigm proposed by Charmaz (2006) as it applies to this study.

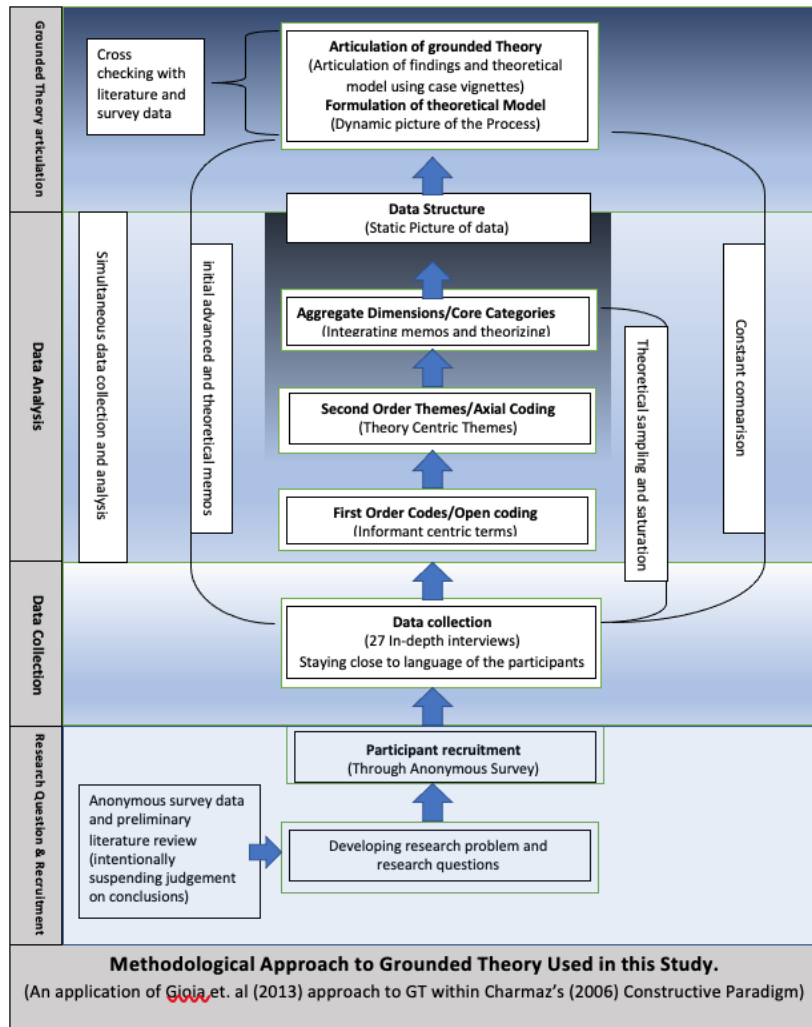

Figure 2: Methodological approach to Grounded Theory used in this study

4. The Research Design

4.1 The Research Setting

This research targeted direct care nursing professionals from different provinces of Canada, mainly Ontario, British Columbia, and Alberta. The nurses participated in this research in their personal capacity even though they worked in different institutions. The interviews took place during September, October, and November of 2020, which was a few months after the onset of the first wave of COVID-19 in Canada in March 2020. The data collection for this research happened through online audio/video in-depth interviews.

4.2 Participant Recruitment and Data Collection

The most concerning aspect of participant recruitment was the challenge of finding study participants who admit to having experienced a negative phenomenon-compassion fatigue. Keeping participant confidentiality appeared daunting with the initial plan of conducting the research in their respective health care institutions. However, the idea of using an anonymous online survey platform emerged as the solution to the issue. The decision to do online research also resulted from the ongoing COVID-19 situation in the country.

After having completed the ethics approval processes through the Lakehead Research Ethics Board (Appendix i), I circulated a poster and link to the anonymous online survey in selected social media platforms, association websites, and personal networks through a passive snowball sampling approach. The poster included sufficient detail about the context, content, and nature of the research. In addition, a consent document to be signed before starting the survey was included. The anonymous survey aimed at serving two purposes, namely, providing a safe and effective medium for participants to self-recruit themselves for the in-depth research interviews and working as a comparable pool of data both to compare the emergent grounded theory findings in conjunction with the literature, and to partially inform the formulation of the research problem and questions. The survey data was not intended to be used directly to influence the emergent grounded theory at any stage, as an intentional suspension of judgement on any conclusions arrived at from any data, other than the in-depth interview was embedded in the research design. Most of the questions in the survey were demographic inquiries, and a few questions addressed the prevalence, potential definition and characteristics of compassion fatigue as experienced by the nurses who worked during the COVID-19 pandemic. One of the questions was an inquiry into the participant's willingness to share their experience of compassion fatigue through an in-depth interview with the researcher. A demographic form was included as part of the anonymous online survey (Appendix iii). The survey was conducted using a secure, Canadian-based survey platform called Hosted in Canada Surveys.

The inclusion criteria for a potential participant in the survey were direct care nurses, educated in any specialty, working in any health care department in the Canadian health care system, working or having worked during the COVID-19 pandemic and have experienced compassion fatigue some time in their career. Appendix iii includes the anonymous survey information and the anonymous survey questionnaire. The study involved all genders, age

groups, years of experience, and different social support systems. The survey covered most provinces in Canada in a limited fashion. Three hundred and five nurses from eight provinces of Canada, a significant majority of them were from Alberta, Ontario and British Columbia participated in the anonymous survey. See appendix x to review the anonymous survey demographic data.

Within the initial anonymous survey, any participant had the opportunity to self-recruit themselves by consenting to be contacted for an online, face-to-face audio/video in-depth interview. The survey participants who chose to participate in the interview were encouraged to provide their email and contact phone number. Prior to the interview, the participants were given full interview details through an information cover letter (Appendix vi). At the beginning of the interview, an informed consent document elaborating the potential benefits and risks of participating in the study was reviewed with the participants. Seven of the interviews lasted between 90 minutes and two hours and the remaining 20 interviews took between 60 to 90 minutes to complete. A demographic questionnaire similar to the anonymous survey demographic questionnaire was used to collect demographic characteristics of the participants (Appendix vii). I used informed consent with participants on an ongoing basis at every data collection step. The interview was done through an online, Canada-based secure telehealth platform called Janeapp. The choice of audio, video or both was according to the personal preference of the individual participants.

Following the requirements of grounded theory, the sample size was undetermined (Murphy et al., 2017) as anywhere from 15-25 depending on the process of theoretical sampling and theoretical saturation. As the study progressed, the theoretical sampling strategies narrowed down emerging themes and looked for the emergence of any new concepts. Theoretical saturation was attained little above the targeted sample size. Around 80 direct care nurses expressed interest in being interviewed through the anonymous survey portal. Even though there was a good initial response for participating in the interviews, in further communications many potential participants withdrew, expressing constraints of time and their work and/or family responsibilities. Some of the nurses who gave their emails to be contacted didn't respond to my interview scheduling communications. At least three reminders were sent to the 80 nurses who expressed interest in scheduling a time for interview. Each time I received responses for an available interview time. After completing the interviews, I would repeat the process to develop

another pool of nurses to work with. This process continued for around three months. This arrangement was helpful for ongoing data analysis, theoretical sampling and deciding saturation. No individual who expressed an interest in participating in the interview process was turned away for any reason. After having achieved saturation, I decided not to send any more reminders to the remaining pool of potential participants. In this way, I believed that whoever wanted to be part of the research were given ample opportunity and no one was turned away from participating. After interviewing 27 nurses from various backgrounds, ages, specialties the data collection process ended. At this stage it was clear that there was no new information contributing the emergence of any new concepts of categories. This indicated theoretical saturation and the rationale for ending the interview process.

The researcher addressed any concerns or questions regarding the interview at the start of the interview and provided resources, such as a list of counselling professionals and support programs, in case of distress during, or after, the interview. In addition, a set of questions as an interview guide facilitated the interview process which was used by the interviewer and not shared with the participants. After the interview, there was some time given for feedback and debriefing. The participants were informed about member check-in after the transcription of the interview data. I also obtained consent from them to return to them with any requirement of further data to facilitate ongoing data collection and analysis, theoretical sampling, and saturation. Charmaz (1996) speaks about the need to go back to participants to collect more data if there is a lack of required data, even though the researcher has already collected data. However, I did not have to conduct a second interview for any participant even though all participants had consented to provide more information if needed at any point in the research. The reasons for not having to conduct a second interview stemmed from four factors. First, every participant was given sufficient time for the in-depth interviews, along with additional time for any feedback. Second, after transcription of the interview data, it was shared with the participants for member checking and the opportunity for any further clarification. Third, any questions that emerged from the initial analysis of the interview data for me as the researcher was clarified in the subsequent interviews. And fourth, the in-depth interviews were comprehensive, covering the life story of participants, their experience of the phenomenon and their interpretation of the phenomenon.

The interviews were initially transcribed using the transcription software Otter.ai, after which I manually went through each interview data for further cleaning up, organizing and de-identifying sensitive personal or institutional information from the document. Subsequently the transcribed documents were sent to participants for member check and clarification (Appendix xii). The interviews were conducted virtually, where the participant remained in their preferred personal setting or any other place of participant's choice that is comfortable, safe, and quiet.

4.3 In-depth Interviews

Charmaz (1996) asks the grounded theorist to collect "rich, detailed data … [and} … thick" (p. 32), written narratives of the participant's experiences through observation, interview, or other means. Data for this study were collected through an online face-to-face in-depth audio/video interviews and personal research memos. This research used in-depth interviews (Appendix viii) as the primary method of research data collection. Charmaz and Belgrave (2012) agree that in-depth interviews are a right fit for grounded theory research. I used a semi-structured interview format for this study as it is the most appropriate for exploring experiences by allowing the participants to speak of their experiences more descriptively. For Seidman (2006), the purpose of in-depth interviewing is not finding answers to the questions, rather it is "understanding the lived experience of other people and meaning they make of that experience" (p. 9). Accordingly, at the heart of interviewing is the interest in other people and their emerging stories during the process. Further he states that, "Their stories defy the anonymity of a number and almost that of a pseudonym" (p. 9). Taking this suggestion seriously, I have preferred to use pseudonyms to mere numbers for referring to each participant. In the selection of pseudonyms, though the choice of names was random, I have made sure to keep the first alphabet of the participant's name intact for the pseudonyms, and maintain the gender provided by the participant. This process helped me honour individual participants and keep the process simple.

According to Charmaz and Belgrave (2012), the emergent and flexible process of the interview has a sense of "control and flexibility" (p. 676), which is particularly suitable for grounded theory. Thus, control and flexibility are mainly achieved through using an interview guide which allows for modification after each interview. Within the semi-structured approach, I was able to flexibly use, or not use, certain questions to assure the quality of in-depth conversation and the comprehensiveness of the data collected. It was also necessary to make sure that I was not pushing a subjective agenda anytime during the interviews.

The interviews were conducted using the open-ended format guided by grounded theory interview questions suggestions (Charmaz, 2006) and phenomenological interview recommendations (Bevan, 2014). I used a set of guiding questions (Appendix viii) as formulated according to Charmaz (2006) and Bevan (2014) to keep the interview focused. The number of questions included in the questionnaire was broadly open-ended, focusing on the participant's experience and helping the participant reflect on the research phenomenon, namely compassion fatigue and compassion. Each participant was invited to add any more information if not sought during the interview. Following the interview structure proposed by Seidman (2006), the interviews were divided into three phases, focused life story, description of experience and description of the meaning of the experience. This structure also facilitated the grounded theory approach for gaining insight into the deep structures and processes of a person and their experiences.

The following is a tabulated presentation (Table 4) of the researcher's interview process while formulating interview questions.

Phenomenological Attitude	**Researcher Approach**	**Interview Structure**	**Method**	**Example Question**
Phenomenological Reduction (*Epoche*)	Acceptance of Natural Attitude of Participants	Contextualization (Eliciting the Lifeworld in Natural Attitude)	Descriptive/Narrative Context Questions	'Tell me about becoming ill,' or 'Tell me how you came to be at the satellite unit.'
	Reflexive Critical Dialogue with Self	Apprehending the Phenomenon (Modes of Appearing in Natural Attitude)	Descriptive and Structural Questions of Modes of Appearing	'Tell me about your typical day at the satellite unit,' or 'Tell me what you do to get ready for dialysis.'
	Active Listening	Clarifying the Phenomenon (Meaning Through Imaginative Variation)	Imaginative Variation: Varying of Structure Questions	'Describe how the unit experience would change if a doctor was present at all times.'

Table 4: A Structure of phenomenological interviewing (Bevan, 2014, p. 139)

5. Exemplary Use of Core Processes of Grounded Theory

Beyond the fact that grounded theory is an inductive theory building approach used in qualitative projects, unlike many other methodologies, the core principles of emergence, constant comparison, theoretical sampling, and theoretical saturation makes it a unique methodology

(Murphy et al., 2017). Understanding these principles and using them effectively was one of the most challenging, yet fulfilling, parts of this work. Even though there are various models of grounded theory, these principles are uncontested across those models and therefore faithful adherence to it during the preparatory, data collection and analysis stages is extremely important.

5.1 Emergence

The concept of emergence means that the researcher is open and receptive to the possibility of new data during the data collection and analysis phases (Murphy et al., 2017). The researcher needs to intentionally keep away from zeroing into a particular set of ideas, or concepts, and rather keep watch for anything that is emerging through the iterative data collection and analysis process. Murphy et al. warn about the danger of discarding new information as an outlier during the process as it is sometime practised in quantitative work. Rather, the researcher is advised to "follow the data" (p. 294) in the direction of the theoretical thread with the most potential. Birks and Mills (2015) state that this strategy of data collection and analysis is one of the salient features of grounded theory that makes it unique compared to other methods where data is collected initially and analyzed at the end, or which starts with a theoretical assumption to collect data prescribed by it. Charmaz (1996) suggests a simultaneous collection of data and analysis, enabling the researcher to focus the data collection on the emerging analysis.

One of the ways that I encouraged the principle of emergence during the data collection is by being flexible and open minded to each participant's story. This involved giving the participant the space to make the connections that they found appropriate by encouraging them to talk more on those areas, even to the point of me resisting the thought that the conversation may be going off track. I also resisted defining concepts even when the participants asked for one, which in turn directed the conversation to allow for the emergence of new ideas. It was also facilitated by my stand of not rushing through but securing enough time for all interviews, as discussed above. During the analysis process, which essentially started after completing the third participant interview and continued throughout the data collection and analysis phase, I kept away from any one focus of the emerging data. Rather, I waited till the final stages of data analysis with the complete data, coded with categories and core categories (first order terms, second order themes and aggregate dimensions) to undertake the decisions for a data structure (Gioia et al., 2013) and the emerging model. This allowed the specific data sets to emerge

independently, which had connection to the whole picture in the final analysis. One example of this is that the causes of compassion fatigue were coded as safety related, stability related, and support related, which though initially didn't make sense but once the whole data set was available, I was able to find connections to the nurse's living and working environments. Similar to this was the experience of the COVID-19 specific codes, which stood alone initially, but made more sense within the whole picture as an acute stressor of the compassion fatigue experience.

5.2 Constant Comparison

Constant comparison (Glaser & Strauss, 1967) is part of the concurrent data collection and analysis process. The process of constant comparison involves various comparisons such as comparing data with earlier or later data, comparing interview statements with data inside the described incident, comparing observations with data in the interview, and so forth (Charmaz, 2006). The constant comparison may happen between the parts of the data with codes, between codes and categories, between categories and the core category, and finally in theoretical integration. This process continues until the grounded theory is formed. Usually, this is an induction process whereby various kinds of data are compared to build the theory.

There were a few strategies that helped me to keep the focus on constant comparison during the data collection and analysis phase. As constant comparison is an intuitive process mainly happening in the researcher's mind, my decision to do all the data collection within a span of three to four months helped me to retain memory of the participant conversations and the concepts, ideas, and theoretical formulations that emerged. This helped me develop an intuitive internal dialogue with the data and the kept open the possibility for me to go back to the participant to clarify as needed. Transcribing each interview and coding them immediately, kept the memory of those conversations further alive in my mind. The use of process and theoretical memos connected various elements of the data on an ongoing basis. As explained earlier, the use of a working tabulated form gave me a comprehensive view of all emerging cases and the themes and patterns emerged for an easy comparison. The use of NVivo software also helped in the constant comparison process as it made the data easily available on a single platform. Finally, the use of a codebook (data table) and the building of a data structure further propelled the constant comparison process which resulted in the theoretical model. The general approach of coding to positive and negative experiences, more connection oriented and less connection oriented, trauma and non-trauma related, COVID-19 and non-COVID-19 related, comparing between RNs

and RPNs, are some of the examples of the areas that actively reflect this process at work during the data collection and analysis phases.

5.3 Theoretical Sampling

While in the initial sampling, we establish relevant criteria to include, or exclude, participants, and establish a sample population representing the phenomenon. Theoretical sampling aims to provide data that explicates the categories. As Charmaz (2006, p. 100) states: "Initial sampling in grounded theory is where you start, whereas theoretical sampling directs you where to go". Through theoretical sampling, grounded theory "purposefully targets data sources—individuals, organizations, archival materials, and so forth—that are equipped to speak to certain aspects of the emerging model either in terms of validating, correcting, or extending it." (Murphy et al., 2017, p. 294).

Theoretical sampling is used in a constant comparative process to collect missing data to saturate a category thoroughly. A researcher must then decide both when, and how, to approach the new data. Theoretical sampling continues until the saturation of data happens at the category level. Theoretical sampling intends to look for "pertinent data to develop your emerging theory" (Charmaz, 2006, p. 96) and, whenever needed, go back to the research field, and collect more data to reach data saturation. According to Charmaz (1996), this process gives the researcher the ability to focus on relevant data right from the start and not collect unfocused data, which may overwhelm the researcher. She also suggests that this approach would give the researcher better control and focus of the research process.

The initial sampling of this study was facilitated by the anonymous survey which received responses from around 80 nurses who reported as having experienced compassion fatigue during their career and have worked during COVID-19. This large pool of potentially available participants made the process of theoretical sampling feasible. I was not worried about the availability of participants in case I needed more during the theoretical sampling process. Right from the beginning after the initial phase of theoretical sampling, I knew that I needed to explore the experiences of trauma and non-trauma related fatigue, connection and non-connection related experiences, COVID-19 and non-COVID-19 related effects and needed insights into nurses' compassion fatigue education from theoretical insights. The constant comparison process kept track of the saturated and non-saturated areas of the larger data.

After having completed interviewing the first three participants, I transcribed and coded, the interview data to develop the various initial codes and potential themes emerged from them. Through constant comparison between the cases, and the case data and literature, I found that the direction of the data collection process was not comprehensive enough. This initial exploration was made possible through several annotations (memos) related to the interview data (Figure 5); reading the interview data closely and conversing with my supervisor, such that the concepts and themes that needed further attention were revealed. There were themes like safety, connection, patient care approaches which needed further elaboration and more data. It also meant that the data was not reflective of several themes like trauma and non-trauma, and COVID-19 and non-COVID-19 related effects on compassion fatigue. Several questions also emerged, such as 'why should a nurse who experienced compassion fatigue find a need for re-engaging with the patient? What causes nurses to move away from bedside or direct caregiving? This process continued throughout the data collection phase until it reached saturation with the completion of 27 participant interviews. Below is an example of the initial theoretical sampling process.

experience of cf	1	P25
The effort to care patients who are scared brings in cf?	2	P25
reflective practice	3	P25
Able to recognize CF	4	P25
Theme of connection	5	P25
This participant shows ability to recognize CF	6	P25
participant speaks about the need for re-engaging with patients	7	P25
Speaks of compassion fatigue as something that occuring before burnout. Very similar to the burnout theory	8	P25
participant thinking about patient suffering	1	P26
personal safety as a theme here	2	P26
valuing compassionate direct care	3	P26
Risk and reward	4	P26
description of cf	5	P26
Reflecting about patient suffering	6	P26
Through the work in street nursing the participant is inspired to work for other causes	7	P26
desire for patient connection	8	P26
participant over identifying with patients	9	P26
participant thinking about patient suffering	10	P26
participant values the compassionate care inspite of CF	11	P26
desire to come back to patient care	12	P26
Overall in this case the theme of safety is very prominent. There are several mentioning of the word safety. The theme safet...	1	P27
not being protected is the reason for disengaging from helping patients	2	P27
The participant thinks that she can't work with patients in direct care	3	P27
participant is thinking about patient suffering	4	P27
participant thinks about patient suffering	5	P27
participant speaks of lack of safety, stability and support as the reason for her compassion fatigue	6	P27
As with many participants, there seem to have some clarity regarding what is compassion fatigue-the inability to care for ot...	7	P27
participant thinks that every nurse is to some extend compassionate but what makes the difference is the work enviornment	8	P27
participant has positive attitude to compassion but not sure if she would continue in direct care	9	P27
participant compassion experience is positive-growing up in church	10	P27
participant reflecting on patient suffering	11	P27
Absence of compassion made me compassionate	12	P27
The participant wants to go to nursing education as she thinks may be she can contribute there	13	P27
If we don't do enough we may end up not having enough bedside nurses	14	P27
Many nurses may be moving to other positions as they are not happy as bedside nurses	15	P27

Figure 3: Initial theoretical sampling example.

5.4 Theoretical Saturation

The concept of theoretical saturation is an extension of the theoretical sampling process. Rather than having a set number of research participants in mind, theoretical saturation demands that the researcher looks for any new concepts of categories, or dimensions, relevant to the

research question or the emerging theoretical model. Murphy et al. (2017) suggests that it is wrong to assume that saturation is achieved when no new insights are found after interviewing a certain number of participants; rather saturation needs to be accounted by "richness and completeness" (p. 294) of the data. They describe it as follows:

> On the basis of the knowledge gained during those initial forays into the phenomenon, grounded theorists oscillate between developing initial theoretical models of the interrelationships between constructs embedded within the phenomenon of interest and additional focused data collections designed to illuminate poorly defined aspects of the model. This process is stopped once theoretical saturation is reached, and the researcher has collected and analyzed enough data to fully develop a model to explain the phenomenon. (p. 294)

The various analytical efforts come to fruition in identifying core categories. The constant comparison and theoretical sampling bring in more elements that would call for data saturation in creating categories. Further coding and theoretical sampling make the categories and subcategories fully saturated and well developed. The categories are considered saturated once gathering new data does not add to the core theoretical categories or properties.

After having transcribed, coded, and analysed 27 sets of participant data, forming them into codes, categories, and core categories (first order informant centered terms, second order theory centred concepts and aggregate dimensions), and creating a data structure (Gioia et al., 2013) which is a static picture of the data, it was clear that I have sufficient saturated data on all the elements. It was also clear that the data has captured the diversity of persons, contexts and experiences related to the model. There were sufficient representative cases and concepts for both positive and less positive experiences which was essential to understand the process. It also showed a rich description of the phenomenon of compassion fatigue as represented in the literature. The work also painted a convincing picture of the process of compassionate care in relation to compassion fatigue. It appeared that the new data was not bringing anything new to be added to the already collected data other than one more exemplar for the concepts already present. It is at this stage that I intuitively knew that theoretical saturation was attained, and further data collection was not warranted.

6. The Role of the Researcher

As a researcher, my interest in pursuing this research on compassionate care and compassion fatigue was guided by two relevant thought processes. First, there was an intellectual involvement in the idea of compassion and its practice among human beings. Second, equally important was the search for understanding the fatigue experienced by various people in caregiving professions. Being a clinician who works with people through their suffering and traumas, I had already started a journey of understanding the issue of fatigue. In addition to my experience in health care, two of my siblings working in the nursing profession contributed to my interest in researching compassion fatigue among nurses.

Choosing a methodology embedded in constructivism was very important for me to bring my self-identity and experiences into the research and see the possible interaction with the participant stories. Given the experiential background of my work with people, it was essential for me not to take things for granted. This situation is well articulated by Charmaz (1996) where she says that one of the ways that the researcher can connect the lived experience of the participants with the research questions is by paying particular attention to the participant language and "avoid taking for granted that you share the same meanings as the respondent (p. 36)". Often reminding myself to pay authentic attention to the participant's voice without diminishing its unique experiential context helped me collect rich data through the interview process. Using the insight from Seidman (2006) regarding phenomenological case interviewing and closely listening to the participant stories to understand the meaning they attribute to their stories was essential for me to avoid blurring the experiential prism. Given the above situation, appropriate use of theoretical sensitivity and self-reflexivity was critical throughout this research.

Mills et al. (2006) describe theoretical sensitivity as the researcher's "level of insight into the research area" (p. 28). Theoretical sensitivity can help reconstruct meaning from the given data and separate between what is significant and not. Traditional understandings of grounded theory (Glaser, 1967) required researchers to enter the research data collection phase without any pre-knowledge in the area, and accordingly, the researcher needed to be *tabula rasa* or clean slate. Mills et al. (2006) think that this naïve suggestion is meant to treat uniquely the "unveiling of a separate entity called data" (p. 28). In the constructive paradigm, theoretical sensitivity is part of the expectation concerning the researcher. Theoretical sensitivity means the researcher's insight about themselves and the subject of their investigation. It would also mean intellectual

involvement in the subject area by learning literature and more profound reflections on the subject matter. The more a researcher can delve deeply into the research area, the better their theoretical sensitivity can be. Even though theoretical sensitivity helps the researcher in a substantial way, unique to the grounded theory methodology, the researcher discovers the analytical categories directly from the data, not from any pre-knowledge per se (Charmaz, 1996).

Just as the constructive paradigm encourages theoretical sensitivity, the researcher also needs to uphold a high standard regarding the interaction between the researcher and the participant data. According to Cutcliffe (2000), reflexivity refers to the researcher's understanding of the researcher privilege, rather than being separate from the data. The researcher comes to center stage in a constructivist grounded theory involving different parts of the theory construction process. That kind of privileged position in research demands that the researcher is more reflexive and aware of the blurring of space between the researcher and the data. Charmaz (2006) says, "constructivism fosters researcher's reflexivity about their interpretations as well as those of their research participants" (p. 131). The researcher is asked to take a reflexive stance regarding how their theories evolve, and their pre-assumptions and beliefs contribute to the codes, categories, and emerging theories. Charmaz reminds the constructivist researcher of the danger of importing pre-conceived ideas into their work if they are unaware of their assumptions.

7. Challenges of the Study

The research process posed several challenges to me during different phases. At the recruitment phase, the biggest challenge was to recruit participants interested in talking about their negative experience of compassion fatigue. The anonymous survey, which functioned as the recruitment platform, provided for detailed responses from the participants. Secondly, the initial proposal was prepared just before the COVID-19 pandemic, and I hoped to conduct it in person within hospital settings. However, the pandemic demanded I revise the proposal to suit an online investigation on the subject. In hindsight, the decision to do online research proved comprehensive and timely. I also had the opportunity to learn about the pandemic, which became an acute stressor to the nurses in their compassion fatigue experiences. The third challenge I faced was in the final phase of participant recruitment. Even though around 80 nurses expressed willingness to be interviewed and met the inclusion criteria, it was challenging to get subsequent responses for several reasons, including the pandemic itself. However, as per my initial plan of

recruiting 15-25 participants, I completed interviews with 27 participants as there was theoretical saturation achieved around that number. The final challenge was in the initial phase of the interview conversations. As I am a healthcare professional, I had to be cautious and intentional to ensure that the research participants get the best experience of a grounded theory qualitative interview integrated with phenomenological inquiry and not overshadowed by my professional practice. This was achieved as I kept a working framework of questions and stayed curious to know participant stories alive through the interviews.

8. Ethical Considerations

Canada's Tri-Council Policy Statement concerning researching with human subjects was the guide in making sure that the research was done as per applicable ethical principles of respect of human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, and respect for justice and inclusiveness (Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada, 2018). The safety and confidentiality of the participants were of at most importance. All efforts for safety and confidentiality were made in all phases of research, including data collection, analysis, and dissemination. Potential risks to the participants included emotional distress during or after the interview due to recollecting some uncomfortable feelings and memories. The interview duration was decided mutually with the participants to minimize fatigue and risks. As the researcher, I was ever sensitive to the emerging pandemic situation in healthcare and made sure to be flexible and open-minded during the recruitment and data collection phases. The research interviews ended with a debriefing protocol. Before the interview, written consent, including ongoing consent, was discussed, and signed. I discussed the benefits and risks of the interviews with the participants. The participants could withdraw from the study at any time without any impact on their career or self-reputation. Sufficient arrangements were made to facilitate support to participants in the event of any distress related to the research process by identifying therapeutic resources and personnel who would administer counselling and therapy to any participant that may have requested it. Fortunately, there was no instance of emotional distress with any participant at any phase of the data collection. Once the study data was collected, any personal identifiers were removed to assure the confidential nature of the data. The participant data was coded as separate cases with a simple numeric to represent

them at the analysis stage. The study data will be kept securely at the Lakehead University at least five years following the completion of the research.

The link between the researcher and participants is an important area of ethical consideration in qualitative research. The research process carries a certain amount of researcher bias, even in quantitative research. Larson (2009) speaks about the debate between deontological and utilitarian approaches to research. The focus on relationships becomes a way to deter the utilitarian approach to research where the participants are considered mere objects of study. Relationality is understood as the ethical approach to researching an Indigenous population (Kovach, 2009). The researcher's "reflexivity" (a reflective process to avoid ethically wrong actions) and "reciprocity" (the principle that speaks about giving back to the community as the practice of research) are part of the idea of ethics of relationality. I have been intentional about the ethics of relationality right from the beginning of the study.

One of the ethical considerations was approaching individuals who have had a negative experience, namely compassion fatigue, for this study. It was imperative to make sure that the research in no way influenced participants' personal, or professional lives. One of the reasons to consider doing an online data collection was to safeguard the confidentiality of the participants, which may not be guaranteed if it happened in institutions. During the Research Ethics Board review (Appendix i), this was one of the points that the committee wanted me to address for the safety of the participants.

As the study demanded some self-disclosure on a negative experience, it was crucial for the participants to self-recruit and avoid any influence on their decision in joining the research. The anonymous survey worked as an excellent choice in this regard. Keeping the survey anonymous was another suggestion by the Research Ethics Board for the integrity of the research and its participants. As the research investigates a negative phenomenon, it was also essential to address every participant without presumption with a positive attitude. Therefore, as revealed in my interview questions, I addressed everyone as compassionate caregivers and invited them to talk about their experience of compassion and compassion fatigue.

Another ethical consideration was not to guide the participants with a particular definition of compassion fatigue as the literature does not have a definitive definition. One of the interview purposes was also to describe the experience of compassion fatigue as the participants saw it. Therefore, to safeguard some level of neutrality with the data collection process, and intellectual

honesty, I resisted defining or describing compassion fatigue for the participants as evident from the interview guidelines. This is also congruent with the grounded theory research methodology.

9. Trustworthiness Criteria in this Study

Charmaz (2006) proposed four criteria, namely, credibility, originality, resonance, and usefulness to be met to make sure the trustworthiness of a constructivist grounded theory research. The criteria for assessing quality in grounded theory can vary depending on the version of it being used. The main difference between earlier versions of grounded theories (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1990) and the constructivist grounded theory of Charmaz (2006) in trustworthiness criteria is the positivist expectation on theory; theories that can explain, predict, and be generalized. Charmaz (2006,2014) contrasts this expectation on theory with a constructivist/interpretive definition of it. Accordingly, grounded theory within the constructivist paradigm aims to understand meanings and actions and the way people construct them. The subjectivity of both the researcher and the participant are valuable and similarly the social, historical, and interactional location is of greater importance. The differences in epistemologies and aims need to be accounted when we are evaluating quality or discussing trustworthiness criteria in grounded theory (Charmaz & Thornberg, 2020). Charmaz (2006) proposes credibility, originality, resonance, and usefulness as the four criteria to ensure trustworthiness of a constructivist grounded theory research. The following section will elaborate on how these criteria is adhered to within this grounded theory research.

Credibility stands for both the data and the researcher. While having sufficient data, making systematic comparisons throughout the research, and developing a thorough analysis (Charmaz, 2006) is contributing to the credibility of the research, the very approach of the researcher towards the data is the most significant. The researcher's own trustworthiness is reflected in "strong reflexivity" (Charmaz & Thornberg, 2020, p. 12)-the awareness of the researcher on how some of their personal believes can influence the research process and "methodological self-consciousness" (Charmaz, 2017)-the knowledge and ability to self-scrutinize researcher decisions within grounded theory. As suggested by Charmaz (2006) as starting point of attaining credibility, the effort to achieve "intimate familiarity with the setting and topic" (p. 182) is visible in the use of a specialized interview guiding questions which maintained a phenomenological angle and constructivist philosophy. Being an online interview process, special care was given in the interview question structure to reveal not only the topic but

also the setting of the participants. The interviews used the three-phase structure of Seidman (2006) which inquired on focused life story, description of the experience and the description of the meaning of experience. I have also made extensive literature review to understand the subject of compassion and compassion fatigue. The fact that my initial exploration of literature on compassion was published in reputed journal is an example of my serious engagement with the subject. The use of sufficient data, systemic comparison and thorough analysis is elaborated in the methodology and analysis chapters. I have placed in the introduction, methodology chapters and the concluding chapter my understanding of the researcher location, reflexivity, and methodological consciousness. The choice of using a phenomenological angle within constructivist paradigm throughout research, analysis and writing is reflective of my use of reflexivity and methodological consciousness.

Originality stands for new insights or fresh conceptualization of an already recognized problem. Charmaz (2006) would ask, “Are your categories fresh? Do they offer new insights? Does your analysis provide a new conceptual rendering of the data? And What is the social and theoretical significance of this work?” (p 182). This research has investigated an already existing issue of compassion fatigue. The fresh look at this subject is made possible by simultaneously exploring the experience of compassion within participants. What is new is the understanding that fatigue commonly experienced among nurses as an outcome of their caring activities may be coming through two etiologically different sources and understanding of it will have significance not only addressing the stigma but also may promote efficient recovery channels. The research not only advocates for a cross correction in the theoretical approach to the issue of compassion fatigue but also brings awareness about most crucial place of the work environment in potentially mediating the negative or positive outcomes.

Resonance would mean that the constructed concepts are not only highlighting participant experiences but also illuminate others who have similar experiences (Charmaz & Thornberg, 2020). Charmaz (2006) asks, “Do the categories portray fullness of the studied experience? Have you revealed both liminal and unstable taken for granted meanings?” (p. 183). The categories reflect most of everything that as a researcher I came across within the study. I continued to rely on constant comparison and theoretical saturation through the research process with an eye on both the macro and micro environment revealed in the study. The use of Gioia method (Gioia et.al, 2013) in grounded theory helped me not to lose the participant voice rather

express the lived experience of participants more fully. Exploring empathy and compassion involved a difficult balancing act as those participant stories had "liminal and unstable taken for granted meanings" (Charmaz, 2006, p. 183) in them. Charmaz (2006) further inquiries whether researcher made links between individuals and institutions? My research highlights the involvement of the work environment as a very important agent within the experience of compassion fatigue. The emergent grounded theory model specifies this connection and its important within the whole study. The use of phenomenological lens in collecting, exploring, and explicating the results is aimed at connecting research with people who may share similar experiences. The use of vignettes in explicating the grounded theory model is aimed at furthering this process of making the research connect with the lived experiences of people in general.

Usefulness highlights the pragmatic philosophy of the constructivist paradigm. It questions whether the understanding of participant experience within the research has contributed to recommendation of meaningful changes in society by encouraging to public policy changes or within research community promoting emergence of new research lines. Though, achieving generalizability is difficult in qualitative research, the applicability of the research implications can be beyond the immediate environment of nurses. A close reading of the research would encourage researchers to look for similar processes and structures in other professional caring environments like educational institutions. As the study was done during COVID-19 the usefulness of it remains unique to any pandemic situation. This can also become relevant for policy making efforts. The research not only advocates for placing compassion fatigue within compassion literature but also speaks about the embracing a spectrum of compassion experiences referred to us self-referential and non-self-referential. This may have implications for the research community and can propel debates and discussions. The intentional clinical and pragmatic approach in the study is aimed at the usefulness of the theory in exploring and addressing caregiving fatigue among direct health care providers.

10. Concluding Remarks

This chapter has outlined and justified the methodology that has been applied to this study and the methods involved in collecting data. This chapter has also explored the philosophical and epistemological foundations of grounded theory inquiry and investigated the potential and scope of using Gioia's approach to grounded theory within the constructive paradigm. A detailed understanding of the methodology and methods has been hugely important

for me during this research. Though there are some prescriptive guidelines regarding grounded theory, a majority of the process is left to the researcher to both unravel, and then skein back together. I was simultaneously learning and practicing the methodology and methods through this research. Being aware that I could fall into blind spots helped me to be cautious in every data collection and analysis step. The next chapter goes into the specificities of data analysis with examples of codes, themes, and categories from the study.

CHAPTER IV

DATA ANALYSIS AND RESULTS

1. Introduction

This grounded theory study had three main purposes, namely, a) to examine the experience of compassion fatigue, its reasons, processes, and effects; b) to understand the role of compassion within the compassion fatigue experience of nurses who engage in a direct caregiving role with patients; c) to build a theoretical model of the compassion fatigue process grounded on the data provided by the participants. Following these goals, the grounded theory analysis focused on the common themes of connection within the formative years of each nurse's life and the recovery strategies which the nurses applied in dealing with compassion fatigue during their work lives. The analysis also closely explored the contexts of safety, stability, and support in the workplace, as they are related to the delivery of compassionate care and the experience of compassion fatigue. The detailed primary analysis of the data produced four separate groups of codes. They are 1) Initiation-focused codes, 2) praxis codes, 3) outcome codes, and 4) recovery-focused codes. In addition, a separate set of codes on the influence of COVID-19 on the participant experience was also developed (This would appear in the finding section (Chapter V) as COVID-19 specific themes). The analysis has integrated both pandemic related and non-pandemic related experiences into the emergent grounded theory model of nurses' multiphase compassion fatigue process. A detailed description of data analysis is presented in the following sections.

The data analysis process of this study follows the grounded theory approach of Gioia et. al, (2013) within the constructivist paradigm (Charmaz, 2006). Though all grounded theory models follow similar analysis process, there is an intentional place for exploring and analysing the co-constructed reality in the constructivist grounded theory. Charmaz (1996) reminds us that the uniqueness of grounded theory is that the researcher derives the categories directly from the grounded data and not from any other sources. Charmaz does not believe that the categories emerge independently of the researcher; rather, the categories emerge because of the "interaction between the observer and the observed" (p. 32). As the researcher is co-constructing data with the participants through constructivist grounded theory, the first question that the researcher

would ask at the level of coding is "what is happening here? (p. 32) and apply the data analysis process "through the prism of their disciplinary assumptions and theoretical perspectives" (Charmaz & Belgrave, 2012, p. 683).

Embracing an interpretive and constructive paradigm, Gioia et al., (2021) suggest that the reason to call the methodology grounded theory is "not because it is grounded in data (which obviously is important), but more importantly, because it is grounded in the informants' experience and their understanding of that experience" (p. 22). The uniqueness of Gioia's method is the extraordinary effort it places on giving voice to the participant in every stage of the grounded theory research. He recommends that it is "always important to grasp that when we do grounded theory, the intent should be to ground the emergent theory in the informant's understanding of their (constructed) world" (p. 22). Following this purpose, Gioia's approach to grounded theory analysis considers the "first order (informant centered) and second order (theory centered)" (p. 23) coding of the data.

2. The Research Data

The data for this study comes from 27 in-depth interviews with nurses drawn mainly from the Canadian provinces of Ontario, British Columbia and Alberta. All participants except one (who used a secure telephone line) were interviewed online using a secure video platform. The general advice for a grounded theory is to use multiple sources of data collection. Due to COVID-19, the in-person observation of the participant social interaction, a recommended approach to be used together with in-depth interview was not possible. The pitfall here is that the researcher may end up capturing only the lived experience regarding the phenomenon but not the social processes (Hussein et al., 2014). To mitigate this issue, the interview questions intentionally integrated an exploration into their social world of the workplace which is consolidated in coding mainly as the work environment.

This study concentrates on the data collected through the 27 in-depth nurse interviews, which reported conversations regarding the subjects of compassionate care and compassion fatigue. The following (Table 5) is the demographic overview of the interview participants.

Summary of Study Participants' Demographics

Participant Gender	
Female	26
Male	1
Other	0

Age Range of Participants	
26-35	8
36-45	8
46-55	4
56+	7

Job Type	
Full Time	15
Part Time	9
Casual	2
Currently Unemployed	1

Number of Years in Direct Care							
Number of years	Min	Max	1-10	11-20	21-30	31-40	41-50
Registered Nurse (RN) (22)	1.5	45	11	4	1	3	3
Licensed Practical Nurse (LPN) (5)	6	31	2	2		1	

Clinical Experience	
Practice Environment	Number
Emergency/ICU/NICU	7
Geriatrics/Long Term Care	2
Medical/Acute Care Surgery/Post Anesthetics Care	3
Mental Health	3
Nephrology/Hemodialysis	2
Labour & Delivery/Obstetrics/Hearing Test (infants)	4
Education/Public Health/Health Link	2
Oncology	1
Community/Parish	3

Educational Qualifications	
Registered Nurse (RN)	22
Licensed Practical Nurse (LPN)	5
Diploma/Advanced Certificate	10
Bachelors	16
Masters	1
Doctorate	0

Province in Canada	
Alberta	11
British Columbia	7
Ontario	7
New Brunswick	1
Québec	1

Table 5: Grounded theory study participants' demographics

3. Data Analysis Tools

For the analysis of this study, I primarily used a paper and computer combination. I used the qualitative research analysis software NVivo to organize the data, word document to register my notes and excel worksheets to arrange tabulation of data. During the analysis and writing phase, I also printed out participant data and exhibited like sticky notes for a comprehensive view of the data. I admit that there was some messiness regarding the process, however it evolved into a more systematic treatment of the participant data. This process helped me be in touch with my instinct to rely on multiple media and not entirely depend on a computer. The two supportive tools that helped the analysis process of this study were memos (process memos and

theoretical memos) and a tabulated form that registered the participant impressions during the interviews.

Memos are an integral part of grounded theory methods (Charmaz, 2006) and are building blocks into the writing of grounded theory. It is an essential step between data collection and the writing of drafts. They capture the thinking of the researcher through the whole process of study. Memos can be in different forms and different lengths. They may be well articulated or sometimes not so fully articulated. However, as they represent an ongoing thought process of the researcher through different stages of the research, they tend to have hidden gems in them. Memos will include the researcher's thoughts about interviews, observations, emerging theories, insights, observed gaps in the process, gaps in the information and the comprehensive comparison of various experiences during each participant interview. The researcher would explore their ideas as grounded on the data produced during the research processes reflecting the values, emotions, and honest account of the happenings. The memo-writing guides both theoretical sampling and the subsequent drafts. Memo writing is an essential part of connecting data collection, coding, and analysis in grounded theory. According to Charmaz, writing successive memos throughout the process helps the researcher to do constant analysis, and it helps to "increase the level of abstraction" (p. 72). The final stage enters sorting and integrating memos into creating a working draft of the grounded theory. It helps in the theoretical integration of the categories and points towards the final theoretical orientation. According to Murphy et al. (2017) memos can be great tools, not only in the analysis phase, but also for writing the findings too. They claim that memos can help the researcher figure out “which codes are likely to make for the best components of the model, as well as which data examples are likely to best illustrate relationships between those components” (p. 301).

The annotation tool in NVivo was used to report some of the memos during the analysis phase, and the ongoing process was jotted down as scattered notes to the paper trail of my study progress. During each interview, I took regular notes to track the general impression of the interview and the theoretical orientation of it. These notes, together with the notes on my ongoing dialogue exploring the research data with my dissertation supervisor, are used as theoretical memos in this study. While the process memos kept track of the process of data collection and analysis, theoretical memos inspired me to further reflect on the various connections of the data while staying grounded in the data. Another use of these memos is in the

context of theoretical sampling and theoretical saturation as suggested by Murphy et al (2017). It helped me to think about what kind of themes should I be focusing on the subsequent interviews. Further, it drove me to consider whether I had sufficiently exhausted the linkage of a charged concept or phenomenon at hand? Below is an example of memos in this study (Figure 2).

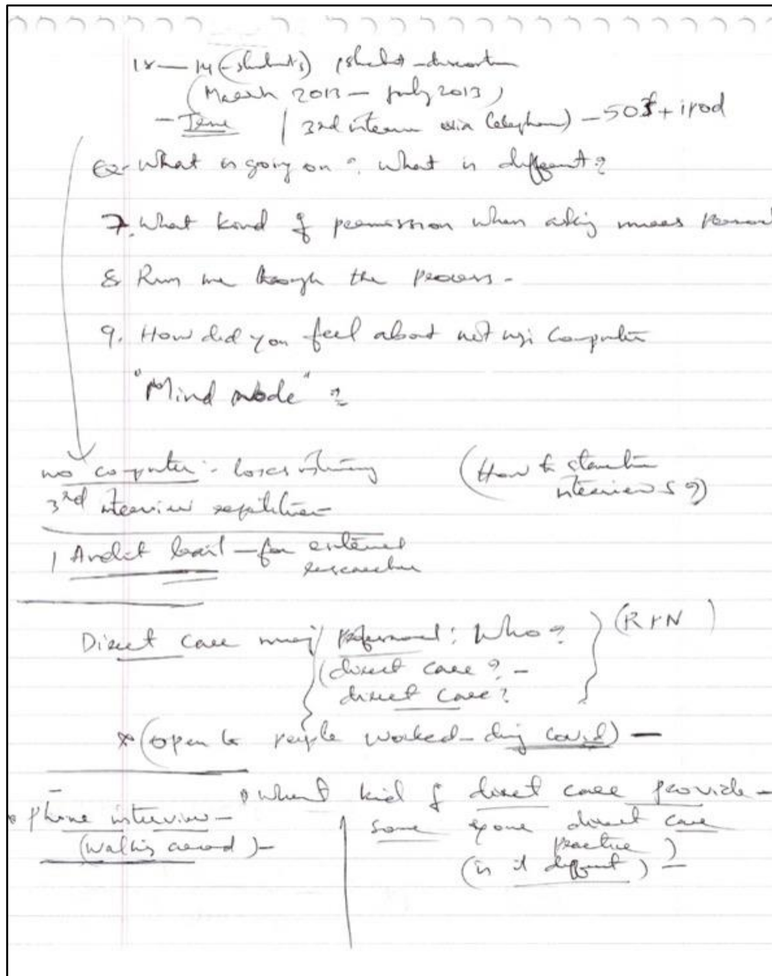

Figure 4: Example of a memo

Another supporting tool which helped me to become familiar with participant data was a tabulated form that I kept updated after each interview. This is a practice suggested to keep the possibility of better grasping the emergence of patterns and clusters in the study unit. This process helped me not only to have a comprehensive view all participants but also allowed “the between person patterns” (Murphy et al., 2017, p. 301) to the forefront. Below is an example of one of those tabulated forms (Figure 3).

1.26-35 RN, NICU, NB, 6 Desire to connect-compassionate care (compassion in childhood, adulthood, spiritual language, positive on universal compassion) Break of safety net (covid, non supportive environment) Compassion Fatigue- inability to connect- causing Job dissatisfaction- risk and reward Desire to connect -Recovery	**2. 36-45, RN, ICU, AB, 8** Desire to connect-nature of connection, personal exp of compassion, patient ex compassion, team work Fear of Covd patients/repeated death Reflective practice, support of team, felt personally protected Back to reconnect, worried about community, **Risk and reward**	**3. 36-45, RN, Heamo, BC, 7** Desire for connection: (connection to patients, navigating through death Personal ex of compassion) Death (as loss of connection) convid fear and anxiety CF Time for self, desire to connect, recovery
6. 56+, RN, Edu & Public H, AB, 45 Desire to connect? (contributing to community, need to be needed) Compassion exp. Happy and cared childhood, ICU exp. (over identification) and covid generalized fatigue Compassion Fatigue Changing jobs, break from work Desire to connect? Is it Compassion Fatigue? Wants to call it so	**7. 56+, RN, Post anesthetic & Union, ON, 33** Desire to connect- nature of caring - compassion ex in childhood, safe stable family, Death exp. Overwhelming demands on the nurse, over involvement with patients CF Reaching out to others to share exp, desire to connect, reflective practices-recovery **Risk and reward**	**8. 46-55, LPN, Acute-Hearing kid, AB, 31** Desire to be effective-sensitive to patients, safe and stable home Over involvement with patient story (is it connected to people pleasing), worry of personal effectiveness, neglecting oneself, non-support, repetit (language of emptiness is not present) Compassion Fatigue? (generalized tiredness)-caring for everyone and no for oneself. Learning balance, desire to be effective-recovery (desire to connect-absent)
11. 56+, RN, NICU, QB, 45 Desire to connect, protect-nature of care (overprotective/caring) personal ex. Compassion-parents valued compassion, positive spirituality, universal compassion Compassion Fatigue -when no time to grief (finish caring), Having to move from painful ending to another beginning Takes a day after 12hour shift (worked part time)-reconnecting, rebalancing **Risk and Reward**	**12. 56+, RN, Parish, ON, 10** Desire to care/connect -nature of care in patient work, compassion in personal life, spiritual language, universal compassion positive Compassion Fatigue-Overload of demand/responsibilities, compassion is obstructed Moved into another job-finally came back to people caring jobs	**13. 46-55, RN, Community, BC, 24** Desire to connect-nature of compassion in care, personal life (safe and s family) spiritual language positive, universal compassion positive Compassion Fatigue: due to covid related chaos and non-compliant pati (safety) like chaos Try to talk about it, spiritual care, Recovery through connection
16. 36-45, LPN, Maternal, AB, 13 Desire to give (desire to connect?) -nature of care-giving, childhood giver to all, examples parents givers, Universal compassion-everyone deserves Compassion Fatigue: due to overload of work (identifies as lack of safety and pre-occupation) (safety-theoretical formulation-altruism)	**17. 36-45, RN, Nephrology, BC, 8** Desire to connect? Or advocate for patients: effort to connect-nature of care, personal ex. Mom's suffering, Universal compassion-some reflection Cf: when effort to give care/suggestions for it was obstructed (felt helpless) Recovery-contiued to advocate for clients	**18. 46-55, RN, Health Link, AB, 20** Desire to connect-personal childhood exp (negative), adult exp (positive of care (positive), Compassion Fatigue : caused by moral distress (fighting injustice around given to work, not able to care for self, not being supported (micro man work) Recovery-connecting with people **Risk and reward**

Figure 5: Data/Case comparison table

4. Coding: At the Heart of Analysis

Within grounded theory, coding can be considered the heart of the analysis. Coding, according to Charmaz and Belgrave (2012), "is a form of shorthand list of events and meanings without losing their essential properties" (p. 684). The constructivist researcher delves deep into the data, engages in different kinds of coding: line by line, in-vivo and incident to incident coding. The constructivist researcher uses mostly active terms while coding. Coding also refers to the elevation from the level of description to the level of conceptualization in a higher level of abstraction (Charmaz & Belgrave, 2012). Within the constructivist grounded theory, during coding and other analysis phases, the researcher follows the data. However, the researcher's interest, pre-knowledge and understanding of the subject are also reflected in the coding and subsequent processes. Thus, the researcher is in the analytical process with several "sensitizing concepts" (Charmaz & Belgrave, 2012, p. 683), and this is the necessity in constructivist grounded theory that emphasizes researchers "to be reflexive about the constructions-including preconceptions, and assumptions-that inform their inquiry" (p. 683). The researcher can either keep these concepts implicit or can make them explicit. For example, one of the key observations from the literature review and the anonymous recruitment survey was the presence of both traumatic and non-traumatic influences on the experience of compassion fatigue. The awareness

of this fact continued to influence me throughout my data analysis process. As Charmaz and Belgrave (2012) suggests, there will be three questions sensitizing these concepts in a researcher's mind throughout the process, namely, "(a) What, if anything, does the concept illuminate about these data? (b) How, if at all, does the concept specifically apply here? (c) Where does the concept take the analysis? (p. 684). Gioia et al. (2013) clearly emphasizes the need to give the participant voice sufficient representation. This can be ensured by the first order analysis being strictly informant centered language, while the second order analysis can bring in abstraction, researchers' interpretation, and theoretical/literature language. My approach to coding has been a mix of both approaches, wherever possible in the first order analysis/open coding I have tried to remain close to the participant language through in-vivo coding but when the descriptions were longer for a code, I used the gerund forms of the event or action. I also followed the incident-to-incident coding method significantly in this phase. In the second order analysis (focus coding and theoretical coding) I have used more abstract terms to conceptually represent the participant voice within the emerging context of meaning. An example of my coding practice is given below (Figure 4).

Caregiver motivation-Connection based

Desire to Care

desire to help patients
Grandparents going to palliative
I like caring for people
I love going to work,
I've never been in a situation where I didn't want to take care of something.
Loving job
more caring space in Long term care
more effort to care in COVID
motivation to nursing-desire to make a difference due to personal exp

Figure 6: Example of coding

5. Stages of Data Analysis

5.1 Stage One: First Order Analysis-Open Coding

Looking for essential words, phrases, groups of words, and sentences is the first stage of coding, called initial or open coding (Strauss & Corbin, 1998). Usually, the researcher codes the data line by line or as paragraphs without any preplan of categories. Coding can be done in-vivo, with verbatim quotes from participants or gerunds, phrases, or incident to incident coding. Gioia et al. (2013) discourages using theoretical or literature-based codes in the first order terms but recommends having exclusive informant centered language. As suggested by Charmaz (2006), in

certain situations, "coding incident to incident" (p. 53) is an appropriate way of doing the initial coding. Concerning the interview data, I have used the coding incident to incident approach in most places together with some line by line and in-vivo coding. Coding incident to incident approach may produce a smaller quantity of codes compared to other methods. In-vivo codes have been particularly useful in exploring nurses' experiences as there was a similarity of language regarding some explanations of the phenomenon.

The open coding or the first order (participant centered) coding was performed following grounded theory methodology (Charmaz, 2006; Gioia et al., 2013;). There were a total of 1581 codes spread in 2104 references within the open coded data. At this stage, I almost felt lost as there were huge amount of data which confuses and overwhelms. Gioia (2021) reminds that getting lost during this phase is an expected part of the process. The initial coding included exploring data in-vivo and incident by incident, searching for concepts patterns to precisely label the description of the data. During the coding, I tried to be faithful to participant language as much as possible to unravel the experiences and meanings of participants in the examined data. It used specific phrases to represent words, lines or sections of data presented by the participant. Initial coding involves studying "fragments of data-words, lines, segments, and incidents-closely for their analytic import" (Charmaz, 2006, p. 42). The initial data, the gaps discovered, and the properties of the categories that need to be explored was part of the ongoing data collection strategy. To ensure the fidelity of the codes, then, the grounded theorist typically uses a coding dictionary or data structure to give hierarchy to the codes (Murphy et al., 2017). I created a codebook using the NVivo software which listed all of the open, focused and theoretical codes. Below is the list of cases and codes in each dimension (Figure 6).

Cases and Codes

Formative Phase Codes

Participant Number	Number of Codes
Participant 01	22
Participant 02	14
Participant 03	17
Participant 04	17
Participant 05	17
Participant 06	6
Participant 07	9
Participant 08	12
Participant 09	8
Participant 10	9
Participant 11	14
Participant 12	9
Participant 13	11
Participant 14	15
Participant 15	13
Participant 16	14
Participant 17	9
Participant 18	14
Participant 19	6
Participant 20	9
Participant 21	22
Participant 22	14
Participant 23	12
Participant 24	7
Participant 25	9
Participant 26	9
Participant 27	12
Total codes	**330**
Total references	**454**

Praxis Codes

Participant Number	**Numb**
Participant 01	35
Participant 02	25
Participant 03	25
Participant 04	27
Participant 05	26
Participant 06	13
Participant 07	27
Participant 08	27
Participant 09	17
Participant 10	10
Participant 11	21
Participant 12	9
Participant 13	16
Participant 14	26
Participant 15	23
Participant 16	20
Participant 17	2
Participant 18	23
Participant 19	8
Participant 20	18
Participant 21	36
Participant 22	20
Participant 23	26
Participant 24	14
Participant 25	13
Participant 26	13
Participant 27	24
Total codes	**544**
Total references	**794**

Outcome Codes

Participant Number	**Numl**
Participant 01	24
Participant 02	17
Participant 03	21
Participant 04	17
Participant 05	17
Participant 06	12
Participant 07	17
Participant 08	30
Participant 09	14
Participant 10	16
Participant 11	7
Participant 12	17
Participant 13	16
Participant 14	24
Participant 15	13
Participant 16	10
Participant 17	9
Participant 18	5
Participant 19	13
Participant 20	14
Participant 21	32
Participant 22	13
Participant 23	14
Participant 24	10
Participant 25	11
Participant 26	15
Participant 27	21
Total codes	**429**
Total references	**525**

Recovery Phase Codes

Participant Number	**Numb**
Participant 01	10
Participant 02	10
Participant 03	4
Participant 04	1
Participant 05	10
Participant 06	5
Participant 07	2
Participant 08	6
Participant 09	4
Participant 10	6
Participant 11	3
Participant 12	2
Participant 13	1
Participant 14	6
Participant 15	2
Participant 16	3
Participant 17	4
Participant 18	2
Participant 19	5
Participant 20	3
Participant 21	8
Participant 22	3
Participant 23	8
Participant 24	3
Participant 25	3
Participant 26	1
Participant 27	5
Total Codes	**120**
Total References	**129**

COVID-19 Related Codes

Participant Number	Numb
Participant 01	10
Participant 02	10
Participant 03	9
Participant 04	3
Participant 05	8
Participant 06	2
Participant 07	0
Participant 08	9
Participant 09	2
Participant 10	2
Participant 11	1
Participant 12	2
Participant 13	2
Participant 14	15
Participant 15	12
Participant 16	8
Participant 17	1
Participant 18	10
Participant 19	2
Participant 20	3
Participant 21	11
Participant 22	3
Participant 23	16
Participant 24	8
Participant 25	3
Participant 26	2
Participant 27	4
Total codes	**158**
Total references	**202**

Figure 7: Cases and codes of this study.

Right at the beginning of the process, I realized that line-by-line coding might not be the best way to look at the interview data, as conversational data can be fragmented in each line. To have a congruent picture of the participant narrative, I used more in-vivo and incident to incident coding in the open coding. An example of NVivo code is "I just did not have it in me to call in sick and leave them short," which is representative of the struggle of a compassionate nurse who faces the issue of nurse shortage in the unit. An example of the incident-to-incident coding is "random auditing of personal protective equipment (PPE)," which referred to a situation where the nurses were being audited by someone from the health authority regularly, which increased the nurse's stress and affected their sense of safety. Instead of doing a relatively mechanical process of line-by-line coding, when I applied the NVivo and incident to incident coding approaches, it helped me be closer to the participant data, which was already familiar through transcription. The following table (Table 6) is an example of open coding within my research.

compassion fatigue Experience	Initial Open Codes
"My tank is on empty, and I have I have a lot less to give my family that I you used to be able to…".	My tank is empty
"I was starting to get impatient and brushing off concerns that were no longer important or seemed important, but obviously were important to my resident, but not to me. So, patience for me is the biggest telltale, but I have done, done more than enough. I can't do any more".	I cannot do it anymore.
"I mean, you get to the point where everybody needs a piece of you, right? When you're at work, everybody needs a piece and then by the time you come home, yeah, you're like, I'm done. Not only am I physically tired, but I'm also emotionally tired, I am mentally tired".	Everybody needs a piece of me.
"So, compassion fatigue, to me, is you can still do all of the physical tasks, but everything else behind it is a lot harder, connecting with the families, knowing the right thing to say, being able to reassure them with extra little things for the babies."	I do not have the drive to do extra.
"I just often feel like emotionally drained because I have to, like, be present for patients all day. And, and it's not a two-way relationship. It shouldn't be like, I understand that. As a nurse, I it's, you know, it's about the client's needs. It's not about mine, but it's like, you're just giving all day all day. Yeah. Um, and so yeah, I just, I feel like my emotions, I just feel really, like, just drained".	You are just giving all day, every day.

Table 6: Compassion fatigue experience (Open coding example).

Besides the coding process, I regularly kept memos and some informal notes in my research diary which continued until the last stage of the coding process, namely, theoretical coding. The constant comparative method helped me understand the patterns and themes slowly emerging from the open coding. Seeing that the factual data leads to more abstract analyses of the found patterns and themes, I realized that it was time for me to switch to focused coding. The open coding also appeared to represent all data sufficiently distributed within each case. It should also be mentioned that as my methodology (Gioia et. al (2013) approach to grounded theory within a constructivist paradigm (Charmaz, 2006) wanted to consider a case study flow within the data together with the grounded theory analysis, I also simultaneously created 27 case memos that described each case's biographical, developmental structure as a separate story. This approach safeguarded one of the concerns around the grounded theory approach in losing rich data to the abstract process in building the theory.

5.2 Stage Two: Second Order Analysis - Axial Coding/Focused Coding

Second order analysis (theory centered) (Gioia et al., 2013) or focused coding (Charmaz, 2006) is the second phase of the data analysis process, where the researcher discovers categories and subcategories from the initial codes. In focused coding, the codes that appear more

frequently and that appear to answer the research questions in some ways are used to "sift, sort, synthesize and analyze" (Charmaz, 2014, p 138) the complete data. There is more integration happening at this stage compared to the initial stage. For example, if the data were separated in the initial stage, there is an effort to connect the data and see the initial patterns in this stage. In focused coding, "we select what seem to be the most useful initial codes and test them against extensive data" (Charmaz, 1996, p. 42). Focused coding aims to identify the most important and frequently occurring initial codes to compare, synthesize, integrate, and organize the data. The codes are developed into core categories and are investigated for their impact and meaning to the participants.

Categories are considered saturated when the new codes do not form new categories but fit into existing ones. Another fundamental approach to coding is to observe the action in the data. Charmaz (1996) says, "Grounded theorists aim to analyze the processes in their data and thus aim to move away from static analyses (p. 35)". In this process, different layers of the participant action are unravelled like the "(1) stated explanation of his or her action, (2) unstated assumptions about it, (3) intentions for engaging in it, as well as (4) its effects on others and (5) consequences for further individual action and interpersonal relations "(p. 35). This way of looking at the meaning of actions throughout the analysis process helps the researcher arrive at appropriate categories. In addition, these kinds of codes help us to "preserve the participant's meanings of their views and actions in the coding itself" (p. 55).

If open coding is meant to zoom the data to a micro-level, focused coding is a process of zooming out by putting together data on a macro level. At this stage, the purpose is to highlight the emerging ideas and themes and categorize them without losing the essential meaning (Charmaz, 2014). Focused coding continues until categories are created, which emerge into significant categories and core categories. The focused coding phase makes the best use of the constant comparison process to distinguish between categorized data and connect them with other parts of the data. Selective coding or focused coding (Charmaz 2006) or second order analysis (Gioia et al., 2013) is more discriminating than the initial coding. The more frequently used codes are observed in their relationship and relevance to the emerging theoretical development. During this stage, the researcher can also connect the emerging categories with the memos, participants' experiences and impressions, the researcher's subjective interpretations and data from the literature (Charmaz,2006).

5.2.1 Main Categories and Subcategories Emerged Within Second Order Analysis/Focused Coding. The following section presents the main categories and subcategories/ second order themes (in tables) derived from focused coding. Each category table also shows how many participants' cases in total reflect a particular theme and how many coded references are in total. A detailed list of examples for each category can be found in the appendices (Appendix ix). Participant pseudonyms are used with the examples.

Nurse Motivation (Figure 7). Caregiver motivation referred to the intentions and aspirations of the nurses when they joined the profession. Some of those initial motivations, like the desire to care and connect, reflect a greater connection-orientation than motivations like the desire to advocate and protect.

▼ 1. CAREGIVER MOTIVATION	27	162
▼ 1. Caregiver motivation (connection oriented-more)	22	78
▶ Desire to Care	11	15
▶ Desire to Connect	18	63
▼ 2. Caregiver motivation (connection oriented-less)	26	84
▶ Desire to Advocate	11	15
▶ Desire to Protect	12	23
▶ Motivated by other reasons	22	46

Figure 8: Caregiver motivation

Nurses' Compassion Experience (Figure 8). Caregivers' compassion experience takes into consideration their personal experience of compassion, professional expression of compassion, attitude to universal compassion and some of the spiritual languages that the participants used regarding compassion.

▼ 2. CAREGIVER'S COMPASSION EXPERIENCE	27	199
▼ Caregiver's compassion experience -Positive	26	164
▶ More Compassion to Patients	6	8
▶ Positive Attitude to Universal Compassion	23	65
▶ Presence of Personal Experience of Compassion	25	62
▶ Presence of Positive Spiritual Language	17	29
▼ Caregiver's Compassion Experience-Negative	14	35
▶ Absence of Personal Experience of Compassion	7	13
▶ Absence of Positive Spiritual Language	6	7
▶ Less Compassion to Patients	5	10
▶ Negative Attitude to Universal Compassion	5	5

Figure 9: Caregiver compassion experience

Nurses' Ideas on Compassion (Figure 9). The purpose of asking the ideas on compassion was to understand the way nurses articulated compassion concerning their work with patients. It ranged from being present and involved in a patient story to doing extra and beyond for patients.

Code		
3. CAREGIVER'S IDEA OF COMPASSIONATE CARE	23	93
Compassionate Care (Non-Connection based)	4	7
COMPASSIONATE-Advocating for Patients	1	1
COMPASSIONATE-De-Stigmatization	2	4
COMPASSIONATE-Maintaining Balance	1	2
compassionate care ideas (Connection based)	22	69
COMPASSIONATE-Acknowledging Patient Suffering	6	8
COMPASSIONATE-Being Present	6	6
COMPASSIONATE-Caring for Small Things	3	6
COMPASSIONATE-Do Unto others... (Golden Rule)	2	2
COMPASSIONATE-Doing Extra, over and Beyond	5	5
COMPASSIONATE-Empowering Patients	1	1
COMPASSIONATE-Getting involved in Patient Story	4	7
COMPASSIONATE-Intentional use of compassion	5	7
COMPASSIONATE-Involving Patient and Family in care	3	4
COMPASSIONATE-Loving communication and Relation...	4	4
COMPASSIONATE-Loving patients and colleagues	7	10
COMPASSIONATE-Person Oriented	7	9

Figure 10: Caregiver's ideas on compassion

.

Nurses' Patient Care Approach (Figure 10). There are four themes included in the caregiver's patient care approach subcategory. It included the initial experience of nurses with their patients, their overall person-oriented-ness or task-oriented-ness regarding patient care, whether they used reflective practices in patient care and their risks and rewards in doing patient care.

Code		
1. CAREGIVER'S PATIENT CARE APPROACH	24	108
Initial approach to patient care	21	55
Person Oriented or Task Oriented	13	28
Reflective practice	3	7
Risk and Reward	10	18

Figure 11: Caregiver's patient care approach

.

Nurses' Safety Experience (Figure 11). This subcategory includes various nurses' experiences, which derailed their personal safety experience. It included themes like death, trauma, lack of self-care, anxiety, anger, and helplessness.

2. CAREGIVER'S SAFETY EXPERIENCE	27	342
SAFETY-Anger and Frustration	15	45
SAFETY-Anxiety	15	37
SAFETY-Chronic alertness	4	4
SAFETY-Exhaustion	13	18
SAFETY-Fear	17	52
SAFETY-Helpless or Trapped	10	13
SAFETY-High Demand	10	15
SAFETY-Lack of Self Care	5	6
SAFETY-Lack of sense of boundary	2	2
SAFETY-Lack of Sufficient Rest	2	3
SAFETY-Losig control	3	6
SAFETY-Mental Health Factors	8	10
SAFETY-Patient Risky Behaviours	13	24
SAFETY-Patient Safety	8	9
SAFETY-Personal Safety	16	41
SAFETY-Self Preservation	3	7
SAFETY-Stress Accumilation	4	7
SAFETY-Trauma and Death	15	40
SAFETY-Unpreparedness	3	3

Figure 12: Caregiver’s safety experience.

Nurses' Stability Experience (Figure 12). Caregivers' stability experience referred to the different factors that confused the sense of stability within the nurse's workplace. Unforeseen constant changes, turnover, information overload, and communication confusion indicated this lack of stability.

3. CAREGIVER'S STABILITY EXPERIENCE	18	61
STABILITY-Constant Changes	13	21
STABILITY-Information Overload and confusion	10	16
STABILITY-Nurse Turnover	4	5
STABILITY-uncertainty	10	19

Figure 13: Caregiver’s stability experience

.

Nurses’ Support Experience (Figure 13). This subcategory refers to different vital factors in providing the perception of support to the nurses in their work.

4. CAREGIVER'S SUPPORT EXPERIENCE	27	281
SUPPORT-Compassion Fatigue within Team	5	7
SUPPORT-Experiencing support	2	2
SUPPORT-from others	5	5
SUPPORT-In Handling patient expectations	3	6
SUPPORT-Isolation	9	16
SUPPORT-Leadership Issues	5	9
SUPPORT-Micro Managing	2	3
SUPPORT-Not valued or being neglected	11	13
SUPPORT-Nurse Autonomy	3	6
SUPPORT-Nurse's personal and family life	8	12
SUPPORT-Resources	4	6
SUPPORT-Self Care	6	7
SUPPORT-Shift Preparation & Debrief	9	16
SUPPORT-Systemic Issues	16	26
SUPPORT-Team Cohesiveness	10	18
SUPPORT-Unit Morale	23	77
SUPPORT-Work Over Load	20	52

Figure 14: Caregiver’s support experience.

Nurses' Compassion Fatigue Experience (Figure 14). This subcategory is trying to capture the compassion fatigue experience of participant nurses, expressed as the inability to care for others or themselves, lack of empathy and experience of exhaustion.

1. CF EXPERIENCE	27	218
EMPTY-INABILITY, LACK OF ENERGY TO C...	20	49
LACK OF EMPATHY	3	3
NOT ABLE TO CARE ONESELF ENOUGH	3	3
OTHER	26	124
OVERALL EXHAUSTION	14	17

Figure 15: Caregiver's compassion fatigue experience

.

The Effects of Compassion Fatigue on Nurses (Figure 15). Compassion fatigue experience affects the nurses not only in their personal lives but in their workplace with patients and colleagues. They may become more hostile and less collaborative, neglecting minor patient needs or completely be withdrawing from patients.

2. CF EFFECTS	22
BECOMING LESS COLLABORATIVE	1
BECOMING MORE TASK ORIENTED	2
BECOMING NEGATIVE	1
COMPARING SUFFERING	4
DREADING JOB	1
FATIGUE	1
GETTING SHORT	6
HAVING MORE SELF FOCUS	1
LACK OF EMPATHY	1
LACK OF PATIENCE	4
NEGLECTING SMALL PATIENT NEEDS	2
OTHER EFFECTS	14
TRYING HARD TO ENGAGE	2
WITHDRAWING FROM PATIENTS (2)	6

Figure 16: Effects of compassion fatigue experience on caregivers

.

The Reasons for Compassion Fatigue (Figure 16). The reason for compassion fatigue is broadly divided into safety-related, support-related, and stability-related. These experiences can be in the nurse's personal life or at work that, over a period, bring forth the experience of compassion fatigue.

3. CF REASON	27	181
OTHER REASONS	7	15
SAFETY RELATED	24	100
STABILITY RELATED	9	11
SUPPORT RELATED	18	50

Figure 17: Reasons for compassion fatigue in Caregivers.

Compassion Fatigue and Patient Engagement Styles in Nurses (Figure 17). The patient engagement styles of nurses can change drastically after the experience of compassion fatigue. It can go from wanting to connect so severely to the extent of complete disengagement.

Code		
4. CF PATIENT ENGAGEMENT	20	53
DISENGAGED	14	29
NEED BALANCE	5	9
WANTING TO ENGAGE	11	15

Figure 18: Compassion fatigue and patient engagement styles.

Compassion Fatigue Recovery Strategies Among Nurses (Figure 18). The recovery strategies of nurses after their experience of compassion fatigue can be broadly divided into connecting and non-connecting strategies. Dealing with issues in therapy, connecting with family, and reconnecting with patients can mean connecting strategies and changing work or disengaging with patients can speak of the less connecting strategies.

Code		
4. FORMATIVE PHASE-Recovery Focused	27	129
changing the work	4	7
dealing with anxiety	2	2
Doing anything that makes one happy	2	2
doing debriefs and therapy	5	6
doing exercise	5	5
Doing self nurturing activities	8	12
Doing things to make oneself feel safe	4	4
Getting support from family and colleagues	12	15
need of compassion from others	9	15
other strategies	12	20
promoting spiritual outlook and self reflection	10	12
Recognizing the problem	2	2
Reconnecting to patients and to others	4	5
taking break from work	15	22

Figure 19: Compassion fatigue recovery strategies in caregivers
.

5.3 Stage Three: Overarching Dimensions-Theoretical Coding/Selective Coding

Theoretical coding looks at the possible relationship between categories developed in the focused coding. According to Charmaz (2006), these codes help the researcher construct a coherent analytic story of the participants. Therefore, it does two things, it "conceptualizes how your substantive codes are related, but also your analytics story in a theoretical direction" (p. 63). The final level of coding is aimed at theoretical integration, and it is one step away from the grounded theory. Theoretical coding will analyze the relationship of focused codes with concepts and other insights. Eventually, the focused codes will be integrated and organized into a coherent theoretical argument that reflects the substance of the participant's experience and thoughts.

As the final stage of coding, theoretical coding brings together the various codes, subcategories, and categories into a framework of a hypothetical theory (Walker & Myrick, 2006). I used theoretical coding to comprehensively understand the data, the internal connections, and the theoretical angles implicit in the data. This becomes possible in this stage by the abstraction of detailed, rich data into patterns, patterns into subcategories and subcategories into categories and themes. With the help of constant comparison, these emerge into a meaningful and cohesive framework to explain the phenomenon under investigation.

One of the difficulties a grounded theory researcher faces is deciding the appropriate time to move from one phase of the analysis to another. This decision is primarily based on the insights and observations of the researcher and the experience of saturation of data in the study. Though I found a lot of scattered information in the initial coding stage, at the stage of focused coding, there appeared to be a better connection within the pockets of data. In this level of abstraction, it was possible for me to see the connection between various participant case data in a more congruent manner. According to Glaser and Strauss (1967), saturation happens when there are no longer any new categories or new properties to the existing categories that emerged from coding. The idea of saturation was experienced initially during my interviews when a participant was reminded of something that others have already referred to, and that was my opportunity to ask more questions related to it to understand this repeated concern. Being aware of this process during the interview process helped me collect enough data for theoretical saturation. This experience repeated during the time of transcription and data analysis. Every time it occurred; my natural tendency was to go back to the data to see enough information to satisfy my questions.

At every stage of the analysis process, I was faced with uncertainty and did not know how to proceed. One of the best ways to deal with it was regular discussions on the participant data and emerging categories with my supervisor. I found it better than using any technique to decide on various stages of the analysis. He asked me questions on the data and categories that prompted me to reflect further. This process continued with my sharing the newer congruent understanding of the participant data and the potential connections. It also helped me show him the preliminary graphical presentation of the emerging theoretical formulation together with the codebook (data table) and data structure. This ongoing discussion through every step of this research, especially during the analysis, has been one of the most powerful experiences. I should

also mention that I tried to use the functionalities of NVivo software in arranging data, and a visual arrangement of all participant data onto my study room wall further helped me make connections between different parts of the data, themes, and categories.

Below is a table (Figure 19) presenting the final categories and subcategories arranged into four phases or dimensions of development.

Name	Files	References
▼ 1. FORMATIVE PHASE-Initiation Focused	27	454
▶ 1. CAREGIVER MOTIVATION	27	162
▶ 2. CAREGIVER'S COMPASSION EXPERIENCE	27	199
▶ 3. CAREGIVER'S IDEA OF COMPASSIONATE CARE	23	93
▼ 2. PRAXIS PHASE	27	794
▶ 1. CAREGIVER'S PATIENT CARE APPROACH	24	108
▶ 2. CAREGIVER'S SAFETY EXPERIENCE	27	342
▶ 3. CAREGIVER'S STABILITY EXPERIENCE	19	62
▶ 4. CAREGIVER'S SUPPORT EXPERIENCE	27	282
▼ 3. OUTCOME PHASE	27	526
▶ 1. CF EXPERIENCE	27	219
▶ 2. CF EFFECTS	22	73
▶ 3. CF REASON	27	181
▶ 4. CF PATIENT ENGAGEMENT	20	53
▶ 4. FORMATIVE PHASE-Recovery Focused	27	129

Figure 20: Final categories and subcategories.

5.4 Stage Four: Emergent Frameworks

5.4.1 Data Structure: Once the stages of coding first order (participant centered) terms, second order (theory centered) themes and aggregate dimensions/core categories are arrived at, the next stage is to create a static picture of the whole data which can be the bridge to the dynamic presentation of the theoretical model. Gioia et al. (2013) considers the data structure an essential element of their grounded theory approach. Though processes are not explained, it gives the researcher, reader and reviewer to see the total picture of the coded data and emerging theoretical connections. The theoretical insights are not obvious in the data structure yet and that will happen when the data structure is operationalized in the grounded theory model. Below is the data structure created for this study (Table 7).

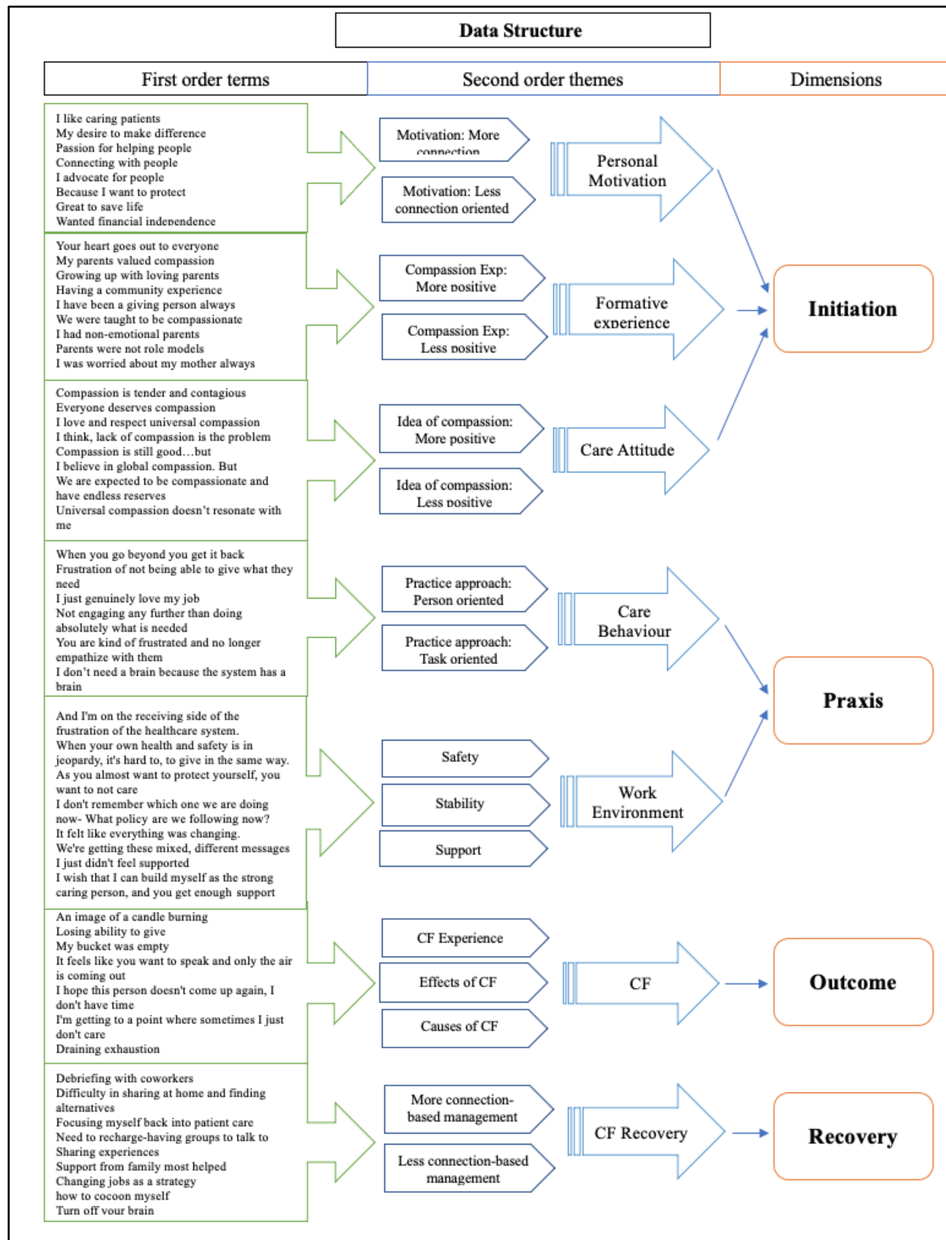

Table 7: Data Structure (Gioia et al., 2013)

5.4.2 Results from Case Comparison Table: Compassion Fatigue and General Nurse Fatigue. The data/case comparison table (figure 3) which I used to observe the emerging patterns between individual case narratives, resulted in mainly two observations. The first one is the pattern of more connection and less connection-oriented experiences, which is already indicated in the data structure (table 7), the second major pattern observed was the essential features of compassion fatigue experience shared by majority of participants (18 participants) and partially or fully absent in the narrative of a few participants (9 participants). The essential

features of compassion fatigue experience are, 1) a reflection on patient suffering; 2) positive attitude to universal compassion/love; 3) desire to connect to a patient; 4) values compassionate care despite compassion fatigue, and 5) expression of the inability to care for patients.

The following is a comparison table (Table 8) of the narrative elements of compassion fatigue found in six representative nurse narratives. While the interview narrative data of Participant 4, 10, 11, 21, exhibit all the five elements, the narrative data of participants 9 and 14 do not show most of these elements.

Participant 4	
A reflection on a patient suffering	"…empathy for their emotional, mental and physical situations that go along with being ill and separated from their families."
Positive attitude to universal compassion/love	"I truly want to believe in a universal compassion…."
Desire to connect to a patient	"I love my patients; we I love the relationships that are built-in long-term care."
Values compassionate care despite compassion fatigue	"Being task oriented is something that we're trying to get rid of..."
Expression of inability to care for others	"The frustration of not being able to give them what they needed…".
Participant 10	
A reflection on patient suffering	"…kind of remembering that this is their first time going through this and this is probably my 100th time seeing a patient just like them…."
Positive attitude to universal compassion/love	"I do wish compassion and grace for everyone."
Desire to connect to patient	"I wanted to know more about what nursing is, what it means to take care of people in health care."
Values compassionate care despite compassion fatigue	"I do think there are ways to care deeply and not to have it negatively impact you."
Expression of inability to care for others	"My tank was empty, and I did not have anything more to give."
Participant 11	
A reflection on patient suffering	. "I hope if my baby was in the hospital, how someone would take care of my baby or if it was my mother or father, how would I care for them?"
Positive attitude to universal compassion/love	"Unconditional love," as she said, "I am happy to get to that point. I have some conditions".
Desire to connect to patient	"My mother was constantly caring for people in the community, and I just kind of went with her as she did and learned how to take care of other people."

Values compassionate care despite compassion fatigue.	"This is a message you get in nursing… do not get too involved because you will burn out. But sometimes, I think it is the opposite. Get involved. And I think it will build you up…."
Expression of inability to care for others	"You know I have unfinished my with this baby [who is dead]. I am empty. I got nothing."
Participant 21	
A reflection on patient suffering	"So, when they often take it out, maybe on me, I tried to personalize it and understand they are just frustrated at the health care system, or they are frustrated in their bodies…."
Positive attitude to universal compassion/love	"It's a very challenging one. And I may try it, but I feel like I am limited in my own flaws, but it's something for sure that I tried to do".
Desire to connect to patient	"And I realized I need people interaction."
Values compassionate care despite compassion fatigue.	"If I have a lot of compassion, and then I get compassion fatigue I can recharge from that. The guilt [of not caring] is not so easy to walk away from".
Expression of inability to care for others	"Not able to empathize with them and try to look beyond my own needs, but looking at their own needs, and putting myself in their shoes."
Participant 9	
A reflection on patient suffering	Not found
Positive attitude to universal compassion/love	"[Universal compassion resonates with me] **maybe in theory**... at the end of the day, I'm caring for people I don't know a ton about"
Desire to connect to patient	Not found
Values compassionate care despite compassion fatigue.	Not found
Expression of inability to care for others	"I think at a certain point, you just **can't hold their emotions** and …you don't you don't feel anything for them anymore".
Participant 14	
A reflection on patient suffering	Not found
Positive attitude to universal compassion/love	"I don't think you can have unconditional love. Or universal love. I think you can have a duty for what needs to be done".
Desire to connect to patient	Not found
Values compassionate care despite compassion fatigue.	Not found
Expression of inability to care for others	"I think, for me, compassion fatigue really looks at, when someone provides human care for an extended duration of time. And you **run out of empathy for human care".**

Table 8: Five common elements of compassion fatigue within representative participant narratives

When these observations were compared to the literature, it resonated with the empirical examination of the factor structure of compassion by Gu et al. (2017). They developed their factor structure of compassion mainly using the definition of Strauss et al. (2016), which also presented five components of compassion. They are,

> "1) Recognizing suffering; 2) Understanding the universality of suffering in human experience; 3) Feeling empathy for the person suffering and connecting with the distress (emotional resonance); 4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g., distress, anger, fear) so remaining open to and accepting of the person suffering, and 5) Motivation to act/acting to alleviate suffering" (p. 19).

The following table (Table 9) has arranged the above factor structure of compassion with the comparable components from the compassion fatigue narratives of the research participants within this study.

Factor structure: Compassion (Gu et al., 2017)	**Narrative elements: Compassion Fatigue**
Recognizing Suffering	A reflection on a patient suffering
Understanding the universality of suffering	Positive attitude to universal compassion/love
Emotional Connection	Desire to connect to a patient
Tolerating uncomfortable feelings	Values compassionate care despite compassion fatigue
Acting to alleviate suffering	Expression of inability to care for others/patients

Table 9: Compassion and compassion fatigue common factors emerged from the study participant data

The presence of the five factors of compassion fatigue indicates the connection between compassion and compassion fatigue, and the absence of these elements may qualify a fatigue experience of a caregiving professional as general nurse fatigue. We call it "general nurse fatigue" because the experience does not seem to relate to compassionate caring rather the practice of empathy.

5.5 Stage Five: The Grounded Model

The data analysis and cross-checking continued as I wrote the discussion chapters using case vignettes and snapshots of participant experiences. This process confirmed the analysis results as rooted sufficiently in the participant data and an honest representation of the participant's voice. During this phase, soon after theoretical coding and integration of the categories into a tentative theoretical formulation, the literature on compassion and compassion fatigue was brought in to see if the new theory could be situated in the larger context of the

literature. The final grounded theory can comprehensively explain the process related to a phenomenon. Grounded theory is understood as an interpretive theory that differs from the positivist theory, which looks for the explanation and prediction of variables. For Charmaz (2006), "interpretive theories call for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual" (p. 126). Accordingly, a constructivist grounded theory tries to explain "how, when, and to what extent the studied experience is embedded in larger and often, hidden positions, networks, situations and relationships" (p. 130) Similarly, the Gioia model interprets theory as “a statement of concepts and their interrelationships that shows how and/or why a phenomenon occurs” (Corley & Gioia, 2011, p. 12). The grounded theory model establishes that not only a deep structure but also a deep process is present in the grounded data which makes one understand the phenomenon and its network of connections in a socially embedded structure. The first draft of the grounded theory model is given below.

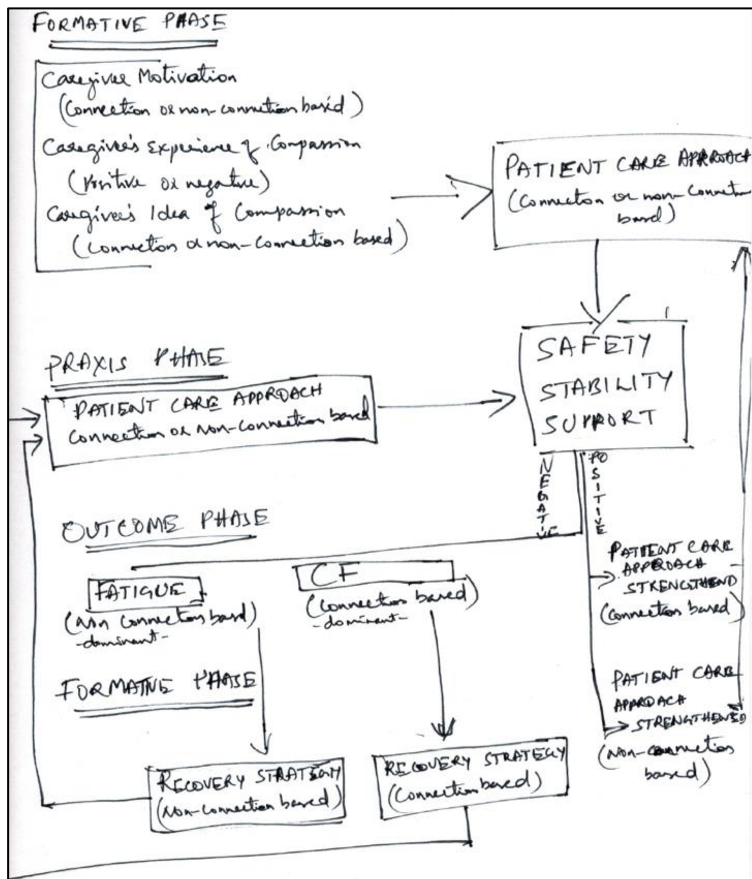

Figure 21: Initial draft of grounded theory model.

The core categories are placed under four phases: Initiation-focused formative phase, praxis phase, outcome phase and recovery-focused formative phase. The patient care approaches appear to result from a formative phase of initial motivation, personal experience of compassion, connection, ideas of compassionate care which are further mediated by the praxis phase of safety, stability, and support. The praxis phase has the three key themes of safety, stability, and support, which addresses trauma and workload/unit moral-related issues. These themes explain the relationship between trauma and non-trauma-related explanations of compassion fatigue. The role of connection-based approaches to recovery is highlighted as that is intimately connected to compassionate care. The grounded theory model is further elaborated in the following chapters on findings and discussions.

6. Concluding Remarks

This chapter reported the analysis of the grounded data, along with the decisions and processes that were used for the analysis. The effort was to describe to the reader the somewhat messy but creative process of analysis which is at the heart of grounded theory. Though it is presented in a somewhat linear fashion, the real process was more iterative and cyclical, sometime feeling lost in huge amount of data. As the next step following the analysis of the data is a detailed description of the themes emerged from the study which is traditionally found in the "Findings" section of a dissertation.

CHAPTER V

FINDINGS: THE MAIN THEMES AND THE EMEGENCE OF A GROUNDED MODEL

As explained in the analysis chapter, several core themes and sub themes emerged within this study which needs further elaboration for the purpose of understanding the saturated themes within the grounded data more fully. The emergence of the grounded model happens in the context of a rich data, through constant comparison and theoretical saturation. For the narrative flow this chapter includes a demographic profile and synopsis for each interview participant (given in appendix xi), followed by a comprehensive treatment of the various themes, including the COVID-19 related themes and concludes with the grounded theory model of multi-phased compassion fatigue process. The main themes of the study are presented with snapshots of experiences from most participants following the approach of Gioia et al. (2013). One of the main characteristics that distinguishes Gioia's approach to grounded theory is the story telling style in reporting the finding and discussion part of the study.

1. Participant Profiles

The participant profile is arranged alphabetically with a pseudonym per participant, which will be used in subsequent sections. The profile starts with demographic data followed by short synopsis on each participant with information on their formative and recovery experiences related to compassion fatigue. For the sake of the flow of this dissertation, the participant profiles are included at the end within the appendices (appendix xi)

2. Key Themes Emerged from the Grounded Theory Interviews

As discussed in the analysis chapter several themes emerged from the interview conversation with the research participants, which included motivational factors to the profession, nurturing experiences during their developmental and formative years, workplace-related experiences and stressors, compassion fatigue, and recovery-related experiences. To bring to life the participant voices, I have used snapshots of their experiences in presenting the themes. What follows is also an evidence of data saturation within 27 interview participants, where the same themes are repeated by many of the participants.

2.1 Initial Motivation

The research participants candidly shared their initial interest in joining the nursing profession. Though some of them did not attribute any specific reasons to their decision, most of

them could articulate the contexts and thought processes related to it. This theme explores the nurses' desire to connect, help or care, protect, or save and advocate as motivational factors for them joining the profession. Each of these desires is discussed below.

2.1.1 To Connect. Making connections with people is an important part of these nurses' professional and private lives. For example, Cyndi considers herself a nursing product, working in the same ICU where her mother worked for 33 years. Though one of her reasons for becoming a nurse was financial independence, she considers "*connection with people*" the most rewarding part of her career. While working in a doctor's office, Chelsey admired the opportunity for nurses to interact with people and decided to join the nursing school. She says, "*My light comes from being around other people and helping and then with my friends like being able to hug them and tell them that they are loved*." Joyce comes from a family of medical professionals, and for her, nursing checks off all the relational boxes, from connecting with people to building relationships with them. As she says, "*I loved connecting with people. That was a huge part of it and ... especially in palliative care; you form these intense relationships with the patients and families to be able to help them through that*". Despite her aunts' discouragement, Anna joined nursing and started working in NICU. For Anna, one of the most joyful experiences has been "*connecting deeply with the families that they looked after*." Mary studied engineering and general science before settling on nursing. The first two programs lacked human interaction: "*And I realized I need people interaction, and I needed to provide a service that was going to be lifelong but also rewarding to me*."

Celine, who used to be a chef, joined nursing when she realized that her elderly grandparents were in palliative care. She loves her patients and the relationship that is built into long-term care. She loves being an extended part of the long-term care family. Like Celine, Clare also joined nursing inspired by her experience of being with her dad at the hospital. Referring to the use of a mask during COVID-19, she says, "*I think it is a tough kind of connection because you only see everyone's eyes now. So, it is tough for patients too, some of them who must read lips to understand what you are saying*". Through her earlier career as a librarian, Juliette was able to connect with people and help them but made a career change as she thought becoming a nurse would be an "*interesting job where you get to know people and then provide them with resources* ."Diew grew up as a caretaker to people and thinks that she has the capacity to do the caring work; however, in retrospect, she would have preferred an academic route within nursing.

According to her, any activity within nursing demands some human interaction anyway: "*whether I send an email to a person versus doing agendas or whatever or reading documents, I will find some way to talk to some person and have a human interaction*."

2.1.2 To Care. Though Stella initially did not think of becoming a nurse, her passion for helping people and love for babies landed her in nursing. For Nora, nursing is more than just a job; it gives her "*spiritual rewards … This is the thing that separates us from animals that we will look after each other*". Jasmine joined nursing in the 1970s when there were few choices for women other than nursing. However, she was very clear about the reason that she went into nursing, "*I went into nursing because I wanted to care, and I wanted to look after people and make them feel better*." While in high school, Edith's aunt asked her what she wanted to do when she grew up. She said that she wanted to do something where she could help people. This desire to take care of people landed her in the nursing profession. For Heidy, there was a strong influence as a role model who was constantly caring for people in the community. She says, "*I had always wanted to be a nurse from when I was little. I used to be a nurse for Halloween*". Lillian wanted to become a kindergarten teacher. However, as she did not have enough money to go to university, she worked as a health care aide. Her colleagues encouraged her to go to nursing, and there was a bursary available for psychiatric nursing, and she became a psychiatric nurse. She says that she has always been a caregiver, and it came very naturally to her, "*nursing came very easily to me. never felt like a job*".

2.1.3 To Protect. Jacob grew up in his family as a nurturing person. He comforted his parents when his sisters fought each other. Jacob liked nursing as it married both science and human interaction. He describes his role on the nursing floor: "*So I think having to be almost that by no means like Savior, but in a way, a little bit of a light of positivity and resilience, especially for the patients that you interact with*." Likewise, Ruby always wanted to be a nurse. For the last eight and half years, she has been working with the residents in a mental health-supported living site. When the pandemic hit, she got distressed about the residents as she said, "*I have known these residents for so long. I do not want to leave them ... I do not want them to be in need of help if there is no staff. I do not think that is fair for the residents that live there*".

2.1.4 To Advocate. It was an accident-related experience that brought Judith into nursing. She was hospitalized due to an accident where she lost her friend. While in hospital, she met with one of the nurses who, according to her, was like an angel, and the rest of them were

horrible. Seeing bad role models, she decided that she could make a difference in the most challenging situations like this. She thought that "*if I could be something like that, make a difference and help people in their time of need, and along their journey, as a good person in a kind of Advocate [role] for them. And that is what I want to do*". Kim always wanted to be a nurse. She started as a volunteer in long-term care and gradually became a registered nurse. Currently, she works in Health Link Alberta (It provides clinical services like tele-triage and health advice to Albertans) and thinks of nursing as a place to advocate for people. Experiencing a moral dilemma, she says, *"... if you are bearing witness to something awful, and you cannot do anything about it. I am trying to figure out how to advocate for people*".

2.2 Earliest Nurturing Experiences

Nature and nurture play a significant role in a person's development. The "*nature-nurture*" question is frequently asked regarding the roots of compassion. This section explores the earliest nurturing experiences of the research participants related to compassion. Themes like safety and stability of a family, good role models, innate compassion and perceptions of bad parenting are intertwined in these narratives.

2.2.1 Safety of Home. Chelsey lost her parents to a plane crash, and her grandparents took care of her. She speaks of the influence of their upbringing in her life, "*They loved me like I was theirs and they took care of me like I was theirs and there was never any question*." Diew explains the safety and security that she experienced in her home. She witnessed her parents loving and respecting each other and never having an open argument in front of her. Penny reflects on her family as well connected and solid emotional support in her life. Ruby lived with her grandparents growing up. She explains the exemplary life of her grandfather:

> *Sometimes, like an 80-year-old lady would call him just to change a light bulb, and he would go do it for free. So, he brings me with them. Because I am just a kid, and he is like, "No, I am just changing her light bulbs." When she tried to pay him, he would not take the money. He is like, no because she was too old. She could not change the light bulbs on her own*.

Sarah speaks of her childhood as a privileged one as her parents worked hard to provide a good childhood for their children, unlike their own parents. She says, "*I think they made this big effort to not be like their own parents*." While Celine speaks of her family as a "*fairy-tale ... perfect*" family, Danielle says that her family was very close-knit, belonging to a small

community which brought in her strong community oriented-ness. Joslyn did not share much about her early childhood, but some teachers and mentors cared deeply for her during adult life.

2.2.2 Missing Safety of Home. Some of the nurses reflected on their parents as not very compassionate. For Emma, her parents were not very compassionate, and they approached life as "*be quiet and do your work; suffering is part of life*." According to Mary, her parents were not opposed to compassion, but they were not very emotional or affective people. Juliette did not see a good relationship between her parents as she grew up. She says that she developed a habit of worrying over her mother, "*So maybe when I was growing up my mom being in tears for whatever reason, probably made me want to worry about her*." Kim says that she grew up with parents who lacked compassion, which was why she developed Post Traumatic Stress Disorder. Lydia grew up with an alcoholic mother and an abusive father. Nora had a lonely childhood and was bullied a lot as a child.

2.2.3 Learning from Home. Anna thinks her experience with her mom, who was a very compassionate person, made her behave the same way with her friends. She recollects how:

> *I was always kind of the mom of the friend group ... Yeah, I do not know. I always remember being in middle school and being out and being the one who would sit down with the person who was crying or whatever.*

Though she lost both her parents, Chelsey felt completely at home with her grandparents. She says:

> *… even as a young child, my mom (grandmother) would always say I would befriend the children who did not have any friends, make sure that they felt included, and hang out with the unpopular children and the popular children.*

Edith reported that she learned the value of caring for others from her parents:

> *I think I just always saw how my parents were willing to step out and care for people in their community in different ways. I just always saw it as something important to do for other people when you have the strength and the skills to do it.*

Samantha grew up in church with her family, and she says some of the values like you should be compassionate and treat other people nicely came from that environment.

2.2.4 Innately Compassionate. Some of the nurses expressed that they were caring for others as children. Jasmine, Jacob, Joyce, Lillian, and Stella were able to recollect events where they took care of others as children.

Jasmine recalls her memories regarding helping her mother at a very early age: "*I was always there to help my mother who worked, which was rare in those days, like get meals and stuff and help out around the house*." Jacob thinks that as a very small child, he was able to perceive the pain and distress of his parents and was able to respond accordingly:

> *So, I had kind of grown-up seeing the stress and anxiety my sisters could cause my parents. Thus, when I saw my parents responding in that way, I wanted to help. I always wanted to make things better. I wanted to be then the one that did not do that. And I guess their golden child made them feel other things that were not stress and anxiety.*

Joyce recalls events in her childhood when she behaved almost like a triage nurse by taking charge of a difficult situation of a child falling off the monkey bars:

> *A child fell off. It was not the monkey bars, but it was this contraption on the playground. Seeing that, I ran over to them and tried taking care of them until a grown-up came in. It is like, I was a triage nurse then, but it was always like that and caring for small animals, I always wanted to make people better.*

Lillian remembers to have taken care of her little brother without anyone prompting her to do that: "*When my little brother was born, I used to look after him. Everybody remembers, I would crawl in the crib and give him his bottle or carry him around or pushing the stroller*". Stella believes that she has ever been a caring person and that it was innate to her. One of her earliest memories was of being hospitalized at the age of five. She recollects, "*And all I could care about was not myself. I was worried about the babies around me that were not eating but were crying. I was sitting there feeding them and helping the nurses. That is just my personality; that is who I am*".

2.2.5 Compassionate Parents. While growing up, some of them had their one parent predominantly caring and compassionate. Cyndi, Judith, Anna and Heidy, Denice, Sarah expressed their mothers as very compassionate, and Clare and Heidy described their dads as the compassionate ones.

For Cyndi, one of the most important aspects of compassion is showing appropriate emotion. She thinks that the environment at home was formative: " *I think that my mom is very compassionate. When we have had pets or different things like that, we have never been scared to show emotion. Like, it is not something that has ever been questioned*". For Judith, witnessing her mom taking care of home, cooking, cleaning and playing with them was a way to experience

nurturing: "*You know, my mom was very nurturing. She took care of us. She cooked, she cleaned, she did all those fun things with us. Her dad took us to fun places. We went camping, and we had a good life*". For Anna, her mother stood out as an example of a compassionate person with gentleness and a sense of justice:

And she is a highly compassionate person. Anyways, she is super, like, gentle and kind and just. She does not say a bad word about anybody. That was certainly a fantastic example.

Finding her mother caring for other people generously made Heidy think of her mother: "*I think she was a pretty big model for me*."

Denise was the only daughter to her mother, and she always knew: "*…at my core that my mom cared about me*". Sarah is surprised at her mother, who is not a nurse, being most compassionate among her siblings who are all nurses by profession: "*And my mom is the only one that's not a nurse. She is a hairdresser. I think she was the most compassionate and caring line of her siblings*".

Clare recollects about her father as very caring: "*My dad, he worked very hard. And then he would come home and just be so engaging and sparing. He was the guy*". For Heidy, her father was not only compassionate but showed great value for care and compassion. She always felt valued by him:

And I remember him affirming me, saying, you know you are special and have something. So, he is dead now, but we are always like that. And I knew he always told me you have something special just because you care, because you help, and just because you are always there for people.

2.3 Outlook on Universal Compassion

The concept of universal compassion refers to the extent to which it can be applied, or rather, the limitlessness of its application. It does not necessarily speak about the ability of the compassionate person to reach that limitlessness. As attitude to compassion is an essential element of the exploration of this research, the inquiry into universal compassion becomes a significant informant. Including the question about universal compassion in the interview was done with the above-stated rationale. As expected, there was variation in the responses of the participants. Some of the nurses narrated their affinity, or disinterest, in the idea of universal compassion. Others replaced universal compassion with unconditional love as being a familiar concept.

2.3.1 The Unlimited View. According to Anna, the demonstration of universal compassion needs to be absolute. She says that it should come first in every situation. Following the same principle, she gives an example:

> *Even though that patient's mom was yelling at me last week, I will still deliver excellent care. I have to be still compassionate and realize that was because she was going through a tough time, and I do not get to be cranky and vindictive about it.*

Cyndi says that compassion can go far from friends and acquaintances to unknown people. She speaks of her experience of being an emergency dispatcher. Referring to the September 11 terrorist attack, she says: "*every September 11, I think about them, because it does not matter what Firehall you are in, you are connected. Like our whole world was affected by people giving themselves*". According to her, this should be the same response to nurses worldwide fighting the pandemic. For Edith, the word grace is similar to compassion: "*I wish compassion and grace to everyone*. " Judith observes that every animal on this earth reserves "*dignity, respect, love and compassion*." Joyce thinks "I either have compassion for everyone or I have compassion for no one."

Though Celine wants to believe in universal compassion, her knowledge of the atrocities committed during World War II makes it difficult. Instead, she finds that the little stories of compassion are powerful, and they seem to provide some trust that everything is going to be okay. Both Diew and Jasmine agree that compassion is universal, but they suggest that the ability to show that compassion is limited in everyone. Jacob suggests that compassion can be displayed in every setting but not every time. He speaks of the importance of reflective practice in the use of universal compassion. For him, compassion cannot be blindly practiced. Denice is of the opinion that compassion can be limited according to the related mental processes; it can either make us compassionate or not. She asks a pertinent question, "*Do you think the Nazis do not love their children like you love your children?"*

Chelsey, Clare, Heidy, Nora, and Stella speak about universal compassion as unconditional love. Clare tries to love her patients as she would try to love her children, however imperfect they may be. Heidy speaks about the concept of loving like Mother Teresa, where you do not expect anything back. Nora compares it with the concept of agape or brotherly love in the Christian tradition. For Stella, it is "*not being judgmental and accepting others for who they are*."

2.3.2 The Limited View. Lydia defines universal compassion as regularly practiced by nurses: when a patient has a need, nurses find a way to fulfill it. Emma offers a similar thought: "*I think at the end of the day, I am caring for people I do not know a ton about, and I think that those ideas are rooted in the community, which we do not yet have in our hospital system*."

Joslyn disagrees with the idea of universal compassion. She says, "*I do not think you can have unconditional love or universal love. I think you have a duty for what needs to be done*". Similarly, Kim disagrees with the concept; she says, "*I do not think there is such a thing. I think people wish there was such a thing as universal compassion. But I do not think that is realistic*".

2.4 The Need for Safety at Work

Anna has been a nurse for the last six years and has worked at NICU all these years. She has a great team to work with and is in a very supportive environment at the hospital. She loves her job and is excited when she meets the infants and their families. Though she blames the uncertainties, confusion, fear, and lack of support created by the institution's pandemic handling as the reason for her compassion fatigue, she thinks issues started at least six months ago with the back-to-back death of babies in her unit. Facing recurring resuscitations and deaths, she asked in the back of her mind, "*Is this going to be what sends me over the edge?*". When witnessing these, she says, "*I see that as you almost want to protect yourself, you want not to care*." As we will see in the following chapters, trauma and death are concurrent themes with nurses, especially in emergency settings.

Samantha has been a nurse for the last seven years and worked on a mental health and addiction concurrent floor for the past year after receiving her RN registration. Most patients in her unit suffer acute psychotic episodes and immediate substance use. As most of these patients are coming directly from emerge, there can be many challenges:

> *So, when I go into the rooms, I'm typically always on guard have my hand close to my alarm, depending on the time of day, which is how I interact with my patients. So, if it's daytime, I can have more of an in-depth conversation with them. I'm not as cautious because there's a lot more staff on the floor. Nighttime, I do not do too much to get into feelings and nursing assessments because if I do stimulate the patient to the point that they are, you know, having some sort of episode because I brought up memory or something. If they do, lash out. There is not enough staff to protect me.*

She always needs to double-check the information provided by the patients and do "*a little bit of detective work with the psychiatrists in terms of what exactly their diagnosis*." She says that she went into the floor "bright-eyed," but as months went by, she realized much verbal abuse. She says, "*if somebody's swearing at you constantly, for three days, and then you get one day off, and you come back to work*." Samantha was able to manage most of the time this way, but as the pandemic hit, there were fewer staff and more shifts for her, which took away the opportunity to come back refreshed. COVID-19 has exacerbated the safety issues on the floor. In certain situations, the nurses can also feel unsafe with their patients, and such a situation is of Samantha. When she asks the COVID-19 screening questions to these patients, she does not always get truthful answers, which makes her feel more unsafe. The risk of violence on the floor is natural as at least three Code Whites (Code White refers to warning for a violent person or hostage in a hospital context) per day. Samantha, who is currently pregnant, says that the lack of safety was so evident that she started hearing the call bells or the Code White in her sleep at home.

Since 2016 Sarah has been working in street nursing. This work is primarily with people on the street who are homeless and who have suffered a lot of trauma and abuse. She works around the homeless shelter, soup kitchen, parks, and places where they congregate. As part of her job, her team needs to do testing, contact tracing, and treat communicable diseases like HIV, Hepatitis C, and sexually transmitted diseases. Even though the work strictly comes under public health, there is a lot more for the nurses to do to get these patients to appointments. Even though she is deeply compassionate about the patient's situation, she feels unsafe most times. She says,

> *There is always a part of me thinking about safety because we often meet people in any area that other people would think are not safe. So, we are, you know, sort of behind back of buildings where there is not a public eye, and people are often in groups, and they are intoxicated, or under the influence of different drugs. So, I might be talking to one person, but there is a couple of other people and fights to break out when we are there. So, part of my mind is always assessing the situation for safety.*

2.5 The Need for Stability at Work

Chelsey has been a nurse for the last six years and has worked in the hemodialysis unit full-time during COVID-19. Before the pandemic, she loved working and developed good relationships with patients. In 2019, she had difficult experiences: one was a woman like her

with whom Chelsey was very close, who died of cancer and another happy young man who has been dialyzing in the center for around 15 years. She was working through the grief of these deaths when the pandemic hit. She says that there was a lot of anxiety and a sense of uncertainty about everything. She recollects:

> *Driving into work every single day, I would think, oh crap, what is the newest thing that's going to come out now? Are we going to run out of PPE or our N 95? ... We ran out of our protective gowns. We did not have masks. We did not have hand sanitizer at one point in time. And we were being told, oh, no, it's fine. Just bring us your masks. We will try to clean them. And it is like, you have that stress. I do not know if it was just anxiety and stress, but it got a lot. I feel like everybody on the unit kind of got numb to it because it felt like everything was changing.*

She says that every day there would be new things happening. Things escalated to a situation where "*all of a sudden you just put your fingers in your ear. You are like, I can't deal with this anymore*". The sense of uncertainty can be so terrifying for a person like her. On her last day at work, she cried in her car for the entire time to reach her workplace because of the "*the anxiety and the fear of not knowing what I was gonna walk into, it was just too much*."

Penny has been a nurse for almost 27 years. She worked at the emergency department during the SARS pandemic in 2001/2002. The difference that she noticed this time is the confusion and uncertainty regarding what needs to be done compared to her experience:

> *It was difficult initially, and then things kind of levelled off, and we had a strategy in place. And it lasted only about nine months, where we were fully garbed in PPE. We wore N95s all the time, and we had shields, and we had gowns; that is what we wore all the time. Here we're getting these mixed, different messages; you do not need this, you do not need that, so that has been fearful because, in my experience, it is a respiratory disease. I should be wearing an N95, but I am told not to.*

For Penny, this lack of consistency in messaging created fear, especially when the pandemic started. They kept getting different messages from management. It appears they did not know about it either.

Clare has been a nurse for the last six years and is working in the acute surgical care unit. She already lost her dad to COVID-19, which has been extremely difficult. Everyone in the family was asking her for information. She was highly anxious as no one understood the virus

and what needed to be done through precautions. Usually, she can deal with everyday anxiety well, but she says it was different in her hospital: "*My patients were not anxious, but you could just tell that there was just this energy in the hospital, or it was just nobody knew what to do* ."The complaints and need for information got too much, and she started losing patience over it. She lamented, "*And you got to fill out this paperwork now and do screening for this now, and it's just one after the other; when do we get a break?*"

2.6 The Need for Support at Work

Lydia has been a nurse for 41 years, and her last employment was in a long-term care home. After having worked in various capacities and facilities, she concludes, "*So I think really, it boils down to how much support that you have from management*." She speaks from her experience of being a manager that what motivates others is not necessarily a dollar amount; instead, "*It is about acknowledging and validating people's exhaustion, and about helping them, listening to them and supporting them*."

Lillian has been a nurse for the past 34 years and currently works in geriatric psychiatry. She says that she started noticing changes in her personality by 2016, and it was not that someone was doing something to her. Her managers, doctors, and patients are held in high regard. However, during that period, there were many changes in the organization. Before it, there was much camaraderie between units and managers and staff. As these unhealthy changes happened, she continued to contribute to work as before. However, she felt not valued by the management: "*However, in the end, they do not care, and it is you are who you are, and it does not matter*." She is upset that nobody except her husband told her that she was doing too much. Lillian felt tired and fatigued, and her extra efforts were not appreciated. She also found that the new manager tried to be a micromanager that she was not used to. According to her, a genuine attempt to appreciate and help the nurses are more important than mere tokenism. She suggests,

> *Many times, what happens is that different organizations send out emails to say, this is what you do if you are not coping, or this is what you do if you are feeling this way. But it just seems like they can say they did it, but it is not a representation that they are caring.*

Kim always considered the workplace as her family. As soon as the pandemic hit, she says that the management could trust the resourcefulness of nurses and entrusted them with responsibilities. Though the nurses managed the workload well, the arrival of the new management style changed everything: "*It started so well when management let nurses form and*

take responsibility and arrange things. It was beautiful. And then it started to change again, where there is now it's being micromanaged". Some nurses were physically sick and immune-compromised in the workplace. Unfortunately, their physical comfort was not safeguarded at the height of the pandemic. She is currently on leave, hoping to recover and be back in the workforce soon.

Mary has been a nurse for the past 12 years and is working in an emergency. She says that there is an expectation for nurses to do the maximum with the minimum resources. There was a nursing hiring freeze that the shifts were not appropriately filled. She was not feeling supported by the government and the system. According to her, the patients do not understand the nurses' tension. For her, it feels "*almost like you are disposable*." She says having no support and resources has a ripple effect in the unit.

There are also encouraging voices of support. Judith has been a nurse for over 12 years. Currently, she works in a maternity unit. She feels that all nurses care and support each other in her unit. She thinks that all of them are focused on giving good care to the patients and working as a good team. She thinks the managers are doing their best, given the situation and changing demands. Another nurse, Edith, works in oncology, and she thinks there is a reasonably supportive environment. However, she says, *"every nurse may be dealing with difficult cancer cases and suffering for an extended period*." So, she says, despite the otherwise supportive work, there can be fatigue in nurses: "*We are all carrying around stuff that's hard. And then when you have personal stuff going on, you know, theoretically you leave all your stuff at home, but that is a theory that does not happen in practice".*

2.7 Compassion Fatigue: In Their Own Words

Most participants in the study had similar narratives regarding the experience of compassion fatigue. Most of them described it as if their resource of compassion was becoming empty that they could not care. A few did not think of it that way; rather, they thought of it as the inability to feel patient emotions.

"*I think compassion fatigue is trying to draw from an empty well*," says Anna. For her, compassionate care meant being able to do more than the minimum and doing beyond the physical tasks of feeding, vitals, ventilation as she suggests:

> *compassion fatigue, to me, is you can still do all the physical tasks, but everything else behind it is a lot harder, connecting with the families, knowing the right thing to say, and reassuring them extra little things for the babies.*

As COVID-19 hit, together with the uncertainties of the pandemic, she felt unsupported by her management. It was almost like being "*thrown under the bus*" for her. She started being irritated with patients and verbally snapped at a couple of work friends. She would not know why she said something or why it came out that way. Given the experience, she describes her compassion fatigue as a "*slow leak on the well*" that she often does not realize its presence.

Cyndi described her experience of compassion fatigue as triggered by three continuous deaths despite their best efforts before the pandemic hit. Coming home after the shift, her experience was that her "*bucket was empty*," and there was absolutely nothing to give to anyone else, including her husband. She says, "*I felt empty, I did not have enough energy or enough in me to give anything … I could not extend the energy even to have a conversation with someone like I was just empty. So, I did not have an ounce to give*". Like Cyndi, in her dialysis unit, Chelsey came across two deaths of young people similar to her. This was pre-pandemic, and she did some work with therapists to deal with her grief. However, as the COVID-19 hit, her sense of safety was shaken. Seeing constant changes and that the place of work is no more a safe place, she lamented,

> *You know a lot of the patients are afraid, and when patients are afraid, they can lash out and become angry, and it was no longer the nice, happy, safe place at work. It was like, what am I going to run into today? Yeah, who is going to yell at me today? And then you kind of like, well, I give up.*

For her, compassion fatigue is when you "*do not have the energy anymore to care about yourself, let alone anybody else's problems*." She experienced it as there is no more compassion left in her that she is empty, as she says, "*my tank is empty*."

Judith goes to work to give. She is a giver; the high demand placed by COVID-19 inpatient care becomes too much for her. She says that she is suffering elsewhere due to high demand and constant caring though she is coping with her work. When she comes back after work, she tells her children:

> *I am sorry, we will not be able to go and do this thing that I want to do. We will do it tomorrow, I promise you. However, today, like mom needs to like, we are getting pizza. We are going to put a movie on. And we are going to...*

She experiences total fatigue when she is home. For her, compassion fatigue is "*when you are giving so much, that you lose some of that ability to be able to give*."She finds that she cannot give the same care as before to the patients.

For Juliette, "*I can think of an image of a candle burning. And it just, it's almost getting to the end of it. I cannot get the support to be able to replenish*," was the response to the question on compassion fatigue experiences. Feeling unsupported in her attempts to advocate for her patients became tiring. Despite her repeated efforts, the managers turned a deaf ear to her queries, which was disappointing. She described her experience as being human and the inability to care the most appropriate way due to the lack of proper support. She reflects on her experience, " *It's not a comfortable feeling because it's the opposite of what I'm supposed to be feeling. However, I guess I come to the recognition that I'm only human"*.

Stella thinks that overwork has brought her the experience of compassion fatigue. She says that she has been working beyond her natural limits in the previous years. She found herself not connected to patients, lacking empathy, concentrating more on task-oriented inpatient care, and becoming jaded. She felt no energy for anything and felt drained. She says her experience of compassion fatigue is "*it is almost like my ability to care, or the ability to be compassionate is almost drained or depleted*." She recognizes this experience and decides to take a break from work to return when she knows that she can give 100% to patients.

A combination of overload at work and a serious lack of sense of safety made Samantha experience compassion fatigue. She started her job with the right intentions and compassionately responded to patient needs. However, as things progressed from bad to worse, and COVID-19 added another layer of safety concerns, she felt she could not take care of herself. Now she is even wondering whether to continue with direct care nursing. She describes compassion fatigue as" *is like when you don't have any more care to give because you don't care for yourself properly*."

2.8 Compassion Fatigue: After Effects

The experience of compassion fatigue made many of the nurse participants reflect on their current job and even the nursing profession. While some needed a period to recuperate from

it, others found the strategy of changing jobs may help, yet others were just eager to come back and reconnect.

Following her experience of compassion fatigue, Anna did not want to go to work as before. Though she enjoyed going to work, the start of COVID-19 brought uncertainties and a lack of support from the administration, which became too much for her. She started experiencing irritability and disconnection from work and did not know why she behaved in a particular way. This scared her over and beyond her tiredness and frustration:

> *I live alone. I do not have too much other than school going on. So going to work was a kind of relief during COVID-19. Because I still got to see people instead of being locked in my house. It was just kind of where I would always look forward to going to work. I dreaded it instead.*

Cyndi felt unable to connect with another human as she went through her compassion fatigue experience. She did not want to talk to her husband or her mother. However, it only lasted a short period for her as she got sufficient rest and downtime, she was able to return to a somewhat normal level of care. She says about her experience the following day: "*I did not have any concerns. It is not like I went back, and I was hesitant, or I felt disconnected. Like, one of the things that I find most rewarding about my career is that connection with the people*". She finds a way to experience the two-way connection between patients, families, and herself by moving into patient floors when she finds it hard to experience human interaction with patients on ventilation. Through her experience of compassion fatigue lasting only a short period, she is concerned about its effects if this experience is prolonged.

Despite the pandemic uncertainties and personal loss, Clare returned to work as she felt a need to be with her team during difficult times. As COVID-19 hit, she lost her dad to it, and it became very difficult for her to carry on with the regular care of patients. The sadness that she could not be with her dad while he passed away gives her great grief. However, returning to life was made possible by understanding human suffering and that everyone is in a similar place in it:

> *So many people have had family members pass away and have had to move and have had large life events happen. And you realize that this is happening to everybody in life, and we can't let little things bother you. We just kind of have to group and work together in a way. Yeah, sometimes I had to take time off and then right in the height of when things*

were getting bad at the hospital. Thus, I felt guilty for leaving my team behind. However, I had to be there for my family. So, kind of you gets caught in the middle.

Some participants thought that when experiencing compassion fatigue, it is better to leave the workplace, or the specialty, to work in a happier environment. In the case of Anna, she was put in triage as part of the emergency during the pandemic. She started hearing everyone's complaints and even people yelling at her from their frustration. When such incidents happened, she generalized every person who came through the door as negative. As she realized this situation creating compassion fatigue in her, she decided to move into labour and delivery, which she believes is a happier place:

So, if I was at triage for five, six days in a row, it was not a cool thing to hear. It is not a great place to be. It is why I went to labour and delivery because I needed to be in a much happier environment.

Samantha came into the nursing profession "*bright-eyed*," thinking that she could understand the concurrent floor where many people had psychotic episodes. However, the experience has shaken her sense of safety to a great extent. She also strongly feels that there is very little support for the nursing staff on the floor, and many nurses do not last many years there. She started nursing as an RPN, and when she was unsure if she enjoyed working directly with patients, she wanted to become an RN. Now that she has been working as an RN, her experience is not very positive, and she is wondering if she wants to continue in direct care nursing:

So, I thought, well, I think it is good for me to still work with patients, at least as an RN, because I have only worked with them as an RPN. So now I have this job. And I feel that same feeling again, where it is like, well, I got to do my masters or something because I do not think I can do a role where I'm working directly with patients for the rest of my life.

2.9 Compassion Fatigue: How to Recover?

The study participants effectively used various recovery strategies to deal with their experience of compassion fatigue. Some of those activities include taking a break, completely shutting off from work, reaching out to others, exercising, eating, sleeping, travelling, finding fun things, reflective practice, personal therapy, and other self-care measures. Most participants used these strategies in conjunction with some human connection strategies for optimal recovery.

We are exploring the recovery strategies that various participants used in their dealing with compassion fatigue.

When Cyndi experienced compassion fatigue because of a pre-pandemic trauma and the acute stressors from the pandemic induced concerns around safety and anxiety, the first tendency was to go through reflective practice. She realized that the COVID-19 isolation patient is like a ventilated patient at the end of the day. She could take similar precautions that she would have taken for a ventilated patient and add some pandemic protocols. Turning the perception of lack of safety into an ability to protect herself helped her cope. As she went home, what she needed was a complete shut-off from the world of duties and deadlines:

> *I needed not to have any deadlines; I did not need to have any I must do's tonight. I had to be okay with dishes in the sink, or I did not do laundry when I got home; I had to be okay with the fact that I ate the whole flatbread pizza and did not feel guilty.*

She says that her husband and mom understood to let her go through the shut-off period. However, Cyndi values the power of human connection that she says, "*You know, had I stayed in that kind of cocoon that I'm sure somebody would have come in, like, pulled me out of it like my mom would have been like, we need to go for a walk.*"

Chelsey tried to disengage from work-related technology like computers and telephones by spending time with her husband in their backyard in a hot tub. She admits that going outside for walks has been helpful too. One of the important factors of her recovery meant that she recognized the problem of compassion fatigue and was slowly feeling all right to share with others:

> *This is so new to say that I have a problem, and I am just trying to wrap my head around it all. Because it is hard to be like, hey, I am not doing well. I am so used to being that person for everybody else that, for me to be like, hey, I am not doing okay, I feel like a failure.*

Clare went through her experience of compassion fatigue triggered by her dad's death during the pandemic and then pandemic-related isolation and stress. She found her manager and team being very compassionate helped her recover through it. The inability to make the human connection was problematic, and she has been trying to reach out to her friends more. She also tried to sit with her children and enjoy their company. She says that it was very humbling to

experience that. Another important part of her recovery method was exercising and listening to music. She says,

> *I always think people should take time for themselves. I think that is very important and whatever that may be read a book, take a bath, hang out with friends, like little things that make your heart full again, sometimes, just that little bit of reset that you need to keep going.*

Using the personal experience of loss to connect back to patients was a way for Edith to deal with her compassion fatigue. She also acknowledges that her doctor was very supportive of spending additional days with her dying dad and grieving his death afterward. As she worked with cancer patients, she found her experience of losing her dad to cancer becomes a connecting link with the sufferings of her patients:

> *Once it was over, it was easier to bring that experience into my nursing. And, you know, without oversharing, with patients, or without minimizing their experience, be able to share a little bit from my own experience with them.*

Jacob advocates for a break from work when nurses go through compassion fatigue. What has helped the most is his self-care strategies and primarily exercise like running. He stresses the importance of making meaningful connections as part of his recovery strategy. He suggests that physical activities and connecting are the two most significant factors of his recovery:

> *I think running and just physical activity…I am making time to have quality connections with the people I love and care about. Because I mean, I have always been more of an extrovert, and I do get energy from having meaningful connections with other people*.

In August 2020, Judith found her hospital overloaded with patients without sufficient nursing staff during one of the worse pandemic phases. The situation triggered compassion fatigue in her, and she describes that when she comes home, she would tell her children: "*…like mom needs to rest, we are getting pizza*". However, she has found strength in exercising and connecting with family and friends. She says, "*It sounds funny because I never thought I would be someone who runs. I run about 30 kilometres a week now*". She could not stress the importance of connecting with family and friends:

> *So what I have learned in my career and my life is the people who are in your life that are your main support like your main tribe, the people who are the kind of like your main*

people that are your everyday people will you know, you speak them every month, you speak to them every week, and you listen to when they support you, and they validate you, and they are supportive of you that is helpful.

When she comes home after a significant shift, Penny needs time to turn off her brain and engage in some mindless TV shows. Once she gets enough time relaxing, she would spend time with her husband with some light conversation. Her husband knows not to ask anything heavy during the conversation. She says it is also essential to have some time given to physical fitness. The compassion demonstrated in the workplace is an important factor for her recovery from compassion fatigue. She mentions the example of her manager: *"We have a really good manager now, not to say that our one before wasn't, but I think that the manager we have now is very kind and very caring. She really reaches out and takes care of her staff"*.

Stella says that each person's recovery through compassion fatigue can be different and recognizing each person's needs is important. Taking some time off is very helpful, and that needs to be accompanied by some reflective process to think from the patient's worldview. Her reflective process is to rethink "*why I am doing what I am doing?"* and focus on patient caring more intentionally.

Summary

The themes mentioned above cover various experiential contexts of a nurse's life. The experiences range from formative childhood experiences to personal and professional learning outcomes in dealing with different challenges related to nursing care. The role of nurturing and compassionate experiences appears relevant in all the phases of their growth. The themes underlie positive and negative patterns of connection, protection, and support. These center themes are further discussed in the following chapters with the help of comparable case vignettes. The following section speaks about some of the COVID-19 related themes. The phenomenological case study approach has provided a detailed description of the nature of the influence of the COVID-19 pandemic on the participants. Even though the main purpose of the research was not to explore the pandemic-related situation, the analyzed data speaks to the nature of the pandemic influence on the nurses in their efforts to care for their patients compassionately.

3. Compassion Fatigue During COVID-19: Related Themes

One of the inclusion criteria for the grounded theory study participants was working or having worked during the COVID-19 pandemic. The nurses participated in the grounded theory

interview during September, October, and November 2020 after the first wave in March 2020. Among the 27 study participants who admitted having experienced Compassion fatigue some time in their profession, 19 of them experienced Compassion fatigue during the COVID-19 pandemic. While for some of them, the pandemic was an acute stressor, it became one of the main reasons for Compassion fatigue for many others. In the anonymous survey conducted before the interview data collection, more than 300 nurses participated from different provinces of Canada. 93.44% of participants reported as having worked, or working, during the pandemic. Among them, around 248 nurses (81.31%) reported having experienced Compassion fatigue sometime during their profession, 235 nurses (77.05%) reported having experienced it during the COVID-19 pandemic. This anonymous survey was conducted the following months after March 2020, when Canada faced the COVID-19 first wave. These numbers give significant information on the prevalence of Compassion fatigue among direct care nurses during the pandemic. Given the share of information on compassion fatigue during COVID-19 within this study data, it becomes imperative to report on the themes and implications of this specific data.

The following are various themes that emerged from the interview conversations with 19 research participants who experienced Compassion fatigue during the COVID-19 pandemic. The other 8 study participants who did not experience Compassion fatigue during the pandemic but worked during the pandemic shared similar work experiences, anxiety, and fears of the virus-related consequences.

3.1 COVID-19 as Acute Stressor

Though not the primary reason for Compassion fatigue, COVID-19 exacerbated the already existing triggers that the nurses were dealing with. For example, Anna has been working at the NICU. Before COVID-19, she witnessed a few deaths of infants in her unit in a rather unusual frequency which had shaken her sense of existential safety. As a result, she is already struggling with a load of grief and loss, and COVID-19 further weakened the possibility of connection and support for her. She says, "*I think it was just an acute stressor. It was slow. For me, it was just kind of a build-up. And then, COVID really kind of pushed me over the edge*". Like Anna, before COVID-19, Chelsie witnessed the deaths of patients similar to her in age and background, which became a huge source of loss and trauma. The inability to acknowledge fatigue and seek support and help from others during COVID-19 caused her to experience Compassion fatigue more intensely. For Clare, the death of her father during COVID-19 was a

blow. Preoccupied with the loss of her father, she continued to work during COVID-19 but could not empathize with the patients in their suffering due to COVID-19. For some of the patients, COVID-19 also meant confusion and added stress at home regarding childcare, children's education, and struggle with the partner's work schedule who were employed in healthcare. The overall stress contributed by the pandemic further impoverished the coping skills and tolerance levels of many nurses.

3.2 Physical and Mental Exhaustion Due to COVID-19

Repeated and tiring personal protective equipment, including face shields and masks, invite both physical and mental exhaustion for the nurses. As these requirements are mandatory and are concerned about their safety and the patients, the nurses make the best use of them. However, Judith speaks about her fatigue of nursing during COVID-19,

> *Am I changing my scrubs? Where am I leaving my shoes? How will I wash my hands and wear a mask all day at work? And wearing a mask all day is hard. It is hard. And it is tiring because even though you are getting fresh oxygen, you are also breathing some of your own. You wear a mask eight hours that shift. So, I'm hoping you are a lot more fatigued.*

The preparatory time and the time after COVID-19 duty are also fatiguing. The experience Judith has been the experience of many nurses. She says, "*Well, even just going into a room to do care takes you sometimes 10 minutes just to prepare everything you are going to need. Because once you're in there, you don't want to come out till you're finished*". Nurses are trying to protect themselves and are trying to protect the patients from cross-contamination demands a lot more effort from them.

> *We were in full PPE all day. Eight hours a day, eight or nine hours a day, and that was in the summer. And I am tired of that, too. I am tired of wearing a mask. We did not know who was infected who was not. So, we were in full PPE with every patient. So, I must have donned and doffed 15-20 times a day. Do you know what donning and doffing are? You put on and remove that. We got pants. We have got gloves. We have got masks. We have got face shields. We have got booties. We are taking it all off and putting it all back on between patients. And there are procedures to prevent infection that go along with all of that* (Denice).

3.3 Isolation, Lack of Team Experience and Lack of Connection

> *Well, the problem I am personally having right now is I am doing okay with my work because that part I can manage. The part I'm struggling with within the office is the collaboration; it is the team cohesiveness that we do not have, just because of how work is right now with COVID. Some people are working at home, some are in the office, and are coping with different stuff. And I kind of feel like a lack of support from management…. But there are so many, there are so many issues, and I just do not feel like it's being managed well, but on the other hand, I do not think anybody kind of knows what to do. So again, I find myself doing more than I've ever done in my career, as I am isolated. I walk into the office, walk into my building, and close the door, and I don't come out unless I have to.* (Lillian)

Lack of support and team experience leads nurses to experience more and more isolation. Due to social distancing, there is already isolation in society, and it becomes more difficult at work. People are silently suffering within. One of the nurses reported her colleague's experience as "*COVID-19 is killing my soul*" in this context. Just as the nurses are working in an infectious environment, society also sees them as possible carriers, which can be very demoralizing for the nurses who care for the sick during a pandemic.

> *When we are in an outbreak, my friends are scared to be around me. They would not see me. They said I do not want to see you until the outbreaks over at your work. So I cannot go for coffee with them or for a meal or a walk. They're scared. Even though I was getting tested every week, I tested negative every time. But they are still scared. I have a daughter. She is 14. And she is scared when I come home. She will be sitting by me wearing a mask.* (Ruby)

3.4 Changing Policies, Protocols, and Information Overload

The theme of constantly changing policies and protocols has been widely reported among nurses as confusing and frustrating. Not having a clear direction regarding anything can be demotivating people. It is not only that the policies are constantly changed, but the communication around it also is very disorganized. The lack of precision of communication can be further damaging, and the overload of information can lead people to get overwhelmed with it. Stella speaks to this experience:

Like I had mentioned before, it's all the different protocols and email after email; you just kind of like blasted with so much information. And it keeps changing constantly. Like, I feel like it's more stable now. But initially, like when COVID-19 first became a pandemic, it was just constant information. And co-workers were very anxious, scared of each other almost, and there is just, there is so much unknown. And so, it became an environment where it was stressful. Yeah, and then again, as I said, it impacted patients too, because they were stressed out, too. It is the unknown. What should we be doing? What should we not? Yeah, many changes, a lot of extra paperwork outside, and just keeping up with all the changes was very frustrating. (Stella)

3.5Fear and Anxiety of Exposure and Lack of Safety

The concerns about fear of exposure to the virus and spreading it to people at home and the overall safety issue are reflected in most participant narratives. Samantha reflected on the issue of safety in a very significant way as she was dealing with a work environment that already lacked sufficient safety:

I'm dealing with people who had an acute psychotic episode, and when I asked them do they have a cough? Or are you exhibiting any symptoms? They are not able to give me a truthful answer. And all I can do as I have to be objective, I cannot say, well, I think you are having symptoms, and you need to get tested. If they refuse it, I just have to take them, and I have to admit them. But now I am feeling unsafe because I might not be getting a truthful answer. And we just have to take it at face value because this is the population, we deal with…And I'm also pregnant, so I was not too happy about that. (Samantha).

The fear is apparent in experience of the triage nurses as they are meeting the infectious persons in the first place. Jacob describes the situation as follows, "*So in that area, I do have a little bit more anxiety because you don't necessarily know what's coming through the doors. And you're one of the first people that's screening them for any COVID symptoms or risk factors*".

3.6 Lack of Support, Overwork, and Anger Towards the System

Nurses often reflected on the issue of support connected to the role of the larger system, which ought to manage the pandemic situation. Whether it is the hospital or the government system, nurses seek support and clear guidance. Cyndi speaks about it in the following words,

If I have to look at it right now, so we are in our second wave, I would say in our hospital, I can foresee that potentially happening. I teach clinical. And I work a .5, I just

worked two 12-hour days this past weekend, and the weekend before and we were busy, we were short-staffed, we only had three/four vents (ventilators. I think that kind of my precursor that would make me most worried is just not being 100% confident that the hospital would have the support for us if we had that happen.

Ruby as: narrates the sense of overwork.

> *when we ran the COVID-19 outbreak, I was anxious. Yes. Because I was like, does this person have COVID? And there was so much stuff to do, and everyone was calling in sick. So, we were working short. And we had 25 people in isolation. Because in that wing, seven people, seven residents tested positive for COVID. So, you had to gown up for every single room for 25 people*, and it was a lot, and you are worrying like, Am I going to have enough time to get everything done?

3.7 Barriers to Compassion During COVID-19

One of the struggles with nurses caring compassionately is the obstacles brought in by the pandemic in the day-to-day caring experiences. The PPE, mask, social distancing, and the inability to touch patients were all reported as obstacles in providing compassionate care. Below given are some examples from the participant narratives. Ruby observes that her patient behaviour changed after COVID-19 compared to before COVID-19. Unfortunately, the additional efforts and hard work needed to keep the COVID-19 protocols limited the ability of compassionate care in the nurses.

> *Just before a resident was ringing their bell, like every five minutes, you would go in, but now they are in isolation. So, you go in and say, is there anything else you need? And they say no. So, you know, it is a process to leave the room, you have to take off the stuff properly, wash your hands, change everything. And then, as soon as you leave the room, they ring the bell again. And you are just thinking like, What now? Instead of before, you are like, is there anything I can help you with? Now? It's like, what do they want now? I was just in there. It is frustrating, I guess.*

Many nurses reported that the inability to touch patients affected both patients and caregivers, especially in situations like long-term care homes. Durkin et al. (2021) and Brown (2020) have referred to the inability of touching the patients by health care workers as causing issues in communicating compassion during COVID-19. Wisniewski et al. (2021) speak about the use of PPE and mask and the inability of patients to read facial expressions of the health care worker as

making the patients feel unsafe during the pandemic. In addition, the COVID-19 condition demanded a sudden change in their behaviour to adapt COVID-19 appropriate behaviours, which was difficult. The following is the experience of Celine:

> *That drove me crazy because we were so physical in our job. We are always hugging and combing hair. For a while, we were not even allowed to hug our residents anymore, and it was so bizarre, and you could tell that is just what people needed, they needed to be touched, and that was a couple of hard months... It was agonizing to watch our residents and ourselves as well. I think we all need it.*

The pandemic affected a certain patient population more than others, like the dementia patients who got frustrated in a smaller space without the caregivers touching them. It was also true about residents in care homes who were hard of hearing. For them, the mask interfered with understanding what the nurses communicated with them. Ruby has a similar experience that she shares,

> *So, many residents read lips when you are talking because they are hard of hearing. So now, when you are talking to them, they do not hear anything. You are saying they do not know what you are saying. It takes even more time. Because they are saying, What? What? And then you have to say it again. And you just have to keep repeating yourself, repeating yourself like yelling, then finally they will hear you.*

4. The Emergent Grounded Theory on Multi-Phased Nurse Compassion Fatigue Process

The grounded theory analysis, results and findings emerge into a theoretical explanation of a four-phase compassionate care and compassion fatigue process among direct care nurses. Before explaining the below-given graphic representation (Figure 24) of the emergent grounded theory, it will be important to give a background of this theoretical formulation within this structure. It was important to me to conceptualize the process of compassion fatigue and compassionate care from the point of view of educational research. This awareness helped me connect various categories into a flow of formative instances within the nursing profession. The interview questions reflected not only the developmental trajectory of the nurses but also the formative milestones within their life, education, and nursing training. As influenced by this approach, the four phases of nursing practice and formation evolved into the structure of the grounded theory.

Another very important fact regarding nurse education that the interview data implied was that nursing education is not done in a degree or training; rather, there is an ongoing education parallel to their nursing practice. This is all the truer about gaining knowledge on compassion fatigue. The whole project of experiential learning on compassionate care and compassion fatigue for nurses was not a linear process where learning leads to a permanent, stable outcome rather a cyclical process of learning that is parallel to their repeated experiences of patient interaction. Though the emergent grounded theory appears as a linear process through the four phases, it is a cyclical process of returning to previous stages to be refined every time. The following figure (Figure 21) is a graphic representation of the emergent grounded theory that I have arrived at through this study.

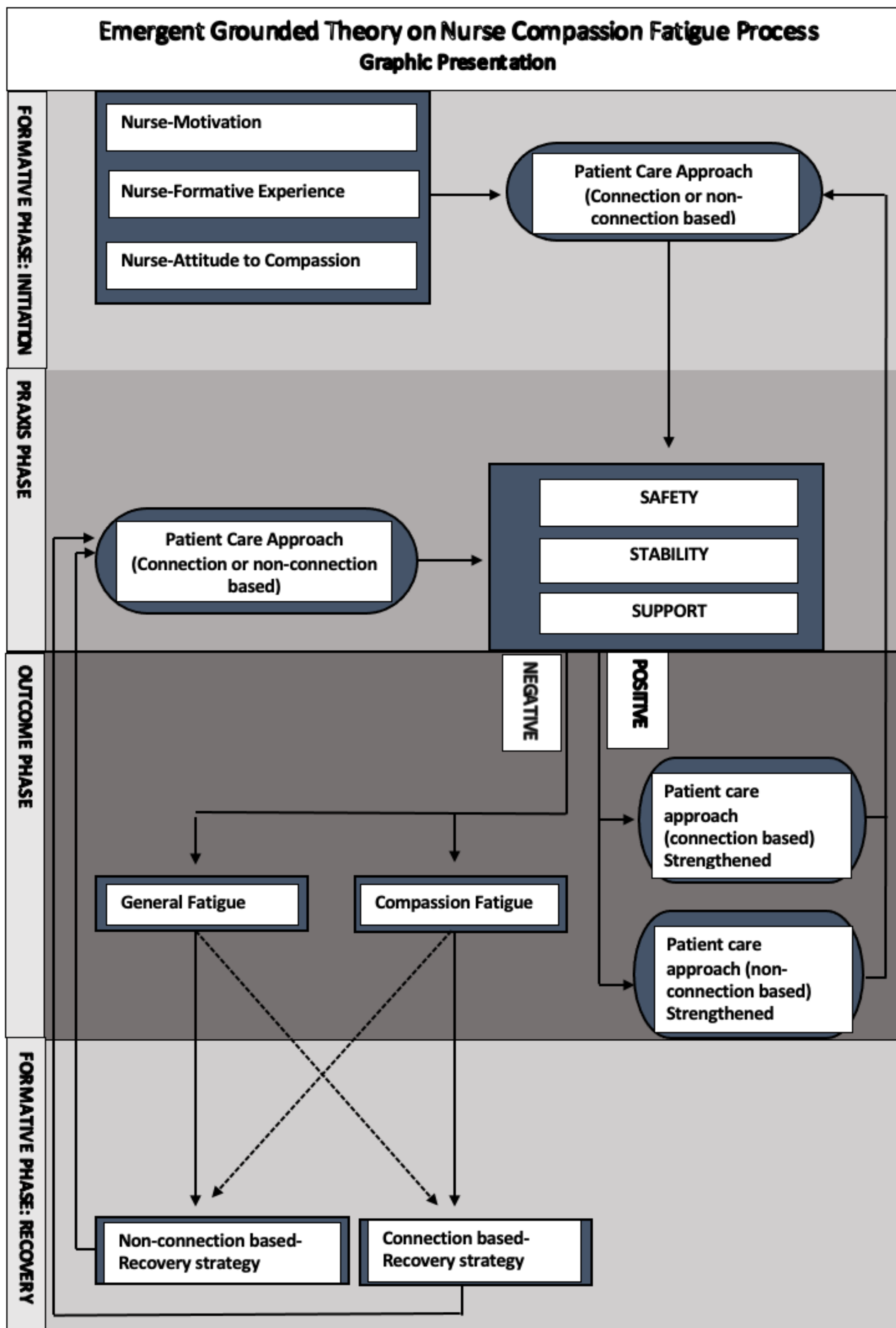

Figure 22: Graphic presentation of emergent grounded theory on compassion fatigue process among nurses

The emergent grounded theory on compassion fatigue has divided the process into four phases: the initiation-focused formative phase, praxis phase, outcome phase and recovery-

focused formative phase. The initial motivation, formative experiences, and the attitude to compassion define the nurses' approach to patient care. Broadly this can be divided into connection-based, and non-connection-based patient care approaches. Regardless of the patient care approach, they ascribe to; a nurse enters the praxis phase of nursing competencies. During this phase, the work environment is perceived mainly through three foundational experiences of safety, stability, and support in the nurse's experience. These foundational experiences influence every transaction of a nurse during the praxis phase. The formative experiences can also colour the overall perception of safety, stability, and support.

The experiences during the praxis phase can either be positive or negative to the nurse, resulting in a positive or negative outcome of this experience. The outcome of the praxis phase could indicate whether a connection-oriented practice is strengthened or weakened. If it is strengthened, the nurse is reinforced to have a robust connection-oriented patient care approach and re-enter into their praxis phase, continuing the cycle. Similarly, if the connection-oriented nurse approach weakened during the praxis, the nurse may experience compassion fatigue with exhaustion, fatigue, and other symptoms. In the same way, the non-connection-based patient care approach is also either strengthened or weakened through the praxis phase. If it is strengthened, the nurse may continue with the non-connection-based patient care approach and enter their praxis phase. If the non-connection-based approach is weakened during the praxis phase, we may call it general nurse fatigue. For both groups (compassion fatigue and general nurse fatigue), the recovery-focused formative phase may offer opportunities through experience and training to either adopt a connection-based recovery strategy or a non-connection-based recovery strategy. According to what strategies they adopt, there is a potential for them to involve a more connection-based patient care approach or non-connection-based patient care approach as they enter the praxis phase and continue a similar cycle of events.

The emergent grounded theory is developed primarily from 27 nurses who reported having experienced compassion fatigue; it has not included possibilities that were not evidenced in the data. For example, at the praxis phase, it may be possible that a nurse whose non-connection patient care approach changes into a connection approach due to the influence of a positive workplace environment and the strengthening of the perception of safety, stability, and support available to them. However, as none of the participants exhibited such a change to their patient care approach in the outcome phase, the grounded theory has not pursued this possibility.

The safety, stability, and support of the workplace function as a positive attachment experience but may not be sufficient to demand a change in nurses' patient care approach. The grounded theory would suggest that if the non-connecting patient care approach is insufficient to meet both patient and nurse needs, the nurse will be challenged by it and may experience general nurse fatigue. In such a case, this may open an opportunity for the nurse and management to consider the formative value of the recovery process. Though the initiation and recovery phases have formative value, it does not rule out the intrinsic formative value of the praxis phase for a nurse.

5. Concluding Remarks

This chapter introduced the profiles of the twenty-seven study participants (as presented in the appendix xi), the key themes that emerged from the in-depth interviews regarding compassion fatigue and specific themes related to COVID-19 and nurse compassion fatigue. This chapter indicated the saturated themes within the study and explicated the emergent grounded theory of multi-phased compassion fatigue process in nurses by elaborating inter-connection of the themes that emerged within a grounded model. These themes are arranged into four phases of development in a nurse's life; namely, the Initiation focused, Praxis, Outcome, and Recovery Focused phases.

Similar to this chapter, the following chapter falls within the “Finding” section of a traditional dissertation. However, as the reader would find, using the representative case vignettes attains the additional goal of theory testing process in a grounded theory. The case vignettes introduced in the next chapter looks for data congruence within the emergent model.

CHAPTER VI

EXPLICATING THE GROUNDED THEORY MODEL USING CASE VIGNETTES

This chapter presents six representative case vignettes which runs through the four phases of compassion fatigue process, namely, the initiation focused formative phase, praxis phase, outcome phase and recovery focused formative phase. Each of these vignettes explore six representative nurse experiences which are chosen from the 27 nurse participants. These nurses are identified by their pseudonyms: Celine (Participant 4), Edith (Participant 10), Heidy (Participant 11), Mary (Participant 21), Emma (Participant 9), and Joslyn (Participant 14). The purpose of this chapter is to exhibit the congruence of the emergent grounded theory model with the participant data, which essentially establishes the "emergence" of the theory from rich, grounded data attained through theoretical saturation and constant comparison. This way of presenting the findings is in line with the phenomenological focus of the grounded theory model of Gioia et al. (2013) in establishing the lived experience of its participants.

One of the main factors in selecting a case as representative has been the difference between participant cases in their presentation of the desire to connect as a primary motivator and the absence or the partial presence of the same. Another major factor is the difference between individual nurses with regard to the presence and absence or partial absence of the common elements of compassion fatigue experience. As explained in the analysis chapter, that the comparison of the narrative data of each individual case, brought to light five specific elements of compassion fatigue, common to most nurses and which are absent in the narratives of a few nurses. While the representative case vignettes of Celine, Edith, Heidy, and Mary exhibit the optimum presence of these characteristics, the representative case vignettes of Emma and Joslyn show the absence of many of these characteristics. Similarly, the cases of Celine, Edith, Heidy, and Mary show a strong desire to connect, however the cases of Emma and Joslyn doesn't show the desire to connect as a primary force. Other reasons include the desire to provide representation to demographic diversity-career lengths, work environment (geriatric care, NICU, psychiatric care and so on) and professional standing (such as RN, LPN and so on).

1. The Formative Phase (Initiation Focused) Case Vignettes

The initiation focused formative phase refers to the formative experiences that a nurses carry with them as they enter the profession. These experiences appear to have a mediating effect

on their practice of compassionate care and experience of compassion fatigue. The following are three vignettes on initial motivation, nurturing experiences, and attitude to compassion.

1.1 Vignette: "Why I Went into Nursing?"

The initial motivation(s) that the nurses in the study had for entering the nursing profession were explored in each of the 27 the interviews that were conducted. The overwhelming majority shared a desire to work with people as the most significant motivator for entering the profession. They variously described their motivations as looking to connect, care, protect, advocate for, or help people. They explicitly narrated their interest in people, which often reflected in their practice. This overarching interest in people, however, also appears as a spectrum of levels of passion for working with people. Some of the nurses showed high levels of a genuine passion for working with people, some showed low levels of passion for working with people, and a few others appeared to show the least amount of passion for working with people. In this vignette, I will be looking to describe this spectrum, as described by the nurses themselves. The first part of the vignette describes four representative cases of Celine, Edith, Heidy, and Mary, who all appeared to exhibit a genuine passion for working with people. The second part of the vignette looks at the representative cases of Emma and Joslyn, who appeared to show a more circumspect passion for people. This is not to say that they do not care for people, but rather, they are in a different place on the spectrum. Having a differing level of passion for working with people does not call for any value judgement on the character of these participants; rather, this could be like extroversion and introversion-related characteristics, which may influence the career paths of individuals.

Celine is a licensed practical nurse from British Columbia who belongs to the 46-55 age group of the interview participants. She works full-time in a long-term care facility and has been in direct care nursing for 16 years. She started as a care aid in long-term care, and after approximately seven years, she qualified herself as a Licensed Practical Nurse (LPN). Celine, who originally trained as a chef, entered nursing when she realized that her elderly grandparents were in palliative care. She loves her patients and the relationship that is built-in long-term care. As she says, *"On a normal day, I love my patients, I love the relationships that are built-in long-term care. I love that feeling of being an extended part of their family"*. Her desire to work with people is also reflected in her appreciation for her team as she commented *"we are very cohesive as a team as well and approach things as a team."* This sense of belonging allows Celine to see

herself as belonging to a family in the long-term care team and drives her commitment to the profession: *"I love being a nurse, and I love nursing and long-term care".*

The COVID-19 pandemic posed a threat to her desire to connect to patients and their families as the in-person conversations with patients' families were not possible. She makes the observation that:

> *... now we deal with people over the phone instead of talking to them in person, and it is just not the same feeling of having to be able to talk to a family member face to face and discuss the residents' concerns or issues or decline in their health status*.

Similar to this situation of not connecting with patient families through face-to-face conversations, the inability to be physically supportive to the majority of her patients who have dementia frustrated her:

> *We are hugging, combing hair and those physical things ... we weren't even allowed to hug our residents anymore. That was so bizarre, and you could tell that's just what people needed, they needed to be touched, and yeah, those were a couple of hard months, where we weren't even allowed to physically touch our residents, aside from just doing the obvious care things.*

Celine's passion for working with people is not only visible in the initial comments but was present all through her narratives.

Edith is an oncology nurse from British Columbia who belongs to the 36-45 age group of the interview participants. She has been in direct nursing care for the last 20 years. She started as an LPN and, after ten years of experience, transitioned into Registered Nursing. Edith has been working part-time hours before COVID-19 and is working around 35 hours a week currently. While in high school, Edith's aunt asked her what she wanted to do when she grew up. She said that she wanted to do something where she could help people. To which her aunt replied, *"you would be a really good nurse*".

A desire for Edith to take care of people saw her enter the nursing profession. As an LPN, she "*wanted to know more about what nursing is ...what it means to take care of people in health care,*" which motivated her to become a registered nurse. Edith's passion for helping people is evident in her patient interactions. For most of her profession, she has worked in long-term care and oncology. When she meets patients the first time, she is reminded "*that this is their first time going through this, and this is probably my 100th time seeing a patient just like them*". It is

important to her that she tries to meet patients where they are at: "*I always kind of start at square one with where they are at, and what their needs are, and what they want to see from their treatment*". An important part of these interactions is to reassure patients, as she knows that for her patients a cancer diagnosis is scary. Cancer treatment can be either curative or palliative. Initially, Edith says she did not know how to approach patients, especially those palliative care patients. However, over time she has learned to have conversations with them, and now she does not run away from the end-of-life conversations that are needed with some of her patients.

Regarding her experiences, these are her words, *"...you can have a conversation about what they need in their end-of-life care. Early in my nursing career, those kinds of conversations made me nervous. I never wanted to avoid them because I knew patients needed the conversations*". Edith's desire to help people, and her efforts to learn how to meet the needs of her patients in order to take care of them has made her grow over the years. In facing these difficult situations and conversations, she has learned to care in a very healthy way.

Heidy is a part-time Registered Nurse from Quebec who belongs to the 56+ group among the nurses I interviewed. She has around 45 years of experience in direct nursing care and is currently working in the neonatal intensive care unit. Heidy's mother was a nurse, and she always wanted to be a nurse. She says that she used to dress as a nurse on Halloween. She learned to care for people from her mother. As she was the oldest of siblings, she had to care for the younger ones, and take care of her sick grandparents. According to Heidy, these experiences helped her "*learn how to take care of other people, and so I had always wanted to be a nurse from when I was very little*."

Her mother had an extraordinary way of helping the community, and there was food for anyone in her home and children could come anytime. As Heidy remembers, "*We could all bring friends. And we had only a pound of hamburger… so the hamburgers just got smaller. That is all*". Heidy's motivation to care naturally translated to her workplace, where she would be meeting with several sick babies and their parents. She is so passionate about her work that she almost cries when she speaks about her patients. Regarding the sense of care, she has towards her patients, she says that she would always involve the parents in the care of the baby, and she deeply connects with both parents and child: "*You do fall in love with these little creatures and most of the time, you fall in love with the parents too and for sure*." Even after so many years

into her nursing career, she keeps the passion for her patients as "*it is pretty easy for me to connect with families*."

Mary is a Registered Nurse from Alberta, currently working in a hospital emergency facility and the labour and delivery unit on a casual basis. She has been in direct care nursing for the last 12 years and belongs to the 26-35 age group of nurses. Before going into nursing, Mary studied both engineering and general sciences at university. From these experiences:

> *I came to nursing because of my first two programs; I did not enjoy them. And I realized I need people interaction, and I needed to provide a service that was going to be lifelong, but also rewarding to me*.

Ultimately her desire to work with people brought her to the nursing profession. Mary's motivation to help the sick originated mostly from her religious and spiritual experiences. A personal religious understanding to "*help the sick*" directed her into the nursing profession, after her earlier studies:

> *My profession had to meet a lot of criteria. One of them was, how can I help and serve someone? But imagine if it was my job? And that's my kind of start to think about different occupations. And then I realized that there's a lot of physicians in our community. I had no desire to be a physician. Then I felt like I could help people but do it in a different area. And so that's when I started to explore nursing.*

Her constant wondering before entering nursing was to find a job where she could earn a living and fulfill her religious understanding: "*It was kind of my drive; how can I actually pick an occupation where I can really help someone*."

Mary has so far worked in radiology, labour and delivery, emergency, and postpartum care. Mary begins her work by assessing patient issues and needs, and she will have one patient if she is placed in the labour and delivery but three to seven patients in the emergency department. Regardless of the number of patients:

> *I try to get to know them by developing a relationship right off the back. So, the next eight hours I have with or even one or two hours, whatever it may be, we have a strong connection, even if it's for a short time. Most people who come into those areas, whether it is emergency or labour delivery, they're quite vulnerable*.

Her initial motivation to help the sick is now enacted in her daily practice to be tuned to patient suffering.

Emma is a Registered Nurse belonging to the 26-35 age group of nurses. She is from Ontario and has been in direct care nursing for the last one and half years. She works at a hospital in the labour and delivery department. Emma was formerly a librarian and was inspired by the nurses she met while volunteering at a clinic. As she explains the context of her becoming a nurse:

> *I worked as a librarian for a couple of years, and I was sort of bored sitting at a desk all the time, I didn't work with the public, I worked with other librarians training them. I missed working with the public, and I started volunteering at a sexual health clinic, and then I met a couple of interesting nurses there. So, I decided to go back to school for the accelerated nursing program.*

Emma thought of working with people as more interesting compared to her boring desk job at the library.

During her regular shifts at the labour and delivery unit, Emma has the ability to choose her patients most times. She has the choice between a patient who is almost ready for giving birth, a postpartum patient, or a caesarian section patient. Emma makes a choice by deciding who would be the least exhausting patient:

> *I'm thinking about looking at how long the person has been in the hospital and how long they've been in labour. I'm looking at whether they're choosing an epidural and, if yes, whether their pain is controlled because a patient without a working epidural is the most exhausting kind of patient*.

It appears her patient decision is based on what is most safe and comfortable for herself first, and consideration of the patient and their condition comes only second:

> *I usually start feeling curious about how they are feeling, because how they feel will determine how my day goes. So, if they are an anxious patient, my day just gets exponentially harder, whereas if they're calm or relaxed, then my day gets kind of, not easier, but a little bit more fun*.

Evidently, unlike Edith, who was never afraid of having difficult conversations with her terminally ill cancer patients, Emma makes her choices to avoid difficult situations in the one-to-one care scenario at the labour and delivery unit.

Joslyn is a Registered Nurse from British Columbia who belongs to the 26-35 age group of nurses. She is currently working full-time in an emergency department and has been in direct

care nursing for three years. Joslyn never thought of going into nursing studies. It was when one of her family friends suggested that she enrol in a nursing school. Prior to entering nursing, she had finished two years of a science program at university and was working full time in a bank. She agrees that there was a lot of pressure on her from her family for a high-status doctor, lawyer, engineer, and accountant career path.

When asked about her typical day, Joslyn explained that patient care prioritized the sickest person first. From patients themselves, Joslyn commented how they were generally grateful for the care they receive:

> *Generally, the patients are very grateful to be receiving care at our facility. Just knowing our hospital, the general wait times, five to six hours is totally a thing. So, for sick patients to be receiving care in beds, they are generally very grateful.*

She also spoke about calls from family members inquiring about their loved ones as being a *"bit frustrating*". Particularly annoying were people who wanted to know about a patient's condition despite having already received an answer to their inquiries:

> *…what part of this is an emergency room you do not understand. You have gone through all of my staff, twice questioning, and many of the staff multiple times. And then now for me to have to direct anger towards you, for you to listen to me.*

While most nurses who were interviewed expressed compassion for patients and families, some even talked about the inappropriateness of expecting any compassion from patients; Joslyn felt that she doesn't experience compassion from others: "*It makes you feel more disappointed in humanity. It makes you wonder why people are the way they are. And why can't they have more compassion towards you?*" Joslyn didn't explicitly express any desire to connect or care for patients or families; instead, there was a sense of the task-oriented nurse in her narrative.

1.2 Vignette: "Nature and Nurture"

The growth environment and genetically predisposed traits contribute to the overall development of a person. It is also possible that these elements of nature and nurture may play a balancing role to some extent. Regarding compassion, the question of nature and nurture often comes up as to whether people are genetically pre-disposed to be compassionate or is it possible to train a person to become compassionate? Though we don't have a definite answer to that question, there are some behavioural observations which imply that children are born with the innate ability to share and help others without a need for reward and encouragement. Tomasello

(2009) says that the earliest helping nature in children is an "outward expression of children's natural inclination to sympathize with others in strife" (p. 13). According to him this trait of being naturally altruistic is an evolutionarily stable behaviour (Warneken & Tomasello, 2009). The neurological studies by Klimecki et al. (2013) found that compassion training had the ability to override empathic distress experience and create positive affect. Buddhist tradition considers compassion both as Buddha's nature and as something that can be cultivated through meditation (Analayo, 2015).

The earliest developmental experiences related to compassion were explored in all 27 interviews. Most of the nurses reported supportive and caring families and persons during their early developmental years. Some, however, reported the absence of compassionate, caring family, or persons during their early childhood days. Some of the nurses, even though they did not experience the presence of compassionate families or people during their childhood, did report strong experiences of compassion during their adult lives. A few of the nurses reported a very strong religious or spiritual affiliation which positively influenced them during their developmental years. Together with the theme of compassion experienced through caring individuals in the nurses' life, the themes of safety, stability and support are also reflected during the developmental years of some of the nurses. The first part of this vignette explores the representative cases of Celine, Edith, Heidy, and Mary, who appeared to have had an upbringing marked by compassion, safety, stability, and support. The second part of the vignette looks at the representative cases of Emma and Joslyn who do not appear to have experienced similar, positive experiences during their developmental years.

Celine remembers that since childhood she had a "*fairy tale family*" where every person is still with their original partners. Celine thinks that she had the "*perfect family*", as she recollects: "*my grandparents were together, and my parents are together. we've never had a rift in our family, which is I know very unusual. We do things as a family; we eat together as a family*". She agrees that it may be unusual to have such a good family around and so she believes she is "*lucky and spoiled*". It is not only that her perception of family is a very healthy one, but also her personal experience was that of deep compassion. According to her, she felt "*deeply loved and cared*" by her family.

Comparing herself with her siblings, Celine says, *"I am the mean one of the siblings … because my sister and my brother even are much nicer than me*". She believes that the caring

nature in her siblings is a result of a loving, stable and secure family. Celine is of the opinion that her sense of compassion is innate which may have been strengthened by having a stable and loving family:

> *I think it's a product of having such a stable, loving family. Obviously, I think that has to have an influence on it. Yeah, I think we're just genuinely kind people, our family in general, we really love other people, most other people, I could really do without Trump right now, but I think most other people.*

When reflecting about some of her colleagues and people around her who have difficult and unstable families, Celine finds it hard to understand their stories as she never experienced anything similar. For her, security or safety at home was a significant experience during her growing up years and she knows that so many people are deprived of such an experience:

> *I know how lucky to have the family in the background that I have and I'm shocked to hear other people's stories because I have a hard time often relating to those, because I don't have experience with it. I do think it is a huge part of my upbringing and my background, and the security I think is a very important word because I know that's not a part of a lot of people's lives*.

Concerning her spiritual beliefs, she is an atheist; however, she profoundly respects people's spiritualities. She believes in the goodness of people and the need to take care of the earth.

Edith's earliest life experiences taught her to value compassion as part of success. When as a child she saw that her parents were stepping into the community to care for people, she realized it as "*something that was important to do for other people, when you have the strength and the skills to do it*". They did the same thing in the Church community that they frequented as a family. Strong values of helping other people were also reflected in this religious context as she admired people like Mother Teresa: "*I've always really admired people like her. You know, they just give everything for, for everybody else. And I've often wondered, how in the world could she be that giving?"*

Edith stated that her parents were not people with a "*super affectionate type of relationship*". However, she experienced deep care from them:

> *They always gave me everything I needed. And I think they helped to put into perspective of need versus want. So, you know, when you realize that you're getting everything you*

need, and you're even getting some of the stuff you want. You do feel cared for. So, whether it's hugs and kisses, or not, your actual needs are met.

Edith's understanding of her parents' role in her caring nature is that of inspirational models. They taught her to value care as part of success in reaching her full potential, while also encouraging the innate nature of compassion to be developed in connection with the community. She describes her understanding of reaching her full potential in these words:

I think they just inspired me to do things with my life I've always wanted to achieve. And not by getting straight A's in school, but by just achieving something that's bigger than just myself. Something that's helping other people, improving someone else's experience.

Heidy had a hard working, generous and strong-willed mother, and a gentle and caring dad. Her mother has been a role model for her. Though her mother didn't have a great relationship with her own mother, Heidy witnessed her mother serving her grandmother even with difficult tasks. She agrees that she saw some hurt and anger in her mother, nevertheless she was devoted to caring. Heidy also witnessed her mother giving her 100% for the community. Her mother's care for the community was like,

She cooked for everybody who was sick all the time. Not just a little meal but all the time. We didn't have a lot of money. You know that it didn't matter. There was always food on Saturday nights at our house. Kids could come anytime. We could all bring our friends. And if we had only a pound of hamburger, it just the hamburgers got smaller, that's all.

Heidy believes that she learned a lot from her mother regarding hard work and giving. Having grandparents at home during her childhood was a joyful experience for her.

Heidy was very close to her dad. Though her mom was not very affectionate, her dad was gentle and affectionate. She and her siblings used to play with her dad and once other siblings left the room she used to stay with her dad and have conversations with him. Being the eldest girl, she had responsibilities in her home. However, she was the least athletic one among the siblings and felt bad about it. Despite it her dad had a way of making her feel valued and special. He used to say, *"you have something special just because you care, because you help and just because you're always there for people*". Heidy realizes that because both her parents valued care and compassion very much that she has been in this profession for so many years.

The fact that Heidy valued care and compassion is evident from the fact that she received the 11th grade the award for the most caring person. She thinks that though all her siblings were

highly successful, they didn't appear to be happy. However, she feels that she is the happiest one among them.

During her childhood days, Heidy experienced the presence of several caring people, and she also felt the sense of a good God: *"I don't know, a sense that God is good. I always had a sense that there was a God, who loved me. And I don't know where that really came from. My mother doesn't really have that"*.

Mary's enrolling in nursing school came as part of her religious experience, rather than being motivated by family and friends. She never had any exposure to a caring career like nursing prior to joining nursing. She remembers, "*I actually never went inside of a hospital until I was in nursing school, which was so bizarre that I would be driven to work in a hospital, but even visiting somebody had never actually got me into a hospital ever".* Mary's parents were not emotional or affectionate people. She thinks that they were opposed to her joining nursing as they didn't appear to understand those specific skills of compassionate care in a profession. Mary remembers helping her younger brother with his homework at school as their mother didn't speak English. She also recollects helping children at the day home which her mother managed.

Even though Mary didn't receive much encouragement in being a caring person from her early childhood experiences, she appears to have been naturally caring as revealed from her childhood experiences and was deepened into the value of helping people through her religious learning and experiences.

Emma, a nurse at the labour and delivery unit, explained compassionate care as "*being able to give the best birthing experience to her patients and involving their partners in the same process"*. When asked to reflect on where these styles of caring came from, Emma shared the examples of the "*client empowering care model*" at the health clinic where she volunteered and the death experience of a patient in the geriatric ward which reminded her of her grandparents' death. She was not with her grandparents when they died. She suggested that if not in labour and delivery, she would be working in palliative care. Exploring it further she commented, "*I think that in many ways, they're very similar, in death and in birth, we're trying to prioritize the needs and wishes of the patient or client*".

Emma neither had any specific spiritual language related to compassion nor any deep caring or compassion experience during her childhood. However, to the question, "*whether she*

called herself a compassionate person?" she said "*yes*". She didn't remember any experience of compassion during childhood:

> *I don't really remember. I'm sure there was compassion in my childhood, but I don't really remember. I don't think my parents were very compassionate people ... Yeah, they were more just the kind of people who liked to be quiet and do their work and considered suffering as part of life.*

Emma was not able to remember any of the growing up experiences of care or being cared for. As an adult she thinks that she is being cared for by friends. It appears that even though she would want to call herself a compassionate person, it is hard for her to pinpoint experiences of nature or nurture that evidence the development of deep caring traits.

Joslyn says "*I think you can have a duty for what needs to be done. But I don't think you have to express love or care while doing it*". She thinks compassionate care needs to be seen primarily from an angle of duty. It is a moral duty to do more than just the bare minimum needed. She describes compassionate care as,

> *When you take a slice of time, and you dedicate it to this patient, whether it's directly or indirectly… Not just because your job tells you to do so. But because you really want to make sure this person succeeds when they go home.*

Similarly, when asked about whether she was a person-oriented or task-oriented nurse, her response indicated a bit more of an impersonal stance:

> *… in a sense that question is more patient dependent. If you have a very simple task in front of you, it might be a lot more task oriented, like measure for the crutches versus if someone is sick you need to be looking at the patient as a whole picture.*

Aligning with her philosophy of care as a moral duty was her explanation of the early influences in her life regarding compassion and care:

> *I did have people who cared very deeply about me, and I feel those people came in the manner of teachers or mentors that came in my life. And I think what I said previously, they did their job, but they also put a little bit of themselves into it.*

It is interesting to note that Joslyn developed a language of care as almost a moral duty and finds the link in the early experiences. As she did not share about her family and parents and any experiences in her childhood related to compassion, it is difficult to understand the nurturing

influences in her nature of care. Joslyn also did not attribute any spiritual or religious source or language to her caring nature.

1.3 Vignette: "I Do Wish Compassion and Grace for Everyone"

A positive attitude to compassion appears to produce positive outcomes related to compassionate care (Kirby et al., 2019). Buddhist practices in compassion training invite the trainee to gradually move from self-referential compassion to non-self-referential, or universal, compassion. Compassionate care also appears to have a spectrum of experiences where the degree of non-self-centeredness vary from case to case. It appears that both the attitude to, and practice of, compassion carry this variation in general experience. An exploration of the individual's attitude to compassion was carried out during the interviews with all 27 nurses. A similar concept of unconditional love, which emerged from the interview language also was adopted in the inquiry with people who were not familiar with an understanding of universal compassion.

The results of this exploration revealed different degrees of understanding and attitude to universal compassion/unconditional love. The answers varied from a deep belief in universal compassion/unconditional love, to a positive approach and desire for these qualities, to a negative attitude towards universal compassion/unconditional love. However, it is to be noted that all 27 nurses admitted that they found their ability to provide compassionate care was always limited in real practice. The following vignette brings the four representative cases of Celine, Edith, Heidy, and Mary who had a very positive outlook on universal compassion/unconditional love and two representative cases of Emma and Joslyn who appeared to have a less positive outlook on universal compassion/unconditional love.

Celine described compassion as the "*innate caring for somebody else and the feeling of empathy for their emotional, mental and physical situations that go along with being ill and separated from their families*". A deeper awareness of the suffering of a fellow human being from an innate place is visible in her description of compassion. The action orientation of compassion is strong in Celine's understanding as she further describes it as the action of "*putting yourself or your loved one in the same position of the people that you are caring for*". She views self-compassion and compassion of the other as parallel to each other. Her idea of compassion also resonates with the golden rule of the Bible: *"do unto others as you would have them do unto you"*. Celine's practice of compassion appears to be similar to the loving kindness

practice of compassion in Buddhism where the trainee starts showing compassion to the close and near ones and slowly transitions towards compassion to far and distant others. Similarly, for Celine, "*when I am caring for someone I think of my grandparents and what I would want for them".*

Reflecting on universal compassion, Celine appears to ground herself in the experiences of individual compassion when she is met with the lack of compassion and enormous cruelties unfolded in war-like situations. Though she wants to believe in universal compassion, she can do that only through the language of the individual acts of compassion. Following words explain her dilemma:

> *I truly want to believe in universal compassion. My son is right now in the midst of learning about World War II, the atrocities of it and you know, you lose a little faith in people's compassion. But I think it's always the little stories that help bring it back. So I don't know if it's universal compassion that you see or individual compassion, which makes you think it's all good, it's going to be okay because sometimes universal compassion doesn't actually seem to be very present.*

Edith's understanding of compassionate care refers to the care where the caregiver gets to know the needs of the patient and empower the patient to fix them instead of the caregiver fixing it for them. It also would mean that whenever the patient needs the caregiver's help the caregiver is available to support. Compassionate care in Edith's words is the following,

> *If we see problems with our patients, we want to fix them. But it's a matter of finding out what they feel that they need. And then providing them with the tools to do it for themselves as much as possible rather than just going in and doing things for people. To me, that's compassionate care. Encouraging a dementia patient to button their own buttons which they're having a hard time doing rather than just taking it over and doing it for them. But also knowing when they do need more help and giving it.*

Edith agrees that her practice of compassion has a limit: "*I don't think I have the strength to do it the way Mother Teresa does. Because I have a limit*". She thinks that she is able to keep healthy boundaries with her patients and others which really helps her in her practice of compassion. The sense of balance is reflected in her words,

> *I don't necessarily dive into the well with people, you know, when they're hurting. I feel they're hurt, right. But it's almost like I can walk away and actually put it in a little compartment where I don't have to think about it again until later, until I have to do so.*

Even though Edith can keep a balance in her compassionate caregiving experience it doesn't mean that she is neglectful or non-caring of the patients. If fact the opposite is true and that is obvious in her description of what happens to her when she has to leave one patient and go to another: "*There are those patients still that I leave the room and I get teared up, and I have to go home and have a good cry*".

Though Edith has only a vague idea about universal compassion, she knows well about the Christian concept of grace: "*I do wish compassion and grace for everyone*". According to her, not having compassion affects one negatively and the societal pressure to not express compassion can affect one in their practice of compassion. The ability to accept one's own emotions, both positive and negative, is also an important factor in the practice of compassion. In the following words Edith elaborates her thoughts:

> *You know, a lot of people are raised with the idea that you're supposed to be happy all the time, or that being sad is somehow bad or crying is somehow bad. And so, I think people who care deeply if they're also combined with somebody who's been told that they shouldn't care so deeply, or they don't get so upset over that. Then it's going to be difficult to stay away from becoming fatigued by your compassion, because you're constantly telling yourself, you shouldn't be that compassionate.*

Heidy considers compassionate care as taking care of others as our own people. As she works in a Neonatal Intensive Care Unit with sick children and their parents, she says:

> *I always want to care for the babies as if they were my babies. I hope if my baby was in the hospital, how someone would take care of my baby or if it was my mother or father, how would I care for them*?

She considers this kind of care is "*tenderness*" and can be contagious as when other people see how this care is practiced, they try to do similar things to care:

> *Sometimes the baby dies right away and maybe was looked after by just one nurse, but sometimes babies will die after a year. In which case, you know we have become the family for the family. Like we have birthday parties for them, and we celebrate every*

month, and you know at Halloween we dress them all up as a little superhero. And you know, it just takes one person starts doing something tender.

When asked about universal compassion, Heidy related it with the Christian concept of "*unconditional love*" as she said, "*I am happy to get to that point. I definitely have some conditions*". Heidy remembered some of her conversation around it with her father. Whenever her father drove her to Montreal, she had deeper conversations with him. One day her father said during the conversation: "*You know what? You are only compassionate when you're getting something back. Like you love somebody because it makes you feel good*". However, shortly before his death he admitted that what he said was wrong and agreed with Heidy for whom unconditional love was "*when you love the unlovable like Mother Teresa and that is the gold standard*". Heidy admits that there have been only a very few times that she was able to keep the gold standard herself.

Mary's religious background taught her to help the sick has been the most significant influence on her caring nature. She did not know the concept of universal compassion but was familiar with the term unconditional love. She has a positive attitude to the idea of unconditional love: "*It's a very challenging one. And I may try it, but I feel like I am limited in my own flaws, but it's something for sure that I tried to do*". It is due to her affinity to the idea of unconditional love that she tried to be reflective around patients:

When they often take it out on me, I tried to personalize it and understand they are just frustrated at the health care system, or they are frustrated in their bodies with their illnesses, or their situations. I just happen to be an outlet. And I try not to let that limit my ability for good care and love for them.

When Mary is challenged with frustrated patients, she tries to remind herself, "*It's situational and that should not be a barrier for me to provide good care".*

According to her even though it is possible that the more compassion you practice the more Compassion fatigue you get, there is both benefit and risk to both:

If I don't feel I'm compassionate at all, I often don't ever get that award for it". She says, "*people don't just need medical treatment, they actually also need compassion, they need to be heard. And if that is never received, they're no better off with that*.

Mary regrets the moments that she found it difficult to exercise compassion with her patients and for her this guilt is difficult to deal with:

> *I never actually in all my years regretted having too much compassion. However, when I go to work, and I automatically tell myself, I'm just going to do tasks. That's when I often have regrets and guilt. And, you know, if I have a lot of compassion, and then I get Compassion fatigue I can recharge from that. The guilt is not so easy to walk away from, that guilt is quite hard. And I feel it carries me for a longer length of time, than Compassion fatigue.*

It is interesting to note that Mary is making a clear connection between compassion and Compassion fatigue in her narrative.

Emma has heard about unconditional love, and she thinks it may be true considering that nurses care for people they "*don't know a tone about*". Emma's understanding may imply that the care of nurses automatically qualifies as unconditional love, just because they are caring for strangers.

According to her, caring is rooted in the sense of community which she says is not in the hospital system. She also looks at caring as part of a gendered expectation:

> *So, we are expected to be compassionate and have endless reserves, and can face other people's feelings, and I do not think that is true. I think that we do not recognize how difficult it is, and it is part of gendered labour, where it is just, unnamed, and unacknowledged and so sometimes I think it is fair to say I do not have the capacity for it.*

For Emma, the patient condition brings about a sense of compassion or pity in her that she is responding with appropriate caring behaviour:

> *In reality there's somebody in front of me worried that their baby is dying, or whose baby has died and how do you just not care?... I don't know how easy it is in other areas for nurses to disconnect but I don't find myself very able to*.

It appears that for Emma, by the very reason of their choice of profession, nurses are in a helpless situation to care as they are presented with difficult patient conditions with a gendered expectation to care for patients. She reiterates her limited capacity for compassion and doesn't seem to indicate a strong value in the practice of compassion as a virtue or a noble action.

Joslyn thinks of compassionate care as "*when you take a slice of time and dedicate it to the patient. Not just because your job tells you to do it but because you really want to make sure that this person succeeds when they go home*". In her understanding, doing a bit extra for the patient qualifies as compassionate care. When asked whether it was enough to be just a task-

oriented person for a patient, Joslyn was surprised at the implication of the question. Her reply showed the moral need to show care as part of being a human person:

> *God, I feel like you probably have to be a sociopath to be able to do that (to not care). I don't think anyone can really tear away their humanity, or their empathy, from someone that is suffering because most of the time people that come into the emerge, they're coming to you at their worst. God, I feel like you'd be a terrible nurse if you can't {show compassion].*

Exploring further, her understanding of compassion as a moral duty is evident in her reply to the question regarding her beliefs about universal compassion: "*I do not think you can have unconditional love or universal love. I think you can have a duty for what needs to be done. But I do not think you have to express love or care while doing it*". Joslyn does not attribute any kind of spiritual sense or language to her caring behaviour.

2. The Praxis Phase Case Vignettes

The praxis phase reflects the active involvement of nurses in their respective practices. The nurses come with certain formative experiences and intrinsic motivations which get challenged at the praxis phase of their process. The three vignettes stand for the experiences of safety, stability, and support at the workplace. Though it appears as a new phase, for a nurse who went through formative experiences, this phase also would work as a continuation of those experiences by strengthening some of the foundational attachment related healthy developmental experiences which in turn result in better personal and professional development. The opposite is also possible that the work environment if not good can discourage an otherwise well-meaning and highly motivated nurse. The discussion part of this phase in the following chapter will look at the influences of the experiences of safety, stability, and support in nurses' life.

2.1 Vignette: "There's Like Always a Part of Me that's Thinking About Safety"

This vignette and the following two vignettes conceptualize the general environment of work through the lenses of safety, stability, and support. The core concepts of safety and support are adopted into this chapter from the attachment theory (Bowlby,1982). Availability of a caring and responsive mother/mother figure creates a sense of security in the child which eventually becomes the "safe haven", as a close recourse in case of danger and the "secure base" to initiate all exploratory curiosity of the infant (Bowlby, 1982). The workplace of a nurse can provide healthy attachment experiences through providing safety, stability and support which is what we

understand by a culture of compassion at work. Mikulincer and Shaver (2017) speak of compassion as an optimally functioning interplay between the attachment behaviour system and the caregiving behaviour system which nurtures well-being and sense of agency in the caregiver.

Following the above theoretical background, this vignette explores the nurses' perception of safety, or the lack of it. The challenges regarding safety can be present in several forms like lack of control, fear of exposure to COVID-19, overwork, spatial constraints and so on. Some of these experiences have been caused by COVID-19, but the experience of safety is a general nurse experience irrespective of the time and context. All 27 interviewed nurses reflected on their experiences of safety, and they all appear to have similar struggles. The representative cases of Celine, Edith, Heidy, and Mary reflect comparable safety issues as Emma and Joslyn.

Celine works at a long-term care facility where two nurses work during the day and one nurse during the night for 40 residents. When COVID-19 started her facility went to lockdown, and Celine is appreciative of that. However, the changes brought in issues of space. There was not enough space for the patients to have their healthy interaction and it got complicated with the sizable patient population with dementia. The issue of limited space affected patient's social behaviour and some of them became negative within the environment:

> *So, we have a very limited space now in which we care for our residents. A lot of our time is actually with population and environment management because space is so small. We have a lot more interactions, negative interactions, unfortunately between residents. We deal with a very large dementia population. So yeah, it's a little more difficult though for sure.*

Working with masks becomes concerning for Celine as she believes that the masks are scaring the dementia patients. It is commendable that in spite of the issue of safety Celine is able to reflect on the suffering of the dementia patients due to masks.

The additional stressor that was brought about by the pandemic was the increased number of phone calls in Celine's workplace. As the families were not able to be with their loved ones, they needed to be given more updates on the patient situation. Celine thinks that a big share of the stress has emerged due to the constant phone calls and emails that they receive for patients: "*And I think a lot of it is working with the families and their stresses that are coming up from COVID-19 and their loved ones".*

Another important experience during the pandemic has been the fear of exposure. Most of the nurses that participated in this study reflected on their desire to protect their loved ones at home and resultant fear of exposure. Celine expresses this concern in the following words,

> *So yeah, I think it's just been really hard that way and staff itself is, you know, working with frail elderly people in their own lives or people that are immunocompromised, or their kids, you know, and the stresses that you see from staff having those.*

Celine saw every nurse, including herself, struggling with the pandemic and often they are faced with the stress of having to make sure that there are no COVID-19 symptoms to return to work every day and avoid exposure once they are at the workplace. As many of them call in sick, some of them had to constantly cover the nursing responsibilities for others by taking overtime shifts. The situation has escalated over the past weeks as she puts it:

> *We have so many sick calls, because you can't come in with a running nose or whatever. So, we have so many sick calls that the overtime is crazy. And I work overtime all the time, my 16 hours a day is nothing these days. So, dealing with so much overtime, and the staff having to go get COVID-19 testing … just the level of stress has definitely increased.*

And finally, the pandemic presents a unique challenge where no one seems to know how to effectively deal with it. The sense of losing control adds to the helplessness experienced by nurses: *"the feeling of not being able to, I guess control some of the situations that are so outside of your control and the frustration of."*

Edith's experience is an example of how personal loss and grief can cause safety concerns to both the nurse and the patients. When her dad was diagnosed with cancer and she knew that he was in the later stages of it, there was an overwhelming sense of preoccupation and anxiety around the health of her dad. This worry over her dad's health started affecting everything including patient care:

> *And so, in the first few weeks after he was diagnosed, I could feel it in myself when I was at work, that I just didn't have the energy to take care of the patients that were in front of me. Because I was so preoccupied with thinking about my own dad, about caring for him and wanting to know what was going to happen for him.*

Edith cared deeply about her patients. However, her personal suffering and worry about her dad's situation became the only focus for her. In some sense she started being self-preservatory as some of the other participants mentioned. There was no energy left to think about

others' sufferings. And whenever she confronted a demand from patients for their suffering to be acknowledged and responded to, Edith found it extremely hard to relate. She appeared to show no compassion for the issues of others which her colleagues found very strange in a person like Edith:

> *And I just remember, feeling frustrated that this person was asking these questions when they were going to be just fine. And I knew that my dad wasn't. And I commented out loud, something about patients being needy, and the nurse who I've worked with for a long time, she just kind of looked at me. And then I realized that I must have said something that surprised her.*

The perception of being overloaded and overwhelmed can shake the sense of safety in a person. In Edith's case it was very clear that the agony of seeing her dad deteriorating everyday brought her world to a standstill. Further, she felt that others were demanding more from her even as her own best support, in the person of her dad, was being taken away.

> *I think when you're dealing with so much already, then it's hard to grab on and really put yourself out there for another person who needs you. That is when you feel like everyone around you is just kind of taken. They're all taking your energy. They're all taking your expertise. Everybody needs something from you. And you don't have anything left to give.*

The perception of the presence of the Divine or a Godhead stands for most people as the ultimate protection and hope. When the tangible yet finite experiences stop being hope giving anymore, it is the heavenly realities and faith that help some people to survive and persevere. During the impending loss of her dad, Edith turned to her God as a place of safety. Her husband encouraged her to embrace the spiritual language of hope which assured her that she was not alone. The faith in the protective presence of the Divine and the presence of others with her continued through the pandemic situation. It was the experience that helped Edith to face her grief, isolation, and COVID-19 related stressors:

> *And that's basically what my husband was saying to me that you need to lean on God more. And it's not about you and your strength, because He gives you strength. So that, for me was a really powerful experience at that time. And it kind of continues, when you think about the tough times that COVID-19 brought, when I reflect on those, it's like, I wasn't in at all alone. And I wasn't doing it by myself. So yeah, I think it's just that knowledge that there are others around. I'm not great at getting on my knees and*

praying, but I still know that God is there listening. I also know that I've got people in my life that are listening. So, sharing with the valuable people in my life is also very helpful, very powerful

For Edith there were two issues, one being the lack of support from her colleagues and the other the concern shared by other members in her unit in maintaining a proper balance between personal and professional. The suffering of the cancer patients demonstrated existential challenges to the nurses' sense of balance and safety:

You know, everybody has got a cancer patient who is 30 years old and terminal, and those are very sad situations. And I think our oncologists, they deal with those all the time and the nurses see those situations as well. So, we're all sort of carrying around stuff that's hard. And then when you have personal stuff going on, theoretically you leave all your personal stuff at home but that's theory which doesn't happen in practice. So, yeah, it's hard to bring up the personal stuff unless somebody is actually going out of their way to ask.

When asked to reflect about the hypothetical situation of her dad's ill health during COVID-19, Edith spoke of the fear of exposure, isolation, and total disappointment even to the extent of some nurses choosing to leave job for fear of the risks:

Initially when COVID-19 started happening, most nurses, their fear to go to work was that they would take it home to their families. And I didn't have to experience that fear. Because even though I don't want to bring it home to my family, there's nobody in my life right now who is particularly at risk. Whereas if it had happened while my dad was sick, then I wouldn't have wanted to go to work.

Heidy works with newborn children who are sick and who may stay at the center for almost two years. Her center may have around 50 children at a time. She would like to involve parents as much as possible, as she understands the difficult feelings of parents when their children are sick. She says, "*You do fall in love with these little creatures and most of the time, you fall in love with the parents too*". Because of her age and years of practice, she gets to be the grandma for everyone in the unit, giving her a special way of working with the children and families.

Her safety concern is related to the vulnerability of the patient population that she is working with. Each day she may have surprises and new situations. Heidy deals with anxiety and

uncertainty by way of being prepared and taking recourse in her faith. On her way to work, a 15 minutes' walk, she prays that "*she does not make any mistakes but [will] do her best*". She relates some anxiety at the start of work, which helps her to be alert during her shift.

Heidy's increased concern regarding the children and a bit more worry than usual is to be seen from a perspective of her concerns for the safety of the patients as well as not making a mistake. Heidy is aware that working with a vulnerable population means that she, as a nurse, can't afford to make even a small mistake. During the shift, Heidy usually finishes her break as soon as possible and comes to the children as she is worried if something goes wrong. She admits that it is very different from some of the new nurses who say that breaktime is their privilege and make the best use of it.

According to Heidy, sometimes the physical structure of an institution can be a safety concern. It can be a small place due to the pandemic isolation which creates a very unhealthy environment for dementia patients, or an unsafe physical structure of a mental health unit with patients who have violent psychotic episodes. In the case of Heidy, her center was a huge place where one can be lost. She felt isolated in that big place. Though Heidy has been in this place for the last five years, it still makes her feel isolated:

> *It's like being in a Walmart and so it's an enormous space. And even though there's a big team around me, this is a new hospital, it's not how I practiced most of my life, but I've been in this unit, this kind of new setting for about six years so it's pretty familiar but you are pretty much alone in your universe for the day.*

The center remains safe during COVID-19, as babies mostly stay there for longer periods. Though there were a few affected staff in the unit, it has never become an issue in the unit. If any of the safety net is broken during the pandemic, it can become a horror story. Heidy recalls, "*COVID-19 didn't affect the unit very much, it could have been a disaster if it did*".

One of her biggest concerns is not having enough time between loss and grief and starting with a new patient. Death of a patient, especially of a child in the unit, can make one very sad and upset. For Heidy the deaths of children are the most difficult experiences:

> *One thing that I really, really hate is when you have a baby die on you … And even though I have a great faith, and I'm not afraid of dying, and in my practice, I want people to have a positive death as much as possible, still it takes a piece of your heart.*

Heidy is not afraid of death and has tried to encourage positive death experiences in her unit; however, the pain is real when death occurs, especially of little ones. And she needs some time to deal with it before she starts her duty with another kid. However, the experience used to be different:

> *I take the babies; usually, I carry them in my arms down to the morgue. I can't bear to have them put on a table and taken down or something. I take them myself. And then you put them in this little fridge or big fridge, and you leave them there. And you walk back up to the unit. And I am not kidding you, you have time to just go to the bathroom and they say, here's your next baby. Here's your next assignment. There is no turnaround time. It's one of the worst things that we do to each other, and we don't have a choice. However, I always wish I want to go home now. You know I've unfinished business with this baby. I'm empty. I got nothing.*

For Heidy, though not afraid of death, the time for an appropriate grieving process after the death of her patients is necessary to feel safe emotionally, psychologically, and spiritually.

Mary found herself challenged several times by difficult patients, some of whom appeared to have no compassion for her: *"I was at triage, and just hearing everyone's complaints day after day. And I would say, especially at triage, people aren't very kind to you"*. When she worked at the triage there were instances that patients yelled at her, complained, and abused her. The constant experience of being yelled at is a safety concern which eventually made her feel uncomfortable with the workplace. Mary moved to labour and delivery as a way of dealing with this situation:

> *Just hearing all of everyone's complaints all day, every day. So, if I was at triage for five, six days in a row, it wasn't a cool thing to hear. It's not a great place to be. It's why I went to labor and delivery there because I needed to be in a much happier environment.*

Patients with specific diagnoses like alcohol withdrawals evoked dislike and lack of compassion in Mary. Her sense of personal safety in working with patients can be colored and challenged with these instances.

> *I would lose compassion for certain kinds of patients even before I got to know them, that's when I knew I also had to step away from it. Just an example, alcohol withdrawals, is something that I am challenged with, I have a hard time caring for someone going*

through alcohol withdrawals, especially when I've seen the patient gone through alcohol withdrawals multiple times, I start to lose patience.

Mary owns the responsibility to care for herself as this is something that she has been working on for the last five years.

By the onset of COVID-19, the worry of exposure to the virus and potentially taking it home and spreading to others is something shared by most of the interview participants. Mary's situation is not different. She has been worrying about virus exposure and spreading to others. She can understand and recognize the concern of those patients and families who are affected by it. However, she appears to have less compassion for people who think that the pandemic is a hoax and who don't follow the hospital protocols:

> *I'm almost not feeling compassion for them, because I feel like they brought it upon themselves. But this is something that we're all in together, and it's not fair. But I noticed that I am, I'm not as empathetic. Because I'm almost thinking that they could have done something on their own.*

Though there is a legitimate situation which may bring on anger, this can also be a situation reminding the nurse about the lack of safety that they confront. It is possible that Mary was angry about the situation partially due to her own fear of exposure.

During the pandemic, though Mary has been working hard, she felt as though she was doing the least amount possible. According to her, the patient expectation to receive the pre-pandemic level of care is unrealistic, although this increases the stress on nurses:

> *And there's an expectation for the same care they may have received pre-pandemic, but it's just not realistic during the pandemic. It comes to you with all the extras, people were gowning on gowning off and extra washing of hands. Everything extra is still very time consuming. And I think the patient sometimes expects that care. And sometimes they may personalize it towards you that the previous nurse did this and you're not where it's just a different time.*

As a result of the unrealistic expectation from some patients and their families, Mary often felt as though she is not doing enough: "*I've never worked so hard in my life, but yet I feel I am doing the least".*

For Mary, the effort and time that she puts in during the pandemic has cost her to lose family time: "*My day just got longer by about an hour and a half just because of COVID-19*".

Another part of the lack of safety is experienced when the unit itself is affected where every nurse is struggling with their personal lives that there is no ability to support each other by extending emotional safety. For Mary this has been an exhausting situation:

> *When you care so much for your coworkers, and you see that they are suffering what you yourself go through it is like a turmoil. It's exhausting to carry the weight of the patient's needs, but also you feel the heaviness and the burden of your co-workers. They're going through unimaginable suffering, someone who has a sick family, and they cannot be with them. And all the challenges they face with COVID-19 with childcare or what not.*

The small things like laughter or fun is not possible due to the presence of various barriers; the mask and personal protective equipment. In the past those small things helped Mary to feel safe and connected to her colleagues and it also made the unit morale strong.

> *But using personal protective equipment (PPE) during COVID-19 has brought on the fact that you can't see anyone's facial expressions. And when you joke with people, even patients, sometimes I'll make a joke with my triage to just lighten up and help break down that barrier and get to know them, or even just have a laugh, you no longer can see any smile.*

Emma experienced issues of safety at her workplace. One of the basic needs for anyone is to feel safe and protected. When an institution or work environment fails to give the experience of protection for the people who work there, it may affect the quality of care and service. A few of the nurses in the study indicated that the lack of the experience of protection will increase the self-preservatory behaviours in nurses which in turn affect their altruistic helping behaviors. Emma experienced a situation of lack of adequate protection within her workplace: "*I still don't think our hospitals are adequately protecting nurses. Ours' is the only hospital in the city where you can go to have your baby without wearing a mask*". It is possible that the situation is different today compared to the time when the pandemic first hit.

Emma's workplace is one of the busiest units in the province and she is left with a sense that the nurses are overloaded with responsibilities. While the COVID-19 protocol at the center required four nurses with a Caesarean section patient, there are not that many nurses available. It brings in added burden and stress to the nurses who are working. They also face the dissatisfaction of the physicians and other staff. It makes the nurses work in a risky place, and one can't assume that these nurses would feel safe at an environment like this.

Another issue that can shake the safety experience of the nurses is the disrespectful behaviors of colleagues, especially other professionals including doctors. Emma speaks about doctors yelling at her which made her to be afraid of her workplace:

> *I think it was in April, I had a doctor yelling at me for retaking a temperature, according to the policy that the doctor, like the head of our department wrote, if we get the high temperature on a patient, we have to retake it in an hour and I had two doctors in the operating room with me telling, one was like why would you have done that, that was so stupid and the other was like, don't chart that temperature.*

It is probable that the sense of safety in Emma was violated through the perceived abusive behaviors of the doctors, that Emma started thinking about leaving her job or finding another job:

> *I think for a long time, I stopped wanting to go to work. So, I guess after that one big incident with those two doctors. I didn't want to go to work again, and I was thinking about quitting for a month or two and I started looking at other jobs because right now there's a lot of work from home jobs in public health and you don't have to work with doctors.*

Joslyn's experience suggests that though patient safety comes first, there can be repercussions when staff safety is not addressed. When patients are highly demanding and are disrespectful, nurses' sense of safety can be seriously affected. For Joslyn, her compassion fatigue experience is emergency specific and her interactions with difficult patients led to conflict and self-doubt in her which in turn made her feel unsafe. Joslyn gets frustrated when patients who have not accessed other available resources come to the emergency, which is meant to be for very sick people. She is conflicted when they come to the door,

> *I think it's sort of like a double-edged sword all the time because you sort of want to be like, yes, they're here. You want to look after them … but why haven't you done this? Why don't you do that?*

Some patients and families have repeated questions that frustrate Joslyn. One such experience is reported as the reason for her compassion fatigue experience. She explains,

> *So, I went through the first day with this patient. And then, I went through the second day with this patient. Moreover, it got to a point where it didn't matter how nice you were, or how polite you were or how respectful you were to scold the patient. And I do not want to*

use that word. However, when you have gone through. I have been nice this whole time to you. And now I have to be rude. Yeah, I have to be more than firm. And I have to tell you that I will involve security if you hassle.

This event paved the way for self-doubt and self-blame in Joslyn. She thinks that the patients and families should show compassion to the nurses.

One of the major ways a healthcare institution can become an unsafe place is when it is short staffed, and the few nurses are given excessive patient duties. Joslyn was unapologetic in her words to refer to the issue of staff overload:

In BC, our hospital has been chronically short staffed. For many years, and it's gotten very bad, very unsafe over the last year. And I think that affects everyone honestly; it affects all the nurses who have to take on another patient now.

For Joslyn, it didn't appear to be in anyway a helpful situation: "*So, staffing is an issue if there is management that either one won't support you or just have their hands tied behind it. There's nothing to do about it that also affects it"*

The perception of safety can be enhanced when there is a better relationship between the leadership, doctors, and the nurses. According to Joslyn, that is not the case. Joslyn thinks that if there is more support for one another the work becomes easier: "*And I think also it depends on your relationship with the doctors … You know, what, if everyone can just treat this as a team? You know, our lives would be so much easier".*

COVID-19 had a significant effect on the safety sense of every health care worker in the unit. When COVID-19 started, they set up new area for the COVID-19 patients and according to Joslyn, there was not enough attention to the safety of the area and safety of the nurses who would be working in that unit.

When this area first got set up, there was no call buttons for the patient. There was no emergency call button for the nurse. There was no way that security would know if you were in trouble over there. There was no way that you could announce that you need help. And this area got put into place in March. And it wasn't until a month ago, that we had all those things finally implemented.

During COVID-19, the fear of taking the virus home was a constant fear in Joslyn just as in her colleagues. The nurses who were appointed to the COVID-19 area had to repeatedly face a challenging unsafe situation, doing patient's blood work, imaging and other conducting others

tests that need to be done. Joslyn says, "*outside of the core area, I think every one of us who has been in that assignment has been very frustrated about that situation"*.

The potential exposure to the virus and the possibility of bringing it home has been real fear for almost every nurse in the study who had to work with COVID-19 patients. Joslyn expressed serious concern and fear regarding it. There was certain helplessness expressed in her words regarding working in a COVID-19 unit:

> *I think the main thing that probably affected care was the fact that knowing that you had to look after these people, and the potential for exposure, you had no choice but look after them. But then having to go back to your family, and potentially exposing them.*

2.2 Vignette: "Everybody on the Unit Kind of Got Numb to It … Everything Was Changing."

One of the themes that emerged out of the nurse interviews was the experience of stability, or lack of it, in their caregiving contexts. The theme of stability is also intimately connected with pandemic related management issues but can be a general feature of organizational culture. The issue of constantly changing policies and overload of information is sometimes the natural offshoot of the non-preparedness of the system. All the representative case vignettes are reflecting similar aspects related to the experience of stability. For most of them, it has been an added challenge posed by the pandemic.

Celine loves her job, as she suggests:

> *On a normal day, I love my patients. I love the relationships that are built in long-term care. I love that feeling of being an extended part of their family. There's not usually much stress. Usually, we're very cohesive as a team as well and approach things as a team. And I think I love being a nurse, I love nursing and long-term care*.

However, COVID-19 has brought a lot more confusion in the workplace. There is added stress, confusion and anxiety expressed by patient's families who cannot be in person with their parents. There are constant phone calls by worried families inquiring into a patient's situation that can get a bit too much for the staff in the unit. The sudden change of rules around visitation, lock downs and COVID-19 appropriate behaviour presented with a sense of uncertainty into everyone. In the middle of this situation, Celine feels that dealing with patient's families has become a huge stress contributing to Compassion fatigue: "*I think the Compassion fatigue is more dealing with all of our families, and residents, confusion and uncertainties around COVID-19*".

The pandemic situation demanded the government and establishments to draft policies and protocols that may protect the public. However, the lack of knowledge and clarity around the pandemic caused those policies and protocols to be tentative and open to change. The constant change creates fear and confusion which results in people becoming exhausted. Similar to her colleagues, Celine was on edge much of the time, not knowing what was coming next:

I mean, there's so many changes that we had to do and every day, so many different uncertainties on what we were going to be doing for our policies and procedures. And every day it changed because the health authority was changing every single day on what we had to do. COVID-19 is ever changing, and our numbers are ever changing, and we're always sort of on the edge of our seats waiting to see what sort of will happen next?

Celine said that by September the situation was a bit better. She is happy that her unit hasn't witnessed any major outbreak. She thinks that the facility has been able to re-establish some sense of stability, however the fear of uncertainty is often looming over them.

But there's always that anticipation that we're going to have to go into complete lockdown or get a outbreak. ... like we've been lucky, we have had no outbreaks, but unlike some of our fellow long term care places, there are outbreaks. And then I think the situation will be completely different if we have an outbreak, it'll be devastating.

Edith's experience speaks of different levels of stability that a nurse desires for. A sense of routine and stability in life experiences helps a person to feel grounded and safe. Irregular schedules can create a situation where nurses miss out of the routine of their family, children, and friends. Having the added pressures of dealing with various demands due to the pandemic can be very disappointing. However, for Edith, while she was going through her personal grief and loss, the time off to be with her dad not only meant a connection with him but also a time of stability at home:

So, I was able to go back and take care of him for his last week of life without having to worry about going to work, without having to worry about just even the pressure, you know, having to get to work, let alone the type of work I was doing. I was able to spend more time with my children. As the situation started to become problematic other issues also emerged. So, we had childcare issues, and with me not having to go to work but stay at home and be with my kids instead helped. And we didn't have childcare issues anymore because I was home with them instead. It really just erased a ton of stress.

As mentioned above, her experience with her children is also a window to the experiences of many nurses who need to confront a sense of uncertainty and stress due to their double roles of being a mother and a professional having to work up to 12-hour shifts:

> *And I say, not only because of the type of work I do, but just the routine of having to get up and go to work and miss out on that time with my kids and getting them to and from school, and, you know, that sort of thing*.

For Edith, the time she got to spend with her family meant support and a sense of stability at her home. She says, "*yeah, it made a huge difference*".

Heidy often walks into the uncertainty of her unit. To some extent most nurses walk into uncertainty as they start their shifts. It can be a new patient, an old patient with new complications, or a patient who presents several challenges. Heidy reflects this part of her experience in the following words,

> *I walk in and there's a schedule and I look to see where my name is and what room number I have and then I look up in the room number to see what babies are in those rooms ... So, there's a kind of place and time where you're just kind of in limbo and you're walking into uncertainty.*

Nurse turnover and nurse shortages can be an issue that affects the unit's stability. It can increase the stresses on both management and nurses. During COVID-19, Heidy's center was not affected as the babies stayed in the hospital, and fortunately, no one at the center became COVID-19 positive. She had to wear a mask that was inconvenient, but already in practice most of the time with sick children. At the beginning of the COVID-19, she says that many nurses, including her, had planned to be retired in Quebec, but when the government asked her to stay on, she agreed to work a little more as needed: "*If I had retired, I probably would have gone to at least volunteer or work at one of those senior citizen homes*."

As the pandemic started, many nurses feared being called into COVID-19 duty. Heidy spoke of some of the part-time nurses whom she knew who were forced to work on pandemic duty, who had to go full-time during the pandemic, and a nurse who had to work in a senior residence where they lost 100 patients due to COVID-19.

> *Could you imagine the stress just of that going to another unit to work where you're not in your comfort zone where you don't know people and you don't even know where supplies are ... other woman had to work full time. For two months, I worked full time*

when I increased my hours. I was exhausted. And, and I wasn't facing COVID-19 or anything else. I can't even imagine. And then the third woman to work in that senior's residence and lose 100 patients.

According to Heidy, she was able to deal with her fear of uncertainty with her spiritual beliefs and faith, which may be obvious in her working style with so many vulnerable children, dealing with their loss and grief and her daily routine of starting the day with a prayer.

Mary's challenge with the influx of information reflects one of the most challenging situations emerged as part of the pandemic. Most of the nurses in the study shared a similar concern around the presence of an overload of information related to policies and protocols. As it was expected for the nurses to follow the changing protocols as they took effect, it became hard and confusing to keep track of them over and above the high patient care demands that they had. Mary's situations were not different, though she respected the protocols and was unhappy about people who didn't follow them properly. Even so, she found information overload a real problem: "*It has been quite challenging. It has been quite challenging to keep up with all the information.*"

Both the pandemic and the experience of Compassion fatigue caused nurses to leave or change their jobs. Frequently changing staff configurations can be challenging in an emergency, and Mary witnessed that reality in her unit. She always thought that nurses left due to some of their personality types and not due to the work environment, however now after having worked for five years in emergency she is better aware of what is going on:

> *I really thought it was the personality type. And I thought this will not affect me and I was very wrong. And it wasn't until my third or fourth year, you see older nurses going through Compassion fatigue... They they're not as empathetic with the patients…I thought it was not going to affect me at all. Because this is not who I am. My heart is in a different spot. Bu it affected me just like it affected every other nurse that I saw on the units. That's when I started to explore what other nurses have done and what they've gone through as well. And I've noticed that it's everyone, there's not one nurse I've met that does not experience Compassion fatigue*.

she knows better about the reason behind nurses leaving the emergency. Her observation was that:

> *… in emergency what I noticed that nurses leave, after five years, it's not that common that nurses are there over 15 years for their career. They just don't last. And I never knew why? But then once I got to your five years, really know this is why. I was quite ignorant. I thought it was just a personality issue…And because it affects so many different personality types. It cannot be just personality.*

Mary thinks that this can be different in labour and delivery unit: *"Maybe in I would say in labor delivery, it's a bit different. It's much more positive environments much happier".*

Emma experienced that her workplace had too much policy change which was almost unmanageable. Policy decisions are made to deal with new and emerging situations in any institution. Following the developing scenario of the pandemic, many health care institutions had to bring in new policies and protocols. Though they are meant to strengthen the daily functioning of the institution, the uncertainty could be destabilizing staff and patient well-being. Most nurses in the study reported changing, confusing policies and protocols during the pandemic. Emma refers to the beginning of the pandemic: "*I think that was also when there was a lot of uncertainty and the policies in our hospital were changing, sometimes twice a day*".

Though having constantly changing policies can be confusing, the worst part can be the way the changes were communicated. Nurses may have to spend a lot of time just the understand the policy and find how to implement the changes. It is always the responsibility of the management to find simple and effective ways of introducing these policy changes to the staff. Emma says, "*I wasn't very impressed by the way the staff were being notified of policy changes. I wasn't very impressed by the way the policies and protocols for COVID-19 patients were devised*". When the policies are not clearly communicated to the nurses, it also becomes very hard on them to convince the patients of the need for the changes.

However, Emma thinks that the situation has improved over time and most of the policies got stabilized. "*I think most of the policies have sort of stabilized, there's not as much change all the time and I think that the patients are better prepared, they know they won't be allowed to have a second and third person in with them in labor, it's just one*". These challenges also can be equally applied to any crisis even outside of a pandemic.

Joslyn got frustrated over the COVID-19 handling at her workplace**.** At the beginning of the pandemic, nurses struggled not having proper guidelines and clarity on the best course of action. As the hospitals started imposing no visitor policies, there was an influx of telephone

calls of families who wanted to know about their loved ones. The sudden demand to attend to the phone and attend to frequent calls of worried family members destabilized the workplace. Joslyn says that "*unfortunately, sometimes family members will call very quickly, or in rapid succession of one another. And that gets, a bit frustrating*". It was during this period that nurses struggled with a lack of proper guidelines from the health system and had to face the frustration of people alone:

> *When this first started, there was a lot of back and forth on 'no they shouldn't be going in there or yes, they should be going there'. Why didn't you put them in there? And there was a lot of blaming going on*.

The lack of clear guidelines can increase confusion and personal responsibility on triage nurse to make those choices in a case-by-case scenario. This became really frustrating for Joslyn as there was a huge burden on the nurse's shoulders. Joslyn explains the situation:

> *They have this protocol put in place that's supposed to be black and white. But if you say that's black and white, then pretty much half the people that come into the emerge will all go in that area. So, then it lands on the nurse's shoulder who is greeting outside of the emergency department, essentially screening everyone to say this person needs to go into the COVE, which is what we call our COVID-19 area.*

However, some things were simpler and more stable than the COVE issue, for example, everyone had to wear a mask.

> *The only thing we really changed was that you had to wear a mask, period. And every patient coming through had to wear a mask as well. For any patient that used to have respiratory issues, or puking or diarrhea, the nurse always had to grow up to begin with. So that part didn't change*.

2.3 Vignette: "… It Boils Down to How Much Support that You Have from Management."

A human child depends on other persons to fulfill their support needs. In attachment theory (Bowlby, 1969), the idea of a "secure base" refers to the fact that the child can confidently function being supported by an environment which is proactive and not critical or indifferent. From the interview data, a supportive and empowering disposition from the managers is what often the nurses desire. There were a few nurses in the study who appreciated their management and their efforts to the extent of showing compassion to them in spite of their demonstrated limitations. Some of them were critical of their managers who were not visible in the unit. Most

of the study participants were not happy with their work environment, especially regarding the management. Some of the participants who were in management positions had suggestions around what can be most helpful for nurses. In this vignette the representative case examples of Celine, Edith, Heidy, Mary, Emma, and Joslyn have a similar take on the issue of managerial support.

Celine thinks that her workplace environment is very supportive:

We try to combat those feelings of stress and everything that staff is having. In order to deal with it we have lots of team meetings, and our management team has been great at sort of just giving small little things on a daily or weekly basis to just know that you are appreciated.

As a head nurse on the floor, she is aware of the cliché, "*overworked and underappreciated*" nurses. She says that in September, staff anxiety increased due to the pressures of childcare and getting children back to school. She promoted her colleagues' well-being with a compassionate approach:

we do have lots of debriefings with staff, I truly try to make sure I'm checking in with staff individually and making sure they're doing okay, I do encourage people to take a day or two off if they need it.

She is trying to keep everybody as a team to address the stress and anxieties on the floor.

Celine's opinion is divided about top management though; she thinks that her management is excellent sometimes and other times not. She says that most times, the top managers are not aware of the ground reality. However, she also acknowledges managers' stress in running a private non-profit facility. Celine thinks that the effort for becoming a compassionate team needs to come from the top to the bottom:

That is why I think we need managers to be very careful on how they introduce things and be compassionate to the members of their team. Even when they call in sick, I do sense that impatience from staffing and things. But this is a situation that everybody is in and together as a team, small and large.

Celine is full of appreciation for the place where she works*, "I am lucky to work where I do. I am honoured to work with some of these people. They are amazing".* However, with COVID-19 there has been a lot more stress on the unit and the nurses. The overload of work and extra shifts had led to nurses not spending enough time on self-care activities. Consequently, as nurses

became more exhausted, the unit's morale was affected, and extra stresses were experienced by both the patients and everyone on the unit. Her management team often are trying to mitigate the effects of this unique situation by team meetings to appreciate the good work.

> *Yeah, lots of stuff on your plate and you don't have the outlets, or you don't have the time for the outlets that you usually have for self-care. You know, there's been a lot more tears, and there's been a lot more impatience with each other as co-workers, you can see, sometimes it was bubbling up and overflowing. We try to combat that, those feelings of stress and everything that staff is having with we do have lots of team meetings, and our management team has been great at sort of, you know, just giving small little things on, you know, a daily or weekly basis to just know that you're appreciated.*

Edith's experience suggests that while going through a very difficult personal situation of grief and loss, every experience of support counts. In such a case, it should not be anything special that you get the support you need from management. However, when the leadership cares enough to see that an individual's need for self-care is insufficient given the personal struggle that one is going through, it is a compassionate leader who provides extra support. Edith went to her general physician asking for a two week leave recommendation, however knowing her situation he recommended her to take at least six weeks to work through this situation. Edith recognized the supportive stance of her physician:

> *He said, you need to take time off work. And he knows I'm an oncology nurse. So, I said, "Oh, good. I was hoping you'd say that. I'm thinking about two weeks". And he said, "No, I think about six weeks, and then we'll go from there". And I remember, I was shocked because I thought, oh, no, I'll be fine. Just give me two weeks.*

Sometimes compassion for others provokes a person to offer more self-compassion. It is a matter of learning to be more forgiving and generous and not being afraid to care for oneself. Nurses often notice this issue of not caring for themselves enough rather than feeling obliged to care for others. The compassionate support of her physician empowered her to take a few more weeks to grieve her loss and restart her life with her family:

> *So, I think I took another probably six weeks on top of the first six weeks off, just to stay at home and get over the loss of my dad and all of the emotions there. And so, when I did go back to work, they did a gradual restart for me as well.*

Regarding her work environment, Edith thinks that some of the colleagues understood her struggle and supported her. Others, she says, were not maliciously distancing but instead did not know about it. She says that it is a somewhat supportive environment, and everybody is dealing with sick people. As everyone is carrying hard personal issues around, individual issues can become too much. Leaving personal issues at home does not happen in actual practice. However, the support that she could get from her colleagues is affected by the sheer amount of grief and sadness in the cancer unit that is absorbed by most of the nurses in the unit. Almost everyone in her unit is stressed by the environment:

I think it's a fairly supportive environment, but it is difficult to be fully supportive in our environment, because everybody is dealing with something that's really tough. You know, everybody's got a cancer patient who is, you know, 30 years old and terminal, and those are very sad situations. And I think our oncologists, they deal with those all the time and the nurses see those situations as well. So, we're all sort of carrying around stuff that's hard.

Even though Edith understands the constraints that her colleagues face including their difficulty in keeping a balance between personal and professional at work, she desires to have a little more support within the unit. Unfortunately, in a situation like this, nurses don't feel encouraged to share their personal struggle at work with colleagues:

So, yeah, it's hard to bring up the personal stuff unless somebody is going out of their way to ask. But I yeah, I would say still, by and large, we are supportive of each other, but it would be nice if there was more, a little more time to do that.

Heidy's experiences are evidence of the fact that sometimes what makes a huge difference in unit morale and the perception of support among nurses is not necessarily the big changes, but rather the small acts of compassion, acknowledgement, and appreciation. In her unit when they have a really bad day they will buy a Pizza, doughnuts, or something, which she says helps the environment.

Heidy has found a way to keep the unit morale pleasant and warm through some of her initiatives that she found helpful during her many years of experience. For Heidy the small things make a big difference:

At the end of the weekend if I have time, usually on my break, I go around, offer the girls a sticker, like a star or maybe an animal or whatever I have. I have my nursing knapsack,

in which I keep all different pages of stickers. When I go around, I say you did such a good job today, I'm giving you a sticker. And they are like, oh, that's nice. And they're so happy and they take a sticker put it on their ID.

Similarly, sometimes she gives out chocolate to her colleagues and even her director. She says that these small gestures and appreciation mean a lot for nurses. Genuine appreciation is something that can affect the sense of support and encouragement among the nurses in a very positive way.

The small acts of kindness and tenderness are not limited to the nurses in the unit. It is also shared among the patients especially when their parents go through the most difficult times during the death of their children "*When a baby dies in the unit, sometimes nurses make a book with 200 nurses writing something on it for the family*". Other times there are celebrations in the unit like every month they celebrate birthdays of children or dress children up on Halloween. Heidy sometimes posts something on Facebook to help a family who may not have money.

Heidy makes a very insightful comment about the contagious nature of compassion: "*you know, it just takes one person to start doing something tender, … I think it's a bit contagious. If other people see your care and they care, it becomes contagious*". Her unit shares a similar contagious culture of compassion through the small acts of kindness. The nurses in the unit intentionally care for the positive environment and Heidy's contribution is central to that effort. Heidy finds that it helps her balance the risks and rewards of caring. "*Even though caring can be tiring … it can also be energizing*".

Reflecting on her younger days, Heidy says that the assumption about a nurse was that getting tired is a good thing and that meant one worked hard: *"In those days if you weren't tired, you weren't doing a good job. You know, hey, you were expected to be tired and, and just set up and don't complain about it*". Today there is mental health day for nurses and some of them make use of those days for self-care. Interestingly there is still a stigma attached to nurses who would take a mental health day in her workplace:

There are some nurses that will take a day off and say I need a mental health day, or this was day was so hard. I'm taking tomorrow off. But if you do that you are universally despised. Like, it is 100% unacceptable on my unit".

Another area that Heidy highlights is the lack of support for nurses from others including the family. She is sympathetic to the experience of several nurses who are not able to find

someone who would understand their struggle, with whom they can share their pain or stress after a difficult day. She often comes across a situation of not having people who are ready to listen to her:

> *It's hard, you just have to dig really deep, really deep. Usually, my very sweet husband hates hearing about anything to do with hospitals. So that's been one of the hardest things for me. I don't have anywhere to go really to let it out. And I think a lot of the nurses I work with; they go home to children. They're single mothers. They work so hard. I don't know how they do it.*

Mary has been a nurse for the past 12 years and is currently working in an emergency unit. She explains that there is an expectation on nurses to do the maximum with the minimum resources and there was a nurse hiring freeze to the point that the shifts were not appropriately filled. The issue of lack of resources, budget cuts and an “unhelpful” system can be quiet frustrating:

> *But we were overloaded, we couldn't change the system, and that was frustrating. Moreover, every time new political powers come in, that also changes our resources, our budgets, and it just seemed like things are worse with COVID-19 now. However, it seems like the resources weren't quite there.*

Mary was not feeling supported by the government and the system. According to her, patients do not understand the tension that nurses go through. For her, it feels "*almost like you are disposable*." Accordingly, having little support and limited resources has a ripple effect in the unit. She spoke of the days when no food was available for diabetes patients in the unit, and the nurses used to bring food from home in case someone needed something to eat at night. Though the nurses do everything in their capacity and are often helpless in the system, she says the patients may not understand it.

> *But really, you try so hard. However, it is just that the resources aren't there. The wait times I have no control of that. However, I am whom they see. Moreover, I am on the receiving side of the frustration of the healthcare system. And then, of course, it trickles down to your coworkers, which you then get frustrated over.*

Mary spoke about the nurse-patient ratio. According to her, there was an expectation to do more with fewer resources and staff. She spoke of government cuts to funds for resources like a preparatory course for nurses in emergency and education days: "*I felt like you weren't*

supported even by the political power who was employing you." Mary recalled an event at her workplace, which was an example of the lack of resources.

> *I remember a certain situation where it was like, someone's feeding tube was ... And a couple of us nurses went and got pop from the vending machine spending our own money. And we dislodged this patient's feeding tube with a can of coke because that is what you can do anyways, but it's just that sometimes there is no food in the hospital for patients who are diabetics.*

She says the patients are not aware of these situations. The nurses can be at the receiving end of frustration with the health care system, which then affects relations with coworkers and patients:

> *And only up until two years ago, there was something called ACLS. It's quite important to have that as an emergency nurse. And it wasn't provided, it wasn't paid for by your employer. So, you would pay out of your pocket, we'll take these courses that were necessary for your patients' care. And all of us nurses did that. But it wasn't covered, we would get covered for the time, but the actual course says $100, you would pay out of pocket.*

Mary makes specific mention of how unit morale can influence the experience of Compassion fatigue She says,

> *It is exhausting to carry the weight of the patient's needs, but also you feel the heaviness and the burden of your coworkers, what they're going through. Someone who has a sick family, and they cannot be with them and all the challenges they face with COVID-19 with childcare or what not. And I feel like the unit morale has gone down.*

She describes the battery analogy within a unit where the coworkers help one another recharge the battery. However, when the whole unit is affected, you cannot get the help of your colleagues:

> *If I go back to the battery analogy, your coworkers recharge your battery in between, when you go through a very stressful situation, or if you yourself are going through Compassion fatigue, they can bring you ... but when the whole unit goes down, and the whole morale goes down, you now cannot fall back on your co-workers to actually help bring you up.*

The situation has worsened during COVID-19, with Mary saying that there is no spot for nurses to sit and have a chat even at the cafeteria. The frustration with the situation is such that

she describes sometimes just standing outside of her unit for half an hour to feel recharged during the winter months. She is disappointed that, although the nurses are to care for others, there is no way to recharge for the nurses themselves:

> *It's just there's nowhere to recharge. And it feels like healthcare you are there to support people with COVID-19. But then yourself, there are times when you are just, it feels like are left behind, and there's nowhere for you to recharge*.

Mary, however, felt supported in the labour and delivery unit during her shifts: "*I work in labor and delivery and over there I feel like you're very well supported*".

Emma is curious about how the patients feel as that will determine how her day goes when she meets new patients. In order to make her day more comfortable, she chooses patients according to certain criteria that may reduce the stress in working with them. Emma, however, thinks that the support in her workplace is crucial in her ability to carry on with her work: *"I wish that you're able to build yourself as the strong caring person, and you get enough support that you can move ahead in your profession in a more fulfilling way".* It appears almost as a cry for support in Emma's case.

One of her struggles is to deal with some of the traumatic experiences and grief in her work environment. She describes one of such events in her life where she needed more support to continue caring:

> *I had a birth, where it was a healthy pregnancy and a healthy fetus and during the birth, the baby died and you know, I still had lots of reserves back then, so I sat at the bedside with the patient while she screamed, and I was able to do that but I think that for the month after, I was just like, unable to connect with anybody having a healthy baby.*

Emma thinks that the proper protocols for debriefing and grief processing would have been immensely helpful for her case. She reported as not receiving such timely support:

> *A lot of people don't know the proper way of debriefing either or the importance of it. And then if you must ask about a debriefing, then that person should be recognizing before you ask that a debriefing need to happen…So yes, it is best practice, and our policy says that we have debriefs but in reality, we don't, or we only have them occasionally. So, for the baby that died in January, there was no debrief. The obstetrics team decided that the debrief would not be productive.*

Unsupportive and indifferent managers can be a real problem in a unit. Emma was not very happy with the previous manager whom she says did not care about the issues in the unit:

> *… you would go to her with something, and she would kind of spin it into thinking like, "Was this your fault?" I had gone to her once with one issue, and I never went to her again because I heard from multiple people that she was a nursing manager who didn't care at all. Like, we've had major issues with narcotics handling in our unit, and her words were, "It's not my problem". I don't know what she was doing there.*

The current manager is good and the nurses in her team are also good. Currently, Emma is getting some support from the management. However, she is frustrated with the physicians in the unit.

Joslyn was upset about the situation in her workplace which was understaffed, and the managers didn't appear to be supportive. As there were issues with staffing, taking a new patient was not an easy decision for a nurse: "*And you know, when you say, oh, you have to take on another patient, it doesn't sound that bad. But when you actually put it into practice, it is terrible. Especially if you've got sick patients in your assignment*".

The perception of lack of support from her managers was obvious in Joslyn's experience. The managers were either not supportive or were not able to support in critical situations as they just had to follow the lead of their superiors who were often not very tuned in to the on-ground realities: "*So staffing is an issue, if there's management that either one won't support you or to just have their hands tied behind it.*"

Another struggle for Joslyn was not being supported by the doctors, and not feeling valued by some of them: "*We have a lot of younger doctors coming up in our emerge. So, a lot of them are very understanding, very appreciative, and then there are other doctors that they're, you know, quite ancient, and are not flexible, and sort of look at you as their maid".* According to her the relationship with doctors would decide the nurse stress levels and whenever there were issues in that area, the nurses struggled. She thinks that the young doctors are more understanding compared to the older generation.

There is a cry for support similar to Emma in Joslyn's case. She really wishes that there is more support, and everyone treats one another as a team: "*You know, what, if everyone can just treat this as a team You know, our lives would be so much easier."*

Joslyn desires to have a team experience within her unit that may make her life a bit easier. Joslyn suggests that a lack of support may have something to do with the experience of Compassion fatigue. She often observes the experience of Compassion fatigue in a deeper level in her colleagues, though she believes that she didn't experience it to that level of intensity:

I feel like I've always just skimmed the top of it. I feel like I have seen Compassion fatigue in other coworkers, and they're on a very much deeper level. And I think it just has to do with however many supports you have around you.

3. The Outcome Phase Case Vignette

The Outcome Phase essentially speaks about the presence of negative or positive outcome of the caregiving activity on the caregiver. This follows the praxis phase in integrating both the formative and environmental influences through the actual practice of nursing care. This phase would decide whether the individual's efforts to care were supported by the praxis phase or not. The Outcome Phase also will reflect any influence, positive or negative, of the Praxis Phase in a nurses' professional caring activity. The following vignette speaks about the nature of nurses' compassion fatigue experiences.

3.1 Vignette: "Compassion Fatigue Is Trying to Draw from An Empty Well"

We find in people who experience Compassion fatigue that one of their struggles is the inability to alleviate suffering through compassionate care. The image of "trying to draw from an empty well" presented this experience in many nurses. Though most of the nurses expressed an inability to alleviate suffering, a few appeared to be not attributing their fatigue to the concept of an inability to care. While the four representative case vignettes of Celine, Heidy, Edith, and Mary expressed the inability to care as Compassion fatigue, the two case vignettes of Emma and Joslyn did not refer to those terms in their description of nurse fatigue.

Celine experienced Compassion fatigue because of the stressful work situation and the stress brought about by patients and families, together with constantly changing pandemic communications. She found herself more tired than usual. She felt exhausted and overwhelmed by the anxiety of families that had loved ones in long-term care. The situation also meant more time away from her home and children, as both she and her husband also were an essential health care worker. Just before she underwent an unexpected surgery and took a month off from work during summer, she was getting impatient with dementia patients. For her, that was the sign of her getting exhausted and experiencing Compassion fatigue.

Celine remembers a similar experience of fatigue when she worked as a care aid and doing her schooling to become an LPN. She had young children at that time and noticed exhaustion and impatience and not a moment to breathe. Celine relates her experience as, "*lots of stuff on your plate and you don't have the outlets, or you don't have the time for the outlets that you usually have for self-care.*"

Celine describes Compassion fatigue as the frustration of not giving the residents what they needed or caring for them in the best way possible:

> *I think Compassion fatigue is just not being able to... the feeling of not being able to, I guess control some of the situations that are so outside of your control and the frustration of... I know I said we probably spend more time with our residents but the frustration of not being able to give them what they needed and it's not... physical care was not necessarily but I guess the emotional, mental care that we want to give to our family members in residence, because they are our family members.*

One of the most challenging areas was that they were not allowed to touch the residents, especially the dementia patients:

> *Oh, you know what, the other one, which I didn't mention is the physical touch. That drove me crazy because we were so we're so physical in our job. We are always hugging, and combing hair and you know, those physical things were for a while they're we weren't even allowed to hug our residents anymore was so bizarre and you could tell that's just what people needed.*

Celine thinks that though long-term care involves the deaths of residents, it is the inability to care for residents and families that contributes more to Compassion fatigue.

Edith's father was diagnosed with late-stage lung cancer two years ago. She started feeling the pinch of it in the few weeks after the diagnosis. She says, "*in the first few weeks after he was diagnosed, I could feel it in myself when I was at work, that I just didn't have the energy to take care of the patients that were in front of me*." She started comparing her dad's situation with some of the relatively better patients in their cancer recovery and became frustrated by their questions. Carrying over this frustration to her patient interactions, she started making comments about those patients as being needy:

> *And there was one specific patient who I went and spoke with who was someone who was likely to be cured of their cancer or at least, they would have five or 10, maybe 15*

years cancer free. And that patient was asking questions about their symptoms. And in the back of my mind at the time I remember feeling like, you're going to be fine. Why are you even asking me this? Why are you troubling me with these questions that aren't important, and this was my thinking at the time is that it's not important you're going to live. So, what's the big deal?

Her colleagues noticed it and were surprised as Edith would never have made such comments in the past. She then realized that she was experiencing Compassion fatigue and could not take care of her dad, patients, and family at the same time. Edith's dad lived for two months with advanced cancer. About two weeks before his death, she went to her GP asking for two weeks off work; however, he insisted that she took at least six weeks away from work. Moreover, he said, "*we do not know what is happening with your dad right now. And you just need that time. You need to be with him"*.

Reflecting on the experience with her patients during this period, she says,

It is hard to grab on and put yourself out there for another person who needs you … They are all taking your expertise. Everybody needs something from you. And you do not have anything left to give.

Edith relates this overwhelming feeling with an image of "*my tank is empty, and I did not have anything more to give*." When she came home, all she wanted was to sit down and have a glass of wine and talk to her husband. She recalls her experience with her children in those days,

My youngest likes to go through a little routine of saying good night, you know, five times or more. I would tell him, and I just can't tonight, honey, it's one good night. It's one hug. I'm not coming back into your room a second time, a third time, you know, and if you would come out of bed after being tucked in, then I was frustrated. And I would tell him in no uncertain terms to go back.

She was able to take care of her dad, spend time with him and not worry about anything about work. It also helped her to deal with childcare issues.

Edith has been in this profession for the last twenty years, and she related a few times that she felt similar experiences but never to this extent. When she worked with dementia patients, she felt frustrated that the patients will not take medication and did not trust her. The situation was also difficult as she was in school. However, she never felt a lack of compassion for them.

However, the experience during her dad's sickness was a sustained feeling of fatigue and irritation.

Her experience happened before COVID-19, and she believes if this happened during COVID-19, it could have been the worst. One of the big fears of nurses during COVID-19 is to carry the virus home to vulnerable people. Moreover, she did not have to go through that.

Heidy thinks that there were a couple of times in her entire career that she felt like not caring. One instance was when she had done her best with a patient family, and the family complained that she was not giving them their space. She says that though she was upset with it, she maintained civility for the baby's sake and made sure that the parents could ask if there was any need. In this situation, she told her shift manager not to give her the same baby again into her care.

Heidy speaks of deaths in her unit and the inability to grieve as a reason for Compassion fatigue. She says that she is not afraid of death and wants others to have a positive approach to death; however, when a child dies, "*it still takes a piece of your heart*." After the death of a baby, she says that she always wishes to go home. She asks, "*You know I've unfinished grief with this baby. I'm empty. I got nothing else. How can you turn to me? And tell to give you more?*" Heidy explains this feeling of *"I am empty. I got nothing else"* as the experience of Compassion fatigue. What she wishes to do is to find time for grieving in order to be back to work. However, her work didn't provide this opportunity.

Heidy also reflected on two other occasions that she felt really fatigued. One instance was that she cared for a child and thought everything was going perfect. Even the family was not with the child on Saturday, and she took full care of it. However, the family when returned were not happy about her service, they complained of not giving them space. She felt unappreciated and upset:

> *So, it's not been often but there have been times when that sort of thing has happened and, and then I just told the team leader, you know, never give me that baby again, you know, because if I can't, if my best isn't good enough, then you know, whatever.*

Another situation that can be difficult for her is when the workload is too much and that she was not able to do everything that was needed:

> *But usually I don't give up, I cry, or I'll feel like, I feel frustrated because at the end of the day, I've done a mediocre job for everybody. That's a really hard and awful feeling to,*

you know to go home and know that you did your best, but nobody is happy with you and including myself but it's not my fault because I only have two hands and two legs.

Mary noticed Compassion fatigue experience in her when she started her fourth year in the profession at the emergency triage. She says that it was triggered by the complaints and yelling of patients who appeared to be not so ill compared to others.

And I would say, especially at triage, when people aren't very kind to you or they are yelling, and you're not. And you know in your mind that they're not ill, or there are much more ill than them, so I started to lose compassion for them.

The consistent experience of patients who are not very sick but demanding brought frustration to her, and she started to assume that every other person would be the same. She also struggled with the experience of difficulty working with a certain patient population, like people with alcohol withdrawal which she has been trying to overcome in the last five years. Mary realized that she could not work full time at emergency and so started being casual at emergency and labour and delivery. She observed herself becoming more negative and was not able to provide good care. She says that she had to step away due to this situation and work at labour and delivery. Mary describes Compassion fatigue as "*lack of caring or lack of empathy*" due to the effort it takes and the inability to look beyond one's needs:

I will say lack of caring, or lack of empathy, not able to empathize with them and try to look beyond my own needs and look at their own needs and have hard time putting myself in their shoes. That's what I would define as compassion and fatigue.

Once she reaches home after work, she often felt frustrated and angry. She recognizes this as a built-up tension,

And I may have suppressed it during the working day. However, when I am at home, I would find that I would get angry and the people on the receiving end were my husband and my children and things that wouldn't bother me before it would bother me then. If something so simple as if they didn't go to sleep right away. It would bother me, and I would yell at them. And that was not normal. That was out of character to me.

Mary continued with this experience almost for a year. It also affected her way of being with her patients. In the past, when patients put up any barrier, she worked hard to overcome it and built stronger rapport. However, now she says, "*it almost seems like I just do what I have to and then go on to the next patient. That's like I do my task rather than really finding out the underlying*

issue, and I'm trying to overcome that barrier". She sometimes thinks that she does not have enough in her to care enough.

COVID-19 has made things complicated for Mary as the constant change of gowns and handwashing demands much time. She thinks that the patients may want the same care as pre-pandemic, and it is not just possible. She says, "*I would say, I've never worked so hard in my life, but yet I feel like I am doing the least*."

Emma felt like not wanting to go to work, having anxiety and no patience for patient questions when she experienced Compassion fatigue. She started noticing this a few months ago. After the incident with doctors, Emma says that she was thinking about quitting her job and looking for jobs where she does not need to work with doctors. She noticed lower reserves for answering repetitive questions and stopped giving better than standard care. She explains it in her own words,

> *… we are one on one. So technically, we should be in the patient room almost the majority of the time. However, I think that I stopped being in the room as much, yeah, and even some nights, even when somebody was in early labour, and when I maybe would have used to be in the room providing active labour support, I would like to show the partner how to do something and then be like, okay, I am going to leave you guys…*

Though it is good to give patients some hands-off time, she says, "*I think that I was extending those hands-off periods more than I should have.*" When she came home, she did not feel patience with her partner, and sometimes she cried.

Emma describes Compassion fatigue as exhaustion and lack of capacity:

> *I would describe it as exhaustion: exhaustion and a lack of capacity. Yeah, I think a big part of nursing is having the capacity to make space or hold other people's emotions. I think that, at a certain point, you just can't hold their emotions and so you might say the words, but you don't you don't feel anything for them anymore.*

She thinks that she was able to sit with people's emotions better before these events. When she calls her experience Compassion fatigue, it only means exhaustion for her, and Compassion fatigue is an easy and recognized term to describe her feeling.

Joslyn speaks of a sudden burst of anger as a sign of her experience of Compassion fatigue. After the experience with the patient with whom she had to involve security, she started asking herself "*what else could I have done? What else could I have said to this patient Instead*

of, you know, 'you need to stop doing this? Or else we're going to involve security and remove you'. In anger, Joslyn keeps wondering, "*what part of this you do not understand that this is an emergency room? You have gone through all my staff, twice questioning, and many of the staff multiple times. And then now for me to have to direct anger towards you, for you to listen to me*. She says it is the build-up of bad days that erupt in anger sometimes. When these things happen, she thinks the standard of care drops. She would have less patience for patients and do not want to deal with whatever the patients or families bring up to you. She admits, when this happens, you miss many things too.

Joslyn speaks of Compassion fatigue as running empty:

> *I think, for me, Compassion fatigue really looks at you when someone provides human care for an extended duration of time. And you run out of empathy for human care. Whether it's due to staffing issues, or patient issues, or just the type of work we do and itself. I think everyone has for lack of a better word, a gasoline tanks worth of empathy for people they're looking after, and you just run empty.*

4. The Formative Phase (Recovery Focused) Case Vignette

The recovery focused formative phase is an exploration of what happens after the experience of compassion fatigue. The recovery phase investigates patient engagement styles following the experience of compassion fatigue or general nurse fatigue. The recovery phase can be influenced by the formative experiences, in addition to what new learnings happened at the praxis phase. The vignette looks at the representative nurses' recovery efforts through their own words. This is followed by a discussion in the next chapter on whether engaging or not engaging is more beneficial for recovery from compassion fatigue.

4.1 Vignette: "If You Need to Eat the Flatbread Pizza … Don't Feel Guilty, Do It"

There are a variety of ways that nurses use to deal with their experience of Compassion fatigue. Those activities were related to self-care, establishing balance and boundaries, and reaching out to others for help and support. Almost every participant used different methods in an intermingled way to deal with their experience of Compassion fatigue. One of the differences that was observed in nurses' recovery strategies was their view of compassionate care even after having experienced Compassion fatigue. While most of the nurses had a positive outlook towards compassionate care in spite of their experience of Compassion fatigue, a few of the participants didn't have a positive attitude towards compassionate care or an intentional desire to

get back to their patients. The ability to tolerate unpleasant feelings is a component of the experience of compassion and the ability in people to value compassionate care in spite of their Compassion fatigue experience shows a comparable experience. In this vignette while the representative cases of Celine, Edith, Heidy, and Mary show a clear intention to re-connect with patients, the representative case examples of Emma and Joslyn do not appear to show an intention to get back to compassionate care.

Celine took a month off from work due to the surgery which came at the right time for her to deal with her Compassion fatigue. She thinks of herself as the lucky one compared to her colleagues. The one month off without bringing work home and not having to look at emails helped her to recover.

Celine does not think that she learned enough about Compassion fatigue in nursing school. She also thinks that Compassion fatigue is something overlooked in the healthcare profession. According to her, in long-term care, workers have more connection with families; it becomes a bit easier than acute care. For her, developing those relationships is what helps with compassionate care and to deal with Compassion fatigue. Though there are deaths in long-term care, unlike acute care, they are not usually unexpected deaths which are more bearable compared to the unexpected demise of people.

> *…in long term care, we used to have client deaths, and make this experience that is good one for both families and staff and residents. You would have time to say goodbye, and you'd have time to prepare and those kinds of things, because that's sort of what Long Term Care is... Well, I think because we deal with death in such a way. But it's also we deal with death that is not unexpected.*

Edith ended up staying a bit longer in her home after the death of her dad. She got an extension of six more weeks to spend with her children after her dad's death. She returned to work on a gradual return to work plan, and she found it good. Despite her feelings of exhaustion and fatigue, Edith did not lose her connection to patients; instead, her experience became something that connected her with her patients more:

> *… when my dad was sick, and we were not sure where things were going, even I couldn't talk about it because it was just so raw. Whereas once it was over, it was easier to bring that experience into my nursing. And, you know, without oversharing with patients, or*

without minimizing their experience, be able to share a little bit from my own experience with them.

The most helpful strategy for Edith's recovery was taking time off work and building resilience with her husband. During her days at home, she went for hikes and wrote a journal. She believes that the resilience that she and her husband built during her dad's death made them able to better adapt to the COVID-19 situation. She also related her strong faith in God as an element helping her through Compassion fatigue and the pandemic together with reaching out to others:

It is not about you and your strength; you have strength because He gives you strength. So that, for me, was a powerful experience at that time. And it kind of continues when you think about the tough times that COVID-19 brought. When I reflect on those, it's like, I wasn't in at all alone. I wasn't the only one trying to deal with it. And I wasn't doing it by myself. I think it's just that knowledge that there are others around.

Her advice to nurses who may be experiencing Compassion fatigue is that they seek some counselling help. She admits that she had support from counsellors during her struggle. She would also advise others to take enough time to care for themselves. She also speaks of the need to take an active role in Compassion fatigue as she does not believe that it can go away on its own. She suggests engaging with our emotions as a way to deal with Compassion fatigue and that may help one to identify the signs of it early enough. According to her, learning about Compassion fatigue needs to be happening at the workplace at frequent intervals as nurses often go through these experiences.

Heidy witnessed the deaths of children at work and when she got home, she says, "*my lovely husband hates hearing about anything to do with hospitals. So that's been one of the hardest things for me is I don't have anywhere to, you know, let it out*". Heidy says this is the situation with many nurses who are single mothers or have similar situations. She says one of the reasons she was able to keep compassion for these many years is that she has not worked full time for almost for 40 years. After three days of work, she says that when she gets home, she does not want to cook and does not want to see the children but rest. Heidy acknowledges talking to others, especially colleagues, as another way of dealing with it. However, she also reflects on the reward of caring, "*I cannot even tell you how. How much I get back*".

Heidy's suggestion to a Compassion fatigued nurse primarily is to take time off. She also wants a lot of encouragement and affirmation for struggling nurses. She would also keep connecting with them through this recovery phase. Heidy speaks of engagement in nursing in the following lines,

> *This is a message you get in nursing that you know, when you're training, don't get too involved? Because you will burn out. However, sometimes I think it's the opposite. You get involved. And I think it will build you up. You will have meaning in your life and career…What is nursing? You know, changing diapers, writing, numbers down, like who cares? It's really about caring for other people. And, if you want to have a fulfilled life, probably in any profession, it is going to be about caring for what goes on with the people around you*.

Mary tried to find a balance between life and work as the way to deal with her Compassion fatigue. She says, "*So I find that when I'm at work, I have more compassion, I'm happier to be at work. And I can give more, but I've had to work less to experience that*." Another major approach in her recovery is taking the days off to recharge by spending time with children. This has become her lifestyle now that after work, she spends the most time with children. She would advise fellow nurses who may go through a similar experience to take a break, or do more task-oriented work, for some time. She also suggests ways for recharging for nurses, like finding a support group where they can talk:

> *I think one of the things that affect nurses a lot is when you feel like you're the only one, you see all these other nurses doing such a great job, but it must be you, must be something wrong with you. However, all of us go through waves, and we go through waves; we have many lows, where we are not, as I would say, almost like a battery, you know, when you're drained. And you need periods to recharge.*

Mary also has created a routine called the "*COVID Cool*" which includes coming home, taking a shower right away, doing laundry and getting children from school. According to her, she has lost at least one and a half hours a day to COVID-19.

Mary thinks that there is a risk and reward to her job. For her being compassionate can also mean that there is greater potential for Compassion fatigue. However, she never regrets having given too much; instead, she regrets and feel guilty for just doing task-oriented care alone. Her observation is interesting in this regard,

And, you know, if I have a lot of compassion, and then I get Compassion fatigue, I can recharge from that. The guilt is not so easy to walk away from; that guilt is quite hard. And I feel like it carries me for a longer length of time than Compassion fatigue.

The idea that the Compassion fatigue experience of the nurse may have something to do with compassion intrigues Mary as she suggests that many do not see that link and cannot pinpoint a specific reason. She spoke of one of her friends who may be experiencing Compassion fatigue, and the only thing she can describe is "*COVID-19 is killing my soul*."

Emma tried to do more exercise, eat well, and visit a therapist to deal with her Compassion fatigue experience. COVID-19 made it difficult for her to get out of the home to take care of herself by meeting friends: "*So we haven't hung out in a long time altogether, and I have no vacation to look forward to, but there is not anything to do or where to go*."

When she is back to work, she is selective about connecting with patients. She says, "*if there is a really anxious one that I can't connect with and calm, then I try not to spend too much time in the room because I am not helping them."* To deal with Compassion fatigue, she advocates self-care and therapy. She says that there was a course on Compassion fatigue during her education that focused on individualistic self-care. She disagrees with it as very much effective, and she finds the issue as much bigger and systematic. She says:

I think that in nursing school, there should be a class on Compassion fatigue, and then everyone should sign a petition that talks about mandatory nurse-patient ratios, like California have benefits that cover therapy automatically for every nurse no matter if you're casual or part-time. And I think that to me, would make way more difference than a course on doing yoga.

She also suggests that there should be debriefs and check-ins after major incidents or traumatic events.

Joslyn says that when she gets home after a stressful anger experience from the hospital, her husband understands and supports her by listening. Joslyn thinks nursing training is not preparing students to work as compassionate nurses. She says, "*I do not think nursing school prepares us for nursing. You know, they prepared, these are the skills you need. This is, you know, how to read someone's blood work, you know, but they didn't prepare you for the people*". Joslyn thinks going part-time may be good to deal with Compassion fatigue. She also thinks that

a nurse needs to find appropriate outlets like fitness, family or counselors and do things that may take the mind off their work.

5. Concluding Remarks

This chapter undertook an exploration of the six representative case vignettes reflecting on their experiences of initiation, praxis, outcome, and recovery phases regarding the experience of compassionate care and compassion fatigue. The detailed understanding of individual nurse experiences through the phenomenological lens helps root the study in the lived experience of its participants. In the following discussion chapter, the grounded theory model and the experiences shared through the representative case vignettes which reflect the different formative phases will be analysed in the light of the literature.

CHAPTER VII

DISCUSSION ON THE GROUNDED THEORY MOEDL OF MULTI-PHASED NURSE COMPASSION FATIGUE PROCESS

The main discussion about the study findings of this research can be found in this chapter. Following the previous chapter, which enumerated the representative case vignettes, this chapter discusses each phase of the compassion fatigue experiences drawing from the grounded data of participants' case vignettes. This chapter also revisits the three purposes of the study: examining the experience of compassion fatigue (reasons, effects, and processes), the role of compassion in compassion fatigue, and discussing a theoretical model of compassion fatigue that is arrived through the constructivist grounded theory investigation. The narrative flow of this grounded theory discussion chapter follows the spirit of Gioia's (2013) approach to grounded theory in integrating phenomenological focus by taking care for representing participant voice within discussions and adopting a story telling style similar to other parts of this dissertation.

1. Compassion as Connection: Discussion on the Formative Phase (Initiation Focused)

The three vignettes presented in this phase, namely: "*Why I Went into Nursing*," "*Nature and Nurture*," and "*I do Wish Compassion and Grace for Everyone*," contribute to an understanding of the nature of nurse motivation, its origins, and the reach within their practice of compassionate care. Though there are many influences in a nurse's life as they begin their career, some of the aspects related to compassionate care are discussed in this chapter through these vignettes. Perry (2008), in their phenomenological study of exemplary, compassionate nurses, found the theme of connection representing successful nursing care. Accordingly, for compassionate nurses, "establishing a connection with their patients seemed to be a precursor to excellent nursing care" (p.89). In the representative case vignettes of Celine, Edith, Heidy, and Mary, we see that the passion for people translates into a deep connection with their patients. However, the cases of Emma and Joslyn are examples of nurses whose initial motivation and experiences may not have translated into optimum connecting behaviours with patients in their care. The following paragraphs discuss the six representative cases by comparing the nature, origin and extent of compassion expressed in their desire to connect to their patients and others.

1.1 Motivated by Compassion

Most nurses' earliest experiences and interests in the study revealed a positive atmosphere of nurturing and compassion. However, the nurturing experiences came through different

sources; for some, it came through parental caring, others through spiritual connections, and others through the discovery of themselves as innately caring. Some of their caregivers held the compassionate behaviour in high esteem; others probably found it valuable through other sources like churches or the community.

1.1.1 Presence of Compassion Models. Celine found a strong family bond between her parents and siblings. More importantly, she felt "deeply loved and cared for" by her family. The presence of compassion modelled in her life as her parents made her value the experience of compassion during her childhood. Edith called her parents "inspirational models" for showing her the value of compassion and at the same time allowing her to evolve in her innate compassionate nature. She saw her parents doing activities related to compassion in her community. In the case of Heidy, it was her mother showing kindness and compassion to her mother despite their not-so-good relationship. Her dad taught her to value compassion as he said that she was special just because she cared for others. For Mary, her interaction with the Church and teachings of the Bible promoted the compassionate side in her through the divine command of helping the sick. Unfortunately, neither Emma nor Joslyn shared any early experiences of compassionate models in their life. Modelling is a way that children learn from parents, and the absence of compassionate models can mean that they were not allowed to explore their innate nature of caring by adults in their life. It is also to be noted that while some of the adults imparted the experience of compassion through their love and presence, others did it through more a cognitive and psychosocial process of being involved in the community's struggles, assessing their needs, and meeting those needs.

1.1.2 Presence of Compassion as Valuable. Following the above analysis of the compassion, compassion models are the positive influence in children's lives of witnessing adults valuing compassion in their lives. For Edith, right from her childhood, she learned to value compassion as part of her success. It was not only that she experienced the compassionate parents doing things for the larger community, but she learned to live with the needs as satisfying even when some of her "wants" were not met. In some sense, it is learning to share the suffering of humanity with scarce resources. She expressed that she felt cared for and valued compassion to achieve something bigger than herself. When Heidy's dad told her that she was special because of her caring nature, she knew the extent to which her dad valued compassion and care. In her case, she seems to connect compassion with happiness as she says about her siblings that

though they were successful, they were not very happy people. Just as modelling is a way that children learn, it is also true that they learn what the adults value and practice and not what they preach. Harvard Graduate School of Education did a nationwide survey among 10,000 students to ask what they valued. The study found that most children from diverse backgrounds valued personal success compared to caring for others. The reason behind this phenomenon appears to be the gap between what their parents say they value and what they practice (Weissbourd et al., 2014). In the case of Emma and Joslyn, we do not see the perception of compassion as valuable within the information of their childhood upbringing that they shared.

1.1.3 Presence of Safe and Stable Structures. Celine's comment about her family as the "perfect" family that she experienced safety and security in her home by witnessing strong family relationships speaks about the presence of safe and stable structures in a child's life. In the four exemplary cases of Celine, Edith, Heidy, and Mary, we see that the parents are together, and they cared for their children and cared about the community together. Whether they were very emotional people or not did not seem to be a big issue. Like Celine, though Mary did not have very compassionate and affectionate parents, she developed her connection to the Divine through her experiences in the Christian community. This is also to be seen as creating a safe and stable structure in the internal experiences of a person, which may have strong protective effects. Similarly, Heidy developed a stronger spiritual sense in her of a "good God." Neither a strong sense of stable home nor a deep spiritual connection is found in the cases of Emma and Joslyn. In their workplace experiences, both Emma and Joslyn appear to desire a strong team to work with. It may express their desire to build safe and stable structures during their adult experience. Similarly, among the other participants of the study, Kim reported that her parents were not reliable people who had serious flaws and were absent from her life, and she called the nursing profession her family. This may be another example of how individuals try to build safe and stable structures which they probably never had.

1.2 Connected Through Compassion

In a general observation, the participants who experienced strong nurturing experiences during their growing up years or who developed a deep spiritual language of connection and discovered their innate nature of compassion appear to use the language of connection predominantly in their interaction with patients. They also appear to understand the suffering of their patients and tolerate the experience of fatigue.

1.2.1 Connection Experience Not Influenced by Demographics. The data collected from 27 participants regarding their demographic background, years of experience, specialties they worked in, and their education background did not show strong patterns connected to their experience of connection. The positive formative experiences, including some of the spiritual perceptions, mostly through childhood growing up years, supported a strong tendency towards the language of connection. When the six cases of Celine, Edith, Heidy, Mary, Emma, and Joslyn were considered, Emma and Joslyn had the lowest years of experience in the profession. However, comparing it with the other participants, Jacob, who showed a connection to patients, had only one and half years of experience. As we notice, the representative cases are chosen from various age groups and demographic representation; however, the positive experience of compassion or the presence of a spiritual language of connection appears to support a tendency to connect. This may speak to the innate nature of compassion and the significance of a facilitative environment during the developmental years.

1.2.2 Desire to Connect - Translating to Patient Care. One of the observations regarding the initial motivation of participants is whether these translate into their patient care approach. There is enough example to show that the initial motivation can be a powerful indicator of their patient care approach among the participants. Celine loved to be in the long-term care and considered it as the extended part of her family; Edith learned to meet the needs of her patients in order to take care of them; Heidy, even after so many years, considers that it is easy to connect with the patient families and Mary usually develop relationship right off the back in their first meeting with her patients. However, Emma appeared to avoid difficult patients in her choices, and Joslyn appeared to be very task-oriented and expecting patient compassion and gratitude. It is also to be noted that some of the participants came to the nursing profession with the initial motivation to protect or advocate, which is also reflected in their patient care approaches as a prominent language of the relationship with patients. Most of the participants shared the interest to connect to their patients, and there are varying levels of the desire to connect present in the nurses.

1.3 Transcending Through Compassion

There is much debate on altruistic behaviours and the motivations behind them, what makes one more altruistic than others, the role of empathy and compassion within the experience of helping behaviours. The participant data reveals some indications on the nature of helping

behaviours through the prism of self-referential compassion and caregiving attachment like that of a mother to the child. The study participants paint a picture of varying levels of compassion. For some of them, it is a reactive response to the patient's plight, very similar to empathy, and for most others, it is relational and the exercise of the limited nature of compassion. Some exhibit a strong desire for universal compassion, which is unlimited in its expression.

1.3.1 Compassion Appears as a Reaction-Like Empathy. While most participants view compassion as emerging from a sense of relationship, some report it as a reactionary experience. This has been the major difference between the foundational literature on compassion fatigue by Joinson (1992) and Figley (1995). Joinson reported compassion fatigue as the outcome of a relational process, and Figley reported it as the outcome of traumatic distress coping mechanism. Among the vignettes, both Emma and Joslyn appear to report their compassion as a response to the pathetic sight of their patients. Emma asks if you have somebody whose baby is dying before you, would you not care? And Joslyn reflects on her experience at the emergency room that one would be a terrible nurse if not showing compassion to someone in their worst situation.

1.3.2 Compassion as a Debated Moral Principle for Some. The care theory projects care primarily as a moral duty (Noddings, 1984), and similar responses were also found among the study participants. While Emma thought of the expectation to show endless compassion as unjust and gendered, Joslyn thought of compassion as a duty of what needs to be done. I do not consider these expressions of the participants as an absence of compassion; rather, they may be transitioning through the understanding of compassion as a challenging enterprise.

1.3.3 Self-Need Comes First. Many of the study participants explained traumatic situations as times that one turns into a self-preservation mode of operation and would reserve the energy for their own well-being compared to the care of patients. This is also how they connected the influence of traumatic events in the development of compassion fatigue as the inability to care. Though this can occur in any person who is taking care of others, the initial motivational and experiential examples of individuals may also reveal a similar pattern of the self-care needs first compared to the patient's needs. When Emma chooses her patients according to what is the best scenario for her and when Joslyn thinks that the patients should show compassion and gratitude to the hospital and the nurses, we seem to find a pattern of self-focus at the suffering of others. It is also to be understood that we all prioritize our self needs first in certain situations, and Emma and Joslyn may have been trying to prioritize their self needs in

their circumstances. Again, this is a process of transitioning to a more tolerant and generous, self-giving side of human capabilities.

1.3.4 Everyone Agrees with the Limit of Compassion. Among the study participants, everyone agreed to the understanding that their ability to be compassionate is limited and imperfect. Despite the limited nature of compassion ability, many aspired towards universal compassion or unconditional love. No one appeared to attribute the limited compassion ability as a flaw; rather, the inability to deal with the fatigue and inability to care were concerns for them. The participants who spoke of compassion fatigue's "risk and reward" found the balancing effect between the risk of fatigue and reward of joy and fulfillment in caring for others. Some of the participants made it clear that it is not that compassion is limited; rather, the ability to be compassionate is limited.

1.3.5 Reflection of Patient Suffering. The transcending of the self needs and the growth into a mature sense of compassion comes with a deeper awareness of the universality of suffering. Compassionate behaviours are also a result of the ability of human beings to perceptually connect with the suffering of the other similar to their suffering. Surprisingly, many of the participants shared their concerns about the patients in their care or the state of suffering that their patients may be in. Celine's words regarding the COVID-19 situation when the nurse cannot offer the patient hugs: "you could tell that is just what people needed, they needed to be touched" reveals her understanding of patient suffering. Edith reminds herself when she meets her patients, "this is their first time going through this, and this is probably my 100th time seeing a patient like them," which helps her connect with compassion. Heidy wants to care for babies as she would care for her baby or her mother or father, and Mary says, "people don't just need medical treatment, they actually also need compassion, they need to be heard." While all these four representative cases give examples of their awareness of the suffering of patients, both Emma and Joslyn appear not to have insight into the suffering of their patients.

1.3.6 Universal Compassion, Grace for Everyone or Unconditional love. A review of the data from all the study participants indicates that the desire for universal compassion or regard for it translates into a positive attitude towards compassion. Though most participants think of it as an ideal state, an aspiration to extend the circle of compassion to more people and situations is accepted easily among them. Some of them did not have any idea about the concept and therefore came up with concepts like grace for everyone and unconditional love. Whatever

the language used, there was an indication of these individuals wanting to transcend their immediate self-centred needs to a bigger community. Celine wants to believe in universal compassion; however, she thinks that individual compassion makes more sense to her; Heidy wishes compassion and grace for everyone, and Mary has an affinity to the idea of unconditional love. For Emma, the mere act of caring for a stranger may qualify as universal compassion, and Joslyn does not think that there is something called universal compassion. The representative case vignettes and participant study data shows a possibility of considering the caregiving space as a transitionary experience through empathy, self-referential compassion to the non-self-referential nature of compassion.

The initial formative experiences related to compassion guide a nurse in their practice of compassionate care. However, the praxis phase can be met with many challenges. The next phase discusses the work milieu in their delivery of care.

2. Compassion as an Attachment System: Discussion on Praxis Phase

Any healthcare institution will benefit from creating a culture of compassion within its structure, especially in the caregiving spaces. There can be debates on whether such initiative needs to happen from top to down or a ground-up fashion. Whatever the approach, creating a conducive environment which encourages healthy, compassionate human interaction and caregiving is imperative. In this line of thought, it is important to understand the pre-requirements for a condition of optimum caregiving behaviour to flourish. Attachment theory sheds some light on the subject with its ideas on the attachment behaviour system and caregiving behaviour system. The theoretical understanding is that an optimum adult caregiving behaviour system can be operationalized if the necessary conditions are met.

According to John Bowlby (1969), human beings are born with two complementary behaviour systems: the behavioural attachment system and the caregiving behavioural system for the survival and protection of the offspring. In Bowlby's perspective, the human child is born almost helpless. So, an attachment system emerged in the process of evolution, increasing the survival possibility, and is active throughout the entire life span, mostly manifested in "support seeking behaviour" (Mikulincer et al., 2003, p. 78). In the first version of the attachment theory, five patterns of attachment behaviour were observed: "sucking, clinging, following, crying, and smiling" (Bowlby 1969, p. 180). However, in the subsequent version of the theory, Bowlby postulated that these behaviours were incorporated between the ages of nine to eighteen months

into a somewhat complicated goal-corrected system in the human child where the goal is to keep proximity to the mother, which may give a survival advantage. Bowlby called this the "control theory of attachment behaviour" (p. 180). For Bowlby, attachment behaviour is instinctive but "not inherited: what is inherited is a potential to develop" (Ainsworth 1969, p. 28) an attachment system.

While the attachment behaviour system operates with the principle of "proximity seeking" to an available caregiver at the signal of danger, the caregiving behaviour system complements it with security giving attachment figures. There are two functions for security - providing attachment figures. The first function is to give protection and support in times of danger, which Bowlby (1969) called "providing the safe haven" and supporting other's exploration, autonomy, and growth when they feel it safe and desirable, "providing a secure base" in his work *Attachment and Loss*. According to Batson et al. (1981), two responses to suffering are triggered in the caregiving behaviour system. One response is what he calls the "empathic stance" (p. 299), which is taking other's perspective to understand and help in their suffering, and the other response is "personal distress" (p. 299) which may motivate a person to help behaviour insofar as it reduces distress. If there is another way to reduce distress without helping the person, the individual may choose that instead. Batson et al. (1981) originally used the term empathic stance to mean "sympathetic, kind, compassionate ..." (p. 299). According to Mikulincer et al. (2009) the empathic stance is characterized by "sensitivity and responsiveness" (p. 231), which are part of parental caregiving responses as described by the attachment researchers. These are also the characteristics of the security providing attachment figures. Sensitivity includes attunement to and accurate interpretation of another person's signals of distress, worry, or need, and responding in synchrony with the person's proximity-and support-seeking behaviour. Responsiveness includes generous intentions; validating the troubled person's needs and feelings; respecting their beliefs, attitudes, and values; and helping them feel loved, understood, and cared for.

In Bowlby's (1969) observation, when the child's need is to protect themselves from imminent danger, and the attachment system is activated, it is possible that any other system like exploration and play can be inhibited. According to Mikulincer et al. (2009), the same principle applies to the adult caregiving behaviour system. They say,

> Potential caregivers may feel so threatened that obtaining care for themselves may seem more urgent than providing care to others. At such times, people are likely to be so focused on their vulnerability that they lack the mental resources necessary to attend sensitively and compassionately to others' needs. Only when a degree of safety is attained, and a sense of security is restored can most people perceive others to be the source of security and support and worthy human beings who need and deserve comfort and support themselves (p. 233).

The question is whether the formal caregiving settings like that of a patient and caregiver could be similar to an informal caregiving setting like that of a mother and child? Noddings (1984) similarly speaks of natural and ethical care where the ethical care may transition into natural care. Unlike Nodding's conceptualization of care as an ethical duty, literature speaks of compassion as an innate human capability with a possibility of improvement through training. According to Tomasello (2009), human children are born with the innate ability to share and help others without a need for reward or encouragement. Accordingly, the earliest helping nature is an "outward expression of children’s natural inclination to sympathize with others in strife" (p. 13) and this being naturally altruistic is an evolutionarily stable behaviour in humans (Warneken & Tomasello, 2009). Mikulincer et al. (2009) believe that though the caregiving behaviour system presumably evolved to protect the close members of a tribe, it is possible that attachment security can "facilitate a compassionate attitude towards all humanity" (p. 245). They suggest that a secure environment and the availability of sensitive, loving, and caring attachment figures can transform the compassionate care behaviours into a chronic disposition, trait, or skills in caregivers. In various studies related to attachment research and compassion fatigue, insecure attachment posed a contributor to compassion fatigue and safety, and security priming reduced compassion fatigue (Mikulincer et al., 2005). In short, I don't draw a line between informal and formal and natural and ethical care when speaking about compassion. Instead, it is the same innate ability to be compassionate, exercised in different settings, intentional or non-intentional, self-referential, or non-self-referential.

According to Mikulincer et al. (2009), though the caregiving behaviour system supposedly evolved primarily to help with the survival of an individual's offspring and close members of the species, it is possible to be made available to all suffering human beings through formative and educational experiences of individuals. The optimum functioning of the

attachment behaviour system and caregiving behaviour system is understood as the fertile ground for compassionate care in a healthcare setting (Mikulincer et al., 2009).

2.1 The Attachment Needs

It appears that as children, both attachment and caregiving systems are not experienced by the same person as the child remains the one in need of attachment security, and the trusting adult (or caregiver) is the security providing attachment figure. Though the role reversal may not be possible during childhood, it may happen in the adult attachment system, where a person may have various attachment needs to address. However, there may also be an obligation to take care of others out of professional or personal circumstances. In such a situation, the optimum secure attachment experience will lead to efficient and genuine functioning of the caregiving behaviour system. The healthy interplay between these behaviour systems (Mikulincer & Shaver, 2017) produces happy caregivers and compassionate workplaces. As explained at the beginning of this chapter, the needs of safety, stability, and support work together as the foundation and springboard for a healthy attachment system. This discussion looks at the attachment needs of a nurse, what disrupts unit morale, what causes nurses to leave their job and what promotes the culture of compassion in the workplace. The representative case vignettes of the six nurses give descriptions of these different levels of need in their everyday personal and professional life.

2.1.1 Levels of Safety. Though we are talking about safety specifically in the work environment, the experience of safety starts very early in life. The experiences of safety and security in early childhood pave the way for the perception of safety and security in a person's later life. It is also possible that some spiritual concepts of God or the Divine can provide this perception of safety in people's lives, as is seen in the case of some of the participants. There can also be various levels of safety that an individual needs. In the nurse's responses, we see personal safety, emotional safety, and workplace safety. When COVID-19 started, the area available to patients in Celine's long-term care home got restricted. The limited space brought about negative interactions between patients, which eventually became a safety concern for everyone. As COVID-19 continued, the fear of exposure and overwork became more of a regular workplace feature. Celine experienced a sense of losing control which affected her sense of personal safety. As Edith's father passed through the worst phase of cancer, she struggled with having no energy left for patient care. She appeared to have experienced the lack of safety more from an existential angle. Though she had a very supportive husband, a supportive doctor and a workplace, she

ultimately turned to God to experience a sense of safety. This, she suggests, helped her with the isolation during COVID-19 and made her able to tolerate the changes wrought by COVID-19. Heidy's main concern was the safety of her infant patients, who were very vulnerable to the pandemic. Heidy reported a lack of emotional safety as she was not given enough time to grieve through the death of infants, which was also a reason for her compassion fatigue. Working in a huge space, the physical structure also gave her a sense of isolation and lack of physical safety. Mary found the triage area unsafe at both the emotional and personal levels. As the nurses were in direct contact with the affected people and sometimes non-compliant people, the triage area became unsafe. For Emma, the hospital was not protecting the nurses, and the work environment was not safe either. She felt that her sense of safety was violated due to disrespectful behaviours from her colleagues, especially some of the doctors. The safety issue was emergency department-specific for Joslyn. The non-compliant patients and families, and lack of support from administration, increased the safety concerns for Joslyn.

2.1.2 Levels of Stability. Just as for safety, nurses need stability for their optimum functioning. Organizational studies (Feldman, 2003; Moss et al., 2017) have shown the power of the experience of stability as an indicator of the successful performance and confidence in the employer. These needs are tied up with the perception of security and safety. During the COVID-19 pandemic, the stability needs have been more at risk than other times like an outbreak of other illnesses. Compared to the COVID-19 pandemic, the outbreak experiences were limited in scope and nature. Things like irregular schedules and higher nurse turnover are stability concerns that frequently appear, even outside of emergencies. From the participant's conversations, I have identified different levels of stability that affect a nurse's life. A nurse may come across personal and family stability issues, work-related stability issues like scheduling, and unit levels stability issues like nurse turnover and changes in leadership. The following section explores the stability issues flagged by the six representative cases in their description of professional life and experiences of fatigue.

During COVID-19, the irregular schedules and routines interfered with Edith's family time. She also had to manage the double role of a mother and a professional. Another challenge for her had a partner who was also in healthcare with an irregular schedule due to COVID-19. For Edith, after her dad's death, she had almost a month to be with her family. She says that really helped her with routines at home with her kids. At the start of the pandemic, many nurses

were also concerned about the childcare needs of their children, online schooling needs and the difficulties of managing the high demands and irregular schedules at work. As Edith struggled with personal and family stability that affected her work, Celine found that the pandemic created policy flux at her workplace, which confused everybody. The constant phone calls from patients' family members emerged as a new situation with which the nurses were unfamiliar. Nurses struggled with the constant demand for communication from family members who were restricted from being with their loved ones due to lockdowns. Most nurses were compassionate about the patient's situation and the worries of family members. Heidy says that she walks into uncertainty every day as she does not know what kinds of patients she has and what demands there are. This could be the case in most nurse experiences, where things at the unit can be good, bad or can be challenging to start with. Another major issue that affects unit stability is the issue of nurse turnover. It not only stresses the manager and administration but also the patients who get deprived of optimum service and the nurses who can be forced to do extra shifts to cover the nurse's absence. Heidy reported about the huge number of nurses who retired at the beginning of the pandemic in Quebec. Mary's concern was the information overload and the constantly changing nature. She found it difficult to deal with the patient situation as she, like many other nurses, did not have a clear guideline on what needed to be done. Mary also referred to the many nurses who leave their jobs due to compassion fatigue and work environment. Emma spoke of the unmanageable policy changes in her workplace and the inefficient communication of these changes to the staff and patients. Joslyn described the struggle of a triage nurse when there was no clarity in the policies that they are forced to make decisions around what needs to be done.

2.1.3 Levels of Support. Like safety and stability, the support needs of a nurse are also multidimensional. They may be categorized mainly as personal, family and colleagues, workplace-related, and system-related support. Support can mean available resources in support of a nurse's work and the supportive stance of the management and colleagues. It is also true that the nurses have a good understanding of the situation at work and can overlook some minor concerns when they recognize a sufficient supportive stance from the management. Just as nurses have personal and family-related responsibilities, the stresses from their environment can affect their work and vice versa. Therefore, support at every level becomes very important for the optimum functioning of a nurse.

In her current role as a head nurse, Celine can support her colleagues in a meaningful way. She understands that there is a huge need for childcare arrangements for nurses every year around September. The understanding of this situation by administrators is very important as they anticipate and respond to the off-duty requests of nurses. She encouraged regular check-ins and allowed days off requests more generously than required, which she says has helped create a better atmosphere at work. While going through the sickness and death of her dad, Edith experienced the support of a compassionate leader in her doctor who suggested she take extra rest before going back to work. One of the areas she struggles with, like many of her colleagues, is the lack of supporting conversations between members of the care team. As everyone is dealing with cancer patients, they are burdened by difficult stories, but shared strategies to help everyone unwind would have been very helpful. Heidy speaks of her workplace as a very supportive environment, and she plays her role in initiating small efforts in support of everyone in the unit, like small acts of compassion and encouragement with her colleagues and working with patients and families in understanding their needs. Mary is very critical of the situation at her workplace, where there is an expectation to do the maximum work with a minimum of resourcing. The nursing freeze in her workplace brought added burden on other nurses. She says that the ripple effect of a lack of support from the system and the management that the nurses now have to suffer. She is also very upset with the government and the system, as many of the issues at her workplace are directly connected to some of the decisions made at the government level. Both Emma and Joslyn desire a team at work to support their well-being. Emma reported that she did not get any debriefing support for difficult deaths. She also feels the struggles with unsupportive and indifferent managers in her workplace. She was frustrated by some of the physician's attitudes. Joslyn also struggled to deal with unsupportive management and not being valued by some of the team members, including physicians.

2.2 Unit Morale and the Attachment Needs

Day et al. (2006) speaks about several factors that may decide the morale of health care workers, such as a shortage of workers, overwork, low pay and issues in retention of workers, quality of educational opportunities and professional support, and a lack of recognition for job performance. They organized these ideas into a few intrinsic and extrinsic factors, with the intrinsic factors being professional worth/respect, opportunity/skill development, workgroup relationships and patient care. The extrinsic factors can be described as organizational structure,

operational issues, leadership traits/management styles, communication, and staffing. In the context of the praxis phase, both the workplace and its operation become an integral part of the reasons for both unit morale and nurse morale. The three experiences of safety, stability and support cover all these areas as overarching categories.

Violation of safety can be at different levels, as explained earlier. The lack of structural safety and lack of safety from violence or non-compliant patients or family members can violate personal safety. It can include the overwhelming fear of exposure, work overload, or overloaded by confusing and constantly changing information. One of the things that can also affect the unit morale is leadership styles and how communication happens between the nurses and the management. Emma and Joslyn reported not feeling valued by their colleagues, and Mary spoke of the lack of professional growth and development opportunities. Staffing levels have been an issue, especially during the pandemic. The lack of support that a nurse experiences in the unit can be because colleagues are overwhelmed by their responsibilities, fatigue from overworking, the perception of a non-supportive leadership and a lack of resources from the administration and government.

2.3 Unit Morale and Initiating Culture of Compassion

The primary responsibility for the management and leadership is to assure unit morale by offering support to every staff member, especially nurses who are in direct work with the patients. The cliché usage by nurses, "*overworked and underappreciated*," which was brought into the conversation by Celine, appears to reference the aspect of unit morale directly. Celine, a head nurse on the floor, described the situation of losing unit morale in the wake of COVID-19 and the efforts of regaining it.

> "*Lots of stuff on your plate that and you don't have the outlets, or you don't have the time for the outlets that you usually have for self-care. You know, there's been a lot more tears, and there's been a lot more impatience with each other as co-workers, you can see, sometimes it was bubbling up and overflowing*".

While the overwork and stress experienced in the unit were overwhelming, the management's efforts resulted in rebalancing the situation. Celine says that to deal with the feelings of stress, the management started having regular meetings and started doing simple things to regularly appreciate and encourage the nurses, which improved morale at her place.

Having worked for so many years, Heidy now knows what helps keep the unit morale better. She says that small things like "*offering a sticker, like a star or maybe an animal*" in appreciation for their work greatly impact the nurses' sense of being appreciated. The unit morale is not just limited to the staff, but also how the patients are experiencing the unit. Heidy makes sure to make every opportunity a connection to the patients and families. For example, when a child dies in her unit, the nurse at the unit makes it a point to send a letter or book to the family with inputs from most nurses who worked with the child. She also makes sure that the families who require something are given the needed assistance. They even get the children dressed up for Halloween. For her, such simple acts of compassion spread in the unit. She says that when people see that someone cares, the resultant caring is contagious. Heidy's workplace appears to be an excellent model of a culture of compassion, especially using a down-to-top approach. It is interesting to note that while Celine's experience emphasized the importance of a top-down approach in a culture of compassion, Heidy's experience is from the ground up.

Edith spoke about the importance of compassionate leaders in the workplace. When Edith's doctor asked her to take extra time off from work, and the management supported such a decision, she found the courageous and compassionate leadership helping her to be compassionate with herself. As self-compassion and self-care are important factors of a nurse's morale, compassion for others and compassionate leadership support nurses to be more compassionate with themselves. This experience can have a ripple effect on patient care and the care for each other.

2.4 Nurse Leaving Phenomenon and Attachment Needs

Some of the nurses in the study spoke about nurses who retired at the start of the pandemic and about the high turnover of nurses in the emergency department even before the pandemic. Among the 27 nurses who were interviewed, at least four of them shared their desire to change their job or change their workplace because of the experience of fatigue. The representative case examples of Emma and Joslyn are two among them. Almost all of them have come across an unsafe workplace with much less support on close analysis. The conversation about leaving their job has been in the context of issues at the workplace, especially of safety and support. Often nurses found the job in an emergency more challenging than labour and delivery. Mary, who worked in an emergency, had to move to labour and delivery to balance her stress levels.

It appears that the root cause of nurses in this study leaving the workplace is the desire for a safe and stable workplace with support structures. The examples of Emma and Joslyn may bring home this idea. Both reported violations of their personal and emotional safety at work, and they both expressed a desire to have a team of colleagues working together in their units. They both had issues with members of their team and did not feel valued by them to care for the patients. It is also true that they did not experience a very positive formative and nurturing experience during their growing up years. However, others within the interviewed nurses had a very difficult upbringing; however, they felt supported by the workplace. It would also be fair to say that the perception of safety and support comes from different sources, and the praxis phase of a nurse's life is extremely important, with the workplace serving as a place for them to meet their attachment needs, and thus support the caregiving system in an optimum fashion.

3. When the Compassionate is Fatigued: Discussion on Outcome Phase

In the Outcome Phase case vignette, we tried to understand the experience of compassion fatigue for individual nurses. Most literature related to compassion fatigue treats it as a phenomenon like burnout or secondary stress disorder (Ames et al., 2017). While Joinson (1992) spoke of it as an experience affecting caring professionals and their "loss of ability to nurture" (p. 117), Figley (1995) described it as the fatigue experienced in a therapist because of being indirectly exposed to someone's trauma and suffering. Lee et al. (2012) asks a very pertinent question regarding the causation of compassion fatigue: 'is it caused by overexposure to suffering or the fatigue of compassion?' While Figley's description fails to explain the situation of non-traumatic exposure to suffering or fatigue as in the experience of a mother-child relationship, Joinson's (1992) description implies that there is something that can potentially bring fatigue in compassionate care, as revealed from her statement that "the profession sets you up for compassion fatigue" (p.119). Sinclair et al. (2017) suggest that one needs to understand compassion to understand compassion fatigue empirically. Following the assumption that compassion cannot be subject to fatigue, Klimecki and Singer (2011) tried to propose that compassion fatigue needs to be called empathic stress fatigue. In the literature chapters of this dissertation, I have presented my rationale in considering compassion fatigue as different from empathic distress fatigue but as connected to self-referential compassion from a literary and theoretical analysis of the phenomenon.

The anonymous survey participants were presented with two working definitions adopted from Joinson (1992) and Figley (1995) or invited to choose their description of compassion fatigue. 53.77% of the survey participants chose the description of compassion fatigue adopted from Figley, namely: *compassion fatigue is the experience of fatigue caused by the overload of emphatic distress (distress and trauma caused by high amounts of empathy).* Alternatively, *40* % of the survey participants chose the description of compassion fatigue adopted from Joinson, namely: *compassion fatigue is the experience of fatigue due to my inability to maintain a nurturing (caring) relationship with my patient caused by a limited reserve of compassion or the limited ability to care*. Finally, 5.57% of the survey participants chose their description of the phenomenon, which was generally a combination of the above descriptions but mostly similar to the idea of the inability to nurture. Compared to the grounded theory interview data, the survey data surprised me like over half of the participants thought of compassion fatigue as caused by trauma and high amounts of suffering, and the remaining sizable minority thought of it as caused by depleted reserves of compassion and the inability to care. The reason for my surprise was that the 27 interview participants had expressed their understanding of compassion fatigue similar to that of Joinson (1992). A probable reason for this difference could be the dominance of Figley's view and the under-representation of phenomenological data in current literature. It could also reflect the confusion and overlap between compassion fatigue and similar experiences like secondary stress disorder, burnout, vicarious trauma, and transference. The interview data of all participants exhibited patterns integrating the experiences of trauma, work overload, limited resources, and the inability to care because of perceived limited reserves of compassion. The experience of trauma often appeared as a concern of safety in the participants, which was one of the main factors leading to compassion fatigue. The following is a discussion on the participant experiences related to compassion fatigue and the description of the phenomenon.

3.1 Participant Nurse Understanding of Compassion Fatigue

Within the 27-participant data, there were primarily two groups of descriptions of compassion fatigue; as either the experience of an inability to care and "*not to have anything more to give*," or as generalized exhaustion and running out of empathy or the "*ability to hold people's emotions"* for a fellow human being. Participants who felt compassion fatigue due to their periods of trauma and loss related their experiences of trauma as making them more concerned with their own self-preservation. This process inhibited their ability to care for others

and continue healthy relationships with their patients. It is interesting to note that various reasons like trauma, death, work overload, lack of safety and lack of support create an atmosphere in which nurses who were previously compassionate and caring experienced the inability to nurture and continue in relational connections with patients.

Celine speaks of compassion fatigue as the inability to give the residents "*what they need or to care the way the residents want*." She explains it as an inability to give the emotional and mental care that one would give to their family members, as she considers a long-term care home her extended family. Edith's experience of her dad's sickness overwhelmed her, and she started feeling that everyone needed something from her. From this experience, she explained compassion fatigue as "*my tank is empty, and I did not have anything more to give* ."Heidy, who was grieving the death of a child in her facility, cannot take any more responsibility for care, saying, "*I am empty, I got nothing else* ."Mary clearly articulates her understanding of compassion fatigue: "*I will say lack of caring, or lack of empathy, not being able to empathize with them and try to look beyond my own needs… and having a hard time putting myself in their shoes*". However, for Emma, compassion fatigue is not connected with caring. However, the lack of ability to "*hold others' emotions*." Joslyn similarly thinks that compassion fatigue is "*running out of empathy for human care*." Though all these descriptions look similar, one of the main differences between then in the narratives is that Celine, Edith, Heidy, and Mary are concerned that they are no longer able to care as they used to do. At the same time, for Emma and Joslyn, it is the inability to feel the emotion of others. On closer analysis, we can see these are two different things that speak of the essential difference between compassionate, caring behaviour and empathic reactive behaviour. Emma and Joslyn, who described compassion fatigue as generalized fatigue, also fall into the group of participants who were less connected to the patients and less motivated by connection. This observation becomes important as the experience of connection appears to have a better chance of recovery from compassion fatigue than the lack of connection (Perry, 2008).

3.2 Participant Nurse Lived Experience of Compassion Fatigue

It is not what causes or influences compassion fatigue that describes it; the nature of the experience can give us a differential diagnosis on the phenomenon. From the data, several experiences can contribute to the shaping of compassion fatigue, including traumatic and non-traumatic experiences. The causative experiences can be death, loss, accident, traumatic events at

work, angry transactions at work, lack of resources or support at work, the experience of lack of safety and stability at work, or even an unsuccessful procedure after-effect. These events interfere with a nurse's ability to carry on with compassionate care, or in the case of a task-oriented nurse, these events can interfere with their ability to carry on the work they do, resulting in general nurse fatigue.

The experiences of the COVID-19 pandemic heavily influenced Celine’s experience of compassion fatigue. Edith's experience of compassion fatigue was triggered by the overwhelming and sad situation of her father's cancer and death, Heidy's experience of compassion fatigue was caused by the death of infants in the unit and lack of opportunity for grieving those deaths, and Mary's experience was influenced by difficult communications with patients and family members, and her difficulty in working with patient populations and the increased workload caused by COVID-19. Emma's fatigue experience was produced by the difficult and traumatic transactions between her, and non-compliant patients and families and Joslyn's fatigue was during COVID-19 triggered by some of the behaviors of doctors.

The above description of the causative elements of compassion fatigue places both traumatic and non-traumatic events as the triggering instances. As we may see in the discussion on safety, traumatic events may disrupt the safety perception of the caregivers, which in turn can also be a reason for the fatigue. These nurses' experiences speak to the fact that what is unique about the compassion fatigue experienced is neither the causative elements nor the fatigue-related symptoms, rather the depletion of the nurturing ability in compassionate, caring individuals. In summary, the essential nature of the experience of compassion fatigue is that it is a relational process based on a compassionate and caring transaction and the ability or inability to sustain it.

3.3 Compassion Fatigue and General Nurse Fatigue

This study explored nurturing and compassion experiences in early life, the initial motivation to enter the nursing profession, patient care approach, workplace environment and support systems, education and the understanding of compassion and compassion fatigue among the nurses. The approach of investigating the whole person has proven to be effective in giving us a complete picture of the experience of compassion fatigue.

One of the main themes that emerged in the study was the presence of connection, or lack of connection, in the initial motivation stage, patient care approach, and the narratives of the

compassion fatigue experience and recovery. From this single experience of connection, there is a pattern among participants who connected more and who connected less, who experienced more connection or who experienced less connection, who was able to transform connection beyond their immediate environment and those who were more self-centred in their practice of connection compared to others. Following this pattern revealed two kinds of experiences that were similar in their effects and causative influences but still unique due to the nature of patient care and subjective interpretation of the experience. While most of the nurses who belonged to the connecting group exhibited the exhaustion and fatigue experience as "*the inability to care*," others who appear to belong to the less connecting group described their experience as mere fatigue or exhaustion with an inability to hold patient emotions. Following this point, one of the observations is that while Celine, Edith, Heidy, and Mary exhibited their compassionate care as relational and a virtuous intention (Sinclair et al., 2017), Emma and Joslyn expressed their care for patients as resulting from a reactive experience similar to empathic distress.

Under closer analysis, what Celine, Edith, Heidy, and Mary describe can be called compassion fatigue, built on the essential feature of connection, and defined by an eventual inability to care and a limited reserve of compassion. Alternatively, Emma and Joslyn can be called general nurse fatigue, which may also be called empathic distress fatigue (Klimecki & Singer, 2011) as it gives a picture of empathy resulting in altruistic behaviour. This clear distinction between compassion fatigue and general nurse fatigue is an important outcome of this research as it establishes the unique characteristics of compassion fatigue within the literature.

4. To Engage or Not? Discussion on Formative Phase (Recovery Focused)

The main difference between Figley (1995) and Joinson (1992) in their approach to compassion fatigue may also be reflected in their understanding of the recovery strategies. While Figley recommends complete detachment from the patient, Joinson suggests that not engaging the caring nature and taking away the nurturing part of a caregiver can be problematic. She recommends engaging with compassion as an appropriate strategy to deal with compassion fatigue. Porr et al. (2010) speak of re-establishing connection as beneficial in managing fatigue at the workplace.

4.1 Comparing the Recovery Strategies

The opportunity to establish deep connections with persons and families at the long-term care home is what essentially helped Celine with compassionate care. It is this same sense of

connection that helps her in dealing with compassion fatigue. For Edith, the experience of connection with the patients was rekindled as she returned to patient care and her experiences with her dad's cancer and death became a tool to connect to the cancer patients in her care. After her experience of compassion fatigue, what Heidy desired was a connection with those closest to her. Unfortunately, she could not get a listening ear from her husband, but her colleagues were able to fill this gap to an extent. She also reflected on the reward of compassionate care despite the experience of fatigue and exhaustion. One of the things that immensely helped Mary was the time that she spent connecting with her children after a very difficult day at work. This is a time for her to recharge and replenish. Mary believes that the fulfillment of care heavily overweighs the compassion fatigue experience. Emma, as part of dealing with her experience of fatigue, exercises, eats well, and meets a therapist. However, when she is back to patients, she is particularly selective in connecting with her patients. Joslyn prefers going part-time to deal with compassion fatigue. She also thinks taking the mind out of the issue through fitness and self-care activities and seeking therapy would help people deal with their fatigue.

Comparing all the representative cases, Celine, Edith, Heidy, and Mary gave significance to connect both to their own families and friends together with an explicit or implicit desire to connect back to patients. Edith's experiences led her to connect more intentionally and meaningfully with her patients. Emma and Joslyn did not speak of reconnecting to patients and instead, Emma was trying to avoid difficult patients when she returned to patient care intentionally.

4.2 Patient Engagement Styles and Recovery

The patient engagement styles are reflected from the beginning of a nurse entering the profession. The initial motivation indicates the style of patient engagement that they may pursue. While Celine, Edith, Heidy, and Mary joined nursing due to their interest in connecting and taking care of patients, Emma had in her mind advocating for patients as the role that nurses played from her volunteer experience. For Joslyn, nursing was not something she thought of going into. Comparing the six cases, it is also evident that while Emma and Joslyn were more self-protective in their nature of care, others were more reaching out and selfless. For example, Mary considered establishing relationships with patients right from the start as important and appreciated the opportunity to establish strong connections, even if it meant just two hours

together. On the other hand, Emma was concerned about making her day comfortable and chose only non-anxious patients for her care. While Celine, Edith, Heidy, and Mary found ways to connect with their patients, Emma and Joslyn appeared to focus on their own needs. While Emma avoids difficult patients, Joslyn felt anger and lack of empathy towards her patients and exhibited limited insight into her role within the struggle with her patients.

Responding to the question of the effect of compassion fatigue in their patient engagement styles, the anonymous survey participants indicated a range of responses, from reaching out more to patients to withdrawing more from patients. 12.79% of participants reported that they tried to reach out more to their patients after their experience of compassion fatigue and 15.41% of the participants responded that they withdrew from their patients following the experience of compassion fatigue. 17.70 % of the participants remained indifferent to the patient's needs most time, and around 32.79% of the participants initially reached out but gradually started withdrawing from patients. While most literature on compassion fatigue reported withdrawing from patients as the main feature of compassion fatigue, the survey data exhibited diverse approaches to deal with compassion fatigue regarding patient engagement styles. This was also reflected in the 27 nurse participants of the study who appeared also to use diverse approaches to dealing with compassion fatigue. The six representative cases demonstrate a similar pattern of diverse approaches to the recovery from compassion fatigue; however, Celine, Edith, Heidy, and Mary differ from Emma and Joslyn in applying connection-focused ideas. The patterns revealed in these cases are of connection, or less connection, within patient engagement strategies. The connection-focused strategy appears to be more efficient in return-to-work situations and ongoing healthy patient care.

4.3 Role of Education in Compassion Fatigue Recovery

All 27 participants were asked about their formal education experience regarding compassion fatigue within their nursing education and training. Unfortunately, no participant reported a robust training element that helped them deal with compassion fatigue. Most participants reported that they did not have any significant training regarding compassion fatigue during their nurse training. Many of them also believe that compassion fatigue is an experience that nurses would realize only when they experience it when they start working as a nurse. In the initial days of their training, they may be so focused on the positive side of the profession that they may not even consider a challenge like this as likely. For this reason, some of the nurses

suggested an ongoing educational process for dealing with compassion fatigue. As we did in other instances, we will look at the six representative cases to draw some understanding on the role of compassion fatigue training in dealing with the issue of compassion fatigue among direct care nurses.

Celine thinks that the issue of compassion fatigue is overlooked in nursing. She does not recollect having useful education on the subject. For Edith, it is imperative that one takes an active role in dealing with compassion fatigue, as it would not go away on its own. She suggests that it is important to identify the signs of compassion fatigue early enough, and there needs to be an educational process at the workplace as this is a regular experience for nurses. She also stresses the need to address the issue of nurse isolation and help nurses to know that many others like them suffer compassion fatigue. Heidy has heard the message often found in nurse training regarding patient engagement, "don't get too involved." She believes the opposite is true that when you get involved and connected with patients, you have meaning in your personal and professional life. Mary reported having no formal programming regarding compassion fatigue during her nursing education. She thought of it as a personality issue among nurses until she started seeing this experience among many nurses. She also thinks that if this subject had been introduced when she started nursing, she probably would not believe it to be a serious issue. Mary's description aligns with having more ongoing education regarding compassion fatigue in workplaces. Emma suggests that there should be a class on compassion fatigue, and the students should sign a petition to establish a proper nurse-patient ratio and to make availabile benefits like therapy more accessible. According to her, this is far better than giving nurses a course on yoga. Joslyn believes that nursing school never prepares a nurse to become a compassionate nurse; rather, it teaches all the skills that a nurse needs, like reading bloodwork. All these representative voices reflect the voices of all 27 nurses who participated in the study. Nurses desire to receive appropriate training regarding compassion fatigue, as many of them come to know more of their colleagues and themselves struggling with the issue.

5. A Short Discussion on COVID-19 Related Themes

Though the focus of the study was not examining the COVID-19 influences on the study participants, the fact that all the participants worked during the COVID-19 pandemic invites some discussion. This is precisely why include COVID-19 specific themes early in this section.

The following are a few of those discussion points related to the feedback of the study participants.

There was a negative shift in public opinion regarding the support to nurses from the beginning of the pandemic to the later phases. An Italian study, Magnavita et al. (2021) reported that in the first phase of the pandemic, between March and May 2020, 87.4 % of people expressed appreciation for the nurses; in a later phase (December 2020), 91.0 % believed that health care workers were viewed less favourably when compared to the first phase. As my research interviews were conducted during September, October and November of 2020, most participants also had a similar opinion: initially, a great sense of support which diminished over time.

Many of the participants reflected on the need for personal safety during COVID-19, which gave them a conducive atmosphere to practice compassionate care. They spoke of self-preservatory behaviours when confronted with a lack of safety and support. Jones-Bonofiglio et al. (2021) has identified the conflict between the health care worker's need for protection and their patient's need for care.

The issue of constantly changing policies and information overload is sometimes the natural offshoot of the non-preparedness of the system. Sasangohar et al. (2020) observed the ineffective communication of policies and protocols, which sometimes came from multiple levels and sources to frontline health workers. The most frequent comment from the participants was of constantly changing policies and the overload of communication, and both indicate ineffective communication, which can negatively affect a unit's morale and nurse motivation. The difficulty in understanding and managing information has created conflict, uncertainty, and fear in nurses during the pandemic. While these conflicting messages caused fear in some health care workers (Arcadi et al., 2021), for many nurses, the conflicting messages created moral anguish that affected their authentic relationship with the patients (Wendekier & Kegerreis, 2020).

One of the under-reported and underestimated issues of the pandemic and its management is that utilitarian interests take over the patient management processes, and the need for compassion and justice may be relegated. Jones-Bonofiglio et al. (2021), speaking on the importance of family-oriented care during a pandemic, compares it with the 2002 SARS epidemic. They suggest that the "same psychosocial collateral damage described then is

occurring again now, and on a much larger scale, because of policies that discount the value of family-centred care" (p. 2). They say that the "one-size-fits-all protocols" (p. 2) produce a negative outcome; the authorities who create them are not witnessing them directly. Instead, it is borne by both the frontline workers and the patients. In my interviews with the nurses, some reported that frustrated patients sometimes expressed their complaints to the nurses. The nurses also reported being helpless before the things that they cannot control. The experiences discussed in the theme, "barriers to compassion," like the inability to touch the patients (Durkin et al., 2021; Brown, 2020), and the difficulty of the patients in understanding nurse communication due to their disabilities are some of the issues that were being overlooked due to the prioritizing of health and safety protocols and policies. Jones-Bonofiglio et al. (2021) speaks about the inability among patients in palliative care to have some of their dear ones with them during their passing away as a serious issue to address from an ethical point of view. Some of the nurses in my study reported on this as they witnessed the suffering of their patients not having their dear ones with them. Some of the nurses expressed the desire to make sure that the patients are not feeling lonely without connection with their dear ones, as it is evident from the comments of Ruby: "*I have known these residents for so long. I don't want to leave them like, and I don't know, I want to still help them. I don't want them to require help if there's no staff. I don't think that's fair for the residents that live there*".

In conclusion the COVID-19 played the role of an acute stressor regarding nurses' compassion fatigue experience, bringing to fore front some of the systematic issues of safety, stability and support more fragile and making the individual nurses more vulnerable to various stresses. Even though in comparison similar factors contribute compassion fatigue in a non-pandemic setting, there is additional fear and safety concerns unique the pandemic. Isolation and work demand are some of the other experiences confronted by nurses who worked during the pandemic. The work environment highlighted as an attachment system within this study remains the most crucial place of intervention for both pandemic and non-pandemic related compassion fatigue experience.

6. Concluding Remarks

The final part of the fifth chapter explicated the emergent grounded theory with a short description. The emergent grounded theory on compassion fatigue considers the developmental process of nurturing attitudes, the educational and formative influences on the nurturing experience and the workplace-related systemic factors that majorly affect the nurturing trends among nurses. The theory presents a comprehensive understanding of the process from psychological, educational, and systemic angles. The study of caregiving and its effects on the caregiver needs to follow the philosophy of studying the "whole person," as explained in the introductory part of this dissertation. Just as the emergent theoretical formulation embraces a comprehensive outlook, the implications of the theory would also be multifaceted. Thus, the management of compassion fatigue may have to involve serious undertaking from various stakeholders within the nursing profession.

While the grounded theory distinguishes between compassion fatigue and general nurse fatigue, either experience is not treated better than the other. Rather, the emergent theory reminds of the possibility of positive systemic support helping both groups to be resilient. It may also be possible that the positive involvement of the systemic factors can encourage compassionate care through secure adult attachment processes. Though the study did not provide a case to evidence this possibility, we need to remember that the study also did not come across an optimum healthy, secure attachment environment within any of the nurse workplaces.

Finally, the connection-oriented relational approach is fundamental to the practice of compassionate care and for recovering from the potential fatigue experienced within compassionate care. Thus, compassion fatigue than general nurse fatigue is better placed for recovery because of the language of connection among these nurses. This is an important reminder that there is no moral judgement on how any nurse experiences fatigue, but the distinction is aimed at what is most healthy for the nurses and everyone who interacts with them.

The emergent grounded theory of the compassion fatigue process will be further reviewed in the next section of this dissertation. It will investigate the purpose and usefulness of the theory and its possible implications to the nursing profession.

CHAPTER VIII

THE EMERGENT GROUNDED THEORY: CONCLUSION AND IMPLICATIONS

This dissertation started with an introduction to the study, followed by a prefacing of the literature, exposition of the methodology, methods, data analysis, results incorporating Gioia et. al's (2013) Grounded Theory approach within the constructivist paradigm of Charmaz (2006). The previous chapter discussed the emergent grounded theory, analysing various themes and connections that were found in the participant data. This chapter will summarize the research, elaborate on the value and implications of the emergent grounded theory.

The emergent theory on the compassion fatigue process was introduced at the end of chapter five, together with a graphic representation. As we recall from the literature on grounded theory, this emergent theory attempts to explain the process of compassion fatigue and compassionate care through an abstraction of the data into codes, themes, and categories. The grounded theory on the compassion fatigue process suggests a multi-phased influence on nurses' direct caregiving activity, an influence founded on two nurse care approaches. These have been described as connecting and non-connecting. In the connecting approach, there is a range of connections from more to less. In the non-connecting approach, patient care appears to be a reactive process, with nurses becoming more task-oriented irrespective of the area of specialty in which they work. The data also suggests that task orientation may be more prevalent in certain specialties (such as an emergency) than in other specialties such as long-term care.

This grounded theory regarding the experience of compassion fatigue strongly suggests that the workplace has a very significant responsibility in the development of compassion fatigue. Consequently, health care management and policy play a significant part in the phenomena and therefore needs to be part of any amelioration. The grounded theory makes explicit that awareness of compassion fatigue and general nurse fatigue is a problem that affects every person on the floor; not only the nurses that experience it but also the ones who do not, along with patients, families, and other staff. Compassion fatigue is not just an issue for nurses; it is an issue for all people concerned with delivering health care.

The following paragraphs highlight some of the salient features of this research. A summary of the research looks at the significant role of this research and the emergent grounded theory by elaborating on their value and speaks of implications of this research for the scholarly community and the specific audiences, including nurse education and training. The final

paragraphs reflect on the limitations of this dissertation research and elaborate on its future research potential.

1. Summarizing the Research Process

One of the purposes of this research on compassion fatigue was to develop a model that represents nurses' experience of compassion fatigue. The model needed to be grounded in data collected from nurses and verified in the literature. To ensure the model is grounded, I approached the data collection and analysis using Gioia et. al (2013) methodological approach to grounded theory. Though there are some theoretical models available in the literature (Coetzee & Laschinger, 2017; Fernando & Consedine, 2014; Figley, 1995, 2002; Joinson, 1992; Klimecki & Singer, 2011; Stamm, 2010; Valent, 2002) regarding compassion fatigue, no research has approached compassion fatigue with an integrated developmental, environmental, and attitudinal approach. With the approach developed through this study, the model I have explicated allows for a more nuanced understanding of the similarities and differences between the experience of compassion fatigue, general nurse fatigue and other similar experiences like burnout and secondary stress disorder.

There is considerable confusion and overlap regarding the concept of compassion fatigue (Cavanagh et al., 2020; Chachula, 2020). While the effects and causes of compassion fatigue, burnout and secondary stress disorder may appear superficially similar (Bride et al., 2007; Collins & Long, 2003; Keidel, 2002; Kadambi & Ennis, 2004), it has been challenging to distinguish compassion fatigue in practice (Boyle, 2011; Cavanagh et al., 2020; Chachula, 2020; Sabo, 2011; Sinclair et al., 2017). Though the nurses in this research preferred to use the term compassion fatigue instead of other terms about their experiences, there has been a strong voice in literature against the use of the term compassion fatigue to refer to the fatigue experienced by nurses. While some of them were opposed to the usage of the term as it implied a lessening of compassion (Fernando & Considine, 2014; Ledoux, 2015; Sabo, 2006; Sinclair et al., 2017), others like Klimecki and Singer (2011) Hofmeyer et al. (2020), and Doran (2018) believe that it should be called empathic distress fatigue. This apparent binary between the literature and the lived experiences of nurses shaped my approach to the research methodology and method, without offering any definitions for the phenomenon under investigation and asking the participants to develop their descriptions provided an avenue for the voices of nurses to be heard. Collecting this information at the commencement of each interview was also a way of not

colouring the nurses' perceptions with other interview questions that included questions about participants' early developmental experiences and experiences of compassion. Giving the nurses a voice is important if the model that has been developed is to have an impact in the field. Understanding the issues from the nurses' perspective gives the model greater credibility.

Drawing from the literature and the data, the model provides a platform for developing educational programs that assist nurses in dealing with compassion fatigue. In the model, the first and last phases are indicated explicitly as two formative phases; the initiation-focused formative phase and recovery-focused formative phase, which may have a mediating effect on the praxis and outcome phases of the nursing experience. During the interviews, the participants were explicitly asked about their educational experiences related to compassion fatigue and suggestions for helping nurses develop strategies for identifying and coping with compassion fatigue. These specific inputs reflected the extent to which the current educational system is helpful to nurses in dealing with fatigue and what could be improved in training to support the nurse's well-being.

Finally, the research returns to the literature. The subject of compassion fatigue has been chiefly placed within the empathy literature, starting with Figley (1995). Having completed a detailed mapping of the literature and subsequent research, I need to revisit the rightful place of compassion fatigue in the literature. To achieve this, I incorporated compassion-related questions into the in-depth interview like "what has been your experience of compassion growing up?" and "What is your understanding of universal compassion?". One of the main themes that emerged through the subsequent conversations was their experience of connection in patient care. A detailed understanding of participant experience of fatigue within the context of their whole person brought to light whether their responses were empathetic (a reactive process) or compassionate (a relational process). This critical distinction indicates two different experiences in patient care outcomes, namely compassion fatigue and general nurse fatigue. While general nurse fatigue is placed within the empathy literature, compassion fatigue is placed within compassion literature by operationalizing self-referential compassion.

The summary of the research process has indicated the emergence of potential new learnings out of the participant data analysis of this research. The value of research would depend upon the novel contributions to knowledge in research. As this dissertation research has

attempted to add new knowledge and challenge the current understanding of compassion fatigue, it would be fair to discuss the value of this research.

2. The Value of the Research

Pragmatism is one of the driving forces of constructivist grounded theory. It is not enough to have grand theories, but theories must contribute to social improvement (Berger et al., 2015). The emergent grounded theory explaining the compassion fatigue process has considered the developmental trajectory of a nurse experience, suggesting different phases of significant influences in the emergence of compassion fatigue and general nurse fatigue experiences. This approach is valuable both from a formative perspective related to recruitment and retention of nursing professionals and from a recovery-focused formative perspective of dealing with the experience of fatigue. The theory also invites a system-level transformation of the health care system facilitating the optimum attachment security communicated through safety, stability, and support as a deterrent to compassion fatigue. The pragmatic value of these ideas is significant as these are the outcome of 27 nurse in-depth interviews within the grounded theory exploration.

One of the aims of the literature review on compassion fatigue was to understand the phenomenon and distinguish it from similar experiences. As explained in the literature (Boyle, 2011; Cavanagh et al., 2020; Chachula, 2020; Figley 1995; 2002; Sabo, 2011; Sinclair et al., 2017) it has been challenging to find this distinction as the consequent experiences and symptoms were similar to other experiences like burnout, secondary stress disorder. Taking a clue from Kanter (2007) in attempting a differential diagnosis of compassion fatigue, the research has advanced in finding the fine line between compassion fatigue and general nurse fatigue within the grounded theory research. While some of the nurses who practised patient care informed by their compassion experiences within the framework of the relational process experienced compassion fatigue, a few nurses who were poorly informed by early compassion experiences and who involved a reactive process similar to empathy within patient care experienced general nurse fatigue. Compassion fatigue experienced as a relational process uniquely stands out in its characteristics compared to other experiences like secondary stress disorder and burnout. Compassion fatigue thus explained through a relational model within the framework of self-referential compassion, becomes a more meaningful and valuable understanding to nurses who practice compassionate care within a health care setting.

With the criticism against using the term compassion fatigue to reflect the fatigue experience of nurses and calling it something like empathic distress fatigue (Klimecki & Singer, 2011), the extant literature discourse fails to value the noble aspects of compassionate caregiving nurses. According to the arguments that "compassion cannot fatigue" (Klimecki & Singer, 2011; Doran, 2018), it appears that the nurses who experienced fatigue were not being compassionate. This research has approached the subject of compassion from philosophical, historical, and etymological foundations to distinguish between its self-referential and non-self-referential expression of it. The grounded theory study data also intentionally approached the subject to understand the connection between compassion and compassionate caregiving experiences and compassion fatigue. The comprehensive approach to the subject of compassion fatigue, analyzing compassion and empathy, both within literature and within-participant experiences, has brought to light a different process than empathic distress fatigue. As Klimecki et al.'s (2013) neurological research reveal, a connection-oriented, attachment-based maternal caring model activated in the relational process of compassionate care of nurses is indicative of the neurological process of compassion, which is subject to fatigue when considered within self-referential compassion (Analayo, 2015; Ekman, 2012; Halifax, 2011; Parattukudi & Melville, 2019). This is a very important understanding as it explores the historical, philosophical debate on the subject and considers the latest neurological studies related to the subject.

One of the main contributions of this research is the focus on nurse praxis and the significant role of the workplace in the well-being of nurses. The workplace and health care system are invited to fulfill the attachment needs of a nursing professional such that the individual can fully direct their caregiving for the benefit of the patients and the whole health care system. The fatigue experienced by a nurse may contribute to the overall corrosion of the system, triggering overwork for others, low-quality care of patients and high nurse turnover through the ripple effect within a workplace or system. Irrespective of a nurse's formative and motivational disposition, the work environment contributes essential building blocks to safe and healthy nursing practice. As I mentioned early, it may even have a formative value in the nurse's life as some approach the nursing community as their family. The three foundational experiences of safety, stability, and support in different levels of a nursing professional is a concept easy to understand but difficult to translate into everyday nursing practice.

As the study was conducted during the pandemic, the data reflected the experiences of nursing professionals on the challenges of COVID-19. The interview data had at least eight participants who did not attribute any influence on the pandemic in their experience of compassion fatigue; however, all the participants had worked during the pandemic and had input into the influences of the pandemic in their lives and the life of their colleagues. Some of the earlier literature on the COVID-19 experience of frontline health care providers also reported the same concerns about safety, both workplace and personal. They also reported on the issues of a limited supply of PPEs and constantly changing policies as sources of stress to the well-being of the health care workers (LoGiudice & Bartos, 2021). As the nurses are already in a vulnerable situation because of the nature of the pandemic, the lack of safety, issues of stability and support can exacerbate their vulnerability to stress, and its result may be seen at the workplace with diminished productivity job satisfaction and stressful personal lives. These experiences also can lead a nurse to experience compassion fatigue or general nurse fatigue with the limited resources in them to deal with patient demands of compassionate care. These concerns are usually more systemic than otherwise. Most participants in the study expressed the non-preparedness of the health care system in dealing with a pandemic such as COVID-19. While both the micro-level and the macro-level of the healthcare system are affected and overwhelmed, it is only logical that its beneficiaries are also similarly affected.

As pandemic-related experiences are interwoven with the main discussion within this research, it adds value to understanding the experience of nurse fatigue within a pandemic situation. It sheds light on the relationship and differences between pandemic and non-pandemic contexts in nurse-patient care experiences.

Finally, the data also contained traumatic experiences like death and personal loss in a few nurses (Edith, Heidy, Anna, Cyndi, Chelsie, Clare), non-traumatic experiences triggered many other nurses (Celine, Mary, Emma, Joslyn, Denice, Danielle, Jasmine, Jacob, Judith, Juliette, Kim, Stella, Sarah, Lillian) and for some their experience of fatigue was triggered by both traumatic and non-traumatic experiences (Diew, Joyce, Lydia, Nora, Penny, Ruby, Samantha). Having representational cases which include these varying experiences made the study more comprehensive and meaningful. Figley's (1995) idea of compassion fatigue/secondary stress disorder mostly implied traumatic events in which the caregiver indirectly experienced trauma within their interaction with the patient. Kanter (2007), critiquing

Figley, argued that reducing all suffering to trauma is wrong, and the response of the individual to both traumatic and non-traumatic suffering would decide who is affected and who is not. Following this line of argument, the research has found value in looking at the caregiver's personal, formative, and environmental experiences when faced with the prospect of fatigue, which may define their response to the triggers. Approaching the experience of nurse fatigue from this lens has enabled the research to focus on the potential of learning and training, facilitating environmental factors in elevating human resiliency in the face of difficult life circumstances and the possibility of fatigue.

The above paragraphs considered some of the contributions of this research that make it valuable for the academic community and clinical research regarding nurse fatigue. Just as the research is valuable in the health care field, the research and the emergent theory have implications for both the academic community and the practice of caregiving professionals.

3. Implications of the Research

This dissertation research has implications for both the academic community and clinical research related to nursing fatigue. The following paragraphs elaborate on those implications to nursing research and practice.

This research brings out the uniqueness of the experience of compassion fatigue as compared to other similar experiences like general nurse fatigue, burnout, and secondary stress disorder. As explained in the previous section, even though there has been research for the past 25 years about Compassion Fatigue, it still suffers significantly from the lack of conceptual clarity (Boyle, 2011; Figley 1995, 2002; Sabo, 2011; Sinclair et al., 2017), and adequate measurement criteria for outcome research (Bride et al., 2007; Sinclair et al., 2017; Steinheiser, 2018). In this research, understanding the uniqueness of the experience of compassion fatigue described as the outcome of a relational process distinguishes compassion fatigue from other similar experiences. The nurse case descriptions evidenced the relational process instead of the reactive process, which results in compassion fatigue. Within the relational process, the language of connection and self-referential compassion finds its space, and therefore the context of compassionate care becomes susceptible to compassion fatigue.

This research is recommending to the research community to return to the original use of the term compassion fatigue (Joinson,1992), which emerged in a nursing context compared to the adapted use with secondary stress disorder (Figley, 1995), which was in the context of a

therapist-client dynamism. The literature and data analysis considered a comparison of two models that tried to explain compassion fatigue. These models were broadly divided into the relational model (Joinson, 1992) and the reactive model (Figley, 1995) and tried to verify the participant's experiences within these two broad categories and various developmental factors contributing to patient care experience. This process finally resulted in two categories of fatigue: compassion fatigue explained by the relational process with a language of connection informed by compassion, and general nurse fatigue explained by the reactive process informed by empathy and its regulatory process. Considering that Joinson's (1992) study was done within the context of nurse compassionate care experience and her ideas appear to be reflected in this research within the nurse participant experience as compassion fatigue, the research recommends the research community to use the term compassion fatigue as explicated by Joinson (1992) to reflect compassion fatigue of caregiving professionals.

This study opens opportunities to take compassion fatigue research in new directions by considering self-referential compassion, which may be subject to fatigue as experienced by nurses. The current field of compassion fatigue research appears to primarily consider the Buddhist idea of compassion, which is non-self-referential and universal. Even though Buddhist universal compassion is most ideal in human flourishing and does not bring about fatigue, no participant of the research reported practicing this level of compassion in their caregiving experiences. However, their caregiving experience attributed the language of connection and deep compassion within a mother-child-like caregiving scenario. This closer analysis of the caregiving experience of nurses has revealed the potential of the practice of self-referential compassion, which is found both in Buddhist compassion literature and Western philosophical traditions (Analayo, 2015; Ekman, 2012; Halifax, 2011; Parattukudi & Melville, 2019). Considering nurse compassionate caregiving activity within the spectrum of compassionate experiences, including self-referential compassion, creates hope for nursing professionals to perfect their compassionate caregiving skills despite the potential for fatigue.

This research connects the ordinary caregiving activities of nurses with the Ideal of compassion. Nursing research sometimes advocates for the idea of nurse compassion as though it is different from the general human experience of compassion. Nursing research needs to remain close to the foundational understanding of human nature and behaviour to effectively support compassionate nurse formation within an existential framework of human formation in care and

compassion. This study clarifies the understanding of the experience of compassion fatigue in literature and places it within compassion literature.

This research gives useful information regarding the culture of compassion at workplaces. This grounded theory identifies a system-level dysfunction that causes compassion fatigue among nurses. The system of health care management is indeed operated by individuals who are not only responsible for running the system but, more importantly, the well-being of the players within it. A system-level change is implied within this emergent grounded theory as the system needs to provide safety, stability, and support to the nurses optimally to feel reassured and confident in their caregiving activity. There were examples of top-down and ground-up styles of implementing compassionate culture within the workplace. There may be multiple ways of making the workplace and organization a place of compassion for its members who care for their patients compassionately.

The emergent theory has implications for nursing education and training concerning compassionate care and the experience of fatigue. One of the reasons I chose compassion fatigue was to understand and contribute to nursing education and training. The theoretical description of the experience of compassion fatigue informs nursing training programs with insights on recruitment, retention, and workplace management. It invites the health care community to contribute creatively to the well-being of nurses and their recovery from experiences of compassion fatigue; beyond understanding the phenomenon and describing it for the academic community, the result of this research challenges nursing educationists. It also highlights the limitation of a nurse training program as a stand-alone process disconnected from the praxis phase in dealing with nurse fatigue. This research offers two specific opportunities within the initiation-focused phase and recovery-focused phase for the formative elements to strengthen the nursing personnel and their experience of compassionate care. In the initiation-focused formative phase, the developmental experiences and education on compassion become important. It also highlights the benefit of having safe, stable, and supportive attachment experiences during the candidate's growing up years. As everyone is not given the privilege to be born to such ideal environments, it is also important to make sure that individuals motivated into the profession are given an optimally supportive and empowering environment in their workplace. Irrespective of the background of the individual who is attracted to the nursing profession, the nursing praxis and the whole health care system must play a role in forming compassionate nurses. Similarly, if

a nurse experience generalized nurse fatigue or compassion fatigue, the recovery-focused phase within the proposed theory presents a further opportunity for education, training, and support that may help the nursing professional to improve their compassionate caring skills.

One of the responsibilities of nursing education and research is to help nurses learn the soft skills of nursing, which essentially involves compassionate care. This grounded theory considers the overall development and various influences that affect them personally, emotionally, psychologically, and socially. There is an indication that many of the participants' nursing training was of a piecemeal fashion, sometimes disjoined from other parts of the nurse experience. This study stresses the importance of considering the whole person and environment in its education and training process. Many of the participants reported that nurses at the beginning of their career do not take compassion fatigue very seriously, and therefore, any training related to it may also face the same challenge. Some of the participants suggested a program of education intertwined into the praxis phase of their nursing practice. As I understand, though nursing education starts with the initial education and training to become a registered nurse, the professional training and formation continue all through the nursing practice. Instead of a particular program once and for all addressing the issue of compassion fatigue, it needs to be part of a continuous effort in creating resiliency in nurses to deal with potential fatigue in compassionate care practice. While nursing formation is the individual nurse's responsibility, it is also equally the responsibility of the nursing community. It would also mean a systemic shift into a compassionate workplace that provides safety, stability, and support to the individual nurses who, in turn, work as the positive mediators against compassion fatigue.

4. Strengths and Limitations of the Present Study

The biggest strength of this study was its design of incorporating a phenomenological approach through vignettes into the grounded theory. By doing this, I have addressed the danger of the data becoming impersonalized in the grounded theory process. As human experiences are best described in their language without abstraction, this approach brings to life the issue of compassion fatigue with its detailed and thick description. The initial anonymous survey with 305 participants and the in-depth interviews of 27 nurses from different provinces and backgrounds makes it more representative and diverse. The study had representation from diverse backgrounds of age, experience, and nursing specialty, which added to the value of the study.

The study approached the experience of compassion fatigue from a place of not knowing by allowing the participants to describe it in their language. Not succumbing to the temptation of giving definitions or descriptions has helped the study to reflect more authentically on the nurse experience of compassion fatigue. Using grounded theory integrated with some elements of case study approach (Gioia et. al, 2013) has been robust in understanding the phenomenon and explaining the observed phenomenon through an emergent grounded theory. The use of rich literature within a constructivist grounded theory helped me be deeply connected with the foundational concepts in question within the research. The online self-recruitment of study participants was one of the best ways to get an unbiased study sample representing the negative phenomenon under investigation. Another strength of the study was the presence of negative cases compared to other cases, contributing to the veracity of arguments presented.

The study is limited in its scope and representation. The study participants mainly came from the provinces of Ontario, British Columbia, and Alberta. They also probably belonged to multiple health care systems within their provinces. The study was conducted online using a secure video platform, and each participant was given approximately 90 minutes for the interview. Online data collection helped the participants speak about a personal experience like compassion fatigue. However, not having the opportunity to observe the participant's engagement with patients within their institutional context can be a drawback of the study, even though I have no reason to believe that participants were not completely open in their responses.

The study did not have gender representation. It had only one participant who identified himself as male compared to 26 female participants. The study also did not take into consideration the cultural, ethnic differences, and representation among study participants. Another limitation of the study is that the researcher is not someone who is a nurse and fully understands the nursing professionals' patient caregiving experience. The research is also limited in its application as the data was based on individual cases (mainly elaborated through personal interviews) and not a longitudinal study where the researcher follows with the participants over a period.

5. Recommendations for Future Research

It will benefit the research community to have more similar studies on compassion fatigue and its connection with compassion. One of the wonderings within this study was the probability of a nurse changing their patient care approach (connection-based or non-connection-

based) due to the influence of the work environment. As the praxis phase is also understood to have the potential to provide a secure attachment experience to nurses, it may be possible that a change of heart is possible because of the work environment and practice of compassionate culture. It will also be important to look at the experience of general nurse fatigue, which is very similar to what has been explained in literature as empathic distress fatigue. Another area worth exploring is compassion fatigue prevention programs which involve training in compassion and mindfulness. A longitudinal study of individual nurses regarding compassionate care and compassion fatigue would be potentially a future project that may complement this research and its conclusions.

6. Concluding Remarks

As we come to the concluding section of this dissertation, the role of this chapter has been to provide some understanding of the usefulness and implications of the grounded theory research result. It would have been good to make specific recommendations regarding dealing with compassion fatigue. However, as the study participants have come from several provinces and aimed to investigate the phenomenon and explain it, a more general theoretical presentation and description were favoured in this dissertation. However, a future project may consider the data and results of this study for an action plan document in nursing education to deal with compassion fatigue. The study reminds us that a system-level change is needed for nurses' well-being and any compromise on it falls as an extra burden to the nurse, their teams, and the patients they serve. This is all the truer and more disastrous during a pandemic like the COVID-19. It would also be problematic to bifurcate compassionate care and compassion fatigue from each other as the study result is clear that only compassionate nurses experience compassion fatigue, which may be defined as "the inability to nurture" (Joinson, 1992, p. 119).

CHAPTER IX

CHALLENGED BY COMPASSION: RESEARCHER'S REFLECTIONS

Helping the reader with an insight into my research journey through the different phases of this research project can be a good way to end this dissertation. As I understand, a moralistic stand for or against, or right or wrong, about a human experience may not be warranted in the journey of compassion. While debating various points of convergence or variance related to the altruistic emotions in human experience, I think an inner voice of compassion ought to lead this undertaking. Coming to know this essential dimension was an awakening that came by reading the enactive philosophy of compassion in Varela et al. (2016). Accordingly, compassion is contextualized in the circulatory movement of cognition and experience as two phenomenological axes of the same coin. Cognition, as the "embodied action" or "enaction" (p. 172), shatters the myth of absolutism or a pre-given situation through the introduction of groundlessness, which propels the enactive process. Doing away with the myth of absolutism can cause possible disillusionment and the threat of another extreme position of nihilism. Therefore, it necessitates a transformative action rooted in groundlessness to perpetuate the circulatory movement and face the challenge of nihilism in existential lines. This axis of experience is taken care of by compassion as an embodiment of groundlessness in a culture that has valued rational thought. Varela et al. (2016) summarize the two phenomenological axes of compassion in the following statement, "If planetary thinking requires that we embody the realization of groundlessness in scientific culture, the planetary building requires the embodiment of concern for the other with whom we enact a world" (p. 245). This awareness constantly challenged my intellectual involvement in questioning the moments of indifference and apathy that emerge in normal day-to-day life transactions. This dissertation has been a very passionate intellectual journey; it was also very personal and existential to my formation. Though the following paragraphs appear to be linear, they are a circular, iterative process that instilled fresh energy in this research endeavour.

1. Starting Point: Self Sacrifice or Self Care, A Conflict of Worlds

I think it is good to start my reflections with some memories of my mother. I grew up in a lower-middle-class Indian family witnessing the exemplary sacrifices of parents, especially my mother, who worked hard and sacrificed a lot to take care of her five children. If I could give a

human form to the word self-sacrifice, that would be my mother. Indian culture appeared to have no issues with the concept of self-sacrifice to the extent that it is glorified in religion and society. Being born to a Christian family where the ideals of Jesus' self-sacrifice were also of the highest importance, the world of my earliest upbringing made me think of self-sacrifice as a noble virtue like love. Critically looking at the sociological fabric of those times, self-sacrifice in various degrees was expected of women, parents, and older adults. However, keeping aside the patriarchal bias in my earliest upbringing, the idea of self-sacrifice was also desirable for everyone, including men and the strong. I witnessed it in my mom, dad, and other older men who deeply cared for their families. This background is important to understand one of the first wonderings that came to my mind when I started my professional and academic life in Canada. During my education and clinical training, instructors and professionals repeated one of the most prominent concepts of self-care. It sounded strange to me, and in comparison, to my childhood, there was no talk of self-sacrifice among my colleagues or instructors. This kept me wondering for a while regarding the two extremes with their implication in practice. While caregiving was a natural process with some degree of self-sacrifice within my Eastern thought process, the Western world talked a lot about self-care in the context of caregiving. Soon enough, I understood through my useful philosophical training in the past that the issue at hand was not about what is morally right or wrong but rather the understanding of the self within the philosophical foundations of these two worlds.

2. Debating the Difference: Compassion of the West and Karuna of the East

When I started exploring compassion as part of my directed study with Dr. Melville, I didn't think there was a difference between compassion and karuna. To me, it just appeared that karuna was another word in Sanskrit for compassion. However, I undertook a serious historical, philosophical, and etymological exploration of compassion within the Western philosophical and religious thoughts and the Eastern philosophy and religion. The exciting journey into the soul of compassion opened surprises to me, aligning with debate on self-sacrifice and self-care. Soon I realized that probably the biggest difference between compassion and karuna is lying in the role of self in the experience and interpretation of the phenomenon. That compassion can't be another term for karuna; rather, it needs to be qualified as non-self-referential compassion to substitute the experience of karuna. Though the Western philosophical traditions depended heavily on the prominence of self, the Judeo Hellenistic world experienced and interpreted compassion more

akin to karuna though the metaphysical foundations were different. However, the scientific community is fascinated with the Buddhist understanding of compassion/karuna and considers it the ideal altruistic emotion beneficial in human flourishing. Understanding this bigger picture, I started exploring another crucial concept for understanding human nature: empathy. The awareness of using the concept of empathy both in clinical and non-clinical spaces, sometimes with a huge overlap with compassion, appeared to be another surprise. As the scientific community is trying to distinguish these two experiences, the considerable overlap in common language has also been problematic in my pursuit of knowledge. The awareness that not knowing is better than believing for the furtherance of knowledge appears to be what I lean on in my investigation process.

3. Arriving at Compassion Fatigue: A pragmatic and Intuitive Jump

Though I desired to continue exploring compassion and karuna, as I started thinking of the specific project for my dissertation, I needed to consider a subject that is somehow connected to the idea of compassion. It was also important for me that the study has some pragmatic implications in that it addresses an issue that may have relevance to some people. Some of my colleagues suggested that it would be good to work within an area that may utilize my clinical training and exposure. Considering these points, I embarked upon the journey of exploring compassion fatigue. I didn't know what I was getting into when I first started looking into the subject. At different phases of the exploration, I thought that I was probably looking at empathy and not compassion as most of the literature on compassion fatigue is based on Figley's (1995) traumatological interpretation of compassion fatigue as a secondary stress disorder. Later I also discovered several pieces of literature referring to compassion fatigue related to compassion, starting with Joinson (1992). It appeared as a challenge due to the lack of clarity of the understanding of the experience. However, I thought of it as an academic opportunity and a relevant subject that needed attention. Given the understanding of the subject, I became more interested in looking deep into it. The most important aspect that kept my passion in delving deep into this subject was the experience of compassion fatigue, connecting the ideal with the real world of caregiving.

4. Being a Psychotherapist and Understanding Figley's Writings

Figley (1995) started exploring the experience of secondary stress disorder, which he later called compassion fatigue, by learning the interaction between a psychotherapist and a

client. As he has been a major influence in the field of compassion fatigue studies, my background as a psychotherapist appeared to be something of value in this process. My clinical background helped me understand Figley's language of trauma, secondary stress and so on. My wondering about empathy also came to play a big role in exploring the literature on compassion fatigue, mainly espoused by Figley and people who followed his line of thought.

5. Being a New Dad: Some Understanding of Caregiving Fatigue

In my clinical practice, when clients bring in experiences that are not fully part of my life or experience, I would try finding an experience that may be similar to get a glimpse of what they speak. My daughter, our first child, (our second child, a baby boy was born to us during the last phase of writing this dissertation) was born in July 2020. During this time, I started preparing for data collection for the research. Though I have two of my siblings in the nursing profession, there was no way for me to understand the experience of caregiving other than reading about it from books and hearing from people who went through that journey before me. Though I wouldn't say that I am fatigued by taking care of the little one and, more importantly, it was my wife who took care of the baby at most times; it was a window to understand the nature of caring; how sometimes it can overwhelm a parent and cause fatigue. I could not imagine an empathic reactive response regarding caring for a child. Therefore, looking at caregiving fatigue as an empathic distress experience did not make much sense. This was also an awakening for me to closely look into Batson et al. (1981) and Klimecki and Singer (2011, 2013, 2014). Their works challenged the idea of compassion fatigue and its connection to compassion.

6. Compassionate Mentoring and Thesis Progress

At the beginning of this reflection, I mentioned that involvement in the sense of groundlessness displayed through genuine compassion has been important for me as I pursued the intellectual knowing process of compassion through this dissertation. A compassionate mentoring would have been a missing piece in this circular journey. However, I was privileged to have a mentoring experience grounded in the sense of compassion, which not only gave me an emotional comfort to deal with my fears of not being perfect but also challenged me with questions of relevance, like “how would you know that you are not setting someone to fail by asking them to be compassionate in a challenging world of competition and success?”. As expressed, in Buddhist writings, "just as a bird needs two wings to fly, you must develop wisdom and compassion simultaneously. Wisdom is a correct understanding of reality, and compassion is

the desire for all beings to be liberated from the causes of suffering" (Ricard, 2010. p. 87); compassionate mentoring was a combination of compassion and wisdom. Compassionate mentoring has been happening through the past number of years within the lived space of interactions with my dissertation supervisor, who appeared to understand and appreciate a student's chaotic mind, which is confused, worried yet wanting to connect and learn.

7. Starting Trouble: Arrival of the Pandemic

My original intention was to conduct this research in person within healthcare institutions. Soon after my dissertation proposal was ready, I approached two health care institutions in two Canadian provinces, hoping that I could research with the nursing staff in their institutions. This was just before the COVID-19 pandemic hit Canada. Though one of the institutions did not think that my proposal was good enough for them, the other institution replied that they were in the middle of managing the health crisis and could not entertain my request to conduct nursing research in their hospital. Expecting that this could be a response that I would receive from any institution during that period, I went back to my doctoral committee, asking for suggestions and support. I was given two options: delay it by six months or rework the proposal to fit an online research method. Given that the committee was very supportive, realistic, and flexible, I embarked on a journey of re-imagining the research in an online world. I should say one of the committee members was so gracious to guide me through this transition.

8. New Directions: Trusting the Process

The new direction was indeed challenging and was the only way to research the pandemic. I sent the survey for data collection and interview recruitment a few months after the first phase of the pandemic started. My biggest fear was if nurses would spend time and energy to do this voluntary survey and self-recruit themselves for the interview during the challenging times of their lives. A negative response would have meant that I needed to return to the drawing-room and re-designed the research. The snowball sampling method was also very limited. I tried only to connect with social media platforms through some of my friends in the first attempt, thinking that if the results were not good, I would advertise it on association websites. It followed days of waiting as the results were trickling in.

9. Surprised at the Need: Momentum to the Research

Taking me by surprise was the result of my first attempt. Within two to three months, I received more than 300 completed responses to the anonymous survey and around 80 self-

recruited interest in participating in the detailed interview. Being very satisfied with the situation, I cross-checked with my supervisor if this was a good enough response, and he agreed with a hunch. At this stage, I stopped populating the call for the anonymous survey and started scheduling study participants for interviews. It was not very easy at this stage as I needed to repeatedly connect with many of the interested participants to get an interview scheduled. I proposed to have 25 in-depth interviews for the study and 27 nurses from different provinces of Canada who belonged to different ages, specialties, and education. It was so convincing that the anonymous survey had 81.31% (248) nurses who experienced compassion fatigue in their whole career and 77.05% (235) nurses who experienced compassion fatigue during the COVID-19 pandemic.

10. Constant Debate: Can Compassion Fatigue?

Though I was convinced about the need and relevance of the subject of my research, I was left with the constant questioning in my mind; Can compassion fatigue? The questions were due to some of the literature on compassion which spoke of compassion as something that can never fatigue or fade. If this is true, then the opinion that compassion fatigue is a wrong term used for this caregiving experience is true. If this is not true, then the ideal of compassion needs to embrace the idea that imperfect, limited capability in human beings who exercise it is a common experience and that there may be a possibility of transition from a self-referential, limited expression of it to a universal, non-self-referential expression of it. This was no answer that would come immediately. It was also impossible to just find an answer from the literature alone. I hoped that the interviews would give me some insight into this question of the limitedness of the practice of compassion. It would also allow me to learn first-hand from individuals who experienced the phenomenon if this was empathic distress, a reactive response to the patients' pitiful plight, or a relational process similar to the mother-child relationship.

11. Participant Stories: Finding Answers

As I started the conversations with the nurses who offered to be part of the study, I got a glimpse of what I found in the literature regarding the role of trauma and overwork in the experience of compassion fatigue. The interview followed a phenomenological case study approach and therefore took a whole person approach to compassion fatigue. It considered the developmental, environmental, and attitudinal influences of what the nurses called compassion fatigue. There was no preferred definition or any definition for the experience of compassion

fatigue, and that demanded the participants to describe their experience from their perspective. To avoid colouring their description of compassion fatigue with the idea of compassion, I made sure to ask the questions on compassion only after they had described their experience of compassion fatigue. This strategy added validity to the whole process. I started seeing the participants speaking the similar language of compassion fatigue, and a few of them represented a negative case scenario which further added the study's credibility. At this stage, I knew I had some answers to my questions, though I was unsure if I had enough of the answers needed.

12. Analysis and Writing: Emerging Out of Chaos

Transcribing the 27 interviews was one of the most challenging things for me as I prepared for the analysis phase; on average, 90 minutes of 27 interview conversations needed to be transcribed and analyzed. The initial coding processes remained repetitive and boring sometimes; however, the constant comparison process and the awareness of theoretical sampling continued to take prominence during this phase. Though all participants agreed to a further conversation or communication to arrive at the saturation point of concepts, the initial phase of coding revealed a saturation pattern of ideas. As I slowly moved through this phase and created categories, I saw more clarity and understanding of the participant stories. Although I made all efforts to have 27 interview data as handy as possible, to have a clear bird's eye view on all the 27 conversations always remained a considerable challenge through this stage.

13. Light at the End: The Grounded theory

Continuing with the analysis and being comfortable with chaotic and somewhat disorganized data, I eventually progressed into the more congruent narrative of the participant experience. It comprehended the personal experience and connected the environmental and attitudinal disposition in the equation. The emergent grounded theory about the process of compassion fatigue was a light at the end of the tunnel after almost a year of effort. Though the analysis phase added some clarity, the following process of writing the results and compiling my thoughts around it was hugely challenging. However, as I am writing this concluding reflection, I am also grateful for finally preparing my dissertation draft for review.

14. Challenged by Compassion: An Ongoing Journey

Writing and defending this dissertation is probably the beginning of a more responsible journey to be constantly challenged by compassion in academic, professional, and personal spheres. It invites me to live compassion and show wisdom in the journey of teaching and

learning compassion. It challenges my biases and power as an educator and clinician. It provides an opportunity to deeply reflect on humanity's sufferings and connect with the philosophy of groundlessness of the interdependent existence of the universe as explained in Buddhism. As Varela et al. (2016), suggests "compassion is not derived from an axiomatic ethical system nor even from pragmatic moral injunctions. It is completely responsive to the needs of the particular situation" (p. 248) and awakened by the awareness of groundlessness which is manifested by a "non-egocentric responsiveness" (p. 252). The process of developing compassionate minds needs to engage the training of the mind in the groundlessness of reality. The process of this research has challenged me to look at one of the most common human experiences of caregiving through philosophical, psychological, and educational lenses. Above all, it leaves me with a better understanding of caregiving professionals who are often challenged by the ever-increasing need for compassion and the inability to meet this need in their caregiving spaces despite a deep desire to care compassionately.

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Appendices

1. Appendix i: Research Ethics Board Approval Certificate

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

August 06, 2020

Principal Investigator: Dr. Wayne Melville
Student Investigator: Augustine Parattukudi
Faculty of Education
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Melville and Augustine:

Re: Romeo File No: 1468148
Granting Agency: N/A
Agency Reference #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Compassion Fatigue During Covid-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory".

Ethics approval is valid until August 6, 2021. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by July 6, 2021 if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:

https://erpwp.lakeheadu.ca/

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Kristin Burnett
Chair, Research Ethics Board

/sw

955 Oliver Road, Thunder Bay, ON, Canada, P7B 5E1 | lakeheadu.ca

2. Appendix ii- Anonymous Survey Poster

3. Appendix iii- Anonymous Survey Information and Questionnaire

Anonymous Survey Information

Title of research project: compassion fatigue During COVID-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory

You are invited to participate in a research study conducted by Augustine Parattukudi, PhD Candidate, Faculty of Education, Lakehead University, Ontario and supervised by Dr. Wayne Melville. The purpose of this research is to examine the role of compassion in addressing the compassion fatigue experiences of direct care nursing professionals during the COVID-19 pandemic. The research aims to develop a theoretical understanding of compassion fatigue unique to a pandemic situation, which can become useful in nursing education by underpinning the development of strategies to address compassion fatigue during pandemic events.

Description: You are being asked to complete a self-administered anonymous online survey sent to Canadian direct care nurses (RN, RPN, LPN) who have worked, or been working, during the COVID-19 pandemic. The questions will include some demographic information and questions on your understanding of compassion fatigue during COVID-19. The anonymous survey also will give you an option to participate in either an online video/audio interview or an audio only interview by the researcher. You have the option to give your consent for the interview through a separate email link or only do the anonymous survey to support the research. The survey is very brief and will only take about five minutes to complete.

Participation: Your participation in this survey is completely voluntary. Your participation in the survey is important; however, you have the right to refuse to answer questions or withdraw at any time before submitting the survey. Once submitted you will not be able to withdraw the data because of its anonymous nature. Non-participation or partial participation will not affect your professional life or employment in anyway as your employers will not be aware of your participation in the study/survey.

Confidentiality: At any point no one can identify the author of the data due to its anonymous nature. The researcher may share the aggregated de-identified data with his supervisor and doctoral committee and may be used in data analysis and writing. All data will be kept secure at Lakehead University for a minimum of five years following the completion of the study. On completion of the study all electronic data will be downloaded to a secure device with password protection and will be stored together with other physical data of the research in a locked filing cabinet in the supervisor's office at the University. The researcher will permanently delete all electronic data from his device after securing it in a physical version at the supervisor's office.

Benefits and risks:
By participating in this survey, you have the opportunity to contribute to the research initiatives to understand and prevent nurses' compassion fatigue during a pandemic like COVID-19. This study may pose minimal risk to some participants due to the sensitive nature of some of the information requested. The anonymous nature of survey protects the identity of participants;

however, the participants are at liberty at all times not to answer a particular question that may cause them personal distress. For further support for participants a list of Canadian mental health support resources is given at the end of this survey. In spite of using one of the most secure Canadian platforms for the survey, there can be some challenges to security similar to any secure online platform. This include potential data breach or intrusions and unauthorized release to third parties. In order to adequately protect the participant data from any such unforeseen situation, the following precautions are in place. Hosted in Canada Surveys adheres to the Personal Information Protection and Electronic Documents Act (PIPEDA), which governs how private sector Canadian organizations collect, use and disclose personal information. It is a PHIPA (Personal Health Information Protection Act) compliant platform operated from Ontario, Canada. As an IT service/hosting provider, Hosted in Canada Surveys reports to fulfill the requirements indicated by the Information and Privacy Commissioner of Ontario (www.ipc.on.ca) which includes sending immediate notification of any privacy breach to the Privacy Commissioner.

Publication of research results: The collected information will be used only for scientific and professional publications and presentations. The published results will be aggregate results only and will guarantee anonymity of participants

Contact: If you have any questions about this study, you may contact the researcher, Augustine Parattukudi at apparatt@lakeheadu.ca or Dr. Wayne Melville at wmelvill@lakeheadu.ca
This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Anonymous Survey Informed Consent:
By signing this consent document, I agree to participate in the anonymous survey titled, compassion fatigue During COVID-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory.
I agree to the following:
I have read and understood the information given above regarding the anonymous survey and research study
I agree to participate in this anonymous survey
I understand the risks and benefits to the survey. The research procedure, risks and benefits of the survey have been fully explained to me.
That I am a volunteer and can withdraw from the survey at any time before the submission and may choose not to answer any question. I understand that once submitted the data cannot be withdrawn due to the anonymous nature of the survey.
I understand that non-participation or partial participation will not affect my professional life or employment in anyway as my employers will not be aware of my participation in this survey.
That the data will be securely stored at Lakehead University for a minimum period of five years following completion of the research project
I understand that this is an anonymous survey and the data collected will be kept strictly anonymous and the researcher will use the aggregated de-identified data for the purpose of consultation, analysis and writing/publishing

I am aware that the anonymous survey platform (Hosted in Canada Surveys) is a Canadian law compliant secure survey platform with its servers in Canada.
All of my questions have been answered
The data from this study may be used for education and publication purposes and that I will be anonymous in any work.
I have read and agree to the above information and would like to proceed to the survey,

Participant signature: ____

Thank you for your participation in advance

Survey Questionnaire

The following questions include some demographic inquiries and questions regarding your understanding and/or experience of compassion fatigue. The information will help understand the reality of nurses' experiences related to fatigue. This information will ONLY be used for the purpose of this research and the participant identities can't be accessed by the researcher and will always remain anonymous.
Question Title: **Age**
18-25
26-35
36-45
46-55
56 and older

Question Title: Gender

____
Question Title: Marital status
Single
Married
Divorced/Separated
Common law
Widowed
Do not wish to disclose
Question Title: What is your field of nursing
RN
RPN
LPN
Question Title: Highest level of nursing education
Diploma/Certificate/College
Baccalaureate
Masters
Doctorate
Other
Question Title: Country of qualification

____

Question Title: Number of years you have been qualified in your current role

____

Question Title: Number of years in direct care nursing

____

Question Title: Province or Territory of employment
British Columbia
Alberta
Saskatchewan
Manitoba
Ontario
Québec
New Brunswick
Nova Scotia
Prince Edouard Island
Newfoundland and Labrador
North Ouest Territories
Yukon
Question Title: Employment status
Full time
Part time
Temporary
Casual
Leave of Absence
Other
Question Title: How many hours do you usually work per week (on average)?

____

Question Title: How many hours did you or do you work per week (on average) during COVID-19?

____

Question Title: Place of work
General hospital
Rehabilitation centre
Palliative care
Cancer care
Psychiatric hospital
Residential facilities
Nursing home / Veteran’s unit
Public health service
Health services centre

Mental health clinic
Physician's office / Family practice unit
Occupational health / Business / Industry
Educational institution
Self-employed
Government
Addiction centre
Fed / Prov correctional institute
Armed forces
Home care agency / private duty
Community health centre
Hospital satellite facility
Other _________________________

Question Title: Primary area of present practice

Medical / Surgical
Maternal / Newborn
Mental health / Psychiatric
Pediatrics
O.R. (operating room)
Ambulatory care / Day surgery
Geriatrics / Extended care
R.R. (Recovery Room)
Rehabilitative care
Chemical dependency
Several clinical areas / Float
Community Health
Occupational Health
Critical / Intensive care
Oncology
Telepractice
Emergency
Dialysis / Nephrology
Palliative care
Other patient care
Administration
Education
Research
Other. ___________________________

Question Title: What would you say compassion fatigue is?

Compassion fatigue is the experience of fatigue due to my inability to maintain a nurturing (caring) relationship with my patient caused by a limited reserve of compassion or the limited ability to care.

Compassion fatigue is the experience of fatigue caused by the overload of empathic distress (distress and trauma caused by high amounts of empathy)

Other ____

Question Title: Have you worked or been working during the COVID-19 pandemic?
Yes
No
Question Title: According to your understanding, have you ever experienced compassion fatigue in your nursing career?

Yes
No
Question Title: According to your understanding, have you experienced compassion fatigue during the COVID-19 pandemic?

Yes
No

Question Title: When I experienced (if experienced) compassion fatigue,

I withdrew from my patients

I tried to reach out more to my patients

I remained indifferent to my patients

I initially tried to reach out but started withdrawing from my patients gradually

Other ____

Question Title: Can you share any four symptoms that you associate with the experience of compassion fatigue?

____

Interview participation question
If you have experienced compassion fatigue before or during COVID-19, would you be willing to take part in an online video/audio interview or an audio only interview with the researcher (who is an experienced clinical professional) about your experience of compassion fatigue?

(your willing participation can contribute to nursing education, compassion and fatigue studies in a significant way. Interview Participants will also be put into a lucky draw to win one of two prizes of 50$ Amazon gift cards. When you provide with contact information the researcher will send you additional information on participation in the study)

Yes
No

If yes, please click the email link of the researcher email below and send your contact details (email id, name) that the researcher can contact you for the interview. ***(The below given email link will take you directly to the researcher email and will protect the anonymous nature of the survey you just completed as it is de-linked from the anonymous survey).***
apparatt@lakeheadu.ca

Canadian Mental Health Support Resources

If you are in immediate danger, please call 911 or go to your local emergency department
Crisis Services Canada– A national network of distress, crisis and suicide prevention contact
439 University Ave., Toronto, ON, M5G 1Y8
1-833-456-4566 (Crisis Line)
http://www.crisisservicescanada.ca
Find a crisis centre in your province or territory
First Nations and Inuit Hope for Wellness Help Line
Service is available in Cree, Ojibway, Inuktitut, English and French.
ON, Canada 1-855-242-3310
Ementalhealth.ca to find various mental health and social support services
Canadian Mental Health Association to find your local CMHA to access mental health help, support and resources
Find a therapist in your local area.
If you want to ease into reaching out, you can try online peer support through sites like Big White Wall
https://www.7cups.com : Free, anonymous and confidential online text chat with trained listeners, online therapists & counsellors
https://wellin5.ca : BC-based online counselling platform providing affordable, accessible video counselling
COVID-19 related nurses' resources in Canadian Nurses Association website: https://cna-aiic.ca/en/coronavirus-disease/faqs-and-resources

4. Appendix iv- Request to Participate in Anonymous Survey-E-Mail Form

Request to Participate in Anonymous Survey-E-Mail Form
(Please also circulate among your network)
Project Title:
compassion fatigue During COVID-19:
Exploring Canadian Nurses' Lived Experiences for a Grounded Theory

Principle Investigator:
Augustine Parattukudi, PhD Candidate, Faculty of Education, Lakehead University
Supervisor:
Dr. Wayne Melville, Faculty of Education, Lakehead University
Request to Participate:
Please support this research initiative to understand direct care nurses' compassion fatigue experience during the COVID-19 pandemic by completing this online anonymous survey. The anonymous online survey also will give you an option to participate in an online video/audio or audio only interview by the researcher as part of the study.
It is About:
The purpose of this research is to examine the role of compassion in addressing the compassion fatigue experiences of direct care nursing professionals during the COVID-19 pandemic.
Usefulness of the Survey:
The research aims to develop a theoretical understanding of compassion fatigue, which can become useful in nursing education by underpinning the development of strategies to address compassion fatigue specific to a pandemic.
How to Access the Survey:
The survey is very brief and will only take about five minutes to complete. Please click the link below to go to the survey web site or copy and paste the link into your Internet browser to begin the survey.
Survey link:
https://compassionfatigue.hostedincanadasurveys.ca/318515
Anonymous and Voluntary:
Your participation in the survey is completely voluntary and all of your identities will be kept anonymous. The researcher may share the aggregate de-identified data with his supervisor and doctoral committee and use for data analysis and writing. All data will be kept secure at Lakehead University for a minimum of five years following the completion of the study. (A detailed information letter and consent document is included in the survey)
Contact Information
If you have any questions about this study, you may contact the researcher, Augustine Parattukudi at apparatt@lakeheadu.ca or Dr. Wayne Melville at wmelvill@lakeheadu.ca
This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807- 343-8283 or research@lakeheadu.ca.
Thank you very much for your time and participation. Let me also request you to forward this survey among your network of direct care nurses
Sincerely,
Augustine Parattukudi, PhD Candidate, Lakehead University

5. Appendix v- Informed Consent Form for Interview Participants

Informed Consent Form for Interview Participants
Project Title:
Compassion fatigue During COVID-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory

Investigator:
Augustine Parattukudi: PhD Candidate, Faculty of Education, Lakehead University
Supervisor:
Dr. Wayne Melville: Professor, Faculty of Education, Lakehead University

By signing this consent document, I agree to participate in the research project titled, *compassion fatigue During COVID-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory*. I have read the letter of information regarding this study and all my questions have been answered to my satisfaction. I will keep a copy of the letter and consent for my information
I agree to the following:

- I have read and understood the information contained in the Information Letter.
- I agree to participate in this research study
- I understand the risks and benefits to the study. The research procedure, risks and benefits of the study have been fully explained to me.
- I am granting permission for the researcher to audio record the interview.
- That I am a volunteer and can withdraw from the study at any time during the data collection period (within 6 months of initial interview) and may choose not to answer any question.
- I understand the data collected through the interview will be kept strictly confidential and the researcher will use only the de-identified data for the purpose of consultation, analysis and writing/publishing
- I understand that withdrawal or partial participation will not affect my professional life or employment in anyway as my employers will not be aware of my participation in this research and interview.
- That the data will be securely stored at Lakehead University for a minimum period of five years following completion of the research project
- I understand that the research findings will be made available to me upon request
- The data from this study may be used for education and publication purposes and that I will be anonymous in any work.
- I am aware that the online telehealth platform (Janeapp) is a Canadian law compliant secure telehealth platform with its servers in Canada.
- All of my questions have been answered
- By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.
- By initialing the statement(s) below please specify your preference and consent,

________ Yes, I would be willing for an **video/audio interview**
________ Yes, I would be willing for an **audio only interview**
If you are willing to have the researcher, contact you at a later time by e-mail for a brief conversation to confirm that the researcher has accurately understood your comments in the interview, please indicate so below. You will not be contacted more than six months after your interview.
________ Yes, I would be willing to be contacted to review the transcript or any clarification questions.
_______ I would **like to receive a copy of the results of this research study** which will be emailed to me at the address below.
(Email) ____
Name: ____
Date: ____
Signature: ____

6. Appendix vi- Information Cover Letter for Interview Participants

Information Cover Letter for Interview Participants

Project Title:

Compassion fatigue During COVID-19: Exploring Canadian Nurses' Lived Experiences for a Grounded Theory

Investigator:

Augustine Parattukudi, PhD Candidate, Faculty of Education, Lakehead University

Supervisor:

Dr. Wayne Melville, Professor, Faculty of Education, Lakehead University

Dear Potential Participant:

You are invited to participate in a research study about the understanding and experience of compassion fatigue of direct care nurses in various health care facilities across Canada during the COVID-19 pandemic. The purpose of this grounded theory research is to examine the role of compassion in addressing the compassion fatigue experiences of direct care nursing professionals during the COVID-19 pandemic. As a participant you are invited to take part in an online semi-structured video/audio or audio only interview using Canadian based secure telehealth platform called *Janeapp*. The servers of this platform are located in Canada and provide a secure, end to end encrypted, tele-health video-conferencing platform compliant with Canadian laws of privacy and confidentiality. Taking part in this study is voluntary. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

Purpose: The purpose of this research is to examine the role of compassion in addressing the compassion fatigue experiences of direct care nursing professionals during the COVID-19 pandemic. The study focuses on examining the health care professional's internal experience of compassion fatigue, external behaviors related to compassion fatigue and their knowledge of, and attitude towards, compassion. The research aims to develop a theoretical understanding of compassion fatigue, which can become useful in nursing education by underpinning the development of strategies to address compassion fatigue.

Your Participation: During the interview you will be asked questions about your experiences of compassion fatigue and compassionate care before, during and after the COVID-19 pandemic. The online video/audio or audio only interview will take approximately fifty to ninety minutes of your time. You are at liberty to choose either a video/audio or an audio only method of interview. The interview will be audio recorded for transcription purposes. Upon completion of the interview you may be asked your permission to follow up with any aspects of the interview. Your participation in any phase of the interviews is totally voluntary. The interviews will be semi-structured and open ended, and you are expected to share your personal, professional experiences and knowledge related to compassion fatigue and compassionate care. Upon completion of the interviews, the transcribed document will be provided to you to check for accuracy and you will have two weeks to suggest changes or edits.

Your Rights as a Participant: As a participant you are under no obligation to participate

and are free to withdraw at any time during the data collection period (6 months from the initial interview) without prejudice. You may also not answer any question, for any reason, at any time. You will be given, in a timely manner throughout the course of the research project, information that is relevant to a decision to continue or withdraw from participation. Non-participation or partial participation will not in any way affect your professional life or employment.

Benefits of Participation: The research aims to develop a theoretical understanding of compassion fatigue, which can become useful in nursing education by underpinning the development of strategies to address compassion fatigue during a pandemic. Your participation may lead to development of foundational theories and solutions to the problem of compassion fatigue among direct care nurses. You may also find it personally helpful and therapeutic to discuss these experiences. Upon request, you would also receive the copy of research reports that are drawn from this work. At the conclusion of the study, the names of the participants will be entered into a draw for two prices of 50$ Amazon gifts cards.

Risks of Participation: There can be some distress experienced by some interview participants as they recall difficult memories regarding compassion fatigue. I will take the following steps to minimize any risk or harm and safeguard confidentiality:

The researcher will use a secure, Canadian law compliant, encrypted telehealth platform called Janeapp for collection of data through the interviews. In spite of using one the most secure Canadian platforms, there can be some challenges to security similar to any secure online platform. This include potential data breach or intrusions and unauthorized release to third parties. In order to adequately protect the participant data from any such unforeseen situation, the following precautions are in place. Janeapp adheres to the Personal Information Protection and Electronic Documents Act (PIPEDA), which governs how private sector Canadian organizations collect, use and disclose personal information and is complaint with provincial specific Personal Information Protection Act. As an IT service/telehealth provider, Janeapp reports to fulfill the requirements indicated by the Information and Privacy Commissioner of specific provinces which includes sending immediate notification of any privacy breach to the Privacy Commissioner.

The research data will be anonymized, including name, any contact detail and specific geographical location. Only the researcher will have access to the original data and de-identified data may be shared with the supervisor and doctoral committee members and used in analysis and writing

During the interview you may experience low-moderate feelings of emotional discomfort while discussing any compassion fatigue experience that you have had. The discomfort is not expected to be more than what you may experience in normal situation of sharing similar information. However, to enhance safety, I will facilitate psychological support to any participant in case they express need for such support. I have also added a list of free and low-cost mental health support resources at the end of this document.

The researcher who would be interviewing you (Augustine Parattukudi) is a registered psychotherapist with College of Psychotherapists of Ontario and is experienced in online video/audio clinical interviews.

Involvement in this study is completely voluntary and you may refuse to answer any questions or to share information that you are not comfortable sharing. You may withdraw from the study at any time during the data collection period (6 months following the initial interview) by informing the researcher either verbally or in writing. Upon such information your data will immediately be destroyed.

Non-participation or partial participation will not affect your professional life or employment in anyway as your employers will not be aware of your participation in the study/interview.

You will have the option to review the written interview transcript which will be emailed to you using a password protected document. You will have two weeks to review the transcript and notify the researcher of any comments, changes, clarifications or withdrawals.
During the research phase all hard copy data will be kept in a locked filing cabinet and all electronic data will be kept in encrypted external hard drive which will be kept in a locked filing cabinet. The study data will be securely stored for a minimum of five years following the completion of research at Lakehead University according to University guidelines. On completion of the study all electronic data will be downloaded to a secure device with password protection and will be stored together with other physical data of the research in a locked filing cabinet in the supervisor's office at the University. The researcher will permanently delete all electronic data from his device after securing it in a physical version at the supervisor's office.

What will my data be used for: The data from this study will only be used for the purpose of research related to this specific project. Results of this study may be published in academic journals and shared at professional conferences. You are welcome to email the researcher for a copy of these communications.

What if I want to withdraw from the study? You may withdraw from the study at any time during the data collection period (6months from the initial interview) by informing the researcher in writing. Upon such a request for withdrawal from the study your data will immediately be destroyed. In case of you wanting to withdraw from the study, you should inform the researcher Augustine Parattukudi via email: apparatt@lakeheadu.ca

Researcher's contact information: If you have any questions about this study, or require further information, please contact Augustine Parattukudi at: apparatt@lakeheadu.ca or the supervisor, Dr. Wayne Melville at: wmelvill@lakeheadu.ca
The researcher declares no conflict of interest regarding this study
This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Canadian Mental Health Support Resources
If you are in immediate danger, please call 911 or go to your local emergency department
Crisis Services Canada– A national network of distress, crisis and suicide prevention contact
439 University Ave., Toronto, ON, M5G 1Y8
1-833-456-4566 (Crisis Line)
http://www.crisisservicescanada.ca
Find a crisis centre in your province or territory
First Nations and Inuit Hope for Wellness Help Line
Service is available in Cree, Ojibway, Inuktitut, English and French.
ON, Canada 1-855-242-3310
Ementalhealth.ca to find various mental health and social support services
Canadian Mental Health Association to find your local CMHA to access mental health help, support and resources
Find a therapist in your local area.

If you want to ease into reaching out, you can try online peer support through sites like Big White Wall
https://www.7cups.com : Free, anonymous and confidential online text chat with trained listeners, online therapists & counsellors
https://wellin5.ca : BC-based online counselling platform providing affordable, accessible video counselling
COVID-19 related nurses' resources in Canadian Nurses Association website: https://cna-aiic.ca/en/coronavirus-disease/faqs-and-resources

Thank you for your assistance in this project

7. Appendix vii- Demographic Questionnaire for Interview

Demographic Questionnaire for Interview

The following questions include some demographic inquiries and questions regarding you and your profession. This information will ONLY be used for the purpose of this research and the participant identities will be ANONYMISED by the researcher before it is used in the research and writing process.
Question Title: Age
18-25
26-35
36-45
46-55
56 and older

Question Title: Gender

Question Title: Marital status

Single
Married
Divorced/Separated
Common law
Widowed
Do not wish to disclose

Question Title: What is your field of nursing

RN
RPN
LPN

Question Title: Highest level of nursing education

Diploma/Certificate/College
Baccalaureate
Masters
Doctorate
Other

Question Title: Country of qualification

Question Title: Number of years you have been qualified in your current role

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Question Title: Number of years in direct care nursing

Question Title: Province or Territory of employment

British Columbia
Alberta
Saskatchewan
Manitoba
Ontario
Québec
New Brunswick
Nova Scotia
Prince Edouard Island
Newfoundland and Labrador
North Ouest Territories
Yukon

Question Title: Employment status

Full time
Part time
Temporary
Casual
Leave of Absence
Other
Question Title: How many hours do you usually work per week (on average)?

Question Title: How many hours did you or do you work per week (on average) during COVID-19?

Question Title: Place of work

General hospital
Rehabilitation centre
Palliative care
Cancer care
Psychiatric hospital

Residential facilities
Nursing home / Veteran’s unit
Public health service
Health services centre
Mental health clinic
Physician's office / Family practice unit
Occupational health / Business / Industry
Educational institution
Self-employed
Government
Addiction centre
Fed / Prov correctional institute
Armed forces
Home care agency / private duty
Community health centre
Hospital satellite facility
Other ________________________

Question Title: Primary area of present practice

Medical / Surgical
Maternal / Newborn
Mental health / Psychiatric
Pediatrics
O.R. (operating room)
Ambulatory care / Day surgery
Geriatrics / Extended care
R.R. (Recovery Room)
Rehabilitative care
Chemical dependency
Several clinical areas / Float
Community Health
Occupational Health
Critical / Intensive care
Oncology
Telepractice
Emergency
Dialysis / Nephrology
Palliative care
Other patient care
Administration
Education
Research
Other. __________________________

8. Appendix viii- Guiding Questions for In-depth Interview

Compassion Fatigue During COVID-19:
Exploring Canadian Nurses' Lived Experiences for a Grounded Theory

Guiding Questions for In-depth Interview

Initial Open-Ended Questions

1. Would you share with me a bit about yourself; your personal background and what brought you to the nursing profession?
2. How would you explain the nature of your direct care towards your patients? Would you give me an example?
3. When you approach caring for a patient, what thoughts do you have?
4. When you approach to care for a patient, usually what feelings do you get?
5. Would you share with me how is a typical day at your job?
6. How has COVID-19 affected your life as a direct care nurse?
7. You reported on the survey that you experienced compassion fatigue. Would you elaborate on what was the experience like?
8. Could you elaborate on how and when, if at all, did you first experience or notice compassion fatigue?
9. Could you elaborate on the physical, psychological, emotional and spiritual parts of that experience?
10. Could you share with me the events that led up to this experience and what happened after?
11. Could you also tell me what happened the days following this experience?
12. What are the factors that you believe contributed to this experience?
13. Could you elaborate on how it affected your relationship and engagement styles with your patients, comparing before and after this experience?
14. What changes have happened, both positive and negative, in you as a person, comparing before and after this experience?
15. What role, if any, has COVID-19 played particularly regarding this experience?

Intermediate Questions

1. What did you know about compassion fatigue prior to your experience of it?
2. How would you describe compassion fatigue now?
3. What sort of things did you do to deal with compassion fatigue?
4. What do you think helped you, if anything, to deal with compassion fatigue?
5. What part of your training/education, if any, helped you to deal with compassion fatigue?
6. What kind of training/education would you wish to have had in order to deal with compassion fatigue?
7. What do you see as the difference if compassion fatigue experienced during the COVID-19 period or outside the COVID-19 period?
8. How would you describe compassion and compassionate care?
9. What is your attitude towards compassion and compassionate care?

10. Would you share with me some examples of compassion that you experienced during your life?
11. Would you also share some examples of your compassionate care towards your patients?
12. How do you see your experience of compassion and compassionate care challenged after your experience of compassion fatigue?
13. How did COVID-19 affect your practice of compassionate care?
14. Are you aware of the concept of universal/unlimited compassion? If aware, what is your understanding about it?

Ending Questions

1. Do you think the term compassion fatigue best represents your experience? If not, what would you prefer to call it? What are your thoughts on it?
2. Is there any part of your experience that we have not discussed about that you would like to share with me now?
3. After having these experiences, what advice would you give to someone who has just found out that they are experiencing compassion fatigue?

9. Appendix ix: Examples of Subcategory Themes in Participant Words

Examples of Subcategory Themes from the Interview Data
1.Caregiver Motivation
Desire to care: "I went into nursing because I wanted to care, and I wanted to look after people and make them feel better" (Jasmine)
Desire to connect: "I have really enjoyed connecting deeply with the families that we look after" (Anna)
Desire to advocate: "And I thought if I could be something like that make a difference and help people in their time of need, and along their journey, as a good person in a kind of an advocate for them. And that's what I want to do" (Judith)
Desire to protect/save: "So I think having to be almost that by no means like Savior, but in a way, a little bit of a light of positivity and resilience, especially for the patients that you interact with" (Jacob).
Other: "There's no real reason why I went into nursing. I think about it out. I really don't know why. But it's not like I had a lot of nurses around me or anything" (Samantha)
2.Caregiver's Compassion Experience
Compassion to patients: "I honestly, actually feel I am more compassionate with my patients. I don't know like, but I feel like there's so much darkness and so much fear and so much of the unknown right now in our worlds that these people need a little bit more. I don't know, like, they just need to be taken more seriously maybe" (Penny).
Attitude to universal compassion/unconditional love: "Regardless, like it's not about them earning it, they just deserve it. That's absolute universal compassion. I like that. That's the first in every situation" (Anna)
Personal experience of compassion: "They loved me like I was theirs and they took care of me like I was theirs and there was never any question. But even as, like a young child, my mom would always say I would befriend the kids that didn't have any friends and I would make sure that they felt included, and I would hang out with the unpopular kids and the popular kids" (Chelsie).
Spiritual language on compassion: "I guess I believe in like; I think that we're all kind of connected. I think that there's always, you know, angels watching over us, and I don't know I think that, you know, if we all just kind of connected a little bit better the world would be a better place" (Clare).
3.Caregiver's Ideas on Compassion
Compassionate care as advocating for patients: "And I have this patient who's been like crying throughout dialysis. And nobody has really talked about it or noticed it. So, I went, and I called his wife. And apparently, it's gotten bad at home, and there's burnout. And so, I finally got the social worker involved. Because you have to care about people to do your job" (Chelsie).
Compassionate care as working for de-stigmatization of patients: "And that's part of the De- stigmatization of mental health is that you can still have a conversation with somebody, and I can talk with people. I mean, it's fascinating that we'll have people with schizophrenia who will phone to kind of check in with their symptoms" (Kim).

Compassionate care as maintaining balance: "I think it's making sure that people are well enough to go home and advocating if we find something is unsafe or they need more help with something and I think it may sound cheesy, but just giving like a little bit of your heart to everyone. ..but then at the end of the day, it's going home and leaving work at work and that's being compassionate to yourself so I can come home and hang out with my kids and not be stressing out about my day and I can smile, and it'd be genuine and you know, so it's about balancing that too I guess" (Clare).
Compassionate care as acknowledging patient suffering: "But to really connect with those families that are going through horrible things. And sometimes it's not even us that's connecting, it's being unobtrusive and, and just making sure that you're delivering compassionate care to the baby, the baby might be passing away, but it's still so important that you know that that baby just deserves everything as well" (Anna).
Compassionate care as being present to patients: "Especially when in a very teaching environment with new families need to have compassion, you need to be present, because they're really counting on you to give them some direction as to where their lives are going now with this new baby" (Danielle)
Compassionate care as caring for small things: "So my co-workers actually asked me because they say, Well, why did the patients like you so much more than others, right? And I say, well, because I do all the little things" (Judith).
Compassionate care as Do unto others... (the golden rule): "And so then I leave and you know, and I make sure that they see me wash my hands and leave and I shut the curtain and I give him that extra privacy. You know, and I leave the room and close the door. And that's what I do for everybody. And that's what I would want someone to do for me" (Judith).
Compassionate care as doing extra over and beyond: "I've been on the phone countless times with different agencies with, different healthcare providers really, like trying to push for her to have housing or appointments that are accessible for somebody that doesn't have a phone and all these things, but I've also like, brought her clothes and a tent and food. Like, yeah, that's like one person that myself and our team of nurses have worked really hard with and gone above and beyond for" (Sarah).
Compassionate care as empowering patients: "To me, that's compassionate. Encouraging a dementia patient to button their own buttons, they're having a hard time rather than just taking it over and doing it for them. You know, working with people, I guess, really, that's compassionate care. But also knowing when, when they do need more help, and giving it" (Edith).
Compassionate care as getting involved in patient story: "It goes back to putting, you know, having that empathy and putting yourself in your patient or your patients family, in my case and realizing where they're coming from and being willing to extend that grace to them that they're in a different circumstance than I am" (Anna).
Compassionate care as intentional use of compassion: "And then when I go, when I go into the rooms, I'm thinking, you know, if it were me, and my sister, my best friend…(Judith).
Compassionate care as involving patient family in care: "We do family integrated care. So, the parents are very much present, and very much viewed as part of the care team and also kind of part of your patient, obviously… If moms there, dads there, I try to make sure that they can get their hands on and do everything that they can" (Anna).
Compassionate care as loving communication and relationship: "So they'll come to me and they'll say, like, I'm getting manic. So, then I ask them why do you feel like that? It

makes sad that and then I can tell them, okay, I'm going to call your psych nurse, and she'll talk to your psychiatrist. And then I make sure I go back and tell them what they said. So okay, we're gonna change your medication. And if that doesn't work, let me know. And then they're happy" (Ruby).
Compassionate care as loving patients and colleagues: "… you have to involve them in the care, you want them to be the parent, even though I'm the one doing most of the care most of the time. So, it's a little bit tricky. So, yeah, you can see that as I am crying. You do fall in love with these little creatures and most of the time you fall in love with the parents too and for sure…(Heidy)
Compassionate care as person-oriented care: "I feel like compassionate care is patient centered care that meets the need of your patient. It's individualized care. And it's really getting to know your patient at a personal level, having those conversations where you're building a relationship, and really understanding them and their needs" (Stella).
4.Caregivers' Patient Care Approach
There are mainly four themes included in the caregiver's patient care approach subcategory. It included the initial experience of nurses with their patients, their overall person oriented-ness or task oriented-ness regarding patient care, whether they used reflective practices in patient care and their risks and rewards in doing patient care (No examples included as there are too many).
5.Caregiver's Safety Experience
Anger and frustration: "I don't know how to describe it, I don't know if it's compassion fatigue, or if it's just pure frustration and anger… it's just, you're angry at the situation… I don't know, how is it affecting me? I'm angry. I feel like I'm angry" (Penny).
Anxiety: "There are days when you don't know what's happening with patients and there's a lot of anxiety that goes with that…sometimes there's more difficult needles and others. And so that brings anxiety was outrageous. And driving into work would be like every single day, I would think, oh crap. What's the newest thing that's going to come…anxiety and the fear of not knowing what I was gonna walk into…?" (Chelsie)
Chronic alertness: "And kind of decoding everything that is said to me, because pretty much everyone who comes in is in an acute psychotic episode. So, I can't really take everything at face value. But I also can't make the assumptions that what they're telling me is not true. Even if it's very outlandish. I have to double check all this information because it might be true. So, it's a little bit of detective work too, and then also a little bit of detective work with the psychiatrists in terms of what exactly their diagnosis will be in the end and where they will be sent out" (Samantha).
Exhaustion: "That's pretty tough because you've got lots of people that you need to see but you've got to treat everybody as COVID positive. So you've got that added layer of complexity and time. And yeah, by the end of the shift, I'm dead, dead tired" (Penny).
Fear: "To feel competent to provide care, but also feeling like the worry of taking something home with you and passing it on to those who are vulnerable in your own life" (Mary).
Helpless or trapped: "The doctor decides whether to pull the plugs or not. But it's the nurse who does it as it and the nurse who it's a nurse who's there, cry with the families, right, and and there's a huge cost to that" (Heidy).
High demand: "So not so much the fear of but it is just the demand. And like I said, it can be frustrating sometimes when we don't have the supplies that we need, when we have these demands. Because it's fine if these demands are there. That's what the health system is there to

do. But when you don't have the supplies or the resources that are necessary for you to do, then it can be taxing” (Jacob).
Lack of self-care: “Because nurses typically want to take care of others before they take care of themselves. Yeah. Because you're the last person that you think of like, you don't think of yourself, you think of others” (Stella).
Lack of boundary: “So again, like, it's not, like an issue of the assignment, I just shouldn't have been there that night. I was emotionally drained. So, I should have just called them sick, but I just didn't have it in me to call in sick and leave them short was my fear” (Stella).
Losing control: “...the feeling of not being able to, I guess control some of the situations that are so outside of your control and the frustration of...” (Celine)
Patient risky behaviours: “I'm having a hard time feeling compassion for the patient, what I've had to fight with their family or they're not following hospital policy or what not. It's, I feel I'm experiencing less compassion with just general with COVID. And especially those who maybe were not social distancing or doing adequate their own part in the community and came with our very sick, I'm almost not feeling compassion for them, because I feel like they brought upon themselves” (Mary).
Personal Safety: “Nighttime, I don't really do too much in terms of getting into feelings and getting into nursing assessments because if I do stimulate the patient to the point that they are, you know, having some sort of episode because I brought up memory or something. If they do lash out. There's not enough staff to protect me in a situation so yeah, really depends on the time of day and how about staff We have available and how about security we have available” (P27).
Self-preservation: “I had a couple of really bad deliveries, probably in June or July, kind of back-to-back, like one stretch. And then the next stretch and like, it was just babies that weren't expected to survive, but I ended up being the one who went to the delivery, and super upsetting. Again, I see that as you almost want to protect yourself, you want to not care” (Anna).
Accumulation of stress: “I think it's just too much of a concentrated giving or feeling of giving or feeling of heightened whatever that is, like these heightened experiences require a heightened response continuously. So, it'd be like some firefighter going to fire once you're doing that once over and over and over again, times, maybe two, three patient rooms… I always say either you explode or implode the two choices when things are too much”(Diew).
Trauma and death: “So last year, in 2019, we had two really hard deaths that they were very difficult on me. They were younger patients. One of them she was a young mom. And then watching her go through her illness, she had cancer and watching her go through her illness as quickly as it was, it was really hard to see she was my age. Oh, and then the other patient I had, he had been dialysing in the unit first, I think 15 years. And he was like, always the happiest, most lovely human. And unfortunately, he passed away very suddenly” (Chelsie).
Being unprepared: “When this area first got set up, there was no call buttons. There was no there was no call buttons for the patient. There was no emergency call button for the nurse. There was no way that security would know if you were in trouble over there. There was no way that you could announce overhead that you know someone that you need help” (Joslyn)
6.Caregiver's Stability Experience
Constant changes: "I mean, there's so many changes that we had to do and every day, so many different uncertainties on what we were going to be doing for our policies and

procedures. And every day it changed because the health authority was changing every single day on what we had to do" (Celine).
Information overload and confusion: "I can brush that off, but sometimes it just got to be too much. And you don't really have the patience for it. And then I think it's also tough with the extra lists of things. And you got to fill out this paperwork now and do screening for this now and how it's just one after the other, it's like, when do we get a break? And then on top of that, you know, are we getting off what's going on with the government in the health cuts and all of like, that's just, there's so many factors, that it's hard to avoid it sometimes" (Clare).
Nurse turnover: "And there were so many nurses in Quebec that quit when COVID broke out. Uh huh. Um, I think there were like, 1500 nurses quit as soon as COVID came out, okay. And a lot of people retired early and stuff like that" (Heidy)
Uncertainty: "I also was working in the emergency department through SARS back in 2001, 2002. Um, it was difficult in the beginning and then things kind of leveled off and we had a strategy in place. And it lasted only about nine months, where we were fully garbed in PPE. Now we wore N95s, all the time and we had shields and we had the gowns, that's what we wore all the time. Here we're getting these mixed, different messages, you don't need this, you don't need that, so that's been fearful because in my experience, it's a respiratory disease I should be wearing an N95, but I'm told not to" (Penny).
7.Caregiver's Support Experience
Compassion fatigue within team: "So, you know, I think it's a fairly supportive environment, but it is difficult to be fully supportive in our environment, because everybody's dealing with something that's really tough. You know, everybody's got a cancer patient who is you know, 30 years old and terminal, and those are very sad situations. And I think our oncologists, they deal with those all the time and the nurses see those situations as well. So, we're all sort of carrying around stuff that's hard. And then when you have personal stuff going on, you know, theoretically you leave all your personal stuff at home but that's theory that doesn't happen in practice" (Edith).
Experiencing support: "I wish that you're able to build yourself as the strong caring person, and you get enough support that you can move ahead in your profession in a more fulfilling way" (Emma)
External support: "I felt like it was you weren't supported from even you're governing your political power who was employing you" (Mary).
Support in handling patient expectations: "Just know if there's less support less resources for you. And your kind of expected to do more with less" (Jacob).
Support in isolation: "I think maybe just the power in knowing that we aren't alone in experiencing this compassion fatigue" (Jacob)
Leadership issues: "Especially if you've got sick patients in your assignment. So staffing is an issue, if there's management that either one won't support you or to just have their hands tied behind it" (Joslyn).
Micro-managing: "It started out so well, when management let nurses form and take response, responsibility and arrange things. It was beautiful. And then it started to change again, where there's now it's being micromanaged" (Kim).
Not being valued: "So I think really, it boils down to how much support that you have from management. And, and some of the courses that I took when I was a manager was you don't motivate people by money. So you know, they're like, oh, like, there's Doug Ford giving you three more dollars an hour. That's not gonna work. It's about acknowledging, about validating,

people's, you know, exhaustion about, about helping them, about listening to them about supporting them" (Lydia).
Nurse autonomy: "Let the nurses nurse. Let people do what they're good at. Don't put constraints in their way. Don't tell them what they can't do. Let them run because we did it and we rocked it. The broken nurses at health link are all the immune compromised sick nurses. They did it. That's what needs to happen. Let people bring their knowledge, we all have knowledge" (Kim).
Resources: "But we don't have a lot of support services, so our intensive care does not have service workers, we don't have quarters, we don't have health care (inaudible)" (Cyndi).
Selfcare: "But the other thing was, I kept getting asked to do more and more, and because of my personality, I did it. And maybe that's part of what contributed to what happened to me. Nobody's going to tell you know, you're probably doing too much" (Lillian).
Support tin debriefing: "A lot of people don't know the proper way of debriefing either or the importance of it. And then if you have to ask about a debriefing, then that person should be recognizing before you ask that a debriefing need to happen" (Joslyn).
Systemic issues: "I mean, you know, in BC our hospital has been chronically short. For many years, and it's gotten very bad, very unsafe over the last year. And I think that really affects honestly affects everyone, it affects all the nurses who have to now take on another patient. And you know, when you say, oh, you have to take on another patient, it doesn't sound that bad. But when you actually put it into practice, it is terrible" (Joslyn).
Team cohesiveness: "I feel that we really were able to de-escalate all of that and do it in a really good way, and like in a way that everybody could feel part of the team and prepared and safe" (Cyndi)
Unit Morale: "And I think we need to like foster a system that allows nurses to say, Hey, you know, I'm having a really hard time, I need to step back before mistakes happen" (Chelsie).
Workload: "That's pretty tough because you've got lots of people that you need to see but you've got to treat everybody as COVID positive. So, you've got that added layer of complexity and time. And yeah, by the end of the shift, I'm dead, dead tired" (Penny).
8.Caregiver's Compassion Fatigue Experience
Empty, inability, lack of energy to care: "You know what, like the word that always just keeps coming back is empty, like I really felt empty, I just didn't have enough energy or enough in me to give anything like I could not extend the energy to even have a conversation with someone like I was just empty. So, I didn't have an ounce to give. So that's how I like how I explained it to my students and how I would explain like, I was just, my bucket was empty" (Cyndi).
Lack of empathy: "I will say lack of caring, or also lack of empathy. And also, not able to empathize with them and try to look beyond my own needs, but looking at their own needs, and putting myself in their shoes, I'm having a hard. That's what I would experience as or defined as compassion and fatigue, I would say this lack of caring because of the effort, it takes" (Mary).
Not able to care oneself enough: "I would say compassion fatigue is, is when people are just having trouble caring for themselves because they can't get their minds off of work, or what's going on? Or they are unable to give up themselves emotionally to their patients, because they're just shut down" (Kim).
Overall exhaustion: "I would describe it as exhaustion. Um, yeah, like, exhaustion and a lack of capacity. Yeah, I think a big part of nursing is having the capacity to make space or hold

other people's emotions. Um, and I think like, at a certain point, you just can't hold their emotions and so like, you might say the words, but you don't you don't feel anything for them anymore. " (Emma).
9.The Effects of Compassion Fatigue on Caregivers
Compassion fatigue experience affect the nurses not only in their personal lives but in their workplace with patients and colleagues. They may become more negative and less collaborative, neglecting small patient needs or completely be withdrawing from patients (examples not included as there are too many).
10.The Reasons for Compassion Fatigue
Safety related: "And so I think sometimes when your own health and safety is in jeopardy, it's hard to, to give in the same way" (Judith).
Stability related: "And it's just like, Well, you know, you're telling us one thing, and then you're not following through. And then you're getting mad at us when we're frustrated over the and consistencies. And then you kind of have to turn around and go right back to the bedside and make the best experience of this for the parents. So, I just found that tough" (Anna).
Support related: "It was just an expectation to do more to have more patients, and there was a point where there was like a nursing freeze, or they just wouldn't fill the shifts. So, you had the same number of patients, but you had less nurses" (Mary)
11.Compassion Fatigue and Patient Engagement Styles in Caregivers
Disengaged: "I just don't feel like engaging any further than doing absolutely what needs to be done" (Samantha).
Need Balance: "Yes, but I think, too, like the trick is figuring out how to do it in a healthy way. Right, so that it's not dragging you down as well. And somehow, I think most of the time I figured out how to do that. Yeah, there are those patients still that I leave the room and I get teared up, and I have to go home and have a good cry. That's what I do. Yeah, it's I go home, and I have a good cry over it, if I need to" (Edith).
Wanting to engage: "I didn't have any concerns. It's not like I went back, and I was hesitant, or I felt disconnected. Like, one of the things that I find most rewarding about my career is that connection with the people" (Cyndi).
12.Compassion Fatigue Recovery Strategies Among Caregivers
Changing work: "That's when I noticed what emergency was, I couldn't be there full time. So, I had to look for another department because I was getting that compassion fatigue. And I noticed that in me as a person, wanted to go home as well, I was starting to get quite negative. And I wasn't providing good care. And if people don't think I care about them, it doesn't matter what I do, they're not going to feel like they're well taken care of. But I could see it in my care. So, I must step away. And that's actually when I went to labor delivery" (Mary)
Dealing with anxiety: “Do something that makes you happy: "if you need to eat the flatbread pizza, you eat the flatbread pizza. You need to get out of it. Don't feel guilty, do it" (Cyndi)
Debriefing and therapy: "But I'm also a big, I love therapy, I think everybody should be in therapy and I think it's absolutely appalling that our benefits don't cover therapy automatically" (Emma).
Exercise: "What I've actually found in the last few years to be also very helpful with compassion fatigue, stress, all those things is exercise. It sounds funny because I never thought I would be someone who run. I run about 30 kilometers a week now" (Judith)

Self-nurturing activities: "you just need to rest you need to nurture yourself, but even in the 70s and 80s, that wasn't even talked about nurturing yourself and taking care of yourself" (Jasmine).
Support from family and colleagues: "So what I've learned, you know, in, in my career and my life is the people who are in your life that you're your main support like your main tribe, the people who are the kind of like your main people that are your everyday people will you know, you speak them every month, you speak to them every week and you listen to when they support you and they validate you and they're supportive of you that is really helpful" (Judith).
Compassion from others: "Truthfully, my manager has been unreal, she's so good. She's very compassionate. Um, I do see the management side, though, where sometimes you speak and but aren't listened to, because they're getting, you know, it's coming down from their boss and their boss. So sometimes we do get caught in the middle" (Clare).
Spiritual outlook and self-reflection: "Take those moments to rest and just reflect on what is important. In a way it can be more positive, and also seek out help" (Juliette).
Recognizing the problem: "I think I'm still so I, this is so new for me to say that I have a problem and I'm just trying to wrap my head around it all, right? Because it's hard to be like, Hey, I'm not doing well. I'm so used to being that person for everybody else that, for me to be like, Hey, I'm not doing okay, I feel like a failure" (Chelsie).
Reconnecting with patients: "And then just kind of really focusing myself back into patient care and being empathetic and making sure that I'm not grouping people all in the same category. Everybody's experience is different and unique, and everybody has different needs, just keeping that in mind. And also, like, what would I want as a patient too? How would I want to be treated?" (Stella)
Break from work: "Probably because I think, if you're well rested, and you're eating well, and you're exercising, you're going to come from a much better place than if you're not doing that" (Lillian).

10. Appendix x: Anonymous Survey: Demographic Data and Results

Number of records in this query:	305
Total records in survey:	305
Percentage of total:	100.00%

Age

Answer	Count	Percentage
18-25 (A1)	20	6.56%
26-35 (A2)	102	33.44%
36-45 (A3)	92	30.16%
46-55 (A4)	46	15.08%
56 and older (A5)	43	14.10%
No answer	2	0.66%
Not displayed	0	0.00%

Marital status

Answer	Count	Percentage
Single (A1)	59	19.34%
Married (A2)	188	61.64%
Divorced/Separated (A3)	21	6.89%
Common law (A4)	30	9.84%
Widowed (A5)	2	0.66%
Do not wish to disclose (A6)	3	0.98%
No answer	2	0.66%
Not displayed	0	0.00%

Highest level of nursing education

Answer	Count	Percentage
Diploma/Certificate/College (A1)	125	40.98%
Baccalaureate (A2)	158	51.80%
Masters (A3)	16	5.25%
Doctorate (A4)	3	0.98%
Other (A5)	1	0.33%
No answer	2	0.66%
Not displayed	0	0.00%

What is your field of nursing

Answer	Count	Percentage
RN (A1)	227	74.43%
RPN (A2)	11	3.61%
LPN (A3)	65	21.31%
No answer	2	0.66%
Not displayed	0	0.00%

Number of years in direct care nursing

Calculation	Result
Count	302
Sum	4455.000000
Standard deviation	11.32
Average	14.75
Minimum	0.000000
1st quartile (Q1)	6
2nd quartile (Median)	12
3rd quartile (Q3)	21
Maximum	50.000000

Null values are ignored in calculations
Q1 and Q3 calculated using minitab method

Province or Territory of employment

Answer	Count	Percentage
British Columbia (A1)	66	21.64%
Alberta (A2)	147	48.20%
Saskatchewan (A3)	3	0.98%
Manitoba (A4)	2	0.66%
Ontario (A5)	82	26.89%
Québec (A6)	3	0.98%
New Brunswick (A7)	1	0.33%
Nova Scotia (A8)	1	0.33%
Prince Edouard Island (A9)	0	0.00%
Newfoundland and Labrador (A10)	0	0.00%
North Ouest Territories (A11)	0	0.00%
Yukon (A12)	0	0.00%
No answer	0	0.00%
Not displayed	0	0.00%

Employment status

Answer	Count	Percentage
Full time (A1)	178	58.36%
Part time (A2)	97	31.80%
Temporary (A3)	3	0.98%
Casual (A4)	22	7.21%
Leave of Absence (A5)	3	0.98%
Other (A6)	0	0.00%
No answer	2	0.66%
Not displayed	0	0.00%

Primary area of present practice

Answer	Count	Percentage
Medical / Surgical (A1)	71	23.28%
Maternal / Newborn (A2)	25	8.20%
Mental health / Psychiatric (A3)	21	6.89%
Pediatrics (A4)	7	2.30%
O.R. (operating room) (A5)	3	0.98%
Ambulatory care / Day surgery (A6)	9	2.95%
Geriatrics / Extended care (A7)	25	8.20%
R.R. (Recovery Room) (A8)	4	1.31%
Rehabilitative care (A9)	1	0.33%
Chemical dependency (A10)	0	0.00%
Several clinical areas / Float (A11)	3	0.98%
Community Health (A12)	11	3.61%
Occupational Health (A13)	2	0.66%
Critical / Intensive care (A14)	26	8.52%
Oncology (A15)	6	1.97%
Telepractice (A16)	2	0.66%
Emergency (A17)	42	13.77%
Dialysis / Nephrology (A18)	4	1.31%
Palliative care (A19)	2	0.66%
Other patient care (A20)	6	1.97%
Administration (A21)	2	0.66%
Education (A22)	5	1.64%
Research (A23)	1	0.33%
Other	24	7.87%
No answer	3	0.98%
Not displayed	0	0.00%

ID	Response
64	Pediatrics
69	Public Health
97	Rural nursing which includes ER, med/surg and L&D/postpartum
104	Covid testing. Urgent care
118	Surgical Service Outpatient Clinic
119	Nursing home
133	Bargaining Unit President
163	Epilepsy clinic
175	Inpatient Concurrent Disorders: Acute Psychiatric & Substance Dependency
182	street nursing
195	Trauma/Neurosurgery
197	Public Health
204	Family health(healthy babies healthy children program)
226	Small rural 18 bed full service hospital, I work all areas
270	Dermatology
279	Urgent csre
281	Interventional radiology
318	Infection Control
327	Obstetrics- labour and delivery
360	ICU and ER
385	NICU (so newborn and critical care)
409	1. Parish Nursing 2. Occ
410	Parish Nursing
425	Geriatric Mental Health Clinic

Have you worked or been working during the COVID-19 pandemic?

Answer	Count	Percentage
Yes (Y)	285	93.44%
No (N)	3	0.98%
No answer	17	5.57%
Not displayed	0	0.00%

According to your understanding, have you ever experienced compassion fatigue in your nursing career?

Answer	Count	Percentage
Yes (Y)	248	81.31%
No (N)	41	13.44%
No answer	16	5.25%
Not displayed	0	0.00%

According to your understanding, have you experienced compassion fatigue during the COVID-19 pandemic?

Answer	Count	Percentage
Yes (Y)	235	77.05%
No (N)	54	17.70%
No answer	16	5.25%
Not displayed	0	0.00%

What would you say compassion fatigue is?

Answer	Count	Percentage
Compassion fatigue is the experience of fatigue due to my inability to maintain a nurturing (caring) relationship with my patient caused by a limited reserve of compassion or the limited ability to care. (A1)	122	40.00%
Compassion fatigue is the experience of fatigue caused by the overload of empathic distress (distress and trauma caused by high amounts of empathy) (A2)	164	53.77%
Other	17	5.57%
No answer	2	0.66%
Not displayed	0	0.00%

ID	Response
104	Compassion fatigue is fatigue related to inadequate resources to meet demand of patients. Fatigue related to being on receiving end of constant complaints about things I have zero control over (wait times etc) and verbal abuse.
118	Compassion Fatigue: My reservoir is empty due to exhaustion, high demand, low return from senior leadership
133	The experience of caring for everyone around you until you can't possibly give anymore of yourself to anything or anyone.
134	At the beginning, when I lost my first patient, I was devastated. Now I am just annoyed thinking of the paperwork.
156	combination of the above (and for sustained periods)
170	not being able to provide suitable care with limited resources that don't line up with morals
174	Tired of exhibiting compassion due to excess requirements
198	... experience of fatigue as a result of too much fear of the unknown and the overwhelming feeling of having little / no control over the work environment leading to the feeling of having little / no energy to care
206	I would say the first but with "limited by the energy to mount a compassionate response from a wealth of compassion or lacking resources in place that create a limit on ability to care to the extent felt personally needed"
223	Compassion fatigue is just not caring about someone one way or the other..apathy
231	Both, cannot choose just 1
264	No other nurse for 50 beds
306	When you are not able to do and be your best
342	Compassion Fatigue is the experience of working in a setting with limited care resources that continuously denies the opportunity to improve its environment using financial reasons as an excuse. Compassion fatigue is working for an organization that does not focus on wellness or promoting its staff for a job well done. Compassion fatigue is the experience of already working in a setting where you give your all every day on a regular day, and then be expected to give more of yourself, your time and your energy due to a pandemic.
349	Both of the above
350	Compassion fatigue is a symptom of frustration and overload manifested as short temper, sharp comments or precieveds uncaring actions by people who expect unlimited patience adn caring from you

When I experienced (if experienced) compassion fatigue,

Answer	Count	Percentage
I withdrew from my patients (A1)	47	15.41%
I tried to reach out more to my patients (A2)	39	12.79%
I remained indifferent to my patients (A3)	54	17.70%
I initially tried to reach out but started withdrawing from my patients gradually (A4)	100	32.79%
Other	54	17.70%
No answer	11	3.61%
Not displayed	0	0.00%

ID	Response
112	Not experienced compassion fatigue
64	I found less tolerance for coworkers who were challenging the policies that were being implemented
70	I haven't experienced yet
86	Intermittently lacked empathy for patients
91	I initially tried to reach out but started withdrawing from not only my patients, but my friends and family too.
94	I initially had less empathy for my patients felt I didn't have the mental energy to support them. I needed to take time off to care for myself so I could give compassionate care to all my patients.
95	Talked to others nurses for support
96	Compassion fatigue + physical fatigue = less effective and empathetic nursing
104	I became less compassionate and more judgemental of patients.
118	I'm a professional. I maintained my high standards of care for patients and the team who works under me BUT, I have been isolating and giving less in my personal life.
122	N/a
124	I tried sharing my feelings with my workmates.
125	I provide the best care but after that there is no energy for anything. No compassion to my family, friends or myself
133	I took a leave from work to care for myself
134	I do my job but remain detached from my surroundings.
137	I had an autoimmune flare and had to take medical leave
140	No change in patient care provided
156	started to withdraw from patients (to a small degree), colleagues and also my family
161	We had decreased pts as OR closed rooms. We were not redeployed. So very quiet. It will be different in October 5 when we go to 120 percent capacity to increase back log of pts
176	I started calling in sick, and withdrawing from everyone.
203	N/A
204	All aspects of my life outside of my work suffer when I experience it, I do my work but feel depleted
206	I changed places of work. It was not a healthy environment for myself of the people I was caring for.
211	I was still empathetic most of the time but I really just wanted to be at home
215	Didn't effect pt care, effected my personal life and home relationships
228	N/A
232	I still continued to care my patients , never give up.
248	When dissatisfied with care I was able to provide patients in hospital, I changed to community care. There are times when taking care of palliative patients, that experience some fatigue and defer to my colleagues if feel patient care suffering
260	I was withdrawing from other people and angry with my work and upset that such bad things could happen to patients in a hospital as in a hospital is supposed to be a safe place where pain is not minimized to the degree that it should be
265	I took on all my patients and families distress and took it home with me
277	N/a
280	n/a
286	I didn't have any issues with this
288	The amount of support that can be given while working virtually is challenging

290	I found a sick day was taken, after all, if I don't care of me how present can I be for the busy Emerg department. I think I took 2 or 3 days in a 7 month period. Usually the lack of sleep contributed to that decision.
302	Didn't feel this
306	Each case is so different- and i react differently. I have always tried to do my best
318	- withdrew from staff and patients to some degree, initially
321	I continue to provide the same level of compassion to my patients at the expense of my personal life
330	Had to make a conscious effort to reach out to my patients and families.
332	I started supporting other nurses emotionally and researching COVID-19 topics to help others understand what was happening.
342	I continued to care for my patients the best way possible, but started to see things more clearly in that the organization I work for does not care about the wellness of its employees. We are just numbers and not people to them.
347	not experienced
362	I just didn't feel like I could give 100% to my patients because I felt mentally drained
383	none of the above
385	I don't think my patient interactions suffered by my mental health and family did
387	My care did not change at work
393	IRRITABLE WITH STAFF
396	irritability
397	I grew frustrated
415	Withdrew from patients. Became disgruntled at work. Unhappy.
427	I am a manager , keep to my office

The more frequent negative effect by compassion fatigue	**The less frequent negative effect by compassion fatigue**
Anger/Agitation	Apathy, burnout, confusion, emotional
Anxiety	Difficulty to focus,
Avoidance	Emotionally drained, fear, feeling hopeless
Exhaustion	Feeling overwhelmed, frustration
Fatigue	Guilt, headache, inability to sleep
Irritability	Indifference, lack of interest
Impatience	Mentally drained, overthinking
Lack of empathy	Stress, tiredness
Sadness	disconnected, dreading work
Depression	Physical fatigue

11. Appendix xi: Research Interview Participant Profiles

The participant profile is arranged alphabetically with a pseudonym per participant, which will be used in subsequent sections. The profile starts with demographic data followed by short synopsis on each participant with information on their formative and recovery experiences related to compassion fatigue.

Participant 01: Anna

Age:	26-35
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Six Years
Employment:	Full-time
Place of Work:	Hospital
Area of practice	NICU
Province	New Brunswick

Anna's motivation for becoming a nurse was her desire to connect. Acknowledging the suffering of the other is an important part of her practice of compassionate care. Anna had positive formative experiences and has a positive outlook towards universal compassion. She described her experience of compassion fatigue as a "*slow leak on the well*" or the "*well is empty* ."This was triggered by the death of children in her unit and the inability to grieve after those losses. Her recovery strategies included antidepressant drugs, self-care and connecting back to people. Anna experienced COVID-19 as an acute stressor related to her compassion fatigue experience.

Participant 02: Cyndi

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors

Experience:	Eight Years
Employment:	Part-time
Place of Work:	Hospital
Area of practice	ICU
Province	Alberta

Cyndi’s motivation to study nursing was the desire to connect to people. She had positive formative experiences and has a positive approach to universal compassion. As part of her compassionate care, she wanted to de-stigmatize the dying process. She explained her experience of compassion fatigue as the “*bucket is empty*” and was triggered by three to four deaths on the same day in her ICU despite the best efforts of the staff. Her recovery strategies included completely shutting off from work and reflective practice. Cyndi's compassion fatigue experience was unrelated to the COVID-19 situation.

Participant 03: Chelsey

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Seven Years
Employment:	Part-time
Place of Work:	Hospital
Area of practice	Hemodialysis
Province	British Columbia

Chelsey’s motivation to become a nurse was propelled by the desire to connect with others. She had positive formative experiences and loved the idea of unconditional love. Advocating for patients was one of the main components of her compassionate care. Chelsey explained compassion fatigue as not having the “*energy anymore to care, my tank is empty*," and this experience was triggered by the death of two patients in her unit who were of similar age and family background to her. Her recovery strategies included shutting off from work and connecting with her family, especially her husband. COVID-19 related stress was an acute stressor concerning her compassion fatigue experience.

Participant 04: Celine

Age:	46-55
Gender:	Female
Field:	LPN
Education:	Diploma
Experience:	16 Years
Employment:	Full-time
Place of Work:	Long Term Care
Area of practice	Geriatric and Palliative Care
Province	British Columbia

Celine joined nursing being motivated by the desire to connect to people. Her formative experiences were positive, and she has a positive outlook on universal compassion. Considering patients like her own family is the way she practices compassionate care. She described compassion fatigue as the "*inability to care for patients the way it should be*," which was mainly triggered by the uncertainty of the COVID-19 related situation. Celine's recovery strategies included taking breaks from work, clearing boundaries, connecting with her family, and having a desire to connect back to patients. Her compassion fatigue experience happened during COVID-19, mostly due to COVID-19.

Participant 05: Clare

Age:	26-35
Gender:	Female
Field:	LPN
Education:	Diploma
Experience:	Six Years
Employment:	Full Time
Place of Work:	Hospital
Area of practice	Acute Care Surgery
Province	Alberta

Clare was attracted to nursing by the need to take care of and/or protect others. Her formative experiences were not very positive, and she did not articulate a position on universal compassion or unconditional love. Compassionate care for her meant the protection of the patients from anxiety and "*giving a little bit of your heart*" to them. Clare explained compassion fatigue as an "*inability to empathize with other*s' pain." This experience was triggered by the loss of her father during the pandemic. Her recovery strategies included exercise and taking time for herself. COVID-19 was an acute stressor in her experience of compassion fatigue.

Participant 06: Denice

Age:	56+
Gender:	Female
Field:	RN
Education:	Masters
Experience:	45 Years
Employment:	Full-time
Place of Work:	University
Area of practice	Nursing Education/Public Health
Province	Alberta

Denice came to nursing to contribute to society, and her formative experiences were positive. She did not have a very positive outlook on universal compassion. Compassionate care for her was a desire to give to patients and students who are reflective practitioners. Denice described compassion fatigue with the words "*fatigue and just draining,"* which was caused by overwork and COVID-19 related general tiredness. Denice's recovery strategies were eating, sleeping, and spending time with her family. Her experience of compassion fatigue was related to COVID-19.

Participant 07: Diew

Age:	56+
Gender:	Female

Field:	RN
Education:	Bachelors
Experience:	33 Years
Employment:	Full-time
Place of Work:	Hospital & Union
Area of practice	Post Anesthetic Care Unit & Union
Province	Ontario

Diew joined nursing to satisfy a desire for human interaction and connection. Her formative experiences were positive, and she has a positive outlook towards universal compassion. Diew described compassionate care as providing a sense of "*complete presence*" to the patient. She described her experience of compassion fatigue as a tangible experience of feeling "*empty-ish*." She speaks of it as the heightened response to a heightened experience of giving like the firefighter. Her experience was triggered by traumatic events in her work and overwork. Recovery strategies for Diew were to connect with family and friends. Her experience of compassion fatigue was prior to the start of the COVID-19 pandemic.

Participant 08: Danielle

Age:	46-55
Gender:	Female
Field:	LPN
Education:	Diploma
Experience:	31 Years
Employment:	Part-time
Place of Work:	Hospital
Area of practice	Acute Care-Hearing Test-Children
Province	Alberta

Danielle joined nursing to care and be effective in her service for others. She described a stable and safe environment growing up and spoke of universal compassion as something like multiculturalism. Danielle thought of compassionate care as "*being present to patients*." She

described compassion fatigue as generalized tiredness because of "*caring for everyone but not caring for oneself*," and this experience was triggered by worry over personal effectiveness, lack of support, and the job's repetition. Prioritizing and balancing was her way to deal with compassion fatigue. Her compassion fatigue experience was unrelated to the pandemic.

Participant 09: Emma

Age:	26-35
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	One and Half Years
Employment:	Full-time
Place of Work:	Hospital
Area of practice	Labour and Delivery
Province	Ontario

Emma joined nursing, driven by the desire to advocate and protect people. Her formative years were not very positive, and she does not have a very positive outlook on universal compassion. Compassionate care for Emma appeared to make sure that patients are not anxious, as it may also affect her work with the patient. Emma described compassion fatigue as "*exhaustion and the lack of capacity to hold others' emotion*," which was triggered by conflicts and issues with doctors on duty and COVID-19 related stress. Her recovery strategies included thinking of other jobs, exercise, and personal therapy. The COVID-19 pandemic partially influenced Emma's compassion fatigue experience.

Participant 10: Edith

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	20 Years

Employment:	Part-time
Place of Work:	Out-patient
Area of practice	Oncology
Province	British Columbia

Edith joined nursing motivated by the desire to take care of, and connect with, people. She had positive experiences during her formative years, her parents valued compassion, and she had a positive outlook towards universal compassion. Edith described her experience of compassion fatigue as "*my tank was empty*," and this experience was triggered by the personal loss of her father to cancer and the overwhelming demands from patients during COVID-19. Her recovery strategies were taking time away, reflection and reconnection with patients to the extent of sharing some of her personal stories on cancer. Edith's compassion fatigue experience happened during COVID-19.

Participant 11: Heidy

Age:	56+
Gender:	Female
Field:	RN
Education:	Diploma
Experience:	45 Years
Employment:	Part-time
Place of Work:	Hospital
Area of practice	NICU, Pediatrics & Obstetrics
Province	Québec

Heidy was motivated to join the nursing profession through her desire to care, connect and protect people. She had positive formative experiences, her parents valued compassion, and she had a positive outlook on universal compassion. Heidy described her experience of compassion fatigue as "*I am empty*," and this experience was triggered by the deaths of children in her unit and the inability to grieve them before starting with another assignment. Her recovery strategies included going part-time, taking a day off after 12-hour shifts and reconnecting with her family. The COVID-19 pandemic did not influence Heidy's compassion fatigue experience.

Participant 12: Jasmine

Age:	56+
Gender:	Female
Field:	RN
Education:	Diploma
Experience:	10 Years
Employment:	Casual
Place of Work:	Church
Area of practice	Parish Nurse
Province	Ontario

Jasmine came to nursing motivated by a desire to care for, and connect with, people. She had positive formative experiences and has a positive outlook on universal compassion. Jasmine explained compassionate care as being "*totally present*" for the patient. She described her experience of compassion fatigue as "*the inability to see and care for people*" due to COVID-19 restrictions. Her recovery strategies included using spiritual outlook, reflection and nurturing oneself. Her experience of compassion fatigue is due to the COVID-19 related situation.

Participant 13: Joyce

Age:	46-55
Gender:	Female
Field:	RN
Education:	Diploma
Experience:	24 Years
Employment:	Full-time
Place of Work:	Primary Care
Area of practice	Community Care
Province	British Columbia

Joyce entered nursing motivated by the desire to connect to people. She had very positive growing up years and has a positive outlook on universal compassion. Joyce described compassion fatigue as "*not having the energy to connect to people the way I used to*" due to the

COVID-19 related chaos and non-compliance of patients. Her recovery strategies were talking about it, using spiritual care and reconnection. Joyce expressed her desire to come back to work after her experience of compassion fatigue. Her experience of compassion fatigue was influenced heavily by COVID-19 related situation.

Participant 14: Joslyn

Age:	26-35
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Three Years
Employment:	Full-time
Place of Work:	Hospital
Area of practice	Emergency
Province	British Columbia

Joslyn speaks about the individual's duty of care, and it appears to be the motivation for her joining the nursing profession. She did not relate to her childhood formative experiences and did not have a positive outlook on universal compassion. Her description of compassion fatigue was that the "*gasoline tank goes empty of empathy*" due to the non-compliance of patients to health protocols and COVID-19 stress. Joslyn's recovery strategies included being more task-oriented and looking to change jobs. Her experience of compassion fatigue has been influenced by the COVID-19 pandemic.

Participant 15: Jacob

Age:	26-35
Gender:	Male
Field:	RN
Education:	Bachelors
Experience:	One and Half Years
Employment:	Full Time

Place of Work:	Hospital
Area of practice	Cardiac ICU & Labour and Delivery
Province	Alberta

Jacob came to the nursing profession with a desire to save and have human interaction. He spoke of professional care and its demonstration in the nursing profession. Jacob's formative years were positive, and he agrees with the concept of universal compassion, qualifying it as reflective compassion and not blind compassion. He spoke of compassion fatigue as the experience of "*constantly combating high demand can be tiring due to high demand on you*." The triggers for this experience were an exhausting workload and the demands of different health protocols related to the pandemic. Jacob's compassion fatigue experience was during COVID-19 and due to COVID-19.

Participant 16: Judith

Age:	36-45
Gender:	Female
Field:	LPN
Education:	Diploma
Experience:	13 Years
Employment:	Part-time
Place of Work:	Hospital
Area of practice	Maternal
Province	Alberta

Judith came to nursing due to her desire to give to people. She had positive formative years and has a positive outlook on universal compassion/unconditional love. Her idea of compassionate care includes caring for small things, the intentional use of compassion and following the golden rule of the Bible. Judith describes her experience of compassion fatigue as "*when you are giving so much, you lose some ability to give*" due to work overload and a pre-occupation with safety during the pandemic. Her recovery strategies include support and connection from people. Judith's compassion fatigue experience was during COVID-19 and caused by COVID-19.

Participant 17: Juliette

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Eight Years
Employment:	Full Time
Place of Work:	Hospital
Area of practice	Nephrology
Province	British Columbia

Juliette entered the nursing profession motivated by the desire to advocate for people. Her childhood years had much suffering, and there was a strong influence of religion in her life. She has a positive outlook on universal compassion. Compassionate care for her is the ability to relate to others with kindness. She describes her experience of compassion fatigue with the imagery of a "*burning candle*," which represented her effort to give care to patients, which was obstructed by management, making her feel helpless. Her recovery strategies included advocating for patients and sharing her situation with people who may have gone through similar contexts. Juliette's experience of compassion fatigue was unrelated to the COVID-19 pandemic.

Participant 18: Kim

Age:	46-55
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	20 Years
Employment:	Part-Time
Place of Work:	Health Link
Area of practice	Not Specific
Province	Alberta

Kim came to the nursing profession motivated by her desire to advocate for people. Her formative years were not very positive; however, she found her adult life having more experiences of compassion. Even though she does not have a very positive opinion on universal compassion, she keeps a very positive outlook on compassion. For Kim, compassionate care means "*genuinely being there*" for people. She describes compassion fatigue as the "*difficulty of caring for oneself as one cannot take eyes away from patients [and as a result] not being able to be available to patients*." This experience for Kim is caused by moral distress, a lack of support at the workplace, and COVID-19 related fears. Kim's recovery strategy is to reconnect with people around her.

Participant 19: Lydia

Age:	56+
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	41 Years
Employment:	Part-time
Place of Work:	Long Term Care
Area of practice	Geriatrics
Province	Ontario

Lydia joined nursing with the desire to advocate for people. Her formative experiences appeared negative, but she has a somewhat positive outlook towards universal compassion. This may be based on the strongly expressed spiritual affiliation. Compassionate care for her is to "*know the patients to help with her strategies to help them*." She describes compassion fatigue as "*given, given and do not have anything left*" due to an unsupportive environment and experiencing difficult stories. Lydia's recovery strategies include leaving her job and self-care activities. Lydia's compassion fatigue experience was unrelated to the COVID-19 pandemic.

Participant 20: Lillian

Age:	56+

Gender:	Female
Field:	RN
Education:	Diploma
Experience:	34 Years
Employment:	Full Time
Place of Work:	Community
Area of practice	Geriatric Psychiatry
Province	Alberta

Lillian was drawn to nursing, motivated by her desire to care for other people. During her formative years, she was mostly a caregiver to others. She did not express any opinion on universal compassion. The experience of helplessness triggered her experience of compassion fatigue as she was not being supported at work and acknowledged in her caring. For Lillian, recovery measures included leaving the workplace, self-care, and connecting with people. Her experience of compassion fatigue was unrelated to COVID-19.

Participant 21: Mary

Age:	26-35
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	12 Years
Employment:	Casual
Place of Work:	Hospital
Area of practice	Emergency/Labour & Delivery
Province	Alberta

Mary joined the nursing profession driven by her desire to connect with other people. She had positive formative years and expressed a strong sense of spiritual belief. She has a positive outlook on universal compassion. Seeking to understand difficult patients was a feature of her compassionate care. She described compassion fatigue as the "*inability to look beyond my own needs*." This was triggered by the COVID-19 related lack of workplace support and a personal

bias toward certain patients. Mary's recovery strategies included taking a break and reconnecting with her children and family. The COVID-19 pandemic partially caused Mary's experience of compassion fatigue.

Participant 22: Nora

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Seven Years
Employment:	Full-time
Place of Work:	Hospital
Area of practice	Medical
Province	Alberta

Nora was inspired to join the nursing profession by her desire to connect to patients. Her formative years were not very positive, as she described much suffering. Nora has some understanding of universal compassion. For her, compassionate care is the "*deep appreciation for a patient's situation*." Nora describes compassion fatigue as "*not able to meet the human connection need of patients*" due to the high demand for jobs during COVID-19 and other traumatic triggers. Nora's strategies to deal with compassion fatigue included connecting with friends, support networks and balancing life and work. Her experience of compassion fatigue was during the COVID-19 pandemic and was partially caused by the pandemic.

Participant 23: Penny

Age:	56+
Gender:	Female
Field:	RN
Education:	Diploma
Experience:	20 Years
Employment:	Part-time

Place of Work:	Hospital
Area of practice	Emergency
Province	Ontario

Penny joined nursing with the intention of helping people. She experienced very positive formative years and has a positive outlook on unconditional love. She thinks of compassionate care as "*tailoring her care to the patient as much as possible*." She describes compassion fatigue as "*I have nothing else to give, my heart is draining*," and this experience was caused by fear and overwork during COVID-19. Penny's recovery strategies included taking time off and relaxing. Her compassion fatigue experience is completely related to the COVID-19 pandemic.

Participant 24: Ruby

Age:	26-35
Gender:	Female
Field:	LPN
Education:	Diploma
Experience:	10 Years
Employment:	Full-time
Place of Work:	Supported Living
Area of practice	Mental Health
Province	Alberta

Ruby entered the nursing profession to help people. She enjoyed her positive formative years but did not articulate her idea of universal compassion. For her, compassionate care means that patients trust enough to communicate with her through her responses to them. She describes compassion fatigue as "*it's kind of like you don't care*," which is caused by overwork, fear of exposure to the virus and isolation from society. Ruby's recovery strategies included taking a break and sleeping. Her experience of compassion fatigue was entirely COVID-19 related.

Participant 25: Stella

Age:	36-45
Gender:	Female

Field:	RN
Education:	Bachelors
Experience:	16.5 Years
Employment:	Full Time
Place of Work:	Hospital
Area of practice	Obstetrics
Province	British Columbia

Stella wanted a career that connected her to people, and nursing seemed perfect. She enjoyed a happy childhood and had a positive outlook on compassion. Compassionate care for her is the "*individualized care and relationship with patients*." She described her experience of compassion fatigue as "*the ability to be compassionate is drained or depleted*," which is caused by overwork, high and sustained demand on limited resources and the inability to say no. Stella's recovery strategies included taking time off, reflective practices and reconnecting with patients. Stella's experience of compassion fatigue is partially related to the COVID-19 pandemic.

Participant 26: Sarah

Age:	36-45
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Seven Years
Employment:	Full Time
Place of Work:	Public Health
Area of practice	Community Care
Province	Ontario

Sarah entered the nursing profession motivated by a desire to be connected to people. Her formative years were positive, and she has a positive outlook on universal compassion. She thinks of compassionate care as “*doing extra [and going] over and beyond*." Compassion fatigue for her is her experience of the "*constant giving and feeling of compassion is burning me out*." This experience is caused by oversensitivity, lack of workplace support and giving everything all

day. Sarah's recovery strategies include taking a break connecting with co-workers and her husband. Sarah's compassion fatigue experience is not significantly related to COVID-19.

Participant 27: Samantha

Age:	26-35
Gender:	Female
Field:	RN
Education:	Bachelors
Experience:	Seven Years
Employment:	Part-Time
Place of Work:	Psych Hospital
Area of practice	Mental Health and Addictions
Province	Ontario

Samantha is not clear about what motivated her to enter the nursing profession. She had somewhat positive formative experiences, and she appeared to be guided by some sense of religious obligation. For her, compassionate care meant doing "*extra and beyond*." She described compassion fatigue as "*I do not have any more to give due to lack of self-care*." This experience was triggered by a lack of safety and workplace support. Her recovery strategies are travel and changing jobs. Samantha's compassion fatigue experience is influenced by some of the COVID-19 related issues, such as lockdown, fear of exposure and work overload.

12. Appendix xii: Email communication for member check

Dear -- ,

Thank you for your participation in my doctoral research on compassion fatigue. As promised, I am sending you a de-identified transcribed document of your interview conversation for your kind review. The main purpose of the review is to make sure the credibility of the data by assuring that the researcher is not adding extra data or deleting any relevant data. (please be advised that I have removed identifiable data including your name, names of some of the institutions and events in your personal life that the public may identify.)

I also would like to let you know that the recorded conversation was cleaned for clarity (meaning sounds like “mm”, repetitions and some sentence construction are edited), however it retains mostly the nature of our conversation (spoken language). You may find your conversation different from written communication and that is not a matter of concern at all.

Would you please have a look at the document and let me know if you are fine with the use of this document in this research. Kindly review it and let me know if you have any suggestions or further comments on the subject? If you don’t find a need to review you can let me know that too. (Please don't make changes to the document directly)

As I have allotted two weeks for this process, I would consider this data acceptable for the research if I don’t hear from you otherwise within two weeks.

***The attached document is password protected. I will send you the password in the next email.**

Thanks for your support to this research
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