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Nurses' Lived Experiences of Coping with the Long-Term Effects of Compassion Fatigue from the COVID-19 Pandemic

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This is to certify that the doctoral dissertation by

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Abstract

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MSN, Mercy College, 2014

ADN, Farmingdale State College, 2006

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing Education

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Abstract

In 2019, health care systems were unprepared for the needs of COVID-19 patients in terms of personal protective equipment, ventilators, and nurses who were the frontline caretakers. Nurses often experience compassion fatigue because of physical, mental, and emotional distress when caring for others. Compassion fatigue had a detrimental impact, both professionally and personally, on nurses during the pandemic of COVID-19. Many researchers studied nurses during the time of the pandemic but what is missing is the long-term effects of compassion fatigue who cared for COVD-19 patients. The purpose of this qualitative research study was to describe the experiences of nurses coping with the long-term effects of compassion fatigue from the COVID-19 pandemic. The theoretical framework used to guide this study was Lazurus and Folkman's theory of stress and coping. The overarching research question was "What are nurses' lived experiences of coping with the long-term effects of compassion fatigue of the COVID-19 pandemic?" Descriptive phenomenology was the approach that was used to answer the research question, drawing participants through a convenience sample of a New York State nursing organization. The data were analyzed using Colaizzi's method of data analysis. The results of this study indicated that nurses wanted and needed to tell their stories about their fears and stresses, and how they survived and coped, negatively and positively. Both nurses and health care organizations may benefit from the results of this study and how to best support and care for nurses who experience compassion fatigue.

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Dedication

First and foremost, I dedicate this dissertation to my first nurses—my mother and father. While they were not with me physically during this time, I could always sense their support and love. I also dedicate this dissertation to my brother, Thomas, my sister-in-law, Kerri, and my three beautiful and amazing nephews, Thomas, Sean, and John. I am also profoundly grateful to my Aunt Carol, who has always supported and encouraged me. Finally, I want to thank all my family and friends, especially Joanne and John, Anthony and Tom who stayed on the course with me during these years, even when they mocked me when I told them I was pursuing another degree.

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I cannot begin to thank Dr. Donna Bailey, Dr. Mary Martin, and Dr. Maria Ojeda for their tremendous support, guidance, and insights to help me reach the point of completing this dissertation. These three amazing faculty members will always have my heartfelt gratitude.

I want to thank the 18 nurses who participated in this study and openly shared their stories and experiences. I also want to thank the nurses who offered to participate in the study. Finally, I want to acknowledge all the nurses who cared for COVID-19 patients during times of uncertainty, fear, and distress. Tell your stories as people need and want to hear them.

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Chapter 1: Introduction to the Study

With the COVID-19 pandemic, health care organizations dealt with unprecedented numbers of illnesses and deaths, taking a tremendous toll on health care workers who cared for these patients and their families while caring for themselves and their families (Shreffler et al., 2020). Nurses, the most significant single health care professionals in caring for COVID-19 patients throughout the pandemic (Sadang, 2021), were at the forefront of caring for patients despite the high acuity and unforeseeable outcomes or an end to the pandemic, which had a significant toll on their physical and emotional well-being (Robinson & Stinson, 2021). The gap identified in the literature was the long-term effects of nurses coping with compassion fatigue from the pandemic and the impact on their professional and personal lives. I aimed to understand how nurses individually interpreted the long-term effects of compassion fatigue on themselves and what lasting effects compassion fatigue from COVID-19 has on them presently. No two individuals experience traumatic and horrific events the same way. In other words, the nurses' experiences and internalization of the pandemic is distinctive, and how they dealt with the events may be understood uniquely.

Conducting a descriptive qualitative study offered insights into the long-term effects of nurses coping with compassion fatigue from the pandemic and the tragic effects they experienced first-hand during these traumatic times. There is current research on COVID-19 and the nurses' experiences during this time but no research on the pandemic's long-term effects on nurses' lives (Ashley et al., 2021). This study has the potential to add to the existing literature on compassion fatigue for nursing practice in

general and provide insights to help nurses in the event of future pandemics (Robinson & Stinson, 2021). Additionally, I examined what health care organizations could do to support nurses as the pandemic continues to exist on some level and any future pandemics. The potential social implication of this study includes adding insights into the day-to-day nursing experiences of coping with compassion fatigue, skills nurses can implement to cope when experiencing compassion fatigue, and the possible long-term effects of compassion fatigue. Given that pandemics do occur and will occur in the future, knowledge gained will help the nurses during these times, provide evidence-based data to improve patient care, and, most importantly, provide coping skills and tools for nurses (Robinson & Stinson, 2021).

The purpose, background, theoretical framework, and nature of the study are examined in this chapter. As a nursing phenomenon related to the pandemic, compassion fatigue is discussed as well as how nurses coped during these unique and challenging times and the long-term effects the pandemic had on their lives, both professionally and personally. The chapter also includes the purpose of the study, research questions, and the nature of the study. Finally, definitions, assumptions, and limitations are provided.

Background of the Study

Compassion fatigue is common among many health care disciplines, particularly in nursing (Hensen, 2020). Compassion fatigue is also referred to as secondary traumatic stress, burnout, vicarious trauma, and victimization (McGibbon et al., 2010). Compassion fatigue also affects other caring professions and people-centered care, such as firefighters, emergency medical technicians, and law enforcement officers (Grant et al.,

2019).

Compassion fatigue, also known as secondary traumatic stress, was first identified in the 1950s by nurses, firefighters, and first responders (Milligan & Almomani, 2020) and is often explicitly associated with the nursing profession (Sacco & Copel, 2018). In 1992, Joinson considered compassion fatigue a variation of burnout, often leading to anger and apathy (Ledoux, 2015). The term compassion fatigue was first defined by Joison in 1992 with implications for nurses' physical, psychological, and emotional health, leading to personal stress, pressure, and distress affecting their work and lives (Hamilton, 2018). More specifically, Joinson concluded that compassion fatigue resulted from the nurses' ability to care for others. In 1995, Figely, a psychologist, considered secondary traumatic stress disorder (STSD) synonymous with compassion fatigue (Cross, 2019). Figley defined compassion fatigue as an emotional "contagion" where caregivers are personally traumatized because of another individual's traumatization and a lack of self-care (Todaro-Franceschi, 2019). Coetzee and Klopper (2010) further defined compassion fatigue in terms of nursing as the outcome of continuous exposure to stress that goes beyond the nurse's ability to endure and persevere in difficult situations.

Compassion fatigue is pervasive in health care workers and nurses who often care for acutely ill patients for extended periods (Xie et al., 2021), adversely affecting nurses' professional and personal lives (Jun et al., 2021). Burnout affects an estimated half of the 4 million nurses in the United States (National Academies of Sciences, Engineering, and Medicine, 2019) and 1 in 10 nurses worldwide (Woo et al., 2020). Compassion fatigue has many adverse effects on nurses' health, including heart disease, chronic pain,

gastrointestinal disease, depression, including death (Salvagioni et al., 2017). In terms of their professional lives, nurses who suffer from compassion fatigue often report elevated levels of emotional exhaustion, which results in medication errors and impacts patient safety (Jun et al., 2021; Monsalve-Reyes et al., 2018).

Compassion fatigue also harms health care organizations, patient care, and outcomes. Compassion fatigue impacts health care overall regarding employee turnover, loss of staff, medication errors, poor quality of care, poor patient outcomes (Jakimowicz et al., 2018), and poor nurse-patient relationships (Xie et al., 2021). Compassion fatigue hurts health care systems and the culture of patient safety, resulting in higher incidences of pressure ulcers, patient falls, and medication errors (Alhardi et al., 2020). Elevated levels of compassion fatigue among nurses can also result in avoidance of working in high-acuity areas such as critical care units, resulting in a nursing shortage (Wijdenes et al., 2019). Additionally, the impact of nurse-related compassion fatigue on the organization can result in high staff turnover rates and increased sick calls, causing financial difficulties and poor patient care (Wijdenes et al., 2019). Nearly 20% of first-year nurses leave the profession in the first year of practice due to compassion fatigue and burnout (Kelly & Todd, 2017).

In 2019, the world experienced the COVID-19 pandemic (Sheposh, 2021) due to a severe respiratory syndrome called SARS-CoV (Halalau et al., 2021; Robinson & Stinson, 2021). The COVID-19 pandemic led to significant lockdowns and quarantines (Short et al., 2018). Health care organizations and personnel were not prepared for the subsequent sickness, death, and the inability to care appropriately for these individuals in

terms of staff, resources, and facilities (Frush et al., 2021). The World Health Organization (WHO) estimated that COVID-19 infected over 189 countries, resulting in more than 133.38 million cases worldwide, of which 2.89 million people died and 75.86 million individuals recovered (Sheposh, 2021). However, rates of infection and mortality are underestimated because of inaccurate reporting due to deaths of people living alone, the homeless, or patients not tested for COVID-19 (Turale, 2021).

The stressors of COVID-19 impacted health care workers' physical well-being levels and caused psychological problems such as sleep issues, depression, and anxiety due to the high acuity of the patients and the numerous deaths from the coronavirus (Mehdi et al., 2020). Nurses also had to deal with the possibility of contracting the coronavirus themselves, infecting colleagues, and protecting their family members who could be exposed to COVID-19 and possibly die from the coronavirus (Turale, 2021). Further, in a study of 210 nurses who worked during the pandemic, 4.8% of the nurses intended to remain in the nursing profession and 24.8% of nurses intended to leave nursing, which may be representative of the nursing profession in general (Said & El-Shafei, 2021). Caring for COVID-19 patients, even with slight symptoms of the virus, generated fear and apprehension among the nurses who considered quitting their jobs and leaving the profession (de los Santos & Labrague, 2021).

COVID-19 is a topic for many studies and interest within the health care profession and other industries, nationally and globally (Arcadi et al., 2021; Ashley et al., 2021; Kanno, 2021; Li et al., 2020; Marcomini et al., 2021; Roy & Das, 2020; Sheek-Hussein et al., 2021; Yomoda & Kurita, 2021). The gap identified in the literature was

the nurses' experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic. Though there was research on nurses' perceptions of working during COVID-19 and their experiences, there was no study on the long-term effects of nursing coping with compassion fatigue from the pandemic. The current study focused on the impact of compassion fatigue on nurses related to the COVID-19 pandemic and the long-term effects of compassion fatigue both professionally and personally as nurses related their personal stories and experiences.

Problem Statement

Nurses are compassionate caregivers who care for people at their most vulnerable times of sickness, often leading to compassion fatigue (Babaei & Horatian, 2020; Bleazard, 2020). Compassion fatigue can impact nurses' physical, emotional, spiritual, and intellectual well-being (Upton, 2018). Compassion fatigue can lead to emotional frustration, helplessness, and difficulty meeting patients' needs (Bleazard, 2020). This phenomenon impacts nurses at all levels of care, including skilled facilities nurses (Steinheiser et al., 2020), oncology nurses (Ortega-Campos et al., 2020), pediatric nurses, and critical care nurses (Bleazard, 2020). Compassion fatigue can also impact health care organizations regarding loss of staff, medical errors, and poor patient outcomes (Jakimowicz et al., 2018). Nurses need coping skills to combat compassion fatigue to maintain optimal personal health and effective patient care. Knowledge of compassion fatigue is necessary to develop coping skills (Lee et al., 2019), which range from balancing work/life (Seymour, 2020), proper nutrition, adequate sleep, healthy exercise

(Slatten et al., 2020), and practicing mindfulness (LeMoine et al., 2020) all of which are helpful even under ordinary circumstances of caring for patients.

Nurses experience compassion fatigue on many levels and at different times, but none has been more significant than during the world pandemic of COVID-19. During the height of the pandemic, nurses faced emotional and physical suffering with unprecedented high death rates (Kemerer, 2020). A gap identified through a literature review was the long-term effects of nurses coping with compassion fatigue from COVID-19 and the impact on their professional and personal lives dealing with exponentially high acuity and numerous deaths. The CDC (2022) estimated over 30 million cases of COVID-19 since 2019, with over 500,000 deaths in the United States. There are continuously new and resistant strains of COVID-19 variants developing worldwide, such as in the United Kingdom and India, which are significant concerns for higher infections and mortality rates that negatively impact healthcare (Duong, 2021). Epidemiologists predicted that pandemics are rising with more virulent pathogens (MacKenzie, 2017). Consequently, nurses may have to deal with more than one pandemic in their careers (Robinson & Stinson, 2021), resulting in a nursing shortage, hesitancy in caring for patients with severe communicable diseases, and a lack of desire to work in acute health care settings. Understanding how nurses coped with compassion fatigue during the pandemic may help identify effective practices for the future to maintain healthcare workers' optimal personal health and, more importantly, maintain effective and optimal patient care.

Purpose of the Study

The purpose of this qualitative descriptive phenomenology study was to understand the long-term effects, both professionally and personally, of nurses who experienced compassion fatigue during the COVID-19 pandemic and the effects on their professional and personal lives. Compassion fatigue is a challenge that nurses experience under normal working circumstances (Pehlivan & Güner, 2020). However, nurses experienced compassion fatigue at exponential levels during the pandemic because of patient acuity and mortality. The study followed a qualitative methodology to comprehend nurses' lived experiences. This research contributes to the body of knowledge and may help develop effective support programs for nursing staff dealing with compassion fatigue during a pandemic and normal day-to-day experiences of compassion fatigue.

Research Question

The phenomenon I studied was compassion fatigue and the long-term effects of nurses who coped with compassion fatigue for COVID-19. Compassion fatigue is a well-known experience amongst nurses who care for acute patients and enter the patient's lives at difficult times. COVID-19 was a strenuous time for nurses physically and emotionally (Steinheiser et al., 2020). The following research question guided this qualitative study: "What are nurses' lived experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic?"

Theoretical Foundation

The theoretical framework for this study was Lazarus and Folkman's theory of stress and coping, which was used to understand how individuals deal with stress internally and externally and how stress affects individuals' well-being (Etchin et al., 2020). Richard S. Lazarus and Susan Folkman, both psychologists, developed the theory in 1984 and suggested that stress and coping are inter-relational between individuals and their environments, which is described as a transactional relationship (Folkman et al., 1986). The foundation of the theory is that individuals respond to their environments and what is perceived as positive or negative, which then initiates an emotional response on how to deal with the situation (Biggs et al., 2017). The interpretation of stress is based on personal values, commitments, aspirations, and beliefs (Folkman et al., 1986). The theory includes all stressors: physical, emotional, psychological, and cognitional (Mustafa et al., 2020). The first aspect of the theory is realizing and determining if the stressor is good or bad and if the stressor is within one's control. When an individual makes the appraisal, the second factor is coping with managing the stress, leading to adaptation, which can be positive or negative (Etchin et al., 2020). The stress, coping, and adaptation theory contains three factors: compassion fatigue (stress), how one manages (coping), and adjusting to the situation (adaption). Lazarus and Folkman's transactional theory of stress and coping aligned with this study as nurses experienced tremendous stress during the peak times of COVID-19 and needed to cope with the high acuity of patients and exorbitant amounts of death. Nurses were the frontline healthcare providers for COVID-19 patients, and nurses needed to find a means to adapt to the times professionally for

themselves and their patients, caregivers, and their family members. Adaptation creates a sense of stability amid these encounters (Folkman et al., 1986). A more in-depth analysis and application of Lazarus and Folkman's stress, coping, and adaptation theory is presented in Chapter 2.

Nature of the Study

A qualitative methodology was needed to understand the perceived long-term effects of the nurses who experienced compassion fatigue in caring for COVID-19 patients, which could not be analyzed as effectively with a quantitative design. Quantitative designs are used to examine causality and probability, whereas qualitative designs allow researchers to hear and study the participants' lived experiences for meaning and understanding (Polit & Beck, 2017). This study was based on qualitative research protocols with a descriptive qualitative design to understand nurses' experiences caring for COVID-19 patients during the pandemic. The interview process allowed the participants to describe and share their experiences caring for COVID-19 patients and the long-term effects of compassion fatigue on their lives. The qualitative design and analysis offered insights by generating common themes and categories from interviews, prompting descriptions of how the nurses coped, appraised their experiences, and coped with the emotional strain of compassion fatigue from the pandemic. Using a descriptive phenomenology method allows the researcher to understand the "experiences of the individuals studied and their common experiences with the phenomenon" (Creswell et al., 2007, p. 255).

The target population for this study was registered nurses employed during the height of the COVID-19 pandemic, specifically from January 2020 to March 2021. Convenience sampling was used with recruitment materials advertised on a New York State nursing organization social media with a screening criterion to determine if the individuals were qualified to participate in the research. Selected participants were interviewed individually with full consent and an understanding of the purpose of the study and the risks and benefits. The interviews were recorded and later transcribed verbatim, along with field notes for accuracy. The transcriptions were returned to the participants for accuracy, if requested. As a backup method to recruit participants, snowball sampling would be utilized.

Definitions

Appraisal: A process through which the person evaluates whether a particular encounter with the environment is relevant to his or her well-being and, if so, in what way" (Folkman et al., 1986, p. 572).

Burnout: The feeling of failure and exhaustion resulting from excessive demands on the energy, personal resources, or spiritual strength of workers that prevent them from providing care and assistance to users of organizations in different fields whose primary objective is to help others (Ruiz-Fernández et al., 2020).

Compassion fatigue: An "emotional, physical, and psychological exhaustion due to exposure to chronic work-related stress" (Xie et al., 2021, p. 1).

Compassion satisfaction: The "satisfaction experienced by healthcare professionals when performing their work correctly, including satisfaction with their

relationship with colleagues and the sense that the work they perform is of social value" (Ruiz-Fernández et al., 2020, p. 2).

Coping: A "constantly changing cognitive and behavioral effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Lazarus & Folkman, 1984, p. 141).

COVID-19: A new strain in the coronavirus family called SARS-Cov-2, also known as coronavirus 2019 (Caldas et al., 2021) and first detected in Wuhan, China in December 2019 (Gunawan et al., 2021), often leading to severe respiratory issues (da Silva & Barbosa, 2021).

Normal: Refers to the time pre-pandemic (Bayingana et al., 2021).

Pandemic: A "widespread epidemic of contagious disease throughout the whole of a country or one or more continents at the same time" (Honigsbaum, 2009, p. 1939).

Post-traumatic stress disorder (PTSD): A mental health disorder triggered by a personal experience or witnessing a traumatic occurrence (Hill, 2021).

Stress: According to Folkman et al. (1986), stress "is conceptualized as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering well-being" (p. 572).

Assumptions

Methodological Assumptions

The methodological assumptions were based on my knowledge of collecting and analyzing the collected data. One assumption was that all data were presented without bias or subjective implications and that the questions asked of the participants did not

elicit biased responses. The data collected were verified by the participants for accuracy and truthfulness if they chose to do so. Finally, the research goal was to discover patterns and themes of what the nurses experienced to be the long-term effects of compassion fatigue on the nurses, personally and professionally.

Theoretical Assumptions

The theoretical assumption of Lazarus and Folkman's theory of stress and coping was that psychological stress is not based on the individual's reflection of the situation or the person's individual qualities. Instead, stress is about the individual's condition, situation, and personal characteristics to deal with the situation (Smith & Kirby, 2011).

Participant Assumptions

Assumptions of this study were that nurses who participated in this study were registered nurses who cared for COVID-19 patients during the pandemic and that the responses/answers were honest. It was also assumed that the interview questions were understood by the participants, which elicited reliable and honest responses to the best of their ability. Another assumption was that the nurses had a complete and detailed recall of the experiences during the pandemic and were able to tell their lived experiences. I also assumed participants came forward willingly without any concern for ramifications or repercussions for withdrawing from the study. Another assumption was that results of the study were independent, objective, and free from personal biases, opinions, experiences, and judgments as possible. The qualitative research data analysis was reported objectively and truthfully to protect the study's validity.

Reasons for Assumptions

The reason for assumptions was to make the reader aware of what the researcher would do to present an unbiased, objective, and honest study. Much of the research studied depended on the nurses' ability to recall experiences and nurses had a selective recall, impeded by professional loss of patients and family members. Recollection of the lived experiences of the nurses may be painful and difficult and prove to be emotionally draining.

Scope and Delimitations

Study Scope

All study participants were full-time registered nurses who cared for COVID-19 patients. The study was open to all nurses, regardless of their specialty units or healthcare facilities, as both were dedicated to COVID-19 units. The nurses were members of a New York State nursing organization. Because this nursing organization was selected, there was an inherent bias as these nurses may not represent other nurses in other areas of the United States and globally.

The scope of the study was to understand the lived experiences of the nurses and how they coped during this dramatic time of their careers. All nurses are affected by some degree of compassion fatigue throughout their careers but dealing with compassion fatigue far exceeded anything previously experienced during the pandemic. The scope of the research involved the nurses recalling their experiences during the pandemic in terms of the acuity of the patients, the numbers of patients, the difficulties the nurses faced, and coping mechanisms used, mindful that the pandemic continues today. The scope of the

study included an extensive literature review on compassion fatigue and nurses' experiences of compassion fatigue in the past and fill in the gap of present experiences and how the nurses coped and survived. I reviewed the impact COVID-19 had on the nursing profession, causing insufficient retention levels, and nursing shortages, leading to inferior patient care and outcomes.

Limitations

A potential limitation of the study was using a New York State nursing organization, which may not reflect other nurses working in other states or countries. Another limitation was that the sample population may only genuinely reflect the experiences of some nurses who worked during the pandemic. Additionally, nurses who experienced the traumatic events of COVID-19 may have wanted to refrain from participating in the research as a recollection of these times might have been too overwhelming or painful or stop their participation in the study once they entered the interview. There was also a limitation of participants responding to the research questions in a way the participants believed that I wanted the participants to respond. Additionally, I may have formed biases based on first impressions of the participants or how they presented themselves. Another limitation was recall bias, as the nurses' experiences who treated patients at the height of the pandemic may have some difficulty recollecting these times. The study's challenge was the emotional hardships and strains the nurses had recalling difficult experiences and may need psychological support.

A major limitation that could impact a study was the threat to validity, particularly internal validity pertaining to this study and external validity regarding the generalization

of the study to other populations. Further, though no study is free from bias (Ross & Bibler Zaidi, 2019), all efforts were made to contain the biases and limitations that may result, including protecting the study's trustworthiness and credibility. I self-reflected on personal biases that were present and welcomed all participants who met the inclusion criteria. To capture self-reflection, analytic memos, and field notes were part of the data set.

Significance of the Study

This research filled a gap in understanding how nurses coped with compassion fatigue during a pandemic. The study was unique because the focus was on the long-term effects of COVID-19 on nurses, which have yet to be reported, and the nurses' lived experiences during these unprecedented times are unknown. The study results provided information and insight into how nurses personally coped with the enormous stressors of high patient acuity and monumental death rates (see Phillips & Stalter, 2020). The study also provided information on possible long-term effects on their professional and personal lives, as little is known about the impact (Morley et al., 2020). Finally, there have been four influenza pandemics in the past 100 years: H1N1 in 1918, H2N2 in 1957, H3N2 in 1968, and H1N1 in 2009 (Harrington et al., 2021), and there are predictions for potential for future pandemics (Robinson & Stinson, 2021). Thus, this study offers insights into the ways nurses can cope during these tumultuous times and be helpful for both the profession of nursing and the personal lives of nurses.

Walden University defines positive social change as a "deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and

development of individuals, communities, organizations, institutions, cultures, and societies" (Walden University, 2022, Vision, Mission and Goals section, para. 2). This study can potentially impact the nursing profession and the community nurses serve by understanding compassion fatigue regarding the pandemic's physical, emotional, and psychological impact on the nurses' professional and personal lives. In addition, the study provides nurses and health care organizations with information on how to support and develop programs to help nurses deal with compassion fatigue (Callis, 2020). The potential research findings may impact positive social change by offering a deeper understanding of compassion fatigue, increasing nurse retention rates (Yang & Kim, 2016), and preventing nurses from leaving the profession amid a growing nursing shortage (Alexander & Johnson, 2021). Finally, the study adds knowledge and insights for nurses who may one day deal with another pandemic and learn effective coping methods and skills during such challenging times (Pickler, 2021).

Significance to Practice

This study gives insight into what nurses experienced during the pandemic but, more importantly, how the nurses coped with compassion fatigue and cared for so many sick patients at one time and the long-term effects of compassion fatigue. Understanding the lived experiences of the nurses gave insight into compassion fatigue and methods to support nurses during challenging times of an epidemic and a pandemic. The study provides insight into the concept of compassion fatigue as it pertains to the nursing profession as opposed to other health care disciplines. In addition, understanding the long-term effects of compassion fatigue on nurses will help health care organizations

develop support groups and resources to help nurses effectively and efficiently deal with such hardships.

Significance to Theory

Compassion fatigue is a phenomenon that is prevalent in healthcare and nurses. Nurses were at the center of caring for patients, as was evident during the COVID-19 pandemic. The study may advance knowledge and offer insight into how nurses dealt with the stressors of the times, learned to cope, and, most importantly, adapted to unprecedented challenges not seen in present times. In addition, I investigated the long-term effects of compassion fatigue on nurses' professional and personal lives.

Significance to Social Change

Compassion fatigue is a common experience among nurses who care for acutely ill individuals and die at times. Caring for the high number of patients, many of whom were extremely ill, took a toll on nurses physically, emotionally, and mentally, all leading to what is known as compassion fatigue. A study of compassion fatigue gives insight into how nurses dealt with their emotions during this time and provide knowledge and information about programs and support systems that healthcare institutions can implement to support their nurses in non-pandemic times. The study helps to initiate positive improvements in "human and social conditions" (Walden University, 2022, Vision, Mission and Goals section, para. 1), namely nurses and the nursing profession. As pandemics tend to repeat, knowing ways to help nurses who are at the forefront of inpatient care will create a positive social change for the nursing profession nationally and internationally. In addition, I examined the long-term effects of coping with

compassion fatigue, which may help health care professionals and organizations create strategies to support nurses. New techniques can positively impact the healthcare organization through higher retention rates, a positive work environment, and improved quality patient care and outcomes. The predicted nursing shortage will necessitate retaining practicing nurses' experiences, knowledge, and quality of patient care and outcomes.

Summary and Transition

The research provided the opportunity to closely examine the lived experiences of nursing during the pandemic called COVID-19. Nurses dealt with complex patient care in their daily practices. However, nothing could prepare these healthcare workers for what they experienced during the pandemic, particularly in dealing with compassion fatigue in both the immediate and long-term effects.

Chapter 2 of the study is a literature review of compassion fatigue and nursing. Chapter 3 presents the methodology used to conduct the study, followed by Chapter 4, which explains the analysis of the results. Chapter 5 discusses the implications of the study's results, particularly in positive social change.

Chapter 2: Literature Review

Compassion fatigue is a known phenomenon in health care, especially in nursing. By nature of the profession, nurses are compassionate caregivers who deal with patients at all levels of acuity. Caring for patients during difficult times can exhaust nurses physically and emotionally, resulting in adverse outcomes for the nurses, their patients, and the healthcare organizations. The pandemic of 2019, COVID-19, forced nurses to care for extremely sick patients, many of whom died. As hospital admission rates rose exponentially daily, nurses worked long, exhausting shifts without personal protective equipment. Patients also needed equipment such as respirators and ventilators. There are studies that examined the effects of compassion fatigue on nurses who cared for COVID-19 patients. However, little was known about the long-term effects of nurses coping with compassion fatigue during the pandemic and the impact COVID-19 had on nurses' lives, both professionally and physically.

The foundation of this study was Lazarus and Folkman's transactional theory of stress and coping. This theory aligned with the research question: "What are nurses' lived experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic?" During COVID-19, nurses experienced high levels of stress, resulting in compassion fatigue, requiring appraisal of the precarious situations nurses found themselves in and their determined ways to cope during these times. In the literature review, the theory's origins were examined, including stress, appraisal, and coping variables. Other applications to the theory were also assessed, including the rationale for selecting Lazarus and Folkman's transaction theory of stress and coping for this study.

The chapter examines compassion fatigue, definitions and history of compassion fatigue, and the coping experiences and interventions of nurses who dealt with compassion fatigue. Compassion fatigue was evaluated by gender, age, ethnicity, education, years in nursing, and various studies of compassion fatigue during COVID-19.

Literature Search Strategy

Multiple databases, search terms, and limited time of publications were used for the study's most current and evidence-based data. Databases include CINAHL, MEDLINE, ProQuest, PubMed, Ovid, Science Direct, and Google Scholar. Publications were limited to the last 5 years, but older articles were used as the articles pertained to the theoretical foundation, primary sources of the theorists, and other resources needed for the study. Search words included *compassion fatigue*, *burnout, vicarious traumatization*, *stress, coping, appraisal, nurses, nursing, COVID-19 compassion fatigue, compassion satisfaction,* and *post-traumatic stress disorder*. Keywords were used separately and in combination. All articles were evaluated for relevancy, application, and quality of usefulness to the study. Peer-reviewed articles and dissertations, theses, and books pertinent to the study were used for the literature review.

Theoretical Foundation

The theoretical foundation for this study was Lazarus and Folkman's stress and coping theory. Stress is a part of everyday life and has subjective and ambiguous meanings to an individual—lethargy, anxiety, and fear can affect a person physically and psychologically (Selye, 1973). Newton (1996) discovered definitions of stress in 16th and 17th Oxford English Dictionaries that are comparable to the present-day definitions of

stress. The term *stress* was first introduced into health care in 1926 by Hans Selye as it pertains to a psychological state to denote strain on the body due to changes that come from external factors (Shadiya, 2015). Selye (1956) developed the general adaptation syndrome, which focuses only on the physiological changes that stress can place on the individual regarding the effect on the body and stimulates defense mechanisms and exhibits symptoms. The three stages of the general adaptation syndrome are the alarm stage, where the body goes into defense mode; the resistance stage is the body's attempt to regain homeostasis; and the final stage, where the stress is dealt with or not, resulting in enervation (Selye, 1956). However, Silverman et al. (2010) argued that stress affects an individual both physiologically and psychologically as reactions to a condition, an emotional event, or a state of mind. Lazarus and Folkman's theory of stress and coping deals with psychological reactions, which aligns with the research question of both personal and professional long-term effects on nurses who coped with compassion fatigue during the pandemic. Nurses who cared for acutely ill patients experienced tremendous stress, fostering a need to adapt to the situations they found themselves in and how to cope with the effects of the pandemic.

Origin of the Theory

In 1984, Lazarus and Folkman developed the transactional theory of stress and coping, which defined the concept of stress as a process by which individuals evaluate their environments, which generates emotions and stimulates an appraisal of the situation as being ominous, harmful, or challenging (Biggs et al., 2017). Lazarus and Folkman (1984) argued that a relationship between the person and their environment depends on

the person's characteristics and the environmental event, known as the transaction stage. The transactional theory emphasizes the cognitive and emotional components of the person to determine the coping strategies to use and the strategies that are lacking to deal with the situation (Weber, 2001).

Lazarus and Folkman (1984) defined two types of coping responses to stress and stressful situations: problem-focused and emotion-focused coping strategies. Problem-focused coping focuses on solving the problem or issue by assessing viable solutions and evaluating the pros and cons, resulting in a plan of action (Lazarus & Folkman, 1984). Problem-solving helps individuals endure stress and be pragmatic when finding solutions to minimize the threat (Lazarus & Folkman, 1987) or changing the cause of the stress by altering behaviors or environmental circumstances (Ozcelik & Erdogan, 2020). Emotion-focused coping strategies are utilized when the threat is not within the person's control, and the strategies focus on managing the person's affective response to the threat (Garbóczy et al., 2021). Emotion-focused coping aims to manage emotional distress during stressful experiences (Lazarus & Folkman, 1987) and in situations where acceptance is needed, whereas problem-based forms of coping can be utilized where change is possible (Lazarus & Folkman, 1987).

Major Theoretical Propositions

Stress

There are three theoretical propositions for Lazarus and Folkman's transactional theory of stress and coping: stress, coping, and adaptation. The derivation of the term stress can be traced to the 13th century to a Middle English word "stresse," which was a

derivative of the word "distressed" (Mish, 2005). In the 14th century, stress referred to tensions (Sebastian, 2013), and in the 17th century, stress meant hardships or afflictions (Lumsden, 1981). In the 20th century, Hooke introduced stress into biology and social sciences (Hinkle, 1974). In 1976, Hans Selye furthered the development of the concept in both medicine and humanities and developed the general adaptation syndrome (Sebastian, 2013).

Stress is a subjective concept experienced by all individuals differently, from external factors such as family or work to internal factors such as sadness or anxiety. When one experiences stress, the balance within oneself is disrupted, causing a desire to return to a state of homeostasis (Wetthington et al., 2015). Stress can have both positive and negative effects on individuals. In terms of positivity, stress can improve biophysical health and motivate improvement and adaptation to a circumstance (Shahsavarani et al., 2015).

Lazarus and Folkman defined psychological stress as a relationship that exists between a person and their environment where the individual feels overwhelmed by a situation that exceeds available resources and threatens their well-being (Folkman & Lazarus, 1985). In the transactional theory of stress and coping, the event alone is not the cause of the stress; instead, the stress exists because of the individual's transaction and their surroundings (Kivak, 2020). For example, during the pandemic, nurses encountered many stresses they had never experienced in their professional careers. The high acuity and mortality rates increased nurses' stress levels and fear of infection and depression. Additionally, this caused a lack of needed resources such as personal protective

equipment (PPE), forcing them to isolate from their own families (Al Thobaity & Alshammari, 2020). The transaction or interactions between the nurses and the surroundings escalated physical and emotional stress (Kivak, 2020).

The awareness of the stressors forces the individual to make a judgment of the situation, primary appraisal, and secondary appraisal. In primary appraisal, the individual judges the event as "irrelevant, benign-positive or stressful" (Lazarus & Folkman, 1984, p. 32). Irrelevant stresses are not important, and benign-positive stresses are deemed as joy, pleasure, and happiness, and stressful events are perceived as threatening, harmful, or damaging to the self (Lazarus & Folkman, 1984). Nurses faced ongoing stressful events during the pandemic, which posed many threats, professionally and personally. As frontline health care providers, the nurses continued to work amid many obstacles and difficulties. When a stressor is determined to be a threat, secondary appraisal becomes the coping strategy to deal with the situation (Kivak, 2020).

A secondary appraisal is an evaluative process where one judges what coping options are available and what strategies can be used to cope with the situation effectively (Lazarus & Folkman, 1984). When secondary appraisal occurs, the individual evaluates their personal coping resources to deal with the situation (Biggs et al., 2017). Lazarus and Folkman (1984) argued that the appraisal stage is vital for individuals to survive or thrive and distinguished between good and bad situations. An example is novice nurses, who entered the profession during COVID-19 and dealt with unyielding stresses due to loss of orientation times, acclamation to the practice setting, and higher-than-normal workloads for a new graduate (Crismon et al., 2021). A study with 295 new nurses who started as

novice nurses during the pandemic found that they felt unsafe due to a lack of skills, concern about making errors, and felt overwhelmed as new nurses (Smith et al., 2021).

Coping

The final stage of Lazarus and Folkman's transactional theory is coping. Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (p. 141). The concept of coping is subdivided into two categories: problem-focused coping and emotion-focused coping.

Problem-focused coping, sometimes called problem management, focuses on taking action to manage the stressor and gather information (Wetthington et al., 2015). Lazarus and Folkman (1984) contended that problem-focused coping aims to define stress, form possible solutions, and weigh the solutions in terms of benefits. In this stage, the individual attempts to solve the problem weigh the pros and cons of the solutions, and then acts on it (Kivak, 2020). During COVID-19, nurses experienced tremendous strain in caring for patients and stress from the lack of information and knowledge of this new virus called COVID-19, the fear of being infected with COVID-19, and the fear of the unknown future (Tan et al., 2020). In addition, nurses and all healthcare workers dealt with the continuous changes and updates to COVID-19 information, impacting how nurses cared for patients and increasing personal stress (Temsah et al., 2021).

Emotion-focused coping focuses on changing how one perceives a stressful situation on an emotional level (Wetthington et al., 2015). Lazarus and Folkman (1984) suggested that in emotion-focused coping, individuals may deny the stressor or find

positivity in a negative situation. Coping strategies may include blaming others, emotional outbursts, reflection, and exercise. Additionally, due to the stressful environments during COVID-19, nurses were victims of bullying due to the fear that they could spread the virus and bullied by patients and their families in the delivery of care discrimination and the limitations of visitors (Somani et al., 2022). People will utilize emotional-focused coping over problem-focused coping when the stressor is unchangeable (Kivak, 2020).

Rationale

Lazarus and Folkman's transactional theory of stress and coping provided a foundation for this study, as it aligned with the experiences and emotions nurses suffered during COVID-19. Nurses experienced many stressors during this time: being forced to care for patients who had an unknown virus, the uncertainty of medications to use, lack of PPE and resources such as ventilators, and lack of staff who were available because they were diagnosed with the virus. COVID-19 forced nurses to appraise the situations and the stressors they felt. The nurses' primary appraisal could only determine that the experiences harmed themselves and their patients. During the secondary appraisal, nurses had to resort to what internal coping strategies they possessed and what coping resources they would need to survive the ordeal of COVID-19.

Following the appraisal stages, nurses needed to find ways to solve the problems presented at hand, analyze the pros and cons of their solutions, and then act on these possible resolutions. This process is what Lazarus and Folkman referred to as problem-appraisal coping. Nurses also used emotion-focused coping to endure their work

experiences. Some nurses coped using support from colleagues and family, mindfulness, and spirituality (Gordon et al., 2021). Nurses also used negative coping skills, self-blame, denial, and self-indulgence (Cui et al., 2021).

Similar studies used Lazarus and Folkman's transactional theory of stress, coping, and nursing during the pandemic. Lorente et al. (2021) used the theory as a framework for a quantitative study on the psychological distress that nurses experienced during COVID-19 and concluded that all stressors had a negative impact on nurses' mental health. Andel et al. (2021) conducted a quantitative study of 120 nurses in the United States who worked during the pandemic to understand how understaffing led to medical errors and injuries that could cause serious harm to the patients. One of the coping mechanisms that the nurses used during the pandemic was safety workarounds, which are shortcuts due to the lack of time and heavy workloads. Garcia et al. (2021) also used the Lazarus and Folkman model foundation for their quantitative study of 896 nurses from the Midwestern United States. Stressors from work environments included the high numbers of infected patients and patients who passed away, and stressors at home included other issues, such as childcare. A positive relationship exists between general stress due to COVID-19 health risks and parenting stress and a negative correlation between self-efficacy and general stress. Suggested coping skills were flexible work hours, more off days, free childcare, and educational opportunities to increase self-efficacy for the nurses.

Previous Applications of the Theory

Lazarus and Folkman's theory has also been used as the theoretical framework for other areas. Labrague et al. (2018) applied the theory to study international nursing students and their coping strategies during their education. In a qualitative study, Couper et al. (2022) investigated the effects of COVID-19 on rural doctors and the ways of coping during the pandemic and determined that focusing on the problem and shared dedication to their patients, other healthcare workers, and communities could lead to positivity in the middle of turmoil and devastation.

The theory of stress and coping served as a foundation for studies in physical and mental illnesses. Park et al. (2018) used the theory in a cross-sectional study on adults diagnosed with type 2 diabetes and the stresses and coping mechanisms while dealing with eating behaviors. The theory was the framework for a quantitative study by Ghaffari et al. (2021) on the effects of teaching hemodialysis patients in Tehran coping efforts and stress reduction in their adjustment to their illness. Avcıoğlu et al. (2019) conducted a study on the siblings of patients diagnosed with schizophrenia and stress management to cope with their relative's mental disease. In the discipline of education, Elomaa et al. (2021) used Lazarus and Folkman's theory to study elementary school principals in Finland and their need for support in their leadership roles and the stresses of the job. Scribner et al. (2020) applied the theory of Lazarus and Folkman to undergraduate students at a state university and analyzed how they managed their stress and coped. Eisenbarth (2019) conducted a quantitative study on the differences between genders and how they coped with stress in college.

Zhu et al. (2020) used the stress and coping theory to study the pressures tourists experience during their travels. Bojkowski et al. (2020) used the theory as a foundation in a study to determine how men and women deal with stress when coaching team sports games. Modranský et al. (2020) aligned their study on project managers who dealt with stress in the automotive industry.

Literature Review Related to Key Concepts

Compassion

The term compassion is synonymous with health care professionals, particularly nursing. The International Council of Nurses (2021) identified compassion as one of the five professional values of nursing. The American Association Code of Ethics for Nurses (2015) also recognized the value of compassion for nurses as one of the significant provisions of the code. The history of the term compassion can be traced to a Pali and Sanskrit word, karma, which means a "trembling or quivering of the heart in response to a being's pain" (Salzberg, 1995, p. 88). In Latin, the term compassion means "to suffer with" or "to feel for" (Perez-Bret et al., 2016). A more formal definition of compassion is a "sympathetic consciousness of other's distress together with a desire to alleviate it" (Merriam-Webster, n.d.). No matter the definition, compassion is at the heart and core of the nursing profession.

Compassion was the foundation of Florence Nightingale's understanding of nursing and the care provided to people (Tierny et al., 2019). The concept of compassion is the essence of nursing and often the reason many men and women enter the profession, grounded in their inner desire to understand another's suffering and the wish to relieve

others' suffering (Arkan et al., 2020; Soto-Rubio & Sinclair, 2018). Corréa (2017) believed that when one offers compassion, the division between the other and the self is dissipated as one enters the other's world.

Compassion goes beyond the nurse alone and dramatically impacts the patients themselves and directly their care. Tehranineshat et al. (2019) determined that compassion care affects patients' recovery, self-care, and happiness, as the patients sense the nurse's interest and concern for their well-being and the improving healthcare systems at large. When nurses' express empathy, their delivery is experienced and felt by others as compassionate care.

Compassionate care is a complex term, as the word is often open to many interpretations (Blomberg et al., 2016). Tehranineshat et al. (2019) defined compassion as a composition of various virtues that fall under the umbrella of compassion. In addition, compassionate care is an outer reflection of nurses' professional ethics, expressed with empathic care and attention (Cao et al., 2021).

Su et al. (2020) believed that compassionate care is a virtue of four attributes – wisdom, love, empathy, and humility – that are conveyed to a person in need or distress. The positive outcomes of compassionate care include improved patient care, safer care, personal satisfaction, advancement of knowledge, and higher levels of contentment and resilience (Tehranineshat et al., 2019). When there is a lack of compassionate care, the results are negative and affect patient care (Tehranineshat et al., 2019), resulting in a lack of passionate care (Babaei & Taleghani, 2019), and the pinnacle negative outcome, compassion fatigue (Henson, 2017).

Definitions of Compassion Fatigue

Compassion is an inherent attribute of the nursing profession. The American Nurses Association Code of Ethics for Nurses (2015) Provision 1 states, "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (p. 1). The ongoing practice of compassion and the devastating physical, emotional, and psychological effects of caring for patients can often lead to a moral phenomenon known as compassion fatigue. Compassion fatigue is synonymous with burnout, which is ongoing emotional negativity resulting in stress, defeat, anger, exhaustion (Yang & Kim, 2016), and secondary traumatic stress from caring for those in a professional setting (Yang & Kim.,2016). Paiva-Salisbury and Schwanz (2022) described compassion fatigue as an individual's continuous exposure to human suffering experienced through burnout and secondary traumatic stress. Secondary traumatic stress, unlike burnout, occurs suddenly (Rimmer, 2021), whereas burnout develops over time (Forsyth et al., 2022). As an emotional state, compassion fatigue arises more efficiently if an individual has high self-demands, expectations, and pressures from life that infringe upon work life (Gustafsson & Hemberg, 2022).

The History of Compassion Fatigue

The earliest reference to the "cost of caring" for others was in 1907 by psychologist Carl Jung in *The Psychology of Dementia Praecox* (Gentry, 2002), which discusses the issue of countertransference from the patient to the therapist. Herbert Freudenberger (1974) introduced the term burnout experienced by mental health workers caring for individuals with emotional issues. Pines and Aronson (1988) formally defined

burnout as a state of exhaustion and emotional strain. In 1974, Figley discussed combat stress based on his experiences in the Vietnam War and how traumatic events can affect soldiers' mental capacity (Gilman, 1989). Cornille and Meyers (1999) further discussed victims of traumatic events from the perspective of family and helpers of war veterans.

In 1992, Carla Joinson, a registered nurse, published an article titled *Coping with Compassion Fatigue* and was the first to coin the term 'compassion fatigue' as attributed to the nursing profession and the loss of nurses' ability to care for others, which can lead to empathy and indifference (Joinson, 1992). Joinson (1992) credited the term compassion fatigue to Doris Chase, a crisis counselor, who argued that compassion fatigue results from overwhelming stress that hinders one's ability to function and cope.

In 1995, Figley believed that secondary traumatic stress and compassion fatigue were interchangeable terms but preferred compassion fatigue, as secondary traumatic stress has a negative connotation. Figley (1995) also suggested that compassion fatigue and compassion stress are suitable substitutes for secondary traumatic stress.

In 2000, various other terms to describe compassion fatigue developed. Stebnicki (2000) used the term empathy fatigue, which he believed develops suddenly and is an unhealthy form of secondary traumatic stress. Thomas and Wilson (2004) used the term "traumatoid stress" to define occupationally related syndromes, including compassion fatigue, secondary traumatic stress, and vicarious traumatization.

Signs and Symptoms of Compassion Fatigue

Compassion fatigue has five major classifications: physical, emotional/psychological, institutional, behavioral, and spiritual. The manifestations of

compassion fatigue impact individuals in various ways, leaving the person feeling void of energy (Gustafsson & Hemberg, 2022; Sinclair et al., 2017).

Compassion fatigue's physical signs and symptoms include issues that cause people somatic problems. Signs and symptoms are present in various degrees, from insomnia, exhaustion, headaches, gastrointestinal problems, and immunity issues (Lee et al., 2019). Other physical problems individuals experience are hypertension, forgetfulness, and weight gain (Henson, 2020).

Compassion fatigue also manifests in behavioral signs and symptoms, often leading to the use of alcohol and substance, which dramatically affects decision-making and patient care (e Silva et al., 2021; Lee et al., 2019; Perregrini, 2019) and causes an inability to make emotional connections with others (Gustafsson & Hemberg, 2022). Additionally, compassion fatigue can leave people irritable toward others, displayed through anger and conflicts in relationships (Gustafsson & Hemberg, 2022). In terms of nursing, behavioral indicators are complaints about patient assignments, dissatisfaction regarding patient care, lack of support from superiors, and high staff turnover (Perregrini, 2019).

Compassion fatigue's psychological and emotional signs and symptoms range from depression, bitterness, a sense of helplessness, and a poor self-image (Lee et al., 2019). Individuals experience inner despair and stress, leading to a sense of failure, loneliness, and weakness (Nolte et al., 2017), as well as feelings of hopelessness and diminished empathy toward others (Sinclair et al., 2017). Individuals who experience compassion fatigue have emotional eruptions, often blame others for their personal issues

and concerns, and experience mood lability (Adimando, 2018). Additionally, people have unfounded fears, intrusive thoughts, and difficulty with intimacy and personal relationships (Perregrini, 2019). Compassion fatigue can also manifest in spiritual distress, including a lack of spiritual awareness, poor judgment, and lack of self-reflection (Lee et al., 2019).

Compassion fatigue adversely affects the institutions one works in, impacting both the employee and co-workers. Signs and symptoms of compassion fatigue in terms of work are more significant use of sick time (Perregrini, 2019; Sinclair et al., 2017) and considerations of leaving the job (Nolte et al., 2017). Institutions also deal with poor retention rates, decreased productivity, work-related mistakes, and poor employee engagement (Adimando, 2018; Perregrini, 2019).

Compassion fatigue affects individuals on many levels: physical, behavioral, psychological, and emotional, and drastically affects the institutional level. Signs and symptoms can vary according to the individual and his/her circumstances. What is most important is how the person copes with compassion fatigue and the methods of dealing with the phenomenon of compassion fatigue.

Any analysis of a concept such as compassion fatigue includes three major components: antecedents, attributes, and consequences. Antecedents are events or incidents that occur before the development of a concept (Cross, 2019) and are described as triggers that lead to the concept (Henson, 2020). The antecedents of compassion fatigue include continuous experiences of suffering, a lack of the ability to care for oneself, an inability to keep professional boundaries, high levels of compassion, and

excessive exposure to stress (Peters, 2018). Beydoun et al. (2019) argue that antecedents of compassion fatigue include the amount of time one spends as a caregiver, the availability of resources, and the tasks required for one to do. Henson (2020) believed firsthand experiences in dealing with traumatic events such as death and feelings of pointlessness and hopelessness that nothing will change the outcome of one's work are antecedents of compassion fatigue. Sorenson et al. (2017) believed that antecedents of compassion fatigue consist of continuous experiences to provide compassion and empathetic care to others and the desire to relieve the suffering of others.

Attributes are characteristics particular to a concept (Beydoun et al., 2019) that are frequently associated with the phenomenon. Peters (2018) defined the attributes of compassion fatigue as declining energy, the ability to deliver empathetic care, and feelings of hopefulness and emotional exhaustion. Cross (2019) believed that the attributes of compassion fatigue include a lack of the capacity to balance emotional and psychological well-being, an absence of empathy, poor judgments, and increased physical ailments.

The final component of a concept is the consequences, which are the outcomes experienced (Cross, 2019) and the events that follow because of the concept (Beydoun et al., 2019). Compassion fatigue has traumatic consequences for individuals physically, socially, emotionally, and intellectually. Compassion fatigue in nurses' results in poor judgment, medical errors (Peters, 2018), and feelings of incompetency, hopelessness, despair, and weakness (Nolte et al., 2017). Nurses also experience isolation, indifference, depersonalization, physical, psychological, and spiritual exhaustion (Henson, 2020), and

desensitized and empathetic care (Gustafsson & Hemberg, 2022; Öztürk & Karabulutlu, 2021). Other consequences of compassion fatigue include feelings of guilt, embarrassment, and anger (Gustafsson & Hemberg, 2022) with thoughts of leaving the profession (Nolte et al., 2017; Sorenson et al., 2017). Kelly and Todd (2017) argued that 20% of first-year nurses leave their positions, and many new nurses leave the nursing profession altogether because of compassion fatigue, which impacts patient care and sufficient staffing.

Coping Experiences with Compassion Fatigue

Coping methods are practices individuals use to deal with compassion fatigue and its effects on them. The most important coping method one can use is self-awareness and self-reflection when dealing with compassion fatigue (Adimando, 2018), which implies that the individual knows the signs and symptoms of compassion fatigue. Resiliency also helps individuals combat compassion fatigue (Sinclair et al., 2017). On a personal level, individuals can self-care through exercise, healthy eating, developing hobbies, volunteer work, and a healthy amount of sleep (Rivera-Kloeppel & Mendenhall, 2021; Wahl, 2018). Rimmer (2021) argued that workers must balance work and personal life by maintaining boundaries between work and home and taking vacations. Spirituality, mindfulness, journaling, meditation, and imagery are other alternatives for coping with compassion fatigue (Adimando, 2018; Rimmer, 2021).

Institutions can support employees with professional development programs that teach the signs and symptoms of compassion fatigue (Nolte et al., 2017). Wahl et al. (2018) believed that nurses must understand that compassion fatigue can occur, given the

nature of the profession and the signs and symptoms that indicate that one is experiencing compassion fatigue. Institutions can support workers and create environments of compassion where workers treat each other, sustain each other with care, and encourage the workers to express concerns and thoughts (Upton, 2021; Wahl et al., 2018). A peer support network is also an intervention that organizations can offer workers to prevent compassion fatigue, foster compassion satisfaction, and develop a better working environment (Wahl, 2018). Another coping mechanism institutions can offer workers to help with compassion fatigue is to conduct debriefing sessions to help individuals discuss experiences with their peers and formulate plans to manage compassion fatigue (Forsyth et al., 2022; Nolte et al., 2017).

Demographics of Compassion Fatigue

Many studies, such as Mooney et al., 2017; Kelly et al., 2015; and Walden et al., 2018, examined the effects of demographics on compassion fatigue. These demographics include age, gender, ethnicity, levels of education, years of experience, specialty, and time of shift. Various studies are congruent in findings and contradict the results of other researchers.

Male Versus Female

Mooney et al. (2017) found that male nurses reported lower levels of compassion fatigue than female nurses. In a descriptive correctional study of 148 intensive-care nurses, Varadarajan and Rani (2021) concluded that there were no differences between male and female nurses regarding compassion fatigue. Roney and Acri (2018) conducted a quantitative study of 318 pediatric nurses in the United States and found that there was

no statistical significance between men and women in terms of compassion fatigue or compassion satisfaction. Aslan et al. (2021) studied 336 nurses who worked at a university hospital in Turkey and determined that women experienced a higher level of compassion than men. Marshman et al. (2022) performed a systematic review of compassion fatigue and mental health workers and concluded that, based on their research, compassion fatigue was 1.2–8 times higher in women.

Age

Age is another factor to consider while analyzing compassion fatigue for nurses. Alharbi et al. (2020) found that older nurses had fewer issues with compassion fatigue than younger nurses. Kelly et al. (2015), in a study of 491 direct care nurses, found that in comparison of three age groups, millennials (aged 21–33 years old) experienced higher levels of compassion fatigue than Generation X (34–49 years old) and Baby Boomers (50–65 years old). In a descriptive design in a large urban hospital in Arizona, a study conducted by Wijdenes et al. (2019) reported increased compassion fatigue in nurses between the ages of 24 and 34. Ko and Kiser-Larson (2016) performed a descriptive, cross-sectional quantitative study and found higher levels of stress (compassion fatigue) in oncology nurses aged 41–50 years old as opposed to oncology nurses aged 20–30 years old. Borges et al. (2019) researched compassion fatigue amongst 87 Portuguese emergency and urgent care nurses and determined that younger nurses with fewer years of experience had higher levels of compassion fatigue.

Education

Education is another demographic element that may impact compassion fatigue. Walden et al. (2018) conducted a descriptive correlational design of 268 nurses and found that nurses with higher levels of education, such as bachelor's, master's, and doctoral degrees, experienced more significant levels of burnout than nurses with diplomas and associate degrees. Aslan et al. (2021) also found that nurses with post-graduate degrees had more significant levels of compassion fatigue. Kawar et al. (2019) studied 1174 nurses in California and concurred that nurses with a bachelor's degree had higher levels of compassion fatigue than nurses with an associate degree in nursing.

Burnout

Burnout or professional burden (Lluch, et al., 2022), which is very prevalent in healthcare (Jun et al., 2021), is a psychological state of prolonged exposure to stressors at work resulting in emotional, mental, and physical exhaustion (Ayaz-Alkaya et al., 2018). Burnout involves hopelessness as one's efforts feel insignificant in the environment, needing more support and a substantial workload.

Freudenberger coined the term "burnout" based on personal observations of workers in a mental health clinic who lacked motivation and reduced commitment (Freudenberger, 1974; Freudenberg, 1975). In the 1980s, psychologists Maslach and Jackson (1981) further studied burnout and identified the burnout syndrome to be three-dimensional: emotional exhaustion, cynical treatment (depolarization) towards patients and co-workers, and a low sense of personal accomplishment. As a result of the work on

burnout, Maslach and Jackson (1981) developed the Maslach Burnout Inventory, which is a 22-item assessment tool to measure work-related stresses.

Burnout manifests both physically and psychologically and causes medical errors, inferior quality of care (e Sliva, 2021), physical and mental fatigue (Ortega et al., 2018), insomnia, depression, fatigue (Perregrini, 2019), and the inability to cope with stress (Ortega et al., 2018). Burnout is distinct from compassion fatigue in different ways. Copeland (2021) believed that burnout and secondary traumatic stress are components of compassion fatigue. Burnout results from stressors that arise in the workplace, whereas compassion fatigue is the exposure to others' stress (Pirelli et al., 2020). Henson (2020) believed that characteristics of compassion fatigue included emotional and physical exhaustion, apathy, and a feeling of helplessness, whereas burnout is emotional exhaustion with cynicism and hopelessness.

Vicarious Traumatization

Vicarious traumatization, also known as secondary traumatic stress (Taylor et al., 2016), is a psychological event first reported by McCann and Pearlman in 1990 to describe the result of therapists' interactions with individuals who experienced traumatic events (Pirelli et al., 2020). Vicarious traumatization is a process that evolves (Muehlhausen, 2021), whereby practitioners internalize the painful events of their patients, which impacts their mental health (Upashe et al., 2020). The concept of vicarious traumatization is not limited to mental health therapists but also to healthcare professionals, including nurses, doctors, and law enforcement professionals (Liu & Liu, 2020).

The signs and symptoms of vicarious traumatization include a decline in concentration, depression, changes in appetite and sleep, feelings of helplessness, and hypervigilance (Lloyd, 2020). In addition, vicarious traumatization can often lead to symptoms of post-traumatic stress disorder due to continuous exposure to others' painful experiences and events (Newman et al., 2019).

Compassion fatigue and vicarious traumatization are the consequences of caring for others, particularly for healthcare professionals. Vicarious traumatization is an emotional response caused by listening to others' difficulties; in other words, it is not a direct experience and affects the caregiver (Cavanagh et al., 2020). Compassion fatigue is an emotional and physical reaction to individual experiences while caring for others (Cavanagh et al., 2020).

Compassion Satisfaction

Compassion satisfaction, the antithesis of compassion fatigue, is the positive emotion an individual feels when caring for others, seen in various professions, such as nursing, medicine, teaching, and law enforcement (Baek et al., 2020). Fernández-Sánchez et al. (2018) believed that compassion satisfaction is the shield from compassion fatigue and the antagonist of burnout.

The concept of compassion satisfaction developed from the work of Stamm in collaboration with Figley, who further advanced the understanding of compassion fatigue. Stamm (2010) used the negative components of compassion fatigue and created positive components leading to the development of compassion satisfaction. Stamm (2010) determined that compassion satisfaction came from the joy of helping others and

doing one's job well. Stamm (2010) contributed to the Professional Quality of Life Scale (ProQOL), which consists of three constructs: professional burnout, secondary traumatic stress, and satisfaction with compassion. A 5-point Likert scale was used to evaluate the participants' personal experiences with each component (Stamm, 2010).

There are specific predictors that can support compassion satisfaction, such as proper staffing and resources, collaborative relationships, and a sense of pride in the work and helping others (Gonzalez et al., 2019). Additionally, when workers feel a sense of control over their well-being, there is an association with compassion and satisfaction, which can give them a sense of fulfillment and pleasure (Braun et al., 2022). In terms of nursing, compassion satisfaction comes from helping the patient improve their health and being conscientious regarding their work (Yu et al., 2016).

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a psychiatric disorder that results from direct or indirect experiences of a traumatic experience impacting an individual (Schuster & Dwyer, 2020). PTSD can also occur with repeated exposure to painful events. Historically, PTSD can be traced back to Homer's *Iliad*, published in 1508, the First World War, and ultimately, soldiers returning from the Vietnam War (Perrotta, 2019). There were also references to traumatic events and symptoms in *Henry IV* by William Shakespeare and *A Tale of Two Cities* by Charles Dickens (Friedman, 2018). The Diagnostic and Statistical Manual of Mental Disorders (DSM) officially recognized the disorder in 1980 (American Psychological Association 2019).

There are four categories of signs and symptoms of PTSD, which include intrusive thoughts and ideas, avoiding situations that can serve as reminders, adverse changes in thoughts and feelings, and hypervigilance (Schuster & Dwyer, 2020). Individuals with PTSD may also experience flashbacks, ideas of self-harm, anger outbursts, sleep disturbances, and a lack of positivity in their lives (Bryant, 2019).

PTSD is also described as "shellshock," "war neuroses," "battle fatigue," and "gross stress reaction" (Friedman, 2018) and was once considered a disorder pertaining only to war veterans (Schuster & Dwyer, 2020). However, the term is also associated with many occupations, such as healthcare personnel, firefighters, and law enforcement officers (Brooks et al., 2019). Xiao et al. (2020) conducted a study and surveyed 958 healthcare workers and concluded that healthcare workers who worked with COVID-19 patients were 2 to 3 three times more likely to experience PSTD than individuals who did not. Nurses are especially prone to PTSD because of caring for sick patients and not being able to protect patients from suffering and facing loss and pain (Schuster & Dwyer, 2020).

Secondary Traumatic Stress

Figley (1995) defined secondary traumatic stress as the natural outcome of helping or caring for those who have experienced a traumatic event. In other words, secondary traumatic stress is work-related exposure to individuals who have experienced and survived a traumatic event (Copeland, 2021). Secondary traumatic stress is often found in caring professions (Kellogg et al., 2018). Rauvola et al. (2019) argue that

secondary traumatic stress results from the indirect involvement of others' difficulties as opposed to compassion fatigue, which is direct personal involvement.

Individuals undergoing secondary traumatic stress may experience physical and psychological symptoms. The physical symptoms include insomnia (Copeland, 2021; Kobayashi et al., 2020; Wang et al., 2020), increased work hours (Wang et al., 2020), nervousness (Kellogg et al., 2018), as well as burnout and hypertension (Partlak Günüşen et al., 2019). The psychological symptoms comprise intrusive thoughts (Kellogg et al., 2018; Kobayashi et al., 2020), ruminating about the patient's experiences (Kellogg et al., 2018), and avoiding situations that serve as reminders of those experiences (Kobayashi et al., 2020). Emotional symptoms of secondary traumatic stress include fear (Copeland, 2021), exhaustion, and depression (Partlak Günüşen et al., 2019). Arnold (2020) believed that the physical, psychological, and emotional symptoms of secondary traumatic stress can lead to a post-traumatic stress disorder-like condition, which can have detrimental effects on one's work and personal life. Finally, Partlak Günüşen et al. (2019) contended that there could be positive attributes to secondary traumatic stress, such as increased coping skills and greater satisfaction in helping others.

COVID-19 and Compassion Fatigue

The pandemic known as COVID-19 impacted the world in extraordinary ways unseen in recent history, impacting the world and health care beyond what one could ever imagine. COVID-19 has had considerable and tremendous adverse effects on the nursing profession. The exorbitant number of sick patients left nurses with overwhelming

physical and emotional strains of compassion fatigue. Studies on the effects of compassion fatigue on nurses are only beginning.

COVID-19 placed many psychological burdens on nurses, manifested in fear, depression, anxiety, burnout (Tokac & Razon, 2021), feelings of vulnerability (González-Pando et al., 2022) as well as mental exhaustion (Murat et al., 2021). Nurses feared being infected by the virus and infecting their family and friends (Kackin et al., 2020). Fear also stemmed from the lack of information on the virus and the lack of evidence-based protocols to follow (Akkuş et al., 2022; Hochwarter et al., 2022; LoGiudice & Bartos, 2021). Also, nurses were utterly uncertain about how to care for the patients with this unknown disease, who rapidly deteriorated. Although nurses were looked upon as superheroes, there was a certain amount of stigma and isolation because as much as nurses were applauded for their efforts, people were afraid to be around them for fear of being infected (Ahmadidarrehsima et al., 2022). Compassion fatigue can lead to hopelessness, worthiness, and even guilt for the patients who passed away (Akkuş et al., 2022) because nurses were the only connection between patients and their families, who could not visit.

During COVID-19, nurses were adversely impacted by compassion fatigue due to the intensified workload (Sullivan et al., 2019) with increased working hours of 1.5 to 2 times the average amount of work hours (Galehdar et al., 2021), often without breaks or time-off. Patients experienced more pressure ulcers and falls, and because of the acuity of patient care, there were medication errors, resulting in lower ratings of patient care and satisfaction (Ahmadidarrehsima et al., 2022; Labrague & de los Santos, 2021). Nurses

often had to change their routines and were forced to work in other hospital units to care for the high number of COVID-19 patients (Lavoie-Tremblay et al., 2022).

Nurses experienced physical issues because of compassion fatigue, which often drastically affected their physical well-being. Some nurses experienced breathing issues and chest pain because of their experiences at work (Zhang et al.,2022), as well as insomnia, headaches, and anorexia (Ahmadidarrehsima et al., 2022). Some nurses turned to substance abuse (Stevenson et al., 2022) and smoking (Akkuş et al., 2022). COVID-19 negatively affected nurses' personal lives regarding spousal issues and parental burnout, resulting in child neglect and abuse (Stevenson et al., 2022). As many schools closed during the pandemic, additional daycare responsibilities and homeschooling caused more strain and stress for nurses (Stevenson et al., 2022).

One of the significant issues that nurses reported was the lack of personal protective equipment (PPE) and the difficulties working with PPE. After the onset of COVID-19, institutions lacked the proper PPE for healthcare professionals, leading to fear of infection and transmission of the virus (Kea, 2021). Nurses, who were at the forefront of patient care, lacked the necessary equipment to take care of patients, which led to a decline in patient care (Galehdar et al., 2021) and, in turn, feelings of abandonment by their employees (Arcadi et al., 2021).

The lack of PPE had detrimental effects on the nurses and patient care. Nurses expressed the difficulties of donning and doffing their PPE while attending to different patients (Ahmadidarrehsima et al., 2022), which left them with suffocation, headaches, skin reactions, particularly on their faces, sore throats, and extreme sweating (Akkuş et

al., 2022; Lavoie-Tremblay et al., 2020)-wearing PPE compromised patient care in terms of the difficulty of communication between the nurse and the patient and the inability of patients to identify their nurses and see their facial expressions (Akkuş et al., 2022). PPE added more physical exhaustion to the nurses, significantly affecting their ability to focus on their patients and impairing their ability (Moradi et al., 2021). Moreover, because of the lack of PPE, many nurses had to reuse their PPE, including single-use masks and N95 respirator, which significantly increased their fear of infection (Cohen & Rodgers, 2020). Rich-Edwards et al. (2021) found that most of the time, PPE was reused with no disinfection, including surgical masks and N95 respirator masks.

Nurses needed coping mechanisms to deal with their compassion fatigue during these times. Such coping mechanisms included turning to spirituality, support from families, friends, and co-workers, and seeking psychological counseling (Ahmadidarrehsima et al., 2022). Other methods for coping were walking, reading, journaling, exercising, and dancing (Akkuş et al., 2022). A study by Akkuş et al. (2022) showed that some nurses coped with COVID-19 by denying that there was a pandemic.

Nurses also encountered ethical dilemmas during this challenging time, creating more tension and stress. During the pandemic, nurses experienced moral injury, a consequence one encounters when going against their ethical and moral values (Hossain & Clatty, 2021). Moral injury is a military term that has had long-lasting consequences on the individual in demanding situations. During COVID-19, nurses prioritized which patients needed to be assessed first and how much time would be spent at their bedside (Hossain & Clatty, 2021). Nurses faced issues of equality and fairness as to which

patients would receive care supplies and equipment (Liu et al., 2022; Silverman et al., 2021). Nurses had to care for patients whom they knew would not live and decide what medications and equipment should be provided to these dying patients.

Additionally, there were tensions between nurses and physicians and a need for more collaboration on the quality of care that patients received or did not receive (Silverman et al., 2021). The lack of support from healthcare institutions created a predicament that left nurses alone in the crisis (Silverman et al., 2021). Another ethical issue that nurses experienced was working in areas of care in which they were not trained or were comfortable, such as intensive care units or emergency departments (Silverman et al., 2021)-changing units created stress and additional pressures for nurses who were not familiar with the protocols or scopes of practice.

Many studies have examined COVID-19, and the compassion fatigue nurses experienced during this harrowing time. Arcadi et al. (2021) conducted a qualitative study of 20 nurses in Italy and concluded that nurses need psychological support with proper training in times of emergencies to help with compassion fatigue and the overwhelming issues of stress. Crowe et al. (2022) examined the mental health difficulties of 425 Canadian critical care nurses who worked during the pandemic and the adverse effects of depression, anxiety, and post-traumatic stress disorder. Another quantitative study conducted by Zakeri et al. (2022) on 508 nurses from southern Iran determined that compassion fatigue and compassion satisfaction levels remained the same during the pre-pandemic and during the pandemic. Labrague and de los Santos (2021) performed a quantitative study of 270 nurses in the Philippines and concluded that

nurses were at the most significant risk of experiencing compassion fatigue during the pandemic. However, learning to be resilient, protected nurses, increased retention of nurses and improved patient care. Kackin et al. (2020) interviewed 10 Turkish nurses who cared for patients with COVID-19 and concluded that the pandemic adversely affected the nurses' psychological well-being.

A general literature review of COVID-19 and compassion fatigue in the United States revealed limited studies on nurses in the United States during the pandemic. COVID-19 severely impacted New York and caused devasting numbers of illnesses and deaths. Holmes et al. (2021) studied 181 social workers who cared for COVID-19 patients who experienced high levels of post-traumatic stress disorder and emphasized the need for healthcare organizations to provide emotional support for employees. Another study by Jones et al. (2021) on 484 pharmacists in the United States determined that COVID-19 fostered high levels of compassion fatigue resulting in medication errors, leading to medication and high levels of depression. Yu et al. (2022) studied 800 healthcare workers in a major hospital in New York City and determined that healthcare workers suffered mental health consequences during COVID-19. In the end, facilities must be prepared for such large-scale emergencies, and contingency plans must be created to sustain their healthcare workers.

Summary

The literature review provided evidence for the need to understand the long-term effects on nurses who coped with compassion fatigue from the pandemic. The review revealed how nurses coped with compassion fatigue with little to no time for reflection,

discussion, or explanation of their experiences or psychological support. Nurses worked countless hours, often without breaks or vacations for months. They experienced physical and psychological consequences because they cared for and did not walk away from their patients, resulting in terrible strains of compassion fatigue.

The gap in the literature revealed that there were studies done on the immediate effects of nurses who coped with compassion fatigue. Additionally, there were limited studies about nurses in the United States of America, particularly in New York, which was an epicenter during the pandemic. The gap in the literature, namely the nurses' experiences of coping with the long-term effects of compassion fatigue, justified this study. This study has implications for nursing for future outbreaks and ways for those institutions to support and care for their nurses who experience compassion fatigue, not only in times of the pandemic but in general times as well. Chapter 3 presents the methodology used for this study, the sample population, and the trustworthiness issues for the study.

Chapter 3: Research Method

The purpose of this qualitative descriptive phenomenology study was to understand the long-term effects on nurses' coping with compassion fatigue from the COVID-19 pandemic and the effects on their professional and personal lives. Since the beginning of the pandemic, nurses worked through tumultuous events and continued to work in the profession. Nurses were the primary caregivers of patients, providing emotional and physical support, witnessing numbers of people pass away, and managing their personal stressors and struggles, only to deal with the same physical and emotional traumas for their next shift. This study explained the effects nurses experience today, the impact the past has on their practice, and the ramifications the pandemic had on their personal lives. The firsthand accounts that nurses provided gave insight into how they coped with compassion fatigue during these times and what the nurses dealt with today. Their experiences had positive implications for nurses to form support groups for nurses who experience compassion fatigue, which may help with job satisfaction and improve retention rates for health care facilities. The research provided explanations of how facilities can support employees when experiencing compassion fatigue.

This chapter examines the methods used for data collection and analysis of the findings. In addition, this qualitative research design and the rationale for selecting this method are discussed. Areas of discussion include the research design and justification, the role of the researcher, instrumentation, recruitment, participation, data collection procedures, and trustworthiness issues.

Research Design and Rationale

This study was a qualitative descriptive phenomenological approach using semi structured interviews. The guiding research question for this study was "What are nurses' lived experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic?" A descriptive phenomenological qualitative approach was used to ascertain a more in-depth analysis and understanding of the lived experiences of the nurses who cared for COVID-19 patients instead of a quantitative approach, which would provide a statistical analysis of data devoid of personal stories and experiences. A qualitative design allows the researcher to explore the real life of the experiences and the meanings that persons placed on the situations (Miles & Salaña, 2020). A phenomenological method approach was used to understand the experiences of individuals and their understanding of the events (Flick, 2018; Merriam & Tisdell, 2016; Patton, 2015). A descriptive phenomenological approach allowed the nurses to provide rich and personal accounts of their experiences to understand the long-term effects of compassion fatigue on the nurses as well as interventions they used.

Role of the Researcher

The role of the researcher in a qualitative study is to ascertain the participants' ideas and thoughts of the participants through interviews and observation (Sutton & Austin, 2015) and to serve as the main instrument of the research process collecting and analyzing data (Polit & Beck, 2021; Shufutinsky, 2020). In a qualitative study, the role of the researcher is to "conconstruct" the knowledge gleaned from the participant (Sawatsky et al., 2019).

I did not have any relationship with the participants or any authority over them that would create an undue influence on their freedom to express their thoughts and feelings openly and unbiasedly (see Polit & Beck, 2021). Any participants known to me were asked not to participate in the study to avoid biases. I remained objective, free of bias and prejudices, and retained reflexibility to present an honest and truthful representation of the experiences. I objectively presented the participants' information to preserve the integrity of the study.

Further, I safeguarded the data, protected the participant's identity, and maintained confidentiality. Confidentiality was maintained by assigning each participant a number, and all printed information/data was protected in a locked file with no one having access other than me. An additional component of maintaining confidentiality was keeping participants' names and their affiliated health care facilities out of the reported demographics and not recruiting participants known to me. No identifying information was posted on the computer files, and I destroyed all identifying information.

All ethical issues were identified at the onset of the study. I identified as a registered professional nurse pursuing a doctoral degree in nursing education and a novice researcher. Before beginning the participant recruitment, approval was sought from Walden University's Institutional Review Board (IRB) to ensure the ethical treatment of the participants. At the beginning of the interview process, the participants were informed that they could end the interview at any time of their choosing or retract permission to use their information in the study without repercussion or negative influence. Furthermore, the role of the researcher was to establish a trusting and

empathetic relationship and not a therapeutic connection to analyze issues and problems that the participants are experiencing (Berry, 2016).

Methodology

Methodology is the process of acquiring, organizing, and evaluating data obtained in the research process (Polit & Beck, 2021). The methodology for this study was a qualitative descriptive phenomenology inquiry to understand the lived experiences described by the nurses who worked full-time during the peak wave of COVID-19, namely, from January 2020 to March 2021. Phenomenology is a detailed description of the experiences of individuals in their everyday lives (Polit & Beck, 2021). There are a few steps in a descriptive phenomenological study: bracketing, where a person's predetermined beliefs and biases are set aside; analyzing the data to gleam the meaning of the phenomenon; and describing where the researcher defines the phenomenon that was studied (Greening, 2019).

Participant Selection Process

I used convenience sampling for this study. Convenience sampling is the recruitment of the participants based on the ease of their accessibility for the researcher, which allows for the collection of data in a short time and is expensive (Bhardwaj, 2019). Convenience sampling has a disadvantage as "the subjects or respondents that are actually fitting for a research objective might not be the set of respondents that were eventually selected for the study" (Etikan & Babatope, 2019, p. 52).

A backup method used for this study was snowball sampling, which is also known as network sampling and chain sampling (Polit & Beck, 2021). The advantages of

snowball sampling are that it is cost-effective, and the samples can be collected quickly (Bhardwaj, 2019). Disadvantages are issues with bias and problematic finding a sample population (Bhardwaj, 2019). Snowball sampling assumes the researcher does not know the participants (van Rijnsoever, 2017).

Participants were recruited from the ranks of active membership in the New York State nursing organization, which has over 8,000 members and opened to all registered nurses. The organization was established in 2012 to promote excellence in nursing, improve the quality of patient care, and advance nursing professional development and leadership of registered nurses. An advertisement was placed on the organization's social media of Facebook, Instagram, Twitter, and Linkedin. No fee was charged for placement of the advertisement as I am a member of the organization.

This study of the nurses' lived experiences of the long-term effects of compassion fatigue from the pandemic was limited to registered professional nurses employed during COVID-19 and over 18 years old. Other criteria included nurses employed full-time and caring for COVID-19 patients during the peak of the virus from January 2020 to March 2021. Nurses who were not registered professional nurses and nurses who did not care for COVID-19 patients were excluded. The needed criteria were placed in the advertisement to specify who can participate in the study. The inclusion/exclusion criteria were verified during the recruitment of participants and before the interview process began. A screening questionnaire was administered to each potential participant to assess the presence or absence of the inclusion/exclusion criteria.

Participant Recruitment

Participants were recruited using the social media of a New York State nursing organization including Facebook, Instagram, Twitter, and LinkedIn. All paid members have access to the organization's social media site. An advertisement was placed on the New York State nursing organization's social media that clearly stated the inclusion criteria for participation in the study, the purpose of the research, and the time needed to conduct the interview (see Appendix A). Potential participants responded by email to set up an interview time. Demographic information included the name of the participant (only known to me and identified by a number), age range, gender, years of nursing experience, marital status, and highest level of nursing education, unit worked during COVID-19, and employment position. The selection of demographic information was based on a qualitative study conducted by Ahmadidarrehmisa et al. 2022 of nurses' experiences who cared for COVID-19 patients.

Participation selection continued until saturation was reached which in a phenomenological study the sample size is between 10 to 15 participants (Polit & Beck, 2021). Saturation is reached when the researcher hears the same information or no new information is discovered (Geddes et al., 2018; FitzPatrick, 2019; Merriam & Tisdell, 2016), and redundancy is found (Alam, 2020; Polit & Beck, 2021). Saturation is challenging to determine in qualitative research as it can be considered subjective.

Instrumentation

The instrumentation for this study was semi-structured interviews to answer the research question, "What are nurses' lived experiences of coping with the long-term

effects of compassion fatigue since the inception of the COVID-19 pandemic?" Other possible collection methods in qualitative research include unstructured interviews, focus groups, discussion groups, direct observation, textual analysis, and secondary analysis of existing data (Coast, 2017). Semi-structured interviews provide the best instrumentation to answer the research question. Semi-structured interviews allowed the participants to talk freely, describe their experiences and stories in their own words (Polit & Beck, 2021), and give a more detailed description of the human experience (Bearman, 2019). Dadzile et al. (2018) argued that semi-structured interviews are the most effective and efficient way of collecting qualitative data while preserving a scientific approach and answering research questions. The interviews were one-on-one via the Zoom platform, with open-ended questions developed by me to hear the nurses' stories and how they coped while dealing with compassion fatigue during COVID-19. Open-ended questions are the best way to elicit in-depth responses during the interview process (Bearman, 2019).

The data collection instrument, also known as the interview protocol for this study, was open-ended questions in an interview setting, allowing the participant to answer in a narrative form in his/her own words. All participants were asked the same questions for consistency and equality with the hope of eliminating any biases. Using open-ended questions aligns with the research question because it allowed the participants to share his/her personal stories on the long-term effects of coping with compassion fatigue from the pandemic (see Appendix B). The interview questions were based on Lazarus and Folkman's transactional theory of stress and coping and the

components of stress and coping and adaptation.

Procedures for Recruitment, Participation, and Data Collection

Participants for the study were recruited from the New York State nursing Organization. Members were invited to participate in the study via a recruitment flyer on the social media platforms Facebook, Instagram, Twitter, and Linkedin. The recruitment flyer included the name of the study, the purpose of the study, and the criteria for participation of registered professional nurses who cared for COVID-19 patients between January 2020 and March 2021. My Walden University email was used for this study and was the avenue for participants to express their interest.

The process of participation and recruitment began with an advertisement on the New York State nursing organization's social media, Facebook, Instagram, Twitter, and Linkedin. Potential participants emailed me through my Walden University's email. Participants who expressed an interest were sent the screening questionnaire to determine eligibility to participate in the study. If eligibility was met, a consent form was sent to the individual, signed, and returned to me by email. I printed out the consent form and will retain the consent form. An interview date and time was arranged once the informed consent was returned. The expected time for each interview was approximately 30-60 minutes, with the possibility of a follow-up interview if needed for clarification. The interview was conducted via ZOOM on my computer in my private home office to be free of interruptions and distractions, and participants were asked to do the same.

At the scheduled interview, participants were reminded of their informed consent and verified once they returned the completed consent form. Participants were reminded

that they could end the interview and could refuse to answer questions. Participants were reminded that the interview would be audio recorded and verified their consent to record the interview. A verbatim interview transcription was offered for the participants to check for accuracy.

The interviews were conducted using ZOOM, using only an audio recording, which were transcribed into a written transcript. Additionally, all interviews were recorded using Rev.com, which offers free recording and transcriptions for a fee. Both ZOOM and Rev.com were used in case one platform failed to record or malfunctions. All recordings were password-protected on a protected computer. All recordings, transcriptions of the interview, and journal notes were placed in a locked box where only I have the passcode and key. Participants were fully aware that the interview would be recorded and would be completely secure. To improve validity and accuracy, each written transcription would be sent to the participant for review and corrections, if he or she requested. This would allow me to ask for clarification. If the participant did not have time to answer questions for clarification, another interview would be set up.

Incentives

The research participants were offered a $20.00 Amazon e-gift card for the initial interview and a $15.00 Amazon e-gift card for any additional interviews if needed. Offering incentives was approved by the Institutional Review Board of Walden University. Additionally, the personal value of participation in nursing research and contributing to nursing knowledge was an intrinsic incentive for the nurses. The appropriateness of the incentive was discussed with the Walden IRB, the Executive

Director of the New York State nursing organization, and my committee chairperson.

Participant Exit

Participants participated in one 30 to 60-minute interview and had the option to review the transcript for any needed errors or corrections, taking about 10 minutes. Each participant consented to the study as noted by the consent form and was reminded that he or she could exit the study at any time and that participation was voluntary. There was a definitive point when the role of the researcher ends, as well as the participant's role who decided when to end the interview, either after completing the entire interview or at any time during the interview. Review of the transcript was optional and a decision that was up to the participants. After the interview, the participants were thanked, and a $20.00 Amazon e-gift card was sent to their email with a thank you note for participating in the study.

Data Analysis Plan

Data analysis aimed to look at the collected data, discover the meaning of the participants' words, and interpret and make sense of the information (Merriam & Tisdell, 2016). Each interview was analyzed immediately after the interview to find patterns to determine whether the questions needed to be refined for the following interview. Minor changes to the interview guide, that is, adding probing questions, were made, and changes to the interview guide were reviewed by my committee and the Walden IRB. Presenting unbiased conclusions was also a part of the process.

Colaizzi's method of data analysis was used for this study, which is based upon the understanding of the human experience as it is told by the individual (Colaizzi, 1978,

Wirihana et al., 2018). Colaizzi believed that in phenomenology "all research occurred through dialogue and that asking the right question was tantamount to eliciting an accurate description of the experience from study participants" (Phillips-Pula & Pickler, 2011, p. 68). There are seven steps in Colaizzi's framework, and only six were used for the data analysis of this study.

- Read each transcript numerous times to obtain the thoughts of the experience as told by the participants.
- Find and extract significant statements about the phenomenon.
- Formulate meanings to "make clear that which is hidden" (Phillips-Pula & Pickler, 2011, p. 68)
- Place the meanings into themes.
- Define each theme and provide paradigms of each of the themes.
- Formulate a description of the phenomenon being studied and how each theme relates.
- Validate the findings with the participants, known as member-checking, which will not be used for this study. Issues with member-checking include participants withdrawing from the study and requesting that some of the data be omitted or changed and may not wish to revisit traumatizing experiences (Motulsky, 2021).

For the purposes of this study, hand-coding was used as opposed to qualitative research software such as NVivo and MAXQDA. As a novice researcher, I used hand-coding to use Colaizzi's data analysis framework because I needed time with the transcripts. Using computer software could deprive the researcher of the opportunity to

understand the intricacies and meanings of what the participants are expressing (Goble et al., 2012). Learning new software can be tedious and laborious and does not always allow researchers to immerse themselves in the lived expressions of the participants (Goble et al., 2012). Additionally, Polit and Beck (2018) argued that using computer software for data analysis removes the researcher from the intuitive processes leaving the analysis to a computerized technical process. All data would be organized using a Microsoft Excel spreadsheet.

Qualitative data analysis started with coding the data line by line into broad categories and themes for common themes and differences (Polit & Beck, 2021). All transcriptions were analyzed line by line to identify and determine categories in the data which required numerous readings for accuracy, clarity, and missed errors (Polit & Beck, 2021). Once the categories were determined, the data was coded and examined for recurring words, topics, or concepts (Polit & Beck, 2018). Creswell and Creswell (2018) suggested the following qualitative data analysis process, the researcher needs to organize the data, carefully read, and reflect on the data, look for shared ideas and thoughts, code the data, determine common themes and subthemes, and create narratives to represent the themes and subthemes. At the beginning of the analysis, I used inductive analysis, leading to deductive analysis, as I moved into a mode of deductive analysis due to a greater understanding of the collected data and familiarity with the data (Merriam & Tisdell, 2016). Analysis of the collected data revealed outliers in the sampling. Outliers, the exceptions to the sample, would be included in the data. Villiers et al. (2019) argued that outliers can often uncover essential issues and information about the phenomenon.

All research materials will be held for five years in a secured space and then destroyed according to the policies of Walden University.

Issues of Trustworthiness

The concept of trustworthiness is critical for qualitative research and must be maintained from writing the questions to the conclusion of the study (Polit & Beck, 2021). The study used four criteria to design trustworthy research: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). The data analysis plan for this study was conducted to ensure integrity and trustworthiness, including using a protected computer, verbatim transcriptions verified by the participants when needed, a meticulous audit trail, triangulation, and peer review. Trustworthiness was based on credibility, transferability, dependability, and confirmability.

Credibility

Qualitative researchers need to establish credibility in a study regarding the truth in the data and interpretation of the findings (Polit & Beck, 2021). Credibility in qualitative research means that the data is credible and trustworthy (Stenfors et al., 2020). One method to establish credibility was to create an audit trail. An audit trail made all the steps and processes that I performed transparent, including the collection of the data, analysis of the findings, and interpretation of the findings (Wolf, 2003). As a novice researcher, my doctoral committee supervised the analysis and interpretation of the data and findings.

Transferability

Transferability refers to how the findings can be transferred to similar settings or

groups (Tuval-Mashiach, 2021). Transferability can be established by describing the demographic characteristics of the participant, the geographical location of the study, the characteristics and the number of the participants, the timeframe of the study, and the process of data analysis (Johnson et al., 2020). Transferability is intertwined with the study's findings' significance, applicability, and relevance (Sundler et al., 2019). Creswell and Miller (2000) believed that transferability can be confirmed using thick descriptions of the studied phenomena. Details for transferability include "location setting, atmosphere, climate, participants present, attitudes of the participants involved, reactions that may not be captured on audio recordings, bonds established between participants, and feelings of the investigator" (Amankwaa, 2016, p. 122).

Dependability

Dependability helps to establish the integrity of qualitative studies and refers to the stability of the data over time (Polit & Beck, 2021). Merriam and Grenier (2019) defined dependability as other researchers obtaining the same results as the original researcher and that the results will be consistent with the original study. The research method was detailed for other researchers to follow the study to ensure dependability. An audit trail is a methodical collection of research data, which would allow others to come to the same conclusions as the researcher (Polit & Beck, 2021).

Confirmability

Confirmability is the ability of other researchers to confirm the findings, that the interpretation and the reporting of the data are accurate (Tuval-Mashiach, 2021), and that the data is presented without the researcher's biases or subjective interpretations (Polit &

Beck, 2021). Biases can result from various sources, such as the sampling process, personal views, data collection, and interpretation of the data (Roulston & Shelton, 2015). Other biases that can occur in a study are participants' lack of honesty in recalling events and events (Polit & Beck, 2021) or omitting events that may be considered too painful to recall. Reflexivity and transparency will ensure ways to reduce biases in the study. Reflexivity is the researcher's self-awareness of personal biases, partialities, and prejudices (Polit & Beck, 2018).

Thus, to support the credibility of the study, I maintained a reflexive journal of preconceptions, beliefs, thoughts, and personal views about the study throughout the data collection, analysis, and interpretation of the findings. Another method to prevent biases from entering the research and reporting the data is bracketing, whereby the researcher attempts to put aside individual opinions and understandings of the phenomena to be studied (Merriam & Tisdell, 2016). "When a belief is temporarily suspended, consciousness itself becomes heightened and can be examined in the same way an object of consciousness can be examined" (Merriam & Tisdell, 2016, p. 26).

Ethical Procedures

Ethical procedures rely on the researcher's ethical standards and his/her determination to provide a study devoid of issues to nullify the study (Merriam & Tisdell, 2016). All components of this research were conducted ethically, particularly in protecting the study participants, according to Walden University's IRB. IRB approval was sought from Walden University. The New York State nursing organization did not have its own IRB. According to Walden University's IRB protocols, no letter of

cooperation was needed from the nursing organization which only distributed the recruitment flyer on their social media, Facebook. Instagram, Twitter, and Linkedin. The researcher's obligation was to maintain all ethical principles of safeguarding the data and protecting the participants (Taquette & Borges da Matta Souza, 2022). Other ethical factors included obtaining and signing informed consent, advising the participants on the purpose of the research, and how the research will be used (Cypress, 2018). Upon obtaining consent from each participant, a pseudo-identification number was assigned to each person. During the interviews and on the report of the findings, participants were referred to by their pseudo-identification number and not by name to maintain confidentiality further. Respondents were informed of the length of the interview and the option of ending the interview at any time and thanking the individuals for their involvement (Cypress, 2018). In addition, if participants were known to me, either professionally or personally, they were excluded from the study to maintain objectivity, which was made known through the screening process. The exclusion of participants who have a personal or professional relationship with me was needed as these participants may have felt they could not express their ideas and experiences freely, and that their confidentiality may not be maintained (McConnell-Henry et al., 2009). Given the recall of difficult experiences, unpleasant memories, and feelings, all participants were given a toll-free phone number to the National Hotline for Mental Health Crisis and Suicide Prevention, 1-800 273-TALK (8255) or 988.

Summary

In this chapter, I described the descriptive qualitative method of inquiry used to

answer the research question: “What are nurses’ lived experiences of coping with the long-term effects of compassion fatigue since the inception of the COVID-19 pandemic”? The chapter reviewed the role of the researcher, the methodology used, the participant selection and recruitment process, and data collection. Furthermore, the instrumentation used, and the research questions asked of the participants were discussed. Trustworthiness, including credibility, transferability, dependability, and confirmability, were discussed. Ethical procedures and the protection of the participants were explained. Chapter 4 explains how the data was analyzed and the interview results regarding codes and themes.

Chapter 4: Results

This qualitative phenomenological study was conducted to understand nurses' lived experiences of coping with the long-term effects of compassion from the pandemic of COVID-19. The research question was designed to address this purpose directly. This study focused on nurses who worked specifically between January 2020 and March 2021, the height of the pandemic. Open-ended questions were used to elicit as much of the nurses' experiences, thoughts, and perspectives of caring for COVID-19 patients and the impact the pandemic had on their lives professionally and personally. This chapter will describe the study's setting, participant demographics, data collection procedures, analysis of the data results, and evidence of trustworthiness.

Research Setting

The recruitment process for the study was from April 20, 2023, to June 7, 2023. A New York State nursing organization posted a recruitment flyer on its Facebook, Instagram, Twitter, and LinkedIn social media platforms. All participants provided a signed consent form and were reminded that they could withdraw from the interview process at any time. All the interviews for the study were conducted through Zoom on the date and time of the participant's choosing and were audio recorded on Zoom and Rev.com for backup purposes. Both recording devices offered transcripts after the interview. I asked the participants to be in a quiet location that was free of distractions and noise and to allow 30 to 60 minutes for the interview. No personal or organizational conditions influenced the 18 participants who contributed to this study.

Demographics

Eighteen registered nurses participated in this study. Of the 18 nurses, eight were male, and 10 were female. The nurses ranged from 20 to 50 years old, with the majority being in the 20-30 age range. Sixteen nurses were full-time workers during this time, and two were part-time workers. The participants' highest professional degree ranged from associate degree to master's degree; the majority, 12 nurses, had a bachelor's degree. The type of facility that the nurses worked at during this time ranged from acute-care facilities to rehabilitation centers with 12 of the 18 participants employed at acute-care facilities. The primary role that the nurses held was bedside patient care to a nursing manager, with the majority, 14 nurses, working in bedside patient care. Table 1 provides a detailed summary of the study participants.

Table 1

Demographics

Gender	Data
Male	8
Female	10
Prefer not to Answer	0
Age Range	
20-30	14
31-40	2
41-50	2
51-60	0
Greater than 60	0
Number of Years as a Nurse	
1-3	2
4-10	15
11-20	1
21-30	0
Greater than 31	0
Working Status	
Full-time	16
Part-time	2
Per Diem	0
Highest Professional Degree	
Diploma	0
Associate's	2
Bachelor's	12
Master's	4
Post-Master's	0
Doctorate	0
Type of Facility	
Acute Care Facility	12
Long-Term Care Facility	4
Rehabilitation Center	2
Home Care	0
Primary Role	
Bedside Patient Care	14
Charge Nurse	2
Nursing Manager	2

Data Collection

Number of Participants

Data collection for this study began with an advertisement placed on a New York State nursing organization's social media, which included Facebook, Instagram, Twitter, and LinkedIn. The organization did not require IRB approval as the organization was only placing an advertisement and not participating in the recruitment process or the study. The advertisement included the criteria needed to participate in the study and my email address and cell number to express interest in participation. Potential participants emailed or texted me to express interest in the study. An email was sent back to the potential participants with the study consent form. When the participant returned the consent form with all the required information, an email was sent to the participant with potential dates and times for interviews. Participants selected a specific date and time, and a confirmation email was returned to the participant with the exact date and time for the interview. Participants who did not complete the consent form completely received the consent form back and were asked to fill in the missing information. Eight potential participants did not return the completed consent form.

Participant numbers were assigned to the individuals when the actual interview took place. Eighteen interviews were conducted between April 20, 2023, to June 7, 2023. Saturation was reached at the 14th interview, but four more interviews were done to see if any new information would evolve. All 18 participants received a $20.00 Amazon gift card. A total of 18 participants were selected for the interview. Any individual who expressed interest after the 18th interview received a thank you email, stating the study

was closed.

Recording the Data

I conducted all 18 interviews using the audio portion of Zoom. Interviewing the participants' using Zoom was convenient and accessible for individuals as the participants could be in their homes or at work. Zoom offers free recording and free written transcriptions. I also used Rev.com to record the interview, offering a written transcription for a nominal fee. Rev.com served as a backup platform to record the interview in case the Zoom recording had any distortion or loss. Interviewees were asked to be in a quiet space and close to the microphone or to use headphones, as this improves the quality of the transcription and less distortion. I also took field notes during the interview. The interview guide provided a consistent format and ensured that all questions were asked (see Appendix B).

At the beginning of each interview, I collected demographic information. Permission to record the interview was asked of each person and all 18 participants agreed to be audio recorded. No video recordings were made. The interviews lasted between 30 to 60 minutes in length. I listened carefully to what the participants were saying and asked probing questions for follow-up or clarification. Upon completion of the interview, the participants were thanked, and each person received a $20.00 Amazon gift card that was sent to each participant's email with a thank you note. Participants were asked if they wanted a copy of the transcript to make any corrections. None of the participants asked for or requested a copy of the transcript. I secured the recordings on a

password-protected computer, and all written transcripts were placed in a locked box. I am the only one who has access to the locked box.

Variations in Data Collection and Unusual Circumstances

The only variation in the data collection was that I used Word and not Excel, as stated in Chapter 3. None of the participants wanted or requested a copy of the transcript after the interview. During the interview one potential participant was not able to secure a strong Wi-Fi connection and was not available at another time for another interview. This participant was excluded from the study.

Data Analysis

I used Colaizzi's method of data interpretation for data analysis. After each interview, copies of the transcript from both Zoom and Rev.com were printed out. The transcripts were compared for accuracy and clarification. If the transcript was unclear, the wording was incorrect, or the recording was inaudible or the transcript stated "inaudible," I listened to the audio recordings numerous times for accuracy and made the corrections on the printed transcript. In addition, I used journal notes taken during interviews to improve accuracy and understanding. I read each transcript numerous times to understand the meaning of what was expressed and what was not expressed. The interview questions offered themes for the study which also aligned with the theory of Lazarus and Folkman, the theoretical framework for this study. I analyzed each interview question for significant words which became my codes. Once I identified the codes, the significant statements of each participant were matched with the code and were highlighted with different colored markers. I created a Word document with the significant statements of

the interviews and read the statements numerous times to search for subthemes (see Table 2).

Table 2

Themes and Subthemes (Specific Quotations are Found in Results)

Themes	Subthemes
Lived Experiences	Emotional Strain Physical Strain Disbelief
Compassion Fatigue (Definitions)	Emotional Exhaustion Physical Exhaustion Sympathy and Empathy
Compassion Fatigue (Experiences)	Dealing with the Unknown Overwhelming
Stresses During the Pandemic	Fear Helplessness Patient Acuity
Appraisal/Assessment During the Pandemic	Desire for the Normal Survival Helplessness Physical/Emotional Trauma Positive Insights
Coping During the Pandemic	Activities Social Support Mindfulness Work
Long-Term Effects of the Pandemic	Fear Psychological Effects Positive Effects No long-term effects
Stresses: Looking Back	Work Fear Lack of Support
Appraisal/Assessment: Looking Back	Traumatic Learning Experiences
Coping Skills: Looking Back	Work Support Mindfulness/Spirituality Physical Activity
Health Care Facilities: Support During the Pandemic	Support Equipment No Support Administrative Support
Health Care Facilities: Support During Normal Times	Work Mental Support Administrative Support

Evidence of Trustworthiness

Qualitative researchers must provide evidence of trustworthiness in their study to certify rigor, validity, and reliability (Morse et al., 2002; Shenton, 2004). Lincoln and Guba (1985) defined trustworthiness according to four criteria: credibility, transferability, dependability, and confirmability. The researcher's responsibility is to instill measures that offer readers a sense that the study's findings have significance and value (Dyar, 2022).

Credibility

Credibility was established by creating a detailed audit trail that allows for full transparency of the steps and processes performed to collect the data, analyze the data, and determine the results. The study's findings reflected the meanings as the participants related to me while maintaining the accuracy of the data and the conclusions. All data were thoroughly analyzed to preserve the validity and reliability of the participants' experiences.

Individuals who wished to participate in the study responded to an ad on a New York State nursing organization's website. Potential participants emailed me, then I sent the individual a consent form. Once the consent form was received and checked to make sure that all the pertinent information was completed, the participants received an invitation with possible dates and times to be interviewed. When there was an agreed-upon date and time, the interview was scheduled. All interviews took place utilizing Zoom and were recorded on Zoom and Rev.com as a backup platform. Interviews were transcribed through the two platforms and the recordings were utilized to check for

accuracy and correction of any words that were not transcribed accurately.

Colaizzi's method of data interpretation was used for data analysis. Each transcript was read and reread for interpretation to understand what the participants were stating and their lived experiences. Significant statements were identified and highlighted to help determine the themes of the interviews and formulate the meanings of the words of the participants. The determined meanings were placed into themes that aligned with Lazarus and Folkman's theory of stress and coping, the study's theoretical foundation, and the study's interview questions. Once the themes were determined, which were reflected in the interview questions and their correlation to each other, subthemes were extracted from the words and statements of the participants. Thick descriptions of the phenomenon were provided in the participants' statements, and an audit trail was established to enhance credibility.

Transferability

Transferability is a component of establishing trustworthiness in qualitative research. Nassaji (2020) argued that transferability is the level at which the researcher's findings are transferable to similar settings, keeping in mind that qualitative research cannot be generalized like quantitative research. Thick explanations and detailed information can allow others to judge the transferability of the study to other settings. One must be cautious to think that transferability refers to the replication of the study with the same results. However, transferability expands knowledge by creating new knowledge based on the original study (Stahl & King, 2020). Demographic information included the number of participants, gender identification, age ranges, years as a

registered nurse, working status between January 2020 and March 2021, highest professional degree, type of working facility during January 2020 and March 2021, and their nursing role during this time.

All 18 participants who came forward after responding to an ad on their nursing organization's website were registered nurses and were emailed a consent form which was returned to me completed and signed. All participants were interviewed via Zoom and asked the same interview questions in the same order to maintain consistency. The interviews were recorded on Zoom and Rev.com, which provided transcripts that needed review and correction as the recordings did not accurately pick up certain words. Colaizzi's data analysis was used for this study.

Dependability

Dependability is the ability to replicate the study to determine if the study were repeated with similar participants; the results would be similar (Dyar, 2022; Nassaji, 2020). Shenton (2004) argued that the research design should be viewed as a "prototype model" as duplicating the study may not yield the same results. The criteria to establish dependability include a detailed methodological description for the study to be repeated (Shenton, 2004) and an audit trail that included documentation of all the processes (Dyar, 2022). An additional criterion for dependability is peer-reviewing, which helps to provide further analysis and feedback (Stahl & King, 2020). Peer-reviewing was completed by the chairpersons of my study.

Credibility was established for this study by providing a detailed methodological description of this study in terms of criteria for participation, participation selection,

interview guide with interview questions, method of data analysis, and data results. An audit trail was maintained, which included the interview transcripts, summary of interviews, formatting codes and subthemes, and results. Members of my committee peer-reviewed the data results and provided feedback for areas of clarification.

Confirmability

Confirmability is the ability to provide data and results that are objective and neutral (Polit & Beck, 2021). Qualitative researchers must provide factual data results and be devoid of personal biases. Creswell and Creswell (2018) believed that credibility can only be achieved when a researcher acknowledges any biases and how the researcher's "interpretation of the findings is shaped by their background, such as gender, culture, history, and socioeconomic origin" (pp. 200-201). Interviews were transcribed by the selected platforms and reviewed for accuracy. Participants were offered a copy of a printed transcript if requested. No transcripts were requested by the participants.

Study Results

Theme 1: Lived Experiences

Each participant shared their lived experiences of caring for COVID-19 patients between January 2020 and March 2021. Fifteen participants, most of the participants, described this time as filled with emotional strain, scary, emotionally draining, and horrible. Three participants discussed the physical strain of the pandemic, particularly in terms of patient workload and the lack of equipment to care for the patients. Two participants expressed disbelief that the virus was serious and would go away quicker than it did.

Table 3

Lived Experiences

Theme	Subthemes	Participant	Participant Responses
Lived experiences	Emotional Strain	P2	I would use the term scary. It was a new experience in my profession and fighting something you do even know. It was stressful.
		P3	I would say it was exhausting and full of anxiety.
		P4	The pandemic was something that hit everybody, and it was spreading so fast. And because I was on the frontline, it kept me with a lot of fears.
		P5	It came as a shock to many of us. It was not a very easy journey, and it was hard for me to deal with.
		P6	It was a tough experience because it was an unforeseen circumstance where everyone suffered, and no one was expecting that Covid to be a big one for us
		P7	Covid was so terrible and so horrible for every individual, and it was huge for us and so shocking.
		P8	My experience as a nurse as that it was very stressful because at that the time, we had a few patients and then it was like from zero to five to 10 to 20 every day. It was very, very stressful. At the same time, I had a lot of questions, and it was tired and wiped out. From this patient to the next, it was very, very stressful.
		P9	Initially, it was very scary, and we as medical professionals had no idea what this disease was and we had no idea how it spread. It was scary and the unknown is just scary.
		P10	COVID-19 was the most stressing period of my life. I experienced a lot of depression and anxiety.
		P11	It was kind of stressful moment for me. As a nurse, you need to work day, after day. Seeing that more patients were getting positive for COVID-19 and they were being brought into isolated units, nurses had to give them all their attention that they needed to see the way that they can get the necessary medications to get them back on their feet.
		P12	It was a difficult time for everyone. We had a lot of people coming in, and a lot to do.
		P13	We were facing a lot of uncertainties and a lot of difficulties in managing our patients. We had a lot of challenges and it truly interfered with the way of doing tasks and patient management.
		P15	Honestly, I would say it was emotionally exhausting for me.
		P16	I was always exhausted. I got home tired, and you know seeing some patients passing away causes depression.
		P17	Let's say that we had a very difficult moment during that period because you were receiving a lot of patients at that point.
	Physical Strain	P8	It was really stressful because at that time we had 10 to 20 patients every day and it was very stressful. I was tired.
		P14	I faced challenges with some patients where I admitted them, and I tried to give them the equipment and attention needed as a nurse to help them.
		P18	It was very hectic because you know the amount of people I had to take care of sort of, you know escalated. So, I mean it was working with one to three patients a day, at that times it escalated to 10.
	Disbelief	P1	I think I didn't take it as serious as I thought it was going to be. People die of the flu just as much as they die as anything else.
		P7	Everyone thought it would not get to this country.

Theme 2: Definitions of Compassion Fatigue

I asked participants to give their own definitions of compassion fatigue and how they interrupt compassion fatigue. Six participants defined compassion fatigue in terms of emotional exhaustion as helpless and stressful. Eight participants defined compassion fatigue as physical exhaustion due to the workload of caring for COVID-19 patients, and four participants believed that compassion fatigue meant sympathy and empathy for patients.

Table 4

Definition of Compassion Fatigue

Theme	Subthemes	Participant	Participant Responses
Compassion Fatigue	Emotional Exhaustion	P2	It has to deal with stress. It is a result of stress actually and not being able to maybe deal with a lot to deal with a lot stuff to deal with. Not being able to function to function as a result of being tired and being exhausted.
		P3	It's a psychological and emotional feeling of as a nurse or healthcare worker being helpless.
		P5	Compassion fatigue is when someone who is a professional is having trouble dealing with things in their professional area.
		P12	I think it has to do with stress. It is just being overworked. It might be the result, maybe you have so much to do at the same time.
		P13	The emotional opportunity that one might experience when he cannot actually care for others or help people who are suffering
		P17	The inability to help someone at least to the inability to help people, or having, not being able to help someone.
	Physical Exhaustion	P6	Frequent contact with traumatic people and other staff. It also comes from when, there's too much workload for you. You have so much to do at the same time and cannot handle it
		P7	You just don't feel like doing anything, You feel so tired and you fell you don't want to be attached to anyone
		P8	I think compassion fatigue is like maybe physical, emotional, and psychological impact of helping others, reducing my sensitivity.
		P9	I would say compassion fatigue is caring for the caring with no results. Caring for something but not having but yielding no results.
		P10	Compassion fatigue means caring for the patients and ensure that some of them are being recovered in a healthy condition
		P11	It actually means much more effort being required from my side and seeing that my patients are okay. I am always tired at the end of everything.
		P14	It means trying as possible of getting rid of something negatively in someone's life.
		P16	It means actually getting tired from what you actually do. Getting weary and stuff like that, Not being all okay due to caring for people.
	Sympathy/ Empathy	P1	Basically, being empathetic to your patient and knowing what they're going through and doing so much more because you didn't even have the staff to take care of the patient
		P4	Working with one another coordinating towards a goal that you are driven and working together
		P15	The current situation you find yourself can cause compassion fatigue.
		P18	I would say compassion actually means for me; you know feeling some type of way for someone you know. Just being exhausted about a particular activity

Theme 3: Experiences of Compassion Fatigue

I asked participants for their individual experiences of compassion fatigue in caring for COVID-19 patients. The subthemes that emerged included dealing with the unknown with 11 participants and 7 participants stating that their experiences were overwhelming. Six participants described actual experiences of compassion fatigue, whereas many defined their experiences in general terms.

Table 5

Experiences of Compassion Fatigue

Theme	Subthemes	Participant	Participant Responses
Experiences of Compassion Fatigue	Dealing with the Unknown	P1	I was caring for a patient in labor who was positive (for COVID-19) who was actually symptomatic, and she was in the ICU, and they kept her in the ICU because she was really, really and, and the idea was they were planning for her induction. She was she could barely breathe. Se's on oxygen and she's laboring, and we eventually got her delivered and she ended going back to the ICU. But it was like such a moving experience that I was a part of something that I prevented her from actually getting worse, and even though it was a tiring experience, it was so gratifying to known that I can help her and even the smallest little way to prevent her from getting worse.
		P2	We had a lot of people to attend to and there was work stress and not knowing.
		P3	Looking at the patients, it wasn't easy, and you feel like you could just make them all of them fine. You could just do something quickly that it gets better soon.
		P4	The experience was not that welcoming but as we continued, I felt that actually it was working out well. We actually needed one another to make things happen in the heat of the pandemic/
		P5	I was a new nurse and like I said it was something that I never expected that would come and it was a new disease that everybody was not aware of. We did not know what to do sometimes and we were worried about how things are gonna end up.
		P8	At the beginning of the pandemic, it was something new to me but as time went on I like got used to it.
		P9	Compassion fatigue is caring for the caring but with no results. That's what I would say the whole gist of it. Caring, caring for something but having, but yielding no results.
		P10	I had experienced a young teenage boy who was actually suffering with Covid, and I was really, I felt so bad for him because a little boy of that age should never have been going through that. So, in order for me to help him, I really put my best to make sure that the boy had been fully recovered.
		P11	There was a lady that was being brought and she was pregnant with a baby, and she tested positive for COVID-19. And with that I felt very bad for her, and I worked for a possible way that she can be set on her feet again.
		P15	I had a patient that I was taking care of, and she was so afraid to die. She was talking about a two-year-old kid, you know, she wishes she could just go back home and be fine and just get away from all of that
		P17	We were not able to attend to a lot of patients and we didn't actually know what to do with the virus. Some people in critical condition who needed help were sent home and maybe given just drugs and go back home without getting proper care.

Theme	Subthemes	Participant	Participant Responses
	Overwhelming	P6	I did experience (compassion fatigue) that more frequently because there as a lot of people to attend to, but you know, you cannot attend to everyone at the same time. It was a very difficult and challenging for everyone.
		P7	You are giving your heart out to someone or helping them or loving them. But as days went by, we had more cases, day in, day out this side, the other side, and everywhere people are dying. So it, was painful. You see, you cannot help someone. They're just dying while you're just looking at them. They're dying in masses. So, it was so, so terrible at that particular moment, and I felt like I was losing myself.
		P12	During that time, you know, we need to work extra hours, you know, double shift and because there were a lot of people to attend to and so much stress, and we had a lot to do at that moment.
		P13	Normally we tend to a lot of people or a good number of patients, but we had to adjust. And we could not just help everyone who wanted to be helped.
		P14	I remember taking care of a patient in critical condition, in the worst condition and there is a part of your self and you are really dizzy and you do not have enough strength to give adequate treatment to the patient. You try to force yourself to do what is needed at the moment and you are not capable of doing it or you're trying to give out the best you are.
		P16	There was a patient I was caring for and the patient actually gave up and she died of the virus and this left me very depressed all night. And even currently when I do remember from that experience I'm always depressed. I see some patients responding to treatments and some not responding to treatments. It's depressed in nature.

Theme 4: Stresses During the Pandemic

COVID-19 was a stressful time for all healthcare professionals, especially nurses. One of the components of Lazarus and Folkman's theory is stress. The subthemes that emerged from the study were fear, helplessness, and patient acuity. Six participants stated that their stress resulted from fear of the virus and fear for their families contacting the virus from them. Six of the participants defined their stress due to helplessness of caring for Covid- 19 patients and not being able to help them or the patients passing away. Five participants defined their stress resulting from patient acuity, the number of patients being admitted, and the number of patients dying while in their care.

Table 6

Stresses During the Pandemic

Theme	Subthemes	Participant	Participant Responses
Stresses during the Pandemic	Fear	P2	My personal stress was the work stress and not knowing what to do.
		P3	It was hectic and fearful for me and coupled with the fact that fear of getting covid and my family was sacred that something may happen to me.
		P6	I had a lot of mental stress because it was a movement that every was afraid.
		P13	I think the stresses in the hospital we had the fear of spreading the disease in environment and the social stigma when working with patients who might have COVID-19.
		P15	It was anxiety, emotional exhaustion. And I had insomnia, so it was really hard on me at some point.
		P17	I had to stay alone so that for a very long period of time and not put my family in the risk of getting the virus because I was handling patients and I didn't know who had the virus and who did not.
	Helplessness	P1	It was the socialization, I think, is one of the hardest thing like you know you're used to being able to just go do things freely. And at this point, you can't do it and you know from being from healthcare, you need an outlet
		P5	It was when people were dying. Many people were dying and sometimes you did not know what to do, to do with them, or how to talk, talk about it with their family and their loved ones
		P7	My biggest stress aside from losing some of my favorite patients. I also had the stress of losing any of my family members. That was my biggest stress because I thought I could live with that. I saw a lot of people dying and that gave me a lot of stress and also the fact that I could not do anything about it.
		P8	The most stress was dealing with the elder patients as we had some serious patients and to take care of them
		P11	Actually, during this period, the stresses, I really don't like talking about them. Cause there were some horrible moments for me during this period
		P12	One of the stresses was a time involved in the work involved, It was much for us and not knowing what to face and knowing the situation.
	Patient Acuity	P4	The stress was creating more time to see the patients with COVID-19. They needed immediate attention after the point where we exceeded our work hours. It always interfered or cut into the hours that I used to spend with family before. I was overwhelming for me and that's where the stress came in.
		P9	It was the large number of them, the patient load. Prior to Covid, we don't see triple assignments, mean three patients to one nurse during Covid because it was so many people that was infected. A lot of older nurse staff members said I don't want to be doing this again. It was also rough being alone.
		P10	I couldn't eat. I hardly had time to feed myself because I was really, really into my work. I had pains in my legs, checking on my patients, making sure everything is being okay and knowing the medications are intact.
		P14	The biggest stress was whenever patients seem not to have a quick recovery and you are not giving the best to them when a patient dies. If seems like you are not giving adequate treatment or you're not giving out the best treatment.
		P16	Walking around the hospital was really stressful. We had patients being registered every day, and patients were found to be infected by the virus and taking care of the patients has been s, was very stressful for me.
		P18	Stresses for me was working extra hours. Working extra hours and also being very attentive, spending more time at work. We sort of had a shortage of labor forces.

Theme 5: Appraisal/Assessment During the Pandemic

Participants reflected on the pandemic and their thoughts on the pandemic. Five subthemes surfaced in the transcript analysis: desire for the normal, survival, helplessness, physical/emotional trauma, and positive insights. Eight of the 18 participants discussed the physical and emotional trauma that the pandemic had on them. They reflected on the period as exhausting, terrifying, and unable to care for many patients. Three participants discussed their feelings of feeling helpless during the pandemic. Two participants expressed their feelings of wanting and hoping to survive the crisis and two participants communicated their feelings of wanting things to return to normal. Three participants expressed that the pandemic offered a positive learning experience for them as they helped patients and saw the time as a learning period for them.

Table 7

Appraisal/Assessment During the Pandemic

Theme	Subthemes	Participant	Participant Responses
Appraisal /Assessment	Desire for the Normal	P2	I was hoping it would just pass away so we can return back to the normal. All the stuff was a bit tiring, and it was risky at times.
		P6	As a professional, I believe that whenever a problem that comes up, there's always a solution. I knew that at the end that everything's gonna turn back in place, but I didn't know how fast it's gonna be. So, I was setting up with emotion for things to go back in place.
	Survival	P9	So, survival. That's it. Survival, Survival. In every single way. Human beings trying to survive with again, everyone, we did not know what it was.
		P12	It was very difficult for everybody. I would say, it was a time we, I would just try to leave and survive and also be there for others.
	Helplessness	P3	I felt like we didn't have enough time to prepare for the kind of pandemic, that kind of situation, like the speed at which it came. And I felt just helpless, and we didn't have enough time.
		P5	At first, I did not know what this was and never know how long it would last. Sometimes we were worried what if we run out of protective gear and that is going to expose us to, the risk of getting the disease.
		P8	My thoughts were like I like everything to just go away. I'm really tired and just hope it would go away. You see some persons in pain, and you wish you could just make it all go, but you don't have the power to do that.
	Physical/ Emotional Trauma	P1	It was very, very scary, because again, a lot of people in the very beginning even throughout the whole pandemic a lot came in and you didn't know what they had, if they had it.
		P4	This time was not easy because some of my friends happened actually to pass on because of the pandemic, because of COVID-19. So, it really tome me a while actually to prepare myself.
		P7	So, looking at most of the patients it was something that it was, it was not that serious for the first patients that I met. But with time, some people come to the hospital after the symptoms have increased and not it's uncontrollable. It becomes terrible and so terrifying.
		P13	I think it was the worst period of my life. It almost led me to the impression I, myself, I could not do it. I think the period was very, very stressful, for me and those around me.
		P14	I was very exhausting and stressful because really not everyone pulls through including the nurse and medical personnel and practitioners.
		P15	I would say it was trauma. I mean patients at their worst and all of them wishes them to get better and you just wish you can really help them, make them go home, make them feel better.
		P16	It was a demanding period, your time and attention.
		P17	Covid just put fear into everyone, and it was really emotional to many people, especially as nurses and the people who were in the healthcare system.
	Positive Insights	P10	It was stressful, but then I'm glad and happy that really helped a lot of patients who recovered for Covid. I felt very happy, especially for the teenage boy who I actually gave him my very best to help him be healthy again.
		P11	It was kind of a learning season for me cause I learned new ways. I got to meet new people from different races.
		P18	It was a whole new experience. I actually learned a lot. I actually learned a lot about myself because I want to learn. So, for me it was a very wonderful learning curve. It was for me to reflect and see you know, how, how good life is and supposed to be lived. You know, ho wonderful I should spend life and all of that just to be happy in the moment.

Theme 6: Coping During the Pandemic

An essential element of Lazarus and Folkman's theory is coping. The nurses in this study discussed how they coped during this traumatic time. Ten participants stated that they coped through social support, namely, family, friends, colleagues, or social media. Six participants stated that work was their coping mechanism in caring for their patients and seeing COVID-19 patients recover. Activities played a means for coping for four nurses as they went to the gym, exercised, and watched movies. Two of the participants practiced mindfulness, expressing gratitude, and praying.

Table 8

Coping During the Pandemic

Theme	Subthemes	Participant	Participant Responses
Coping	Activities	P1	I made it my business to get better, get better. My daughter and I would just put on a mask and walk. We did a lot hiking in the park instead of going to the gym.
		P8	I did exercise. I ate healthy and I took all the necessary precaution measures to stay healthy.
		P10	I normally go out on a picnic and watch movies.
		P17	I just stayed in the house, occupying myself with activities, like watching movies and like social media things.
	Social support	P3	Just a few words of encouragement and comfort for my family. And my mom used to pray for me, like a real prayer.
		P4	After doing the work, I use to ensure that I have someone that I could talk to when I got back at home whom I could share the experience with a person who is not actually who is working in the medical with who can sit with me and make me feel comfortable
		P5	So I can say most of the time, like I said, during the time, we really close with my colleagues, and the only time that we used to spend most of the time together. We had prayer sessions with my colleagues.
		P8	I coped with the help of colleagues. They were very helpful. We had this bond that we shared each other.
		P9	We coped with the support of my family. Also, meeting different nurses from different states. There was a great sense of support. Also, the support from the community, the support from family friends, the support from medical staff.
		P10	My family was so supportive during that period of my life. They were always encouraging, putting every effort to make sure that I'm okay.
		P13	For me it was social media to at least take away the boredom and loneliness. It was my way of communicating with the world at that point. Also, meditation and exercise as I had limited contact with my family members.
		P15	Sometimes I talk to my family members. My mom used to encourage me and my husband too. So they just talk to me each time because after the day, I'll just make them understand what I felt or exactly what I passed through that day and they'll kind of encourage me.
		P16	When I have some free time, when I'm back home from work, I do try to sit out with my friends, and I told a relative of mind and I would try to sit with him and have a discussion with him about the different frustrative things that happened in the hospital.
		P17	I just stayed in the house, occupying myself with activities, like watching movies and like social media things.
		P18	I really didn't have much in terms of coping. I always found time to just take a rest and, you know, relax a bit. You know, just unwind in terms of sitting down and looking at the water or just having a few friends of mine whom we work together and just sit down and talk and just leave off of the stress. I also went on social media.
	Mindfulness	P11	I practiced gratitude. I was always grateful. I look forward to seeing my patient's getting back on their feet,
		P14	I definitely worked on myself, and I tried to regulate my movement and I tried to observe myself. I'm very conscious of myself and some of my activities and tried to balance my lifestyle and I prayed, and I exercised.

Theme	Subthemes	Participant	Participant Responses
	Work	P2	I was just hoping that you see the next day because you just go out there to just take the risks and you don't even know what's going to be the end. product at some point. You might be in danger.
		P4	While at work, the only thing that I used to do is actually concentrate on the work fully
		P6	Just do my job that I was doing, and they needed me, and they needed me to do my work. You needed to tell them (patients), "You'll be fine." I love what I do actually.
		P7	You have to be a nurse; you have to be strong. I did not want to show my patients that I was scared. I just had to be that strong so that they may be and also have some hope that everything was going to be okay. So, I had to put myself together and try my best to make them have a positive environment and which could help them have a positive vibe and heal and have hope that they're going to heal
		P12	I was taking it day by day and just keeping hope and doing my work. I had support from my colleagues.
		P16	One of the things that helped me was seeing the patient being admitted that they were okay and me looking forward to seeing them always kept me going.

Theme 7: Long-Term Effects of the Pandemic

The primary focus of this study was the long-term effects the pandemic had on the nurses. Four subthemes surfaced from the data: fear, psychological effects, positive effects, and no effects. Two study participants expressed fear as a long-term effect as COVID-19 continues today and fear of what might happen next, the next pandemic. Nine participants felt that they experienced psychological effects regarding feeling distraught, anxiety, trauma, and depression. Five participants experienced positive effects as they felt they gained more knowledge, felt stronger as individuals and nurses, and felt they could provide more competent care to critical patients. Three participants felt that they had no long-term effects of the pandemic.

Table 9

Long-Term Effects of the Pandemic

Theme	Subthemes	Participant	Participant Responses
Long-term effects	Fear	P1	It just doesn't go away and it's like it seems like there's always going to be somebody positive in the hospital. Everyone is going about their business and thinking that everything is okay when you're still in the hospital and you still see that there are patients who are positive.
		P6	We never know what is going to happen next. I need to be prepared.
	Psychological Effects	P3	It was a very emotional moment for me because the family (of the patient) was very sad, and they needed all my help. I wish I could help. I meant I wish I could help, but it was hard.
		P4	The long-term effect of COVID-19 is the distress that came with it. I felt a bit of trauma. I worked on my mind sot that I can actually get that over that.
		P5	The anxiety is not fully gone but I've been trying ways to help me reduce that. The being scared of losing people what we saw really opened our eyes and minds and give is that idea that life is too short, and we can lose the people that are very close to us anytime.
		P7	Its changed how I see things. It left something on me because of the number of deaths that I saw during the particular time was quite big and it was traumatizing for me. I'm still trying to heal.
		P9	Covid has definitely opened our eyes to how the hospital truly feels about us. There are not open wounds but there are definitely scars.
		P10	Sometimes I used to experience anxiety, mentally I experience anxiety and depression which I currently do.
		P11	Whenever I think about the pandemic, I get depressed because I saw people lose their lives
		P16	Sometimes I get depressed when I'm alone thinking about the scenarios that happened in the hospital. It leaves me with flashbacks, not nightmares.
		P18	It's the trauma, you know, having to lose a lot of people during that period. Cause there were a lot of, I mean, if you follow the news there were a lot of deaths recorded. Or maybe now it's a little more relaxed. I still feel sometimes I, I feel I am working faster than I should be in the sense that I accomplish a lot of tasks faster.
	Positive Effects	P2	Covid just give me experiences and make me understand everything more in my field.
		P3	It actually kept me empathetic towards the patients and also protect my safety and it boosted my confidence.
		P8	The pandemic is not let's say made me prepared for anything, anything that could happen. . . I've been more healthy.
		P12	I say that we have a lot to do as nurses and we shall always be ready when we are called upon in such situations, similar or different situations. And, also let us know that at some point there can be risks, because you might not know what you are facing,
		P14	It's not been a nightmare to me or scaring issue to me during the pandemic because we will be in condition where we handle some patients that have worse critical conditions like this.
	No long- terms effects	P13	No long-term effects. I think after 2023 we are done, we've done well, we've done so well.
		P15	Not anymore. I am totally fine now
		P17	I think we worked around the emotional changes that came with Covid. I think I really up to now it doesn't affect me that much, but it had some effect on me back then.

Theme 8: Stresses Looking Back

I felt it was important for the 18 participants to reflect on their lived experiences of caring for COVID-19 patients, and I used the same three elements of Lazarus and Folkman's theory. When the participants reflected on the stresses of this period, three subthemes emerged: work, fear of loss, and lack of support. Thirteen participants felt that their significant stresses were work, namely, patient care, workload, long hours, and lack of time for self-care. Four participants stated that the fear of loss was a significant stress for them. Four participants stated that fear was their biggest stress: losing patients, being infected, and fearing death. One participant felt that lack of administrative support caused stress and did not support the medical staff.

Table 10

Stresses Looking Back

Theme	Subthemes	Participant	Participant Responses
Stresses: Looking Back	Work	P2	The situation itself was stressful. We had a lot of people coming in, more than usual. The workload was much.
		P3	My biggest stress was the anxiety form work which impacted my mental health.
		P4	The biggest stress was all about managing the patients. You come home in the evening, you watch the news, and you see like so many people actually have died due to the pandemic. And you wake up tomorrow and you are the one who is on the frontline actually with many so many patients.
		P5	We helped other people to survive this and gave others hope even as much as we were all down and losing ourselves tome point. I usually ask myself," how did I do that."
		P6	We did not really have much time to think about ourselves to even take care about ourselves or worry about ourselves.
		P8	My stresses were making sure that everyone was okay, and we had supplies. Sometimes I even if my shift was over, I had to stay behind cause of short staffing.
		P10	Caring for patients and wanting them to recover.
		P11	The biggest stress for me was actually my patients.
		P12	I'd say one of the things that was really tiring because I didn't really have time for myself or my family because of the situation I was mostly in the hospital working.
		P14	Trying to help the patients with their own health conditions and the lack of a vaccine. We were trying to prevent the spread of it at that moment.
		P15	Just making sure they are a least fine, I mean, that was a big stress because the patients were really, really scared.
		P16	The biggest stress for me was attending to the different patients in the hospital. Some responding positively to the medications and some not responding.
		P18	My stresses were making sure that everyone was okay, and we had supplies. Sometimes I even if my shift was over, I had to stay behind cause of short staffing.
	Fear	P1	I have elderly parents and they're not well. I was fearful that us my mother gets it that could be the end of her, and she lost friends from it.
		P7	My biggest stress was losing my family members, which I thank God did not happen.
		P13	The biggest stress during that time was the worry about my health, My health was a priority and how to manage in my facility that I worked in.
		P17	The biggest stress was fear of death. It was a cruel, a very cruel virus. Something I've never witnessed before and something that I didn't have any control over. And we didn't have any vaccine to suppress it.
	Lack of support	P9	I would just say the lack of support. We know as nurses that we struggle the same across the board that we did not have the support from administration management. Some managers weren't great, but some managers were. And they definitely could have given medical staff more support during the time.

Theme 9: Appraisal/Assessment Looking Back

I asked participants to reflect and give their appraisal of this time and to explain what it was like being a nurse at this time. Two subthemes emerged from the data analysis: traumatic and a learning experience. Fourteen nurses stated that COVID-19 was a traumatic experience in their lives as it was described as scary, unexplainable, shocking, and disastrous. Four participants stated that the time was a learning experience for them as the pandemic offered the opportunity to learn how to be more compassionate, appreciate life, and gain more nursing knowledge.

Table 11

Appraisal/Assessment Looking Back

Theme	Subthemes	Participant	Participant Responses
Appraisal Assessment: Looking Back	Traumatic	P1	It was extremely scary with so many people coming into the hospital.
		P2	I just did what I did because that is what I needed to do.
		P3	It was unexplainable.
		P4	I could tell someone it was not easy. It was hard for me. I can say it was really hard.
		P5	I can say previously even before COVID-19, there have been other pandemics too. But they were not severe as COVID-19. And each time they come doctors, researchers and nurses get to learn from them and know what to do. Unlike this one, they were not aware how to deal with it. Cause the number of people getting infected and the number of people that were dying, this was shocker to many of the people that were involved in trying to the vaccines or things to help them with the pandemic. And I can say, it was real nightmare and eventually woke up.
		P6	It was scary and exhausting at the same time.
		P7	In my own assessment during this particular time, I'd say that COVID-19 is something that came as a shock to everyone. Nobody expected it. Nobody thought it would spread to all parts of the world.
		P8	It was disastrous and very sad. I don't want it to happen again.
		P9	Like I said before, I would say chaotic. L mean, that's really it. That's the one Word for me, chaotic.
		P10	Looking back, it was an unforgettable experience and an unpredictable experience.
		P13	A very creepy period and a lot of emotions for me, a very, very long period for me. But we go through it at last.
		P14	The vividly remember trying to work and protecting myself in the lockdown and care for so many patients.
		P15	The worst part of it was the helpless feeling. Maybe you can help someone get better and some lost their lives, and you just feel so helpless.
		P17	A very confusing part of my life but also looking back, a very confusing part of my life. A very confusing time in living in the world.
	Learning Experience	P11	I would describe it as a learning season. I learned to be compassionate. I learned a different way to be compassionate towards patients. I learned to be more patient with the patients. I learned different medications in the field.
		P12	Covid did have negative and positive aspects of it when it let us know that life is nothing. You know it can be taken away from me anytime.
		P16	It was a learning time for me and a depressive moment. I got to meet new people. I got to learn new techniques of administration of medications.
		P18	I'll describe the period as exhausting, and I would say wonderful. It was wonderful in the sense that it was more like an adventure for me at some point because I had to discover more of myself as a nurse.

Theme 10: Coping Skills Looking Back

Coping during the pandemic was vital for nurses. The nurses for this study reflected on the coping skills they used to survive this time. Data analysis revealed four subthemes: work, support, mindfulness/spirituality, and physical activity. Six of the nurses felt that work was their primary coping skill, as they love seeing patients recover and working with their colleagues to care for them. Nine participants stated that support from their families, friends, and colleagues as well as others who were dealing with aspects of COVID-19 helped them cope. Three of the nurses used mindfulness and spirituality to cope during the pandemic using prayer or going to church. One of the participants used exercise as a means of coping.

Table 12

Coping Skills Looking Back

Theme	Subthemes	Participant	Participant Responses
Coping Skills: Looking Back	Work	P2	I just love what I do and there was no time for anything else.
		P6	I was hopeful and I love what I do, and I love my job and that this would end also being there for the people to give them hope at the same time.
		P7	I just had to do my job as a nurse. I had to wake up every day, go and do a good job and do what I had to do good. Nursing is something that has always been in me and that's something that I always dreamed of since I was a kid. So, this is something that I love.
		P8	Looking back at this point, it's what they're (patients) going through. So, they have that strength, like that you want to save them.
		P11	I got through the season was that do would talk about my frustrations to people around me. I looked forward to seeing my patients getting back on their feet very well looking healthy and sound.
		P14	We collectively work where we all worked together to get over this covid or trying to make a better life for the patients and we try to give them what we got, who we are and capable of giving at the moment.
	Support	P3	The words of encouragement and comfort for my family. And my mom used to pray for me, like a real prayer.
		P5	I can say I got through that, and I got help from my family nurses. Because like I said before, I had to isolate myself from my family to avoid putting them at risk of getting infected. And I had this one friend that really helped me stand up and push through it.
		P9	Like we talked about before, my support was my family that they were definitely helpful.
		P10	Like I said before, I normally go on picnics with friends. My family was like God. They were so supportive during that period of my life. They were always encouraging, putting every effort to make sure that I'm okay.
		P13	I think that realizing that okay, the fact that this is, this is a worldwide pandemic really, really made it a bit easier for us and for me because everyone was experiencing these difficulties. We have done well to get to this point and we did use that as a advantage or as a motivation because we can say that we are not the only person, people are experiencing these challenges because the covid affected everyone. So that was the most motivation to do whatever we could do to get through this.
		P14	We collectively work where we all worked together to get over this covid or trying to make a better life for the patients and we try to give them what we got, who we are and capable of giving at the moment.
		P16	I would say talking with a friend, my relatives about it. I spoke with him about it about frustrations in the hospital that were frustrating me.
		P17	Occupying myself through social media and this was how I connected with my family and friends.
		P18	I would say my family and also, my group of friends in terms of whom I was working with also because basically we were here to save humanity and my family was there to give the moral support.
	Mindfulness/ Spirituality	P4	I would say actually spiritual intervention, praying, going to church, and getting some therapies for the mind, the meditation thing and getting the materials to keep you mind healthy.
		P12	I used to pray a lot.
		P15	I have so much belief in God I would say that was got me through it. I was down emotionally at some point, but then I would say a prayer.
	Physical Activity	P1	Exercising outside was a way to get outside and get air was my outlet.

Theme 11: Health Care Facilities Support During the Pandemic

Compassion fatigue is a phenomenon that is common among nurses, especially during the pandemic. I asked the nurses what support they experienced during the pandemic from their facility and what support the hospital can offer should there ever be another pandemic. Three subthemes emerged from the interviews: support, equipment, and no support were offered. Ten participants described the support from their colleagues, or the rooms set aside for breaks. The nurses also stated that they wished there was more mental support for themselves, support groups, and care for their families during the time. Five nurses stated the need to be prepared for anything by having enough patient PPE and beds. Three nurses felt that their healthcare facilities did not offer any support during the pandemic.

Table 13

Health Care Facilities Support During the Pandemic

Theme	Subthemes	Participant	Participant Responses
Health Care Facilities Support During the Pandemic	Support	P2	I think actually we also need some mental support.
		P4	Provide resources for families, and actually they'll take care of your family, like paying for their health insurance who are affected by the pandemic.
		P6	Guidance and support, that's all we need at some point. Provide counselors to just sit you down, talk with you how you feel. I think sometimes we just need that someone is there, someone's who looking out for us too.
		P7	I'd say that if, if there could be maybe programs where nurses could have these focus groups and when they're free, which was quite impossible at that particular moment, at least they could talk about their experiences during this particular moment. They got the chance and the platform to do that, they will do it. And at least it'll help them
		P10	The hospital was very helpful, and they were nice and always gave us a lot of safety tips on how we can treat the patients.
		P11	During the pandemic in my hospital, there was kind of like a break, a break session for us. A break session for nurses. We walk all day and we can break down easily. So there was always a break station for us and the break sessions actually (nurses) are supposed to come and sit down. You can take a nap, or you get something to eat, or you just watch the screen.
		P14	We collectively worked together to get through this covid and try to make a better life for the patients. We tried to give them what we got and capable of giving at the moment. We did have general workshops where we shared ideas. So, we tried to share among ourselves, I guess on how we tackle this.
		P15	I would talk to my colleagues most time and you see in their faces it that they just all of this would be alright.
		P16	There were break moments and break sessions, especially the bedside nurses and sometimes they can give you a day off from work.
		P18	We had some moments for social gathering. We also had a support in terms of you know like metal support, like counseling therapy for the people that needed therapy, because it was a very difficult period for some people to talk to just to keep on going, to continue with the job at hand, and I loved that.
	Equipment	P1	The first support is being better prepared for the inevitable. I remember you know, especially like the whole PPE system like now it's like now PPE we have tons of it, like we didn't have when we needed it.
		P3	Give us the necessary protectives and necessary equipment, make us feel safe and not get infected and just make us realize and understand that we are health workers, and this cannot easily get to us and that we could be fine.
		P5	There were not many beds to help the patients. I would recommend that they build bigger hospitals. If we had more hospital beds, I can say we save even more lives.
		P8	I feel like what the patients need the most, like in terms of beds, we needed a lot of beds.
		P13	Our health was our first priority, and we had to ensure that we had enough PPE.
	No Support	P9	There were not available free mental health services. A lot of nurses complained, and our outlet was social media at that time, because at that time, that's all we had.
		P12	We didn't have time for anything. We attended to our patients, you know, make sure they are safe.
		P17	We didn't receive any support and any help for encouragement to stay safe.

Theme 12: Health Care Facilities Support During Normal Times

I asked nurses what healthcare facilities can do to support nurses who might experience compassion fatigue during normal times. Three subthemes emerged: work environment, mental support, and administrative support. Eight participants desired flexible work schedules with more time off, improved work conditions, and increased learning safety skills. Eight nurses expressed the need for mental support and for the facilities to offer free counseling services, more therapists for the nurses, and recharge rooms. Two nurses wanted administrative support to listen and hear nurses more in order for the nurses to be able to express their feelings and receive more education to provide better patient care.

Table 14

Health Care Facilities Support during Normal Times

Theme	Subthemes	Participant	Participant Responses
Health Care Facilities support during Normal Times	Work Environment	P1	We have a holistic council. So sometimes they come up with like a cozy cart, and they bring us teach and snacks, and something they offer some like meditation classes and they teach you some mediation techniques that you can do a on your own, We have a recharge room, so a lot of time the nurses will go down there, even if it's just on their 15 minute or 30 minute break and they sit there and it plays all that music.
		P3	Not being exposed to severe work conditions and keep an eye on our health.
		P4	Give nurses access time to work that is being flexible for them and get some time off and not being overwhelmed for them to work effectively.
		P6	I think that when you're actually exhausted you know from work, I would say making, ensuring that there are more nurses to help ease the work stress or the workload. And also provide necessary equipment tools to ensure that is eases the work stress.
		P8	They should just be aware of things that make the nurses happy to work and know to keep them going. Make the environment more conducive for them.
		P10	Provide more incentives to all the nurses so they can put on their very best in working
		P11	The hospitals can provide incentives for nurses and bring resources for teaching the nurses to help them upgrade their safety skills.
		P12	Making more nurses available to help out in their in the daily activities to them, more hands less work.
	Mental Support	P2	I think we also need some mental support.
		P5	So, there are people who can help with mental health to help nurses. Doing things to enhance people's health during such time as covid
		P7	Maybe some time off so you can go and stay with your family and do what do you do and try as much to talk about everything that happens.
		P13	I think maybe just what they can do is motivation, maybe financial or whatever, but a lot of motivation should be invested, even emotional motivation. They can offer counseling services to nurses who might feel this way.
		P15	Well, I think there should be a therapy session or a therapist that is always in the hospital. People accumulate a whole lot of emotions and there are some point you can't really take it anymore and you just need to let it all out.
		P16	Firstly, is to make provisions for therapy and also making sure that the sessions are free and that nurses are not being charged for the sessions with the therapist
		P17	Creating a counseling center or a counseling office, an emotional counseling center. Days for nurses to relax, sponsoring vacations.
		P18	Organize people who have more experience, people how have more insights to come in and just speak to people who are experiencing compassion fatigue and also just share ideas.
	Administrative support	P9	Administrators can support more compassion than they are doing now and hear our voices about how they can support us.
		P14	Hospitals can do more research in order for nurses to give the best care and for them to work together to improve patient care.

Summary

I studied the lived experiences of nurses who cared for COVID-19 patients between January 2020 and March 2021, and the long-term effects of compassion fatigue on their lives. Included in this study was what the nurses identified as the stresses, personal understandings of the pandemic, and how the nurses coped. I used convenience sampling to obtain the 18 nurses who volunteered for the study. All interviews took place via Zoom at a convenient time for the participants. Colaizzi's method of data analysis allowed me to determine the codes and subthemes. The themes for the study emerged from the interview questions. The nine major themes included the lived experiences of the nurses who cared for COVID-19 patients, the stresses during this time, appraisal/assessment of the pandemic, and the coping mechanisms used during this time. Participants reflected on this time and discussed their stresses, appraisal/assessment of the pandemic, and how they coped. The nurses also shared their experiences of how facilities can support the nurses who experience compassion fatigue during pandemics and during normal times.

Chapter 5 provides further discussion and explanation of the themes/subthemes that materialized from the data analysis, further recommendations for future studies, limitations of this study, and final conclusions based upon the findings of this study.

Chapter 5: Discussion, Recommendations, and Conclusions

The purpose of this qualitative descriptive phenomenology study was to understand the long-term effects on nurses' coping with compassion fatigue from the COVID-19 pandemic and the effects on their professional and personal lives. I employed a descriptive qualitative design to understand nurses' experiences caring for COVID-19 patients during the pandemic. Participants recounted their experiences and explored compassion fatigue's long-term effects through interviews. The analysis uncovered common themes, coping strategies, and appraisal processes related to the emotional strain of compassion fatigue. The target population comprised registered nurses employed during the pandemic's peak from January 2020 to March 2021. Convenient sampling was used, involving recruitment emails, a screening questionnaire, and individual interviews with informed consent. Recordings were transcribed and validated for accuracy.

Key Findings

The key findings revolved around the experiences of registered nurses caring for COVID-19 patients from January 2020 to March 2021. Participants shared their experiences, revealing that the majority characterized this period as emotionally strained, draining, and horrifying. Some participants highlighted the physical strain resulting from patient workload and inadequate equipment. Some participants even expressed initial disbelief in the seriousness of the virus. Compassion fatigue, a prominent theme, was defined differently by participants. Emotional exhaustion, stress, and physical fatigue due to patient care were common definitions. Participants recounted personal experiences of compassion fatigue, encompassing feeling overwhelmed and dealing with the unknown.

Reflecting on the pandemic, participants shared mixed feelings. While desiring normalcy and survival, they also stated the trauma, helplessness, and physical/emotional toll they experienced. However, several participants identified positive insights gained from the challenging situation. Coping strategies were crucial as participants navigated the traumatic period. Coping mechanisms included seeking social support, finding solace in work, engaging in mindfulness, and even exercise.

Furthermore, there were many long-term effects of the pandemic. Fear of ongoing COVID-19 impacts persisted, as did psychological effects such as anxiety, depression, and trauma. However, some participants reported positive outcomes, including enhanced knowledge, resilience, and a sense of competence. As participants looked back, stresses during the pandemic were reassessed, pointing to issues like workload, fear of loss, and a lack of support. Additionally, appraising the period revealed the contrast between trauma and personal growth. Participants sought coping skills retrospectively, highlighting work-based support, social connections, mindfulness, and physical activity.

Participants emphasized the need for mental support, support groups, and adequate supplies. During the pandemic, health care facilities support varied, with colleagues and specific rooms serving as sources of respite. Looking forward, participants envisioned support for nurses during non-crisis times. Flexible work schedules, mental health resources, and improved administrative understanding were identified as vital for addressing potential compassion fatigue. The study captured various nurses' experiences, showing the complex interplay between stress, coping, and the evolving health care environments during a pandemic.

Interpretation of Findings

This study pertained to compassion fatigue and its implications on nurses who encountered and managed compassion fatigue during the COVID-19 pandemic. Thus, I sought to answer the following research question: "What are nurses' lived experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic?"

Theme 1: Lived Experiences

The participants' extensive descriptions of their experiences during the COVID-19 pandemic aligned with the well-documented emotional and physical strains that health care professionals have faced in similar crises (Foli et al., 2021). Most participants expressed emotional strain, fear, and exhaustion, mirroring prior studies' sentiments (Couper et al., 2022; Kackin et al., 2020; Scribner et al., 2020). The participants' accounts confirmed that the pandemic profoundly impacted health care workers. The pandemic created an environment filled with uncertainty and heightened emotions, consistent with the broader literature on crisis response in healthcare settings. Participants' descriptions of the emotional and physical strain they experienced while caring for COVID-19 patients align with Lazarus and Folkman's theory of stress and coping and its effects on individuals. The participants' accounts of feeling "emotional strain" and experiencing "horrible" times reflect the subjective and ambiguous nature of stress (Lazarus & Folkman, 1984; Selye, 1973). These aspects can impact an individual both emotionally and physically.

Theme 2: Definitions of Compassion Fatigue

The participants' definitions of compassion fatigue as both emotional and physical exhaustion corresponded with the many components of this phenomenon, as discussed in the literature (Beydoun et al., 2019; Labrague & de los Santos, 2021) Peters, 2018). The nurses' perspectives mirrored the established understanding that compassion fatigue encompasses emotional weariness and the physical toll of caring for patients, especially during high-stress situations like the pandemic. This finding validated the participants' comprehension of compassion fatigue within the broader healthcare context.

Theme 3: Experiences of Compassion Fatigue

Participants' accounts of dealing with the unknown and feeling overwhelmed resonated with the experiences that health care professionals often face when providing care during uncertain and challenging circumstances (Elomaa et al., 2021; de los Santos and Labrague, 2021; Sorenson et al., 2017). Their descriptions aligned with the documented emotional responses of health care workers who find themselves in situations where they are caring for patients in distressing times and conditions. These shared experiences further validated the emotional and psychological toll that health care professionals endured in such scenarios.

Theme 4: Stresses During the Pandemic

The participants' discussion of fear, helplessness, and patient acuity as sources of stress aligned with the stressors commonly reported by health care professionals during pandemics (Avcıoğlu et al., 2019; de los Santos and Labrague, 2021). Their narratives echoed the vulnerability and powerlessness that health care workers often experience in

the face of overwhelming patient numbers and limited resources. Patient acuity and limited resources highlighted the universal stressors that healthcare professionals encounter during crises and lend credibility to their experiences.

Theme 5: Appraisal/Assessment During the Pandemic

Participants' reflections on their experiences, the desire for normalcy, survival, and positive insights mirrored the psychological responses observed in healthcare workers during crises (Crowe et al., 2022; de los Santos and Labrague, 2021; Tehranineshat et al., 2019). The nurses' expressions of exhaustion, terror, and yet the potential for positive growth resonated with the documented psychological impact of providing care under duress. This finding reinforced the complex emotional environment that health care workers worked in during unprecedented challenges.

Theme 6: Coping During the Pandemic

Participants' strategies for coping, including social support, work engagement, activities, mindfulness, and spirituality, aligned with the adaptive mechanisms commonly employed by healthcare professionals to manage stress (Akkuş et al., 2022; Blomberg et al., 2016; Crowe et al., 2022). Their narratives reflected the many ways in which individuals sough emotional resilience and rejuvenation during these demanding circumstances. The shared coping strategies reaffirmed the importance of individual and interpersonal resources in managing the effects of compassion fatigue.

Theme 7: Long-Term Effects of the Pandemic

The long-term effects mentioned by participants, fear, psychological impact, positive changes, and lack of effect, show the diverse outcomes observed in health care

professionals' post-crisis (Crowe et al., 2022; Rich-Edwards et al., 2021; Walden et al., 2018). Their reflections captured the enduring psychological and emotional consequences that can result from exposure to intense stress and trauma. This alignment emphasizes the range of responses and suggests the potential for long-term growth despite the challenges faced.

Theme 8: Stresses Looking Back

Participants' personal accounts of work stress, fear of loss, and lack of support reflected the post-event stressors reported by health care workers in the aftermath of a crisis (Crowe et al., 2022; de los Santos & Labrague, 2021; Walden et al., 2018). Their discussions confirmed the sense of feeling overwhelmed and frustrated that can emerge when reflecting on the pressures faced during critical times. This finding underscored the significance of examining these stressors in the context of healthcare professionals' broader experiences.

Theme 9: Appraisal/Assessment Looking Back

Participants' descriptions of the pandemic as both traumatic and a learning experience aligned with the dual emotional responses that healthcare workers often exhibit following a crisis (Crowe et al., 2022; de los Santos & Labrague, 2021; Walden et al., 2018). Their narratives paralleled the complex interplay of distress and personal growth that healthcare professionals encounter when revisiting their experiences during challenging times. The nurses' accounts showed their reflections' multifaceted nature and growth potential.

Theme 10: Coping Skills Looking Back

The nurses' reliance on work as a coping skill aligns with the existing literature (Aslan et al., 2021; Crowe et al., 2022; Walden et al., 2018). Healthcare professionals derived meaning and satisfaction from their work, aiding their coping strategies. The nurses' focus on work as a coping mechanism aligned with the positive aspects of compassion satisfaction discussed in the literature. Additionally, the nurses' support from family, friends, and colleagues aligned with the importance of collaborative relationships in coping (Arcadi et al., 2021; Gonzalez et al., 2019). Nurses recognized the shared challenges of COVID-19, reflecting the camaraderie seen among healthcare professionals in times of adversity. This highlights the importance of social support networks in promoting resilience.

Theme 11: Health Care Facilities Support During the Pandemic

Participants' suggestions for work environment improvements, mental support, and administrative backing corresponded with the strategies recommended for addressing compassion fatigue in healthcare settings (Arcadi et al., 2021; Labrague & de los Santos, 2021; Tehranineshat et al., 2019). Their insights highlighted the importance of systemic support structures to promote healthcare professionals' well-being and help decrease compassion fatigue's impact. This alignment reinforced the significance of organizational interventions in fostering a strong workforce.

Theme 12: Health Care Facilities Support During the Normal Times

The need for mental support emerged as another crucial aspect. Participants strongly desired healthcare facilities to offer accessible mental health services, including

free counseling and additional therapists dedicated to supporting nurses. This aligned with the recommendations from de los Santos and Labrague, 2021, who stressed the importance of providing psychological support and resources to address the emotional toll that caregiving can take on healthcare professionals.

Concerning theme 1, participants' descriptions of the emotional and physical strain they experienced while caring for COVID-19 patients align with Lazarus and Folkman's notion of stress and its effects on individuals. The participants' accounts of feeling "emotional strain" and experiencing "horrible" times reflected the subjective and ambiguous nature of stress, which can impact an individual both emotionally and physically (Selye, 1973; Lazarus & Folkman, 1984). Likewise, within the context of theme 2, participants' definitions of compassion fatigue, such as emotional exhaustion and physical strain due to workload, resonated with the concept of stress and coping (Lazarus & Folkman, 1984). Emotional exhaustion and physical strain are manifestations of stress, and the participants' recognition of these definitions showed the relationship between stressors and coping mechanisms.

In line with the findings above, the experiences of compassion fatigue and the stresses faced by participants, as discussed in themes 3-4, demonstrated the transactional nature of stress and coping. The participants' experiences of dealing with the unknown and feeling overwhelmed supported the cognitive and emotional components of stress appraisal and coping proposed by Lazarus and Folkman (1984). Moreover, participants' reflections on the pandemic, as explored in theme 5, including their desires for normalcy, survival, and the positive insights gained, relate to the cognitive appraisal stages outlined

by Lazarus and Folkman (1984). The participants' judgments of the situation as challenging, harmful, or positive reflected the theory's emphasis on primary and secondary appraisal processes.

Furthermore, participants' coping mechanisms, as discussed in theme 6, such as seeking social support, engaging in work, practicing mindfulness, and turning to spirituality, aligned with Lazarus and Folkman's categorization of coping strategies. Social support, work engagement, and mindfulness mirrored the problem-focused and emotion-focused coping strategies proposed by the theory (Lazarus & Folkman, 1984). The long-term effects described by participants, including fear, psychological effects, positive outcomes, and no effects, echoed the adaptive processes discussed in Lazarus and Folkman's theory. The theory emphasized that individuals could experience positive or negative outcomes based on their coping efforts and stressors.

Likewise, participants' reflections on the stresses, appraisal, and coping skills utilized during the pandemic, as discussed in themes 7-8, illustrated the intense nature of stress and coping. The subthemes of work stress, fear of loss, and use of coping mechanisms aligned with the theory's description of how individuals appraise stressors, employ coping strategies, and adapt over time. Finally, participants' suggestions for support from healthcare facilities, as explored in theme 9, reflected the theory's focus on coping resources. The need for mental support, flexible work schedules, and administrative backing (Lazarus & Folkman, 1984) aligned with the theory's emphasis on the availability of coping resources to manage stressors effectively.

Limitations of the Study

There are limitations of my study that include the following. I am a registered nurse and knew I there was the potential of bring my biases, perceptions, and knowledge into the study. I maintained awareness of my biases by studying the interviews and transcripts and presenting the data unbiasedly. Although my chairpersons also reviewed the study, biases may still exist. Another limitation of the study is that transferability may be limited as the interviews consisted of nurses who had access to the New York State nursing organization's social media.

There were only audio recordings of the participants as no one was videotaped, and I could not view any non-verbal communications exhibited by the participants. Additionally, I may have formed biases based on first impressions of hearing the participants or how they presented themselves. Another limitation of the study was that some participants did not understand the term "compassion fatigue," which may have impacted their definitions of the term and their firsthand experiences of compassion fatigue.

Another limitation was that participants may have responded to the questions in a way that they felt I wanted them to answer the questions as we both were registered nurses. Also, nurses who experienced the traumatic events of COVID-19 may not have wanted to participate in the study as the recall of their lived-experiences may have been too complicated and overwhelming for them, or they were not ready to tell their stories. Also, there may have been a fear for nurses to participate in the study as they may have worried or had concerns, they would need to end the interview once it started because of

recalling these distressing events leading to the need for psychological support. A major limitation that can impact this study was the threat to validity, particularly internal validity, and external validity, in terms of the transferability of the study to other populations both domestically and globally.

Recommendations for Future Research

Recommendations for future research are to interview these same nurses five years from now to see if there are any long-term effects of compassion fatigue from the COVID-19 pandemic. Future studies should apply strategies to help recruit other participants to reduce issues such as fear of recall, especially for sensitive topics. These strategies are efficient in ensuring the retention of participants up to the end of the study. Future studies should employ a diverse number of participants which will help reduce research bias by validating results and interpreting findings. Another recommendation is to apply this study to other healthcare professionals, such as doctors, emergency medical technicians, paramedics, and nursing assistants. This study may also be conducted in other parts of the United States and countries.

Recommendations for Practice

COVID-19 was a devastating virus for which no one was prepared as the virus was unknown, with no knowledge of how to treat the virus or vaccines to protect the public. Healthcare professionals experienced high acuity of patients and unprecedented numbers of deaths. Healthcare facilities did not have enough PPE and were often short of nurses, resulting in high ratios of nurses to patients. Nurses feared getting COVID-19 or spreading the virus to their families and friends. Caring for numerous patients had a

tremendous toll on nurses who experienced compassion fatigue, feeling tremendous stress, and finding their own coping methods during this time.

Nurses should create workshops to help them discuss compassion fatigue and the mechanisms that can be used to cope with it. Through discussions, it becomes easy to understand the various concepts associated with compassion fatigue. The current evidence-based practices on COVID-19 should be disseminated to guide nurses on the safety precautions they should take in the future. Nursing leaders must advocate for other nurses who experience compassion fatigue to share their experiences. This will provide adequate information that other nurses can rely on and know how to deal with it in the future. Counseling services should be provided for all nurses who experience compassion fatigue. In addition, nurses can create support groups with professional therapists to communicate their feelings and experiences. Health facilities should consider employing qualified counselors to support nurses and help them cope with compassion fatigue. Healthcare facilities and management should implement a system of follow-up. Nurses who worked during the pandemic should be followed to determine whether they have any long-term effects and how they are coping. Providing adequate resources for nurses, such as PPEs, is crucial in helping them work in a conducive environment. Consequently, it is crucial to recognize the need for nurses to be heard and supported and its impact on their mental health.

Implications

Walden University (2023) defines positive social change as "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and

development of individuals, communities, organizations, institutions, cultures, and societies. Positive social change results in the improvement of human social conditions" (para. 1). Positive social change can be influenced through engagement with individuals in society and comes through studies on society and individuals motivated to influence people in the right direction. Through studying the long-term effects of COVID-19 on patients, the study anticipates influencing a change in the dimensions of dealing with pandemics. Nurses play a crucial role in society. Advocating for improvement of their well-being influences positive change in society.

Individual Social Change

The advertisement for this study yielded over 300 individuals who wanted to participate in the study. This can lead one to ascertain that nurses have stories to tell of their lived experiences in caring for COVID-19 patients and want to be heard. This study allows individuals to read how nurses coped with the overwhelming challenges during the pandemic and read the untold stories of these healthcare professionals. Additionally, the study may help other nurses understand that they are not alone in what they experience and what they may still experience today.

Organizational Social Change

The study can offer insights on how to help healthcare professionals, namely nurses, who experience compassion fatigue during normal times and times of crisis such as a pandemic. Nurses who participated in this study wanted facilities to know the need for preparation for pandemics regarding equipment and physical and mental support. This study can also offer healthcare administrators awareness of the need to support their

nurses and all healthcare professionals, especially mental support.

Societal Social Change

Society supported healthcare professionals, particularly nurses, who spent countless hours caring for COVID-19 patients but may not understand what the nurses encountered and what they did to cope. This study allows others to read the first-hand experiences of nurses, understand the difficulties and responsibilities, and gain deeper insights and appreciation for the nursing profession and how nurses impact society and the care they provide to patients.

Methodological, Theoretical, and Empirical Implications

The methodological implications for this study can impact future research and studies. I selected a qualitative approach instead of a quantitative method as I wanted to understand and hear the nurses' lived experiences caring for COVID-19 patients and the long-term effects of compassion fatigue. The nurses who participated in the study recalled their personal stories of what it was like during the height of the pandemic. Using a qualitative descriptive phenomenology study allowed the nurses to interact freely and openly, discuss the experiences, and use follow-up questions to obtain thick descriptions of the experiences. Stahl and King (2020) believed that rich descriptions offer readers "text so rich in details that the event or the object of description is palpable" (p. 26). These thick descriptions allowed me to analyze what the participants stated and define common themes and offer readers insights into the lived experiences of the nurses. Using qualitative descriptive phenomenological techniques helps researchers to consider alternative data collection and analysis methods, such as a quantitative study. This use of

in-depth interviews implies a deep understanding of information and careful data analysis through thematic analysis.

The theoretical implication refers to how this study contributes to the existing theory. The research questions aligned with Lazarus and Folkman's stress and coping theory. This theory was the theoretical foundation for the study in terms of formatting the research questions, developing the literature review, and the data collection and analysis. This study's theoretical implications expand knowledge on stress and coping strategies, especially for nurses. The influence of the environment of nurses during COVID-19 is the main contributor to stress, which causes long-term adverse effects. This study's results also imply the importance of understanding the relationship between stress and the environment. Additionally, a further understanding of better coping strategies can assist in alleviating stress during periods such as COVID-19.

Empirical implications for this study are for further studies to be conducted on strategies that can be used to assist the nurse in overcoming the overwhelming effects of compassion fatigue. In addition, research should establish ways institutions can ensure nurses' well-being, especially mental health which can affect nurses both professionally and personally. Establishing adequate measures to help nurses cope is an important aspect. Policies that support and improve nurses' work environment, especially in stressful and burnout environments, should be implemented. Lastly, research can help healthcare facilities to establish protocols and policies for such times of crisis and pandemics.

Conclusion

There were over 300 nurses who wanted to participate in this study and tell their personal experiences of caring for COVID-19 patients. Of the 300 participants, I interviewed 18 nurses, leading one to determine that nurses wanted to be heard and that there are many more stories and experiences that need to be told. COVID-19 had devastating effects on people worldwide, especially on the nurses who directly cared for these patients and continue to care for these patients. New strains of COVID-19 are continuing to surface, causing fear and anxiety among all healthcare professionals.

This study enables one to understand the experiences of 18 nurses, what they endured in their professional and personal lives, and how they coped during these challenging times. The lived experiences will help healthcare facilities support and care for their nurses employed at the facility, gain insight into what these nurses experienced, and lead to programs to support nurses. The study demonstrated the resiliency and fortitude nurses displayed during the pandemic and how they survived, which will hopefully serve as a conduit for such times as a pandemic and even during normal times. Knowing how to support nurses and what they need will help decrease compassion fatigue experienced by nurses and lead to greater retention of nurses, which can only improve healthcare overall. Additionally, this study may serve as a foundation for future studies on nurses and their experiences of compassion fatigue.

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Appendix A: Demographic Information

Name:

Assigned Participant Number:

Identified Gender:

Male Female Prefer not to Answer.

Age Range:

20-30, 31-40, 41-50, 51-60, greater than 60

Number of Years as a Registered Nurse:

1-3, 4-10, 11-20, 21-30, greater than 31

Working status between January 2020 to March 2021:

Full time Part Time Per Diem

Highest Professional Degree:

Diploma, Associate's, Bachelor's, Master's, Post Master's, Doctorate

Type of Facility or Service at which you worked during this time:

Acute Care Facility, Long-Term Care Facility, Rehabilitation Center, Home Care

Primary Nursing Role between January 2020 and March 2021

Bedside Patient Care Charge Nurse Nursing Manager

Appendix B: Interview Guide

Hello! My name is Philip Nelan, and I am currently a doctoral student at Walden University, and I am conducting a research study. The purpose of this study is to understand the lived experiences of nurses who cared for COVID-19 patients and what long-term effects of compassion fatigue the nurses are experiencing today because of caring for COVID-19 patients, namely between January 2020 and March 2021.

Thank you for completing the informed consent and returning it to me. Do you have any questions about the consent form? I would like to record this interview as it will allow me to focus on your answers and to analyze the information gathered in the interview. Do I have your permission to audio tape this interview? Thank you.

Your participation is voluntary, and you may stop the interview at any time you wish. Please know that all information will be confidential. All recordings will be password protected on a protected computer. All recordings, transcriptions of the interview and journal notes will be placed in a locked box where only I will have the passcode and key. Each participant will be given a participant number to maintain confidentiality.

During the interview, I will be asking you questions and spending most of the time listening to your responses to the questions. I may ask you to clarify some of your information and may ask follow-up questions. I may also be taking some notes during the interview. Please provide as much information as you can.

I want to sincerely thank you for your participation in the interview and for your time. As a thank you, I will be sending you a $20.00 Amazon e-gift card. Do you have any questions before we start the interview? Thank you and we will begin.

RQ: What were nurses' lived experiences of coping with the long-term effects of compassion fatigue from the COVID-19 pandemic?

Interview Question 1: In your own words, please describe your experiences of the COVID-19 pandemic and caring for patients with COVID-19.

Interview Question 2: How do you understand the term "compassion fatigue?" How would you define compassion fatigue?

Interview Question 3: Can you describe times when you experienced compassion fatigue during the pandemic?

Interview Question 4: What were some of the stresses you experienced during the pandemic? Professionally? Personally?

Interview Question 5: What was your overall appraisal/assessment of what was happening during this pandemic?

Interview Question 6: What coping skills did you use during the pandemic professionally? Personally?

Interview Question 7: What are the long-term effects of the pandemic on your professional life, and can you describe them? On your personal life, and can you describe them?

Interview Question 8: As you look back over your time caring for COVID-19 patients during the height of the pandemic, what do you think were the stresses?

What is your appraisal/assessment of the situation?

What coping skills did you use to get through the pandemic?

Interview Question 9: What support can healthcare facilities offer nurses in dealing with compassion fatigue under normal circumstances? And in times of a pandemic?

Closing Interview Script:

Ending the Interview:

I want to thank you for your valuable time and assistance in this research study. Before we end, is there any other information that you would like to share about your experiences and want others to know?

Again, thank you. Your responses to the questions will be kept confidential and will be a part of larger data collected from other participants. Once the study is completed, I can email a copy to you if you would like one.

Thank you so much again for your time.

Appendix C: Summary of Participant's Demographics

Participant Number	Identified Gender	Age Range	Number of Years as a Registered Nurse	Working Status between January2020 to March 2021	Highest Professional Degree	Type of Facility Employed at this time	Primary role during this time
P1	Female	41-50	4-10	Full time	Master's	Acute Care Facility	Bedside Patient Care
P2	Male	31-40	4-10	Full time	Bachelor's	Long-Term Care	Bedside Patient Care
P3	Female	20-30	4-10	Full-time	Bachelor's	Long-Term Care	Bedside Patient Care
P4	Male	20-30	4-10	Full-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P5	Female	20-30	4-10	Full-time	Bachelor's	Long Term Care	Bedside Patient Care
P6	Male	41-50	11-20	Full-time	Master's	Long Term Care	Charge Nurse
P7	Female	20-30	1-3	Full-time	Associate's	Acute Care Facility	Bedside Patient Care
P8	Female	20-30	4-10	Full-time	Associate's	Rehabilitation Center	Bedside Patient Care
P9	Female	20-30	4-10	Full-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P 10	Female	20-30	1-3	Full-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P11	Male	20-30	4-10	Full-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P12	Male	31-40	4-10	Full-time	Master's	Acute Care Facility	Nursing Manager
P13	Female	20-30	4-10	Full-time	Bachelor's	Rehabilitation Center	Nursing Manager
P14	Male	20-30	4-10	Full-time	Bachelor's	Acute Care Facility	Charge Nurse
P15	Female	20-30	4-10	Part-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P16	Male	20-30	4-10	Full-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P17	Female	20-30	4-10	Part-time	Bachelor's	Acute Care Facility	Bedside Patient Care
P1	Male	20-30	4-10	Full-time	Master's	Acute Care Facility	Bedside Patient Care