THE EXPERIENCES OF COMPASSION FATIGUE AND RESILIENCE AMONG NURSES IN PRIVATE MEDICAL FACILITIES

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DECLARATION

I, Simoné le Roux (2011040512), hereby declare that the dissertation *The Experiences of compassion fatigue and resilience among nurses in private medical facilities* submitted for the Magister Artium Clinical Psychology degree at the University of the Free State is my own independent work and that it has not previously been submitted to another university/faculty for assessment or completion of any other postgraduate qualification. I further cede copyright of the dissertation in favour of the University of the Free State.

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PROOF OF LANGUAGE EDITING

20 July 2018

I, Wendy Stone (ID 7806270156089), hereby declare that I am a qualified language practitioner and that I have proofread and edited the Master's dissertation *The Experiences of compassion fatigue and resilience among nurses in private medical facilities* by Simoné le Roux.

Please contact me should there be any queries.

Dr Wendy Stone
PhD; HED

DEDICATION

This research study is dedicated to all the nurses in South Africa who persistently strive to put their patients' needs above their own.

"Moreover let us exult and triumph in our troubles and rejoice in our sufferings, knowing that pressure and affliction and hardship produce patient and unswerving endurance. And endurance develops maturity of character. And character produces joyful and confident hope." Romans 5:3-4.

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ABSTRACT

Individuals choose nursing as their occupation due to their desire to care for others who are in pain or are experiencing suffering. Although they experience a high level of satisfaction from their occupation, not all nurses are equipped to deal with the effects of being exposed to secondary trauma. Those working in trauma units are exposed to trauma on a daily basis and are therefore at risk of developing compassion fatigue (CF). The consequences of CF are noticeable in the personal and interpersonal lives of individuals, as well as in their occupation. Resilience, however, can mitigate the negative effects of CF. Therefore, it is important for nurses to enhance their level of resiliency.

The aim of this study was to explore and describe South African nursing professionals' experiences of compassion fatigue and resilience. A qualitative multiple case study approach was used to elicit rich descriptions from research participants in connection with their experiences of CF and resilience. Six participants were chosen for the study. These participants were recruited by means of purposeful sampling. Semi-structured interviews were used to collect the data for this study. Transcriptions of the interviews were done verbatim and thematic analysis was conducted in order to analyse the data.

Four main themes emanated from the data analysis: firstly, the different types of fatigue and their impact on nurses emerged as a theme. The second theme consists of the coping strategies that aid nurses in overcoming CF and developing resilience. Thirdly, the intrapersonal characteristics needed to cope emerged as an important part of nursing. Finally, the ways in which nurses care for and support their patients emerged as a theme within this study. The findings reveal that trauma nurses experience various types of fatigue due to the amount of compassion they display. Therefore, making use of coping strategies that aid them in developing resilience, reduces the negative effects of CF.

The insights gained throughout this study may contribute towards developing a greater understanding of resilience and how it can be used to mitigate the negative effects of CF.

Keywords: compassion, compassion fatigue, resilience, nursing, trauma, coping strategies

ABSTRAK

Mense kies verpleging as beroep omdat hulle ander wat pyn ly of leed verduur, wil versorg. Hoewel hulle in 'n hoë mate bevrediging uit hul beroep put, is nie alle verpleegsters daartoe toegerus om die gevolge van hul blootstelling aan sekondêre trauma te kan hanteer nie. Verpleegsters wat in trauma-eenhede werk ervaar daagliks trauma. Daarom loop hulle gevaar dat hul medelydsaamheid afgestomp kan raak. Die gevolge daarvan is duidelik te sien nie slegs in die persoonlike en interpersoonlike lewens van verpleegsters nie, maar ook in hul beroepsbedrywighede. Veerkragtigheid kan die negatiewe gevolge van emosionele tamheid verminder. Dus is dit belangrik dat verpleegsters die vlakke van hul veerkragtigheid moet verhoog.

Die doel van die onderstaande studie is om die ervaringe van Suid-Afrikaanse beroepsverpleegsters ten opsigte van emosionele tamheid en veerkragtigheid te ondersoek en te beskryf. 'n Kwalitatiewe veelvuldige gevallestudie is gebruik om van die deelnemers in die navorsing diepgaande beskrywings te bekom ten opsigte van hul ervaring van emosionele tamheid en veerkragtigheid. Ses deelnemers is vir die studieprojek geselekteer. Hierdie deelnemers is deur die gebruik van doelgerigte steekproeftrekking gewerf. Semi-gestruktureerde onderhoude is gebruik om die data vir hierdie studie in te samel. Die onderhoude is woordeliks opgeteken waarna die data volgens tematiese analise ontleed is.

Vier hooftemas het uit die data-ontleding geblyk. Eerstens het vier soorte emosionele tamheid en die uitwerking daarvan op verpleegsters aan die lig gekom. Die tweede tema bestaan uit die coping-strategieë wat verpleegsters help om emosionele tamheid te oorkom en om hul veerkragtigheid te ontwikkel. Derdens was dit die onmisbare interpersoonlike hoedanighede wat 'n integrerende deel van verpleging uitmaak. Die laaste tema wat uit die studie geblyk het, was die wyses waarop verpleegsters hul pasiënte versorg en ondersteun. Die bevindinge toon dat trauma-verpleegsters verskeie soorte tamheid ervaar, as gevolg van die medelye wat hulle met pasiënte ervaar. Dus word die negatiewe uitwerking van emosionele tamheid verminder namate verpleegsters coping-strategieë aanwend wat hulle help om hul veerkragtigheid te ontwikkel.

Die insigte wat deur hierdie studieprojek bekom is, kan 'n bydrae lewer tot die

ontwikkeling van 'n dieper begrip van veerkragtigheid en hoe dit aangewend kan word om die negatiewe uitwerking van emosionele tamheid te verminder.

Sleutelwoorde: medelydsaamheid, emosionele tamheid, veerkragtigheid, trauma, coping-strategieë

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Individuals who have been exposed to severe trauma are often negatively affected in terms of their mental health and physical wellbeing (Burnett & Wahl, 2015). Moreover, the helping professionals assisting these individuals are also adversely affected (Burnett & Wahl, 2015). Helping professionals such as nurses are constantly exposed to traumatic experiences that can have a significant impact on their coping skills and ability to consistently provide quality care to patients (Burnett & Wahl, 2015).

In South Africa, nurses are the driving force behind the healthcare system as they currently outnumber doctors five to one (Bhaga, 2010; Campbell, Lawrence, Spiehler, & Williams, 2009; Engelbrecht, Bester, Van den Berg, & Van Rensburg, 2008; Naik, 2016). Nursing relies on treating patients from a holistic point of view, considering patients as multifaceted human beings and taking their environment into consideration (Richmond & Aitken, 2011). A nurse is there to comfort the patient and to provide those who are in pain or suffering from life-threatening diseases and incapacity with a sense of support (Farrington, 1995; Richmond & Aitken, 2011).

The high level of occupational stress experienced by nursing staff frequently results in countless health-related issues that directly influence their job performance (Bhaga, 2010; Campbell et al., 2009). Among a group of Pakistani and South African nurses, it was discovered that high levels of stress led to lower levels of job satisfaction (Makola, Mashegoane, & Debusho, 2015; Pillay, 2009; Zulfiqar, Khan, & Afaq, 2013). In addition, a stressful work environment may adversely affect nurses' overall health and wellbeing (Burke & Greenglass, 2007; O'Donovan, Doody, & Lyons, 2013). Therefore, although nursing can be seen as a rewarding profession, it can be highly stressful as a result of the emotionally challenging situations experienced on a daily basis (Kath, Stichler, Ehrhart, & Schultze, 2013; Moustaka & Constantinidis, 2010). This may increase the risk of developing compassion fatigue (CF) (Figley, 1995; Jackson, Firtko, & Edenborough, 2007; Ledoux, 2015; Lombardo & Eyre, 2011).

The Profession of Nursing

In the constantly changing world of healthcare, nurses worldwide are exposed to repeated physical and emotional stress (Gandi, Wai, Karick, & Dagona, 2011; Mealer, Shelton, Berg, Rothbaum, & Moss, 2007). The current literature on occupational

stress among nurses has focused predominantly on the public health sector. Therefore, little is known about the experiences of nurses who work in the private health-care sector, especially in the South African context. It has, however, been established that nurses working in both the private and public sectors face various external stressors (Bhaga, 2010; Showalter, 2010; Tyson & Pongruengphant, 2004; Yoder, 2010). These stressors include extensive working hours, a constant increase in workload and a need to respond to the needs of patients on an hourly basis (Bhaga, 2010; Campbell et al., 2009; Naik, 2016; Pillay, 2009; Showalter, 2010; Tyson & Pongruengphant, 2004; Yoder, 2010). Furthermore, a high level of interpersonal conflict has been observed in the workplace, which leaves nurses feeling inadequate, self-conscious, irritated and depressed (Arquharson et al., 2013; Hillhouse & Adler, 1997; Jennings, 2008). This may also lead to a lowered self-esteem and overall lower quality of patient care (Arquharson et al., 2013; Hillhouse & Adler, 1997; Jennings, 2008). Nursing professionals in South Africa are required to deal with an array of difficulties, including exposure to bacteria, viruses and needle prick accidents, increasing numbers of HIV/AIDS patients, and being surrounded by staff who are constantly overworked (Hartley, 2005; Hayes et al., 2012; Mosendane, Kew, Osih, & Mahomed, 2012).

Furthermore, statistics reveal that approximately 50% of health-care workers in South Africa consist of nurses (South African Nursing Council, 2013). In 2013, the statistics stood at 129 015 registered nurses in total, who were serving a population of 52 982 000 patients. In other words, there was one registered nurse for every 411 patients, placing nursing staff at the forefront of our healthcare system (SANC, 2013). While the number of registered nurses had increased in 2016, which stood at a total of 270 437, there was still a shortage of 44 780 professional nurses (SANC, 2016). The annual enrollment of nursing students is decreasing and a predicted shortage of professional nurses in our country (SANC, 2016) may lead to a further increase in the amount of stress and workload for the remaining nurses. A high workload and shortage of staff are two factors that may contribute to a state of CF (Austin, Goble, Leier, & Pyrne, 2009; Melvin, 2012).

Nursing in South Africa takes the form of various specialties, including mental health nursing, midwifery, child health, aged care, oncology, intensive care, operating theatre, community health, remote area nursing, research, management, education,

and workplace health and safety (Wildschut & Mgqolozana, 2008). Another area in nursing is trauma care, which is often also referred to as an emergency unit. However, to avoid confusion, this area of specialisation will be referred to as a trauma unit. In this study, the focus is on nurses who are registered with the Health Professions Council of South Africa and who are currently working in or have previous experience in trauma care.

Trauma nurses are normally the first line of professionals who are exposed to traumatic events as they are the 'first responders' to tragedies before other professionals such as doctors intervene (Ebright, 2010). As a result, nurses witness and experience trauma on a daily basis (Showalter, 2010; Yoder, 2010). They must be available to respond to the needs of patients in a variety of ways. Examples of interventions may include prevention of injuries, prevention of further complications, and recovery of patients who may be severely traumatised and/or injured (Richmond & Aitken, 2011). Moreover, a trauma nurse must be able to recognise a life-threatening situation, prioritise patients according to their care needs, take part in resuscitation together with other medical staff, and provide patients' families with the appropriate care and support (Emergency Nurses Society of South Africa, 2010). In turn, this may expose nurses to severe emotional pain and suffering (Coetzee & Klopper, 2010; Hooper, Craig, Janvrin, Wetzel, & Reimels, 2010). Many nurses may state that they view their occupation as a calling. However, few of them are completely prepared for the emotional distress encountered due to forming caring relationships with their patients and their families (Aycock & Boyle, 2009; Walton & Alvarez, 2010).

Compassion Fatigue

Compassion Fatigue (CF) is a concept that has been researched in professional fields, such as counselling, psychology, teaching, social work and medicine (Yoder, 2010). However, over the past 20 years, the phenomenon of CF has been studied more rigorously within the area of caregiving strain, thus taking into consideration a broader selection of health-care professionals (Thomas & Wilson, 2004; Yoder, 2010).

The term CF was initially used in the area of burnout among nurses almost three decades ago (Joinson, 1992). Joinson (1992) discovered this state of fatigue while

studying nursing staff who displayed feelings of helplessness and anger. During this period, Joinson (1992) made use of this term in order to define a decrease in the ability to nurture that he had noticed among nursing professionals who worked in trauma units.

CF refers to the emotional, cognitive and behavioural reactions that are evident when a person becomes aware of an event that was traumatising to a significant other, the strain that is a direct result of wanting to relieve someone's suffering, or the result of over-involvement in patients' care (Anewalt, 2009; Chung, 2015; Day & Anderson, 2011; Figley, 1995). CF can also be defined as the "cost of caring" in terms of the physical, spiritual, cognitive, emotional, behavioural and interpersonal impact on individuals responsible for providing patients with the necessary care (Figley, 1995; Hinderer et al., 2014; Ledoux, 2015; Lombardo & Eyre, 2011; Yassen, 1995).

Compassionate Care

Compassion is imperative in a healthcare profession as it starts and sustains a caring and helping therapeutic relationship by showing sympathy towards a patient who is experiencing distress (American Nurses Association, 2015; Bramley & Matiti, 2014; Burnell, 2009; Davies, 2009; Roberts, Fenton, & Barnard, 2015; Young, Derr, Cicchillo, & Bressler, 2011). The compassion that nurses display towards their patients is an emotion that arises when exposed to the patient's suffering (Lown, 2016; Lown, Rosen, & Marttila, 2011; Post, 2011). Compassion enables health-care professionals to display a more affectionate response towards their suffering patients, as well as a deeper understanding of the trauma that the patient is experiencing (Beaumont, Durkin, Hollins, Martin, & Carson, 2016; Lown, 2016; Lown et al., 2011; Post, 2011). It may also help nurses to show patients that they are not alone during their time of suffering (Catarino, Gilbert, McEwan, & Baião, 2014; Pauley & McPherson, 2010; Van der Cingel, 2009). Compassion has various benefits, but the most prevalent is the fact that it produces a therapeutic relationship and environment which brings about patient and clinician satisfaction (Post, 2011). In nursing, compassion is an integral part of competence and is therefore something that should be cultivated (Geraghty, Lauva, & Oliver, 2016).

However, being exposed to traumatic situations on a regular basis can cause nurses to become emotionally detached. Emotional detachment indicates that nurses may be unable to connect with their patients on an emotional level, or may avoid situations that trigger unpleasant emotions (Hinderer et al., 2014). In other words, their level of compassion towards their patients may decline (Hinderer et al., 2014). Subsequently, this detachment can develop into compassion fatigue (CF) (Figley, 1995; Harris & Quinn Griffin, 2015). It is likely to bring about negative behaviour, such as poor patient treatment, errors in judgment and other mistakes that may be dangerous in a helping profession (Maiden, Georges, & Connelly, 2011). It is important to consider that nursing professionals working in trauma units are particularly susceptible to experiencing CF (Boyle, 2011). Not only do they display compassion towards patients, they also enter the patients' life at a significant time and become an active partner, rather than a mere observer in this patient's journey towards recovery (Boyle, 2011).

The constant exposure to trauma may explain the lack of compassion that has been noticed within healthcare systems and health organisations abroad (Francis, 2013; Health Information and Quality Authority, 2015), yet there is a lack of programmes such as therapeutic services that can aid nurses in recovering (Mohamed, 2016). Unfortunately, the consequences of working as a nursing professional, such as the development of CF, have been under-recognised and under-researched (Sabo, 2011). The fact that CF has not been formally defined within the nursing profession may have contributed towards the lack of exploration that would provide nursing professionals with an opportunity to recognise and overcome it in an effective manner (Coetzee & Klopper 2010). Furthermore, nurses receive limited to no formal support that can aid them in overcoming the negative emotional effects of CF (Aycock & Boyle, 2009; Potter et al., 2010). Therefore, there is a need for CF to be researched, specifically among nursing professionals working in a setting where a significant amount of trauma is experienced (Bhaga, 2010).

Fagin and Diers (1983) state the following:

> Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of patients' lives and they cannot hide behind technology or a veil of omniscience as other practitioners in hospitals do.   Nurses do for others publicly what healthy persons do for themselves behind closed doors. Nurses,

as trusted peers, are there to hear secrets, especially the ones born of vulnerability (p. 116).

Stressors

From the above literature, it has already been established that nurses work in highly stressful environments as they have to manage and cope with both chronic and acute trauma (Healy & Tyrell, 2011). This type of exposure may influence various aspects of nurses' lives (Cavanagh, 1997; Rajan, 2017; Rathore, Shukla, Singh, & Tiwari, 2012). The stress that nursing professionals experience is categorised according to three types of stressors, explaining the impact these stressors have on their overall wellbeing. The first category comprises **personal stressors,** which may include difficulties with regard to managing domestic, work and academic duties (Lambert & Lambert, 2008). In a study conducted in Udaipur, nurses reported that they had found it difficult to meet the needs of their spouses (Rathore et al., 2012). Furthermore, Rajan's (2017) study revealed the prevalence of family conflict as a result of the long hours that nurses work on a weekly basis. These long and inflexible hours may lead to a lack of care within nurses' families (Rajan, 2017). In addition, the feelings of depression and irritability experienced by nurses may have a negative impact on their family members and occupation (Banakhar, 2017; Caruso, 2014).

The second category, **interpersonal stressors**, consists of conflicting relationships with colleagues, senior staff or doctors in the work environment (Basson & Van der Merwe, 1994; Guidroz, Wang, & Perez, 2012). Conflict among nursing staff may arise due to competition among staff members, undefined expectations and roles within the workplace, the inability to function as a team and a lack of interpersonal communication skills (Marquis & Huston, 2012).

Lastly, providing care for distressed and dying patients, making mistakes, balancing countless responsibilities, long working hours and a heavy workload form part of the **occupational stressors** that nurses experience (Basson & Van der Merwe, 1994; Costa & Martins, 2011; Kilfedder, Power, & Wells, 2001; Lambert et al., 2004; Lim, Hepworth, & Bogossian, 2011; Najjar, Davis, Beck-Coon, & Doebbeling, 2009). Also, the death of patients brings about emotional fatigue as nurses may be exposed to death frequently (Chung, 2015; McCourt, Power, & Glackin, 2013). Studies by De Clercq, Meganck, Deheegher and Van Hoorde (2011) and Martins et al. (2014) found

that experiencing a patients' death and conveying the bad news to family members serve as two of the most stressful aspects in nursing. Not only do nurses have to experience the physical death of their patients, but they may also have to take care of remaining patients straight after a death has occurred (Gates, Gillespie, & Succop, 2011). As a result of moving on to care for other patients without having the necessary time to grieve, nurses may experience emotional build up (Gates et al., 2011; Gerow, Conejo, Alonzo, Davis, Rodgers, & Domian, 2010). In addition, nurses may experience a sense of loss, helplessness, frustration, guilt, a sense of failure, decreased self-esteem and sadness (Aycock & Boyle, 2009; Gerow et al., 2010; Martins et al., 2014; Shorter & Stayt, 2010; Walsh, 2009). If emotional build up is not addressed over time, it may become chronic and develop into CF (Aycock & Boyle, 2009).

In addition to the above-mentioned stressors, nurses may be subject to emotional depletion as a result of the emotionally demanding situations and stressful environments they encounter (Al-Shaqsi, Gauld, McBride, Al-Kashmiri, & Al-Harthy, 2015; Dolan, Esson, Grainger, Richardson, & Ardagh, 2011; Lyneham & Byrne, 2011; Richardson, Ardagh, Grainger, & Robinson, 2013). Nursing staff are further required to hide certain emotions as displaying them may come across as inappropriate (Gray, 2009). They follow a hidden rule book on which emotions are displayable and which are not (Diefendorff, Erickson, Grandey, & Dahling, 2011). Emotions, such as empathy, compassion and care are acceptable, whereas negative emotions, such as anger, sadness and severe distress should be regulated appropriately (Chou, Hecker, & Martin, 2012; Filstad, 2010; Hayward & Tuckey, 2011; Pisaniello, Winefield, & Delfabbro, 2012). In fact, only emotions that are beneficial to the patients' wellbeing may be displayed by a nurse (Morgan & Lynn, 2009). This may amplify the amount of stress that nurses experience in a situation that is traumatic to them as well (Chou et al., 2012).

CF in Health Care

CF is unique due to health-care workers' pre-occupation with the distress and trauma that patients experience (Figley, 2002; Price, 2013; Showalter, 2010; Thomas & Wilson, 2004). As a result, recent studies began to define CF specifically within the area of healthcare as the negative emotional consequences that are linked with the

caring process as health-care professionals are exposed to the physical and psychological pain and distress of patients (Davies, 2009; Hinderer et al., 2014).

For the purposes of this research, the focus will be solely on CF. However, there are various similarities between CF and burnout (Najjar et al., 2009; Yoder, 2010). Therefore, it is important to differentiate between these two concepts. Burnout was originally defined by Maslach (1982) as a state of emotional fatigue, depersonalisation and a feeling of decreased personal competency that develops among individuals who work with people. Tucker, Weymiller, Cutshall, Rhudy, and Lohse (2012) further state that burnout develops as a result of chronic stress in the work environment. Even though burnout affects individuals in all occupations, it is more prevalent within the healthcare system as health-care providers are continuously exposed to stressful situations (Angelo & Chambel, 2015). On the other hand, CF is experienced as a result of individuals' perceived failure of their rescue-caretaking strategies, which results in guilt and distress. Furthermore, CF occurs as a result of close health-care interactions with patients who are experiencing distress, whereas burnout is acquired as a result of environmental or systemic stressors (Figley, 1995, 2002; Potter et al., 2010).

The literature states that CF is related to terms, such as secondary traumatisation, vicarious traumatisation and secondary traumatic stress (STS) (McGibbon, Peter, & Gallop, 2010). STS indicates that nursing professionals may experience emotional trauma as a result of being exposed to high levels of stress (Mealer et al., 2007; Van Dernoot Lipsky, 2009). STS is related to Post-Traumatic Stress Disorder (PTSD) and its symptomatology corresponds with individuals who have been subjected directly to a traumatic event (Bride, Robinson, Yegidis, & Figley, 2004; Cieslak et al., 2013; Figley, 1995; Motta, 2008). STS is also connected to emotional exhaustion resulting from depersonalisation (Cieslak et al., 2013). STS may include symptoms, such as avoidance of cues that serve as reminders of the event, continuous physiological arousal and re-experiencing the trauma (Cieslak et al., 2013; Figley, 1995; Stamm, 2010). These symptoms may develop among trauma care providers one month or more after they have been exposed to a traumatic event (Cieslak et al., 2013; Figley, 1995). STS tends to take place more frequently among nurses who are empathetic towards their patients as compared to those who are less empathetic (Mealer et al., 2007; Stamm, 2010).

Compassion and empathy have been found to play a significant role in being a successful nursing professional (Dunn, 2009; Hooper et al., 2010; Mealer et al., 2007; Schantz, 2007). As stated above, compassion can be defined as the capacity to understand the emotions of another person or oneself; it is a state where one feels concern *for* the patient (Klimecki & Singer, 2015). It can be portrayed by warm-heartedness, displaying concern towards another person and a personal drive to improve a patients' state of suffering (Klimecki & Singer, 2015). Empathy can be seen as sharing a patient's emotions without taking them on as one's own (Klimecki & Singer, 2015). Even though compassion and empathy are two separate concepts, having compassion for someone can lead to the development of empathetic feelings for that person (Klimecki & Singer, 2015).

CF does not develop overnight; there is a gradual progression of emotional unease up to the point where CF is experienced (Showalter, 2010). The process begins with an individual experiencing compassion discomfort, followed by compassion stress and, finally, experiencing a state of CF (Coetzee & Klopper, 2010; Day & Anderson, 2011; Yoder, 2010). This state of CF often surpasses nursing professionals' capacity to recuperate from it (Townsend & Campbell, 2009). In turn, CF can result in burnout if it is not treated (Adams, Figley, & Boscarino, 2008; Bhaga, 2010; Day & Anderson, 2011; Dominguez-Gomez & Rutledge, 2009; Maier, 2011; Sabo, 2011; Ward-Griffin, St-Amant, & Brown, 2011). Figley (1995) states:

> There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care. Sometimes we feel we are losing our own sense of self to the clients we serve (p. 1).

Figley's (1995) statement is supported by Bush (2009), who found that the environmental stressors of nursing staff, such as a heavy workload, extensive working hours and the continuous need to react to a patient's needs may leave nurses feeling tired, depressed and detached. In addition, long-term effects can include a diminished sense of personal safety and empathy, a decline in self-control, a feeling of hopelessness and the use of maladaptive coping mechanisms, such as drug or alcohol use (Portnoy, 2011). In turn, these effects may cause nurses to provide ineffective health-care services, an increase in sick leave, and a decrease in job satisfaction and productivity at work (Aycock & Boyle, 2009; Coetzee & Klopper, 2010; Najjar et al.,

2009). The consequences seem to increase gradually over time, especially if nurses refuse to pay attention to the symptoms or are unaware of how to deal with them (Drury, Craigie, Francis, Aoun, & Hegney, 2014; Figley, 2002).

In spite of the potential negative effects of CF, this phenomenon often goes unnoticed among nursing professionals due to lack of awareness in practice and contradictory definitions in the literature (Aycock & Boyle, 2009). Therefore, the provision of findings on ways to reduce CF can be beneficial to both individual nurses and the hospitals in which they work (Aycock & Boyle, 2009; Sheppard, 2015; Sorenson, Bolick, Wright, & Hamilton, 2016). The potential benefits include a decline in sick leave, increased participation in service initiatives, improvement in staff morale and their overall productivity at work, an increase in personal and family satisfaction at home, and patient satisfaction at work (Aycock & Boyle, 2009; Coetzee & Klopper, 2010; Najjar et al., 2009).

Bush (2009) suggests that early retirement or a change in occupation often occurs as a result of nurses continually giving of themselves without having the correct coping strategies in place. This includes taking time off to recuperate from trauma or fatigue. Yoder (2010) also emphasises that:

> An understanding of compassion fatigue, trigger situations, and coping strategies in nursing may help prevent negative effects on the nurse's personal life and on the ability to perform his or her job and help prevent nurses from leaving the profession at a time when the need for nurses is great (p. 191).

Research in this area has been predominantly quantitative in nature and has focused on the negative effects associated with CF (Ungar, 2012). Moreover, most recent research in the field of nursing is focused on burnout and job-satisfaction (Baranda, 2017; Khamisa, Oldenburg, Peltzer, & Ilic, 2015; Lahana et al., 2017; Yasmin, & Marzuki, 2015). Various interventions to combat CF have been introduced in recent studies, including education on mindfulness and self-empowerment (Flarity, Gentry, & Mesnikoff, 2013; Gauthier, Meyer, Grefe, & Gold, 2015; Günüşen & Üstün, 2009; 2010; Portnoy, 2011). These interventions also include teaching coping strategies and empowering health-care managers. It has been found that CF can be successfully identified and prevented when nurses are taught about effective coping and resilience (Coetzee & Klopper, 2010; Hart Brannan, & De Chesnay, 2012;

Sorenson et al., 2016). Such programmes can aid in increasing individuals' levels of self-esteem and coping with stress and trauma (Finzi-Dottan & Kormosh, 2016). Furthermore, a qualitative study is capable of providing a deeper comprehension of CF that will enable people to identify the need for educational programmes on coping with CF and resilience (Florczak, 2013; Potter, Pion, & Gentry, 2015).

There is a specific need for research on the enhancement of personal skills such as resilience to overcome CF, especially in South Africa (Najjar et al., 2009). Resilience is a multifaceted concept that refers to an individual's ability to overcome adverse circumstances (Kinman & Grant, 2011; Rutter, 2007) and it has recently been acknowledged as significant in overcoming CF (Kapoulitsas & Corcoran, 2015; Kinman & Grant, 2011).

Resilience

Resilience has been studied for the past 50 years. As a result, various perspectives on resilience have developed in research (Anderson, 2015; Cutter, 2016; Dugan & Coles, 1989; Glantz & Johnson, 1999; Grove, 2013; Joseph, 1994; Robinson & Carson, 2016; Taylor & Wang, 2000; Thomsen, 2002; Ungar, 2005) although there is still no formal agreement on a distinct definition for it (Masten, 2004; McGeary, 2011). Research states that resilience must rather be recognised as a process: it must be seen as an interaction between individuals and their environment, and a balance between the ability to cope and the stress experienced (Kim-Cohen & Turkewitz, 2012; Masten, 1994).

Resilience is a construct that stems from the Latin word *resiliens* and was used in the natural sciences to refer to the elastic capacity of a substance (Joseph, 1994). According to Rutter (2008), resilience is an individual's ability to bounce back after difficulty. Moreover, when individuals thrive and develop positively despite adversity, they are seen as resilient (Wu et al., 2013). Within a workplace setting, resilience can be seen as the ability to overcome stress by making use of adaptive coping mechanisms that aid an individual in recovering after being exposed to a significant amount of stress (Herrman et al., 2011). Similarly, Ungar (2008) defines resilience as follows:

In the context of exposure to significant adversity, whether psychological,

environmental, or both, [and] is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways (p. 225).

However, for the purpose of this study, resilience is conceptualised in line with Bonanno's (2008) work as a skill that an individual possesses in order to sustain stability and healthy levels of physical and psychological functioning despite experiencing adversity. In other words, when resilient individuals are exposed to risk factors within the workplace, they experience a positive (rather than a negative) outcome and are capable of eluding the undesirable consequences of stress (Kinman & Grant, 2011; Saleebey, 2006). His definition is utilised in this study as he has done groundbreaking work among individuals who have experienced severe loss or trauma (Bonanno, 2008; Bonanno & Mancini, 2008; Bonanno & Mancini, 2012; Bonanno, Westphal, & Mancini, 2011). Bonanno (2008) sees resilience as the core experience that people have when working through traumatic experiences.

In order to research resilience adequately, it is important to comprehend the connection between stress and resilience (Everly, Welzant, & Jacobson, 2008). Overcoming adversity is often more about the manner in which an individual responds to stressors than the actual stressors themselves (Bush, 2009; Lazarus & Folkman, 1984).

Resilience is multifaceted (Bonanno, 2008) and is composed of various components, including positive emotions, such as smiling and laughter, hardiness, repressive coping and self-enhancement (Bonanno, 2008; Masten, 2004). In addition, resilience originates from a number of sources, including one's social support system (family and external sources of support) (Bonanno, 2005; 2008; Bonanno & Mancini, 2008). Various effective coping mechanisms have been linked with resilience, which include facing one's fears, being optimistic, having a moral compass, an individual's religion/spirituality, role models who are resilient, social support, being physically and cognitively fit and flexible, and having meaning and purpose (Gito, Ihara, & Ogata, 2013; Glass, 2009; Southwick & Charney, 2012). These problem- and emotion-focused coping mechanisms are positive ways of coping with the amount of stress experienced by nurses (Southwick & Charney, 2012). Support and meaningful

connections with friends and family can also be seen as resilience-building strategies (Zander, Hutton, & King, 2013). Moreover, studies among people experiencing trauma have revealed a clear link between social support and resilient outcomes (Bonanno, 2008; Bonanno, Galea, Bucciarelli, & Vlahov, 2007). Therefore, it is clear that problem- and emotion-focused coping mechanisms can aid nurses in having a more balanced lifestyle and provide them with a source of support (Southwick & Charney, 2012).

Resilience in the South African Context

Over the past ten years, resilience has been thoroughly researched in the South African context. However, this research involves resilience within contexts of poverty, education and crime (Cooke, 2015; Leoschut & Burton, 2009; Theron & Theron, 2010). While Matheson and colleagues (2016) state that research on resilience among health-care professionals is not as prevalent, Stephens (2013) mentions that it is becoming increasingly prevalent within healthcare professions. Most of the recent research studies that have been conducted on resilience within the South African healthcare sector focus on overcoming burnout within the public sector (Koen, Van Eeden & Wissing, 2011; Phyffer, 2015; Ramalisa, 2014). However, as CF develops before the individual reaches the point of burnout (Adams et al., 2008; Bhaga, 2010; Day & Anderson, 2011; Dominguez-Gomez & Rutledge, 2009; Maier, 2011; Sabo, 2011; Ward-Griffin et al., 2011), a greater understanding of diminishing the effects of CF by means of resilience would make a valuable contribution to the field. Tubbert (2016) confirms that increasing one's resilience may aid in countering the adverse effects of CF.

Therefore, there is a need for the development of effective approaches to promote resilience which, in turn, counter difficulties and allow individuals the opportunity not only to cope in their environment, but also to thrive (Bowden, Smith, Parker, & Boxall, 2015). Resilience can be developed and strengthened by making it a part of nursing training before nurses enter into the official workplace (Jackson et al., 2007).

Ungar (2003) emphasises that qualitative methods are relevant to resilience research as they enable the detection of unidentified processes. Furthermore, because qualitative research examines resilience within a particular context, these studies tend to empower the minority "voices" such as those of nurses' (Ungar, 2003). Nurses

may be seen as minority "voices" as they hardly receive the recognition they deserve (Finkelman & Kenner, 2013). Furthermore, the public does not always understand what the field of nursing entails (Finkelman & Kenner, 2013). It is important to keep in mind that every individual's resilience process is unique; therefore, it is important to take into consideration that the attempts to predict resilience may be challenging (Ungar, 2003).

Coping Strategies Contributing to Resilience in Healthcare

Since the main objective of this study is to explore the experiences of nurses with regard to CF and resilience, the coping mechanisms they use form an important part of this study in that they protect against the development of CF and can enhance resilience (Najjar et al., 2009; Yoder, 2010). Coping mechanisms can be defined as thoughts and behaviours that one adopts to deal more successfully with difficulties (Martins et al., 2014). Coping mechanisms can either be emotion- or problem-focused (Akuroma, Eye, & Curran, 2016; Lazarus, 1993). Emotion-focused coping is aimed at managing emotional suffering (Akuroma et al., 2016; Fresco, Williams, & Nugent, 2006). For example, a person's reactions to stressful factors may be altered (Lazarus & Lazarus, 2005; Lim, Bogossian, & Ahern, 2010). During problem-focused coping, active steps are taken to change negative circumstances into something more positive (Akuroma et al., 2016). In other words, factors in the environment that are causing distress are removed (Lazarus & Lazarus, 2005; Lim et al., 2010). Both types of coping mechanisms may bring about emotional tranquility (Akuroma et al., 2016), and most people make use of these methods in order to cope successfully. However, the use of problem-focused coping has been connected to positive outcomes with regard to coping in an occupational setting (Beh & Loo, 2012).

According to De Beer, Brysiewizz, and Bhengu (2011), nurses need to acquire the correct knowledge and skills in order to cope with constantly having to care for severely ill and traumatised patients. However, an individual's ability to make use of the correct skills and coping mechanisms may be something that is learnt over time (Mrayyan, 2009). Therefore, experience in this field is one of the most important aspects of coping successfully (Mrayyan, 2009). It has been discovered that distressing emotions tend to decrease with experience (Shimizu, Couo & Merchan-

Hamann, 2011), while an individual's skills, self-confidence, motivation and competence in the field tend to increase with experience (Gaki, Kontodimopoulos, & Niakas, 2013; Gulzar, Shamim, & Khuwaja, 2010; Hertting, Nilsson, Theorell, & Sätterlund Larsson, 2004; Koch, Proynova, Paech, & Wetter, 2014; Sparks, 2012).

In addition, turning to a social support system in times of distress can be seen as a problem-focused coping mechanism as the individual actively pursues support from loved ones in order to reduce his or her distress (Akbar, Elahi, Mohammadi, & Khoshknab, 2016). Having a strong support system can improve overall quality of life, aid individuals in dealing with a stressful environment, contribute towards resilience, and may decrease physical and psychological health problems, including anxiety and depression (Button, 2008; Davis, Lind, & Sorensen, 2013; Prati & Pietrantoni, 2009; Prati & Pietrantoni, 2010; Yılmaz, 2017). Gumani (2012) also found that support from both family members and colleagues aids in the coping process. Family members may be supportive as they are the people with whom one feels most comfortable (Gumani, 2012). On the other hand, colleagues provide a sense of support as they are the people who truly understand what you may be going through and are able to empathise on a deeper level than anyone else (Gumani, 2012). Moreover, positive collegial relationships may assist in coping as these relationships create a supportive and pleasant working environment (Akbar et al., 2016; Duffy, 2013; Kubichka, 2016; Sias, 2008; Vessey, Demarco, & Difazio, 2010).

Thirdly, being prepared to face the next traumatic situation (Sandström, Juuso, & Engström, 2016) may serve as a problem-focused coping mechanism for nurses as they actively pursue the right knowledge and skills in order to prepare themselves for the unexpected.

A number of emotion-focused coping strategies have also been found to be helpful in the nursing profession. Emotional expression in the presence of a trusted source can aid indviduals in managing their emotional responses (Pennebaker & Evans, 2014). Moreover, it can assist them in adjusting their emotions according to what is applicable to the specific environment, and can also increase overall life satisfaction (Pennebaker & Evans, 2014). Research also suggests that emotional expression can protect nurses against emotional fatigue (Perry, Toffner, Merrick, & Dalton, 2011; Van der Colff & Rothmann, 2014). Furthermore, speaking to someone about the trauma that has been experienced can aid nurses in displaying their true emotions in

the presence of a trusted source and therefore enable a higher level of emotional control in stressful situations (Kinman & Leggetter, 2016). According to Burleson's (2009) findings, individuals who vent their emotions in the presence of another may experience a decrease in the amount of negative emotions and an increase in positive thoughts and overall wellbeing. In other words, emotional expression can assist nurses in adhering to the rules regarding appropriate emotional expression towards patients and staff (Kinman & Leggetter, 2016).

Furthermore, it has been found that religion frequently emerges as a positive coping mechanism among individuals who have experienced trauma (Bryant-Davis, Ellis, Burke-Maynard, Moon, & Counts, 2012). Victims of secondary trauma may make use of religious coping mechanisms to form a more intimate relationship with God and other individuals with a similar religious viewpoint, to feel more in control of their lives during stressful situations, thrive with regard to their mental and physical wellbeing, find a sense of meaning and strengthen their level of resilience (Claborn, 2009; Southwick & Charney, 2012). Research conducted in Uganda revealed that religion provides nurses with a sense of support during difficult times (Harrowing & Mill, 2010; Nderitu, 2010). Globally, religion is considered one of the adaptive coping mechanisms that nurses can make use of in order to work through trauma (Ekedahl & Wengstrom, 2010; Rose & Glass, 2008; Shinbara & Olson, 2010).

Self-compassion is another factor that has emerged as a buffer against developing psychological disorders and aids in developing a healthy level of resilience (MacBeth & Gumley, 2012; Mantzios, 2014; Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, 2009; Smeets, Neff, Alberts, & Peters, 2014). Various researchers have found a link between compassionate care towards others and self-compassion (Lindsay & Creswell, 2014; Neff & Pommier, 2013; Welp & Brown, 2014). Self-compassion can be defined as compassion that is displayed towards oneself, contributes towards the prevention of CF and enhances compassionate care for patients (Beaumont et al., 2016; Gustin & Wagner, 2013; MacBeth & Gumley, 2012; Neff, 2003; Wong & Mak, 2012).

A study in Norway also identified reflection as a valuable means of coping among nurses (Bakibinga, Vinje & Mittelmark, 2012; Vinje & Mittelmark, 2008). Wright (2010) states that self-reflection aids in maintaining the necessary energy needed to

fulfill tasks and being more conscious of the passion you have for your occupation. In turn, it may lead to self-fulfillment and personal growth (Wright, 2010).

A positive attitude (Chang & Chan, 2015), motivation (Toode, Routasalo, & Suominen, 2011) and openness to experiencing a complete range of emotions, from happiness to sadness (Gjengedal et al., 2013) have also been found to serve as helpful ways of coping among nurses, especially among those working in trauma units.

Some nurses may not necessarily have the required strategies to cope in a stressful environment (Magyar & Theophilos, 2010). Therefore, Mohamed (2016) states that hospitals should make classes and therapeutic services available to medical staff that find it difficult to deal with traumatic situations. Johnson (2016) further recommends that debriefing takes place immediately after exposure to a traumatic event. Lavoie, Talbot and Mathieu (2011) found that nurses working in trauma benefited from therapeutic sessions.

In light of the above, CF and resilience play a fundamental role in the lives of nurses and are therefore worthy of further investigation. As part of the research process, certain methodological steps were implemented.

Methodology

Research Question

The aim of this study was to explore and describe South African nursing professionals' experiences of compassion fatigue and resilience. Thus, the following research question was posed: What are the experiences of nursing professionals with regard to compassion fatigue and resilience?

Research Design and Methodology

The approach of this research study was qualitative in nature. Qualitative studies place emphasis on collecting rich and descriptive data, with the main goal of encapsulating each participant's unique experience of the topic at hand (Denzin & Lincoln, 2011; Howitt, 2010). A qualitative method was used to gain a better understanding of the topic on which a limited amount of literature is available (EBSCOHost database search, January 2018).

Furthermore, the study was conducted by subscribing to a social contructivist paradigm. Therefore, the main objective of the research is to emphasise each individual's views and knowledge of a situation (Andrews, 2012). The use of a social constructivist paradigm and spending time with nurses enabled the researcher to understand and share their experiences of compassion fatigue and resilience.

Language and everyday interactions are important factors in the construction of subjective reality (Lewis, 2015). In the current study, the participants often made use of metaphors to explain their experiences. However, the interviews were mostly conducted in Afrikaans, and it was therefore important for the researcher to capture the rich meaning of each metaphor while translating the interviews into English for academic purposes. In this study, translation occurred after interpretation. Van Nes, Abma, Jonsson, and Deeg (2010) state that the researcher can avoid mistranslations by keeping the research in its source language which, in this case, was Afrikaans, for as long as possible. Researchers also suggest that the involvement of a single translator, who is competent in both languages, can result in a reliable translation (Squires, 2009; Twinn, 1997).

A multiple case study design (Yin, 2014) was used as this allows for the same research question to be addressed in numerous settings by making use of the same data collection methods and analysis (Stake, 2013). Qualitative case studies facilitate a deep exploration of concepts within a particular context and make use of several sources of data. This warrants that the phenomenon is not studied solely through one lens, but various lenses, which allows multiple facets to be exposed and recognised (Baxter & Jack, 2008). Another advantage of this approach is the fact that researchers are able to research the phenomenon at hand while working in close collaboration with their participants (Crabtree & Miller, 1999). At the same time, this approach allows participants' voices to be heard (Crabtree & Miller, 1999). It is imperative for nurses' voices to be heard in South Africa as they are currently the leading health-care professionals in our healthcare system (Bhaga, 2010; Campbell et al., 2009; Engelbrecht et al., 2008; Naik, 2016). In addition, this design allows the researcher to gain an increased understanding of the participants' actions (Lather, 1992; Robottom & Hart, 1993) with reference to CF and resilience in the current study. Although this method is widely used and has various advantages, it is not always fully understood. As a result of contradictory epistemological hypotheses and intricate characteristics,

proving scientific precision may be problematic and the findings diffcult to justify (Baškarada, 2014).

Participants and Sampling Procedures

The purposeful sampling (Nishishiba, Jones, & Kraner, 2013; Yin, 2011) of participants was most suitable for the current study. The researcher selected participants intentionally according to their potential to make a meaningful contribution to the data. According to Yin (2014), a total of six to eight participants is suggested when conducting a qualitative study. Crouch and McKenzie (2016) state that a small sample size is sufficient and may even increase a study's validity as the researcher can form close associations with each participant, which also enhances the overall quality of the interviews. Sample size in qualitative research relies on how well it can inform the subject being studied (Baker & Edwards, 2012; Sargeant, 2012). Therefore, a total of six participants were selected from a population of nurses who have previous experience or who are currently working in a private trauma unit. Data saturation was reached with the six participants who were selected as sufficient information was available in order to replicate the study (O'Reilly & Parker, 2012; Walker, 2012) and additional coding was no longer possible (Guest, Bunce, & Johnson, 2006).

The inclusion criteria for this specific study were that participants had to have at least five years' experience in the nursing profession and had to be capable of expressing themselves comfortably in either English or Afrikaans. Nurses who were being treated for a mental health condition at the time of data collection were not included in the study.

Participant 1 was 28 years of age and employed at a private hospital situated in Bloemfontein. As she is bilingual, both interviews were conducted in English. She had a total of five years' experience in nursing, during which time she had worked in a private trauma unit for three years and a psychiatric hospital for two years. She had decided to pursue a career in nursing because she found the science behind it fascinating and challenging. She described nursing as one of her biggest passions in life and loved being able to serve others and make a difference in their lives on a daily basis. She was married and stated that she truly appreciated her husband's support in terms of her career.

Participant 2 was 31 years of age and employed at a private hospital situated in Gauteng. As she is Afrikaans speaking, both interviews were conducted in Afrikaans. She had a total of six years' experience in nursing. She was employed at a trauma unit and had a total of four years' experience in trauma care. Initially, she had studied for a different career, but later realised that nursing was the career she wanted to pursue. She described herself as a positive and religious person who applied her faith to situations regarding her career. She stated that her religion was where she got her support and motivation to continue her work. She enjoyed working with people and strove to be the best nurse she could possibly be. Participant 2 was married and had one child. Even though she found it difficult to balance her occupational and family responsibilities, she derived enough inspiration from her career to continue in this field.

Participant 3 was 30 years of age and employed at a private hospital in Bloemfontein. As she is Afrikaans speaking, both interviews were conducted in Afrikaans. She had a total of seven years' experience in nursing, during which time she had worked in various departments, including ICU, oncology and medical wards, and was working in a trauma unit at the time of this study. Her passion for helping others had always been present, and she could not have found a better career to fit her personality. She described herself as a vibrant and positive person, who enjoyed the challenges associated with working in a trauma unit. Participant 3 was engaged and living with her fiancé. She found that her career often had a negative effect on her relationship with her fiancé as it was difficult for him to understand what she was experiencing on a daily basis. However, she was grateful for his support and stated that by simply listening to her stories, he had already lightened her load.

Participant 4 was 28 years of age and employed at a private hospital situated in Bloemfontein. As she is Afrikaans speaking, both interviews were conducted in Afrikaans. She had a total of five years' experience in nursing, during which time she had worked in ICU for two years and in a trauma unit for three years. During the interviews, she explained that ever since she could remember, nursing had always been the career she had wanted to pursue. Her mother was also a nurse, which had encouraged her to pursue this career, particularly since her mother's stories had always been so fascinating. She also enjoyed being surrounded by people in her occupation as she did not enjoy functioning alone. She explained that she had found

joy in helping others and receiving feedback from patients stating that they had appreciated her services. Participant 4 had recently married her husband and mentioned that her career had had an influence on their relationship as they both worked difficult hours, which resulted in their seeing each other for limited times during the week. She also stated that she had been considering moving to a different area in nursing as it would be difficult to work nightshifts while raising her children in future.

Participant 5 was 52 years of age and had been qualified as a registered nurse since 1989. As she is Afrikaans speaking, both interviews were conducted in Afrikaans. She was pursuing her own business within the medical field, and had completed a postgraduate degree in oncology and wound care. For eight of the 28 years she had spent working as a nurse, she had worked in a trauma unit. She had also worked in psychiatry, theatre and oncology wards. She described herself as someone who loved working with people as she derived energy from being around people. She entered the field of nursing because she had felt passionate about assisting people in a medical setting. Participant 5 was married and had two children. She explained that her career was such an integral part of her life that it automatically influenced her family life. She stated that she had often arrived home and taken out her frustrations on her husband and children, but that this had improved drastically over the years as she continually learned how to cope effectively with her stress.

Participant 6 was 29 years of age and employed at a private hospital in Bloemfontein. As she is Afrikaans speaking, both interviews were conducted in Afrikaans. She had a total of five years' experience in nursing and was employed in trauma care where she had been working for four years. She had also worked in psychiatry for one year. She stated that she had wanted to be a nurse ever since she was a little girl. She loved being able to assist people on a daily basis and had a passion for working in trauma. She would be furthering her career soon by specialising in trauma nursing. She mentioned that she had loved the adrenaline rush she got from working in trauma units, that she had enjoyed the challenges she had encountered in her job and that she never wanted to stop learning. Although she had been married, she and her husband were in a long-distance relationship at the time as his job had involved travelling internationally. Her mother lived with her and provided her with a sense of support. She felt as though she had often taken negative

experiences home from work and had spoken to her mother about this. Even though this helped her to work through these experiences, it had had a negative impact on her relationship with her mother.

Data Collection Method

Individual, semi-structured interviews (Howitt & Cramer, 2011) were used to collect the data. The interviews provided the researcher with the opportunity to obtain a deeper understanding of each participant's unique experiences and insights (Seidman, 2013). Furthermore, the semi-structured nature of the interviews allowed the researcher to be flexible during the interviews and to structure follow-up questions according to the insights and experiences of each unique individual. This brought about rich and descriptive data on the nurses' experiences with regard to compassion fatigue and resilience.

Triangulation was used in order to increase the study's trustworthiness and rigour (Braun & Clarke, 2013; Merriam & Tisdell, 2015). Therefore, two in-depth interviews were conducted with each participant between April and October 2017, thus allowing enough time for reflection between interviews. Interviews were recorded with the written consent of each participant and were conducted after working hours in a confidential space of their choice.

Interviews are considered a significant source of evidence, especially for case study research (Yin, 2009). It provides the researcher with the opportunity to gain an in-depth understanding of the participants' experiences, emotions, feelings and opinions regarding the research subject (Braun & Clarke, 2013; Seidman, 2013). Personal interviews were helpful in collecting data on this specific research subject as they allowed the researcher to have personal and direct contact with the interviewees. It is, however, important for the interviewer to have the necessary skills to conduct an interview in a successful manner (Kvale, 2008). In order to ensure that the interviewer was prepared and had the necessary skills to conduct an interview, a pilot interview was conducted before commencing with the official interviews for this study. Firstly, the pilot interview helped the researcher to feel more comfortable in the official interviews conducted for this study. It also assisted the researcher in swiftly and accurately formulating follow-up questions. Lastly, it helped the

researcher to develop the required confidence and professionalism to successfully conduct the interviews.

The interview schedule for the first interviews can be found in Appendix A. The second interview's questions were formulated in a unique manner according the interviewees' answers during the first interviews.

Data Analysis

Thematic analysis was used to ensure epistemological flexibility and rich, detailed data (Braun & Clarke, 2006). This method was used in order to identify, analyse and report the key themes and sub-themes contained in the data set (Braun & Clarke, 2006).

The first step involved transcribing the recorded interviews, while the second involved becoming familiar with the data (Braun & Clarke, 2006). During the second step, the researcher immersed herself in the data by reading and rereading it. This step also created the foundation for more in-depth analysis. The third step included generating initial codes (Braun & Clarke, 2006), which involved recognising a basic element within the raw data that can be measured in a significant way with regard to the topic being studied (Boyatzis, 1998). An example of a code that was identified in this study is: "Sometimes I can feel I need a holiday due to mental and emotional exhaustion."

Thereafter, the codes were retyped into a separate document and the researcher searched for themes based on an analysis of the recognised codes. This included focusing on the broader themes rather than merely on the codes, as well as categorising the codes into possible themes (Braun & Clarke, 2006). An example of a theme that was identified in this study is "fatigue". The fourth step involved reviewing the themes that had been identified already. The themes that were identified as overarching were sorted accordingly (Braun & Clarke, 2006). Examples of overarching themes in this study were "emotional fatigue" and "fatigue: its impact on friends and family". These two overarching themes were combined to form the theme "fatigue". Next, the researcher defined and named the themes. This involved further refining and defining the existing themes and then analysing the data within these themes to ensure that they fitted together in a meaningful manner (Braun & Clarke, 2006). In the sixth step, definitions and names that encapsulated the core of each

identified theme were formulated. The last step consisted of writing a dissertation based on the analysis of the collected data in order to address the research question.

Rigour and Trustworthiness

Credibility, dependability, confirmability and transferability were applied in order to ensure the trustworthiness of this research study (Ryan, Coughlan, & Cronin, 2007). Credibility (Maree & Van der Westhuizen, 2010) was increased by providing the participants with an opportunity to view the findings and offer opinions on whether these were in agreement with their own experiences. The interviewees were consulted regarding the findings of both interviews. Reflective journaling (Ryan et al., 2007) allowed the researcher to maintain a record of the research process and to document all the decisions made. It also allowed the researcher to provide evidence of the acquired data, to recognise samples of the work in progress and, lastly, to take previous reflections into consideration. This ensured dependability (Ryan et al., 2007). Notes were written by the researcher throughout the research process and after interviews, which allowed the researcher to become aware of and manage any personal biases. The researcher's reflective journal can be found in Appendix C. Dependability was further enhanced by making use of triangulation which ensured the replicability of the findings (Saldaña, 2015). The supervisor and co-supervisor of the study aided in anlysing the data and external reviews, which ensured that the findings were verified and validated, thus ensuring confirmability (Maree & Van der Westhuizen, 2010). Lastly, the findings can potentially be applied to similar contexts as the researcher provided a comprehensive description of the research process and methodology of this specific research study, thus ensuring transferability (Krefting, 1991).

Ethical Considerations

Permission to conduct the study was granted by the Research Ethics Committee of the Faculty of the Humanities, University of the Free State (Letter of ethical clearance can be found in Appendix D). The researcher adhered to the broad principles of non-maleficence and beneficence throughout the research process. Therefore, written informed consent was gathered from every participant. The participants were informed that their participation was entirely voluntary and that they had the right to withdraw at any point in the process (Maree, 2007). In order to maintain

confidentiality, pseudonyms (Maree, 2007; Merriam & Tisdell, 2015; Pope & Mays, 2013) were used throughout the data analysis, discussions and report writing. Electronic copies of the data were saved on the researcher's personal laptop and all files were password protected. Hard copies were stored in a locked cabinet. Due to the sensitive nature of the research, it was important to have strategies in place to mitigate any harmful emotional consequences that could have been associated with this study. If a participant experienced distress, the individual would have been referred to a student psychologist who could provide her with therapeutic services free of charge. Alternatively, a referral to a private psychologist could also be made, depending on the individual's preference. However, none of the participants were in need of such services.

Results and Discussion

The analysis of the transcribed interviews revealed four main themes and 14 subthemes. Therefore, this study contributes to a deeper understanding of nurses' experiences of CF and resilience. The first theme focuses solely on the development of compassion fatigue among nurses. The next theme, coping strategies, focuses on overcoming CF and the development of resilience. The last two themes explore the development and significance of CF and resilience in the nursing profession.

The first theme that emerged consisted of the fatigue that the participants had experienced within their occupation. Several subthemes also emerged within this theme, which included the impact of fatigue on the nurses as individuals as well as on their families, the experience of emotional fatigue, distressing emotions, CF and secondary traumatic stress that had developed as a result of nursing. Lastly, the impact of patient deaths on nurses will be discussed.

Theme 1: Fatigue and the Factors Contributing to It

The impact of fatigue. The participants mentioned that physical and emotional fatigue had impacted their interpersonal lives. For example, they mentioned that on several occasions, the fatigue and trauma they had experienced never stayed at work; instead, they always ended up taking it home and talking to their families about it. Furthermore, their work became the main topic of discussion; therefore, their other responsibilities tended to be neglected. P1 stated that it had felt as though she was

always talking about work-related topics and that as a result, her personal life was being neglected:

> And even if you're at home, you talk about your patients or what happened during the day. You don't talk about yourself, or, or personal problems you're experiencing. And that's also important to kind of, you know, let out.

P2 spoke about the impact of fatigue on family relationships due to working long hours. She stated that her neglectful behaviour towards her family was not always fair as they also required the same level of attention her patients had received on a daily basis:

> We don't see our families often due to our occupation. The people you spend the most time with are the people that you work with … You become tougher on the people who are closest to you … You can still show compassion at work, but it is difficult to show compassion at home when a family member is sick because you deal with it everyday and get so tired of it … It isn't fair towards one's loved ones to go on about what has taken place at work.

P3 explained that her occupation had impacted her relationship with her fiancé due to the long and impractical hours she worked on a weekly basis. She further stated that she often tended to take out her frustrations on him:

> My job does have an impact on my fiancé and my relationship. Sometimes he will tell me that I am being rude … My job also impacts on our relationship as we don't have as much time together; we don't always have time to talk in the evenings and sometimes I'm just too tired. We will lie in bed speaking and then I will fall asleep … It gets to you but you are under pressure so you just have to carry on and then you reach a day where you just want to cry or you just get angry and then I end up being mean towards my fiancé. When it gets to this point you realise how much a situation really touched you.

The participants mentioned that they were not always able to pay as much attention to family responsibilities as a result of the constant fatigue they had experienced. Similarly, a study done internationally, in Udaipur, revealed that nurses had found it difficult to meet the needs of their spouses (Rathore et al., 2012). Rajan's (2017) study among nurses also discovered that family conflict had arisen within the homes of nurses due to the long hours that they had worked on a weekly

basis. Moreover, these long and inflexible hours may lead to a lack of care within their families (Rajan, 2017). Emotional fatigue emerged as a significant contributing factor to the overall fatigue experienced by the nurses in this study.

Emotional fatigue. Several participants agreed that they often felt emotionally fatigued as a result of their occupations. Some participants mentioned that they had become emotionally numb or blunted towards their patients due to the amount of trauma they had to deal with daily. For example, P1 commented on the conflicting emotions she had experienced as a result of protecting herself from emotional fatigue:

> You harden yourself towards traumatic events and/or patients … It's difficult because you want to feel empathy towards your patients … You can sympathise with your patients, but you can't feel empathy all the time as it will drain you emotionally.

Similarly, the emotional fatigue that P3 experienced while working in a trauma unit sometimes became overwhelming for her:

> You do get more tired and emotionally drained as compared to working in other wards because it is a lot of responsibility and pressure that you have to deal with. Sometimes I realise that something is almost suffocating me and that it is too much for me to handle … I also sometimes feel like I can't carry something with me any longer but when I talk to someone about it then it is out in the open and I can move on … I get tired and irritated so quickly and I have told myself to just back off from a situation if I'm not sure how to deal with it in the moment.

P5 spoke about the negative effect that emotional fatigue had upon her occupation. She mentioned that the emotional fatigue she had experienced developed into aggression and irritation, which could lead to compromised patient care:

> I become aggressive towards my colleagues and family, which means that I still don't know how to deal with my emotions … The patient is first priority. If you are not well yourself, then the patient will suffer as a result … I become very aggressive and irritated when I'm stressed, especially with people who talk about nonsense or things that aren't so important to me …

The environments in which nurses spend most of their time may place them in a position to experience emotional depletion as most of the situations they face are

emotionally demanding (Al-Shaqsi et al., 2015; Dolan et al., 2011; Lyneham & Byrne, 2011; Richardson et al., 2013). The participants experienced emotions, such as aggression and irritation due to the fatigue caused by the amount of compassion that they constantly displayed towards their patients. Banakhar (2017) mentioned that feelings of depression and irritability may increase as a result of physical and emotional fatigue. In addition to irritation and depression, it has been found that fatigue may also lead to feelings of sadness and a reduced ability to cope effectively with the emotional demands of their workplace (Caruso, 2014) and personal life (Lambert & Lambert, 2008).

In this study, the participants also acknowledged that they had experienced various distressing emotions within their occupation, which was often the result of emotional fatigue and/or the amount of secondary trauma experienced.

Distressing emotions. The participants often mentioned that they were unsure of how to deal with certain situations in which they had been placed, resulting in distress. For example, P1 spoke about a situation that had brought about conflicting emotions in that she did not know how to deal effectively with the situation. These conflicting emotions led to the dismissal of the situation without dealing with it on an emotional level:

> … it was very difficult to deal with that because I don't know what to do. You can't really go and hit the person back or, or –. And they don't understand that what they're doing is wrong, you know. It's just this, this feeling they get I guess, that they –. Ja. That was quite traumatic to me. I did not really know how to go about it … You know, it was so shocking to me I really, I really just brushed it off. I was, you know, I was almost in tears and I thought: no, come on. This is not that bad. And I just left it. You know, I just went on with my day, which isn't – I mean, you need to deal with it, but I just brushed it off.

Likewise, P2 also spoke about her first experience with a young girl who had aborted her own child and how her personal emotions interfered with her professional interaction with the patient:

> My very first encounter made me cry; it was very upsetting to me ... This was probably the last time I cried about a patient ... The young girl that had an

abortion had a big impact on me; it is not something one can forget easily. I said, "It was a boy. What did you do? You can't just carry on like that…" Afterwards, I realised, listen here, my behaviour is not always professional.

P4 discussed how overwhelming the experience of a child's death had been to her on a sensory level. According to her, it was something that she would never forget:

There is a lot in your environment that you take in daily when working in trauma. You see, hear and smell things all day in trauma. Your senses work overtime in the trauma unit … The experience of the child passing away will stick with me forever … It is an incredibly sad situation to see and to hear.

As mentioned by the participants, they had either reacted in a manner that may have been emotionally harmful to the patients or were unsure of which emotions to display. Nursing staff are often required to hide certain emotions as displaying them may come across as inappropriate (Gray, 2009). They follow a hidden rule book on which emotions are displayable and which are not (Diefendorff et al., 2011), which may amplify the amount of stress they experience in traumatic situations. Furthemore, nurses are often required to display compassionate care in very difficult interpersonal conditions (Chou et al., 2012).

Distressing emotions are not only problematic in terms of interpersonal relationships; they also increase the risk of developing CF.

CF. Participants spoke about CF in their own lives and how it may occur in their occupation. For example, P1 stated that a prolonged period of time spent with a specific group of patients often led to CF as she became less compassionate and patient towards them:

Because they (patients) do tend be a little more difficult, or difficult to work with ... and, and because we are very … We have a lot of experience with dealing with them … We tend to get less compassionate and less patience comes out for these people.

P3 mentioned that she had experienced CF which, in turn, had caused a sense of guilt:

I do get tired of caring and being sympathetic towards patients. Sometimes I feel like I don't have time to sit and listen to a patient; I just want them to get to the point and then I often feel guilty because I realise that I'm getting

emotionally blunted towards my patients. I end up feeling like a bad nurse when my emotions become blunted.

Similarly, P4 stated that CF develops due to the significant trauma one hears about and experiences daily. As a result, working with patients whose problems seem less significant may cause one to react in an unsympathetic manner:

Sometimes I become short-tempered because some patients sit and talk about their problems but you have just recently seen someone that has been through a lot of trauma and then this current patient's problem doesn't seem so serious anymore.

Lastly, P5 acknowledged that CF develops due to the need to protect herself against emotional distress.

The trauma takes away your humanity. Trauma takes away your empathy for people because you try to protect yourself against the trauma ... On the other hand, over-involvement in patient care can be the result.

A nurse's main goal is to care for patients. However, due to the daily exposure to caring for ill patients, they are at risk of developing CF (Ledoux, 2015; Lombardo & Eyre, 2011). Often nurses place others' needs above their own. However, over time, this can have an adverse impact on their ability to care compassionately (Chung, 2015). It has also been found that over-involvement in patient care my increase the risk for developing CF (Anewalt, 2009; Chung, 2015).

The impact of fatigue, whether physical or emotional, on nurses and their families is vast. Two contributing factors towards fatigue are secondary trauma and death in the workplace. Therefore, the impact of secondary trauma on nurses will be discussed in the following paragraphs. Thereafter, the emotional impact of death will be examined.

Secondary trauma. As a nurse, trauma is a reccurring event that often leaves deep emotional scars. P2 spoke about the difficulty in dealing with secondary trauma as a young nurse, but stated that as soon as it started becoming easier to experience or work through the secondary trauma, she realised that it was time for her to enter a new area of specialisation:

To me it was always difficult to deal with traumatic situations. Later on, it started getting easier to deal with traumatic situations. When it started getting easier, I changed my area of specialisation. Everyone experiences trauma and the emotional results differently. It's difficult to work through experiencing trauma on a daily basis.

Furthermore, P2 also mentioned that her emotions had fluctuated according to the type of trauma she experienced:

It is normally the bad/traumatic situations that you take home with you. The impact on my emotions varies according to the situation. For example, rape, assault and those types of things make me angry.

P3 highlighted the feelings of guilt connected to experiencing secondary trauma:

Most of the situations we experience are a form of secondary trauma. You constantly experience traumatic situations and deaths. In the first few traumatic situations regarding death, I often thought it was something I did wrong as a nurse. I would ask myself whether I neglected the patient.

The participants agreed that working through any form of trauma and/or secondary trauma is often difficult and that every person responds to it differently. Psychological and physiological responses connected to the experience of trauma should not be seen as abnormal. These responses to secondary trauma, as mentioned in the above excerpts, often decrease over time. However, trauma or secondary trauma that is repetitive over a period of time may lead to a psychological disorder, especially if the individual cannot successfully work through the trauma (Mealer et al., 2007). Moreover, it has been found that the death of a patient may end up causing feelings of failure and lead to a decrease in self-esteem (Walsh, 2009).

Another contributing factor to fatigue that emerged within the study was the number of deaths faced by the nurses on a daily basis.

Death. The participants provided various reasons as to why death had had such a significant impact on them and why it caused fatigue. P1 mentioned that one specific death in trauma had had a significant impact on her career. This experience of death was so emotionally overwhelming for her that she avoided the pain of having to deal with it:

The patient that passed away after the car accident. Ok, well, I must be honest, when I say that I –. This was the one thing that gave me a completely negative view of, of trauma … And, and mostly because I didn't really –. I wasn't sure how to deal with it. And I didn't really get over it, or you know, I didn't –. I never thought of the situation and tried to make sense of it and all that… Because we, you are so busy that you don't, you don't have time to deal with a situation, a traumatising or an emotional loss ... because you have all these other things you have to worry about … Now this patient has passed away and you can't think about this patient anymore because you have other lives to save, you know.

P2 stated that she had to start dealing with death at a young age which had forced her to become emotionally mature:

When you are a student nurse, you just have to walk in and start dealing with death without any preparation. When you are young, you do experience death but you have most likely never stood next to someone's bed and watched the life leave their body. As nurses, we always speak about our first death because it changes one's life. You are forced to become emotionally mature in order to cope with your surroundings.

P5 spoke about the difficulty of conveying the news of death to a patient's family. The emotional distress that she experienced as a result of having to convey bad news within the trauma unit caused her to enter a new field of nursing:

The patient's death was very difficult for me; having to carry over the news and to experience it with them ... I did not handle this situation well, especially because I so often had to carry over negative news ... Due to carrying over bad news so often, I decided to exit the area of specialisation for a while so that I wouldn't have to deal with it anymore.

From the above excerpts it is obvious that the participants had been through various experiences of death and that these had a negative impact on them emotionally. Chung (2015) stated that nurses' involvement in end-of-life situations can cause severe emotional exhaustion. Furthermore, the participants mentioned that they did not have time to work through the trauma of a death because they had other patients to care for. According to Gates and colleagues (2011), this leaves very little

time for recovery, which is necessary for the prevention of emotional build-up. Death and conveying bad news to patients' families are two of the most stressful events for a nurse (De Clercq et al., 2011). As human beings, we mourn the death of a loved one. Similarly, nurses experience a tremendous sense of grief and loss when a patient passes away (Aycock & Boyle, 2009). Nurses may experience an array of emotions, including helplessness, frustration and sadness (Gerow et al., 2010; Martins et al., 2014; Shorter & Stayt, 2010). In addition, they may feel obliged to continue providing the best possible care for their other patients (Gerow et al., 2010; Martins et al., 2014; Shorter & Stayt, 2010). Often, due to moving on to the next patient without taking the necessary time to mourn, this unadressed grief may accumulate and end up becoming chronic (Aycock & Boyle, 2009; Gates et al., 2011). When this happens, the individual is at risk of developing CF (Aycock & Boyle, 2009).

The second theme indicated that several coping strategies form an important part of nurses' experiences of overcoming CF and strengthening their level of resilience. Although the participants mentioned a number of coping strategies that were unique to their own coping, common ways of coping emerged among them. For example, religion served as a helpful coping strategy in overcoming CF and aided them in becoming more resilient. Therefore, this subtheme will be discussed first. The next subtheme that emerged from the study was that the participants' social support systems aided them in coping with their stressful work environments. Similarly, their relationships with colleagues at work also formed part of coping with fatigue and trauma. Lastly, the participants also mentioned that reflection had aided them in coping and contributed towards resiliency in their careers and personal lives.

Theme 2: Nurses Use Coping Strategies to Deal with CF and be more Resilient

Religion. Forming part of a religious system and making their religion a part of their occupational journey was seen as an important way of coping with fatigue and enhancing their level of resilience. P2, for example, indicated that her religion had helped her to discover her passion and God's plan for her life. In turn, this provided her with a sense of motivation to remain and thrive in her occupation:

> Ok. So, firstly, I decided to study nursing because I felt like it was God's plan
> for my life. Just knowing that there is a bigger purpose behind my occupation
> motivates me. So even on the days that I don't necessarily enjoy my

occupation, I just know I have to be here and do my best ... because you can spend time with God when working through a difficult situation. You can also spend time with Godly people who can provide you with a different perspective; this helps one to see things differently … Positivity goes hand-in-hand with religion; there is nothing negative about it.

P1 highlighted how religion had helped her to cope with feelings of guilt and had provided her with a sense of peace when dealing with difficulties:

The will of the Lord was maybe different, you know. So at least at the end of the day, you have that peace inside of yourself that says, "You did the best you could."

P6 stated that her religion had provided her with a sense of purpose and had made her more resilient:

... religion helps. Knowing that you serve a bigger purpose. Other people may not see the influence of religion on your life. But just knowing you have a belief system to fall back on, is very –. That is what makes it possible for me to bounce back after adversity.

The participants indicated that the support and tranquility that religion had provided were helpful in coping with CF and developing resilience. It has been found that religion frequently emerges as a positive coping strategy among individuals who have experienced a sense of trauma (Bryant-Davis et al., 2012). For instance, victims of secondary trauma may make use of religious coping strategies to form a more intimate relationship with God and other individuals with a similar religious viewpoint to feel more in control of their lives during stressful situations, thrive with regard to their mental and physical wellbeing, find a sense of meaning and strengthen their level of resilience (Claborn, 2009; Southwick & Charney, 2012). No local research has been found on the link between religion and coping among emergency nurses. However, internationally, it has been discovered that religion is one of the adaptive coping strategies that nurses can make use of in order to work through trauma (Ekedahl & Wengstrom, 2010; Rose & Glass, 2008; Shinbara & Olson, 2010). A study conducted in Uganda also revealed that religion provides nurses with a sense of support during difficult times (Harrowing & Mill, 2010; Nderitu, 2010).

Seeking social support also emerged as a helpful coping strategy among the participants.

A social support system. The participants in this study stated that speaking to a friend or family member served as a helpful means of coping with their stress and the secondary trauma they had experienced on a daily basis. This type of expression in the presence of a trusted source also aided them in bouncing back after traumatic experiences. For example, P1 stated that talking about her emotions had helped her to move forward. In other words, it strengthened her level of resilience. She also mentioned that it had assisted her in dispelling negative emotions:

> After speaking to someone, really you get to just go on … It works like that ... and if, you know, if you keep all these bad things bottled up inside of yourself, it's really –. You're gonna get depressed or something.

P1 also mentioned that her colleagues often were negative about their work circumstances, which may have had a negative effect on her wellbeing. Therefore, it was important to have support outside of her working environment:

> … because you're surrounded by nurses or medical health people, whatever, and you just keep talking about these morbid things that kind of happen … we just kind of build each other up to, to be negative. So if you, you get time, spend –. You get to spend time with positive people, and people who can kind of teach you how to, you know, bounce back or whatever. Or deal with things. That is good … You need, you need people – like I don't know if you can call it social, a social environment, whatever ... that definitely plays quite a big role.

Similar to P1, P2 also said that speaking to someone had assisted her in avoiding a negative emotional state:

> As nurses, we need to speak more about these experiences so that we can get rid of these negative experiences that build up over the years … When you start talking about these negative experiences then you realise that you have not worked through the emotions as yet ... It helps one to recover when you can speak to someone who can provide you with advice and feedback about things that were traumatic to you so that it can teach you how to deal with the situation yourself.

P2 further stated that as a nurse, debriefing was important as it had assisted her in overcoming secondary trauma:

> I once experienced a baby's death in trauma and they gave me the option to attend therapy for debriefing, but I didn't have the time and now I sit here three or four years later and I still remember this traumatic experience.

Furthermore, the following statement by P5 corresponded with that by P1 regarding the link between speaking about trauma and resilience:

> Talking to someone helps in order to put traumatic experiences behind you. You need to relive it and talk about what you could have done differently. You must also accept that the situation is in the past now and that you can do things differently next time you face the same situation.

P3 stated that her fiancé provided her with a sense of support even though he did not necessarily understand what she had been going through:

> My fiancé does help me cope with the stress … my fiancé doesn't necessarily understand what I'm going through because he has never experienced these types of situations, but he listens and it helps a lot already.

It is evident that the participants viewed their social support systems as a helpful coping mechanism and something that aided them in being more resilient after difficulties had occurred. The literature states that a social support system can improve overall quality of life, aid individuals in dealing with a stressful environment, contribute towards resilience, and may decrease physical and psychological health problems, including anxiety and depression (Button, 2008; Davis et al., 2013; Prati & Pietrantoni, 2009; Prati & Pietrantoni, 2010; Yılmaz, 2017). It has also been established that expression in the presence of a trusted source can aid individuals in managing their emotional responses, adjusting their emotions according to what is applicable to the specific environment, and increasing overall life-satisfaction (Pennebaker & Evans, 2014). Additionally, research suggests that speaking about one's negative experiences can protect against emotional fatigue (Van der Colff & Rothmann, 2014). Furthermore, it can help nurses to display their true emotions in the presence of a trusted source, therefore enabling a higher level of emotional control within stressful situations (Kinman & Leggetter, 2016). The participants also mentioned that speaking to someone had helped them to get rid of negative

experiences. According to Burleson's (2009) findings, individuals who express their emotions in the presence of another individual may experience a decrease in the number of negative emotions and an increase in positive thoughts and overall wellbeing. Furthermore, the participants mentioned that they had had access to debriefing services, but that time was their limitation. Johnson (2016) recommended that debriefing take place immediately after a traumatic event has occurred as debriefing currently only takes place on request in most hospitals. In a study by Lavoie et al. (2011), it was also found that nurses working in trauma had found therapeutic sessions to be an essential part of their recovery and overall wellbeing.

The next subtheme that emerged was "collegial relationships." Even though social support may include the support of colleagues, the participants often spoke about relationships with colleagues as a separate event and recognised that these had influenced them either in a positive or negative manner. They also emphasised that support from colleagues was different from that which they had received from family and friends.

Collegial relationships. Forming positive relationships at work emerged as something that had provided the participants with a sense of support and contributed positively towards their levels of resilience. For example, P1 stated how her colleagues had influenced her mood:

> … I have two different shifts that I'm working with currently and I just experience myself on the one shift to be very –. Well, I don't know, like joyful and happy. And everything that you do just goes easy because they're –. They also take care of their patients and they have respect for you. And, ja, they –. It's just easy to get along with them and –. And then on the other hand, you have people who aren't really –. They're not really into what they do, and they're not respectful towards their superiors and things … So, it definitely makes a very, very big difference. Also, it contributes to whether your, you, you are physically and emotionally fatigued at the end of the day.

P2 started by explaining that her colleagues were like family due to the amount of time she had spent with them:

> As nurses, we aren't just there for the show, and therefore a trusting relationship between yourself and your fellow colleagues are very important ...

Your colleagues end up becoming your family because you see them more than you see your own family … Your colleagues understand you and we share a sense of humor that is often a bit dark and bitter, but it is something that helps us to cope.

P2 further stated that socialising with her colleagues served as a helpful coping strategy as they understood what she had been through:

I like talking to people who understand where I'm coming from about what I've seen and what I've experienced … Talking to people in the same profession as me is helpful … Because I mostly surround myself with people that I know well, we normally end up talking about things that have taken place at work, but this is something that aids me in recharging and recovering.

Similarly, P3 spoke about how collegial relationships had aided her in coping with trauma and how they had also taught her to be resilient:

Talking to people at work about things that were traumatic to me helps me to recover because they normally know how to handle work-related situations effectively. They also know how to adapt and to move on. My colleagues have taught me to be more resilient ... I would ask myself whether I neglected the patient … One of my colleagues told me that I will go crazy if I kept asking myself this and that it isn't my fault.

The participants felt that the relationships they had formed at work aided them in coping with CF. One participant even mentioned that she had learned to be more resilient by listening to a colleague's advice. While the majority of studies on collegial relationships among nurses focuses on its helpfulness with regard to creating a more pleasant working environment and the fact that it helps nurses to cope (Duffy, 2013; Kubichka, 2016; Sias, 2008; Vessey et al., 2010), none of these refer to resilience. Therefore, this may be one of the first local studies linking collegial relationships with resilience. With regard to coping, Sias (2008) stated that collegial relationships play an important role in providing support, mentoring and exchanging important information. Furthermore, social support provided by colleagues is known to facilitate positive ways of coping (Gumani, 2012).

Reflection is the last factor that emerged as a helpful coping strategy in this study. The participants stated that the process of doing interviews for this study motivated

them to reflect more often as they had recognised its value in dealing with difficulties related to their profession.

Reflection. The participants mentioned that reflection had aided them in coping with stress, overcoming secondary trauma and contributed towards their level of resilience. For example, P2 mentioned that reflection had helped her to become more resilient:

> Resilience develops when you are able to reflect on the experience and realise where you acted negatively or positively ... When doing introspection, I normally realise that I cannot change where I am and I just have to stick it out ... I'm someone who likes introspection so I will sit and realise: I must get my mindset right and I have chosen this occupation so I'm here by choice.

P3 further mentioned that negative situations that had taken place at work caused her to engage in reflection. She also stated that spending time alone led to reflection, which had a positive effect on her work:

> Patients' complaints about me have also made me reflect on my behaviour and then I often realise that I was rude and unreasonable, but this happens because of being emotionally blunted ... I am often short tempered and I think it would be good for me to spend some time by myself … I need to become relaxed and just spend time by myself thinking about everything … Spend time thinking about mistakes and future behaviour in the same situation.

P4 spoke about reflection often throughout her second interview. She started by saying that the first interview had caused her to become reflective:

> The interview made me think about the emotional side of my work … The interview also made me think of how much sympathy and empathy I show and what influence it has on me personally … Thinking about everything made me realise that my job must be a new experience for me every day ... that I must be open to new experiences … We are forced to just be OK and we must always be ready to give … When I sat still and thought about everything, I realised how significant the impact is on my personal life.

Although this may be one of the first South African studies conducted among private health-care nurses linking reflection with resilience, a study in Norway found

that reflection is a valuable means of coping among nurses (Bakibinga et al., 2012; Vinje & Mittelmark, 2008). Furthermore, Wright (2010) states that self-reflection aids in maintaining the energy needed to fulfill tasks and enables one to be more conscious of your passion for your occupation. In turn, it may lead to self-fulfilment and personal growth (Wright, 2010).

The next theme focuses on the intrapersonal characteristics that nurses require in order to be successful. Four subthemes emerged within this theme. Firstly, the participants mentioned that a positive attitude contributed towards being resilient. Secondly, resilience emerged as an important factor in nursing. Thirdly, having self-compassion is important within their occupation as it aids in overcoming CF and enhancing resilience. Lastly, the amount of nursing experience also emerged as a significant factor.

Theme 3: Intrapersonal Characteristics

Positive attitude. The participants mentioned that a positive attitude is important as it strengthens their resiliency levels and aids in overcoming fatigue. For example, P1 mentioned that a positive attitude had helped her to persevere and enjoy her occupation:

> I feel it got, it goes a lot about your, the attitude that you have. So every day you wake up – even though it's not fun to wake up in the mornings – you, you get your mindset right, you know. You say, "Today will be a good day." Or just keep yourself excited because this, this is what you do; this is the job you love, you know … My attitude towards it is quite [laughing], quite good. And that helps a lot.

P2 stated that a positive attitude is significant as one's mind is the most powerful tool in overcoming fatigue:

> Positivity is also very important in our occupation as nurses because one's mind is the most powerful tool you have.

P5 felt that her attitude had played a significant role in bouncing back after experiencing secondary trauma:

> One's attitude counts for ninety per cent of one's resilience.

The participants agreed that having a positive attitude in their occupation was significant with regard to coping successfully. This corresponds with the research conducted by Chang and Chan (2015), which found that individuals who have a positive attitude are more motivated to work through challenges.

Another characteristic that was identified as significant in terms of overcoming secondary trauma and being successful as a nurse is resilience. The participants often referred to this psychological term throughout the study and viewed resilience as one of the core elements of their success in this occupation.

Resilience. The participants mentioned that having resilience is an important factor in overcoming the amount of secondary trauma experienced. P3 spoke about the importance of being able to adapt to one's environment as a nurse. She stated that this part of her occupation had aided her in developing resilience:

> If you don't have resilience in this occupation then you will go crazy … If you don't have resilience then you will wake up with a negative attitude every day … When you become a nurse, it is often difficult to adapt as you suddenly have authority over you and you must learn to take responsibility for your actions … You have to sort things out when something goes wrong but this has taught me to cope and to be more resilient.

P4 mentioned that resilience had protected her from developing psychological disorders, more specifically, depression and CF:

> Resilience aids one in staying sane … I would've been depressed a long time ago if it wasn't for resilience … Resilience is important as you will go into depression or you will get blunted towards your patients if you didn't have it.

P5 highlighted the link between a positive attitude and one's level of resilience:

> One's attitude counts for 90 per cent of one's resilience … I don't see the hole; I see the possibilities in each situation and this also aids in coping … By seeing the good in a situation also helps one cope … I change my mindset in order to stay on top of things.

The participants mentioned that they would not have been able to survive in their occupation if they had not been resilient. According to previous research, it has been established that resilience plays a fundamental role in aiding health workers to cope

with the amount of stress and secondary trauma they experience (Kapoulitsas & Corcoran, 2015; Kinman & Grant, 2011; Rutter, 2007). P5 mentioned that a positive attitude contributes significantly towards one's level of resilience. The literature confirms this and states that resilient individuals are capable of foreseeing a positive, rather than a negative outcome (Kinman & Grant, 2011; Saleebey, 2006). Furthermore, Southwhick and Charney (2012) found that a positive attitude is associated with higher levels of resilience.

Self-compassion, the next characteristic that will be discussed, is closely linked to resilience (MacBeth & Gumley, 2012; Mantzios, 2014; Neely et al., 2009; Neff, 2009b; Smeets et al., 2014). The participants mentioned that being kind towards oneself is something that had aided them in building resilience and overcoming fatigue.

Self-compassion. The participants also mentioned that self-compassion was important in overcoming trauma and coping sufficiently within their occupation. For example, P1 explained that self-compassion had aided her in overcoming feelings of guilt and doubt:

> I have experienced situations where I, I do feel hard on myself. Like, "You should have known to do this," or "you could have done this," or "someone shouldn't have told you to do this, you know;" "you should have done it by yourself." But I feel like it is a learning experience. Every day we learn. So don't be too hard on yourself, you know.

P2 stated that she had been too hard on herself but that she realised she needed to rest:

> Often we are too hard on ourselves … Last week, I just told myself, "I really need a holiday."

P4 stated that she had realised that self-compassion aided one in recovering from trauma:

> It is important to know yourself well and to have sympathy with yourself first as it aids in recovery … Being sympathetic towards oneself is the most important thing in our occupation … You cannot force yourself to get over things … We all need time to work through trauma.

As mentioned in the above excerpts, compassion is given continuously but it is not always received. However, it has been found that compassionate care for others may have a connection with self-compassion (Lindsay & Creswell, 2014; Neff & Pommier, 2013; Welp & Brown, 2014) as self-compassion is simply compassion focused inwardly (Neff, 2003a). The participants mentioned that they had often realised that they were being hard on themselves. They also mentioned that having self-compassion had aided them in working more successfully through trauma. The literature suggests that self-compassion plays an important role in the prevention of psychological disorders and promotes psychological wellbeing and resilience (MacBeth & Gumley, 2012; Leary Tate, Adams, Batts Allen, & Hancock, 2007; Mantzios, 2014; Neely et al., 2009; Neff, 2009b; Smeets et al., 2014). Self-compassion contributes towards the prevention of CF and enhances compassionate care towards patients (Beaumont et al., 2016; Gustin & Wagner, 2013; MacBeth & Gumley, 2012; Wong & Mak, 2012).

The last subtheme for this section consists of the amount of experience that participants had gained in their years of practising as nursing professionals.

Professional experience. The participants mentioned that professional experience was something that had helped them to cope with trauma. They also stated that past professional experiences, whether these involved positive or negative outcomes, had taught them how to be more resilient and how to cope more successfully with challenges. For example, P2 mentioned that her experience in the field of nursing had assisted her in recovering successfully:

> I think my past experiences aid me in developing resilience. Resilience develops when you are able to reflect on the experience and realise where you acted negatively or positively.

Likewise, P3 stated that professional experience had helped her to cope more effectively with situations:

> Experience in this profession has a big impact on how to deal with situations more successfully; it teaches you how to sympathise and where to or not to display emotions.

Similarly, P5 said that personal and professional experience enabled one to learn how to deal with difficult circumstances:

> Our occupation doesn't get easier; it is a problem if it gets easier for you. You can only handle situations better, but it doesn't become easier. Your coping mechanisms improve over time. With experience, you learn how to handle yourself and the families of patients.

The participants mentioned that their ability to cope with the trauma had increased with professional experience. As P5 mentioned, her coping mechanisms and social skills had improved over time. According to Mrayyan (2009), it is imperative that experienced nurses are retained as they deal with a stressful environment more successfully than those who are starting out in the occupation. In order to care for ill and traumatised patients as well as their families, nurses require a broad spectrum of knowledge and swift decision-making skills, which are acquired over time (De Beer et al., 2011). Furthermore, research conducted abroad by Shimizu and colleagues (2011) revealed that distressing emotions were more prevalent earlier in a nurse's career and subsided towards the end. Skills, self-confidence and competence are the result of experience in the field of nursing. In turn, these skills lead to empowerment and increased motivation (Gaki et al., 2013; Gulzar et al., 2010; Hertting et al., 2004; Koch et al., 2014; Sparks, 2012).

Theme four focuses on the participants' experiences with regard to caring and providing support for their patients. Two subthemes emerged within this theme. The first subtheme consists of the means by which the participants display their compassion for their patients. The second subtheme to emerge was distancing personal emotions from one's occupation as the participants felt that this had aided them in becoming more resilient.

Theme 4: Caring for and Supporting Patients

Compassion. Compassion can be displayed in various ways. Nonetheless, all of the participants stated that compassion is something that nurses must have even though it often becomes difficult to display in all circumstances. P1 stated that it became difficult to show compassion all the time. Furthermore, she explained how she had displayed compassion for her patients.

> Because it is something you get used to, it becomes something you do not want to deal with. You are often not in the mood to be compassionate …

Love, kindness and a smile or just a gentle touch does a lot with regards to showing compassion.

Similarly, P4 explained that displaying compassion can become tough:

Supporting patients on all levels gets difficult every now and then.

On the other hand, P2 stated that being compassionate towards patients was often rewarding:

Being compassionate means to do everything possible for my patients. Being compassionate is very satisfying for me. It is a good feeling to see what I can do for a patient and what the outcome is.

Compassionate care is one of a nurse's main duties (American Nurses Association, 2015). It therefore comes as no surprise that "care and support for patients" emerged as a theme in this study. Compassionate care develops by means of a relationship that is based on empathy and an understanding of what the other person is experiencing (Lown, 2016; Lown et al., 2011). Compassion includes taking care of someone's needs, providing him or her with physical and emotional support, encouragement and respect, and communicating that one cares (Lown et al., 2011). As mentioned by the participants, displaying compassion for patients on a daily basis becomes difficult. As a result, a lack of compassion has been noticed within healthcare systems and health organisations abroad (Francis, 2013; Health Information and Quality Authority, 2015). This may be due to the lack of programmes, such as therapeutic services, that can aid nurses in recovering.

In this study, distancing personal emotions from one's occupation emerged as an important factor in successful nursing. This will be discussed in more depth within the following paragraphs.

Distancing personal emotions from occupation. Throughout the interviews, the participants often spoke about how important it is to distance one's personal emotions from your work as it aids in enhancing resilience and prevents emotional fatigue. They provided various reasons for this statement. P1 stated that distancing her emotions from her occupation had strengthened her resilience:

But you learn, you have to learn to, to kind of distance yourself from, from these emotional things … And I guess it can also link to my, my level of

resilience. Because it, it's also a way of, you know, bouncing back after experiencing a traumatic experience. Ja, just helping yourself, or just aiding yourself in, in you know, not getting too close or getting too involved.

P2 mentioned that she had learned to set aside her emotions and face them again as soon as she arrived home. This prevented her emotions from interfering with her work:

When you put on your uniform, you put aside your personal emotions and you do what you need to at work, and when you get home, you face these emotions again.

Similarly, P5 spoke about how important it was to keep personal biases separate from one's work and how unconditional positive regard was needed at all times:

You must put your emotions aside. You cannot get angry with someone even if you do not agree with what they have done. You must be able to put it aside and remove yourself from the situation if you can't.

Furthermore, P3 stated that distancing her emotions from her work was important as it protects her from emotional fatigue:

I can become very involved in people's stories but I have realised that I won't survive emotionally if I carry on doing this.

From the above excerpts it is clear that the participants felt strongly about distancing their emotions from their work. Not only was this a personal opinion regarding maintaining their own wellbeing, but nurses also follow a moral code that restricts them from displaying certain emotions towards patients. It is required of them to display appropriate emotions, such as empathy, compassion and care. They are also required to regulate negative emotions, including anger, sadness and severe distress (Filstad, 2010; Hayward & Tuckey, 2011; Pisaniello et al., 2012). P5 mentioned that if one did not agree with a patient then it was better to remove oneself from the situation. According to Morgan and Lynn (2009), this is the appropriate manner of dealing with a situation as one's main goal should be to enhance the patient's wellbeing and put aside one's own emotions if there is a chance that they will interfere with this process.

Conclusion

The above findings highlight the fact that the participants experienced CF and resilience as two important constructs in their profession. Even more so, they saw these as integral aspects of working in a trauma unit due to the highly stressful environment in which they had to function. The participants emphasised that continuously showing compassion towards their patients is pivotal in their occupation. However, as a result of the constant caring, they may become fatigued which, in turn, may manifest in various areas of their lives. When fatigue occurs and is left untreated, CF may develop. However, there are multiple coping strategies that can be used by nurses to overcome CF and enhance resilience which, in itself, aids in successfully mitigating CF. Furthermore, the participants highlighted that they had possessed certain intrapersonal characteristics that served as a buffer against developing CF and aided in increasing their resilience. Therefore, the above findings could be seen as making a valuable contribution to the field of nursing as they enhance nurses' knowledge about CF and ways in which to successfully overcome it. In addition, the findings can provide them with a deeper understanding of how to recognise their own resilience, how to enhance it and, ultimately, use it in mitigating the consequences of CF. The researcher hopes that this study will contribute positively to the field of trauma nursing in South Africa.

The limitations of the study should be kept in mind when interpreting the findings. Firstly, all of the participants in the study were female and predominantly Caucasian. Secondly, even though all of the participants had five or more years of nursing experience, the majority were younger than thirty years of age. According to the South African Nursing Council (2017) statistics, the highest percentage of registered nurses falls in the age category of 40 to 59 years of age. Therefore, this group of participants is not representative of the South African population of nursing professionals. As a result, there is a possibility that this may have affected the outcomes of the study. Even though the results of this research study make a valuable contribution to the understanding of CF and resilience among trauma nurses in the South African context, inferences based on the results should be made with caution. Furthermore, while the researcher constantly worked at remaining conscious of her biases, her subjectivity may still be present to a degree, which may impact the results of the study. Although various limitations have been mentioned, the outcomes of this

research study make a valuable contribution to increasing nurses' knowledge of CF and resilience in the field of trauma nursing in South Africa. Furthermore, the hope is that an increase in knowledge regarding these constructs may inform potential interventions for trauma nurses that are focused on psycho-education and provide a place of safety where debriefing can take place.

It is recommended that this study be replicated on a more diverse population group, including different racial groups and a broader spectrum of age groups as opinions regarding the researched constructs may vary according to race and experience within the field. This will enable a broader view of nurses' experiences of CF and resilience and will make a valuable contribution towards nurses' level of work satisfaction.

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APPENDIX A

INTERVIEW PROTOCOL

1. Compassion fatigue:

1. As a nurse, what does being compassionate mean to you?

2. Could you tell me more about a recent event where you had to show compassion?

3. Can you tell me more about a recent traumatic event where you experienced emotional and/or physical exhaustion due to showing compassion?

4. In which ways did you respond to this experience of emotional and physical exhaustion?

5. What have been some of the behavioural consequences you have experienced following a traumatic experience within the workplace?

6. What are some of the strategies that you currently make use of in coping with compassion fatigue?

7. What is your perception of the helpfulness of the strategies that you use in coping with compassion fatigue?

2. Resilience:

1. How does your current work environment demand resilience from you?

2. What have been some of the most challenging obstacles you have faced at work?

3. How did you go about dealing with these obstacles?

4. What do you do to refresh yourself when working in such an environment?

5.   What behaviours do you take part in in order to unwind after a stressful week at work?

6. What factors in your life do you experience as contributing towards making you more resilient?

7. How do these factors contribute towards your resilience?

8. Can you tell more about how resilience has been beneficial in your occupation?

Data removed to maintain confidentiality.

Contact: openaccess@ufs.ac.za

APPENDIX C

EXAMPLE FROM THE RESEACHER'S REFLECTIVE JOURNAL

Initially, the process of sampling was quite stressful for me. Firstly, recruitment of participants was challenging. It was especially difficult to find participants who met the inclusion criteria for the study. Secondly, after I contacted the first participants, I found it difficult to schedule the interviews- considering differences in schedules. Finally, I was rather nervous, anxious, and uncertain about conducting the interviews. As a result, I discussed the possibility of conducting a pilot interview with my supervisor. She confirmed that she thought it was a good idea as it would give me the opportunity to practice my interviewing skills and eliminate some of the doubts I might have regarding the interviewing process.

It was helpful to discuss the doubts that I had about my own skills with my supervisor. I also engaged in self-reflection and I listened to my pilot interview a few times before conducting the first official interview. The first interview went well. Although there were some aspects that I would have liked to improve on with each of the interviews I felt at ease with my overall attempt. After I completed my first interview for the study, I felt a great sense of relief. Although I felt comfortable with my attempt, I was still hard on myself regarding certain aspects.

My data collection took longer than I expected as most of the nurses that I contacted had busy schedules and would often cancel our apointments at the last minute. As a result, I felt extremely demotivated and struggled to find the motivation and perseverance to contact more people. However, I eventually managed to schedule a sufficient number of interviews. I motivated myself by reasoning that the study would progress quickly once the data collection was complete. Nonetheless, to my surprise, writing chapters did not happen overnight. This was a reality check. I often spent whole days on my dissertation and found that I only wrote two or three pages. Even though this journey was tough, I still enjoyed it thoroughly and I have discovered some of my strengths and weaknesses throughout this process

APPENDIX D

LETTER OF ETHICAL CLEARANCE

Dear **Miss Le Roux**

Faculty of the Humanites

Ethics Clearance: **Experiences of compassion fatigue and resilience among nurses in private medical facilities.**

Principal Investigator: **Miss Simoné Le Roux**

Department: **Psychology (Bloemfontein Campus)**

APPLICATION APPROVED

With reference to your application for ethical clearance with the Faculty of the Humanities. I am pleased to inform you on behalf of the Research Ethics Committee of the faculty that you have been granted ethical clearance for your research.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2016/1300 This ethical clearance number is valid for research conducted for one year from issuance.** Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the ethics office to ensure we are kept up to date with your progress and any ethical implications that may arise.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. Robert Peacock Chair: Research Ethics Committee Faculty of the Humanities

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22-Mar-2017

APPENDIX E

TURNITIN REPORT

The dissertation has been submitted to Blackboard Turn-it-in software on Tuesday, 24 July 2018 for feedback on the level of plagiarism. A plagiarism percentage of 11% was indicated. The plagiarism report can be requested from the supervisor, Dr. Anja Botha: bothaa@ufs.ac.za