COMPASSION WITHOUT FATIGUE

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Abstract

Nursing is in the grips of compassion fatigue and burnout with no clear plan to heal the care givers in the profession. This study sought to give voice to the unique experiences pediatric nurses manage as they continue to care for their patients and families. It invites each participant to share narratives that take the invisible challenges of nursing and make them visible. The study then interweaves the multiple realities together and looks at them through the lens of Jean Watson's Caring Science. Finally, it offers a path that uses theory guided practice to both honor these nurses' experiences and offer new ways of thinking and being that could help heal the nurses so they can continue to heal others. **Approach:** Using the philosophical underpinnings of qualitative research this study used the Relational Caring Inquiry method to honor the unique narratives of each participant and allow for the immergence of narratives and a collective insight into the experiences of being a pediatric nurse on an inpatient unit. Relational Caring Inquiry combines the principles and rigor of Husserl's qualitative research to understand the essence of a live experience, and the moral commitment to preserve, protect and enhance human dignity using the relational ethical-moral foundation of Jean Watson's Theory of Human Caring. **Conclusion and significance**: The participants stories revealed a deep desire for the complexities of nursing to be seen and honored. The stories reflected an unyielding passion for not just having empathy of patients but for practicing compassion to ease the suffering of patients and families. This is revered as the unique calling of a nurse, but the study also addresses the complexities and consequences nurses are face with. This study showed the barriers and contributors weaved throughout the participants narratives highlighting both internal and external factors that shape the nurses' ability to stay compassionate. It then offered a new way of patterning these experiences through the essential truths found in Jean Watson's theory guided practices in Caring Science. Caring Science does not ask that these nurses change who

they are, it invites nurses to become fully who they are meant to be, so they have the capacity to answer their calling as a compassionate and caring nurse. This study offers a path that lets nursing live up to their irreplaceable contribution to medicine by creating environments where the best sides of humanity can find expression. Finally, it offers an ideal where compassion and consciousness found within transpersonal relational caring moments become the hallmark to help the patient and nurse simultaneously heal.

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CHAPTER I

Introduction

As witnesses and healers' nurses' step into their patients' lives in the midst of intense emotions of pain, suffering, illness, trauma and sometimes impending death. These are not experienced in the abstract but in each tangible moment of care and compassion. The reality is nurses, who are called to care for others, quite often experience intense pain and suffering as they cope with the world's needs. This chapter will offer insight into a nurse's path through the lens of my personal narrative, the significance of the current environment and a perspective of using nursing theory as a way to support nurses as they remarkably tend to the health of others.

Personal Narrative

Becoming a nurse was not always my career of choice. I knew growing up that I wanted to work with children. I knew early on in life that I enjoyed caring for other people. There is something magical when you make a unique difference in someone else's life, especially a child's. It grounds you in a way that is both fulfilling and gives you a sense of reason for your existence. Like many nurses I idolized the idea of saving lives and being a hero. I thought every nurse shared the same belief that the role meant giving of yourself in order to make a meaningful difference in the world. That the ability to care was the reward for the job. I quickly learned that while many nurses start with this in their hearts, the demands of the job can overwhelm that ideal, leaving caring people in survival mode with not a lot left to offer their patients. Before I even left school, I was already becoming disheartened by the realities of what nursing had become. There were times I had decided that nursing was not going to be my path, but every time I got close to stepping away something would happen to bring me back in. Rather someone would happen. One such person was a woman who I met on a surgical rotation. I was pawned off on a clinical assistant by a busy nurse who did not want to precept yet another nursing student. I

worked with this clinical assistant as she robotically gave every patient their bed bath for the day. She was always rushed and never talked to the patients because in her words “they don’t even know we are here”. They had become objects to her. Tasks that she could check off and move on to the next. One of the patients was a woman had fallen in her kitchen and could not get to a phone to call for help. She was found comatose and during her recovery was not able to move or talk. The second day I again found myself on bath duty and was assigned to this patient on my own. Since I had the time, I took extra care of her. I wanted her to know I cared. That she mattered. I talked to her even though she could not make eye contact. I covered her body to offer dignity even though she had no control. I made sure she was warm through the whole process as I cleaned her body and massaged in lotion to bring relief to her muscles. She never moved or made a sound during the whole time I was with her, so I left not knowing if I accomplished helping her feel care. The next week I went back, and she asked to see me. I was surprised as I was told her prospects of recovering were low. As I approached her, she began to cry. She asked to hold my hand and told me that the bath I gave her saved her life. She had decided not to try and get better because she felt like she was no longer human, and that she didn’t matter to anyone. Then I talked to her, told her she had beautiful eyes. I gave her dignity by seeing the human behind the diagnosis and gave her the hope she needed to keep trying. A simple bath, that offered dignity and a simple connection was what sustained her as a human until she could recover and heal. I went back to school with an entirely different perspective of what nursing was supposed to be. Dignity, care, connection, moments all matter. If you forget these, you forget your purpose and you become a robot offering medicine not healing.

As a brand-new pediatric nurse, I still had the image of a superhero who would make a difference by prioritizing care and connection over efficiency and science. I sought to bring the

humanity into each moment and never forget about the dignity that everyone deserves. For a while, these moments of care were enough to sustain me as a nurse. Even when the hospital system seemed to fail me, my patients and their cards of thanks or cute crayon pictures made everything else worth it. For the first year, outwardly everyone would report that I loved being a nurse. I always found a way to laugh, connect, hold other nurses up, take on the saddest cases without any effect on my attitude. Like many nurses, I had a secret. Outwardly I appeared fine, inwardly I was silently suffering and slowly losing myself to the grips of compassion fatigue and secondary trauma. It was subtle at first, I found myself being exasperated by the call lights, increasingly irritated by acuities and staffing issues. I seemed to have less and less empathy for my patients and at home, I had less energy for my own growing family including a husband and two small children. To manage this, just like many of my colleagues I decided the answer was to care more. Take on more intense diagnosis and emotional complex patients and at times even come in on my days off to continue caring. I was rewarded with these actions from my peers. Seen as the ultimate nurse who can carry the world on her shoulders without appearing to be weighed down. I was determined to push beyond my limits to prove to myself that I was the perfect nurse.

This all shifted for me when I met a little girl named Jenny. I walked into her room one day because I heard her mom call out from the bedside. As I entered the room, I noticed her mom sitting in a chair, bent over, pale and I could tell she was trying not to throw up. I looked around at Jenny and immediately understood why. She had managed to pull out her IV and had begun to swing it around her head spraying blood everywhere, no doubt the reason her mom was sent over the edge. I went to her bedside, held her arm to add pressure so it would stop bleeding. To this day, I still remember the way Jenny looked up at me. She had these big brown beautiful

eyes that looked at me with complete trust even though we had just met, and I had not had a chance to earn that yet. I immediately signed up to be her primary nurse and from then on almost every shift that I was at the hospital I was spending with Jenny.

Jenny lived with us on the floor. She was too medically complex to go home, not really sick enough to be stuck in a hospital but had nowhere to go. Her mom allowed the state to put her in foster care and there were several attempts to get her to a home. One of those attempts lasted just two hours when the family brought her back, crying and upset that they were in over their heads. We opened our arms and welcomed Jenny back home.

I could go on and on about this amazing little girl. She was nonverbal, had low muscle tone and had enough tubes coming from her to scare any new resident. I remember one time a new provider picked her up and her g-tube came flying out. He turned very white, threw her back in my arms and literally ran away. Jenny and I just smiled at each other and as I put her tube back in, she looked at me with those trusting eyes again. She would place her little hand ever so gentle on my cheek during these moments. This was how she thanked me and showed me her heart.

The one thing that really got to me was Jenny's laugh. She never spoke and often was in discomfort, but every once in a while, she would let go of this belly laugh that could melt away all of my stress in an instance. So much so that we would go to great lengths to get her to let loose one of these precious laughs. She would often give us this gift if we worked for it by singing the hokey pokey. For some reason if you were willing to spin around and 'shake it all about', Jenny thought that was worthy of one of her contagious giggles. There would be times that the entire nursing staff would gather at her wagon and start singing "put my right arm, put my right arm out" just in the hopes of glimpsing her belly shake.

Just as Jenny's life had a significant influence on me, her death was also a profound turning point in my nursing career. Jenny needed to have yet another surgery but shortly after her last one, it became apparent that her fragile body was not going to be able to recover. As the medical team realized that Jenny was in a critical state, they pulled together a meeting with the team and Jenny's mom. They tried explaining how serious her condition was to her mom but in her state of grief, she was not able to process what they were asking her. They really wanted to decide if we should pull her medical support and let her pass away. In her confused state, Jenny's mom turned to me and asked me to make the decision, she said: "Tell me what to do." The next few moments are forever seared in my heart. I answered from a nurse's perspective. We knew Jenny had a life-limiting disease. We knew she was not going to live much past her current age. Now, as she was so sick, everything we would try to do to help her would surely cause more suffering and probably not save her anyway. The nurse in me looked at her mom and said, "I don't think we shouldn't prolong her suffering anymore." That one sentence has haunted me more than any other nursing moment. Who did I think I was? How could I tell someone to stop fighting for their child's life? Her mom listened and we pulled support for Jenny. She passed within just a few hours of that discussion. The quickness of her passing gave me some solace that it was the right decision, but it did not take away the burning desire to take back being the one who made that call. In fact, that one moment changed me forever.

After Jenny died, I struggled to come to work. When I did come it was out of a sense of duty rather than as a sacred calling to care. I was in the midst of profound suffering because I deeply cared for one of my patients and had no training or knowledge of what to do with these unprocessed emotions. This suffering continued well beyond my time with Jenny and affected my personal and professional wellbeing.

This is just one story of one nurse and one patient. If you try to imagine the millions of other stories of compassion and loss, of hope and despair, and you can begin to consider the depths of suffering and need that the nursing profession deals with. It is reflected in the number of nurses who report compassion fatigue and burnout as seen next in the section.

Significance

This constant exposure to pain and suffering puts nurses at great risk of developing compassion fatigue (CF) and burnout. The weighty effects of Compassion Fatigue, defined as the inability to form nurturing relationships with the patient and the resulting distress caregivers experience, are well documented in nursing (Zerach & Shalev, 2015; Mealer et al., 2012; Johnson, 2013). Along with the continuous exposure to suffering, nurses face organizational stressors like increasing workload, insufficient rewards, and lack of control (Moss et al., 2016). In turn, these nurses report poor job satisfaction, have high absenteeism, and increasingly poor retention rates. (Brunero, Cowan & Fairbrother, 2008). The cost of empathy and care, either through intense secondary trauma, or the effect of accumulative exposures over time, are significant, and have a tri-fold effect on the nurse, patient and organization (Berger, Polivka, Smoot & Owens, 2015; Drury, Craugue, Francis, Aoun & Hegney, 2013).

Nurses report psychological symptoms associated with Compassion Fatigue which have long term effects including post-traumatic stress disorder, anxiety, hopelessness and depression (Johnson, 2013; Moss, Good, Gozal, Kleinpell & Sessler, 2016; Beck, 2011; Sorenson, Bolick, Wright & Hamilton, 2016; Berger et al., 2015). Compassion fatigue has an overpowering effect on a nurse's ability to care for their patients, leading to decreased compassion and empathy, and the inability to create healing environments (Meadors & Lamson, 2008; Najjar, Davis, Beck-Coon & Doebbeling, 2009; Meyer, Klaristenfeld & Gold, 2015). Compassion fatigue also

diminishes the altruistic satisfaction nurses desire, highlighted in current nursing shortages and poor nurse retention rates (Flarity, Gentry & Mesnikoff, 2013; Johnson, 2014; Sinclair, Raffin-Boucha, Venturato, Kondejewsku & Smith-Macdonald, 2017; Quinn, Smith, RiteZoeaugh, Swanson & Watson, 2003). Through these conditions, compassion fatigue directly contributes to a deterioration in safety, patient satisfaction, quality of care, and the effectiveness of care (Moss et al., 2016; Branch & KlinkeZoeerg, 2015; Meadors & Lamson, 2008; Drury et al, 2013). In competitive healthcare systems, hospitals pay a cost for not addressing Compassion Fatigue with high rates of turnover, ineffectiveness in the workplace, increased absenteeism, poor quality of care, and decreased patient satisfaction. (Branch & KlinkeZoeerg, 2015; Drury et al., 2013; Heckman, 2012; Maytum, Heiman, & Garwick, 2004).

In pediatric care settings, nurses are comparatively even more at risk of Compassion Fatigue. The vulnerability and perceived helplessness of a sick child increases the risk of Compassion Fatigue in pediatric nurses (Branch & KlinkeZoeerg, 2015; Czaja, Moss & Mealer, 2012; Meadors & Lamson, 2008). Pediatric nurses are faced with not only chronically ill children, but also ethical concerns, futile care dilemmas, and anguish related to the death of a child (Branch & KlinkeZoeerg, 2015; Czaja, Moss & Mealer, 2012; Meadors & Lamson, 2008). Pediatric nurses also have the added responsibility of caring for the family of the child including parents, grandparents, and siblings (Branch & KlinkeZoeerg, 2015; Czaja, Moss & Mealer, 2012; Meadors & Lamson, 2008).

With the significance of compassion fatigue in nursing and ongoing pressure of nurses to care for their patients, a different perspective within our discipline could help find ways to better support nurses.

Revisiting Nursing theory

One way to consider minimizing the effects of compassion fatigue is to return to the philosophy found in nursing theory. It is a returning to because practicing nurses take pathways as far around philosophy as possible. Then as the experience of suffering and the pain of compassion fatigue take over, nurses reached out for a new framework to find the meaning behind the struggle. This is not just a reflection of the individual nurse but a question the discipline must begin to ask in order to support the new nurses stepping into this profession.

In nursing school, students are asked to see nursing as a scientific discipline with curriculum solely focus on the empirical aspects of treating the human body. While these skills are important, the singular concentration on them fails to honor the aesthetical services nurses yearn to offer. The expectation of nursing practice is that a nurse comes prepared with an endless capacity to treat the whole person with knowledge on how to heal their mind, body, and spirit. Nurses also set this expectation and are driven by a deep desire to heal. Once out of school, nurses quickly discover they have not been prepared for the staggering amount of need they will face. There is always something more to care about, more to take on, more to worry about. Without a philosophical foundation or at least a theoretical lens, there is no way to process this information or truly understand the personal cost paid as a care provider.

In my personal experiences like the one with Jenny and the countless other moments in which I felt lost and humbled, I would tell myself the answer was to care more, to do more, to give it all. So, I gave with abundance and crossed boundaries by caring for my patients long after I had given report and my shift was over. I needed to take suffering away from my patients, so I made it my mission to ease their pain by taking it on myself. For a while this care, while exhausting, was enough to sustain my practice. When I could make just one difference with a

patient or family, then I would have enough to come back the next shift. In times I had nothing left, instead of meeting my own needs, I would berate myself for being weak and pushed myself to do more. On the outside, no one could see this struggle as I slowly lost my ability to uphold my sacred covenant to care for those in need.

Nursing philosophy traditionally helps keeps the discipline grounded in the purpose and calling of being a nurse. If a philosophical perspective can remind nurses the uniqueness of the care nursing offers, it can both sustain a nurse and build personal resiliency. This use of philosophy was absent on the pediatric nursing unit I worked on. In my experience, when a nurse outwardly appears to be able to manage the pain, fear, suffering, the answer was to reward that nurse by continually giving them more to manage. A hospital remembers how well you handled the angry parent or how you seemed to be able to cope after an end of life case, so the system assigns you those complex situations over and over. I emerged as one of those nurses because on the outside I appeared calm in the midst of chaos. The one who always seems to have the ability to find levity and remain positive when others struggled.

Just as life is a series of moments, so is a nursing career. Moments of joy when I felt like I made a difference but also moments of pain where I felt helpless and inadequate. One moment that forever changed me happened when a desperate mother, who could no longer cope with the death of her child, literally handed him to me and asked that I not leave him alone. In the moment, I did what everyone expected me to do. I stayed, I held him, but to be honest, I was never the same again. Something happens in you when you are the last person to hold a dying child. Something in your soul cries out for peace and understanding when there is not any answer that is enough. Perhaps if I was grounded in philosophy, or if this was just one moment, I could have recovered from it. A nurse's story never holds just one chapter. It is a journey of moment

after moment, person after person accompanied with an overwhelming exposure to emotions. Even the positive emotions of another can be too much to bear as you try to separate yourself from what is yours and what is not meant to be yours. When Jenny died, I was at my lowest point, and I just could not take anymore. I built up such a protective wall that I no longer even wanted to know the story of those in my care. I only wanted to know what tasks I needed to do to get through my shifts. This of course only caused more personally suffering because it went against my very nature.

At this point the anguish was so great I knew something had to change. Like many other nurses I considered leaving the profession all together because I felt like I was not strong enough to be a nurse. This is not a unique problem as we know that 13 % of nurses leave after the first year of employment and up to 37% of new nurses leave the profession within the first three years (Park & Jones, 2010). Fortuitously for me, this was not my story because this is the instant in my career that I met Jean Watson and was introduced to Caring Science. Dr. Watson explained that building walls were not the answer to suffering, love was. By studying the philosophy of Caring Science, I begin to appreciate the need to care for myself as much as I cared for others. The idea that self-care is never selfish is a foreign concept to nursing. Caring Science accentuates that self-care is paramount to ensure that a nurse has the capacity to hold the world's suffering. To offer enough space in the heart so the innate stress of caring doesn't break it apart but can help a heartbreak open so as to see more, hold more and in the same moment find healing. It allows a nurse to offer their whole being to another without losing who they are or being consumed by the emotions.

The lens of Caring Science contemplates the writings from several disciplines including both eastern and western medicine, humanistic psychology, noetic sciences, quantum physics,

feminist theories, ethics, theology, and consciousness theory (Clark, 2016, Falk-Rafael, 2000; Galvin, 2010; Watson 2002). Watson intentionally draws on the philosophies of both Levinas and Logstrup. Levinas writes about the face to face connection two humans can have and how each see infinity in the other and it is then reflected back (Peperzak, Critchley & Bernasconi, 1996). Logstrup calls for a practice to be and become more human and humane with each other as both an ethical practice and true pathway to be in service to another (Logstrup, 1997). Having a new perspective of humanity and the ethics of belonging and being seen are ways Caring Science can contribute to the disciplines self-actualization. A path of nursing that can lead back to self and be a part of both the discovery and remembering of a nurse's true nature and calling into healthcare.

The philosophy of Caring Science is not just foundational to be a nurse, it is the basis for understanding our own humanity. At a most basic level Caring Science reminds us that as humans we are meant to be connected and walk through life together. Amid the disorder everyone experiences in life, we simply forget how to see ourselves in the other. To see beyond the masks of fear and anger to the spirit-filled person in front of us who, just like us, only wants to feel safe, to be heard and to know love. In this sense philosophy, might not be teaching us new concepts but rather simply reminding us of our true nature. This is what Jean Watson is speaking to when she talks about using theory from its Greek root word of theoria or to 'see' (Watson, 2018). Seeing is the first step to knowing. We must see empathy and feel compassion even if it is hard to describe how these skills help us and our patients heal. Watson also reminds us that to see another, first we must be able to see ourselves which calls for each of us to become in right relation with self-first before we can be in right relation with another. Philosophy can help nurse learn these tools needed to be and become all they can be as care givers. To walk towards their

own wholeness as they walk others toward theirs. To see their own humanity as they look for it in others. Jean Watson (2008) reminds nursing that "We learn from one another how to be more human by identifying ourselves with others and finding their dilemmas in ourselves. We learn to recognize ourselves in others." (p. 5)

It is this right relation with self that nursing can look to philosophy to aid in its evolution and help each nurse expand to a higher level of consciousness. This awareness which Watson refers to as Caritas Consciousness is an ideal that allows nursing to bridge the gap between medicine and love. To be okay with opening your heart to your patients. To understand that we have a responsibility to treat everyone with loving kindness and dignity. From each other, to our patients, to the world. To be the example within medicine that it is not only okay to show our patients how much we care but that it is our responsibility. To remind nurses we are all called to the bedside for the sole purpose of connecting with the patient, regardless of who they are and to show them the love and compassion that they deserve. To give nurses permission to enter a moment open and be open to the vulnerable of another person. Jean Watson inspires nurses to have the courage to practice from this moral-ethical foundation, in order to experience the depths of what being a nurse is all about. Theory and philosophy hold these ideals for the discipline of nursing and offers the practices that teach and sustains nurses throughout their caring journeys.

Conclusion

There is currently a gap in Compassion Fatigue research that seeks to understand how pediatric nurses experience compassion fatigue in an acute hospital setting, how they flourish, hold onto compassion satisfaction (the altruistic values of caring for others), and combat the effects of compassion fatigue. To truly understand this phenomenon, this research requires exploration of a first-person narrative from nurses who are working in the field of pediatrics.

Qualitative research can help attain this in-depth understanding of the meaning behind these concepts for pediatric nurses. Due to the prevalence, and profound personal cost that Compassion Fatigue has on nurses, research in this area should consider the unique perspectives of this role within healthcare. It should also incorporate the principles found within nursing theory to respect the time honor tradition of nursing as the care within healthcare.

Nursing is at a pivotal moment in its history. Medical models that alienate nursing practices and nursing ideals are the predominate paradigms found in hospital settings. Nurses in these organizations feel marginalized because as they are called upon to care for their patients, they are abandoned by the healthcare system. The nursing discipline must return to the heart of caring if we are to not just survive these times but attempt to thrive during them. Nursing needs a theoretic road map to shine a light on how to be present, how to use all ways of knowing, how to practice self-compassion, and how to make transpersonal caring our true gold standard of care. The kind of care that understands it is the relationship of caring that leads to the space needed to heal. That it is a journey for both the care giver and the care recipient. This dissertation is a calling card to the discipline of nursing and the healthcare organizations as the world cries out for nurses to stay connected to their purpose, be able to see the dignity of each patient, to care enough to not look away and have the capacity to hold up all of humanity.

CHAPTER II

Review of the Literature

There is not a shortage of terms used to describe the emotional costs of caring for others. Compassion fatigue, secondary traumatic stress, burn out, vicarious trauma, emotional labor, care giver stress and post-traumatic stress disorder have all been attributed to the effects of working with patients (Adriaenssens, DeGicht & Maes, 2014; Beck, 2011; Berger, et.al, 2015; Branch & KlinkeZoeerg, 2015; Cricco-Lizza, 2014; Czaja, Moss & Mealer, 2012; Joinson, 1992; Mealer, 2014). This chapter explores what is needed to understand the lived experience of compassion fatigue among nurses working in an acute pediatric inpatient setting. It will begin by defining the key concepts of compassion fatigue including a review of the variables including historical axioms like compassion fatigue, burn out, secondary trauma, compassion satisfaction and new components of emotional labor. Considering these variables and the current state of the science combined with a new ideal of incorporating nursing theory into practice, a new model to understand compassion fatigue emerges. One that includes new pathways of research with the vision and hope of leading the profession of nursing away from compassion fatigue and towards a nurse's experience of compassion without fatigue. Next, it will discuss the foundations of qualitative research and the unique properties of Husserl's phenomenology that seek to expand knowledge through the vivid description of the lived world within the phenomenon. Finally, it will describe the merging of Caring Science and Husserl's phenomenology within the Relational Caring Inquiry method that helps researchers and nurses co-create the meaning of the lived experience, in this case, of compassion fatigue, burnout, secondary trauma and compassion satisfaction.

Compassion Fatigue

The term compassion fatigue was first introduced by Joinson (1992) to explain the absence of nurturing in emergency department nurses who appeared to lose their ability to care. Joinson recognized the unique stress nurses faced with meeting both the physical and emotional demands of their patients combined with environmental stressors from working in a hospital setting (Bush, 2009). Nurses report being tired, depressed, angry, and eventually apathetic and detached (Bush, 2009). Researchers draw on the work of Charles R. Figley as he suggested Compassion Fatigue is common in healthcare professions due to the tendency of care givers to be empathetic, and the natural cost of having this empathy for traumatized patients (Maytum et al., 2004; Sinclair et al., 2017). This capacity for compassion is both the reason nurses care, and the reason nurses suffer (Figley, 2002). Nurses with prolonged exposure to suffering have changes in their cognitive schema around intimacy, trust, safety, self-esteem, and control (Bush, 2009). This leads to questioning their purpose as a nurse, and hopelessness can prevail (Figley, 2002). Figley was the first to linked Compassion Fatigue to the concepts of burnout, secondary trauma, and compassion satisfaction (Gentry, 2008; Branch & KlinkeZoeerg, 2015; Figley, 2002).

Burnout

Burnout, often associated with inefficient or imbalanced organizational practices, is the syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment (Gentry, 2002; Beck, 2011; Canadas-DeLaFuente et al., 2015; Mealer, 2014). Committed professionals like nurses, begin their careers with energy, dedication, and efficacy, but poor organizational environments cause nurses to become cynical, ineffective, and less caring (Bush, 2009). Burnout is evident as an employee shows lack of interest in work, reports being

physically and emotionally exhausted, and if unchecked, over time can experience physical and emotional collapse (Sinclair et al. 2017; Adriaenssens, DeGicht & Maes, 2014; Maytum et al., 2004; VanMoi et al., 2014; Canadas-DeLaFuente et al., 2015).

Secondary Trauma

Secondary trauma is attributed with feeling overwhelmed due to the constant exposure to extreme events, or suffering experienced by another (Gentry, 2002; Beck, 2011; Najjar et al., 2009). As a pediatric nurse in an acute hospital setting, there is not a shortage of exposure to secondary trauma. The nurse's reaction in secondary trauma depends on how close they are to the situation, combined with intensity, and duration of the exposure (Meadors & Lamson, 2008). The symptoms manifest as over identification with the patient, trouble separating work life form personal life, outburst of rage and anger, or depression (Gentry, 2008; Beck, 2011; Meadors & Lamson, 2008).

Compassion satisfaction

Nurses are innately motivated to offer compassion to those suffering, which is why many consider it a calling rather than a career. Compassion is defined as a sense of shared suffering, combined with the desire to reduce such suffering (Schultz et al., 2007; Sabo, 2006). Compassion satisfaction refers to the gratification nurses feel when caring for others stays in balance allowing them to embody the positive aspects of altruism (Meyer, Li, Klaristenfeld, & Gold, 2015; Berger et al., 2015). Altruism, acting on the behalf of others instead of for personal reasons, is a core characteristic of competent health care professionals (McGaghie, Mytko, Brown & Cameron, 2002). Compassion and empathy are the driving force behind compassion satisfaction as the nurse is moved to alleviate suffering of another and feels good about making a difference in another person's life. This increases optimism, and hope, and gives the nurse the

impetus to continue in the care giver role (Sacco & Copel, 2017). Compassion satisfaction is linked to the ability of the nurse to be caring and has a positive correlation between increased work meaningfulness, and improved patient satisfaction (Burston & Stichler, 2010).

Compassion Fatigue Model

The conceptual model developed by Stamm and Figley (2009) gives a framework for defining and measuring Compassion Fatigue. The Professional Quality of Life Assessment (ProQOL), developed by Stamm and Figley, is a validated compassion fatigue tool used widely in hospital settings to determine the risk of Compassion Fatigue for a variety of healthcare providers (Gentry, 2008; Berger et al., 2015; Shepard, 2015; Stamm & Figley, 2009). The model and assessment comprise of three subscales contributing to Compassion Fatigue: high secondary trauma, and burnout, combined with low compassion satisfaction, each depicted within the model (figure 1) (Johnson, 2013, Stamm, 2010).

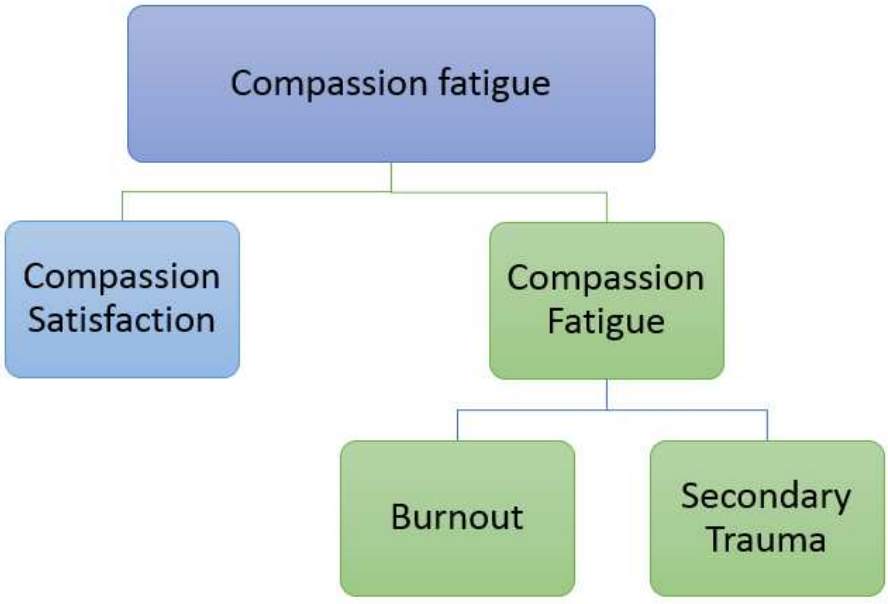


Figure 1. Compassion Fatigue Model (Stamm, 2010).

New Model for Compassion Fatigue

Emotional Labor

The limitations to Stamm's model include the absence and consideration of the work environment and the inherent or 'emotional labor' that nurses endure. Emotional labor depicts the unique demand on healthcare providers, as they manage the intricacies of caring for others in the complexities of a hospital setting. Importantly, emotional labor considers not just the quantity of emotional demand on nurses but the quality of the experience and environments where the care occurs (Brotheridge, 2002). Emotional labor also gives credit to the amount of energy required to complete the often disgusting, distasteful and embarrassing medical tasks nurses are called upon to do. To put their patients at ease, nurses suppress otherwise normal reactions to these tasks in order to sustain an outward appearance that reassures the patient they are cared for (Brotheridge, 2002). To understand the complexities of emotional labor it is important to look at three components nurses face in a hospital setting including the nature of compassion, the experience of suffering and the presence of moral distress.

Nature of compassion

Any nurse who has held a child going through a painful procedure or comforted a mother who learned they are not anything more to be done to save her child understands that being compassionate with another is often painful. In these moments, authentic compassion demands presence, vulnerability and empathy. The very nature of this compassion puts the nurse at risk as they are fostering care for another within the openness that it demands. Compassion, defined as a sense of shared suffering, combined with the desire to reduce such suffering, is a natural human capacity that is developed as early as 18 months (Schultz et al., 2007; Sabo, 2006; Austin, Golbe, Leier & Byrne, 2009). Lewin (1996) illustrated the complexities of a nurse's compassion as

being able to stay in personal balance, while holding a patient's despair in one hand, and hope in the other. When these are not held in balance, either due to nurse's inability or practicing in an unsupportive environment, the same level of compassion will indubitably lead to fatigue (Figley, 2002; Lewin, 1996).

Experience of suffering

Nurses are innately motivated to help those suffering, which is why many consider it more of a calling than a career. The vulnerability of seeing and experiencing suffering with another also adds to the emotional labor experienced by nurses. Suffering is unavoidable in nursing as Figley (2002) explains "in our effort to view the world from the perspective of the suffering we suffer" (p.1434). Nurses on inpatient units endure ongoing exposure as their patients remain in their care for longer periods of time and often over several shifts (Boyle, 2010; Bush 2009). The proximity to the patient, and the suffering they endure has prompted the images of nurses as wounded warriors, bearers of inner pictures of human suffering, survivors of healthcare, or vessels that hold all of humanities suffering (Austin et al., 2009; Conti-O'Hare, 2002; Mealer, 2014).

Moral distress

Moral distress, described as the suffering experienced when a nurse knows the right thing to do but cannot carry it out because of institutional constraints, also contributes to these professional's emotional labor (Maiden & Connelly, 2011; Leggett, Wasson, Sinacore & Gamelli: 2013). The nurses' physical and psychological safety combined with existence of an ethical climate contribute to the degree of moral distress (Leggett, Wasson, Sinacore & Gamelli: 2013). Unsafe physical environments directly contribute to moral distress as a nurse understands the organization lack respect and care for their employees yet demand they provide safe

environments for the patients (Meadors & Lamson, 2008). Psychological safety is at risk when there is disequilibrium between a nurse's core values and ethical obligations with organizational policies. These happen predominately in organizations that use medical or business models, where nursing perspectives are marginalized (Austin et al., 2009). These environments ignore moral distress and are described as oppressive increasing a nurse's experience of powerless, exploitation, marginalization and physical or psychological violence (Austin et al., 2009; Peter, Macfarlane & O'Brian-Pallas, 2004). Integrating the concepts of emotional labor with compassion fatigue constructs a new conceptual model (figure 2)

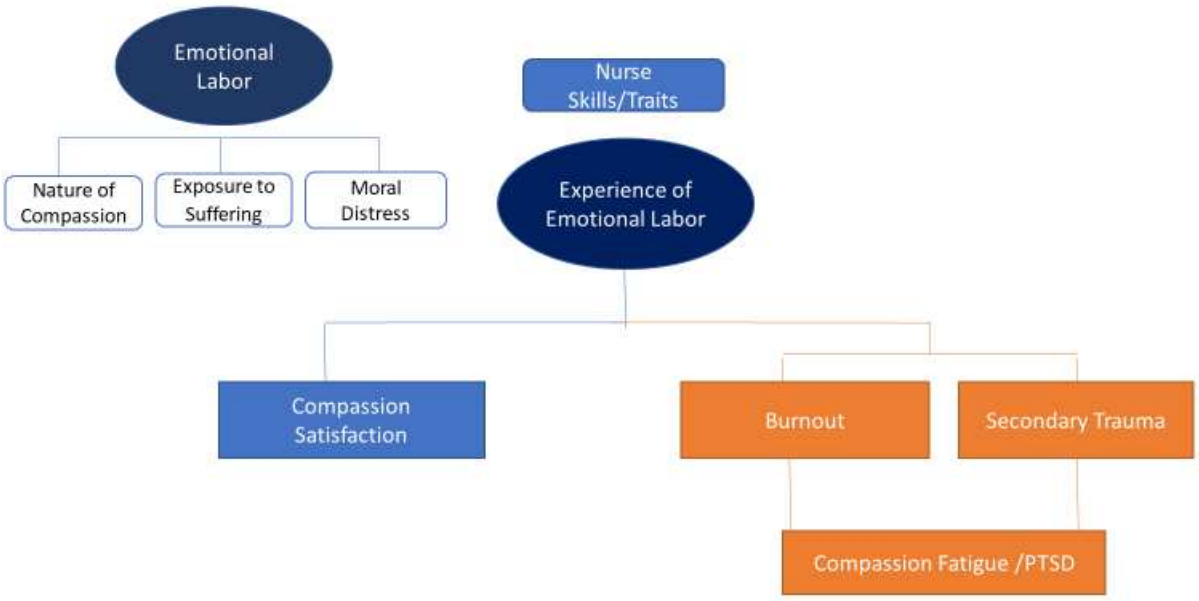


Figure 2. Emotional Labor and Compassion Fatigue (adapted from Stamm 2010).

State of the Science

Considering compassion fatigue variables combined with the emotional labor aspects of nursing, what do healthcare organizations need to develop to combat compassion fatigue? To date, hospitals have focused on stress reduction modalities for clinical staff including cognitive

behavioral therapy, debriefings, resiliency programs, and mindfulness (Burlison, Scott, Browne, Thompson & Hoffman, 2016; Brunero et al., 2008; Sorensen et al., 2016). Other hospitals have changed organizational structures including ethics consults, maximum days of consecutive work, self-scheduling, increasing teamwork, staffing to acuity, and increasing the recognition of nurses (Moss et al., 2016; Sorenson et at., 2016).

A metasynthesis of qualitative research among pediatric nurses illustrates the need to go beyond and surface issues and address deeper concerns of the nurses working in the environments. These include, but are not limited to, recognizing the extensive effect of seeing another in suffering, not having control of the outcome, and being unsure of their ability to make the moral decisions needed (Cricco-Lizza, 2014; Gardling, Mansson, Tornqvist & Hallstrom, 2015; Huang, Kellett, Wang, Chang & Chih, 2014; Maytum et al., 2004; McConnell & Porter, 2017; Morrison & Morris, 2017 Shimoinaba, O'Connor, Lee & Kissane, 2015; Stayer & Lockhart, 2016). These studies illustrate the increased risk of compassion fatigue for pediatric nurses due to the high demands on emotion, always needing to be vigilant, and exposure to poor outcomes, and death (Cricco-Lizza, 2014; Drury, et al., 2013; Gardling, et al., 2015; Huang et al., 2014; Maytum et al., 2004; Morrison & Morris, 2017; Stayer & Lockhart, 2016). Also prevalent is the increase in stress when organizations do not recognize the importance of creating healthy work environments, defined by allowing time to connect meaningfully with patients, structures for peer support, organizational recognition for the emotional labor, ethical environments and prioritizing self-care (Drury et al., 2013; Mayturn et al., 2004; Cricco-Lizza, 2014; Morrison & Morris, 2017; Shimoinaba et al., 2015; Stayer & Lockhart, 2016).

Relationships and meaningful connections are key components to compassion satisfaction for the nurses in these studies. In truth, the factors that protect against Compassion

Fatigue like contributing to patient's recovery, compassion, empathy, being a part of a supportive team can only occur in organizations that create supportive environments (Austin, 2009). Compassion Fatigue emerges when professional-patient engagement is not supported or valued as an integral part of nursing practice. When nurses have enough time, and the skills to connect with the patient or family they can see the difference they make, and nurture their compassion satisfaction (Cricco-Lizza, 2014; Huang et al., 2014; Maytum et al., 2004; McConnell & Porter, 2017; Morrison & Morris, 2017; Shimoinaba et al., 2015 Stayer & Lockhart, 2016). Conversely, when rushed or unable to build an intentional relationship with their patients, they felt disheartened and disconnected to their purpose (Drury et al., 2013; Gardling et al., 2015; Huang et al., 2014; Maytum et al., 2004; Morrison & Morris, 2017; Stayer & Lockhart, 2016). This metasynthesis reveals the importance to build skills to manage the complex emotional aspect of caring for others, which are not an innate ability but rather learned over time in the supportive environments (Cricco-Lizza, 2014; Drury et al., 2013; Maytum et al., 2004; Morrison & Morris, 2017; Shimoinaba et al., 2015).

Supportive Environments

These studies highlight the need for organization to create environments that recognize the nature of caring, manage the suffering experienced by nurses and create morally conscious environments. Supportive environments that step outside of the oppressive nature of the medical and business models and focus on nursing perspectives and values (Peter, Macfarlane & O'Brien-Pallas, 2004). One approach to honor the complexities of nursing and seek a more deep-seated clarity of what supportive environments look like, is to look within nursing theory.

Jean Watson's Philosophy and Science of Caring

Jean Watson's 'Philosophy and Science of Caring', a nursing theory-based practice paradigm, addresses the distinct stress that nurses experience as they tend to their patient's physical body, mental state, and emotional landscape (Watson, 2005; Watson & Smith, 2002). This nursing theory offers a philosophy, an ethic, and a practice for nursing to understand its unique contribution to healthcare, to sustain human dignity, and to stay connected to its caring values (Levy-Malmberg, Eriksson & Lindholm, 2008). Watson (2008) challenges healthcare organizations to regard nurses as a precious source of compassionate care. Weaved throughout the theory are philosophical perspectives that speak to the environment of care which attunes to the nature of caring, the exposure of suffering of others, and offers practices that sustain all involved. Watson then textures these perspectives to understand the unique stress that nurses face as they are called to create healing environments (Watson, 2005; Watson, 2008). The core concepts of Caring Science include the moral commitment to preserve, protect, and enhance human dignity using a relational ethical-moral foundation that promotes mindful caring as a consciousness and intentionality (Clarke, Watson, & Brewer, 2016; Norman, Rossillo & Skelton, 2016; Watson, 2002; Cohen, 1991; Norman, Rossillo & Skelton, 2016; Watson, 2005; Watson, 2008).

Caring Science approach to Compassion Fatigue

Watson teaches care providers how to use heart-centered practices, and caring-healing modalities to create compassionate healing environments for themselves first, and then for others (Watson, 2008; Cohen, 1991; Watson, 2005; Norma & Skelton, 2016) These concepts are actualized through caring practices within ten Caritas processes (shown in figure 3). Watsons defines 'Caritas' as connection between caring, and love actualized by the nurse when creating

healing environments (Watson, 2008). The Caritas Processes combine the practices of authentic presence, compassionate communication, trusting relationships, healing environments, with the concepts of loving kindness, faith, hope, and human dignity (Watson, 2003; Watson & Smith, 2002; Martsolf & Mickley). The core concepts and micro-practices taught in Caring Science, address how a nurse can process, and deal with the suffering they are exposed to, and remind the nurse of the unique difference they make in each of their patients' lives. In turn, the nurse is better prepared to manage the emotional labor described above and improve on compassion satisfaction which in turn increases the prospect of experiencing compassion without fatigue (Cohen, 1991, Watson, 2005; Watson & Smith, 2002). Caring Science proposes a nurturing and supportive environment for nurses includes practices that support caring consciousness,

1. Practicing loving-kindness and equanimity within context of caring consciousness.
2. Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being-cared-for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within another's frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared-for; "allowing and being open to miracles."

equanimity and the ethics of care.

Figure 3 Jean Watson Caritas Processes (Watson, 2012)

Caring consciousness

Caring Science looks at compassion through the lens of caring consciousness. Nurses want to heal but often are required to contribute to their patient's agony with painful procedures.

This dichotomy of care adds to the emotional labor and moral distress that decreases compassion satisfaction. Caring Science draws on the teaching of Emmanuel Levinas to understand why these experiences are a dilemma for nurses. Levinas writes that our experiences with another person and being in relation with them is the basis for our being (Peperzak, Critchley & Bernasconi, 1996). We experience our own humanity through the face of another, and this connection is then reflected back and creates our reality (Peperzak et al., 1996). In other words, when we cause suffering, we experience suffering, and when we sustain another person, we sustain ourselves. This connectedness or 'oneness' explains a nurse's sensitivity to the suffering of another as the experience is mutual. Caring Science expands on Levinas to remind nursing of its calling, to remember this shared humanity, and to treat each nursing act as a sacred act (Watson, 2008). Watson states when we forget the humanity of the patient, we risk reducing them to the moral status of an object. This allows us to separate ourselves from the act, potentially increasing the suffering of both patient and nurse. By using the caritas processes and practicing loving kindness to self and other the nurse maintains the connection to the humanity of the other, treating them with dignity and care. Jean Watson has said

> "By being sensitive to our own presence and Caritas Consciousness, not only are we able to offer and enable another to access his or her own belief systems of faith-hope for the person healing, but we may be the one who makes the difference between hope and despair in a given moment." (Watson, 2008, p. 62)

This connection or caring consciousness reduces the suffering for both the patient and nurse as they work toward healing together. This ideal of being aware or conscious and connected to the patient allows the nurse to see beyond the suffering of the moment, allowing them to focus on the difference they can make and the experience the positive altruism received from caring for another human in need.

Equanimity

Jean Watson honors the tradition of the nurse's sacred covenant with society to be present and caring when a person is most vulnerable, and suffering. Compassion satisfaction is increased when a nurse can help another in their time of need, but this constant exposure to another person suffering is a significant contributor to Compassion Fatigue (Cricco-Lizza, 2014; McConnell & Porter, 2017). In response to Compassion Fatigue, nurses avoid exposure to suffering by disconnecting with their patients, which decreases their compassion satisfaction, and compounds the issues of Compassion Fatigue (Cricco-Lizza, 2014; Drury et al., 2013; Maytum et al., 2004). Watson understands the complicated nature of suffering and addresses the need to support both the nurse, and the patient in the experience (Watson, 2005; Watson, 2008). To increase compassion satisfaction, and decrease secondary trauma, a Caring Science approach shapes nursing practice so the nurse eases the suffering of another with authentic presence and find personal peace through practices of equanimity and attenuating the suffering (Watson, 2008). Equanimity allows the nurse in the midst of caring for another, stay in balance of care so as to not own all of the world's suffering and be able to let go of an outcome. As noted above, pediatric nurses are at high risk of compassion fatigue due to the exposure of poor outcomes and death (Cricco-Lizza, 2014; Drury, et al., 2013; Gardling, et al., 2015; Huang et al., 2014; Maytum et al., 2004; Morrison & Morris, 2017; Stayer & Lockhart, 2016). Caring Science attenuates the suffering a nurse experiences with a poor outcome by reminding the nurse their core purpose is to simply be a witness to and present with their patients. Janet Quinn (1992) supports this:

> "it is clear that in the process of expanding our own consciousness, of becoming healing environments, sacred spaces, we ourselves are healed" (p. 35).

When the nurse's aspiration is shifted to creating a healing environment through this authentic presence, regardless of the outcome, the nurse has made the difference they hope to which naturally leads to compassion satisfaction and decreased risk of compassion fatigue.

Ethics of care

Moral distress increases when a nurse is asked to work against their personal or professional ethics. To address the ethics of care, Caring Science intentionally draws on the ethical perspective of Knud Logstrup. Logstrup (1997) called for a practice to be and become more human and humane with each other as an ethical demand and true pathway to be in service to another. These practices of trust, assisting with basic needs, creating healing environments and being authentic present help the patient determine their own self-worth, allow them to heal and, ultimately informs their personal attitude towards health and wellness (Watson, 2003; Watson, 2005; Watson, 2008). As the nurse is sustaining the patients in this healing manner, their own needs of altruism, and desire to create meaningful interactions increase compassion satisfaction and combat burnout and secondary trauma (Austin, 2009). These ethical practices are rooted in what Logstrup called a 'radical demand' based on his key understandings of the connectiveness of all humanity (Logstrup, 1997). Logstrup contended that life is a gift, that every interaction with another person affects them either positively or negatively, and therefore we must always care for the person that trust has placed in our path (Logstrup, 1997). Jean Watson's basis of transpersonal care and healing environment are based on congruent beliefs that humans energetically affect each other (Watson, 2005; Watson, 2008). Transpersonal care occurs as the nurse and patient connect in the moment and both are nurtured and fulfilled. These practices incorporate Logstrup' s understanding of humanity and require a skilled nurse who can be authentically present, caring and open. As healing is the core of nursing practice, these skills

reconnect the nurse to his/her purpose and decreases the effects of moral distress and increase compassion satisfaction.

Caring Science to combat Compassion Fatigue

The philosophy, ethic and practice of caring science offers a path to combat the devastating effect Compassion Fatigue has on the nurse, patient and healthcare system. Weaved throughout the theory are philosophical perspectives that speak to the environment of care which attunes to the nature of caring, the exposure of suffering of others, and offers ethical practices that sustain all, regardless of the work environment. Watson then textures these perspectives to understand the unique stress that nurses face as they are called to create healing environments. The metasynthesis previously mentioned reminds organizations that nurturing environments include the same practices that Jean Watson has shown to increase compassion satisfaction. The nurses covet time to connect with their patients, time to be sustained by their peers and organizational support that both recognizes the inherent nature and risks of caring for the suffering of others, offers ethical practice to combat moral distress and helps to prioritizing theory guided practice and self-care (Drury et al., 2013; Mayturn et al., 2004; Cricco-Lizza, 2014; Morrison & Morris, 2017; Shimoinaba et al., 2015; Stayer & Lockhart, 2016).

A new model incorporating the environment of care which includes the supportive nurturing environment created using the Caring Science principles of caring consciousness, equanimity, and ethics of care is represented in figure 4.

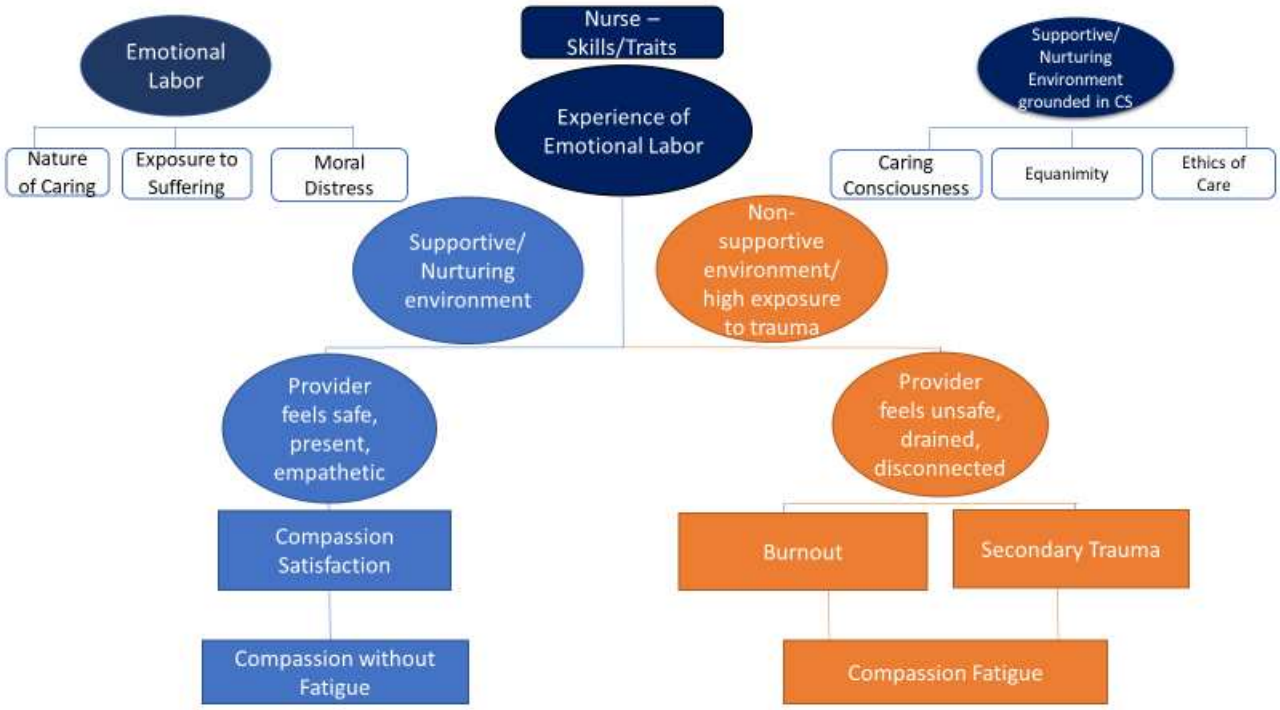


Figure 4. Caring Science & Compassion Fatigue (adapted from Stamm, 2010).

Qualitative Research

To gain an in-depth understanding of compassion fatigue it must come from the perspective of those experiencing it. Qualitative research focuses on the meaning-making of those immersed in the phenomenon and can recall, reflect and offer descriptive details of the experience (Vaismoradi, Turunen & Bondas, 2013). Gathering this type of information allows the researcher to delve deep into the data and view it from the inside of the experience (Wertz, 2011).

Qualitative Foundations

Philosophical underpinnings of qualitative research value the person-centeredness of a lived experience, assumes there are multiple realities within each moment, and emphasizes the need for the researcher to get close to the subject, positioning themselves within the study, to get an inductive understanding of the phenomenon (Heaton, 2004; Wertz, 2001). Qualitative

interviewing creates a reflective space for a research participant to gain a deeper understanding themselves and reveal their own reality. The qualitative researcher learns true perception of the experience by guiding the subject to a deeper understanding until they can distinguish between what is thought to be, and what reality is given to them in the experience (Heaton, 2004; Zahavi, 2003). Qualitative research holds an ontological view that there are multiple realities within each moment, and interviewing several subjects on the same phenomenon, allows themes and patterns, to emerge naturally from the data in an inductive process (Srivastava & Hopwood, 2009). To evoke this data, and know what the participant knows, the researcher must get as close to the participants as possible. Eide and Kahn (2008) affirm "Qualitative research requires a mutual standpoint, researcher to participants, human being to human being" (p. 199). In this way, the researcher positions themselves within the study often sharing their values and biases up front. In qualitative studies, the researcher "becomes the research instrument with all the results being filtered through her perceptions and understanding of the social situation for which she is working" (Heaton, 2004, p. 60).

Phenomenology

Phenomenology, a well-established methodology of qualitative research, uses interviews to investigate an individual and their relation to the world. It does not set out to understand new knowledge as an empirical study would. Rather, it seeks to see the deeper essence of human experiences through reflection, focused description of the individual's perceptions, self-awareness, and exploring the conscious relationship the participant has with the world around them (Zahavi, 2003; Wojnar & Swanson, 2007). Zahavi (2003), described the intention and skill to delve deeper into another's consciousness, and be able to fervently describe their perceptions, as the central accomplishment of phenomenology. " Our relation to the world is so fundamental,

so obvious and natural, that we normally do not reflect upon it. It is this domain of ignored obviousness that phenomenology seeks to investigate" (Zahavi, 2003, p. 665).

Husserl Phenomenology

The Relational Caring Inquiry method, chosen to study this research question, is modeled after Husserl phenomenology. In this method, the researcher uses the first-person point of view to understand the essence of the participant's consciousness, and the meaning of their lived experience (Wojnar & Swanson, 2007). Edmund Husserl established this eidetic (descriptive) approach to research that looks to understand a shared consciousness of a phenomenon through introspection that asks each participant to gaze inward as they respond to interview questions (Wojnar & Swanson, 2007; Zahavi, 2003). Husserl combined the experience of the mind and the body to understand how the person co-creates their unique meaning with the world. He contended that reality does not exist in some tangible identifiable outside world but in human consciousness itself. Zahavi (2003) explained "In other words, what is paramount importance is how we order, classify, structure, and interpret our world and then act upon these interpretations" (p. 671). Eidetic research illuminated even seemingly trivial aspects of the experience to create meaning and achieve a deeper sense of consideration (Wilson & Hutchinson, 1991).

To understand a phenomenon like compassion fatigue, the methods cannot use empirical means to prove one reality, but instead focus on an inductive approach that seeks common meaning, ideas, and the lived experience from the perspective of multiple nurses' realities (Creswell, 2013; Zahavi, 2003). Husserl's contended this is not a process of separating oneself from reality, yet a reflective process that leads the participant back to investigate the experience as it truly was. Zahavi (2003) related this as "the turn from naïve exploration of the world to a

reflective exploration of the field of consciousness does not entail a turning away from the world, rather it is a turn that for the first time allows for a truly radical investigation and comprehension of the world" (p. 670).

Husserl asserted that descriptive research is not merely the sum total of casual relations but as the context of all meaning. "A rigorous investigation of the essential structure of consciousness of the world" (Reeder, 1984, p. 274). The purest form requires rigor through adherence to strict guidelines (described below) of collecting and analyzing the data from one to one interaction with the participants. Up front, this starts with intentionally selecting the right subjects. It also calls for the use of bracketing to address bias, the use of reduction methods to bring to the surface what the participants feel in their consciousness, and inductive analysis to understand the universal essence from the particulars of each to arrive at a collective consciousness.

Bracketing. Bracketing is the intentional practice of a researcher to put aside any preconceived notions, and suspend judgment, in order to have an unbiased analysis of the data and see the phenomena clearly (Laverty, 2003; Biber & Leavy, 2011). In its virtuous tradition, the researcher abandons their own lived reality, to truly described the immaculate essence of the stories they are told (Wojnar & Swanson, 2007). Husserl's critics contend the ability for a researcher to achieve complete neutrality within a study and still stay present with the subjects and experiences is an impossible task (Zahavi, 2003). Relational Caring Inquiry contends that bracketing in the beginning of the research process aids the researcher to be authentically present with the participant but contends that ongoing inquiry requires the researcher's authentic presence and personal discernment as well. Husserl's techniques for successful bracketing include the use of field notes, research mentors, and continual reflection of personal bias to aid

the researcher to remain neutral (Wojnar & Swanson, 2007). Bracketing is useful in that there is conscious intentionality to allow the essence to emerge rather than entering into the study with preconceived expectations, or unchecked biases. For this study, bracketing increased the likelihood of protecting the experience of each nurse while still allowing for co-creation of the meaning (discussed below in Relational Caring Inquiry).

Reduction. The end goal of descriptive phenomenology is to have a complete picture of the phenomenon so that anyone who has also experienced it can identify themselves within the universal truths discovered (Wojnar & Swanson, 2007). To gain this understanding the researcher peels back the layers of the experience until the essence of it exposes the meaning of it. This allows the researcher to see not just want the experience was, but what the experience meant to the participant. The focus of reduction is away from natural science which seeks to prove existence of a phenomenon and towards the human science of understanding the meaning of that existence for the participants. This requires skills in listening, interaction, and astute observation of the researcher as they guide the subject deeper into the experience so they can bring to the surface what they feel in their consciousness (Zahavi, 2003; Creswell, 2013; Heaton, 2004; Richards & Morse, 2013).

Essence of the lived experience. The analysis of phenomenology aspires to bring light to the essence of the experience by making the invisible visible (Wojnar & Swanson, 2017). This begins with reading the data openly and focusing on intentions and meaning. This is different than coding as it allows the patterns and insight to emerge, and placed in a theme within the meaning, rather than counting say occurrences (Wertz et al, 2011). By combining the textual description (what the participants experienced) with the structural descriptions (how the participants experienced it) the researcher can begin to convey the essence of the experience

(Zahavi, 2003). The essence emerges as the researcher looks for the deeper meaning by seeing beyond the topics and capture the spirit of the experience for these participants (Prasad, 2005). This is also a time to refine specifics and distinguish what overall story the research is telling (Vaismoradi, Turunen & Bondas, 2013). For example, a nurse might discuss an end of life experience by recounting the vital signs, medications given, and remembering how the patient's parents reacted. Further exploration may reveal experiences of feelings of failure, guilt or ruminating over the sound of the mother's cry. This peeling back of the layers lets the researcher see more clearly that the experience is not about the sequence of events but about the lingering meaning for the participant. Further analysis of the essence describes the underlining meaning within the text, recurrent concepts that unify, or a common thread woven throughout (Bradley, Curry, Devers, 2007; Clare & Hamilton, 2003; Saldana, 2013). Hence, searching for the essence will denote the tone of the data, a response pattern or meaning that emerges during the interview or in the analysis phases (Clare & Hamilton, 2003, Prasad, 2005).

By adjusting and adapting to the emerging concepts there is an increase depth of understanding of the lived experience of the participants within the research question (Saldana, 2013; Creswell, 2013; Prasad, 2005; Heaton, 2004). Analyzing multiple interviews, the researcher can move beyond one individual story towards the emergence of universal meaning and a co-creation of universal truths within the phenomenon (Brousseau, Cara & Blais, 2016).

Relational Caring Inquiry

To combine the core values of Husserl's phenomenology with the core values of Caring Science, Chantal Cara (1997) develop a groundbreaking form of research coined Relational Caring Inquiry (RCI). RCI includes the principles and rigor of Husserl's qualitative research to understand the essence of a live experience, and the moral commitment to preserve, protect and

enhance human dignity using the relational ethical-moral foundation of Watson's theory of human caring (Zahavi, 2003: Watson, 2005; Watson, 2008). This research method focuses on a co-creation of universal truths within a phenomenon through connection, and presence between a researcher and the participant. It transforms nursing research into a human relational process and draws on the art of presence and care to be the core of the inquiry process (Brousseau, Sara & Blais, 2016). RCI necessitates caring literacy of the researcher as they use all ways of knowing, including art, creativity, and presence, to elicit the true essence of an experience, and help the participant find meaning within their world (Cara, 1997; Watson, 2008). Relational Caring Inquiry translates a research question into a narrative which offers a deeper interpretation of the experience. These narratives are negotiated between the researcher and the participant as together they co-create universal truth and deeper meaning of the experience. To study compassion fatigue this method creates a platform for truth, meaning and potential healing for the nurses as they speak to their calling as a care giver and healer. RCI incorporates Caring Science into the research process by honoring Caring Science consciousness, a caring ontology, and the ethics of caring.

Caring Science consciousness. Caring Science consciousness, as seen in Relational Caring Inquiry, draws on wisdom within Jean Watson's theory and Science of Caring. The Theory of Human Caring creates the ideal platform to honor the dignity of the research participant and support a caring environment needed to learn the essence of their experience. Watson (2012) recognized that caring is effectively based on humanistic and altruistic values that demand attention, understanding, listening, empathy and mutual recognition of individuals. Using caring consciousness guides what Watsons (2012) called a moral ideal towards authenticity, collaboration, trust, and kindness with each other. Using this focus on caring

consciousness in research is imperative to create an environment for someone to who can then speak freely in a climate of mutual respect that is filled with interrelation responsibilities (Saldana, 2013; Creswell, 2013; Prasad, 2005; Heaton, 2004).

Caring ontology. Cara (1997) emphasized the use of Caring Science within nursing research as a way to combine epistemology (the study of how we rationally know) with ontology (the study of how we experience existence). This caring ontology, guided by Caring Science, focuses on the relationship between the researcher and the participant. Watson described a transpersonal relationship between a nurse and the patient as a series of caring moments that allow both to reach a higher level of consciousness and therefore a higher degree of harmony and healing (Norman, et al, 2016; Falk-Rafael, 2000; Watson, 2005; Watson, 2008). Cara brings this relational care to the research realm by drawing upon authentic, caring connections during the research process. This allows the same transpersonal relationship to emerge between researcher and participant (Cara, 1997). Interviews within a caring ontology, therefore, become an interpersonal relationship, with the potential to discover new significance and possibly deeper meaning for the participant. This approach potentially leads to an interpretation that the participant may or may not have uncovered with personal reflections only. This intentionality calls for compassion, openness, trust, and authentic presence which can lead to a deeper meaning, higher consciousness and in itself may begin a healing process for the participant.

Ethics of Relational Caring Inquiry. What is the ethical relationship between a researcher and the subject? Approaching research using caring consciousness and a caring ontology is linked to Knud Logstrup' s ideal of ethical principles used to inform all human interactions. Caring Science calls on Logstrup' s ethics to inform a nurse-patient relationship, and in the same manner, RCI proposes that the researcher-participant relationship should also

follow these principles. As a reminder, Logstrup calls for a practice to be and become more human and humane with each other as an ethical demand and true pathway to be in service to another (Logstrup, 1997). Watson expands these ideas into the principles of human dignity, trust, creating healing environments and being authentically present to help nurses expand compassion within the care they offer (Watson, 2003; Watson, 2005; Watson, 2008). Both Logstrup and Watson saw the dignity of another as a core obligation. When it is ignored humans run the risk of reducing another person to the moral status of an object, and potentially becoming cruel when it otherwise would not (Norman, Rossillo & Skelton, 2016; Watson, 2003; Watson, 2005; Watson, 2008). Relational Caring Inquiry also advocates for the research participants in this manner. Those telling their stories are not reduced to the status of an object, in this case 'just data', and are instead honored in the process to co-create the meaning of the phenomena alongside the researcher (Cara, 1997).

Stages of Relational Caring Inquiry. Relational Caring Inquiry, as with other qualitative research, appreciates the need for validity of the research findings. Cara's (1997) research methodology incorporates the concepts of transferability, dependability, confirmability and credibility to reach a generable finding that is not based on "statistical confidence or power but rather through meaningfulness of the findings" (p. 77). Findings are transferable by reaching saturation and reporting a thick descriptive text to show redundancy and clarity (Cara, 1997; Saldana, 2013; Creswell, 2013; Prasad, 2005; Heaton, 2004). Field notes, journals, memos, and audit trails show the progression of the study lending to its dependability (Cara, 1997, Creswell, 2013, Heaton, 2004). Cara (1997) used audit trails and journaling to show the how the themes have emerged from the data to demonstrate confirmability of the findings. Multiple interviews,

triangulation across sources, and peer debriefings are all components of credibility within Relational Caring Inquiry.

The goal of RCI mirrors that of qualitative research in that the as the participants of the study, and those within the phenomenon itself, read the findings, they can see themselves and their own experiences within the text. As with Husserl's Phenomenology, the rigor of the process is crucial to honor the participants and their narratives. Cara also adheres to a process including many of Husserl's ideas about phenomenology. Bracketing, choosing the right participants, allowing the data to emerge are drawn from Husserl's phenomenology method. Caring Science is merged throughout RCI with attention to healing environments, being authentically present, caring for the participant with dignity, and honoring their stories by asking them to co-create the meaning with the researcher.

Relational Caring Inquiry includes seven steps including, recognizing the researcher's world view, seeking participants, creating healing environments, discovering the essence of stories, reciprocating the stories, relational caring process and elucidating the essence of the phenomenon.

Acknowledging world view. Acknowledging the researcher's world view is essential the bracketing phase traditionally seen in Husserl's phenomenology. RCI ask the researcher to be aware of their past experiences that could influence how they are present with the participants and their stories. In the book Global Advances in Human Caring Literacy (Lee, Palmieri & Watson, 2017) Cara contended that knowing how to be present with personal beliefs allows the researcher to be more present with the participant. Authentically listening honors, the Caring Science practice of being present to, and supportive of the expression of positive and negative feelings (Watson, 2008). To study compassion fatigue the researcher will need to let go of

personal experiences or even preconceived notions of what nursing is to create a safe space for the lived experience to be shared.

Seeking participation. Gathering the right representation of a phenomenon in study is crucial to build on meaning and discover universal truths (Patten, 1999; Prasad, 2005; Thomas, 2006, Cara, 1997). While convenience sampling is often employed, Cara calls on Benner's idea of reaching saturation through being open to a variation of exemplars and recruiting until there is redundancy (Lee, Palmieri & Watson, 2017; Brousseau, Cara & Blais, 2016). This step first considers who should be interviewed and then honors those chosen by protecting and advocating for them. The ethical responsibility of confidentiality, informed consent, support during and after the interviews hold reverence for both Husserl's and Watson's call for dignity of the participants.

Being present to participants stories. This step draws implicitly on the need to create a safe and healing environment in order for the participant to be able to share parts of their story that may not have been shared before. Caring Science goes back to the teachings of Nightingale that focus on clean, aesthetic, warm, safe environments of care, as core practices of nursing. Watson contends this goes well beyond just the physical space, to include a shared consciousness, compassion, intentionality, energy, connection, and awareness (Watson, 2008). Relational Caring Inquiry brings these ideals into the environment between a researcher and the participant whereas the setting, and the researcher's thoughtful open-ended questions guide the conversation into a narrative or storytelling opportunity (Lee, Palmieri & Watson, 2017). Using storytelling and narratives as a technique in research is understood to help the participant communicate their experience, highlighting not just the events but their understanding of them (Prasad, 2005; Heaton, 2004; Zahavi, 2003).

To ensure a caring ontology perspective these narratives were met with compassion, openness and authentic presence (Brousseau, Cara & Blais, 2016). This presence included the awareness of not just setting an intention but being intentional. In the latter, the researcher lets go of any agenda, and through authentic presence and consciousness, can read the environment and meet the unique needs of the participant in front of them (Norman et al., 2016). Watson predicted in this human to human caring moments the nurse (or researcher) goes beyond creating healing environments and essentially becomes the healing environment (Watson, 2002; Watson 2008). As compassion fatigue stories are not readily shared due to the stigma associated with not being a strong provider, or simply because they can be painful to relive, the creation of this space is paramount to understand the true essence of these events (Meadors & Lamson, 2008; Showalter, 2010).

Essence of stories. Allowing the essence of the narratives to emerge was drawn from Husserl's notion of analyzing and interpreting for meaning. This requires a vivid and detailed attentiveness to the description of the narratives (Richard & Morse, 2013). Following Husserl's concepts of the live world plan (the interaction between researcher and participants) the researcher becomes immersed with participants in the interview, and then again through looking for the essence in the transcripts (Wojnar & Swanson, 2007). To achieve this the RCI researcher takes each interview, reads it multiple times, reflects on the meaning within the stories, and then transforms it into a summarized story (Lee, Palmieri & Watson, 2017). While still bracketing to ensure the experience remains the participants, Cara (1997) uses these transformed stories to describe her interpretation of what the stories are essential saying about the phenomenon. This requires skills in reflection, intuition, interpretation, and analysis to assure the essence of the life experiences can emerge (Cara, 1997).

Reciprocating the participant's stories. Having a relational dialogue with the participants to co-create the meaning within the experiences, is a hallmark stage in RCI. This process includes a second meeting to have an open, caring conversation to explain the initial interpretations and begin to co-create the meaning within the summarized stories (Cara, 1997). Before the second meeting, the participants are sent the emerging story and analysis in order to have space to reflect on the researcher's ongoing interpretation (Cara, 1997; Lee, Palmieri & Watson, 2017; Brousseau, Cara & Blais, 2016). This step validates the summarized story and its evolving analysis.

The second in-person meeting occurs to integrate mutuality in the progression to discovery. RCI draws on knowledge that relational dialogue between the researcher and the participant allows for deeper understanding as it brings clarity, using dialogue to confront beliefs and affirmations of knowledge and meaning (Cara, 1997). There is ongoing conversation and cooperation to co-create the meanings related to the phenomenon for each participant. A revisiting of the content might also give the participant insight into their vision on how to resolve the problems in regard to their experiences (Brousseau, Cara & Blais, 2016). The relations caring process is highlighted in this step by sharing the analysis, allowing the participant to co-create meaning, and contribute to the knowledge of the phenomenon. It also incorporates caring ontology through the Caring Science practice of mutual authentic presence, engaging in genuine learning experience, allowing for opening, and attending to the unknown (Watson, 2008).

Elucidating the essence of the phenomenon. To arrive at an understanding of the phenomenon under study, the final stage of RCI "moves beyond each individual story, towards the emergence of the universal meaning (or essential structures) of the phenomenon" (Brousseau, Cara & Blais, 2016, p. 44). Following Husserl's eidetic reduction, RCI looks to grasp the

universal essence from reviewing the particular components of each story, honoring the individual narrative, while placing them within a similar group of understanding and allowing the universal themes to emerge. Just as the researcher and participant co-created the individual essence, examining the assembly of findings in this way allows the collective discoveries to co-create the universal truths of the phenomenon.

Relational Caring Inquiry, that honors both Husserl's phenomenology and Caring Science offered the ideal methodology to study the complexities of compassion fatigue within pediatric nursing. The tenants of Husserl's phenomenology focus on the vivid description to understand the essence and meaning of the phenomenon. Caring Science offers the relational ontology to create the relationship and space for these experiences to emerge. Using the outlined stages within RCI provided the road map to truly understand what it is like to experience compassion fatigue as a pediatric nurse.

Conclusion

The effects of Compassion Fatigue reach nurses, patients, and healthcare organizations. Pediatric nurses have an increased risk of developing Compassion Fatigue. Compassion Fatigue is measured by rating the nurse's ability to cope with suffering, chronic workplace stress, and the nurse's capacity to stay connected to the positive aspects of caring for others (Johnson, 2013). Interventions in the past have failed to address the core issues of Compassion Fatigue in pediatric settings (Cricco-Lizza, 2014; Gardling et al., 2015; Huang et al., 2014; McConnell & Porter, 2017; Morrison & Morris, 2017; Shimoinaba et al., 2015; Stayer & Lockhart, 2016). Jean Watson understands the complicated nature of suffering, and with theory guided practices, addresses the need to support both the nurse, and the patient in the experience (Watson, 2005; Watson, 2008). To combat Compassion Fatigue more research is needed within these

subcategories including understanding if Compassion Fatigue is a natural progression of being compassionate and considering if theory guided practices found within Caring Science can decrease the risk of Compassion Fatigue. Research can also help understand if caring is an innate skill or needs to be taught. It can help to appreciate if the openness and vulnerability shown by a nurse in a healing environment should be considered a weakness or a strength. There is more to understand about the flow of compassion that when nurtured by individual practices and organizational structures helps attenuate the inherent suffering and stress that so often accompanies nurses throughout their careers. Research can also investigate if Caring Science practices are needed to begin to heal healthcare and the nurses within and set the stage for nurses to experience compassion without fatigue. The aim of this study was to advance the knowledge and understanding of compassion fatigue and compassion satisfaction by documenting the lived experiences of pediatric nurses on inpatient medical units. Then it examined these findings through the lens of Caring Science and offered connections among essential truths between these narratives and the foundational truths and practices found within the framework of Watson's theory guided practices.

CHAPTER III

METHODS

The purpose of this chapter is to describe the methodological procedures that were used to answer the following research question

What is the nurses' experience with compassion fatigue working in a pediatric inpatient setting?

What are the contributors and barriers to maintaining compassion satisfaction as a pediatric nurse on an inpatient unit?

Study Design

This phenomenological qualitative study incorporated the principles of phenomenology combined with the ethics and dignity upheld in Jean Watson's Caring Science and honored within the Relational Caring Inquiry method. Following the stages of Relational Caring Inquiry this study included, seeking participants, recognizing the researcher's world view, creating healing environments, discovering the essence of stories, reciprocating the stories, relational caring process and elucidating the essence of the phenomenon. Weaved throughout this study were also elements to increase the rigor and trustworthiness of the findings including what Letts et al. (2007) describe as credibility, transferability dependability, and confirmability.

Seeking Participants

Participants for this study were nurses working on an inpatient unit at a pediatric hospital that manage patients with both acute and chronic diagnosis. These nurses experience patients and families who were inpatient for a one to three-day admission and others that require hospitalization for years. This gave the nurses unique insight into how they maintain or lose their compassion satisfaction working with different types of patient populations within the same unit.

This population of nurses can also speak to the effects of being a sustained responder, one described by Bush (2009) as a nurse who manages episodic care over longer periods of time. All genders, ages and educational levels were included in this study to represent the normal demographics of an inpatient pediatric setting. The whole span of experiences levels were included as studies show that compassion fatigue is documented early on in nurses' careers starting in nursing school and resulting in up to 40% of new nurses leaving the profession within the first year (Michalec, DiefeZoeeck & Mahoney, 2013; Fink, Krugman, Casey & Goode, 2008). Exclusion criteria included nurses who may float to an inpatient unit but also work in critical care or emergency departments. These nurses have a multitude of experiences with different patient complexities outside the scope of this study. Seeking the right participants also includes the plan to recruit, protect and gain consent.

Recruitment. Once this study received institutional review board approval, this researcher reached out to the pediatric inpatient units located in freestanding pediatric hospitals of Children's Hospital Colorado and Lucile Packard's Children's Hospital Stanford. These included departments managing patients with general medical diagnosis, surgical patients, High risk pregnancies and diagnosis' requiring rehabilitation in an inpatient setting. The plan was to enroll three to twenty nurses from these inpatient units. This sample size offered a range to continuing recruiting until the immerging themes within the narratives become redundant and information saturation is met (Creswell, 2018; Lee, Palmieri & Watson, 2017; Brousseau, Cara & Blais, 2016). Using phenomenological principles, saturation will not be determined by the number of participants but rather data that offers thick narratives that show clarity and repetitive themes (Cara, 1997; Saldana, 2013; Creswell, 2018 Prasad, 2005; Heaton, 2004).

To recruit nurses the director of the inpatient unit were contacted by email with a request to include their team, asked permission to recruit staff, and asked to grant approval for staff to participate in the study. Emails were sent from the participating managers to nurses within the inpatient unit as an invitation to participate. (Appendix E) Some nurses were recruited directly based on referrals form the unit mangers. The email invitation discloses participation was voluntary and enrollment procedures included screening questionnaire to determine eligibility as an inpatient pediatric nurse whose primary unit includes patients with both acute and chronic diagnosis. The email also included an invitation to set up a face-to-face meeting to explain study parameters and answer any questions. Once participant met the inclusion criteria, communication was sent to describe the study design including time commitment and explanation of the stages involved within the Relational Caring Inquiry method.

Human Subject Protection. This was a phenomenological qualitative study used inpatient pediatric nurse's interviews. As such the medical risk was minimal to participating subjects. There was no legal risk to participating and the potential social or psychological risks were minimal. There was a risk of distress from telling or recalling their experiences as a nurse on the inpatient unit. However, some participants stated they found benefit from telling these stories. The nurse may have experienced a social risk if they felt the experiences of compassion fatigue told may be traced back to them and either peers, supervisors or organization will use the information against them. To mitigate these risks, all efforts were made to protect the confidentiality of the subjects. All participants were told they could withdraw at any point if they were distressed or feared retribution for participating. Participants had the opportunity to review the analysis in a second interaction, through a second interview or email exchange to ensure confidence in anonymity and offer advanced reflection. During the interview the researcher

offered support, resources as needed, offered to stop the interview if necessary, and offered to reschedule if needed. There were times the participants reflected on difficult experiences and expressed emotions, but no one asked to stop the process and reschedule.

Consent. Informed consent took place face-to-face in a secure location at a time convenient for study participant (which included at hospital or on a secured online platform Zoom). Informed consent was explained verbally by the researcher. Eligible participants were informed of research procedures, research purpose, possible risk and benefits. It was also explained that participation was voluntary and non-participation will not affect employee. The participants' identities were de-identified to ensure they remained anonymous during and after the study and their answers remained confidential and not shared with employer. (Appendix F)

Data Collection. Transcripts were digitally recorded using a handheld recorder and stored on a laptop that is connected to a secured server with password protection. The analysis was shared with the participants during the process until final approval is reach between this researcher and the participants.

The interviews were conducted using a semi-structured interview guide previously tested by this researcher in a pilot study. Each interview included the same initial question with the intention to allow further questions to emerge from the flow of the conversation. A sub list of questions was also available to the participant to ensure the depth of the interview is stimulated. Each session ended with an opened-ended invitation to ask questions, add any information erroneously neglected or if there was a question the participant hoped was asked.

Semi-Structured interviews, also called open-ended, were used to get portrayals of a lived experience to interpret the meaning of a phenomenon (Brinkmann & Kvale, 2015; Rubin & Rubin, 2012). In this method, the interviewer had enough knowledge about the topic to develop

guiding questions but still cannot predict the answers and is open to discover new ideas (Richards & Morse, 2013). A detailed interview was used to learn more about the subjective knowledge of an experience (McIntosh & Morse, 2015). The study questions were used to narrow the topics but still allowed for open-ended answers to ensure discovery of new concepts within the themes. Probes were adapted for each participant to create space for deeper reflection and understanding to immerge.

During the interview this researcher asked permission to take notes in order to record critical insights and allowed what was emerging to stimulate additional questions. These notes were handwritten and stored as part of the interview. After each interview, this researcher documented field notes in the form of a reflective summary to note the tone and initial analysis of what was said. Field notes also included any bracketing of this researcher's experiences to ensure a purer representation of the participants' expressions including significant moments and personal bias or interconnections that may interfere with an unbiased emergence of participants experiences. This post-interview reflection and bracketing ensures a reduction approach to the data and increases the credibility, dependability and confirmability of the study (Letts et al, 2007; Laverty, 2003; Biber & Leavy, 2011).

Researchers World View

Hesse-Biber and Leavey (2011) defined reflexivity as the "process through which researchers recognize and understands how their own social background and assumptions can intervene in the research process" (p.120). Saldana (2013) noted that perceiving, documenting and coding are all influenced by the level of the researcher's personal involvement. In this study, the researcher studied nurses who work with pediatric patients over extended admission, a topic this researcher understands intimately as veteran pediatric inpatient nurse. Understanding

phenomenology, the researcher cannot distance herself from the data the way a quantitative researcher could with a survey (Heaton, 2004). It was, therefore, crucial for the researcher to be aware of personal bias and triggers to respond consistently to each interviewee regardless of similarities or differences the researcher saw between her practice and theirs.

Creating Healing Environment

Using the components of Relational Caring Inquiry by Dr. Chantal Cara, the nurses participated in an interview process and were invited to share their stories and experiences in an open and compassionate environment. The participant was asked to choose the best place for the interview to take place where they feel both physically and psychologically safe and comfortable to speak openly and candidly about their experiences as a nurse. A quiet space was also chosen to ensure the recording device can capture what is said.

Relational Caring Inquiry seeks to create a trusting relationship between researcher and participant where there is mutual respect and caring intention. Incorporating principles of Caring Science, we know the healing environment goes beyond the physical space and includes emotional security. To evoke meaningful data, and know what the participant knows, the researcher had to get as close to the participants as possible. Eide and Kahn (2008) affirm "Qualitative research requires a mutual standpoint, researcher to participants, human being to human being" (p. 199). In this way, the researcher positioned themselves within the study often sharing their values and biases up front. In qualitative studies, the researcher "becomes the research instrument with all the results being filtered through her perceptions and understanding of the social situation for which she is working" (Heaton, 2004, p. 60). To create the healing environment the first step is to set an intention of being open and present. This researcher paused and centered prior to meeting with participants to create a caring intentional environment and

invite all ways of knowing to understand the essence of what was shared. This researcher also share intentions to both protect the participant and advocate for their unique contribution to be honored and heard. This stage also includes recognizing and sharing the researcher's world view. For this study, it will be necessary to render salient the context as a researcher in analyzing the data from the study. This researcher explained her personal history of seventeen years as a pediatric nurse with experiences working on an inpatient medical unit with patients and families. This researcher also disclosed personal experiences with compassion fatigue and the process of coming back to purpose and increasing compassion satisfaction. This enhanced the researcher's ethical connection to the individual and increases the credibility of the findings through a mutual shared experience (Letts et al., 2007).

To create this environment and uphold their individual dignity, this researcher opened each interview with an invitation to share their strengths, values and current self-care practices in an aesthetic format. This evolved from a series of questions that allow for self-reflection and then expression in the form of a drawing. This practice allowed each participant to ease into a space of reflection and be more in tune with their experiences from both an intellectual and emotional lens. To allow them to be present with their past and feel safe to share all aspects of the experience. This drawing was used to set the tone of the interview and was not interpreted with the analysis. However, after each interview this researcher created an aesthetic representation of the participant's strengths, what they stand for and how they flourish by creating a unique drawing of a tree for each participant. The roots of the tree represent their strengths. The trunk of the tree offers what they stand for and the top of the tree illustrates what each participant shared they needed to flourish as a nurse. These drawings will be added to the analysis portion to offer a new way of viewing the meaning within each participants narrative.

Discovering the Essence of the Story

The initial interview was recorded and transcribed verbatim for analysis. After each interview this researcher begin to analyze and extrapolate the essence of the participant's experience. A phenomenological approach to research requires a rigorous review of the data to look for emerging themes and using meticulous methods of reduction to seek the meaning behind each experience. This began by setting an intention to read the data openly and focusing on intentions and meaning behind what was shared. To be immersed in the data this researcher reviewed transcripts, relistened to the audio recording and revisited the field notes several times until the essence of the story was succinctly told. Spending time with the data will allowed this researcher to peel back all the potential layers of meaning to as mentioned, make the invisible visible (Wojnar & Swanson, 2017). This was then summarized in a one to two-page interpretive description that painted an immerging picture of this participants contribution to the meaning behind the phenomenon of compassion fatigue. It highlighted the importance of the personal experience by honoring the emotional aesthetics that surfaced during the conversation. The story within the stories. This initial analysis and offering are meant to both honor the individual's unique perspective of compassion fatigue and shine a light on their own humanity within the lived experiences of pediatric nursing. This document was sent to the participant, so they can review and reflect on its truths prior to another offering feedback in another interview or email exchange.

Reciprocating the Stories/Relational Caring Process.

A hallmark stage of the Relational Caring Inquiry is the co-creation of the meaning within the experiences through a series of relational interchanges. The first step of this co-creation occurs when the essence is shared with the participant. As mentioned, this was sent to

the participant in advance of the second connection to allow time for reflection and to see if their truths were portrayed or if anything was overlooked or neglected. This is a crucial step to increase the trustworthiness and transferability of the study, by ensuring the meanings are co-created by the participant and the researcher (Letts et al., 2007). After the participant had time to reflect on the descriptive summary, a second dialogue was arranged with the participant. Due to the restrictive nature of the COVID 19 pandemic, the second dialogues were email exchanges with the participants to clarify the essence of the story and offer space to edit, adjust or add to their story. The shared intention of these emails was to allow the nurse to share perceptions of the analysis and invite advanced reflection and co-creation of the findings. This relational caring process allowed the nurse to contribute to the knowledge development and honors both their dignity and protection within the process (Lee, Palmieri & Watson, 2017).

Elucidating the Essence of the Phenomenon

Once the second interaction was completed and the nurse was given the opportunity to adjust, clarify and co-create the true essence of their experience, this researcher began the analysis to extrapolate the meaning and patterns seen within all of the stories. The collective aim of qualitative research is to understand the significance of a phenomenon from the perspective of those going through it (Creswell, 2013; Heaton, 2004; Thomas, 2006; Vaismoradi, Turunen, Bondas, 2013). This researcher used inductive analysis with the collective data to look for the emerging essential truths, meanings and patterns. It continued to focus on the rigor of the process to ensure discovery of universal truths so that anyone working in pediatric nursing can see themselves within.

Inductive Analysis. Qualitative analysis is different from content analysis in that it does not simply identify or list the elements discussed but seeks to understand the meaning behind the

responses (Sargeant, 2012). Understanding the ontological view that there are multiple realities within each moment, this researcher analyzed all of the data from all of the participants and allowed the experiences and relationships, to emerge naturally from the data in an inductive process (Srivastava & Hopwood, 2009). The collective essence emerged as the researcher looked for the deeper meaning by noticing recurring concepts and patterns within the tone or spirit of the experiences (Clare & Hamilton, 2003; Prasad, 2005). Analyzing the multiple interviews, in this manner, this researcher moved beyond one individual story towards the emergence of a universal meaning and a co-creation of essential truths within the phenomenon (Brousseau, Cara & Blais, 2016). This was also used as a time to refine specifics and interpret what the overall story the research is telling (Vaismoradi, Turunen & Bondas, 2013). This last step of Relational Caring Inquiry was a crucial step in interpreting this combined meaning of all the participants and potentially leading to the discovery of universal meaning of compassion satisfaction among pediatric inpatient nurses (Lee, Palmieri & Watson, 2017).

Rigor. The rigor of qualitative research lies within the authenticity of the data and the trustworthiness of the analysis (Sargeant, 2012). Patton (1999) states the credibility of qualitative inquiry is ensured through high-quality gathering methods, credibility of the researcher and a strong qualitative philosophical foundation. As noted, field notes, journals, memos, and audit trails were used to show the progression of the study lending to its dependability (Cara, 1997, Creswell, 2013, Heaton, 2004). This study included trails and journaling to show how the meanings emerged from the data to demonstrate confirmability of the findings. Multiple interactions, triangulation across sources, and peer debriefings were all components of credibility that this study incorporated throughout the process.

Summary

The personal and professional cost of compassion fatigue are a daunting prospect for nurses who feel called to care for their patients. This chapter highlighted the study design and method using Relational Caring Inquiry in a qualitative study to understand the meaning behind compassion fatigue and compassion satisfaction. Relational Caring Inquiry created the process and space to focus on both the dignity and protection of the research participant as they told their unique narrative on the topic. It also opened the door for deeper understanding and potential healing as the essence of the experiences were reviewed and new meaning was co-created. The participants remarked that reading their summative essence from the interview allowed them to see themselves in a new light. For many it was a reminder of their purpose and for others it became a beacon of hope and inspiration during a time of intensity surrounding the nations response to COVID 19. Gathering enough narratives to reach saturation offered a universal essence and meaning to walk towards the universal truths found within this phenomenon of compassion satisfaction and compassion fatigue. To combat compassion fatigue, and release its hold on healthcare providers, research like the one described here are urgently needed. This research question and methodology not only add to our understanding of the universal truths within compassion fatigue but also positively contribute to the development of interventions to help care for the nurses as the care givers and healers they are.

CHAPTER IV

ANALYSIS AND FINDINGS

Introducing the Participants

The ten nurses in this study work in two different organizations, in two different states within the borders of the Unites States. Both organizations are free standing pediatric facilities and these nurses all worked on inpatient, non-critical care, units. The participants' experience level ranged from three years up to twenty-eight years with a mean of eleven years and a median of nine years. Two of the participants identified as he, him and eight identified as she, her.

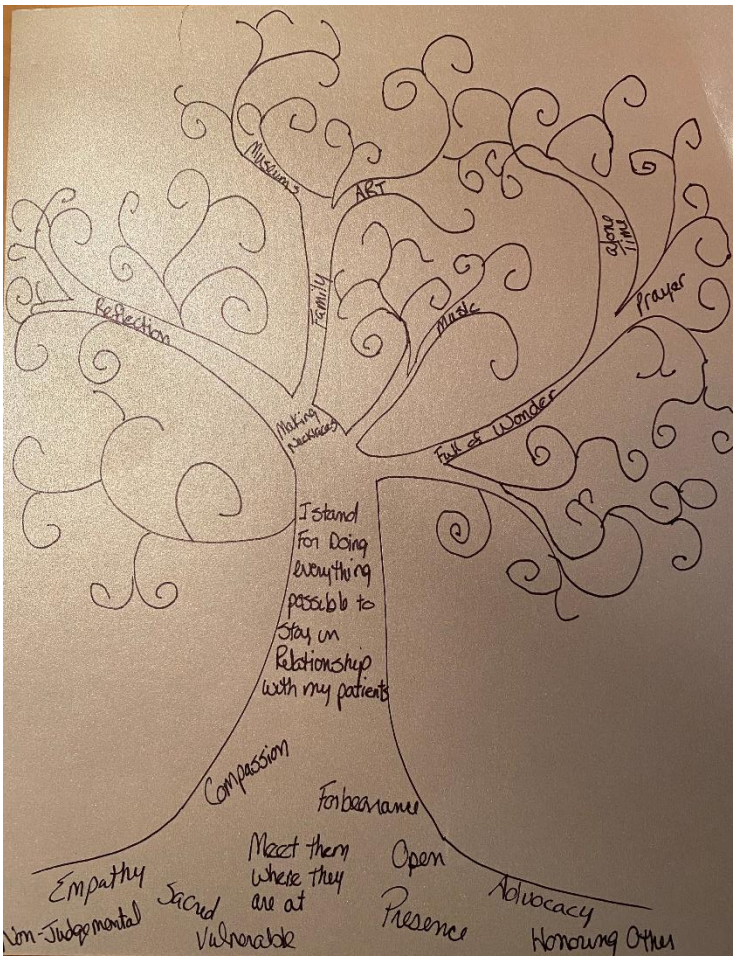
There is an honor in witnessing another's story. It is even more of a distinguished honor to listen to colleagues in the nursing profession be willing to share their experiences of both hope and pain. To be in a space with someone and see a physiological response as they relive their experiences and look to find meaning with in them so they can process for themselves but also help other nurses. To not shy away from the depths of what it is like to be a pediatric nurse and freely recount all the fears, anxiety, guilt, and the worthlessness they felt at times. To always come back to the pride they feel for choosing this profession and understanding of their purpose and calling as a nurse. I was both in awe of each of these participants and in the same moment witnessed my reflection within them. The following are the essence of their interviews that were shared with them to ensure I captured not just the truth of their words but the emerging meaning within the stories.

Also included are this researcher's aesthetic representation of each participant in the form of the tree drawing. My ode to these nurses who opened up and shared with me. It was also my way to use another way of knowing to express my understanding of how each participant showed up in the interview. It uses the same process I asked them to consider by showing their strengths

in the roots of the tree, what they stand for on the trunk of the tree and how they flourish within the branches and leaves of the tree. Some are whimsical because they express the artistry of being a nurse. In one I attempted to capture the tree as a dancer to represent the heart of this nurse. Others are strong and sturdy in their understandings. Others flow more easily or bring heart to the experiences. One depicts two trees because of that nurses' deep ties to protecting the young patients she cares for. Each of these trees are as unique as the participants and attempt to capture another layer of who they are within their shared experiences.

Essence of Participants

Esther's Story



Esther has been evolving her nursing practice for well over twenty years now. In her career she has taken care of countless patients and families going through intense healthcare crisis that don't always have a happy ending. She continues to develop her practices to take in account the whole person she is treating and remember to connect with the human behind the diagnosis. Some may think that working with patients is what drains nurses. Esther would argue that coming through an adverse situation with another human being actually adds to her capacity to be compassionate. Some of her most heart wrenching moments become the sacred reasons she is a nurse. On one occasion, Esther recounts being the nurse called on to help a mother say goodbye to her baby. She remembers feeling the necessity and desire to be "very, very present" in order to honor how difficult this moment was. At one point she could feel the gravity of the grief the mother was holding onto and she leaned in close to her ear and unassumingly said "this isn't your fault". She just knew this is exactly what this mother needed to hear because Esther was present to her own vulnerability in the moment and knew that is what she would be feeling. Looking back on challenging moments like this one and innumerable others, don't fill Esther with dread, rather they are powerful reminder of the gratitude and honor she feels to be the one called on to be present.

This doesn't mean that being a nurse is easy. If you take a balcony look on Esther's career you will see times of despair. Times where she could not help but judge the situation or people in it. Times where the baggage of working in all the hierarchies and complexities of healthcare weighed her down. Times when she joined in the suffering of her patients as she tried to figure out why they had to go through what they did. Times when being kind was used as a weapon against her and incivility ruled the day. Burn out for Esther feels a lot like the image of

constantly having to swim upstream when advocating for what she knows in her heart is the right thing for her patients.

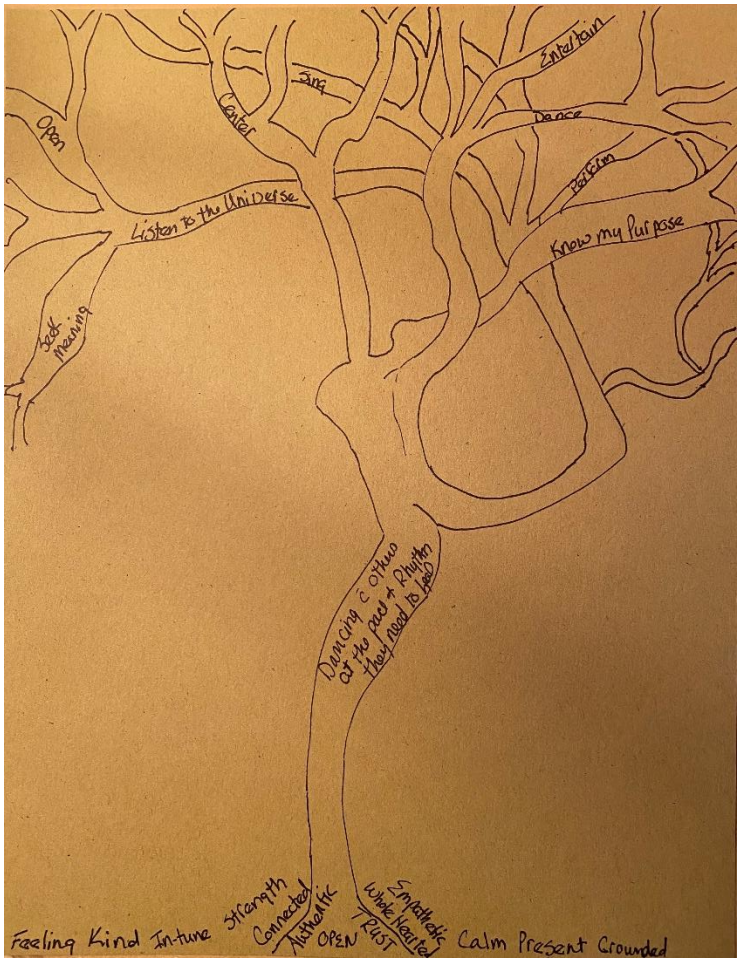
If Esther could sit down with all of nursing, she would first ask them to take a deep breath. She would want them to look at what they do with a sense of wonder and privilege that only comes when we remember how special this job is. Nurses get to choose if they walk into a room with sense of 'aren't I lucky' to meet a new human who is unique and full of surprises or walk in with a sense of dread and worry. Esther would remind every nurse that it is within the relationship you create that colors the experience. In fact, she would say you have to do everything you can not to fall out of relationship with your patients. To do this she has had to develop her own practice of knowing her purpose and letting go of what doesn't serve her. Trying not to get all tied up in knots if she can't meet all of the patient's needs. Leaning into the vulnerable moments rather than hiding from them. Remember that the more you care the more you need to care about yourself too.

If Esther was running the show, she would make sure that every patient has the opportunity to receive all the care they need. Treating mind, body and soul would be a standard and not just if you are lucky enough to be somewhere that offers art therapy or massage. 'It's the right thing to do' would be her motto and it would inform all the care decisions that happened. You can guess this would also include some common sense and respect for all involved. It would also mean that regardless of how high your role is in the organization you are still asked to think about the human in each situation before blanketly saying no to the bedside staff.

Esther is still in awe of being a nurse. She has always known how important and unique her gifts are. She has always understood that getting to know her patients and treating them like family helps them feel safe and cared for. The meaningful moments of care she offers her

patients have had a profound impact on their ability to heal and grow. She is still learning how to expand her self-care practices so that she has all she needs to be present and gracious towards herself and others. Esther's evolution and dedication to self-awareness and development is a shining light for other nurses to remember that within all the imperfections of nursing there still lives the opportunity to be the one person who presence and care changes another life forever.

Misty's Story



Growing up Misty was always the one who was a source of strength for her families and others. So much so that her mom told her she was always the one who played the "malambing" role which is Philippines for someone who is always happy and sweet to others and considered 'saint like'. It appears this characteristic stayed with her as a nurse because she has many

experiences where she was the sole source for her patients and families. A source of strength. A source of compassion. The nurse that would be there for you when you needed someone to cry with or listened to. Misty would have it no other way. She knows that when she is with a patient her most important role is to be fully present and create a safe space for a deeper connection if the patient needs it. She says it's like having a dance. You show up and allow the patient to take the lead but are always willing to take the next step if they want to open up and share more. This gentle and kind way of being present really allows her patients to trust her which leads to the flow of compassion and care.

Just because Misty was born with the gift of compassion, it does not mean it is always easy. Misty recalls many times in her career where she has become overwhelmed with being another person's source of strength. One time she was caring for a patient who needed a bone biopsy and while she was watching the needle being jammed into the bone and holding onto her patients' hand, all she wanted to do was cry with the patient. Not just because it was a painful procedure, but what it meant for this patient who most likely was going to get bad news from the results. She carried the worry with her, even though she was not working for a few days, it was always on her mind. When she did learn about the cancer they discovered, Misty found herself in a bathroom crying. Crying for how hard this would be for the patient and her family. Crying because it was so unfair and as a nurse you know too much about what happens next. Interestingly Misty, found herself feeling guilty for crying. Nurses are meant to keep it together and not break down ever, especially at work. Misty has grabbled with this notion of wanting nurses to be compassionate and expecting them not to have or show emotions. The two notions are not compatible in her world of connecting meaningfully with her patients.

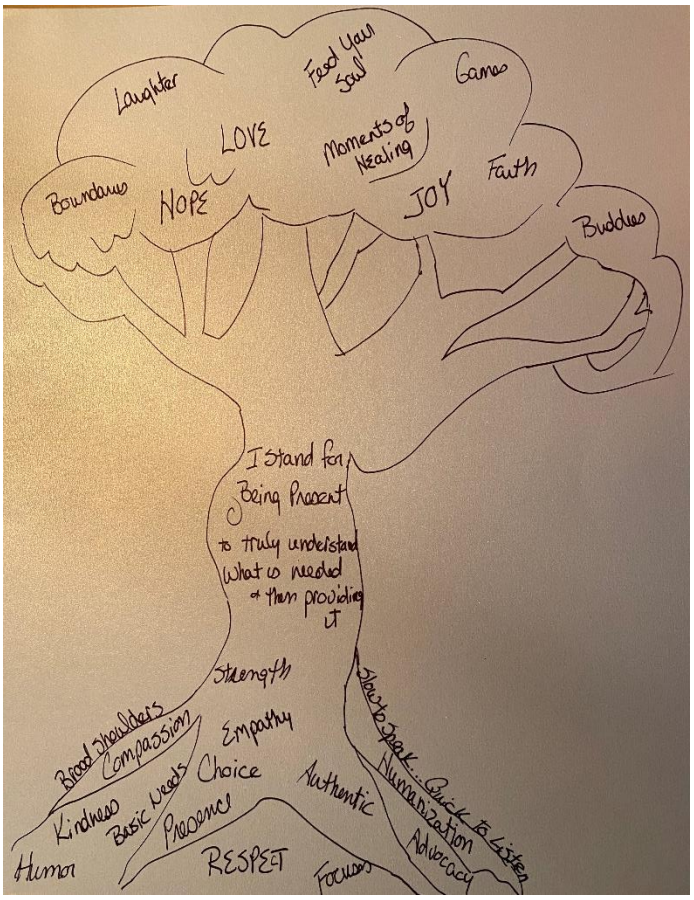
Mostly what gets in the way of connecting with her patients and families is time. Charting and paperwork can distract from patient care or helping peers. Also, not having enough staff almost ensures the connections will be just surface level for that shift. This comes with a cost for both Misty and her patients. You see, it if not possible for Misty to be cold to her patients. It doesn't sit right with her soul and as soon as she recognizes what is happening, she shifts. She finds a new rhythm, apologizes and makes it right as soon as she can. Even though she mends it in the moment, these are the times that she ruminates and worries about. Connections are essential for Misty because she las learned in many poignant ways that it is the little acts of kindness that make all the difference for her patients. Sitting with them while they grieve. Bringing a token to their bedside so they know you are thinking about them. Compassion for Misty is the ability to sit within another person's suffering and become that source of strength.

If she could, Misty would teach nurses how to become dancers themselves. To be present and tune into their unique rhythm. To pay close attention to the patient when they start to talk about what they are worried about. They are sharing their needs and as a dancer, you need to listen to the song in order to help them. There maybe more information to gain, but unless you slow down and take the time, you may miss a critical element of the care they need.

Misty has been offered many signs that she is in the right profession. Her narrative is full of times when seemingly impossible obstacles cleared away so she could become or stay a nurse. It is like the universe knows that she is meant to be a nurse and has continually composed the right music for her to dance to along the way. The beauty of her story is that it is an authentic human experience. It is full of struggle and miracles that clearly light her nursing path and inspire those around her. It is not surprising that in the midst of her own experiences of health

issues, those around her were not stunned to learn that it what she needed to do was get back to nursing. They reminded her that she was born to be a healer and her patients, families, nursing colleagues and the universe all agree.

Arthur's Story



If you call up to the rehab unit at Children's Colorado and ask for Arthur, you made get told we don't have an Arthur here today. If you call up and ask for Art, they will know exactly who you are looking for and probably tell you that he is in with one of his patients so hold on. Art has worked on the rehab unit for over five years and in that time has developed the down to earth reputation of an easy going, easy to talk to ally who is always there to listen and help out. This is just what he does with his peers and doesn't even begin to describe how he shows up with his patients. You see, Art believes that the most important aspect of his job as a nurse is to be

present with his patients. To be with them during crisis and show up with empathy, respect, and the authentic presence so you know that in this moment he is not just doing a job he is doing what he is meant to do on this earth. He does this from the first moment and carries it through the sometimes months of care by building relationships, helping to shoulder the burden the families face and helping the families manage the changing expectations and hopes they have for their child. Art describes his job as being like an air traffic controller because it is serious, and often intense with a lot of things that happen all at the same time. What he brings to being a nurse is presence, respect, empathy and an authentic desire to partner with each patient and family and learn what their unique needs are so he can meet them one by one. This requires a lot of himself at times, especially on his unit where the patient can stay for months at a time. Then there are the patients who he gets to know so well only to lose them when their diagnosis limits their life span. Art recalls a time when he got a call from a family that their child, who Art had taken care of during his inpatient time battling a brain tumor had died. When he answered the phone, the first thing he said to the father was “please don’t tell me this”. When he looks back, he isn’t sure why he said that and feels guilt over not being strong for the family in that moment. While these are the hardest part of his role these connections, knowing the families this well, taking care of kids for months, are all the reason Art loves his job. He believes it is his purpose to be that stalwart companion from beginning of the diagnosis to whatever outcome develops.

Knowing your purpose doesn’t mean that being a nurse is always easy. There have been times when Art has become overwhelmed by the amount of himself that he has given the job without remember to care for himself. This is especially true when both work and home become places where you have to give of yourself. During these times Art noticed that he is not as patient, find he talks more and listens less and can recall times when being asked to care felt like

a burden rather than a privilege. During one particular busy and tiresome part of his career he was reminded that he was neglecting to do the things that gave him energy and made him happy. This was an important lesson for him. One that he now talks to other nurses about. Art recognizes that the gut reaction of "I want to be a good nurse" will only take you so far if you don't take care of yourself. You have to meet your own basic needs first for compassion to flow out of you for another. Art tells his peers to go figure out what feeds your soul and makes you happy so when you come to the crossroads of 'can I really keep doing this' you can decide to continue as a nurse.

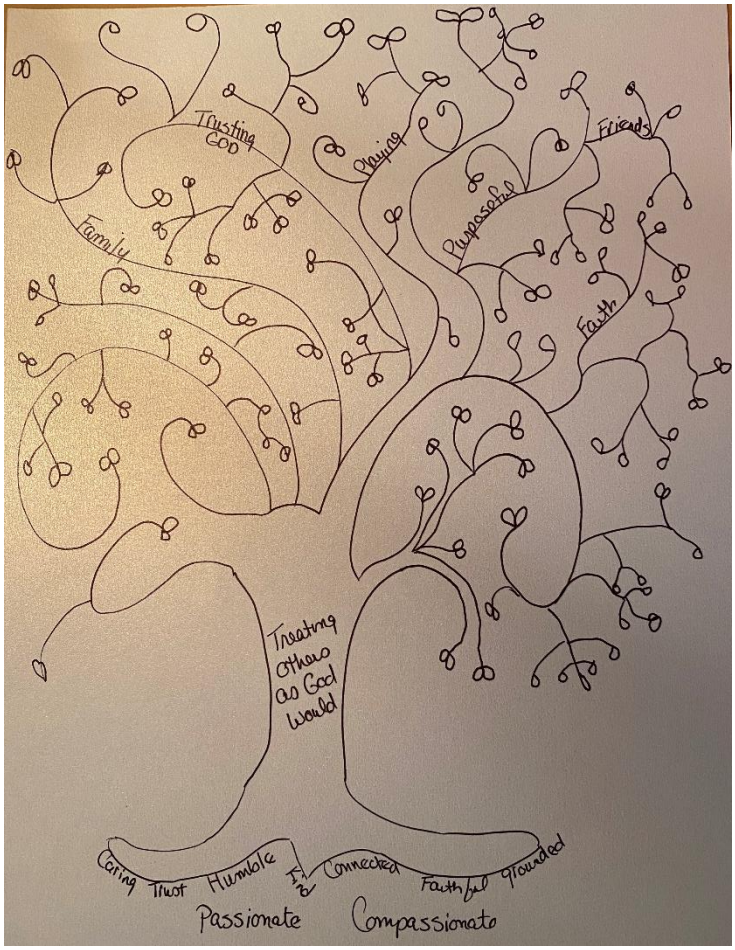
Art wants nurses to remember that it is the small subtle things that you need to focus in on to become the best nurse for the patient. That means consciously not letting your mind drift to what is next. It means sitting down with the family and putting them at ease, so they know they you are a safe person to talk with. It means demonstrating that you truly care about what is concerning them and are going to really partner with them. It means the difference between being their nurse for a time slot or becoming their one of their favorite nurses.

If Art was running the show, he would make sure that nurses where trained in how to be present. It is not an innate skill but a learned practice. He would remind them to take every opportunity to educate the families because the only way for them to be safe at home is to practice being safe when at the hospital. He would make sure that nurses have people they can talk through the tough moments with so that they can learn from mistakes and grow rather than let self-criticism keep them from being better and learning.

Above all, Art honors the profession of nursing by demonstrating the unique ability nurse have to walk alongside the patient and family for often long periods of time. He understands that while everyone has the ability to be compassionate, nurses make a choice to be compassionate to

complete strangers in their most desperate moments. This doesn't just happen. It takes courage, vulnerability, knowing who you are and always remembering the trust that the family is giving you when they let you care for their child. Art has become that favorite nurse for so many of the patient and families he takes care of. It is not unusual to hear a high screech voice yelling "ART" as they run to greet the nurse who became the best part of being stuck in a hospital. Yes, Art is a competent, focused air traffic controller, but he does it with such heart and joy that each person he meets feels like they are the most important person he is helping, and that makes all the difference.

Brooklyn's Story



For Brooke nursing comes down to being able to be what you are meant to be in an environment that radiates hope over sadness. Brooke is the kind of nurse who walks into a room and immediately thinks about what is needed to have a holistic approach to healing. You see it's not just about the right diagnosis or treatment that creates health, it is letting the child thrive within their situation. So, Brooke focuses on what others might deem the small stuff. Play, joy, laughter become the building blocks to development. Tummy time and being on that play mat are as important as getting the right medication at the right time. Offering a bath to a child who hasn't be able to take one for a long time let Brooke both assesses her entire patient in one act and let the child remember they like to splash and giggle in the water.

As a pediatric nurse, she also holds dear the times she can help an entire family with a difficult diagnosis. She has a gift to see beyond the fear of a dad who doesn't want to give his trached son a bath because he thinks he will drown and help him build confidence to manage anything he might face. She gently and skillfully takes them from fear back into joy, from doubt to confidence and from despair to hope. It is in the relationships between nurse and patient and nurse and family that the care happens and Brooke feels at her best when she has the time to develop and nurture these connections. In fact, she notes one of her greatest accomplishments is when a family trusts her enough to feel like their child is safe with her and feel comfortable to leave them in her "good hands".

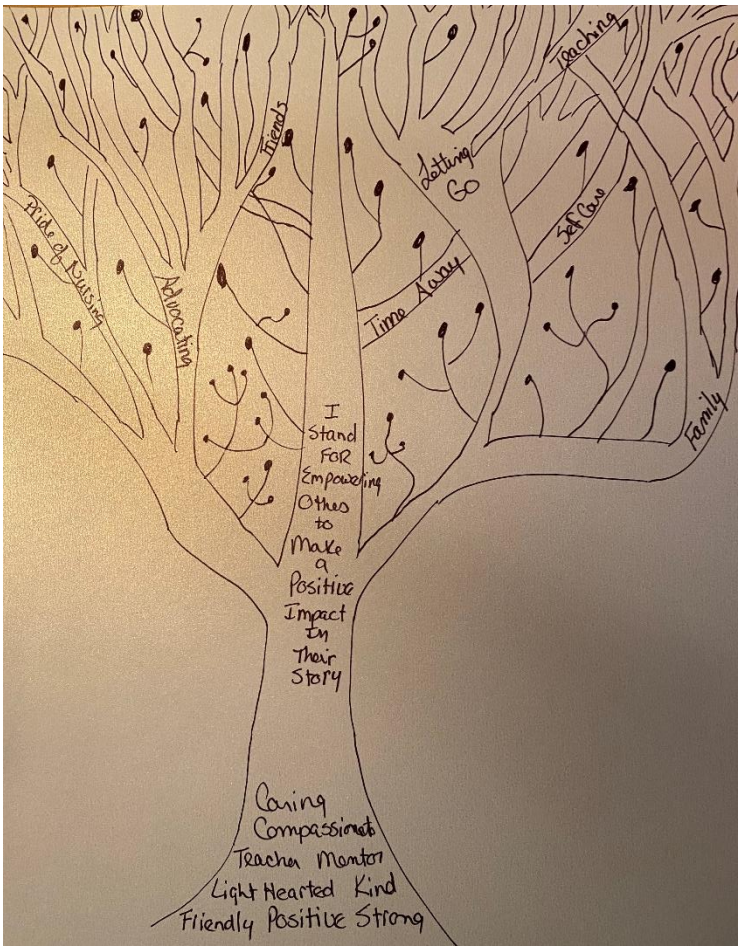
If Brooke was allowed to be this kind of nurse to each of her patients, she knows she would be making the difference she is called to do. Unfortunately, the hospital environment at times has focused less on this type of care and more on efficiency and delegation. One of the most stressful times in her nursing career was a time that she was told she was too important to give baths. She was told her skills were being wasted on a task that anyone else can do. Both the

micromanagement of her skills and the inability of leadership to comprehend the care she provides during bath time were disregarded and she suffered dearly because of it. It is like the hospital becomes a “medical factory” instead of a place where real care happens, and it made Brooke feel empty inside about her role.

The hospital also sets up nurses to suffer from a customer service policy that allow parents who are not coping well, attack the team member assigned to them. She recognizes that the families are probably suffering more than the child, but when fear and frustration are not handled well, the nurse takes on the brunt of the pain. She has had families accuse her of withholding pain medication, not taking care of the patient’s basic needs like diaper changes, all the way to accusing her of having an affair with another team member. Being this unhealthy outlet for families can be really hurtful and it is hard to constantly remember that it is not about her. These moments, while they don’t define her career, cut deeply into her own self-worth and she reported being wrecked by these situations. Unfortunately, an organization that is focus solely on customer service often ignores what the nurse might need in these moments and focus more on keeping the family happy. So, she gets reassigned under the guise that it is better for her when really it makes her feel like just another number and instead of appreciating someone who gives a big part of themselves every time they work. Brooke states that in “an effort to support families we haven’t done a great job in supporting staff”.

Brooke loves being a nurse. She knows she was called to this profession and her faith and belief in a higher power sustain her for all the hard things she endures. If you ask Brooke if she is proud to be a nurse, you will see her whole face light up. Telling people what she really does, the stories of hope and grief, making a difference and being part of another’s story, are deeply rooted in her values and the knowing that she is doing exactly what she was meant to do.

Zoe's Story



Zoe has been a nurse for 7 years but really, she has been one since she was a little girl. From a very young age she knew she wanted to be a nurse. When others where dreaming up being professional athlete or firemen, Zoe was thinking about caring for others. This is a point that she is very proud of. How many people can say they knew so early on who they are and then it actually happens. More important, may be the fact that she loves being a nurse. Not just any nurse though. Zoe loves being a pediatric nurse. Taking care of young patients that depend on her for both big and little needs. In some cases, keeping them alive, in other cases helping them forget they are stuck in a hospital. She comments that the only reward she needs is a giggle from a child she had made laugh or a thank you from a mom who she helped advocate for.

In fact, one of the biggest differences Zoe makes in the lives of her patients and families is to be their advocate. Zoe talks about some of her proudest moments as the times she could help a family who was scared and nervous, maybe over something that she knew was not a significant medical event. Recognizing that to them it is significant so not ignoring or minimizing their feeling but helping them ask the right questions so they could be confident in their care of their child. She also advocates for new nurses who are unsure of their abilities. She came to this city all alone with no experience at a large hospital like Children's. She needed others to take her under their wings and now she seeks out the less confident nurses to pay this forward.

What about the gloomier side of nursing? Zoe prides herself in having a practice of not taking her patients home with her. Knowing what she did during her shift was all she could do and handing their care off to the next nurse. Zoe views her time away from work as sacred. A time for her, to be filled up. This can't happen if she is constantly thinking about her patients. Her husband is a police officer and so their house could be potentially full of sad, traumatic events of a given shift. This is not acceptable for Zoe, so she makes a conscious choice to leave work at work, to have good boundaries and to trust the other nurses she works with.

Although this is a strength of Zoe, she has at times found herself not able to let go completely. One particular patient that Zoe talked about holds a special place in her heart. He was a long-term patient that was in and out of the hospital for several years. She was a primary nurse and very close to both him and his family. His diagnosis was life limiting and so when it came time for end of life conversations Zoe was not surprised. She was however, taken back by her reaction and the different stages of the process. He would close his eyes for days and they would prepare for the end and then he would recover for a time. She speaks of being there for the

last time he closed his eyes. Why was she the last one he looked at instead of his parents? This lingered with her for some time. When she got the call a few days later she realized the impact of that moment had on her and it stills makes her cry talking about it.

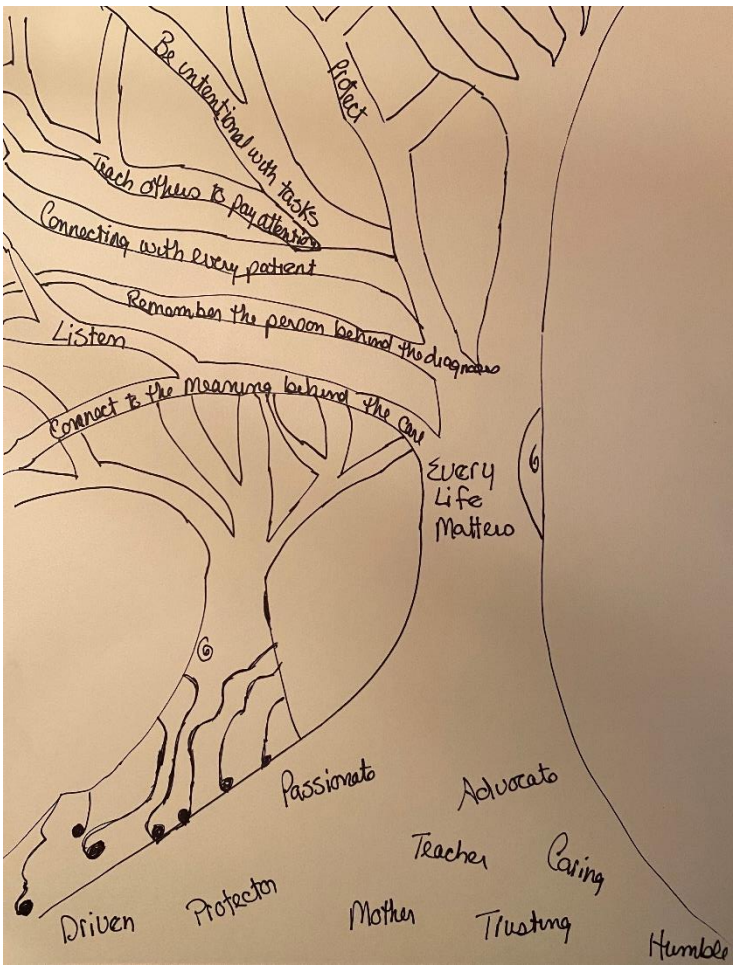
When Zoe talks about the stressors, she has in her job there are quite a few. She does think the hardest part of her job is dealing with families who take out their fear on the nurses. She recalls a story about a code situation where the nurses where doing compression on a patient and the mom was screaming at them the whole time saying it was their fault for not coming in sooner. The patient recovered but it took longer for the nurse to. Staffing issues and having high acuity assignments also cause stress. The shifts are harder when she is not able to do the little things for her patients or advocate for them because she is running from task to task. As a senior nurse, she was called on to take assignments that were not only busy but felt unsafe. Zoe doesn't like to see herself or other nurses put into those positions and there were times when leadership's only response was there isn't anything we can do. Times like these are stressful for Zoe. When things weren't okay and didn't seem like they would change, and the hope was taken away from the nurses. One of her hardest times when actually when she had a difficult new graduate nurse to precept. The kind of new nurse that was too confident for her own good and wouldn't listen to Zoe's advice. This really shook her as she loved precepting, but she worried about the patients in this nurse's care and it stayed with her outside of work.

All these positives and negative aspects of being a pediatric nurse have at times left Zoe exhausted. She is very frank about times in her career that she did not know if she would recover or being able to come back from the negative feelings. It is hard to attribute these times to a single event or say a single Patient death, like in the case of her patient above. During these times, the predominant emotion she was experiencing was defeat. Not just defeat in that she was

feeling down but defeat in the notion that she had not solution. Others leave the floor or go on to a different role. Zoe believe with her whole heart that she was meant to be a pediatric nurse on this particular unit with this particular population so her solution could not include moving on. During these times of profound defeat, she would find herself crying for no reason. Not just any type of cry, but actual weeping. It was like she was okay with the suffering, and knew what she signed up for, but having no hope in sight magnified her situation until she would just give up.

Zoe is still a nurse on that unit. She has come back in her words from three or four 'seasons' of defeat. Each time she found something to bring the hope back. Using her vacation time up instead of holding onto it. Focusing on the successes of her job like empowering a mom or being asked to be a primary. Teaching a scared trach vent family to hold their child, maybe for the first time. Not fixating on the bad. Taking breaks from harder patients to get a break. Taking time off from precepting new nurses so she could only have to think about herself and not another nurse. Hearing from her own family how proud they are for her to be a nurse. Using the resources at work like the resiliency conference or moral distress rounds. Talking with her peers and drawing on their wisdom and support. Understanding that every patient has a book about their life and while their time with her is a part of their story, it is just a small piece of their journey. Zoe doesn't want to leave this job. She says while others leave because they can't cope, at the end of day she loves her patients too much. She loves being even a sentence or two in her patients and families' books and knowing that they trusted her, and she made a difference for them as their nurse. The kind of nurse she knew she would be as a little girl.

Shannon's Story



For Shannon nursing is about always remembering that the care is about a person, not a task. Her best example of this is talking about going into a room to do a routine g-tube feed. This can easily become a mundane practice, unless you remember that it is not about the g-tube it is about the child who needs to be fed. This takes these simple acts and makes them more than just a checklist of things to do. Shannon does not see compassion in a checklist. It is the kindness, empathy and nurturing that comes when you see the person behind the task that equals compassion.

One of Shannon's greatest pleasures as a nurse is teaching. Teaching the patients and families but also teaching her peers. As a mom and foster mom of medically complex children,

Shannon brings a whole new insight into what it means to care for pediatric patients and their families. She has seen it from the other side, often inpatient with her own children on the floor she works on. This perspective gives her the street credibility to say I know what it is like to be in a hospital and scared for your child. It also allows her to teach about the little acts of kindness that are so meaningful to the patients and families they serve.

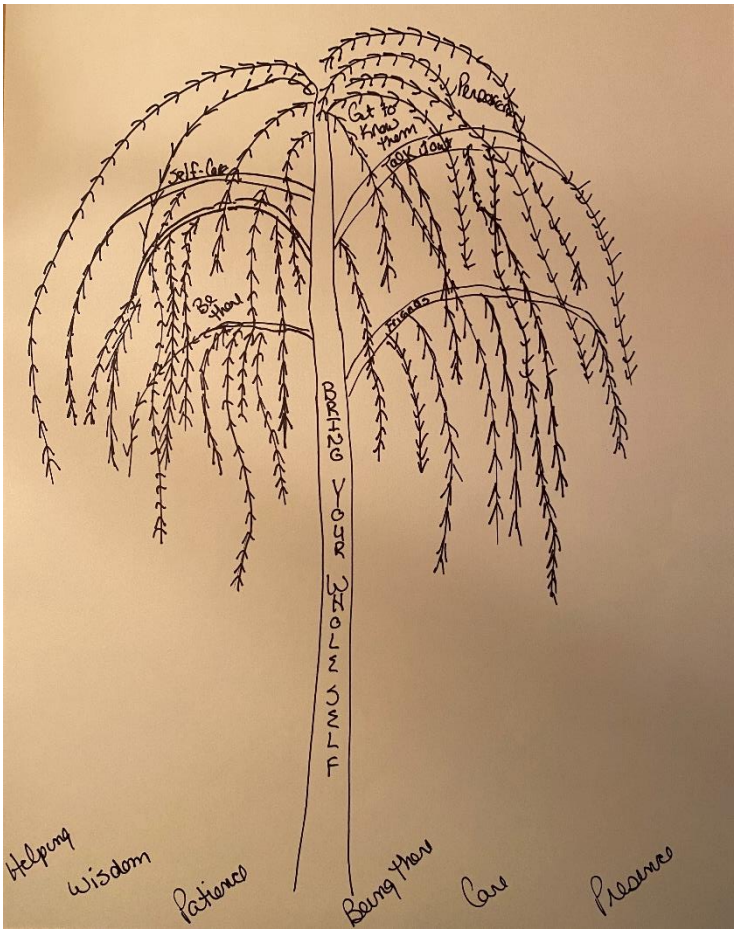
It is not surprising that the things that fill Shannon up are also about the person. A child meeting a milestone or connecting with a teenager that no one else has been able to. Taking a scared parent and giving them the skills and confidence to help their medically fragile child. Shannon stated that "Nursing is so important because it is about someone's life, and in pediatrics it's about someone's child". A lot of the time she spends with families to make them feel safe to care for their own child. To stay motivated even when they are anxious or worried that they will make a costly mistake with something so precious to them. On days when the job is physically exhausting and her feet, back and head are all aching, and she questions is this all worth it. It is times like this that Shannon remembers that her unique style of seeing the person behind the diagnosis makes a significant difference for them.

Shannon would remind other nurses that kids are different than adults. They can't always care for themselves, so they depend on the nurses for everything. This goes beyond diagnosis and treatments. This means development and play. This means daily bath time and splashing in the water. This means getting your nails painted by your teenage patient or talking about where to get the same shoes you are wearing. This means celebrating milestones when the patient does something new. This means being held by someone when they are in pain and that there are no rules when the situation becomes an end of life event. It's about helping others in big and small ways. Connecting with the patient and family so you know them well enough to teach them in a

way that makes sense to them. This is crucial for the types of patients that Shannon cares for because they will so often go home with medical equipment that is quite literally keeping them alive. One mom in particular that Shannon worked with over months, required constant reassurance and patience. Shannon stayed on as a primary even when this mother was triangulating staff against each other and telling the physicians she couldn't go home because no one would teach her anything. Shannon knew that this mom needed someone to trust. Someone who would take the time to build a relationship with her. She knew that this mom needed compassion to work through her fears and feelings of guilt over her child's diagnosis. So, while others gave up, Shannon doubled down and looked for the reasons behind the behaviors. She eventually helped get this family home, but Shannon still wonders about how they are doing.

If Shannon ran the place, she would make sure that nurses have enough time to be the kind of nurse they want to be. She would let them be compassionate and not use boundaries as a way to scare nurses into not getting to know their patients and families. She would role model focusing on relational based care that opened space for having each nurse get their own cup filled every day. She would recognize the uniqueness of nursing and give support and understanding to the emotional toll that happens with the heaviness of the role. She would recognize that it takes courage and pride to come back every day and hope that a as nurse you get to help someone, especially a child, feel better in some way.

June's Story



June has been a nurse for 28 years and if you ask to her take a break, she is going to tell you it's time to get back to work. This is because June loves being a nurse, and while the roles she does has changed over the years, her purpose of being compassionate and caring stays the same. June believes that what make nurses unique is the desire to give of yourself so that the patient and family have whatever they need to get through what they are faced with. June practices honesty and care to 'get her foot in the door' so patients and families trust her. Nurses get to know their patients. They know what works for them like no one else. Whether June is helping them get out of the hospital or just sitting quietly with them so they are not alone,

she is giving them all of herself so that she can to help them. This comes from knowing that this is more about the emotional suffering from loneliness that her patients experience often.

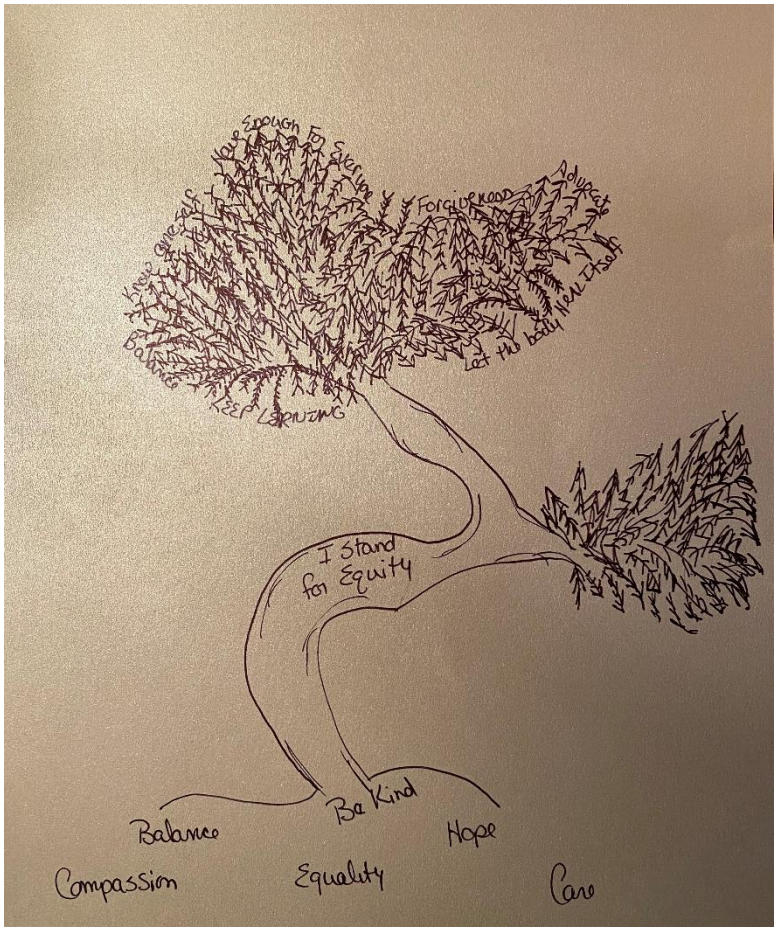
Pediatrics has always been the nursing that June loves. It is the opportunities to help the whole family get what they need. She notes one of her favorite times is seeing a parent's face light up when they learn they get to take their child out of the hospital. June also has a special place in her heart for the teenagers she cares for. They can often be alone and sometimes closed off. When she has the time, she will just sit with them and connect through simple gestures of seeing how they are feeling that day. Getting to know her patients so well also means that is it hard when she is called to help them with end of life decisions. June has lost patients that she worked with for over years and always wants to make the process easier. She does this by being there and an offering a safe person to talk to. This care and openness help the patient, but all can mean it hurts a lot more when you lose one. When it came time for one of her patients to make decisions about his continually fight to live, June remembers every moment she spent with him. She had taken care of him since he was just nine years old, and now as a nineteen-year-old adult she again offers her whole heart and soul to just be with him as he decided to end the battle.

June wants to remind nursing that you need time to recover. June wants to give all that she has to her patients and families and recognizes that can take a toll. It is especially draining when you want to help but can't give them the answers they want. This at times can feel like the whole world is on your shoulders and you can feel the drain physically in your body. It is times like this that June depends on her peers to support her, offer an ear to listen or a hug to support each other. June also recovers when she has a quiet space to rest and someone to talk to who understands what it is like to care for patients and families.

If she was running the hospital June would help the nurses get the time, they need with their patients to understand them on a deeper level and be able to help them more. She would make sure that nurses held leadership positions as it is hard to understand how complex being a nurse is unless you are a nurse. She would recognize nurses all year long, not just during nurse's week. She would hold debriefings and create space where nurse can talk to nurses so they can be supported by someone who understand how complex it can feel.

June describes compassion as giving of your whole heart and soul and for the past 28 years she has done just that with her patient and their families. Even through all of the hard times, even when she finds herself thinking about her patients outside of work, or remembers the loss of a long term patient, June is proud to call herself a nurse and will continue to give everything she can to make sure her patients and families get exactly what they need.

Bradford's Story



As a nurse Bradford knows he has to be a jack of all trades who main focus is to the support the patient's body so that the body can do its work to heal. This means paying close attention both medical issues but not forgetting that person's physical and mental response to being in stress and at a hospital. This is especially important in pediatric patients who are more vulnerable than adults in terms of what can physiologically go wrong and how they understand the world around them. Bradford knows that these are not just little adults who can comprehend that illness, pain, stress, or being away from family is usually a temporary condition. Bradford's keen eye on treating the whole person means he is always looking for meaning behind the medical tasks he completes as not to miss what the child really needs to heal both mind and

body. Bradford is also committed to doing this not just for one patient, or for the patients he connects with or likes but with every single patient he encounters as a nurse.

To maintain this equity Bradford knows exactly what his limits are. Getting too close to a family or working with a patient too often, might put him at risk for having a connection cloud his ability to prioritize all his patients need equally. To see every individual in the moment and give the best possible care to whoever he is caring for right now. This not only means that every patient of his is getting the same excellence in care, it means that Bradford has the energy he needs to be at his best for not just a select few patients, but all of his patients.

Bradford is also aware of the how the demand of being a nurse can have a toll. In times of stress, where the demand from the patients exceeds the nurse's immediate abilities, frustrations can immerge. This can look like exasperation, complaining or complacency about just getting a task done and deviating from best practices. Over time nurses can get desensitized to even their own jadedness and might wear the outward appearance of being disassociated as a badge of honor. Bradford doesn't blame nurses though. He recognizes that often this a protective measure that nurses take to manage the accumulation of stress they face. Nurse have long memories for the mistakes they make, and the feelings of guilt and failures can resurface. The moments when you wonder if you have done everything you should be doing for your patients. The times when a patient's condition deteriorates and guilt about lack of skill or attentiveness overwhelms you. Bradford imagines that every nurse carries with them an employee file of all mistakes that weighs them down and makes them feel not just like a bad nurse but at times like a horrible person.

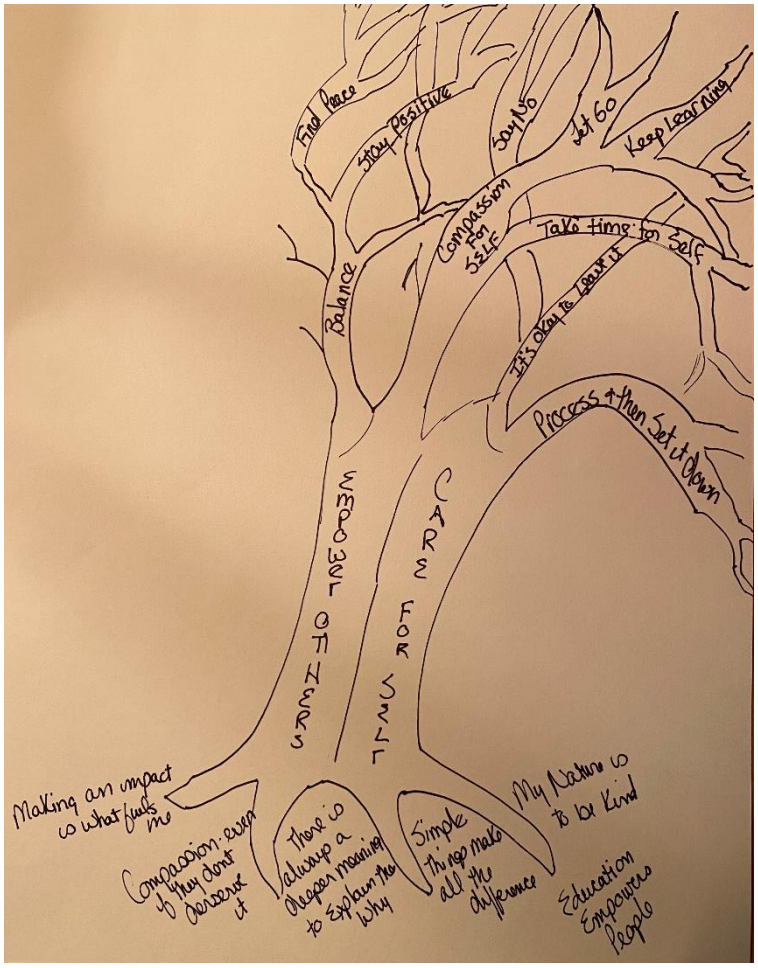
Bradford wants to remind nursing that simple cares are profound. Even paying attention to our behaviors and attitudes make a difference to a child. When you remember to use the right

pronoun for a transgender patient or help a weight restoration redefine their relationship with eating by involving art therapy. These may seem like not part of the job to heal the physical body, but they matter to the person behind the diagnosis. Bradford is very attuned to how microaggression and stigma, whether intentional or not, color how a nurse shows up with a patient. He reminds others that we are not just here to take care of the medical issue but the whole person that has been placed in front of you to care for in this moment of crisis and need.

Above all Bradford sees his duty is to find the humanity in every moment he has with each and every one of his patients. He believes strongly that everyone he treats deserves to get the best possible care and strives to bring equity, empathy and deeper understand of what is really going on with each family and child. He has a profound perspective of what nursing is meant to do that is unique from all other caring professions. A nurses' job is to take away fears and anxiety and put the patient in the best condition so that they body can heal itself. For Bradford this goes beyond the right medication or diagnosis. It means seeing the whole person in front of you and recognizing the privilege you have to see and treat them when they are most vulnerable. This means paying attention to details, seeing beyond the tasks, looking for meaning, meeting basic needs and above all doing all of this for every single patient every single time.

Bradford is absolutely a jack of all trades when it comes to his knowledge of nursing and his value-based care of not just managing the diagnosis of his patients, but the whole person. He brings his whole self and being to each patient to make sure their whole self and being are cared for and it matters to everyone he treats.

Jade's Story



Jade is a nurse who understands how complex nursing is and at the same time wants everyone to remember that is about connections. Nurses are the discipline that look at the whole picture and connect all the dots so the patients and families have everything they need to be empowered and take care of their child the best way they can. Nurses as connectors, translate complex medical language to ensure that they families truly understand all that matters. Connectors build trust with patients and families, so they have enough of a rapport with the nurse to open up feel and be heard. Connectors bring meaning to the bedside by looking for ways to increase dignity and care for both the patients and families. This can come from education but also from paying attention to little details and meeting everyone's basics needs. Connectors also

bring compassion to the experience. This means always trying to put yourself in someone else's shoes to see how they feel. Jade knows that there is almost always a reason for the behaviors nurses face and compassion means they don't write people off just because they are being mean in a moment. All of these skills are even more important in pediatrics because you have to take care of more than just the patient. Jade knows the big impact you can have on a child's life. Being there to help them feel better, see them grow and develop and playing a positive role that they will remember you for. She has been recognized by both children and parents for being the one who helped them feel comfortable taking care of their child. Going from being afraid to touch their child to wanting to learn how to care for them. She will never forget the children who don't want her to leave because she was going to miss when she is gone. The hugs and letters that remind her that she is meant to be a nurse and help her remember why she comes to work each shift.

Jade understands that there are hard parts of being a nurse too. Those recognitions from the hospital or patients are rare. Being in a pediatric setting also contributes to the burden. In pediatrics nurses are faced with children who have chronic diagnosis that make her worry about their quality of life and question the difference she can make with them. Jade gets filled up by hope and improving a child's experience. When a child lives the same day after day, with the same pain and no hope for a change, Jade questions her purpose and cannot bare to work with them for too long. There are also end of life patients. While Jade notes that it is an honor to be the nurse who helps with end of life, it is also very draining. As connectors nurses spend a lot of time with the families and this can mean they take the brunt of the negative emotions that can spill out from families. In her words they can "suck up your kindness and throw it in the trash". Jade has needed to become skilled in knowing when to say enough is enough and helping herself

and other nurses keep good boundaries with angry families. Then comes the times that Jade worries about her patients going home. There are times that families don't seem to have the right amount of knowledge or resources to create safe and healthy environments for their own children. Jade tries to send them off with enough education but at times her heart feels like they are not ready. Then she finds herself wondering if they are going to have what they need to develop and grow and thrive. What do you do with the fears that regardless of how much a family loves their child they will not give them what they need? Its these hard cases and hard questions that drain Jade and seep into her mind and dreams when she is not at work.

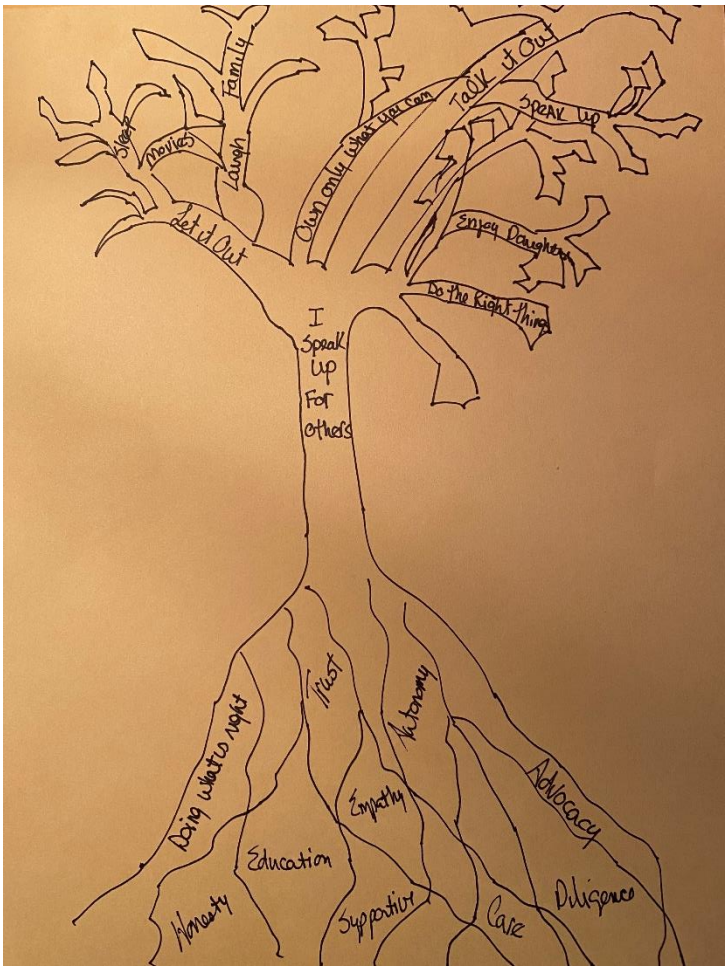
Jade wants to remind nursing that they if they are feeling unhappy, they need to speak up. To remember they deserve to be in environments where they can be the best nurse possible. To know they are able to do their best. She also wants nurse to be kinder to themselves. She wants nurses to forgive themselves and learn from mistakes and help others learn from them too. For new nurses need to remember they are meant to be a nurse and when they feel like an imposter or they are not supposed to be a nurse to remember it is okay and we all make mistakes. Nurse also need to have a life outside of work. Nurse want to take care of others, but it is easy to get lost and not take care of yourselves. Self-care can be about separating work life and home life. Processing on the way home as a therapeutic practice to sort through and then set down once you are home. Jade knows that she is am thinking about kids outside because she will have bad dreams about them. A dream about the child dying- means she is worried that they are not okay.

If Jade was running the show, every nurse she work with would remember that building a rapport and trust is what helps the families open up to you so if something happens, they are honest and work with you. She would make education a priority for all admissions. Jade believes deeply that education is what empowers people. Helps the families go from not wanting to touch

their child to getting back to be the care giver and being a part of their child's experiences. She would also create environments where the nurses are not just given more and more task to do without thoughtful consideration about what the effect is on patient care. Everything that takes away time with the patient is too expensive a cost.

It is in Jade's nature to be positive and kind. It is why she is able to find balance at work and at home. It is why as a nurse she can bridge the gap between the difficult parts of the job and look for the differences she is making every shift. Jade has also found a way to bring forgiveness and peace into her practice as a nurse. To allow space to process and let go of negativity while still wanting to learn and do better every shift. Having this perspective helps her stay both passionate and grounded as a professional who understand the importance and value of being the nurse connector she has become.

Maddie's Story



Maddie has been a nurse for just over five years but really, she has been preparing for this job much longer. From playing with her mom's nursing books as a kid the time she realized the fact that doctors spend just minutes with their patient and nurses are there the whole time. Maddie wants to care for others when they are most vulnerable. After a short time working with adults, Maddie quickly learned that she could make the biggest difference with kids. Kids are innocent and even though parents know their children, Maddie learned that a pediatric nurse could help in ways that the parents can't.

It is really important for Maddie to make a difference. To know what she does matters. This drives her to always do everything she can in her power so she never has to look back and

wonder if there was something else, she should have done. Even if there is an uncertain outcome or unknown future, as long as she did her best she can sleep at night and remind herself that she did what she could, she did her part. She also deeply believes that medicine has to focus on ethical care and that there are times that death is not the worst thing in life. We should always ask the quality of life questions like will this child have the ability to form their own personality. Will they have a memory? For this Maddie can help but find herself thinking about her own daughter and wondering what she would choose to do. She thinks about a family who decided to let go of their child until a physician offered to fix the breathing problem even though there was no hope to fix the damage to the brain. She doesn't fault the parents who keep their child alive, but she does question a pediatric system that does everything they can knowing full well that this child will never be able to get out of bed.

Maddie has a lot of questions that she processes in the complexity of caring for kids. Questions like how do I advocate for the child above and beyond what the parent's needs are? Why do we allow any amount of suffering for a child when we have the knowledge and resources to ease their pain? How can we trust a system that tells us to report dangerous social situations but then ignores the nurses' gut feeling and we send the child home anyways? How can we make decisions based on the ego of "I can fix that" without processing "If I fix that what is the quality of life the child is left with"?

Caring this much about all of these questions means that Maddie thinks about her patient a lot. She takes things homes with her and worries about them too much. She couldn't give it a number but if she had to guess she thinks about her patient somewhere between 'every night to probably all of the time'. When it is fresh in her mind she often cries about the situation. After

she has had time to process (which typically includes some venting, moaning, groaning, bitching and complaining) she still thinks about them but doesn't necessarily still need to cry.

Maddie wants nurses to remember that there is always offers opportunities to learn more skills. She wants nurses to remember that they are responsible for serious stuff and they need to be able to rely on each other. That education is a huge part of the job and to never stop laying the foundation of knowledge that can ensure a child has what they need to grow. To use each other as experts and draw on others experiences and passion to get the best possible knowledge to those who need it.

If Maddie ran the show, she would make sure that the organization did everything in its power to get the nurses what they need for the shifts. It starts with the right staffing. Enough nurses, CA's, mental health counselors and environmental service staff that clean the rooms and remove the trash. She would focus on new nurses and precept them correctly so they could learn what they need and be the best possible teammate. Maddie understand that having good coworkers equals having a good day. She would make sure everyone was more diligent and learned from experiences so as not to repeat mistakes and put more kids at risk or miss our chance to save a child and prevent more suffering.

Like many other nurses at times Maddie wonders what the hell she was thinking taking on this role. It can be dramatic and at times annoying. She doesn't always feel heard or have the autonomy she has earned. Even though she knows there are other professions where she could care and teach, Maddie also knows she loves her job. She knows she was meant to be a nurse. She knows she makes a difference. She wants to continue to fight so no child falls through the cracks. She knows that despite all odds she will come back shift after shift and continues to fight

for quality of life, quality of care, and the best possible outcomes for the kids she staunchly advocates for as a pediatric nurse.

Emergence of Essential Truths

Phenomenological research does not set out to demonstrate how everyone is the same but rather to show how unique each person is. The process of telling a personal narrative can help that person gaze inward and seek to create their unique meaning within their experience and within the world (Zahavi, 2003). Not just what the experience was, but what it meant to the participant. This process done with a group of people, in this case pediatric nurses, lends itself to the discovery of common meaning from multiple realities. By using methods of reduction, getting inside the experiences and allowing meanings to emerge naturally, fundamental or essential truths have the opportunity to surface. The essential truths that emerged from these interviews are outlined here and include truths about nurse's experience with compassion fatigue, and the contributors and barriers to compassion satisfaction.

Emergence of Essential Truths of Compassion Fatigue

Essential nature of compassion is more than caring

Compassion, empathy, care are often associated as values of nursing. Each of these words comes with multiple definitions and constructs. Until we understand what they mean to nursing we will not clearly understand what happens when nurses can't offer them because of fatigue. Empathy is described as feeling what someone else is feeling, putting yourself in their shoes, trying to find meaning behind what another's experience is (Conti-O'Hare, 2002). Care could be considered a form of empathy and is the cornerstone of what nurses feel for their patients. Compassion is also considered a type of empathy, but one that is motivated into action. Compassion is defined as a sense of shared suffering, combined with the desire to reduce such

suffering (Schultz et al., 2007; Sabo, 2006). Whereas empathy and care live in the heart as a feeling, compassion lives in the hands as willingness to go beyond and do something about the suffering. I feel your pain and I want to alleviate it. This call to act is where nursing exists and is reflected in the participants stories. Misty reports that "compassion equals suffering" because as a nurse once you step into a relationship with the patient it is the suffering you are signing up to help with. She sees this in action because it requires connection, seeing the whole person in that relationship and seeking to find their unique need you can then meet. Misty shares that it is becoming the source of strength by giving of yourself to make another person whole. June says compassion is bringing your whole self to get to understand the patient like no one else does. Art does this with presence, dignity, respect, acknowledgement of fears and frustrations, and recognizing the devastating emotions that come with the patients and family's loss of autonomy. He knows when he is able to be compassionate beyond caring because it is the difference between just being someone's nurse and "*being their favorite nurse of all time*". Jade knows that there are children in the world who will never forget her and the compassion she showed them.

The effect of compassion is not limited to the size of the act. In Brooke's words it is the "*small but mighty acts*" that usually put compassion into action. Many participants shared that really listening to the patient or family may seem small but has much larger ripple effect. Art sits down with his patients to show he is all ears. Shannon lets her patients paint her nails, so she has time to listen to their needs.

Giving a patient or family hope is also no small gesture. Sometimes is just not being the one to take away the hope a patient or parent has and just walking with them along the way. June has needed to hold this space with many of her patients as they reach the limit of their diagnosis. Both Bradford and Art help patients and families look for hope by offering new ways to look at

expectations. Art works with families to say, '*We may not have this anymore but look at what we can strive for'*.

Every participant shared some form of compassion in the form of education. The act of educating, meeting the patients and families where they were at, empowering them with knowledge, helping them feel safe to care for themselves or their child when they leave the safety of the hospital, getting to know them well enough to see how they learn. It is Zoe's favorite event when a family who just a week ago were too scared to touch their child transitions to only needing her as a cheerleader for cares and not their educator. "*That to me is huge. It's like mommy bear moment. Like I taught them that"*. Jade knows that educating parents empowers them by letting them get back involved in the care of their child instead of having to watch someone else do it. When his peers can't find Art, chances are he is in the room doing some education. He takes every opportunity to teach knowing that he will not be able to go home with the patient and this is the only chance he gets to provide practice time for the parents under his teaching supervision. Shannon shares this belief that every moment in the hospital is a teaching moment. Brooke speaks to an impactful moment she had with a family who was too afraid to do a bath with their son who was recently given a tracheostomy to help him breath. She recounts how the experience started with a simple question:

> *"Has he ever had a bath. And dad was like "no I don't want to give him a bath". "What is your fear with that" He was having recurring dreams of him drowning and I remember I kind of teared up when he said that cause all I could think about was all this mom and dad have had to think about since their child got this trach and how terrifying that would be to have this child that was previously doing so great and thriving and now all the sudden you feel like even a bath is the scariest thing you can imagine so I said we will just get him down on the mat and play first and so we did we got him down on the mat and we played and they both were just kind of really worried about everything, worried about where he was moving and so we worked through that a little bit and they started to get more and more comfortable. As the day went on, I revisited the bath and I was just like what do you guys think about just trying it. I will be right with you and they agreed to it, so we got them some bath toys and we filled up the tub and he was so excited to take a*

> *bath. He like loves bath time so he was trying to climb in before we were ready to get him into the tub and he got in and started splashing and the dad was like 'no no' and he got really upset and I was like it's okay and I should him how his trach was covered and was safe and the water was not going to hurt him and so they both got down on the ground and started playing with him in the tub and both of them started bawling. I couldn't help but tart crying because you know it was a really powerful moment and they both just looked at me and said thank you. And I think that you know that was defining moment for me in my career. And just exactly why I feel so lucky that I get to do this work*

Several of these nurses hold space for their patients, sometimes in silence, to offer compassion just with their presence. Misty describes this type of compassion in her beautifully illustration of it as a dance.

> *I really try to focus. I take my breaths and I kind of like do a dance with my patients, like checking out how they are that particular day, because if it's a new diagnosis then they're in that certain place in their mindset. So, when you go in there, it's more of a relaxed state. I do that dance with the patients and just create that field for them to be open enough to trust me, giving them that space to trust me and building that rapport with them. And when I hear those worries from patients, then that's my lightbulb to tune in more to them, making myself more available to them. Then I sit down, and I don't delve in too much until they opens up to something, I'll ask a question. But then I don't delve in too much until they opens up to the next level. Again, there's that dance.*

Nursing is a sacred calling

The connection from nursing to the term sacred has its roots from earliest of healing traditions linking health to spiritual practices. Nightengale reminded nurses that the care of the soul and the care of the body where not separate acts (Nightengale, 1859). More recently Jean Watson (2005) entitled her third book 'Caring Science as Sacred Science' and overtly draws connections between care of the patient as a spiritual practice. In her Philosophy and Science of Caring, Jean Watson speaks to the covenant nurse have with their patients as a sacred act (Watson, 2009). Sacred can be connected to spiritual practices and it can also be described as something that is worthy of awe and respect. This is the context that I will use when describing how the participants regard what being a nurse means to them. Each expressed this in different ways with different words but the collective pride and sense of being 'called' to be in this

profession was palpable during the interviews. The idea that nursing is a more than a career choice emerged as an essential truth for these participants. From the how Esther accounts being with someone during death as a sacred moment. To how so many of the participants look for their purpose on earth being tied to compassion for others. In one way or another each participant used the words of showing up with their patients whole heartedly, completely, intentionally so that as Maddie puts it "*no one falls through the cracks on my watch*". Bradford understands that his calling as a nurse means he has to go deeper with his patients. To find the meaning behind the behavior so that he can make them feel safer. He says his job is "*literally to walk into the room and take away anxiety and take away fears*". If he can't then he believes that he is not doing his life's work to support the person so their body can heal. Art takes an enormous amount of pride in being a nurse who decides to care for often complete strangers. He believes that everyone has the capacity to be compassionate but as a nurse he consciously chooses to do this with patients and families at some of their worse moments. When they can't think or show basic civility. When they are taking their fears, grief, anxiety out on him and yet he remains calm, caring and compassionate. Ask Art what makes nursing a sacred calling and he will explain that very few individuals have the ability to choose compassion in these situations. Brooke also sees the work she does as a God giving gift. She shares what happens when she gets asked about being a pediatric nurse:

> *When I tell stories about what I do, every time they are crying with tears of joy or tears of sadness. I think that just knowing that people are impacted by what I do every single day in a huge way and I get to have the privilege of being in that opportunity to be part of their story is such an honor. I would not change what I do for anything. I am so thankful that I was brought to this a place and you know I feel like this is what I was meant to do, and I feel seriously blessed to do it every day.*

Zoe also sees the honor of being part of her patients' stories as she recounts how a mentor of reminded her to remember the importance of a nurse's role in their patient's lives:

> *She said your patient they have this book. This giant novel of their life. And their disease process it makes appearances in this book. You as their nurse make an appearance too… I'm proud because the work that we do it so powerful that I'm, even if it's just a sentence, in so many people's books. And it's hopefully a good sentence. Of me advocating for their daughter or son or helping them during a code. I just love that I can make an impact. Even if it's, there was this blonde nurse and she was the most calm, or she had this way to calm me or make this serious situation a little better. I just love that I get to make changes like that. Not everyone gets to do that. Not everyone gets to say, that right? Were pretty lucky*

It doesn't mean because each participant's feels knowing they are meant to be a nurse makes it any easier. In fact, Maddie stated that she loves her job but there are still moments where she wonders "*what the hell was I thinking*" when she decided to follow her heart into nursing. Being 'born to be a nurse' means you have a responsibility and duty to not disappoint the world. It can put a lot of pressure on nurses who feel this is their souls' purpose. What if you fail at your soul's purpose? Jade knows it is in her nature to be kind and yet there are times that her patients or families can "*suck up your kindness and throw it in the trash*". Misty feels actual pain when she is cold to a patient or family. It hurts her so much she has to do whatever it takes to make the situation right. In the midst of her own mental health crisis Misty describes coming back to her souls' purpose as the only way to get through and reconnect to herself as a healer:

> *I had a mental breakdown. I ended up having a panic attack. A panic attack that lasted for two or so weeks I finally went back to work, I come into work, and I'm shaking. From my house to go to work even to cross a bridge—to even just going through the bridge, I was already anxious. Even walking from the car to the unit, I was already shaking because I'm like, "I don't know if I can do this anymore." But guess what happened? I go in to check on my patient. I was a little bit shaky. And I told her, "Hi. I am here and take care of you. And as soon as I touched her, everything went away. And when I talked to both my chiropractor and to my psychologist about it, they said, "You know why that happened?" I said, "Why?" "Because you were born a healer." And so knowing that—Knowing that this is my purpose in life. That this is what I was meant to do. I was meant to be of service to others with my love and compassion. So that's how I fill my cup knowing that I have God, the universe, working with me to do what I need to do for the person that I'm encountering.*

Pediatric nursing is unique

I would be remiss in a pediatric study not to share what emerged around how it feels to be not only be a nurse but a pediatric nurse. Each of the participants has at one point or another expressed what is unique about caring for children. There are some universal truths that are well known about caring for kids. It is more emotional to see a child suffer and a child's death is usually met with a heighten sense of injustice (Branch & Klinkenberg, 2015; Czaja, Moss, Mealer, 2012; Meadors & Lamson, 2008). Maddie has experienced the desire to keep children alive by all means in her career and it has left her grappling with the ethics of saving children's lives at all cost regardless of the quality of life they will have. This is a hard area for nurses who often are not the ones writing the orders but are the ones who are asked to do the care. Here is an experience she shared that she still thinks about:

> *I feel like, in pediatrics, we are more, "Do everything you can, do everything you can," because they're kids, and I agree. I totally understand that. But, when there's nothing to come back from and we just push these trachs down these kids' throats. I had a kid that, she was going to be in bed for the rest of her life. There was not going to be any memories, any personality. And her parents saw that, and they decided no trach, which was a very hard decision, I couldn't imagine. And then ENT comes around and says, "Oh, no. We can fix her." I mean, yeah, you can fix this, but can you fix her brain? So, I feel like we get a lot of those like, "Well, they can save them" But what are you saving? Just because you can put a trach in, doesn't mean every kid should get a trach.*

The participants did share some entities that are easier about caring for children. Jade expressed that while adults can refuse to do something, for the most part children can't say no. Many expressed that children can be more easily distracted with toys and play then their adult counter parts may be. Multiple realities of the participants highlight the shared understanding that children are not just little adults. They have unique requirements concerning developmental and distinct needs for social interaction, touch, play and communication. Children, especially younger ages, cannot meet their own basic needs of feeding, bathing, being held and soothed.

These tasks are met with enthusiasms unless as Bradford reported they happen at an inconvenient time and then the nurse feels guilty about not be able to meet these basic needs beyond feeding and diapering. Bradford explains why this is so important as he talks about why kids are not just little adults:

> *So, you have to be considerate—you have to be considering how pediatric patients are especially vulnerable. I think more vulnerable than adults in terms of things that can physiologically go wrong. So you have to be always thinking about what's their hydration status? Their fluid balance status is such a fine-tuned thing that anytime if it slips through the cracks with people, they've just insidiously become dehydrated on top of everything else. You have to think about how is what we're doing promoting their growth and development? And how is being in this setting, in this albeit stressful environment, limiting that growth? And what are we doing to actively kind of counter steer and counterbalance for that? You have to think about how are we shaping a child's understanding of the world around them, being in such a contained environment? Especially with patients and families that, as we kind of previously eluded to, basically live here. Are here all the time for chronic conditions. How do we meet just as important, social needs when our floor, for example, might be on an outbreak of a GI bug around precautions so no one can leave their room? Or during respiratory season when younger family members can't visit. How do we balance the, again those social development needs, and those feelings of relationships and belonging and comfort, with also the very real balance of keeping everyone safe and stopping the spread of disease? So again, it's just so many—if I could sum it up with one thing I would say it's so many balls that you're juggling in the air constantly thinking about every single patient.*

What emerged beyond those for the participant as essential truths are more about the complexities within including the care of the patient to include the care of the parents and family. Most children are not alone when they stay at a hospital. These nurses noted that there are times that is would be easier, if not better to not have the parents involved in care. This doesn't sit right with Shannon who as a parent herself understands the need for the families to be at their child's side. Art also appreciates the help of his families when they are engaged and ready to learn how to help their child heal. He also understands that as a pediatric nurse you never have just one patient, it is the whole family and sometimes extended family that you care for.

Naturally there is a whole spectrum of families who either contribute to the care of the patient or detract from it. Every participant shared a story of difficult social situations where the

focus had to be put on the adults instead of caring for the patient. Times when the nurse has to be the 'bad guy' and ask family members to leave or be the go between two parents who cannot come together to make decisions about care. Many stories where shared about parents who respond to the stress of being in the hospital by lashing out at nurses, firing them from care or going as far as accusing them of mistreating their child. There are times being this outlet for families is really hurtful. Brooke takes these events to heart and it can be hard to remember why she loves her job.

> *One of my patient parents accused me of withholding pain medication from her child and I actually was told that I couldn't take care of that patient anymore because the mom didn't like me. And then in another situation I had taken care of a patient for a very long time when he was a baby and had taught the mom how to take care of him at home. I had a really good relationship with the mom and on this one day he was just having he was having profuse diarrhea and got a horrible diaper rash and I had been in his room changing diaper at least every hour. And with three patients and I was running and hadn't taken a lunch I think I maybe peed once the entire shift and the mom came in and he had just happen to poop right before he just got there- and she laid into me 'I don't trust you' 'I don't trust taking care of my son'. Like 'I should have never left him here with you' and it was just like very personally attaching especially coming from someone that knew the kind of nurse I am and knew the kind of care I provide. And for her to say those things was so cutting. I was honesty pretty wrecked by it. Like just felt like I you know it's so hard when you feel like you do so much and then one thing goes wrong and it's like all the good stuff that you have done all the times that you have been there and all times you have done the best you possible could it doesn't matter and you know those situations just make me not want to keep doing this work- (crying)*

Compassion can have natural consequences

This emerging essential truth may be the most important aspect of nursing that leads to compassion fatigue. The natural consequences that occur when you choose to help another human being during their times of suffering. Caring for others is never a benign event. It doesn't matter if it is a positive or negative encounter, whatever the outcome the care effects both the patient and the nurse. Brooke talks about the suffering and emotional toll nurses experience and the cost when this side of the work is not recognized.

> *Suffering amongst staff and just feeling all of their burnout out. Feeling like they are just another number as opposed to a person, to someone who is giving a huge part of themselves to their work every single day and not necessarily being appreciated for that. And just them feeling like there is a part of you that literally doesn't have the emotional capacity sometimes to come back and do your job well. And I think that we suffer, and we make our patients suffer and make their families suffer when we are forced to come back and do that work and we are not in place to do it.*

This emotional burden of caring for pediatric patients cannot not be ignored and is best illustrated from the other stories the participant shared. June recounts what it is like to care for patients for years only to watch them lose their battle.

> *I have a CS* (Cystic Fibrous*) patient that died in January and I had been taking care of him since he was 9 years old. And he was now 19. And I would make an effort to go to his room just to talk to him about things. He wanted to do everything and wanted to keep going. And he finally came to the realization that that wasn't for him. But I wanted to give up myself to help make this process easier for him. I guess by showing the families that I care for them and that I'm there for them so that they can have a person that they can talk to if it's necessary that they need. I mean, I just give myself. Sometimes it's hard to. When you give your heart and your soul to these kids and their families—with the patient that I had that passed away, that was very difficult on me just because I had known him for so long. And these teenagers are getting to the point where they have to start making their own decisions about their care and what they want to do. So it's kind of giving it, like I said, my whole heart and soul for those kids.*

Maddie recounts how her heart breaks for a child that has already been through too much trauma and she has to fight for others to pay attention to this child's suffering.

> *This two-year-old—this one's really fresh, so I'm sorry. Oh, she needed—she had Ativan because she was withdrawing from drugs. She came in positive for meth, cocaine, and Ecstasy, from dad's house, supposedly. And so, she wasn't comfortable. Withdrawal is not comfortable. We have no idea how long she's been exposed to these drugs, no idea. And yes, they're fast-acting drugs, they're out of your system pretty quickly, but she's going to want them for however long, she's going to crave that. We don't know how long she'll crave that. And they just they discontinued the Ativan. And then 1:00 AM, she needs it. She's screaming and hurting herself and hitting like a 2-year-old demented child, losing her mind. And they're trying to fix her IV, and she's hitting herself and she's biting herself and she is scratching. We ended up having to put her in a therapeutic hold thing. We wrapped her in a blanket, and the nurse was holding her and talking to her and slowing her down. There was also concern for sexual abuse. So, I look at the doctor and I said, "Can we do some intranasal Versed, at the very least?" And he's like, "Well, we just did Ativan." I said, "I get that, but if she's abused at home, we are re-traumatizing her right now. Because if she is sexually abused, I guarantee you she's held down, and we're doing that to her right now." And he goes, "Oh,*

you're right." I guess dad was getting looked at for trafficking. So, I guarantee you he's either drugging her or holding her down for these acts, if it's going on, which we don't know. But I'd rather err on the side of caution. I don't care if mom's abusing this child or not. I'd rather err on the side of caution, because she is the most important person in this room right now. Not her, not me. That kid is. So how do you do that? Because you hold the weight of the world as a nurse.

Jade tells how hard it is to release the children back out into the world when she is not sure what challenges they will have to face and has no control over how this child will live.

I had a primary patient where I was involved in a lot of things trying to get them home, and social work got involved and DHS got involved. It was a real struggle for me because I saw both sides. They were good people trying to take care of their kid or wanted to, but there were mental health issues with mom and cleanliness that was a problem. And then there's just weird things that people weren't sure she's actually feeding him what she said she was. And then he went home with them. I was worried about—I know that they love him. I saw it. But I was worried that he is not going to get the attention that he needs because he's behind milestones. I just can see him just sitting there at home. And yes, maybe they're feeding him and they're doing what he needs for cares, but I just I'm afraid that he'll be stunted because they don't have the resources. But ultimately, the decision was made. So that's the hard part about being a pediatric nurse. I know that I'm thinking about him is when I had dreams about him. And actually, I had an awful dream, where he died. And I went to work and say, "Oh, my gosh. I had a dream that he died." And I think that that's me working through my fears of what's going to happen if he goes home and they don't take care of him.

Brooke shares about experiencing guilt of helping patients who diagnosis slowly takes away their autonomy and there is nothing she can do to help.

One of our patients is been with us for a very long time and he has SMA so he can't really move any part of his body but neurologically he is totally normal. And he just has a horrible life and it's just hard. Every time I take care of him I just feel like everything that I do I feel guilty about. Because he can't do any of it and I feel I think about him a lot when I am at home just being able to go to the bathroom like a normal persona and being able to have a husband and be in a relationship and to have friends that I get go see all the time to be able to go on vacation. Every time I do those things I think about him and the fact that he can't anymore and it just I feel just heartbroken by his situation.

Zoe's talks about the slow death of one of her primary patients and the struggle she carries with her around his last moments.

> *I have had a few primary patients pass. Most notably this one was and will forever be my most difficult one. His was difficult just because he just lived on our floor for so long. And he was just love him and we just bonded so well with him. So (*pause for crying*) his families and they were just the sweetest people. Which also didn't help. We all knew it was coming, that's not the thing. And it's part of nursing. I was very mindful of that that this is part of my career. But it was hard. The process was very long term. I think we knew that his wishes were to pass on our unit and that it was coming to an end. We knew for 2 months or 3 months, so it was a long like waiting period and you just wait. And then you hear this is the weekend and then it doesn't happen. And so it was like a lot a like a rollercoaster. I was doing well with the whole thing but I'm the last person who got to see him awake. And that (*pause, talk through crying*) and his family wasn't thrilled and that's where I (*pause for crying*) I just always think about that moment when he fell asleep and didn't wake up. And he had so many good moments and his family did too and that's not it. It is just hard that I was the last one. It was hard to see his decline too. It was really hard to see him fall asleep for a day and then wake up. So that was really hard. I just really felt bad for the family because they were doing funeral arrangements and so they weren't there and …yeah.*

Pediatric nurses don't just hear about stories like these, they live them every day. And every single story that was shared felt like it had just happened to them even if months or years had passed. At times the participants noted that the world can forget that nurses are human to. With their own emotions, their own fears, their own grief and a desire and want to be back in control of all the outcomes. Each participant describes how this shadow side of compassion affects them. Some have developed ways to recovery while others can only report that they are aware that it causes distress but don't know what to do with it all of the time. Misty says she absorbs it all and then worries that she will breakdown at the wrong moment. Her practice of always coming back to her purpose on this earth help her refocus but even that doesn't take the pain away. Bradford tries to control the "*valve of investment"* he puts into each patient, so he has enough for all of them. Esther wisely knows that when she is not managing it well, she can trigger more anxiety in her patients. She knows that as a human she is going to asks the same 'why' questions. She also shared that at the same time she desperately needs her patients to be

happy as if it was some measure of her worth, or lack of, if they are still suffering on her watch. Jade knows this job can make her sad and as a positive person feeling sad translates into misery for her. Art says it shows up in tangible ways with him. He notices that both at home and work he is less patient, does more talking and less listening, and can get easily annoyed when the demand for care is constant. Brooke cries and thinks about her patients constantly. Maddie gets angry and vents until she can let go of the frustration or at least take the edge off. Zoe takes long breaks and never lets her vacation time pile up. June talks it over with her peers so that she is not shouldering all of the burden. She also makes sure to show up for her colleagues in this manner. Shannon just keeps coming back and *"has another go at it"* with the hopes that there will be something that next shift that fills her back up.

Summary of Essential Truths

What emerged from the participants as the essential truths reflect a profession that has huge responsibilities place on its shoulders. These also speak to the heart and dedication nurses have to be the best possible compassionate care giver they can be. It matters to them that they go beyond the promise to 'do no harm' and carry out their covenant with the world to care for each person they are called to serve. This is illustrated time and time again in the collective truths that compassion is more than caring, nursing is a sacred calling, pediatrics nursing is unique and devoting themselves to compassion has some natural consequences.

Emergence of barriers to compassion satisfaction

Compassion satisfaction refers to the gratification nurses feel when caring for others stays in balance allowing the nurse to embody the positive aspects of altruism (Meyer, Li, Klaristenfeld, & Gold, 2015; Berger et al., 2015). The participants in this study had clarity around what contributes to their ability to have balanced care and what blocks it. Poignantly they

shared both internal and external contributors and barriers highlighting their ability to reflect on their past from both inside and outside of the experiences.

External Barriers

To illustrate barriers, it is important to give attention to some of the known common factors nurses' historically report as barriers to their jobs. Literature clearly outlines the perceived lack of time, high acuity patient load, hierarchy in healthcare, poor recognition and lack of autonomy as stressors for nurses (Cricco-Lizza, 2014; Drury et al., 2013; Gardling et al., 2015; Huang et al., 2014; Maytum et al., 2004; McConnell & Porter, 2017; Morrison & Morris, 2017; Shimoinaba et al., 2015 Stayer & Lockhart, 2016). The participants reported each of these in their interviews as well as some new insights.

There are significant amounts of tasks these nurses have to attend to for each patient and each shift they have to balance between what is required and checked off for the shift and what their patients' needs are. Staffing, acuity, experience level, relationships with other medical peers all make or break a nursing shift. They reported that the endless charting that is 'never going away' seems to be where organizations put their focus on and takes more and more time. There is a collective sense that as more and more is asked of them without the balance of taking anything away. It is always more to do, more to chart, more evidence to consider. Jade illustrates this here:

> *There is always a 'now you have to do this every shift'. I'm not saying that those are even wrong but it's like each time we come back to respiratory season there's new evidence on that we should actually be doing this, and it just adds more and more to what we've already been doing. They never take anything away or give us more staff. I feel like it's less employees but more work.*

Time is also on all of the participants minds. It takes time to care, be present, do the things that make them feel like they are being a good nurse. Shannon craves have the time to

connect with the children in her care. To keep from making a joyous event like taking a bath and splashing in the water, to a mundane check on a check list. This may seem like not a big deal to others, but these pediatric nurses who care for chronic long-term patients know that taking away play from their patients' lives will have lifelong effects. Many recounted that development, playtime, and the mental health of their patients are their top nursing priority for pediatric patients. This is something they think about, worry and about and just can't accept as a non-medical issue. Brooke recalls a time when nurses were being asked to function at the 'top of their scope' which put task that were deemed mundane cares, like baths, out of the nurse's responsibilities. This is how that felt to Brooke:

> *You know I think if by the end of the day I have given my patient bathes put them all in new clothes done their hair done tummy time or done rolling or crawling. I would consider that a successful day for me. So a few years back we had to start with this new care model where we were supposed to delicate far more task to our Clinical assistants then we previously were. And I think that that transition of having to give over parts of patient care that I feel like matter to me as person, and not just as a nurse but they matter to me as a person and they matter to my resiliency I was being forced to hand those over to someone else and it felt like I was actually being limited from providing the care, the only way I knew how to provide true patient care. It felt like that was being taken away from me and I was being micromanaged on how I can be a nurse and it had to I literally felt like I was a member of an assembly line just passing by patient's rooms and not actively being involved in their care and building a relationship with them but just giving them medications and doing the necessary procedures I had to follow what was ordered and shipped them out of the hospital and it just completely made it …it was empty for me.*

Who you work with can also make or break the shift. If you trust your fellow nurses and know the providers on respect you and will listen to you, it makes all the difference. Shannon knows the moment she walks in and sees who the fellow nurses are if this is going to be a good shift or a rough one. Trusting each other, having each other's back, not allowing your fellow nurse to drown all matter to these participants. This is most important when there are busy times that coincide with poor staffing ratios. The participants report that the environment changes when nurses feel like they can't keep up and begin to go into survival mode on their own,

decreasing teamwork and causing tension between nurses. Art articulates that this is a common problem on his unit. He says the when one nurse gets overwhelmed and isolates themselves it affects everyone else as *"busy can spread like a cold".*

Being trusted and allowed to feel supported as you prioritize the patient's needs, is another key component of a good shift where compassion satisfaction flows. This goes beyond the nursing staff and speaks to the multitude of professionals who work together to determine a single patient's care plan. Zoe sees advocating for her patients as on top of caring and empathy "*I just think advocacy*". She believes that it is often pride that gets in the way and has had to remind providers that it should only be about the goal of the patient. Esther knows what it is like to have to advocate for patients needs with providers who as she describes is are "*so far removed from the bedside and inundated with bureaucracy that common sense and care are misplaced."* At times like this she has to go into "*advocate mode"* where her time is spent not caring for the patient but arguing about what is the right thing to do.

> *(*Advocacy*) It's a big part of our job because we're at the bedside with them. We're the ones who're with them. The docs come in, the residents. They do rounds you have to be speaking to them. I don't like power and things like that but I'm like, "No, that does not make any sense. And no, that's not the way this is going to be." I don't turn around and walk away. It's interesting that sometimes the higher up the rungs you go, the more likely you are to come to a person that says, "No, That's ridiculous. That can't happen. This needs to happen." Maybe because they have a bigger picture and they're not in the day-to-day having to do things, I have to say "Oh, no, no. That's not the way it's supposed to be.". So most of the time I was taking care of this patient, I spent seven and a half hours trying to make sure, in the way that I can make sure, that she was getting the care she needed. But what it does is that that detracts from my attention on the patient.*

Another barrier that emerged from the participants' multiple realities, is dealing with the incivility. Becoming the outlet for patients and families stress has already been touched on but the multiple stories that were shared bring this to the level of an essential truth for these nurses. When you ask Art about the barriers to compassion satisfaction, he says *"it is not the medical*

side of things, it's the life part." At times there is palpable amounts of stress in the room as the patient and family cope with whatever the medical event is. Art was one time 'fired' by a family who refused to offer any reasoning behind the request. He thought about this for weeks until they finally approached him and explained the stress had gotten to them and then asked him to become a primary nurse for their son. Since the nurse spend the majority of their time in the patient room, they are there when this stress bubbles over. Jade says "*we're the ones that take the brunt of negative energy, sometimes, when people are frustrated. We're the ones that are there, so we're quickest hit. That backlash I think".* A tangible example of this burden lives in Zoe's recount of the most difficult code situation she had to manage.

> *For example, our code on Sunday. This patient plugged- a trach patient. They had to do compression for less than two minutes. During the code. While nursing is doing compressions on this patient. The mother is screaming at nursing. Screaming at staff that no one was responding to her call light. We did a full review and it was like a ten second response time. But that was her perception. Its already a difficult social situation. The anxiety levels are already so high in that room but during the code as they are trying to say a life, and she is screaming at staff "YOU DID NOT RESPOND".*

Brooke has had her fair share of 'taking the brunt' of angry parents.

> *I feel like families are actually the hardest part of being a pediatric nurse. There are families that I think that just struggle and don't know how to, don't have a healthy outlet for all that they are having to take in every single day. The stress the pain and the burden of it. Unfortunately, we have to be that outlet for families and sometimes they can be really hurtful. We constantly have to tell ourselves that it's not about me… it's not about me. But sometimes you know when you hear something enough or you are treated one way enough you start to sometimes allow yourselves to start to think those things. A lot of us have experienced a lot of emotional abuse from parents and sometimes even scary you know. I think that that is something really hard and really draining.*

Internal Barriers

The idea that the barriers to compassion fatigue can also come from an internal struggle faced by nursing is new and groundbreaking. As these participants shared their experiences and were asked to go deeper, they were able to beautifully reflect on their own humanity and when

they found themselves getting in their own way of the flow of compassion. These participants pulled back their own veils and shared what I believe are revealing truths that need to be normalized in nursing. It is in these essential truths that emerged where other nurses will find themselves reflected and honored and as a whole so we can begin to destigmatize the hurt of nursing so it can begin to heal.

To open, let's be reminded of Art who says that as a nurse, every interaction with a patient is a choice point. He asks himself "*will I bring compassion and care to this moment or will another part of me take over and bring emotions and actions that decrease compassion and care?*" He doesn't discount the energy and presence required to make the right choices. He doesn't dishonor the complexities of working with others in suffering and despair that make it sometimes impossible to choose compassion. He does however, honor nursing as a profession that has an innate calling to make this choice. He also knows from personal experience the pain caused when the negative emotions win. Here is how he describes it and the cost when this choice is disregarded

> *I hate to call it emotion, because it's not an emotion. It's like love. Love is there, but to love something or to love someone, that is a choice to do that. And so I think that as a human, you have compassion in you, but it's a choice to be compassionate to a stranger, and it's a choice to be compassionate to a family who you may or may not agree with or don't see eye-to-eye with whatever view they may have. But it's a choice to love and care for and take care of that patient and family. So I think that compassion is innate in all of us, that it is a choice to care for somebody for who's not related to you. Or a stranger. Compassion is just—it's in there. It's just if you didn't feel like you could do this, you wouldn't do it. And then for some people, you don't reach that point until after you get your job. And then you're like, "This is not what I signed on for". Then it becomes a burden and you can't make that choice so easily. (*When this happened to me*) I was behaving differently. I was not nearly as patient. I was not nearly as—I was much more—I was quicker to speak than I was to listen. And, yeah, that was rough.*

Falling into task mode is another trap that these nurses talked about as in internal struggle. Misty is especially hard on herself when she finds that she has let the ever-present to-do

list color her interactions with her patients. She can tell because she doesn't take the time to make eye contact or ask questions that are meaningful to the patient's experience. She gets out of rhythm with them and forgets about the dance and who she is and meant to be. Notice how she describes this experience and the way she has to immediately remedy it because of the meaning behind how she feels when it happens.

> *I think you tend to feel cold sometimes. The lack of compassion when you're wearing your time of restraint. Patients say it like this "They'll come in here, they'll slap on the blood pressure cuff and they put me on a monitor, and they don't even seem to make eye contact with me. And blah, blah, blah" So that's an issue that has happened to me and I feel there's a part of me that feels guilty. I feel like I'm doing a disservice. So yeah, I feel guilty. Yeah. Because whenever I feel like I'm about—whenever I get to that point where I think I'm going to I feel like I'm doing a disservice I make eye contact. And I'll even say-"Sorry." And then I'll do what I have to do in that room but while I'm doing that stuff, then that's when I talk to them. I'll ask them simple questions that we'll get them to open up. I talked about how it must be tough for them being hospitalized. But I try to make the most of my time with them because again, yeah, this feeling, that whole guilty part, of having that connection—yeah. I'm hugger. But I know you can't hug all your patients. But I just feel like—I'm one of those that I just feel like I need to connect them.*

Jade also gets frustrated when the tasks take over.

> *There's a lot of tasks, and that's part of the reason why it's hard to be a nurse too. Because you're trying to be all these things that—you have to document, you have to do this, you have to do this. But then, the main reason why I became a nurse is I want to do it for the patient; I want to be there for the family. And that's what's heartbreaking about nursing, is that you have so many things you have to do in your 12 hours that sometimes, the thing that gets dropped is the patient care, which is why I went into it. Because of the patient care.*

The gravity of what a nurse does and experience each shift is mind boggling to most other professions. In a typical shift a nurse will interactive with a lot of the physical anatomy of their patients. This means exposure to fluids, blood, secretions, excrement. It means physically touching another human being to assess, gather information, examination and at times cause pain by doing procedures like IV starts, lab draws, suctioning, wound care. Nurses are granted access

to their patient's physical bodies in exceptional ways. In pediatrics this is even more true as the child does not have as much autonomy that an adult might be afforded. This gravity is not taken lightly by the participants in this study. They feel how daunting their responsibilities are and often hold themselves to a very high standard of bringing dignity and respect to their patients in these moments. The enormity of this pressure for these participants resonates in how hard they are on themselves when they make mistakes. It haunts them, showing up in their day to day lives even when they are not at work. It can seep into their dreams and affect their ability to function. In the interviews, it presented itself as an ever-present self-critic that is hard to ignore. Esther sets a high bar for herself as a nurse. She wants to be perfect and sees this as a bioproduct of caring. "*The more you care, the harder you are on yourself and the more self-doubt you will have*". Both Esther and Art recognize they are the last people to forgive themselves and it weighs them down emotionally. When nurses like Jade are worrying about her patients at home it is often tied to wondering if she did enough for them. As a new graduate nurse, she cried a lot when she fell short of perfect. Misty remembers mistakes she made like they just happened even when some of them are ten years ago. Here, Bradford revealed how his self-critic shows up:

> *"A lot of second guessing of like, I was so focused on "What did I miss? What's the whole picture that really should've been considered in and how did I deviate from the best care that could've been provided for them tonight." And a lot of going in hand with that of, I guess, comparing yourself to like a theoretical—imaginary standard of like, " What does this say about you as a care provider?" I've found myself hold onto it. It would be stuff that I would hold onto for a while. And it accumulates. "Remember six months ago when you did this wrong?" And it can be something completely unrelated. But then a screw up happens here, and you're like, "Oh. Yeah." You just review this imaginary employee record you have of all the screwups you've made. And I really am a horrible care provider and a horrible human being."*

The list continues of the internal struggles that these nurses expressed. Not knowing what they don't know causes anxiety. They are always in learner mode which can keep the role interesting but never allows them to feel like they are on solid ground. As Art describes it "*you*

never fully arrive at nursing because every patient is different". Not knowing is one thing, not having control is another internal stress for these nurses. Outcomes are not seamless; medicine is not a perfect science and as caring nurses; they want to be in control over the uncontrollable.

There are also times when being a human as a nurse detracts from compassion. It is natural for humans to judge others or get caught up in ego driven notions like righteousness or misplaced blame. Esther remarks that she knows this affects her ability to be compassionate and states *"if I judge, I am lost and that balls rolls up hill quickly".* Bradford is also sensitive to times when nurse use judgement as a way to process and cope in the moment, but worries is can carry over into nurses' interactions at the bedside. He reflects

> *"Nurses see some incredible stuff that you just become desensitized to over time. And it can lead to a little… a gradation of jadedness. I think, the majority of people, it's more just like a kind of unintentional stigma that people can default in as kind of a way to process and to kind of laugh about. We get kind of a lack of empathy for this population and think like, "Oh, they're just druggies, and stuff like that"*

Beyond the prevalent self-critic, these nurses noted they also have their own baggage from life that they can consciously or unconsciously bring into the bedside with them. They feel the same emotions that their patients and families do and at times also lose hope and question what the point of caring is all about. The heaviness of the role takes its toll at times and they just need a break from the life and death weight of their job. When Bradford wants to release that pressure, he asks an important question "*does this moment have to always mean everything. Does it have to be tied to my soul or can I just do a good job today?*".

Emergence of contributors to compassion satisfaction

So far, the picture that has been painted is one of an incredibly serious careers filled with daunting responsibilities and extreme amounts of pressure and stress. One might question why anyone stay in a role that looks like this on paper? If you ask the participants just that, they often

chuckle and then say over and over that they love their jobs. They can't imagine doing anything else. Maybe it is because nurse are a different kind of breed that thrive on pressure and find comfort in playing a self-effacing martyr. These participants would tell you different, because for every hard aspect of being a nurse, there are moment of pure joy, of deep pride and of honor that keeps them both grounded in who they are and connected to a boundless pursuit of caring. They each speak of seeking a balance between the difficult and amazing. Between the hardship and joy. Essential truths began to emerge when asked to share how what contributes to their flow of compassion satisfaction.

External Contributors

As the spoke of the little things making a big difference in their patient lives, these nurses also reflected that it is the little things that keep them going. A note from a patient, a smile or laugh that they are able to illicit. A hug from a patient who is returning to the floor just to show off how well they are doing. Art talks about a moment seared on his heart when a past patient visited and as soon as he recognized it was him, he began running down into his arms yelling "ART…ART".

Being recognized by other team members is also a source of energy. Brooke figured out that when her patient with downs syndrome would desaturate, it was better to teach him to put on his oxygen by himself instead of running in the room which always made it worse. She was honored by the providers and peers for knowing him well enough to figure this out.

Looking for overt ways to create joy also struck a chord with the participants. Counter balancing stress by having patient centric singing and dancing parties, nail painting parties, syringe water fights or choosing to laugh at predicaments rather than be drained by them. That

same patient that Brooke cared for would at times cover himself in crayons and think it was the funniest thing ever. She always remembered to laugh along with him.

Internal Contributors

Looking inward for what contributes to an increase in compassion satisfaction, these nurses again put me in awe of the depths they considered prior to answering. A lot of it came down to knowing what feeds your soul. There is no way to generalize the specifics each participant shared because it is how they uniquely interpret their interaction with the world of nursing. For Esther, Shannon and Brooke it them meant spending more time at the hospital, being on committees and working to change big picture issues. For others like Jade and Zoe it was honoring the space between work and home and ensuring they had plenty of away time to recovery enough, so they want to return. Esther and Misty know they must let their creative side find expression. Singing, art, creating, all connect them to something greater than themselves and fill their cups. For nurses like June it is about being in community and drawing on collective healing to find peace. They do all agree that knowing what feeds your soul is directly related to your capacity to be the best nurse possible. Art figured it out when he was at a low place and drained to the point, he wasn't sure he could come back. For him it was actively spending time with his friends and reconnecting to his faith. It changed his compassion levels so much that he now tells every new nurse to take the time to decide what their soul needs first before they hit their own wall:

> *Oh my gosh, you, like with anything in life, if you're basic needs aren't being met, you're not going to be able to have that all flow. You just can't. And that's something that I always tell students that I work with, new hires that I—especially new grads who this is their first job right out of school. I'm like, "You got to figure out something that feeds your soul. And whatever that means for you because you're going to have choices that are healthy and not healthy and you better find something that is going to feed your soul and going to allow you to be happy because if not, you are not going to survive here." Because guts and "I want to" is going to only take you so far. And then when you run*

> *into a situation where rubber meets the road and it's like, or you're at a crossroads, and you're like, "Do I really want to keep doing this?" You better have something in place. Otherwise, that crossroads is going to come a lot sooner than you want.*

Beyond feeding your soul, these nurses collectively shared multiple realities around not just knowing their purpose but nurturing it. Misty knows when she centers and breathes before entering a room, she is much more likely to be able to read the energy field and begin that dance with her patients. She knows her purpose on earth is to be a healer and she nurtures this by exuding presence in a moment. Esther knows her purpose on earth is to stay in relationship with her patients, so she nurtures this by being open to what they need in the moment. This requires sensitivity, care, asking for help, and often personal vulnerability. Esther talks about the moment she figured out that being vulnerable with your patients doesn't drain you of energy, it actually increases your capacity for compassion. She knows "*It's not the care that drains us*". Jade believes her very nature is to be kind and offer compassion, so nursing is a natural expression of her purpose. Art simply nurtures his purpose by remembering the why behind what he does. He takes moments of stress and despair and infuses dignity, kindness and respect to make hard situations the best that they can be. Brooke believes the divine guided her to pediatric nursing. She spends her time nurturing this purpose by accepting her abilities as gifts from above and not arguing with how they are used to improve children's lives. Zoe knew from an early age that she was preoccupied with caring for others. She knows it is rare to know as a child you are meant to be something and never takes for granted what comes from deep within her roots.

Summary of findings

In any profession there are going to be both barriers and contributors to thriving in a role. For these nurses they were able to articulate the specific entities that either filled their cup up or drained them of their energy. The ability to look at both external factors is one thing, but to get

so introspective and honest about the internal features was extraordinary to observe. Externally, these nurses confirmed that common barriers like time, staffing, patient acuity, teamwork, respect and incivility detract them from experiencing compassion satisfaction. The externally contributors for compassion that emerged also validated what the literature has found with other nurses. Recognition, being thanked, respected from peers, finding joy all helped these nurses build compassion satisfaction. The internal barriers and contributors is not found in most studies I read about compassion fatigue and compassion satisfaction. These participants thankfully showed up in their own vulnerabilities and deeply shared what it feels like in moments of compassion. The internal barriers are wide ranged and very human. They feel empowered that they can make a choice to be compassion for another person but also feel the pressure and heaviness of wanting to always be perfect at it. They have strong self-critics that keep track of each failure or missed opportunity to connect and be kind to their patients and families. They do this in the venue of medicine that is not a perfect science so there is a lack of control of the outcomes and an ever-present burden that you will never really know the complications that may emerge. They also choose to do all of this while working with children whose lives have just begun which makes them more precious and extraordinarily more vulnerable. The internal contributors to compassion satisfaction interestingly fall into two main buckets. Figure out what feeds your soul so that you can facilitate your own recover and always remember to appreciate and nurture your unique purpose as a nurse. It is focusing on these internal things that captivates me. Imagine if each nurse had a practice that centered on evolving and nurturing their internal persona to see how much that might shape their external experiences. I will explore these possibilities in the discussion section.

CHAPTER V

DISCUSSION

There have been studies that measure the effect of caring on the patient and studies that look at how the lack of caring in environments creates a toxic environment. There have been countless studies on compassion fatigue in medical professions. Burn out, secondary trauma, moral distress are now common phenomenon's studied in healthcare. We know that nurses' stress has risen to the level of Post-Traumatic Stress Disorder (Mealer 2014). How healthcare has failed to honor the unique role that nurses play within the complex medical system. We also know studies can show that organizations have had success with wellness programs that focus on the physical and mental health of their employees. There are many on how self-care practices can help with compassion fatigue and burn out. What I believe is still missing is support for the nurses as humans doing extraordinary work. To support them as they experience the internal struggles that are often not talked about or deemed too personal to shed light on. It is within these complex but common factors that I believe Caring Science can bring attention and healing to.

Phenomenological studies allow us to see the experiences of others and determine if we can see ourselves within their meaning. This study set out to not just hear the narratives of pediatric nurses but to seek what the experiences meant to the participant. What emerged where common meanings from multiple perspectives and realities. I would now like to discuss how the essential truths that emerged relate to and can be informed by looking at them through the lens of the theory of Caring Science. As I listened to and later delved into these nurse's narrative it became apparent that many of the essential truths they experience are reflected in and informed by the essential truths of Caring Science.

Essential Truths of Caring Science

The core tenants of Caring Science live within the relationship between the nurse and the patient. Jean Watson has spent her life's work understand the ontological nature of caring as a relational event between two individuals and their shared humanity in that given moment. Dr. Watson describes the fabric of these caring moments as a vibrational experience felt within the soul of each person. This is reflected in the stories the participants shared of deep connections and empathy felt by the nurses. This can explain why these nurses tie their self-worth to how their patients feel and why they so vehemently advocate for their patients and families. Other essential truths within Caring Science can help illuminate the meaning discovered in this study and also offer a new way of attending to the needs of these nurses as they continue to be and become the nurses they are meant to be.

Sacredness of Nursing

To begin connecting Caring Science to the findings in this study it is first and foremost important to understand how Dr. Watson honors nursing. As a nurse, she understands the uniqueness of what happens between a nurse and patient. The covenant that nursing has with the world to see beyond a diagnosis and care for the spirit-filled person that the universe has place in their hands. Watson speaks to these complexities by not shying away from the emotional and sacredness of this promise. Watson also recognizes that nursing is one of the few professions in healthcare that actually touch their patients. In fact, a nurse might be the only one who touches that person their entire stay. Watson reminds nurses that this is one of the greatest gifts and privileges nurses have. In the Philosophy and Science of Caring (2008) she states, "such personally, intimate connections touch on the Holy as well as horrific at times" (p. 143). She

honors nursing by calling out that even the smallest of cares, when accompanied with love become sacred acts.

Nurses love their patients, and it is a disservice to the profession to say otherwise. How else do you explain Zoe's concerned about who was the last one to see her favorite patient awake or Brooke's ability to see the humanity in her downs patient who she empowered to see his own strengths? What about each participant who shared how they cared so much about their patients that they think about them outside of work and often dream about them? Braford sees his job as literally coming into a room and taking away his patients fear and anxiety. Even within their suffering you can see love. Shannon refuses to give up and keeps coming back to do better and protect more children. These are all expressions of love and by speaking the truth of what nursing really is, Jean Watson honors the complexities of the nursing discipline and its caring professionals.

Ethics of Caring Using Transpersonal Relationships

Another layer Caring science offers to honor nursing is the proponents found within Dr. Watson understanding around the ethics of caring. Watson intentionally writes about the perspective of Knud Logstrup who calls for a practice to be and become more human and humane with each other as an ethical demand and true pathway to be in service to another (Logstrup, 1997). Watson expands these ideas into the principles of human dignity that helps the patient determines their own self-worth, allows them to heal and, ultimately informs their personal attitude towards health and wellness (Watson, 2003; Watson, 2005; Watson, 2008). These ethical practices are rooted in what Logstrup calls a 'radical demand' based on his key understandings of humanity (Logstrup, 1997). Logstrup contends that life is a gift, that every interaction with another person affects them either positively or negatively, and we must always

take care of the life that trust has placed in our path (Logstrup, 1997). Watson speaks to this ethic when she teaches how we both teach and learn from our patients:

> *We learn from one another how to be human by identifying our self with other, finding their dilemma in ourselves. What we all learn from this is self-knowledge. The self we learn about…is every self. It is universal human self. We learn to recognize ourselves in others. It keeps alive our common humanity and avoids reducing self or other to the moral status of object" (Watson, 2008 p. 81)*

The nurses in this study collectively understand these concepts. Art talked about providing dignity to his patients and families as a starting point in the relationship. Others regarded the quality of life their patients experienced and the most important goal they advocated for. Caring Science offers even more room to expand the ethic of care for the participants by including self within this ethical demand and not reducing self as Watson describes above to the moral status of an object.

Another lens to understand dignity to self and other is the use of what Watson calls the transpersonal caring moment. This is really the cornerstone of Caring Science as it describes a relational care that allows both the nurse and the patient to reach a higher level of consciousness and therefore a higher degree of harmony and healing (Norman, et al, 2016; Falk-Rafael, 2000; Watson 2005; Watson 2008). Watson (2002) believes transpersonal care requires the nurse to understand both compassion, and empathy as they read the energy field of another, and co-create a healing environment (Caruso, 2008; Normal et al., 2016; Watson & Smith, 2002).Watson predicts using transpersonal care techniques allows the nurse to go beyond creating healing environments and essentially become the healing environment (Norman et al, 2016; Swanson & Wojnar, 2004; Watson, 2002; Watson 2008). This practice could help shift many of the draining experiences the nurses in this study shared. When Zoe thinks back to spending the last moments with her patient, if she shifts her guilt to understand that her presence and love for him may have

been the reason he was able to let go and die then it is no longer a burden that is was her, it was meant to be. She was the healing environment he needed in that moment.

Watson understands that most of the time in healthcare, the patients and families are overflowing with stress. Watson has used Parker Palmer illustration of this as he describes how all humans are standing in a tragic gap between what they want and what their reality is presenting (Parker, 2004). The humans in this gap are dealing with a breaking heart that can either break apart or break open to create more space for growth. Working with this imagine Caring Science attends that nurses have to stand in this gap with their patients and families in order to be fully present and intentional. A Caritas nurse understands that there are choices in this space. A Caritas nurse has learned that by sustaining compassion for the other person, the nurse is actually sustaining compassion for self at the same time. What we give the other we also gain. So, the only logical choice is to expand the amount of compassion, care, or peace in the moment. To infuse it within yourself and beyond so that its fills the environment. In this way the truly compassionate choice for everyone is for the nurse to be present to the suffering, see how the heart is breaking, and create opportunities for the heart to break open rather than into a million pieces. No small task when the gap is filled with anger, fear and frustration that often attaches to the nurse. We heard story after story of how incivility and anger reach the nurses in this study. We also heard stories of frustration when others could not feel what the patient needed in the moment. Maddie's frustration for the little girl who was forced to withdraw from drugs without medication to ease her suffering was a reflection of the suffering she shared with that patient. She not only imagine this child being held down in trauma she could sense that the medical team was causing just as much suffering. She put herself in that little girls' consciousness and the pain was intolerable. This led her to advocate and fight to bring peace to

the child, but also to herself. This was a transpersonal moment for Maddie and one that with knowledge of Caring Science could offer understanding of why she felt that child's pain so deeply and how in that moment she honored both the patient and her by attending to the pain. She invited dignity and compassion and introduced authentic healing for everyone involved.

Transpersonal moments of care can happen unconsciously when there is care between a nurse and a patient. It is when we build them into a conscious practice that every moment with a patient has potential to be more meaningful, healing and life-giving for the patient *and* the nurse. To begin developing this practice, Watson would start by making sure each participant had a practice of self-care. Often nurses need to be reminded that taking care of yourself physically, mentally, emotionally and spiritually, is not selfish but in fact a key component of being able to care for others. Watson reminds care providers that they have to pull what they need from an internal source, and if that source is empty, it is impossible to meet the radical demands of nursing. Then Watson would ask each participant to imagine what dignity looks like and feels like for themselves. This practice of self-awareness connects each nurse to a practice that invites a deeper connection to the heart and gives them the energy they will need to be in these environments. The participants will understand this connection the next time they are in a space where blame, anger, frustration are the prevailing emotions, but they are able to stand their ground and shift the environment back towards compassion. This in no way means to take the brunt of violence, it means staying intact within their limitations and creating the space the other human needs to invite a different response to the suffering. Every nurse in this study shared a story that reflected holding space for their patients even when it was hard. Caring Science honors that and offers a way to not let it drain the nurse but rather using the understanding of dignity and

the skills of transpersonal relationship to make this a moment of self-confidence and renewal for the nurse.

Compassion as a consciousness

The nurses in this study looked to the ways compassion helped define how they care for their patients. It includes empathy and hope but is moved into action through tangible forms of care and compassion. These include supporting the body physically and expertly carrying out the medical care plan. For the participants is also included education, listening, advocating, and being wholeheartedly present with the patient and family. Caring Science offers the next step for an evolving compassionate care by seeing compassion as a consciousness. A deeper practice of compassion by being in tune with everything contained within an environment and co-creating a space where the best parts of humanity can find expression. Love, hope, forgiveness, peace are all basic needs of humans. By cultivating compassion for self and other in a moment, a nurse gives access to these emotions regardless of what is happening. Many of the nurses were already consciously or unconsciously practicing in this way. Misty talked about taking breaths and centering before entering a room. She paid attention to the environment to see how she was showing up within it and to course correct when she found herself being cold or disconnected. Esther knew what to say to the mother who just lost her child when she leaned in and told her it wasn't her fault. She allowed herself to be present to her own vulnerability in order to truly understand what that mother's heart needed to hear. These are beautiful examples of how compassion as a consciousness serves the patients and the families but also connects the nurse to who they want to be.

There is an opportunity to see how this intention may serve to help break through the barriers to compassion satisfaction. Cultivating compassion as a consciousness provides

knowledge about both self and other in a moment. Everyone has experienced compassion and can most likely draw up the positive feelings associated when being cared for. To cultivate it at the bedside Watson asks the nurse to build an awareness of how compassion feels in their body, so they know when it is missing. Dr. Watson also reminds nursing the power of connecting to your own basic needs in a moment, so you have enough as you co-create a healing environment with the patient or family. Slowing down to breathe. Pausing before acting. Taking a moment to reconnect to your heart. Remind yourself how you want this moment to unfold. All of these are micro-practices that can be done in any moment to reconnect the nurse to compassion. Taking a breath as Misty does is one. It meets the need of the physical body by providing oxygen, but it also meets the human need of a nurse who needs a moment to collect herself/himself before choosing what to do next. Art reminded us of how important that choice point is, and this micro-practice offers the space needed to be conscious about that choice. I would propose the times that the nurses talked about when they just did not think they had enough left to care would be altered if they began a practice of cultivating compassion as a consciousness for themselves. It might take the sting out of what the self-critic says. Practicing compassion for self as consciousness may help release some of the pressure Esther puts on herself to make every patient happy on her shifts. Remember she ties their emotional state to her own self-worth. As if she is less of a nurse, less of a person when she is not able to transform their suffering to a positive state. Consciously drawing in compassion into these thoughts will remind Esther that she is not meant to hold the whole world's suffering but rather called to be present to and hold space for another human. This allows for all emotions that her patients may need to feel in a moment. It gives permission for a patient to be sad or angry and honors that this is okay. Compassion as a consciousness offers nurses like Esther a practice to set down their own feelings of inadequacy and offers recognition

and praise for being the person who chooses to show up and help another person. This helps by bringing balance to the gravity and heaviness of pediatric nursing. It also increased the likelihood of being connected to purpose which Esther and the other participants highlighted as an essential nursing need.

Right Relation

Caring science doesn't ask you to change the world. It asks that you become who you are meant to be as a nurse and a healer, so you are capable to answer your calling when the world needs you. This capacity to offer care, compassion, love, peace is directly related to how in tune a nurse is to her own essential needs. Like Art reminded us, if you don't meet your own basic needs you will never feel like you have enough to give to others. Jean Watson approaches this by teaching nurses how to be in right relation with self-first. This means building an awareness of what a person uniquely needs to feel whole. It is a connection to values, beliefs about how to interpret the universe and a personal world view. It is an awareness and connection to something that is greater than self, whether that be a belief in a deity or that there is something greater that brings meaning to our time on earth. It is knowing and having access to a source that feeds the soul and fills a person's cups up with energy, love and passion to spare. Humans, in general, forget to build a practice of being in right relation with themselves. Nurses who crave caring for others have even more opportunity to build a practice for paying attention to themselves before they attend to another.

The participants in this study both reflect being in right relation and also demonstrate they need more of it. Brooke stands unflinchingly within her beliefs about the world and her connection to something greater than herself. Her process of being in right relation could mean greater understanding of the human part of her experience. Noticing when she is taking

something personally and it wrecks her self-worth and self-confidence. From a stance of right relation, she could begin to see that the other person in the equation is not currently in right relation with themselves. This allows awareness that the anger and blame is just an expression of being disconnected from their own source. This doesn't excuse the behavior, but it gives it space to not carry too much meaning.

Caring Science would remind nurses in these moments that being in right relations allows you to listen to both positive and negative expressions without taking them into your heart. Dr. Watson uses the term equanimity to build on this practice. Equanimity is the practice of finding balance in a given moment as to not get stuck in the negativity of them or conversely pretend everything is good. Watson links this practice in her first caritas process, practicing loving-kindness and equanimity for self and other within the context of caring consciousness (Watson, 2008). She states that equanimity is a "gentle acceptance of what is, without having to resist or avoid or alter what it is" (Watson, 2008 p.53). It is like being in the storm but not allowing the storm to be in you. This is not to minimize the moment or giving permission for its occurrence. What is does is allow the nurse a vast amount of space to hold all of the emotions in a moment. This way they can stay present, read the environment, quickly decide what they need to hold onto to, what is meant for then to own and begin to let go of what is not serving themselves or others in the space. Brooke may be able to use the practice of equanimity when she finds herself feeling sad for her patient with SMA who cannot do the normal daily activities that she can take for granted. Accepting that her life is different from his without guilt doesn't mean she is not empathetic or uncaring. It allows her to home in on not what she can't control but focusing on how to be present with him and accept his own path. Helping another accept their journey puts them in right relation and opens them up to hope and possibilities. I think hope

is the highest level of consciousness that nurses offer their patients. Art does this devotedly with his families as he gently walks them towards their new normal with new expectations and a different kind of joy.

It is notable to mention the idea of discovering your source. The participants shared how central feeding their souls was to their capacity to care. Jean Watson doesn't shy away from the ideas that humans draw on a source of universal love that both connects them to each other and creates a wholeness from within. I was inspired by these nurses who used their own language and understanding about what their source is and what it meant to them. Knowing source is essential for nurses but, as illustrated by the diversity of the participants reflections, this cannot be a prescriptive process. It is the internal process and feeling that as the participants gazed inward, they connected to. Caring Science would invite all nurse to look for their source. To make their invisible needs visible. To build a practice of knowing source and having access to it on a regular if not daily basis. I would argue it is what makes us whole and being whole means the chances of being depleted of compassion for self and other are significantly minimized. I do wonder if caring for others is one of a nurse's sources. The participants shared times that when they were who they were meant to be and could care intentionally and meaningfully for their patients, they left feeling closer to whole.

Summary of Discussion

Caring Science does not have all the answers to magically fix the complexities of being a nurse in a pediatric hospital. It cannot change acuities of patients or take away the inadequacies of medicine as an imperfect science. It does not attempt to minimize the pain and suffering of the experiences to create a false sense of 'just do this' and it will be easy. Caring Science begins by honoring all these intricacies and giving voice to deep connection the nurses have to be the best

care giver possible. It unabashedly reminds medical models that nurses offer expertise that no other part of healthcare understands or attempts to provide. Watson herself, draws on concepts like consciousness, oneness, vulnerability, dignity that at times seem intangible to modern medicine but are a perfect description of what a nurse does. She then freely imparts her comprehensive understand of human caring to provide a theoretical foundation that nurses can stand on as they work through the complexities of their roles. Most importantly Jean Watson presents a way to build a practice around these concepts so that every nurse has a path toward wholeness. In this discussion section these practices are outlined and related back to the experiences of the nurses in this study. They include honoring relational based care that invites love and transpersonal care to the bedside, an ethical foundation that honors dignity and compassion for both nurse and patient, and practices that bring in compassion as a consciousness, being in right relation with self, equanimity and loving kindness that celebrate the sacredness of the compassion nurses offer the world.

Implications for Nursing

The aim of this study is to understand the lived experience of pediatric nursing but what emerged are some implications that may serve every nurse. It starts with the two key presuppositions. First, we must agree that no nurse should suffer because they choose to care for others. Also, we must agree that no nurse should feel dehumanized because they find themselves unable to care anymore. What is offered here honors both of those beliefs and offers some tangible ways to minimize suffering for the nurse. The greatest thing about the use of Caring Science practices is they superimpose the role of the hospital. This is not to say that working in poorly run organization is not excruciating, but it does seek to minimize the effects on the nurse's relationship with the patient. A nurse can transform the inpatient environment towards

compassion despite the bureaucracy that occurs outside the room. A nurse doesn't need permission from her supervisor to radially accept a moment for what it is without bringing in the self-critic or shame. Being in right relation and connecting to a source are both meaningful practices that are personal and can begin without an organization's acquiescence

The practices within Caring Science are an offering to nurses. An invitation to examine a new way of being and becoming within a nursing practice. A way to build new patterns and possibilities towards flourishing as a nurse. If Jean Watson had interviewed these nurses, she would have bowed to honor everything they do and gently remind them that they deserve to be whole. She would have reminded each of them to be kinder to themselves. Permission to not heal the entire world because attempting that will simple break them. Rather she would ask them and all nurses to begin to heal themselves knowing that when nurses are healed, so is the world.

Implication for patients

The consequences for being out of right relation are apparent in our world today where anger, fear, separation and inequality are the predominate headlines in the news. The consequences for nursing affect not just the nurse but also every patient the nurse attempts to care for using an empty cup. The literature shares the risks of this type of nursing practice conveying the dehumanization of patients or the regression of a healing environment to a toxic environment void of healing potential (Halldorsdottir, 2008; Swanson, 1993). Compassion fatigue lives here as it is the inability to form nurturing relationships with patients. It is important to remember that compassion fatigue is also the suffering this inability causes the nurses. Nurses don't get into healthcare to harm others; they get in it to heal. They get in it to care. When they can no longer do this, it is just as painful for them as it is for the patient. Caring Science offers another path.

The implications for supporting the wholeness of nurses in healthcare are vast. It will increase the dignity offered to each patients and family. It will no longer tolerate any procedure that dehumanizes any more patients. The ripple effect will seep into every healthcare environment and create a space that is healing and filled with compassion. It will recognize and honor the unique contribution of the nurse by remembering that it is within the compassionate connection that healing occurs. It will encourage seeing each patient as a spirit filled human, beyond a diagnosis that requires personalized transpersonal care. The current medical model relies heavily on algorithms and standardized practices. While these are crucial to care we must also realize that an algorithm never healed a human spirit. It takes care, compassion and being in right relation to do this. Luckily this is where nurses excel.

Implications for Nursing Education

There is extensive education needed to prepare students to become register nurses. To understand how this research informs nursing education it is helpful to understand what a well-rounded nurse looks like. It is irrefutable that a new nurse needs a strong understanding of empirical knowledge of how the human body functions, the pathology of illness and effects of medical interventions. This scientific approach is where most nursing programs focus. This study showed that nurses need much more. A well-rounded nurse needs to be a well-balanced nurse. A nurse who has the ability to treat the whole person in front of them, understand the sacredness of helping another heal and has the capacity to offer compassion to each patient. It also includes an awareness of the emotional labor side of care and a nurse who has the knowledge and ability to develop practices that help deal with the staggering amount of emotion that comes with each moment of care.

Imagine if a nursing student, before ever walking into a patient room, had the knowledge of equanimity, understood compassion as a consciousness, knew how to practice being in right relation with self and others, and was able to provide dignity and care to each person. Caring Science informs each of these components and speaks to how to establish the foundation for this idyllic balanced nurse. It offers a theoretically road map for nursing that teaches how to be present, how to use all ways of knowing, how to be centered, authentic, and how to make transpersonal caring a gold standard of care. These give the nurse the specialized skills needed to attune to the uniqueness of the person they care for and allows them to treat the body, mind and spirit of their patients. To address the emotional labor of nursing, Caring Science honors the complexity of nursing and offers self-care practices that expand dignity and care for the nurse. It notably reminds nurses that self-care is not selfish, but instead essential to have the capacity to never fall out of relationship with their patients and families. Finally, learning Caring Science as a nursing student will give the new nurse a path to stay connected to why they were called to be a nurse so they can continually nurture their purpose as a healing professional.

Limitations

The scope of this study was limited to ten nurses from two free standing pediatric hospitals. Each nurse worked on an inpatient unit so does not speak to the experiences of nurses working in critical care units or emergency departments. Phenomenology calls not for generalization of information but to gather enough so that anyone who has also been a pediatric nurse on an inpatient unit can identifies themselves within the universal truths discovered. This therefore cannot be generalized to all of pediatrics nursing or all of nursing as a profession.

The extraordinary circumstances surrounding nursing's response to COVID 19 also is presented a limiting factor. The nurses in this time had limited time so a full in-person second

interview, which could have brought more depth to the content was not possible. Beyond the logistics of setting up these interviews, it was decided by the committee to not risk skewing the data. Each of these bedside nurses were immersed in the unprecedented stress of nursing during a world pandemic and that may have colored a second interview and changed the outcome.

Future Look

This study is meant to be a springboard for more research. We are at just the tip of the iceberg when it comes to understanding how intentional theory guided practices can inform new patterns in nursing. Many questions came to me while listening to and studying these narratives. Is caring for others an actual source for nurses that can be explored, and what practices can be built to support this source. Is vulnerability at the bedside a sign of strength or weakness? Going back to the model I shared in chapter two what are the next steps to create a model that can address both internal and external experiences of emotional labor. How does creating the right environment either nurture compassion satisfaction or contribute to compassion fatigue. Does having a theory-based model tangibly increase compassion satisfaction and combat compassion fatigue?

Each of these deserves more exploration as the nursing profession needs a complex solution for the complex issues it faces.

Conclusion

This research study was an ode to my fellow pediatric nurses as well as a calling card for the disciple of nursing. In the midst of modernizing medicine and pushing nurses to be more like other healthcare disciplines we have lost some of the beauty and unique purpose of nursing. Ask any nurse about their proudest moment as a care provider and you can be sure it will include some form of compassion. The actions they took in a moment of need to hold another human

being up until they could do it for themselves. The honor and sacredness of being given this opportunity to share in another person's suffering, not as a burden but as a privilege. Being able to put their own needs aside to offer dignity and respect to another. To stand up for another when those are being threatened by a medical model that is often more concerned with efficiency than actual healing. To have a tender need to connect with another and make a difference in their life. The courageous nurses in this study were willing to expose their own vulnerabilities and needs to both tell their story and be counted but to also help other nurses. I am both in awe of their contributions to the world and see myself within their challenges as they continue to give of self in service of others. I am also hopeful, for myself and these nurses as we open up to the possibilities outline by revisiting nursing theory and Jean Watson's Caring Science. I believe we can change the patterns we have created and begin to honor nurses for who they really are and what they really need. To destigmatize the superhero image that perfection is needed to create transpersonal caring moments that are life-giving for both the patient and the nurse. To honor the humanity within the nurses in order to offer them the compassion they so altruistically and nobly give to their patients. To finally, once and for all say that the consciousness of love and compassion, that nurses have a sacred calling to offer, are what will heal this earth and all the humans within.

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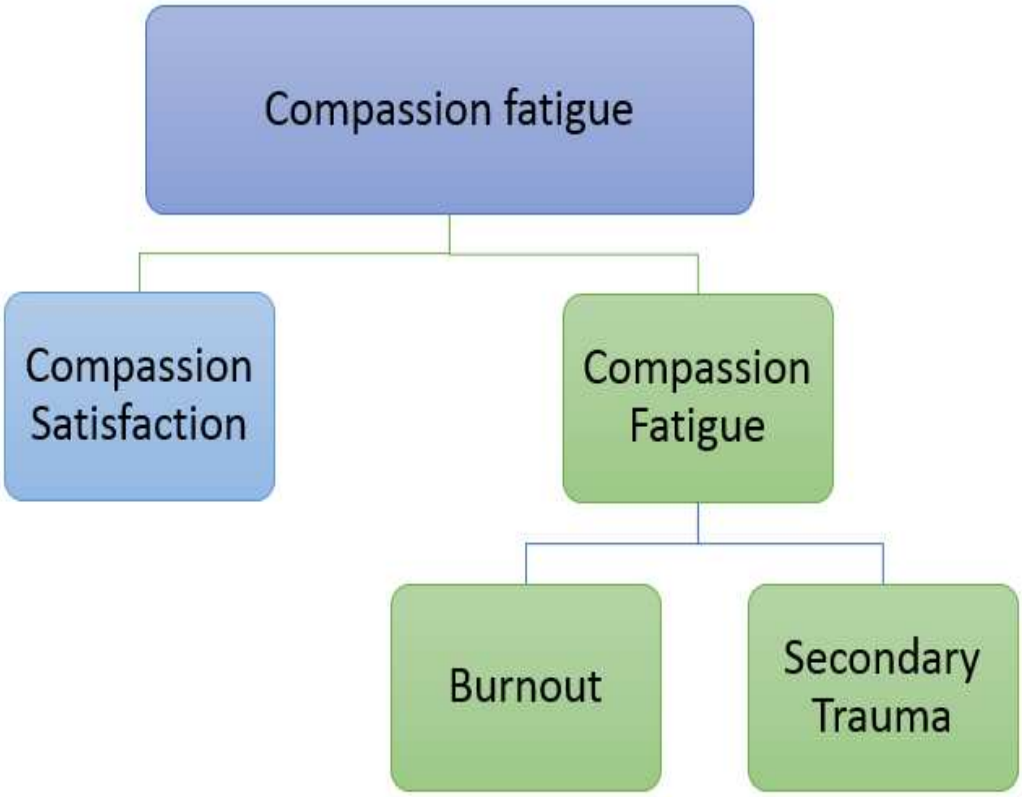
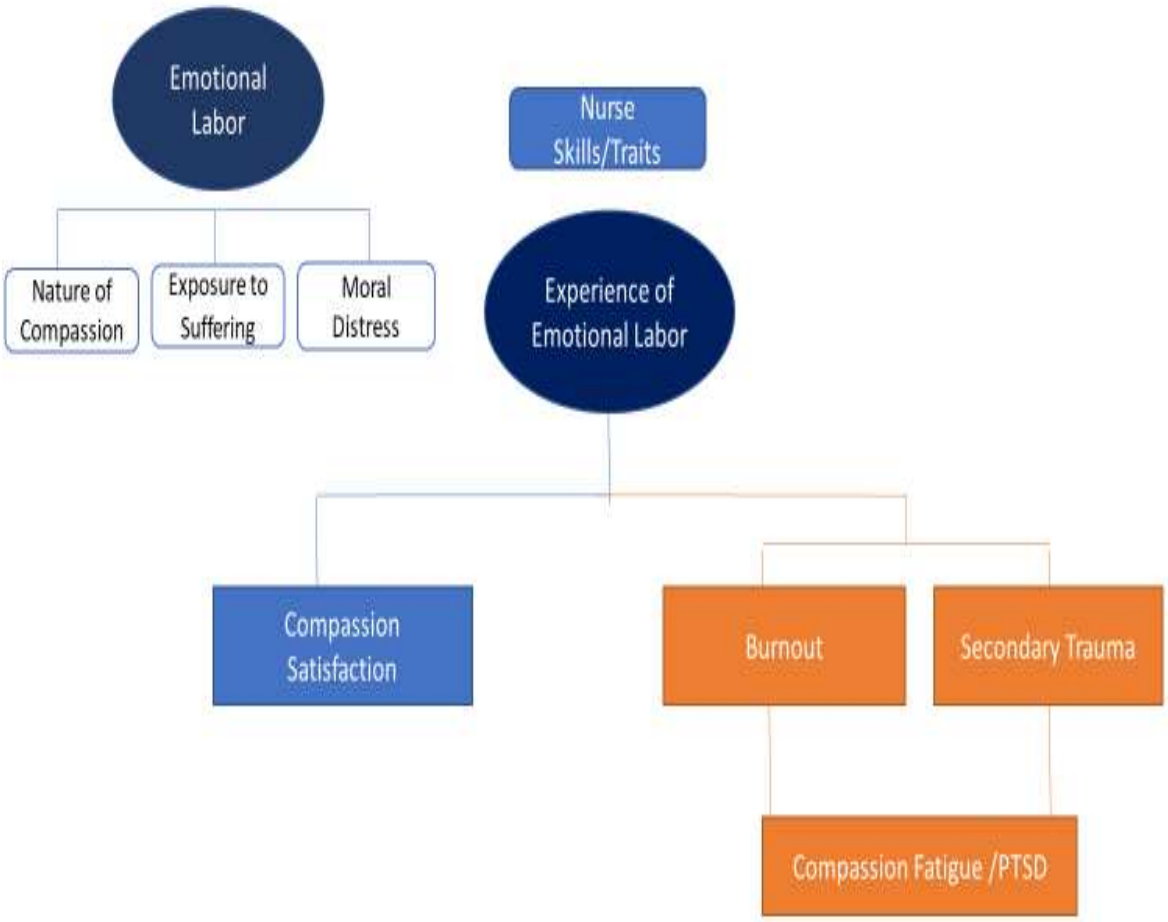
Appendix A: Compassion Fatigue Model: Stamm



Compassion Fatigue Model (Stamm, 2010).

Appendix B: Compassion Fatigue Model Adapted to include Emotional Labor and Compassion Fatigue

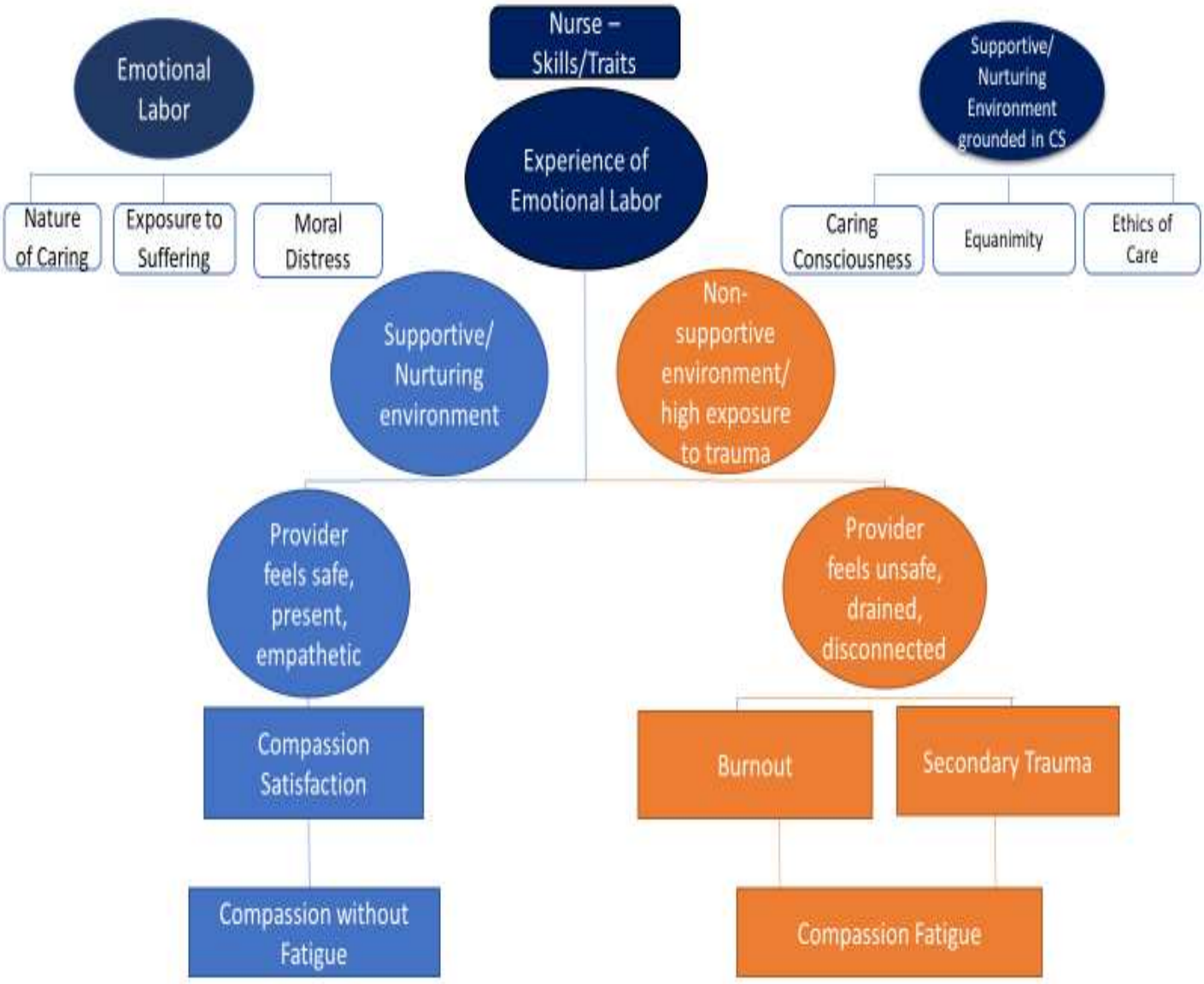


(Compassion Fatigue Model Adapted from Stamm 2010)

Appendix C: Jean Watson's Ten Caritas Processes

1. Practicing loving-kindness and equanimity within context of caring consciousness.
2. Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being-cared-for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within another's frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared-for; "allowing and being open to miracles."

Appendix D: Caring Science and Compassion Fatigue Model



Appendix E: IRB Recruitment Email

Protocol #:	**19-1801**
Project Title:	**Compassion without fatigue: the lived experience of compassion fatigue for pediatric nurses in an inpatient hospital setting**
Principal Investigator:	**Christine Griffin**
Version Date:	**August 18, 2019**

My name is Christine Griffin and I am a doctoral student in the school of nursing at Colorado University. As a pediatric nurse I know firsthand the complexities of working with patients and families in a hospital setting. I am conducting a research study examining compassion fatigue among pediatric nurses who work on inpatient units that care for patients with both acute and chronic diagnosis. I would like to invite you to participate because you work on an inpatient unit of this nature. If you agree, you are invited to participate in an interview discussing your experience as a nurse and perception of compassion fatigue, secondary trauma, burn out and compassion satisfaction.

The interview is anticipated to take no more than 60 minutes and will be audiotaped. There will also be an opportunity for a follow up discussion summarize your interview and experiences. Participation in this study is voluntary. Your identity as a participant will remain anonymous during and after the study. Your answers will remain confidential and not shared with employer.

If you have questions or would like to participate, please contact me at Christine.griffin@childrenscolorado.org or 720-777-6101.

Thank you for your considering being interviewed,

Christine Griffin PhDc, RN-BC, CPN,

Appendix F: IRB Consent

Protocol #: **19-1801**

Project Title: Compassion without fatigue: the lived experience of compassion fatigue for pediatric nurses in an inpatient hospital setting

Principal Investigator: **Christine Griffin**

Version Date: **August 18, 2019**

You are being asked to be in this research study because you are a pediatric nurse on an inpatient unit at a pediatric hospital that manage patients with both acute and chronic diagnosis.

If you join the study, you will be asked to answer questions in a face to face interview in a setting of your choosing.

This study is designed to learn more about pediatric nurse's experience with compassion fatigue, burnout, secondary trauma and compassion satisfaction.

Possible discomforts or risks include difficulty discussing issues you have faced in your nursing career, concerns about confidentiality and employer learning of perceived burnout level or distress, experiencing distress from recalling or reexperiencing painful or sad events. There may be risks the researchers have not thought of.

Every effort will be made to protect your privacy and confidentiality by limited access to data to just PI and faculty mentor, storage in password secured platform, data will be de-identified, transcription will be personally completed by PI, audio will be destroyed once transcribed transferred to platform and data will not be shared with your employer. You will have the opportunity to review the analysis in a second interview to ensure confidence in anonymity and offer advanced reflection.

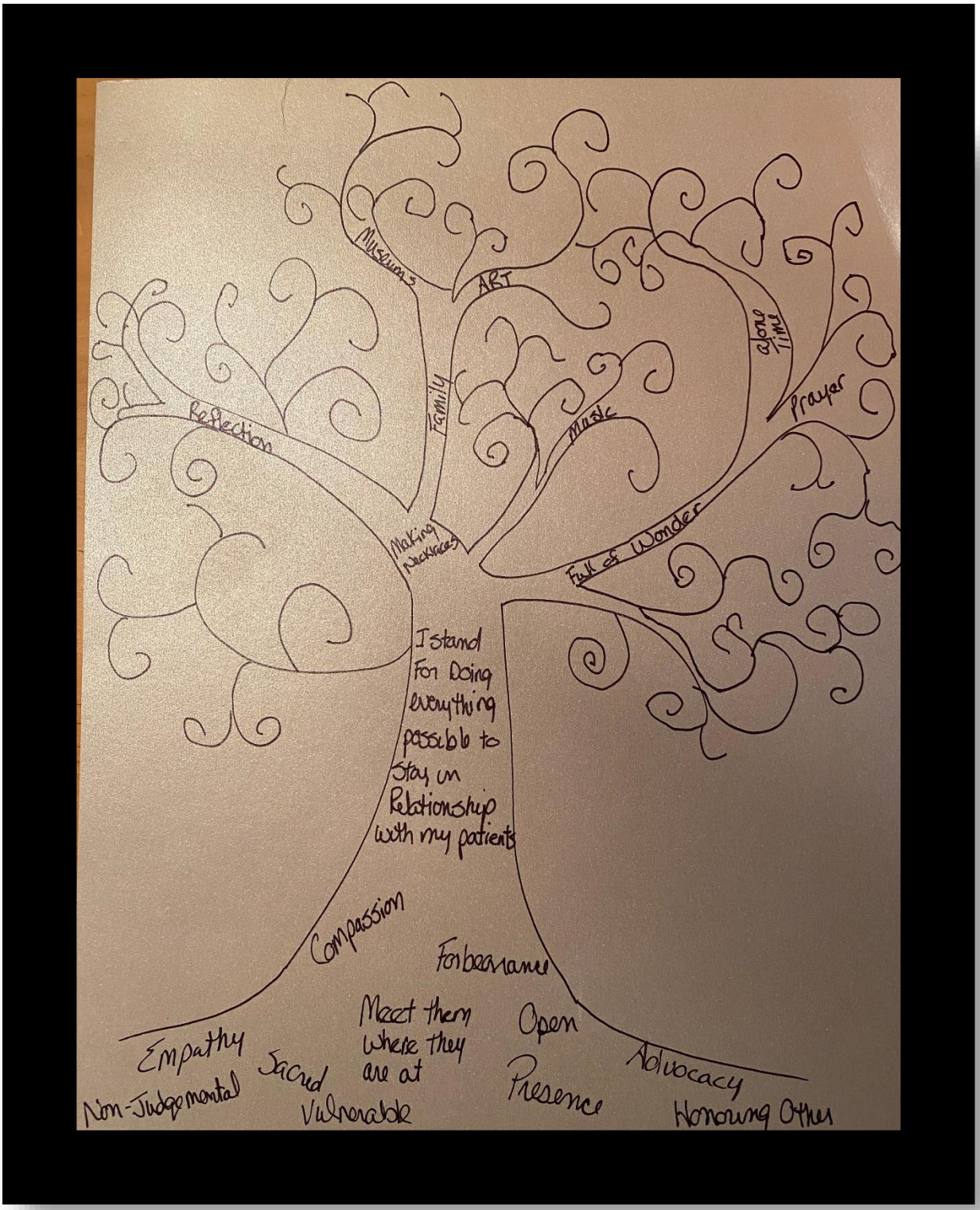
You have a choice about being in this study. You do not have to be in this study if you do not want to be. You can withdraw at any point.

If you have questions, you can call Christine Griffin at 720-777-6101. You can call and ask

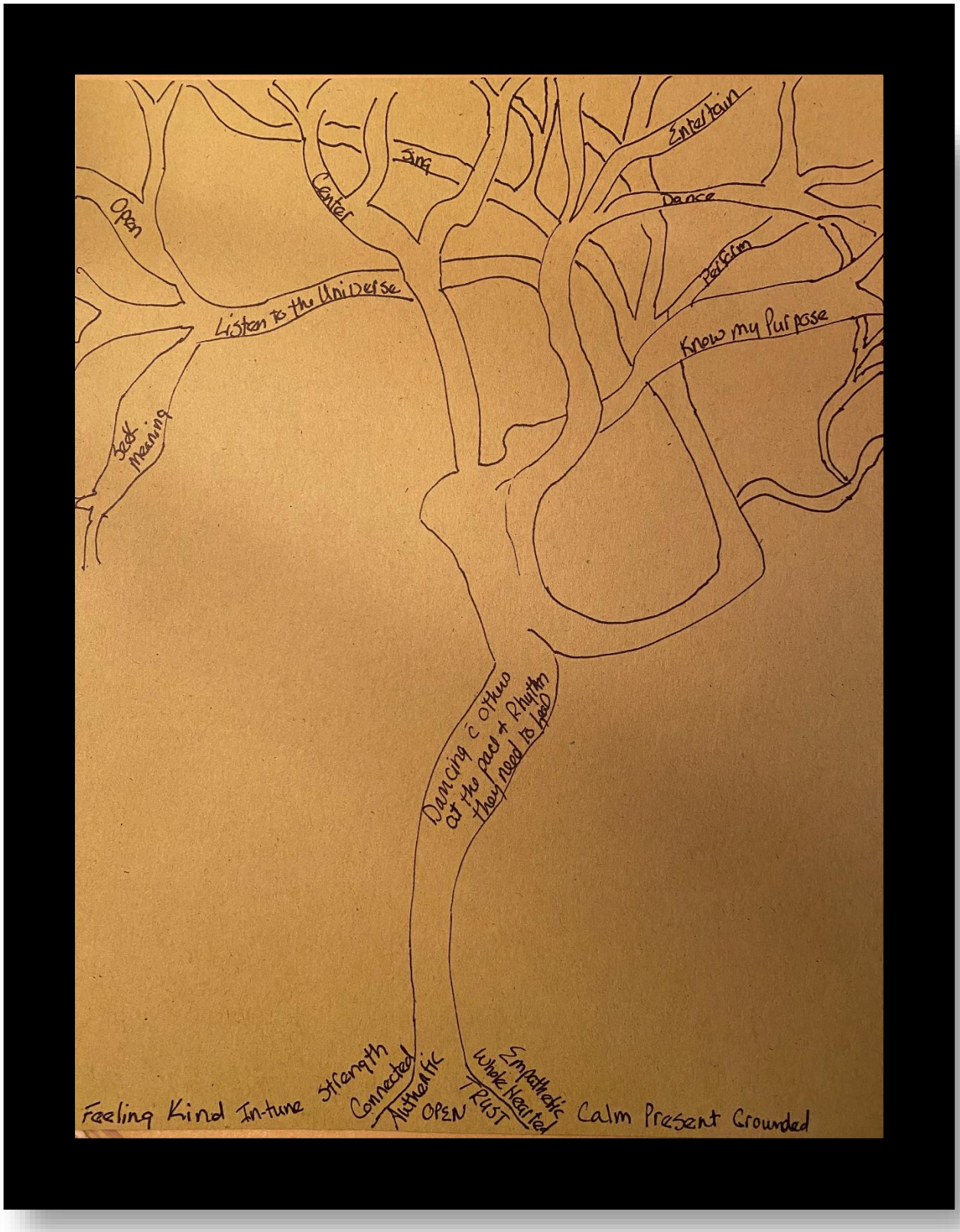
questions at any time. You may have questions about your rights as someone in this study. If you have questions, you can call the COMIRB (the responsible Institutional Review Board). Their number is (303) 724-1055.

Appendix G: Participant Trees

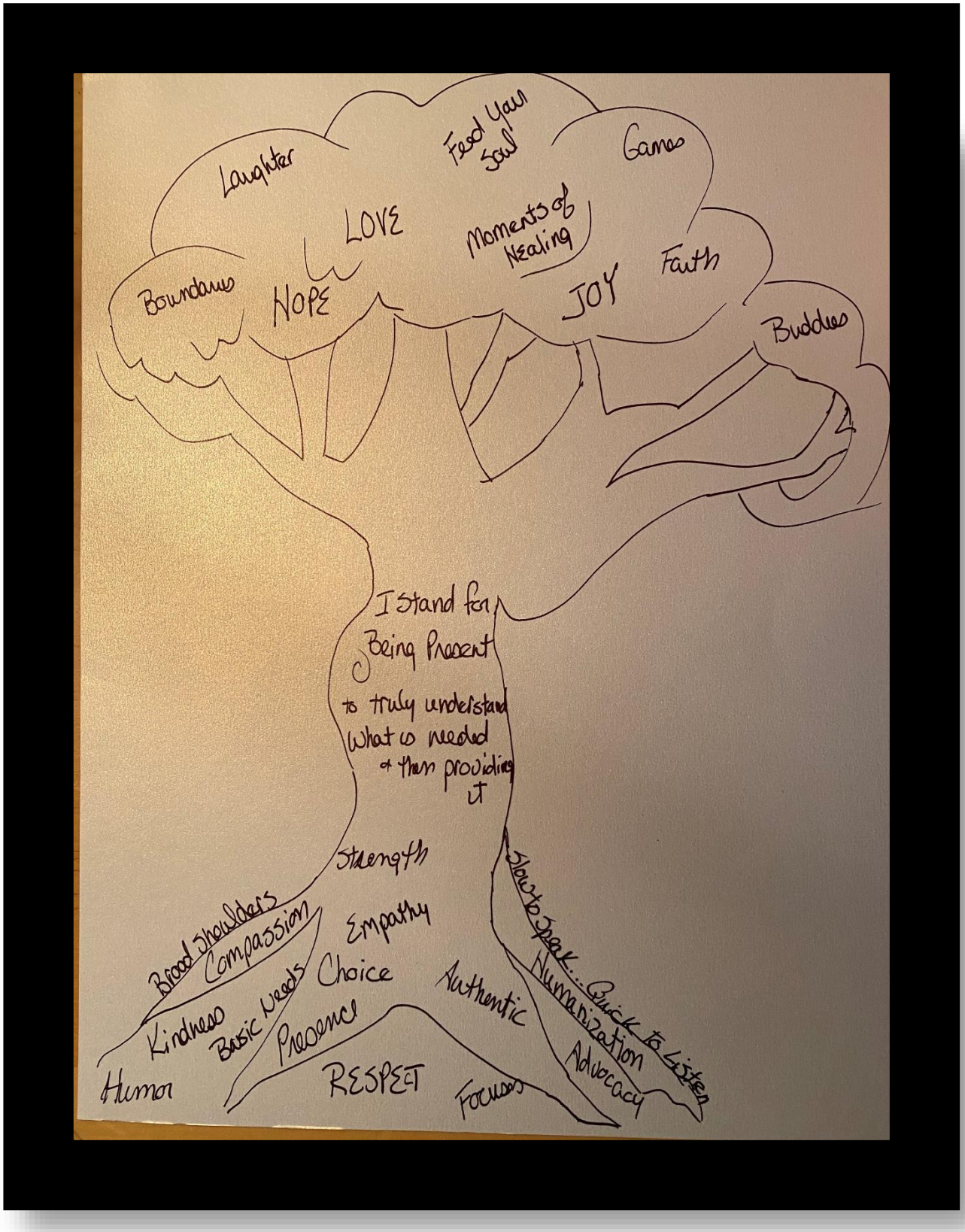
Esther



Misty


Open
Center
Sing
Entertain
Dance
Perform
Listen to the Universe
Know my Purpose
Seek Meaning
Dancing c others at the pace + Rhythm they need to lead
Feeling Kind In-tune
Strength
Connected
Authentic
OPEN
TRUST
Empathetic
Whole Hearted
Calm
Present
Grounded

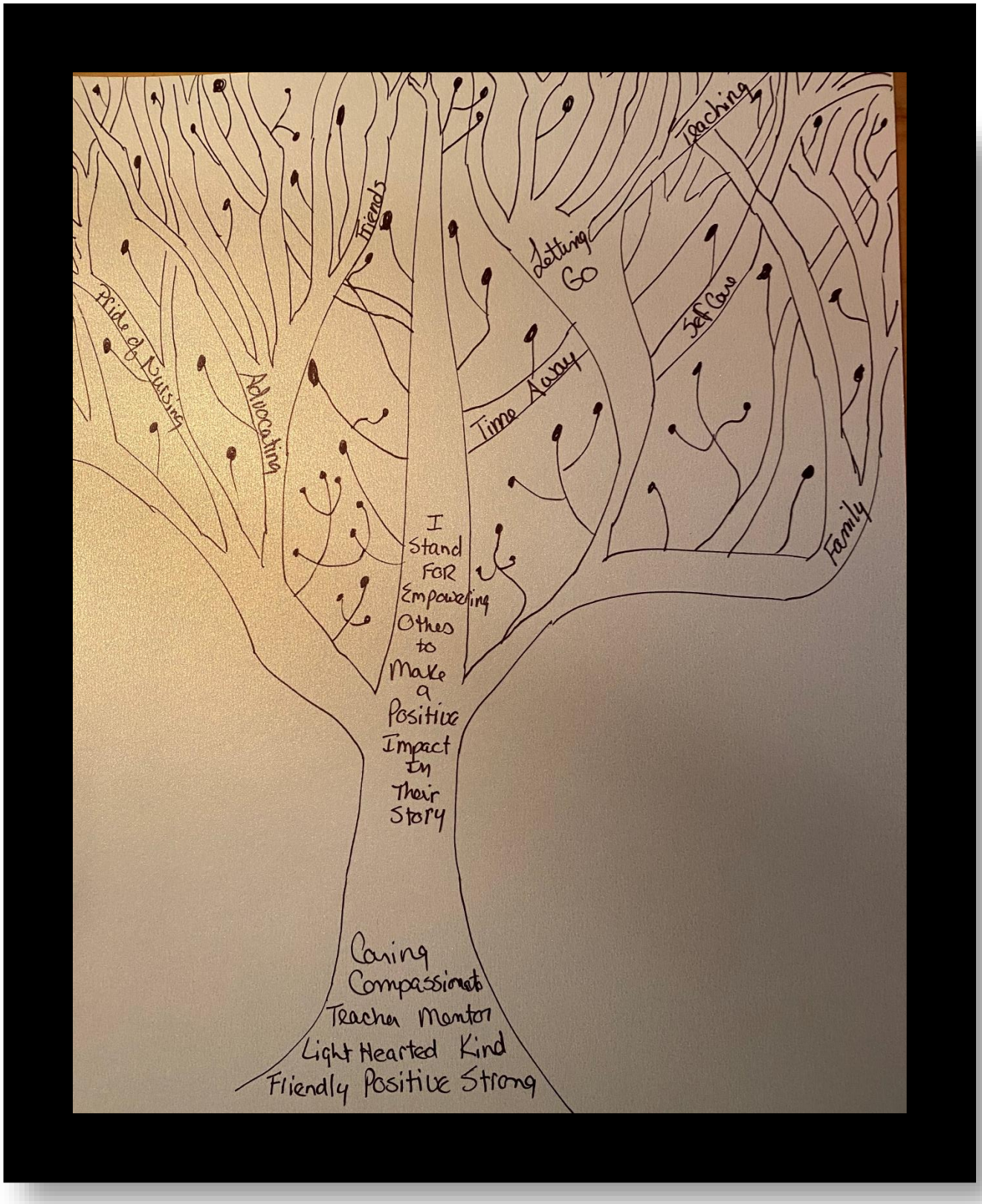
Arthur


Laughter
Feed Your Soul
Games
LOVE
Moments of Healing
Boundaries
HOPE
JOY
Faith
Buddies
I Stand for
Being Present
to truly understand
what is needed
& then providing
it
Strength
Broad shoulders
Compassion
Empathy
Kindness
Basic Needs
Choice
Presence
Authentic
Slow to Speak...Quick to Listen
Humanization
Advocacy
Humor
RESPECT
Focus

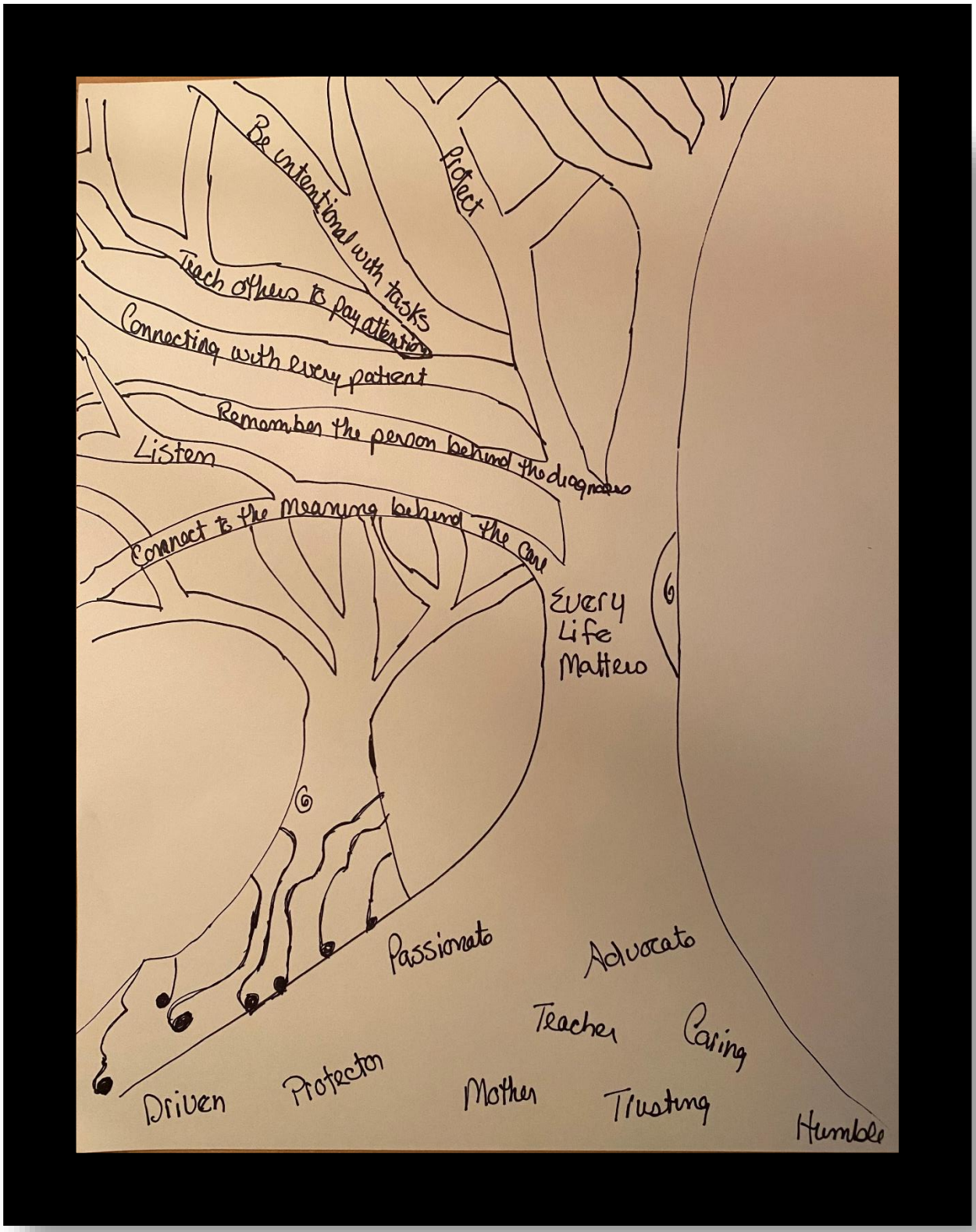
Brooke


Trusting God
Playing
Friends
Purposeful
Family
Faith
Treating others as God would
Caring
Trust
Humble
Kind
Connected
Faithful
Grounded
Passionate
Compassionate

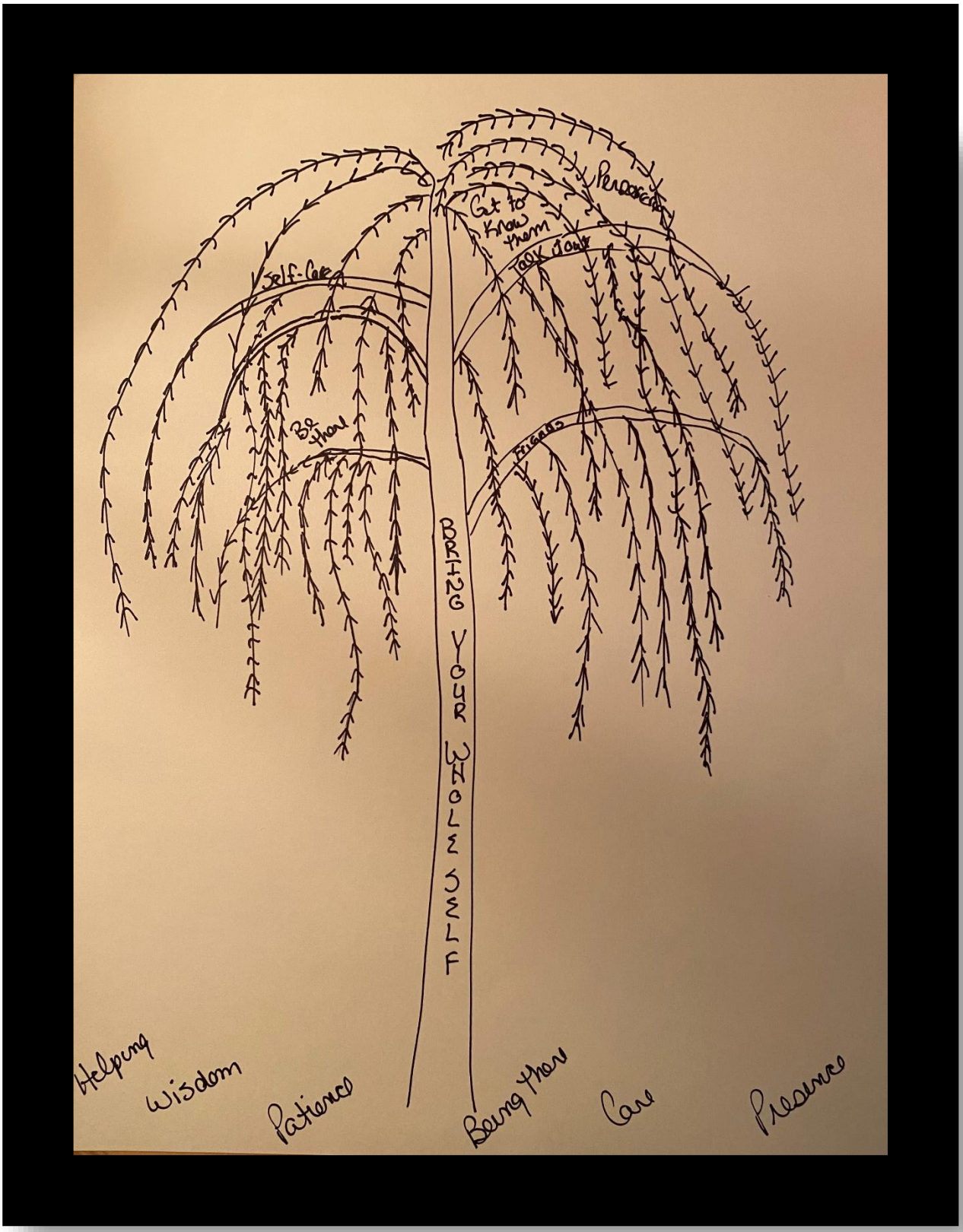
Zoe


Friends
Teaching
Letting Go
Self Care
Time Away
Family
Ride da Nursing
Advocating
I Stand FOR Empowering Others to Make a Positive Impact In Their Story
Caring
Compassionate
Teacher Mentor
Light Hearted Kind
Friendly Positive Strong

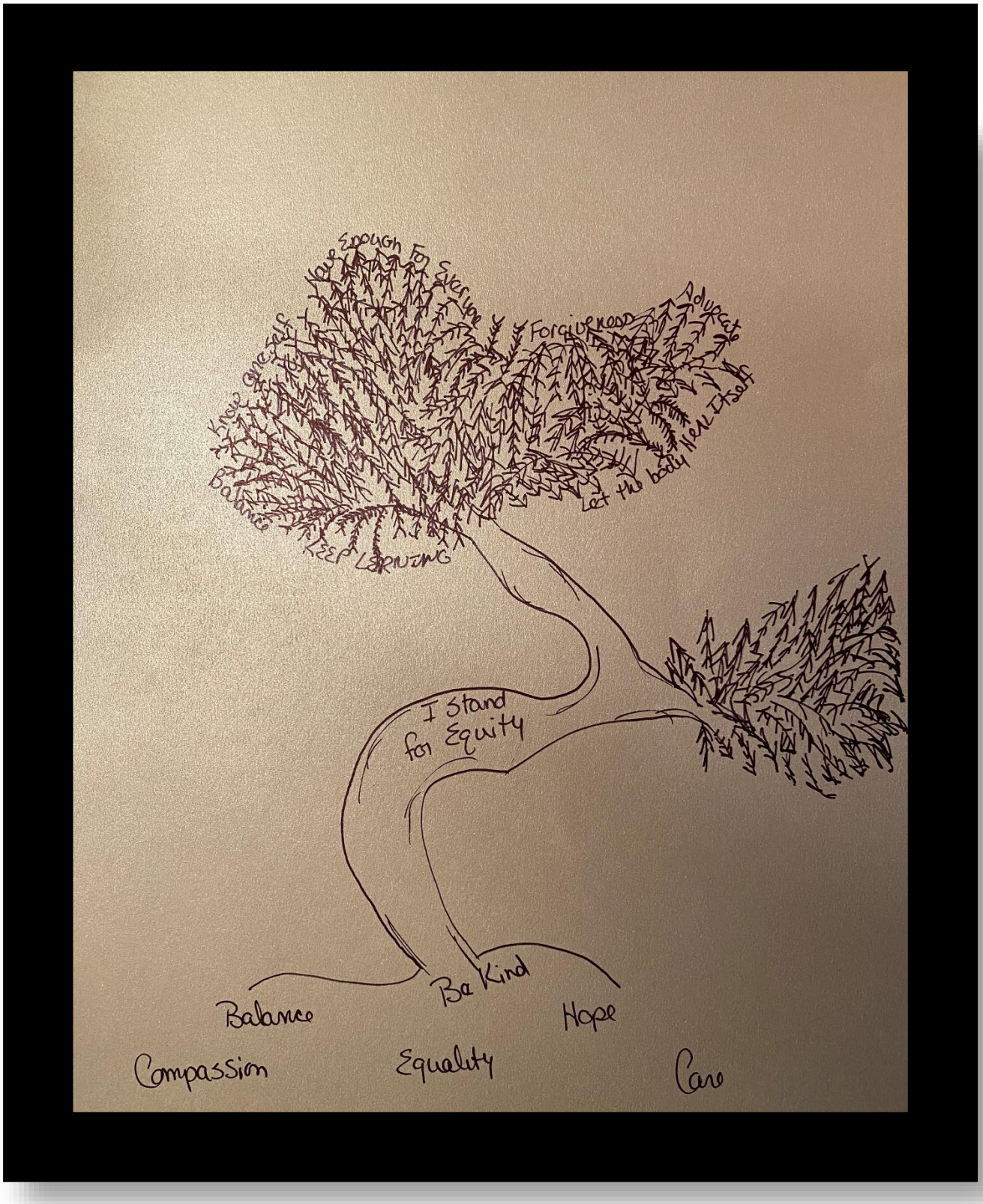
Shannon


Be intentional with tasks
Protect
Teach others to pay attention
Connecting with every patient
Remember the person behind the diagnosis
Listen
Connect to the meaning behind the care
Every Life Matters
Passionate
Advocate
Teacher
Caring
Driven
Protector
Mother
Trusting
Humble

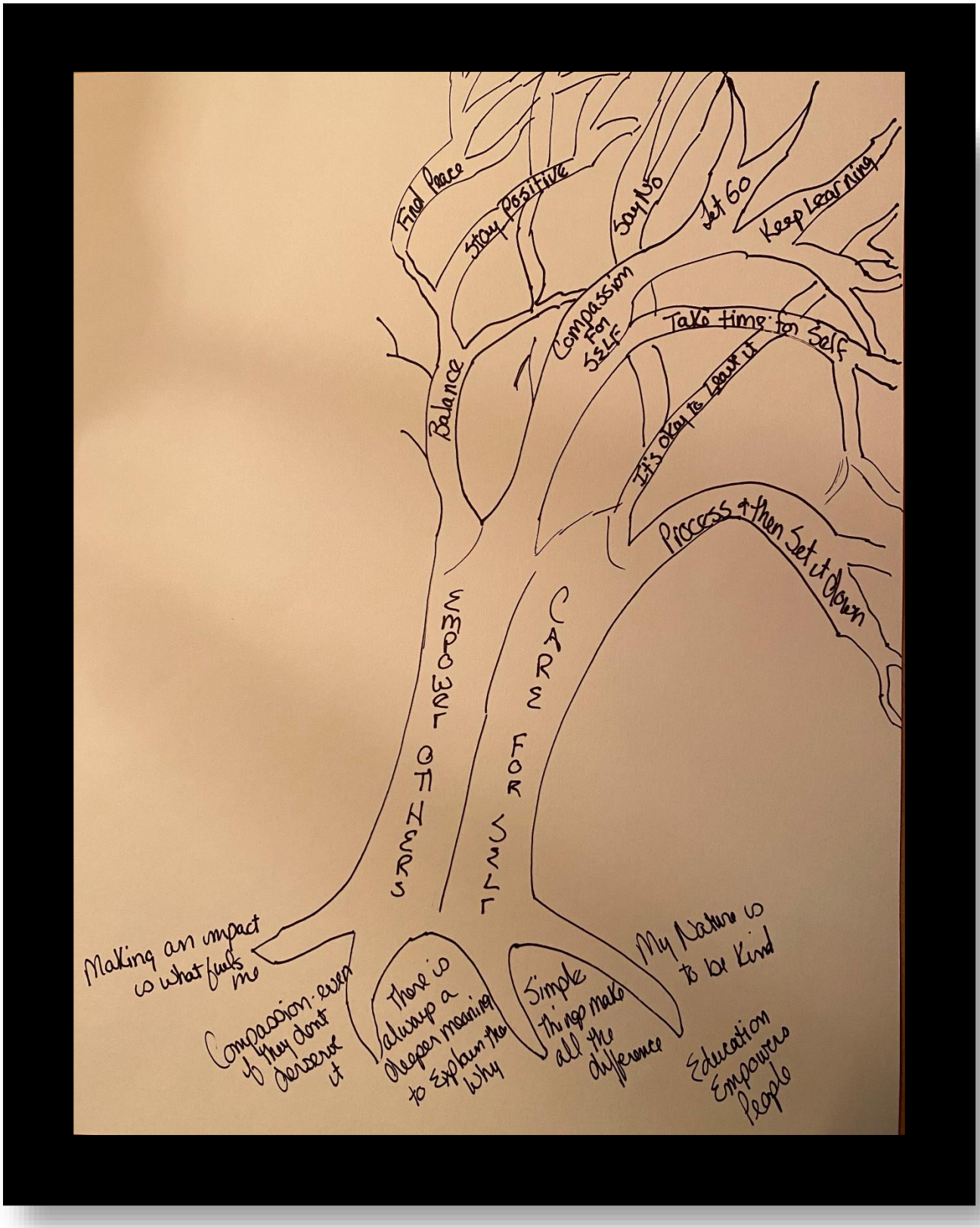
June


Self-Care
Get to know them
Presence
Be Kind
Friends
BRING YOUR WHOLE SELF
Helping
Wisdom
Patience
Being there
Care
Presence

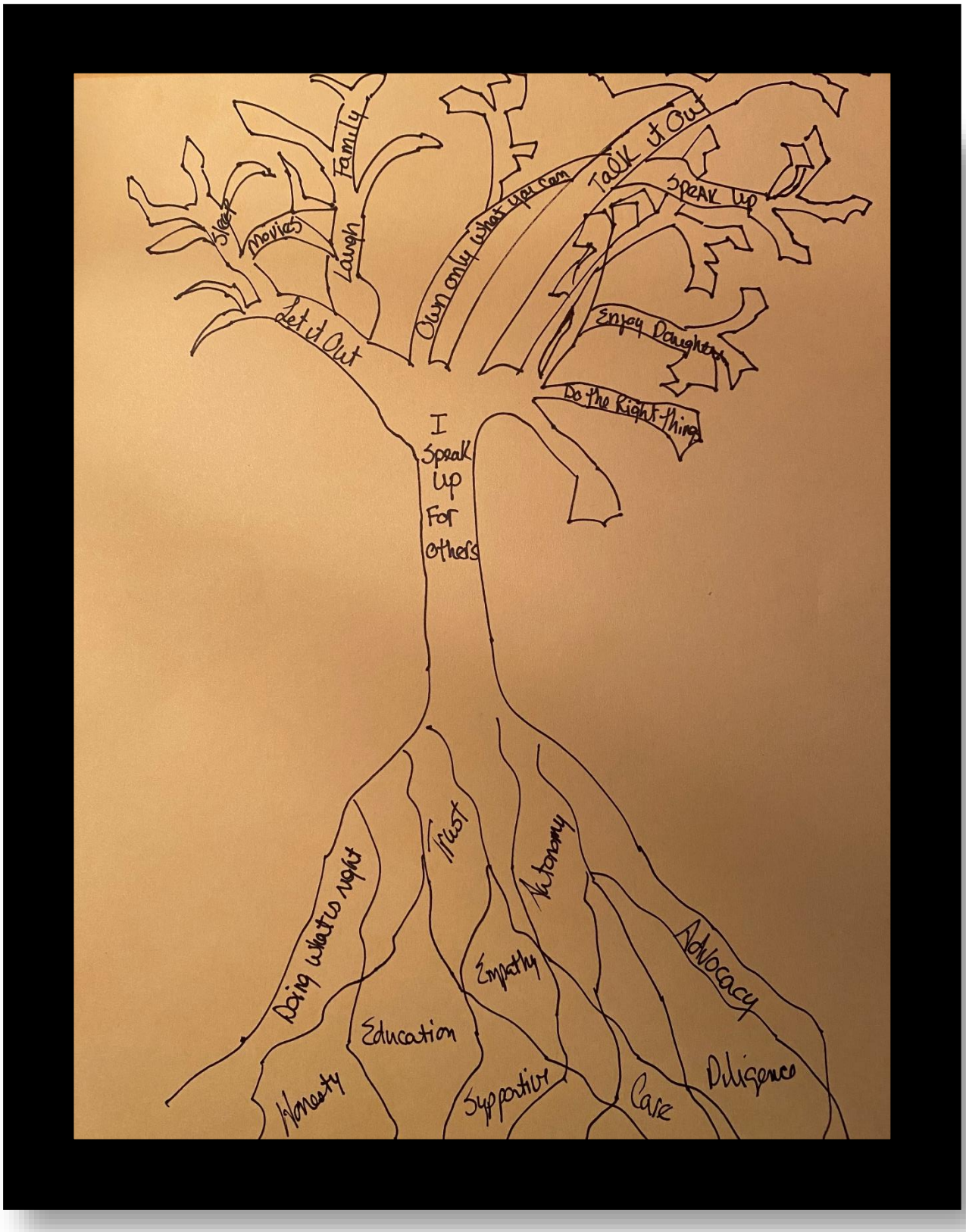
Bradford


Enough For Everyone
Forgiveness
Advocate
Let the body Heal Itself
KEEP SPROUTING
I Stand for Equity
Be Kind
Balance
Hope
Compassion
Equality
Care

Jade


Find Peace
Stay Positive
Say No
Set Go
Keep Learning
Compassion for Self
Take time for Self
It's okay to Leave it
Balance
Process & then Set it down
WISDOM OF THE ELDERS
CARE FOR YOUTH
Making an impact is what fuels me
Compassion: even if they don't deserve it
There is always a deeper meaning to explain the why
Simple things make all the difference
My Nature is to be Kind
Education Empowers People

Maddie


Family
Sleep
Movies
Laugh
Let it Out
Own only what you can
Talk it Out
Speak Up
Enjoy Daughter
Do the Right Thing
I Speak Up For Others
Doing what is right
Trust
Autonomy
Advocacy
Education
Empathy
Honesty
Supportive
Care
Diligence