Women Healthcare Workers, Compassion Fatigue, and the COVID-19 Pandemic

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Abstract

This mixed-methods study focuses on women essential healthcare workers and their experiences of compassion fatigue during the COVID-19 pandemic. The pandemic exacerbated compassion fatigue levels in healthcare, a field predominantly comprised of women. The study used quantitative (survey) and qualitative methods (interviews). For the survey, I received 44 viable responses. These questions sought feedback on each participant's experience with compassion fatigue, alterations to the services that they offered, and experiences with ever-changing regulations and restrictions. They also highlighted the unique struggles that participants potentially faced as caregivers and how they were able to balance the ever-changing demands. Survey participants were invited to participate in a follow-up interview. The interview questions focused on individual impacts and experiences in their role and their personal life exploring experiences of moral injury, guilt, and shame. Participants also reported on what support they had, and recommendations they had for the government, their employer, their managers, and the public. Eight women across Ontario completed the interview, which began with the Professional Quality of Life Scale (ProQOL). The six themes from the survey and interviews were, theme 1: The Impacts of the Pandemic on Participants' Personal Lives including the Emotional and Mental Health Impacts of Compassion Fatigue, The Physical Impacts of Compassion Fatigue and The Impacts on Family, Theme 2: Participants Experiences with Moral Injury, Theme 3: Participant Feelings of Guilt and Shame, Theme 4: Supports Provided and Sought for their Well-Being, and Theme 5: Perceived Gaps and Limitations including The Experiences with the Federal and Provincial Government, Experiences with their Healthcare Employer and Experiences with the Public, and lastly, Theme 6: Recommendations for Improving Systems and Supports. The goal was to share information about women's firsthand experiences with Compassion Fatigue. Although differences existed among participants, they shared the common perspective that the last few years were challenging personally and professionally. This study’s mixed methods design enabled this researcher to explore women healthcare workers’ direct firsthand experiences. This study contributes novel evidence that highlights women’s challenges and their recommendations for changes needed and future improvements in support provided to them by the healthcare system and workplaces.

Acknowledgment

This has been one of the most challenging yet rewarding tasks in my educational journey. When I took this on, I did not realize the time commitment and personal growth I would experience. The learning curve into research has been a stressful, overwhelming, yet empowering experience.

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Dedication

This is dedicated to my grandmothers (godmothers) who always believed in me no matter what. I know they are still with me every single day. My parents who supported me in whatever I wanted to be from the very beginning even though I know I was not always an easy daughter to raise. My husband, Devin, who is always in my corner encouraging me to go get whatever I want, and believing in me, even when he has no idea what I am up to. My stepdaughter, Raegan and my cousin, Jared, for keeping me grounded, convincing me to never give up even when I came close, the endless laughter and re-reading this (and all my other work) many times, with little complaint. I could not have gotten through this or the pandemic without both of you. To all my friends, family, and colleagues who supported my learning adventures, I hope you know that everything said and done means the world.

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Higher education is possible. I am sure most doubted I would have even surpassed Grade 12 (me included) and here I am with a master’s degree. Find your passion and let that guide you. It always seems impossible until it is done.

Chapter I: Introduction

Introduction

The novel coronavirus (COVID-19) has been flagged as one of the world's worst challenges since World War II (World Health Organization, 2021). Originating in Wuhan, China, this contagious respiratory disease caused a worldwide pandemic resulting in unknown high mortality rates across the world. The World Health Organization (WHO, 2021) reported global mortality rates exceeding 3.3 million. Scientists at the WHO believe we faced significant undercounts of the total deaths directly and indirectly attributed to COVID-19 due to a variety of factors across different countries, such as testing and reporting abilities across the world (WHO, 2021).

In addition to high mortality, other consequences of the pandemic around the world include mental health impacts (Chaudhury et al., 2020). The world was unprepared to deal with an infection this contagious and dangerous, resulting in high rates of disease and mortality (Chaudhury et al., 2020). Lockdowns, social distancing, and self-isolation were some of the preventative measures utilized to limit the spread of infection. Although strict measures were necessary to reduce the spread of infection, these preventative measures came with catastrophic economic impacts that have been felt globally (Chaudhury et al., 2020).

The COVID-19 pandemic has highlighted the disproportionate and inequitable healthcare available to marginalized people and communities (WHO, 2021). It has also put immense pressure on the healthcare system, patients utilizing the necessary services, first responders, mental health professionals, doctors, nurses, and other healthcare workers (Brindle et al., 2020). In many countries, strict measures were implemented, laws were created to force people to stay home except for essential reasons, and processes were implemented for individuals to work remotely (Chaudhury et al., 2020). Healthcare workers had to work under extreme staffing shortages, navigate redeployments, and continually put themselves at risk—mentally, emotionally, and physically (Chaudhury et al., 2020). The result is a population of psychologically impacted and traumatized workers.

Research Problem

The research problem I explored was compassion fatigue experienced by frontline women healthcare workers during the COVID-19 pandemic. Compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice or prolonged exposure to difficult situations, which renders a person unable to love, nurture, or care for/empathize with another's suffering (Chaudoin, 2020) (See Appendix A for the definition of Compassion Fatigue used in this study). Women are essential workers in healthcare and social services, and they are also over-represented as caregivers (Carey, 2012). In Canada, during the pandemic, approximately 82% of healthcare roles are held by women (Statistics Canada, 2022).

The level of compassion fatigue amongst healthcare workers was exacerbated immensely by the pandemic, and individuals in this profession have left (or are leaving) the field in droves. An estimated 18% of healthcare workers (aside from those who are already planning to retire) had intended to leave their current job or change jobs within the next three years - one in four nurses, one in six personal support workers (PSWs), one in eight healthcare workers, and just over one in 10 physicians (Statistics Canada, 2022). As this data was from the beginning of the pandemic, it would be curious to see what those statistics are now and in the future.

It was, therefore, important to obtain women's perspectives on their experiences during the pandemic to ensure that women healthcare workers can be better supported in the future. For this research, I explored my home province of Ontario, Canada, and I utilized a mixed-methods research approach, informed by feminist standpoint research.

Research Question

The literature review demonstrated the need to further explore compassion fatigue during the COVID-19 pandemic. I chose to focus on women due to the complexities they experienced in the pandemic, as they comprise most of the healthcare workforce, and they are more likely to be caregivers (both personally and professionally) using both quantitative and qualitative methods. Therefore, the overarching research question for my project was:

What are the personal and professional experiences of compassion fatigue among women healthcare workers during the 2020–2022 COVID-19 pandemic in Ontario?

Rationale and Objectives of Study

The rationale for this study is that we are still living through a global pandemic, and the effects of this must be explored to ensure that we support the people on the frontlines who have risked their lives to care for others. Compassion fatigue can impact individuals and have devastating lifelong consequences for their mental health, as well as for the service they provide to others. I chose to focus on women given the significant mental health impacts on essential healthcare workers during the pandemic, which I will demonstrate further.

The objectives were to develop an understanding of women healthcare workers' experiences to ensure that we, as a system and society, do better in future crises and pandemics, as well as support those who need services immediately. I selected healthcare workers because I am a social worker in mental health services and have seen firsthand what the pandemic has done to the system and how it has impacted myself, the patients I serve, and my colleagues. I also have many family members and friends working in this system, so this research is near and dear to my heart.

In this project, I have chosen to use the term "compassion fatigue" instead of "secondary traumatic stress" or "vicarious trauma," as my professional training and background have incorporated this conceptualization. However, substantial research suggests that the terms “secondary traumatic stress,” “vicarious trauma,” and “empathic strain” are now the preferred terminology. This is an issue I addressed with my thesis committee, and we agreed to carry on with the term compassion fatigue, although we had many in-depth conversations about the change in terms and what it means for future research.

Chapter II: Literature Review

Overview of the Literature Review

Explorations were done on compassion fatigue's historical definition as well as secondary traumatic stress, who it impacts, and what risk factors are included. I wanted to highlight the unique experiences of frontline workers, women, and the exacerbation of this in strenuous times such as the COVID-19 pandemic.

The main gaps were limited research on women's perspectives and the experiences of frontline workers with the COVID-19 pandemic. There was limited information on how the rapid changes of the virus impacted the systems, and people's ongoing exposure over time impacted women. Also, there was little exploration of the disempowerment effects on caregivers. As my research was happening during the waves of the pandemic, and daily developments were being made, further exploration will need to be done on the long-term effects of the pandemic as well as continued recommendations.

Compassion Fatigue and Secondary Traumatic Stress

Compassion fatigue, vicarious trauma, and secondary traumatic stress/secondary trauma have been explored since the early 1990s (Crisis Preventions Institute, 2021). Compassion and empathy are at the very heart of many of the helping professions, including social work, whose practitioners help some of the most vulnerable populations (Chaudoin, 2020). Working with vulnerable populations can be a valuable experience: however; it can become increasingly stressful in turbulent times (Mathieu, 2012).

Compassion is defined as the feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering (Mathieu, 2012). Compassion is different from empathy, which refers to suffering together and fully engaging in others' suffering (Mathieu, 2012). Fatigue is defined as extreme tiredness resulting from mental or physical exertion or the state of being weakened under repeated stress (Chaudoin, 2020).

Although there are varying definitions of compassion fatigue (and of compassion), it is often described as the “cost of caring for others”, and it affects those directly working with others, such as nurses, social workers, police officers, personal support workers, and many other direct helping professions (Mathieu, 2012, p. 8). Compassion fatigue is an occupational hazard, and most helpers who care for their patients will eventually experience it firsthand (Mathieu, 2012).

According to Mathieu (2012, p. 9), “Compassion fatigue is known as the death by a thousand cuts, meaning that the gradual erosion of the pain and suffering we are exposed to will catch up with us over time.” Most helpers will experience some form of this throughout their careers, and it impacts how they feel about themselves, the work they do, and their ability to handle their lives (Mathieu, 2012). Compassion fatigue is often exacerbated in turbulent times, especially during the COVID-19 pandemic because of the ever-evolving changes, continuing uncertainty, and the disease’s unpredictability (Jones et al., 2021). The COVID-19 pandemic created a perfect storm for compassion fatigue, like the H1N1 pandemic and the 9/11 terrorist attacks. The lack of control and fear of the unknown impacted people's mental health similarly to other large-scale crisis we have experienced in the past.

Dr. Chelsea Harris (2020) is a Canadian professor who has explored the long-term effects of prolonged exposure to demanding situations in students and employees. Harris believes compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice or prolonged exposure to difficult situations, which renders a person unable to love, nurture, or care for/empathize with another’s suffering (Chaudoin, 2020). Many workers in the healthcare and helping professions often choose this line of work due to their traumatic past: a substantial percentage (60–70%) of workers come into the field with a personal history of trauma (Crisis Prevention Institute, 2021). Many people who are motivated to work in the helping professions do so because they can relate in some personal way (Crisis Prevention Institute, 2021).

Continual exposure to the internalization of another's suffering can rob an individual of their ability to care or empathize, leading to an inability to nurture (Chaudoin, 2020). Common symptoms of compassion fatigue are feelings of failure, self-doubt, sadness, and powerlessness (Crisis Prevention Institute, 2021). Many individuals report varying symptoms that often echo those of post-traumatic stress disorder (PTSD), such as secretive addictions, self-medication, isolation, withdrawal, exhaustion, interruption of dreams or nightmares, bottled-up emotions, and pessimism. These concerns can lead to detrimental consequences such as mental health and health issues or suicide (Crisis Prevention Institute, 2021).

The symptoms of compassion fatigue can vary among individuals, and many do not seek treatment, as they believe it is normal for the role they are in (Crisis Prevention Institute, 2021). Physical signs and symptoms of compassion fatigue include exhaustion, insomnia, headaches, increased susceptibility to illness, somatization, and hypochondria (Mathieu, 2012). The psychological and emotional signs and symptoms include dread of working with certain patients, feelings of professional helplessness, depersonalization, disruption of worldview, problems with intimacy, distancing, negative self-image, depression, reduced ability to feel sympathy or empathy, cynicism, and resentment (Mathieu, 2012). Behavioural signs can include an increase in drug and/or alcohol use, anger and irritability, avoidance, absenteeism, impaired ability to make decisions, problems in relationships, attrition, and compromised care for patients (Mathieu, 2012).

Typically, those who are affected by compassion fatigue are the last to recognize what is happening and may need others to help them realize it (Crisis Prevention Institute, 2021). Interestingly, when multiple employees in the same organization are experiencing compassion fatigue, they will often negatively feed off one another, emotionally detaching and creating a toxic work culture (Crisis Prevention Institute, 2021).

Compassion fatigue can influence those who experience both primary and secondary trauma in their duties (Mathieu, 2012). Primary trauma concerning the helping profession refers to the worker directly experiencing the trauma—meaning it happens regardless of whether one is in harm's way or terror of the situation (Mathieu, 2012). Secondary trauma concerning the helping profession refers to when someone experiences secondary exposure, such as hearing abuse stories from victims, reading graphic files, debriefing colleagues, or sitting in court (Mathieu, 2012). Survivors' guilt can be relevant to compassion fatigue when people survive a life-threatening situation in which others have died (Anand, 2021). Consequently, individuals begin to question their existence and have feelings of helplessness and hopelessness. This has been another factor in the COVID-19 pandemic and has had the most impact on workers in the helping profession aged 20 to 30 years (Anand, 2021). Women are more likely than men to experience compassion fatigue due to self-reported feelings of empathy, making them more vulnerable (Mathieu, 2012).

The Impact of the COVID-19 Pandemic on Women Healthcare Workers

In terms of gender and age differences, Galanis et al. (2020) found that women who work in frontline healthcare services had higher levels of emotional exhaustion, as did younger individuals with higher education levels. Healthcare workers who were mothers with children under the age of 18 in their households were noted as the most likely to report stress and worry about COVID-19 (Kearney et al., 2021). Of mothers who worked in healthcare that were surveyed, 25% stated that they had not reached out for the mental health services or medication they might need (Kearney et al., 2021). Regarding their inability or unwillingness to access services, 24% were not able to find a provider, 23% were not able to afford the cost, 18% reported being too busy or not being able to get time off work when they experienced difficulties with their health, 10% said they had problems with insurance, and 5% said they were too embarrassed to seek treatment (Kearney et al., 2021).

In addition to coping with the pandemic and juggling at-home responsibilities, healthcare workers who were mothers had experienced an increase in work and home demands, personal protective equipment (PPE) limitations, fears of infection, lack of childcare, longer work hours, and lack of access to accurate information or inconsistent/changing information and regulations (Mellins et al., 2020). Moreover, intimate partner violence and child abuse within family units have increased significantly due to the pandemic (WHO, 2021).

Galanis (2020) and his team of researchers completed 16 studies centred in Greece that highlighted the main risk factors for burnout in healthcare. Their findings included several sociodemographic, social, and occupational factors. Concerning COVID-19, the main risk factors identified were being a younger professional, decreased social support, low family support, colleagues' readiness to cope with the outbreak, increased perceived threat of COVID-19, prolonged work in quarantine areas, working in a high-risk area, working in hospitals with staffing issues, and lower levels of specialization training regarding COVID-19 (Galanis et al., 2020). The meta-analysis assessed three aspects of nurses' burnout and found that 34% experienced emotional exhaustion, 15% experienced depersonalization, and almost 13% experienced a lack of personal accomplishment (Galanis et al., 2020).

Other factors contributed to increasing complexities, including the shortage of intensive care unit beds, the lack of ventilators, and an influx of sick patients without enough available supplies (Jones et al., 2021). The back-to-back crises and emergencies alongside the lack of opportunity to debrief, decompress, or de-stress made professionals more vulnerable to compassion fatigue, burnout, and empathic strain (Jones et al., 2021).

The extreme and persistent psychological pressures on frontline healthcare workers due to the threat of the virus and the overwhelming fear for their safety, as well as for the safety of their families and patients, had negative mental health impacts (Galanis et al., 2020). The feelings workers experience can make them more vulnerable to emotional exhaustion. Many healthcare workers experienced extreme psychological distress from decisions they had to make under extreme pressure (Pal et al., 2020). The empathy and compassion that these workers developed for their patients during such a frightening situation have impacted them, as they may be feeling compassion at a deeper level. Symptoms of this ongoing distress for workers include (but are not limited to) depression, anxiety, PTSD, psychological distress, sleep disturbances, insomnia, and fear (Galanis et al., 2020).

A study in China, when the pandemic was raging through the country, concluded that women (especially nurses) had the highest burnout rates, and their ability to be resilient had decreased (Sayilan et al., 2020). Due to gendered socialization for caregiving, women were more likely than men to experience disruptions in their daily routines and work functions due to prolonged school closures, shifts to online learning, and eldercare responsibilities (Gupta et al., 2020). Not only are women overrepresented as staff in the healthcare system, but they also occupy many of the roles in other essential services such as grocery stores that were essential during the pandemic (Kearney et al., 2021). Unemployment rates skyrocketed in women-dominated professions such as retail, hospitality, and personal care services, placing more strain on those left in the workforce (Kearney et al., 2021).

For those who work in the helping profession, becoming emotionally involved in the lives of the people they work so hard to save can be normal and natural (Anand, 2021). During a global pandemic, this looks vastly different: people are working in isolation from one another or are forced to change everything about the way they practice things (Anand, 2021). Due to the longevity of the exposure to trauma and its actual severity, along with the additional component of fear, workers found themselves struggling with the unknown—for example, wondering about the virus's capacity, what would it do, or if there would be a vaccine (Chaudoin, 2020).

Supporting Our Women Healthcare Workers During COVID-19

How we treat our healthcare workers after the pandemic is crucial so that they can cope with the negative effects of the devastating events (Galanis, 2020). Several other factors can be introduced to mitigate the mental health impacts of disasters such as COVID-19, such as screening for mental illness and early support for those in high-risk areas who require it (Galanis et al., 2020). The future short-term emergency response training and mobilization goals include the development of protocols to inform the reallocation of resources and task-shifting, pandemic-adjusted staffing models, expanded training, and engagement of volunteers on a standby type of arrangement (Gupta et al., 2020). The ongoing flexibility and adaptability of employers and workplaces are crucial in reducing continued absenteeism.

The pandemic brought about ethical challenges for frontline healthcare workers, as the need to support their moral and legal obligations to their patients was in jeopardy. We need to address and investigate the impacts and causes of absenteeism (Gupta et al., 2020). For future thorough, timely, comprehensive, internationally comparable, and equity-informed human resources to enhance preparedness, response, and recovery policies need to be a focus for ongoing preparedness and planning (Gupta et al., 2020). Because women are overrepresented in healthcare, these resources should be tailored to and researched by women to meet their specific, unique, and evolving needs (Gupta et al., 2020).

It is critical to educate helpers about compassion fatigue, what to expect, and what resources are available at the initial stages of their careers. Investments in intervention programs to assist with compassion fatigue are necessary. Training, workshops, and raising awareness are crucial in developing public awareness (Crisis Prevention Institute, 2021).

Early interventions, standardized training in all healthcare settings, and training methods—such as resiliency training focusing on psychological health and well-being—are crucial in limiting compassion fatigue (Tsamakis et al., 2021).

Effective supervision is key in supporting staff and it is necessary to tailor the clinical supervision of compassion fatigue to the needs of new or less-experienced providers. It is crucial to support pandemic-type crisis training with action plans created and shared with all staff, including how to execute the plans and how to access the written records (Tsamakis et al., 2021). It is beneficial for managers to hold regular team meetings with a focus on communication and processing their feelings regarding any stress or anxiety. Managers, administrators, and human resources staff must encourage and stimulate conversations about compassion fatigue (and mental health in the workplace, more broadly), both formally and informally (Crisis Prevention Institute, 2021). Employee assistance programs and wellness programs/committees are other opportunities to raise awareness and help those who are experiencing compassion fatigue (Crisis Prevention Institute, 2021). As compassion fatigue is often rooted in broader systemic issues and is exacerbated in challenging times, healthcare leaders need to strengthen existing efforts to support mental wellness and actively monitor and prevent mental health challenges in the workplace (Mellins et al., 2020).

To ensure the psychological safety of healthcare workers who are tasked with caring for patients, we need to learn from the unpreparedness of society and systems experienced during the COVID-19 pandemic and work to develop adequate and appropriate support systems. Psychological PPE, resiliency/disaster training, and increasing mental health services are crucial in preparing for the future (Lateef, 2020). Early support interventions, immediate attention to mental health services when needed, designated rest periods, social support to reduce isolation at work, and sufficient PPE are necessary for psychological safety (Galanis et al., 2020). We need to ensure we are going above and beyond to meet women's ever-changing needs by providing them with the resources and services that meet their unique, individual demands (Kearney et al., 2021). Creating and adopting flexible schedules to accommodate needs, ensuring rest, and conducting regular check-ins are critical.

An early example of a creative effective response to support frontline workers early in the crisis was implemented by the Department of Health Social Work in Texas, in the United States (Jones et al., 2021). A list of social workers was organized to be on call for providers who needed support, and this list was distributed to the medical school. There was such high demand that a hotline was created that was developed and informed by everyone in the field (Jones et al., 2021). Jones (2021) also highlighted that healthcare systems need to respond with a compassionate, coordinated response to the ever-changing crisis. It would benefit systems to have uniquely trained social workers to ensure that community organization, clinical care, and compassionate care are being delivered (Jones et al., 2021). This worked in supporting the healthcare service providers, who were mostly women. Effective programs and services should be modelled, and the lessons learned should be communicated throughout so that we can ensure that service providers are receiving the effective services they need.

Summary of the Literature Review

This literature review revealed that we still have much to learn as we navigate the waves of the pandemic. Canadian data is absent regarding the impacts of COVID-19 on women workers in terms of their level of compassion fatigue. We are also learning and adapting our understanding of compassion fatigue to meet evolving psychological impacts—for example, shifting from the terminology of compassion fatigue to secondary traumatic stress or empathic strain—to highlight the pain and exhaustion that workers are feeling.

When disaster strikes, professionals often learn after the fact about the need to enhance services for future development, inquests, and better service. As discussed, mass exoduses have happened from many of the professions, as unions and staff fight their way through issues that arose. Further research must explore the unintended consequences of essential workers’ perceived disempowerment during resource reallocations (Gupta et al., 2020). Action must be taken to protect the brilliant minds of healthcare workers across the world to address compassion fatigue so that we still have healthcare workers in the years to come (Brindle et al., 2021).

Chapter III: Theoretical Framework

My research used a feminist standpoint approach since a major purpose of the study was to uncover and understand the gendered impact of the COVID-19 pandemic (i.e., the impact on women healthcare workers). As demonstrated in the literature review, women experience traumatic events in unique ways (both personally and professionally). I concentrated on the personal experience of women as healthcare workers in the COVID-19 pandemic, with a focus on compassion fatigue. From the literature review, it was evident that further research is needed to develop a better understanding of the impacts of compassion fatigue on healthcare workers during and after the COVID-19 pandemic. Women are more likely to be caregivers both personally and professionally and are, therefore, responsible for many people's well-being. There is also research indicating that Double Duty Caregiving has a large impact on women. Double Duty Caregiving involves helpers needing to participate in elder family caregiving that impacts both the public and private domains of caregiving, where they need to constantly negotiate the boundaries between professional and personal caring work (DePasquale, 2019). As COVID-19 continued to change workers' lives and wreak havoc, women were among those hit hardest (Kearney et al., 2021). COVID-19 exacerbated existing gender inequality for women, as women are more likely to be key workers as well as primary caregivers, leaving them at greater risk of psychological and financial stress (O'Connor et al., 2020).

Broadly speaking, "feminism is a movement to end sexism, sexual exploitation, and oppression" (hooks, 2014, p. 12). It begins with the premise that gendered positions in society are socially, economically, culturally, and historically shaped, not biologically determined (Mandell, 2020). Feminist perspectives explore and try to empower women's diverse situations and enlighten the institutions that frame those situations (Hesse-Bieber, 2012). As women are at the center of my research, it is essential that their voices are heard in the research process and that I am working towards social change for women (Hesse-Bieber, 2012).

Feminist methods challenge beliefs and practices that were previously assumed to be acceptable, unified, and natural instead of an explanation of the normal (Kronsell, 2005). Institutions of hegemonic masculinity have been monopolized by men and norms created solely based on male bodies and masculine practices (Kronsell, 2005). This can include healthcare systems. Feminist standpoint theory argues that women's historical situation of subordination within a system of gender hierarchy creates the conditions to see the operations as male-as-norm (Kronsell, 2005). Power relations constitute the conditions of knowledge; however, knowledge should come from the struggles and experiences of the deprived and less privileged to challenge dominant and repressive social practices (Kronsell, 2005). Knowledge gained from having a feminist research agenda and charting the experience of women in institutions remains valuable to feminist politics, as it provides a vantage point on male supremacy that can critique patriarchal institutions (Kronsell, 2005). Emphasis has been placed on the importance of grassroots activism and mobilization around women's concerns, paying attention to protest and articulation of critical and alternative politics outside mainstream institutions (Kronsell, 2005). Research topics from a feminist perspective may include policy issues relating to realizing social justice for women in a specific context or knowledge about oppressive situations for women (Morris, 2006).

By locating women's oppression as rooted in capitalism, economic dependence on men is defined as the source of their inequality (Mandell, 2020). Paid work is valued within a capitalist system and unpaid family work is devalued: for example, domestic roles are not regarded as legitimate work, leaving those in such roles unable to pay for healthcare, receive pensions, or exercise childcare and maternity leave options and making them more susceptible to violence (Mandell, 2020). For women to be liberated, domestic labour must be equalized, as the responsibility for childcare and housework (in addition to many other pressures) often falls solely on the women in the household (Mandell, 2020). By separating women’s work and men’s work, household labour is devalued as a natural consequence of a woman’s love for her family, and it is not recognized as real work (Mandell, 2020). There is also an increased presence of women in the paid labour force, in post-secondary education, and in single-parent homes headed by women (Mandell, 2020).

It is important to note that while I am examining women’s experiences during the pandemic, there is no one set of issues that will be the same for all women, nor will they share all the same experiences regarding the COVID-19 pandemic. Standpoint feminism allows these individual differences and realities to be explored. Since it was important to capture individual experiences, I explicitly asked for the study participants’ perspectives on their lived experiences during the pandemic. This, allowed for opportunities to expand on and further explain the unique experiences they faced in a women-dominated profession rather than if they all shared the same perspective.

Concerning COVID-19 specifically, women essential workers in healthcare have worked with inadequate support, were lacking protective equipment to do their jobs, and have often been put in situations where their physical and mental health are in jeopardy. Women working in healthcare-related jobs are also often primarily responsible for caring for children and other loved ones (e.g., sick, or elderly family members).

Feminist research allows us to look at differences so researchers can gain a more complex and richer set of explanations of the lives of the oppressors and the oppressed (Hesse-Bieber, 2012). We must explore the connection to a wider set of gendered power relations that structure those experiences by looking at isolated events and placing them in larger contexts to make gendered practice visible (Kronsell, 2005). Feminist scholars argue that women are oppressed in society, and we must consider their everyday experiences, paying attention to the gaps that occur in their lives due to oppression (Hesse-Bieber, 2012). Feminists must engage in the theory and practice of their research before, during, and after the formulation of the research questions and when reporting their findings (Hesse-Bieber, 2012). We must question and critique bias within the disciplines and challenge traditional research.

As a woman and a feminist, I am passionate about completing feminist research and advocating for social change and justice. It is necessary to start research into women's lives and consider their unique everyday experiences of multiple caregiving roles by paying attention to the findings and analyzing women's experiences as they try to fit into the dominant culture's ways of trying to see their situation (Hesse-Bieber, 2012). In the literature, the occupation of informal caregiving roles for dependent children (that is double-duty child caregiving) or adult relatives (that is double-duty elder caregiving) by practicing health care professionals is called double-duty caregiving whereas the occupation of informal caregiving roles for sandwiched care recipients, or dependent children and adult relatives, among such professionals, is considered triple-duty caregiving (DePasquale, 2019). The caregiving roles interface between professional and personal lives and individuals often feel sandwiched between care recipients and dependent relatives which can result in double or triple-duty caregiving depending on the degree of expectations (DePasquale, 2019). Power issues flow through everyday life and practice. The dual roles that women occupy—in their professional lives (as healthcare workers) and personal lives (as caregivers for children and elderly relatives)—expose them to significant consequences of the pandemic. These consequences must be carefully examined.

Standpoint feminism, specifically, was used to guide my research by researching women in a women-dominated role. I surveyed women and asked for their direct perspective on the roles they occupied that were dominated by women, also exploring the implications that their caregiving had on their mental health and levels of compassion fatigue.

Feminism (including standpoint feminism) is any research project that is carried out by those who identify as feminists or those focused on aspects of the feminist agenda (Morris, 2006). This explores creating a partnership with participants and listing the issues that are unique to each participant. This partnership requires a two-way negation or plan in that modifications can be made based on input from the people who are being interviewed (Morris, 2006). This draws attention to themes that may otherwise be ignored or generate a debate that can challenge or support some of the views of feminist theories (Carey, 2012). This was crucial in my research and why I waited for the survey results information to guide my interview questions. I did not want to go in with a preconceived notion of what themes, theories, and further clarity I would need until I had a fuller understanding of their lived experiences.

Qualitative research is a means for exploring and understanding the meaning individuals (and groups) ascribe to social or human problems (Creswell & Creswell, 2018). By doing qualitative research questions can be asked and people can meet where they are to collect and analyze the data by putting it into themes through interpretation. The final report is flexible fitting to what was discovered (Creswell & Creswell, 2018).

In this study, I was guided by exploring the gender inequality in the roles that the women were in and the additional roles they occupied (i.e., more likely to be caregivers in their personal and professional lives). The questions I asked were based on my literature and guided by the premise of standpoint feminism by clarifying any literature, exploring any gaps, and allowing space for participants to expand on issues that were unique or relevant to their own experiences. This helped in my analysis, by ensuring that I was separating my thinking from women’s lives and exploring the intersection of everyday practices, policies and the production of knowledge. In supporting that theory, I only interviewed women, therefore, allowing for their voices on their experiences. I used a full woman advisory committee and am a woman myself, to honour the women’s lived perspectives. As the experience of the COVID-19 pandemic was new and there was not a substantial body of research done on this topic, I provided the opportunity for unique experiences and perspectives.

Chapter IV: Research Design and Methods

Methodology

As noted earlier, the purpose of my research was to explore compassion fatigue experienced by frontline women essential healthcare workers during the COVID-19 pandemic. A mixed method design involving both quantitative (online survey) and qualitative methods (semi-structured interviews) was used to explore my research question.

Research Question

My research focused on women's experiences of working through a pandemic as essential healthcare workers. It also highlighted the connections between being a caregiver, psychological and physical safety, and compassion fatigue. Therefore, the overarching research question for my project is: What are the personal and professional experiences of compassion fatigue among women healthcare workers during the 2020–2022 COVID-19 pandemic? I defined those working in healthcare as doctors, nurses, social workers, healthcare aids, and anyone who actively worked in the field during the pandemic.

Research Design

A mixed methods research approach involving quantitative (online survey), and qualitative (semi-structured interviews) research methods was used in this study. By incorporating both qualitative and quantitative approaches, I was able to identify and explore in-depth issues that this population (women healthcare workers in Ontario) faced, and I developed a rich understanding of the impacts of the pandemic from their perspective.

Furthermore, the study's theoretical framework of feminist standpoint theory aligned with my choice of mixed methods to better understand the experiences of female healthcare professionals in Ontario during the COVID-19 pandemic. The survey enabled me to reach many women, and the follow-up interviews allowed me to further explore their individual experiences, giving voice to their unique realities. By highlighting women's complexities and experiences, I can support and advocate for their unique needs (Flowers & Hesse-Biber, 2018).

Research should facilitate new ways and means to support people and encourage questions and challenges to taken-for-granted assumptions, policies, ideologies, or practices (Carey, 2016). The pandemic has brought about many different challenges to many healthcare workers, mostly women, and it was important to gather information to support, inform, and make practice better for the unsung heroes of the pandemic. The burnout and compassion fatigue that these individuals have experienced over the last few years must be acknowledged, validated, and explored.

Quantitative Methods

An online survey administered through Qualtrics software was used to capture the experiences of women healthcare workers in Ontario (Appendix B). The data were used to gain insight into women's experiences and identify recommendations for healthcare policy and practice. The online survey included questions about participants' demographics (such as, age, income, education, immigration status, education, length in role/role), their healthcare work (for instance challenges, coping strategies, relationships with co-workers, work with patients/services users), home or personal life (e.g., caregiving and other family responsibilities, impact on familial relationships, family stress, and coping strategies), as well as their experiences of compassion fatigue or mental health struggles during the 2020–2022 COVID-19 pandemic (e.g., their perceived stress, emotional toll, and coping strategies) (Appendix A).

The survey was shared broadly across Ontario, as I wanted to complete the research in my home province, to recruit at least 50–75 study participants over three months. The survey was shared through different agencies and regulatory bodies. I received 55 responses from women who work in essential healthcare service settings, from diverse cultural backgrounds, economic statuses, and household structures.

I recruited healthcare social workers and nurses (Appendix C) by contacting organizations such as the Canadian Mental Health Association Ontario, as well as through professional/regulatory bodies and associations such as the Ontario College of Social Service Workers and Social Workers and colleges and universities throughout Ontario, requesting that they reach out to their students and alumni (Appendix D). Several organizations wanted large fees for their members' emails or for the body to disseminate the survey. As a student researcher, I tried to only utilize places that would share the information with no fee barriers. Unfortunately, this may have impacted the representativeness of my study sample by only being able to reach limited places/individuals across the province. I would have liked a more representative sample consisting of different cultural perspectives and experiences. To be eligible to participate in the survey, participants needed to be over the age of 18 years, identify as women (see definitions in survey attachment), and have worked through the pandemic in some capacity supporting healthcare patients/patients in Ontario (Appendix F).

I created the 42-question survey (Appendix B) using Qualtrics software and piloted it with family members and co-workers (n = 15) who are in the healthcare field. At the beginning of the survey, there was a document provided for review entitled, "Definition of Compassion Fatigue for this study." This was to preface the information I was seeking from the participants and how I was defining compassion fatigue, so they were clear as noted earlier, there are varying definitions of compassion fatigue. (Appendix A).

Individuals who piloted the survey were representative of the participants I hoped to reach. I requested that they review the questions, complete the survey, and time themselves to ensure that the survey was easy to understand and did not take more than 15 to 20 minutes to complete. I considered their feedback when making and creating my interview questions.

There was not a significant amount of feedback provided in the survey itself, therefore, no major were no changes made to the survey that was piloted. The quantitative data were then extracted from Qualtrics and de-identified (de-identification of medical record data refers to the removal or replacement of personal identifiers so that it would be difficult to reestablish a link between the individual and his or her data. Although a de-identified dataset may contain an encrypted patient identifier with which authorized individuals could relink a patient with his or her dataset, this dataset must not contain data that will allow an unauthorized individual to infer a patient's identity from the existing data elements.) (Kushida et al., 2021), and entered Statistical Package for the Social Sciences (SPSS) for analyses. There was a master list kept of participants' names, and I assigned codes (example= A= Jane Doe, Code #1). Before analysis, the data was cleaned. Data analysis primarily involved running descriptive statistics to explore means, standard deviations, frequencies, correlations and tests of differences (Plichta et al., 2011). The significance levels for all inferential statistical tests conducted in this study were set at $p < 0.05$.

Due to the small sample size, I recoded and collapsed my data into smaller. With the guidance of the biostatistician (Dr. Rasheda Rabbani), data was explored in SPSS by employing cross-tabulations (to compare associations between categorical data), Analysis of Variance (ANOVA) (to compare means of two or more groups), and Pearson Chi-Square (to test for differences in categorical data (Plichta et al., 2011).

Qualitative Methods

At the end of the survey, participants were invited to participate in a follow-up interview and were asked to provide their email so I could contact them. Twelve participants agreed to an interview; however, when it came to scheduling the interviews, some participants were unable to due to life stressors and lack of time ($n = 4$). Therefore, eight participants ended up scheduling and participating in the follow-up interviews. Prior to beginning the interview, I reviewed the consent form with individuals (Appendix G). I employed qualitative methods, such as semi-structured interviews, to gather a deeper, richer understanding of their lived experiences (Appendix E). The interviews allowed participants to expand on their experiences, explore survey responses, and address questions that required further exploration (e.g., contradictory findings among survey participants more detail into the experiences, examples, and stories from the pandemic).

Due to the continued risk of potential COVID-19 safety and health concerns, as well as accessing participants from several geographical locations across Ontario, the interviews were conducted over Zoom versions 5.12.6 and 5.12.7 video-conferencing platforms. A phone interview was also an option, but all chose to participate via Zoom. As mentioned previously, the interview questions were developed after the survey responses and data had been preliminary analyzed. In November and December 2022, eight participants were interviewed from across Ontario using the same semi-structured interview questions (Appendix E). Participants were sent documents before the interview to review, and they were asked to sign and return the consent. The documents included the questions that would be asked, information on the Professional Quality of Life Scale (ProQOL), I read a script for debriefing and offering counselling resources (Appendix H) a list of free mental health supports and resources (Appendix I), and the consent form (Appendix G). They were allowed to select the day and time that they preferred, and I did my best to accommodate them. All interviews took place over Zoom and were recorded on Zoom and lasted approximately 90 minutes each. The follow-up interviews used a semi-structured interview guide for participants to reflect on the impacts of the pandemic on their personal and professional lives (see Appendix N for a list of interview questions). I developed the interview questions based on the findings from the literature review as well as from the survey results once they were analyzed. The topics I wanted to explore were the open-ended responses in the “other” sections, including unanticipated responses. I also wanted to explore some of the major themes identified in the survey in greater depth.

I attempted to analyze the ProQOL scores by measuring the negative and positive effects of helping others who experience suffering and trauma. This tool looked at three subscales: compassion satisfaction, burnout, and compassion fatigue. However, there were only eight participants, therefore, only descriptive statistics could be explored. In the end, the tool was utilized to introduce the topic, prompt discussion around compassion fatigue, and provide clarity on some of the content we would be covering.

In addition to the semi-structured interview guide, I completed the ProQOL with all participants at the beginning of the interview to develop a rating of their quality of life; however, due to the low number of interview participants, I was unable to analyze participants' responses on the tool. Instead, I utilized this tool's question items to stimulate discussions with the participants. The ProQOL is a standardized measure that is commonly used to measure the negative and positive effects of helping others who experience trauma. It consists of 30 questions about the positive and negative aspects of caring while measuring compassion satisfaction and compassion fatigue. I received permission to utilize the ProQOL tool as part of this study (see Appendix M).

All the interviews began with the participant and myself completing ProQOL as I shared my screen, and we went through it. Again, this was just used as a tool to stimulate conversation and scoring was not used for analyzing. The ProQOL is a 30-item self-report questionnaire designed to measure compassion fatigue, work satisfaction, and burnout in helping professionals. The tool was developed to use with helping professionals who perform emotional labour, as well as those who are exposed to traumatic situations. This tool explores how one feels about one's work as a helper, exploring both the positive and negative aspects of one's life in the interviews conducted with study participants. The Cronbach's alpha reliability estimate for this tool is excellent (.88) as reported by Geoffrion (2019). This tool is one of the most widely used measures of compassion satisfaction and fatigue: however, there is little published evidence to support its validity.

All interviews were digitally recorded and transcribed verbatim (by me). I adopted a generic thematic analysis approach to analyze all interviews. A thematic analysis focuses on identifying themes or patterns regarding groups, and then looking for patterns, behaviours, or values (Carey, 2012). I followed the steps of thematic analysis in collecting data, transcribing conversations, categories, and patterns within transcripts, piecing together scripts to create a comprehensive list, building an argument for developing themes, and finally applying the findings to practice (Carey, 2012). I reviewed the relationships and main themes with my advisor. Reflexivity was utilized throughout (before, during and after my data collection) by continually examining my subjective point of view by documenting, exploring, reflecting, and speaking with my advisor whenever issues/concerns arose or when clarity and guidance were needed.

Ethics

Ethics approval was obtained from the University of Manitoba Fort Garry Research Ethics Board (Appendix K) before administering the survey (both the pilot and final versions) and the interviews (Appendix K). I submitted an ethics amendment for approval for my follow-up interview questions (Appendix N), as I wanted to develop the questions based on what I received from the survey and wanted further clarity.

The approval from Fort Garry (Appendix N) was obtained before the interviews were conducted. A small honorarium ($40) was provided to each woman who participated in the interview, given that I was asking for their valuable time (Appendix J). Steps were taken to ensure minimal risk and participant confidentiality, such as deleting any identifying information from transcripts of the recorded interview. All project data were stored securely in Qualtrics housed in Canada for five years as indicated in my approval (Appendix 4). Any piece of data that may identify a survey participant was deleted. There was the potential that individuals would become distressed when they participated in the study; therefore, I provided a list of free, accessible mental health resources at the end of the survey in the event they needed extra support (Appendix I). Participants also had an option to receive a copy of the study's summary findings at the end of the survey.

Quality and Verification

To enhance rigour, I was thoughtful and deliberate in all my planning and carrying out of the research study by continually thinking critically. I took detailed notes during the entire research process, especially during the data analysis stage, and I ensured that I rigorously analyzed the data with appropriate statistical tests. I had regular meetings with my thesis advisor during all stages of the research so that I could incorporate her expertise and utilize any feedback that she had. I also met with my committee members who had expertise in data analysis and suggested additional resources that I could access at my university. I also consulted with a statistician to ensure I employed the most rigorous and appropriate statistical tests to address my research questions which also supported in confirmability. Confirmability extends the confidence that the results could be confirmed or corroborated by another researcher (Guba & Lincoln, 1981).

Credibility was obtained by conducting follow-up interviews and using the ProQOL to measure levels of compassion fatigue. Credibility establishes confidence that the results are true, credible, and believable (Guba & Lincoln, 1981). The interviews confirmed what my survey results had indicated as clients were able to expand and explain further why they were selecting the issues they had. Participants were able to have more of a dialogue and noted exacerbation in various symptoms of compassion fatigue. They noted that many of their experiences were highlighted in the survey as well as additional issues and impacts that were summarized in the ProQOL as they reflected. I debriefed with my advisor and committee members and discussed my preliminary findings to determine if they were reasonable and based on participants responses, enhancing my study's credibility. Research dependability ensures the findings of the qualitative inquiry are repeatable if the inquiry occurred within the same cohort of participants (Guba & Lincoln, 1981). Dependability was important in ensuring rigour in my study and was therefore a core focus throughout my entire research process. It was established through using an audit trail, journalling, and consultation with my advisory committee. As a woman healthcare service provider working during the pandemic, I was aware of my personal biases and examined them while I conducted my interviews and analyzed the data. I mitigated this by using a reflexive journal, documenting the actions, thoughts, and feelings I encountered through the data collection and analysis, as well as having transparent conversations with my advisor and committee throughout the process.

Chapter V: Results of Online Survey - Quantitative Component

The survey was open from August 2022 until October 2022, with 55 people completing the survey. However, only 44 surveys were useable (i.e., many had no information, and some were half-completed) and retained for statistical analyses. There appeared to be an issue that happened after question 17. One speculated cause for incomplete responses is that the survey changed and got longer and where participants were asked to provide more intimate details at that point. However, the reasons for why this happened remain unclear. I had conversations with Qualtrics experts and members of my advisory committee to determine what else could be done. The conclusion was made that, given that over half the survey was incomplete and the beginning questions were more demographical in nature, those responses would be omitted from the survey. I consulted with a biostatistician and assistant professor at the University of Manitoba, Manitoba Centre for Nursing and Health Research (Dr. Rashida Rabbani) for assistance and support with my data analyses as suggested by my advisor and another member of my advisory committee.

Data was extracted from Qualtrics and analyzed in SPSS statistical analysis software. I categorized the data according to their measurement levels, i.e., ordinal, nominal, and interval scaling questions. I was careful to enter all the participants' responses for the survey questions, including missing responses. Prior to analysis, the data was cleaned; note that several survey questions had no responses. Using SPSS, I ran basic descriptive frequencies and utilized crosstabs. Given the exploratory nature of my research, I conducted several supplementary correlational analysis and tests for differences (ANOVA) to identify potential relationships among variables. However, because my study's sample size was small, I did not anticipate finding many (if at all) significant findings ($p < 0.05$). Statistical tests such as correlations through Pearson Chi-Square and tests to determine group mean differences with ANOVA were employed. I avoided fishing by predetermining what I wanted to explore before running the tests based on my literature review and findings. I wanted to see if my findings were consistent or contradictory to what previous research had found.

Demographics of the Survey Participants

Of the 44 survey participants, 43 identified as women and one as non-binary. Most, 70% (n = 30) of the participants were married, 7.5% (n = 3) were in common-law relationships, 2% (n = 1) were engaged, 14% (n = 6) were never legally married, 2% (n = 1) was separated, and 4.5% (n = 2) were divorced. Their relationship status was collapsed into smaller groupings for later analysis. Most participants identified as White 70% (n = 31), 18% (n = 8) as South Asian, 7% (n = 3) as Indigenous, and 4.5% (n = 2) as Latin American. Due to the small sample size, participant race was collapsed into three categories (White, South Asian, and Other) so that further statistical tests could be performed (Table 1).

Participants' ages were broken down into categories. The largest age group was 36 to 45 years with 36% (n = 16) and the smallest group was 66 to 75 years with 2% (n = 1). Age was then collapsed into smaller groupings for further analysis (Table 1).

Most of the participants completing this survey identified as mothers with 73% (n = 32). Twenty percent (n = 9) of the participants had one child, 30% (n = 13) had two children, 14% (n = 6) had three children, and seven percent (n = 3) had four children. Twenty-seven percent (n = 12) of the participants did not identify as mothers. I collapsed the number of children into smaller groupings for further analysis (Table 1).

Thirty-two percent (n = 14) of the participants had received a college diploma from a technical or applied college, 30% (n = 13) had a university bachelor's degree, 30% (n = 13) had a university master's degree, and 4.5% (n = 2) identified as "other" (they wrote in medical doctorate) (Table 1).

The participants held a variety of professional designations, with the highest number being nurses (n = 19; 43%), followed by social workers (n = 16, 36%), and physicians (n = 3, 7%). Fourteen percent (n = 6) identified as other healthcare providers including a pharmacist, a psychotherapist, a director, a clinical nurse educator, a case manager, and an occupational therapist (Table 1).

Over three quarters, 77% (n = 34), of participants identified as frontline staff, 20% (n = 9) worked in management positions, and one identified as “other” (a clinical educator). Most participants worked in their roles full-time, 80% (n = 35), 14% (n = 6) were part-time workers, 5% (n = 2) were casual employees, and one identified as a contract worker. Sixteen percent (n = 7) had been working for less than a year, 20% (n = 9) had been working one to two years, 20% (n = 9) had been working three to four years, 18% (n = 8) had been working five to 10 years, 25% (n = 11) had been working for over 10 years (ranging from 13 to 34 years) (Table 1).

Participants were asked for their geographical location (i.e., rural, or urban): due to there being more answers than participants, one can speculate that they chose more than one answer because they identified with both communities or worked and lived in both communities. In hindsight I should have been clearer with my question, specifying where they lived or where they worked. Ontario has many small First Nation communities and surrounding cities, and many workers likely travel or commute from home to work. (such as travel nurses, district roles, etc.). Most participants reported living in smaller areas (28 in a small city or town, five in a rural non-Northern community, 11 in a rural Northern community, and one in a First Nations community), with the remaining participants living in larger, urban areas (six participants identified as living in a large city or urban centre, one in a suburb near a city centre) (Table 1). Further investigation was limited with this data, as it was not clear whether participants had responded based on where they lived or where they worked.

Survey Results

The remainder of the survey was comprised of various question formats such as yes or no questions, scaling questions looking at how they agreed or disagreed with certain topics, multiple choice answers that allowed them to select all that apply, and questions that asked them to select their top options (i.e., select the top three). Each section had an option of "other" where they could add additional information if they wanted.

a) Compassion Fatigue Trends at Work

The first question (Question 14) asked participants to note what trends about compassion fatigue they witnessed in their professional practice. Participants were able to select as many answers as they would like and question 15 allowed them to add anything that was not listed. All 44 participants noted at least one of the five trends (Table 2), with many participants (80% or n=35) agreeing with five or more trends. Trends include deterioration of mental health and well-being of staff, and patients, workplace culture, and increased levels of compassion fatigue at work and impacts on work-life balance. Participants were also able to select a "do not know" option if they did not know an answer to a question. Importantly, no participant said they "do not know" suggesting that all participants were clear with their areas of struggle within the professional practice (Table 3).

Almost all participants, 95%, (n = 42) experienced deterioration of mental health and deterioration of the well-being of staff. The vast majority (n = 40 or 80%) experienced deterioration of mental health and well-being of patients. Almost all, 89% (n = 39), experienced deteriorations in mental health and well-being of workplace culture. Most (n = 35 or 80%) also noted they had experienced increased personal levels of compassion fatigue at work and 81% (36 of the 44) noted impacts on work-life balance (Table 4). There was an option for participants to select "don't know". However, as noted earlier, no one selected that option, suggesting the exceptionally common experience of compassion fatigue during the pandemic.

Participants were then asked to select the top three challenges. The highest answer selected by almost all participants, 95% (n = 42), was experiencing deterioration of mental health and deterioration of the well-being of staff. The next highest selected was 91% (n = 40) of participants selecting deteriorations of mental health and well-being of patients (Table 5), and the third highest option was 89% (n = 29) experiencing deterioration of mental health and well-being of workplace culture. There was an option for participants to select “don’t know”: however, as noted earlier, no one selected that option, suggesting the common experience of compassion fatigue during the pandemic. Important to note over 79% (n = 35) selected all the options provided (Table 5).

Participants were asked to note any “other” trends related to compassion fatigue and were able to add comments that they felt were applicable. Participants highlighted how they were feeling about their careers and others highlighted the exacerbated effects on their mental health. A third of the participants (34%: n =15) responded.

Trends (or theme clusters) in the comments (the other section) were separated into two sections below. Here, the participants noted their feeling about the ability to do their job/resources they lacked, and the exacerbated effects on their mental health.

i) Trend 1: Feelings Toward Role or Place of Employment

The first theme concerns how they were feeling about their job or their place of employment. They noted struggles with how their role was being changed, feeling undervalued and underappreciated. Many felt that their employer did not support or understand the ever-changing demands of their roles, the emotional impacts of the pandemic nor the complicated demands that emerged between work and home.

Participants highlighted many struggles such as, “I leave work most days feeling like I haven't done a good job for any of my patients”, another experiencing a “loss of job satisfaction”, and one feeling they had “a lack of resources.”

One participant reported that they planned to change professions altogether due to the stress created by their job, noting: “it has taken the passion away from my career, and in its place, anger: only professional growth activities such as completing my BScN and involvement in professional practice groups are keeping my passion alive.”

Some felt that they were judged or unable to meet their family’s needs with childcare, or working from home/needing time off without judgement. The consequences of their poor experiences led them to make career changes that they never had thought of as an option in the past.

ii) Trend 2: Exacerbated Mental Health Symptoms

The second theme focused on how participants noted the exacerbated effects on their mental health. Participants explained how this was impacting them in their role. Comments were about their experiences of compassion fatigue such as “staffing crisis caused by the pandemic accelerated compassion fatigue,” and issues with self-confidence with comments such as “COVID-19 has made me scared that I’m the one directly causing my patients harm and infecting them when I’m a nurse so that I can care for others”. Finally, a social worker in healthcare noted:

> It feels like it is never going to end, and I fear this is the new normal and it does not feel sustainable. The advocacy for vulnerable populations with minimal forward movement and the associated frustration leads to feelings of burnout. Additional disconnection from advocacy efforts leading to increased suffering in vulnerable populations and increased burnout in providers.

Participants were asked how their workplace had altered its service delivery model within the context of COVID-19 (Question #17). I wanted to explore this as changes and adaptions can be very hard on staff, forcing them to pivot both personally and professionally, and creating additional stress on staff. Most importantly, all participants reported changes within their organization (Table 3). Almost all participants noted several changes to the delivery of services. The top three concerns noted were the majority 93% (n = 41) reported needing to be continually cleaning and sanitizing common spaces, 86% (n = 38) reported switching to virtual means (i.e., phone, video conference) to deliver services, and 84% (n = 37) reported the use of communal spaces. The least common changes were 2% (n = 1) reporting a decrease in work hours and then 27% (n = 12) reporting the need to cancel/amend fundraising activities.

Participants were asked to provide additional open-ended comments with 7% (n = 3) responding by highlighting that: “emergency departments needed to alter assessments”, “the geographical layout changed”, and “facilities had to utilize assessment tents, and more activities were downloaded to nursing duties, such as meal delivery and care.”

b) Pandemic Impacts on Participants’ Work

Participants were asked to identify how the above-noted changes impacted their ability to do their work (Question 18). Importantly, of the 44 participants, only one person noted that the changes did not impact their ability to do their work, and most participants selected several options (Table 6).

Many participants 68% or (n = 30) reported having to focus their attention to the changes required of them to deal with COVID-19 and had less time to connect and work with their patients or service users. Additionally, 63% (n = 28) said that the changes at their workplace left them more stressed and overwhelmed, 57% (n = 25) reported that they have had to take time off work due to illness or mandatory self-isolation, 56% (n = 25) reported that changes in their home/personal life have left them more stressed and overwhelmed, 32% (n = 14) reported being worried for their patients'/service users' physical safety/health, and 30% (n = 13) reported that they were worried for their physical safety/health (i.e., contracting COVID-19 at their workplace). No participant reported being temporarily laid off or had their hours reduced due to funding cuts. Eighteen percent (n = 8) reported that because they were working from home, it was difficult to separate their home and work obligations thus leaving them feeling stressed and overwhelmed. Twenty-three percent (n = 10) reported that they had to learn to use new technology that added to their workplace stress, 16% (n = 7) reported that because they are working from home, they feel disconnected from their co-workers/colleagues, 16% (n = 7) had to provide services to patients or service users that are beyond their scope of practice or responsibility (e.g., completion of Canada Emergency Response Benefit [CERB] applications), and only one participant reported that the changes did not impact their ability to do their work.

For the next question, I reported on the top five challenges as reported by participants. The most selected option by 82% (n = 36) participants was, "Because I am working from home, it is difficult to separate my home and work obligations, leaving me feeling stressed and overwhelmed. Sixty-eight percent (n = 30) selected that “I am worried for our patients'/service users' physical safety/health”, 64% (n = 28) selected that “I have had to focus my attention to the changes required of our organization to deal with COVID-19 and have had less time to connect/work with my patients/service users, the changes at my workplace have left me more stressed and overwhelmed” and 59% (n = 26) selected "I have had to take time off work due to illness or mandatory self-isolation" (Table 6).

Participants were asked to provide additional comments. Nine percent (n = 4) of participants responded and included issues with workloads such as, “most changes resulted in added workload for nursing staff, no increase in staffing ratio,” and “nurses overworked, having less time for patient care, breaks resulting in a high turnover of nurses.” Another participant comments on issues with how administration had pivoted by noting:

> We were left in a position where non-clinical administrators were making decisions about clinical issues that affected clinical programs and services. They don't have the training to understand the consequences of those decisions and were not able to follow or learn from other sites that were able to modify their workplace in such a way as to continue a greater level of clinical service.

A positive comment was left by one participant noting “We were one of the first to return to in-person services, which surprisingly had a positive impact on my mental health.”

Participants were asked to select the three most significant challenges they had encountered in providing services within the context of COVID-19. The top answer was tied at 70% (n = 31) of participants selecting two options: the inability to meet the complex needs of patients and supporting families, and that they experienced decreases in staffing. The second most selected responses were also tied, with 61% (n = 27) selecting: confusions around public health orders and health directives and how this translates to the workplace and adapting to new policies and procedures to manage COVID-19, as well as dealing with angry patients and families due to the challenges that they are facing. The third most selected response, indicated by 54.5% (n = 24) of participants needing to deal with angry patients and families due to challenges they are facing (Table 7).

c) *Preparedness of Agencies (or Lack Thereof)*

The survey also asked about participants' perception of their agency's preparedness (at the beginning of the pandemic and at the time of the survey), and how they were equipped to provide support services to their patients (Question 20). The purpose was to see if participants found their agency’s ability to pivot over time helpful for their work environments. Participants were asked to rate their experiences with the following questions:

At the beginning of the pandemic, my workplace was well-equipped to provide support services to patients within the context of COVID-19. There were mixed views with 45% (n = 20) strongly disagreeing or disagreeing, and 41% (n = 18) strongly agreeing or agreeing. Four participants selected neutral (one can speculate that this included individuals who moved jobs during the pandemic). Eleven percent (n = 5) of the participants responded, “I don’t know”. One can speculate that the “don’t know” responses may have been due to the participants changing jobs and not being aware of what their current employers’ conditions were like in the early stages of the pandemic (Table 8).

They were then asked about how prepared they felt their organizations were at the time that they completed the survey; *My workplace is currently well equipped to provide support services to patients within the context of COVID-19.* A few participants 18% (n = 8) strongly disagreed or disagreed while the majority agreed 82% (n = 36), and none responded, "don’t know" (Table 9).

d) Personal Life Impacts

Participants were asked how COVID-19 impacted their personal life and to select all that apply (Question 22). Surprisingly, only one person noted that they did not experience any personal impacts, with almost all participants noting several impacts.

Participants were asked to select all that applied. The top five responses were: experienced increased stress with the majority (86% or n=38) responding, the second highest was tied experienced burnout and that they felt isolated from family, friends, and co-workers (79.5% or n=35), the third most common response was that they experienced moral distress or concerns with professional/personal boundaries (68% or n=30), experienced lack of sleep or trouble sleeping, and experienced mental health issues (i.e., anxiety, depression, etc.) (59% or n=26) and lastly, at times, I felt uncertain about my future in this profession (54.5% or n=24) (Table 7).

The next section of questions specifically related to the health impacts of COVID-19, and participants were asked to provide either a "yes, no, and I don’t know" response (Table 7). Almost half of the participants 45% (n = 20) said that they had patients who died from COVID-19 (question 23), 43% (n = 19) said no, and five said “I don’t know.” One can speculate that the “I don’t know” was due to changing roles or not knowing what happened to their patients after they provided care.

The participants were asked if they fell ill with COVID-19 (question 24), with a majority saying yes, (80%; or n = 35). Four participants replied that they "don’t know” if it was COVID-19, one could speculate they potentially fell ill when there was not easy access to testing and isolated based on symptoms.

Over half, (68% or n = 29) of participants felt that they did not have enough breaks and struggled with their work-life balance due to the increase in demands from the pandemic.

Participants were asked if they believed the policy adaptations and messages received from leaders were clear: the majority said no (77% or n=34), and one said that they "did not know.” Regarding experiences with having time off (57% or n=25) reported having time off, and about a third (30% or n=13) were redeployed.

Sixty-six percent (n = 29) of participants noted they felt safe at work with a quarter (25% or n = 11) reporting they did not feel safe at work and two participants reported not knowing if they felt safe at work. Over half, (57% or n = 25) felt that their employer met their ever-changing needs, a few (9% or n = 4) reported that they did not know, and many (66% or n = 29) said no to the question, “did anyone check on your physical and mental health” with only one reporting they did not know. Over half (52% or n = 23) did not feel they had adequate support during the pandemic and four said “I don’t know.”

Participants were asked if they had access to adequate PPE. Almost all (93% or n = 41) said they did have access to PPE, while only 7% (n = 3) said they did not. Sixty-six percent (n = 29) believed their health was put in jeopardy. Only 2% (n = 1) said that they did not know if their health was put in jeopardy. Slightly more than half or 57% (n = 25) thought their primary caregiving responsibilities regarding caring for children or the elderly had impacted their work, 89% (n = 39) felt their coping strategies, personal stress, and emotional tools were impacted, and three said they don’t know, 73% (n = 32) felt there were impacts on their home and personal lives, and one said, “I don’t know.” Ninety-three percent (n = 41) felt they had compassion fatigue and mental health struggles: with only one saying no, and two saying they "don’t know" (Table 7).

Participants were asked to add comments about adequate resources where 34% (n = 15). Themes arising from this question included responses (or about?) government, personal and work struggles, and changing professions.

Some responses geared towards the government appeared around participants feeling a lack of recognition for all the chaos that was caused due to the poor organization, concerns with the government "leaving people in the dark about issues", by doing things like reporting things to the public first, thus, making healthcare workers look incompetent. Additionally, participants noted struggles with discrepancies in COVID-19 pay (i.e., who received it and who did not, and the payment amounts) that they believed were initially rolled out by the government.

There were struggles with frustrations at work due to: short staffing and the inability to do their assigned jobs effectively, safety concerns, feelings of stress, anxiety and fear, moral distress, and an inability to debrief. Lastly, participants discussed changing jobs or professions due to the stress and compassion fatigue they were experiencing. In summary, the thematic findings of (list them from above) arose often in participants’ responses to the survey’s open-ended questions. The frequency of these topics as noted by participants suggest how impactful the COVID-19 pandemic was on the experiences of women healthcare workers. These topics were further explored in the follow-up interviews.

Supplemental Findings

In addition to the descriptive analyses, I examined the potential existence of significant relationships between compassion fatigue and several demographic variables. Such analyses aimed to identify additional trends in participant responses, including those identified in the literature review. I was also curious to learn if my sample was like those of previous studies.

Participant demographics that were correlated with their experiences of compassion fatigue were race, number of children, age, level of education, and role/position title. I did this as these areas were flagged as significant predictors of compassion fatigue in my literature review. Given that my main research aim was to examine the experiences of compassion fatigue by women healthcare workers**,** I explored potential linkages between these identified demographic characteristics and Question #39 which captured the existence of compassion fatigue: "Did you experience compassion fatigue and mental health struggles during the COVID-19 pandemic.” This question yielded yes, no, or I don't know responses.

a) Participant Race and Compassion Fatigue

To examine the relationship between race, White, Asian, and Other (all other cases were collapsed) and levels of compassion fatigue and mental health struggles during the pandemic, a Chi-Square Test of Independence was performed to assess the relationship between compassion fatigue and race (White, Asian, and Other with all other cases were collapsed). There was no significance between the two variables, (N = 44) = 6.197, p = .185. There was no association found between race and compassion fatigue (Table 10).

b) Number of Children and Compassion Fatigue

A Chi-Square Test of Independence was performed to assess the relation between the number of children and compassion fatigue. Interestingly, the only person who responded that their mental health was not impacted was a mother who had three children (challenging the idea that mothers with more children will be more impacted). There was no significant relationship between the two variables, X^2 (df = 2, N = 44) = .75, p = .963 (Table 10).

c) Age and Compassion Fatigue

I wanted to look at participants' age and explore correlations given previous research implications that younger healthcare workers were more prone to compassion fatigue. Several tests were used to explore age including and impacts on coping and compassion fatigue.

First, I explored the impact of age and compassion fatigue given the literature suggests that younger healthcare workers are more likely to experience compassion fatigue (Kearney et al., 2021). A Chi-Square test of independence reveals no significant association between age and levels of compassion fatigue X^2=3.097, df 6, p = .797 (Table 10).

Second, previous research indicated that younger healthcare workers were more likely to experience mental health struggles therefore I wanted to see if this was the case for my study. A one-way ANOVA revealed that there was no significant difference between multiple groups. Results showed no significant difference between roles, (F(3, 43)= .587, $< p$= .627) Scheffe post hoc analysis revealed that women in healthcare aged 18-26 years (n = 4, M .50= SD=.577) were no more impacted than women aged 26-35 years (n = 12, M=.75, SD=.452), nor was women aged 36-45 years (n = 16, M=.56, SD=.512) and finally, women age 46+ years (n = 12, M=.50, SD=.522) did not experience significant levels of mental health issues during the COVID-19 pandemic. There is no difference between age range and women's experiences of mental health issues, (i.e., anxiety, depression, etc.) during the COVID-19 pandemic for this study. Again, it would be important to investigate further with a larger sample and I would recommend posing an open-ended question to participants to identify their specific age in years versus having them select an option based on age range categories (Table 11).

d) Age, Mental Health Struggles, and Coping Strategies

Third, I wanted to utilize Chi-Square correlations to explore other associations between variables that I was curious about to see if my literature review findings were consistent with this current study's findings involving, for example, healthcare workers' age and their coping strategies in the workplace. I explored whether the participant's age was associated with coping strategies (i.e., see Question #37 which asked, "Were your coping strategies with personal stress and emotional toll impacted by COVID-19"). A Pearson Chi-Square test of independence revealed no significant association between age and if patients' coping strategies with personal stress and emotional toll were impacted by COVID-19 df = 6, p = .690. I can conclude that a significant association does not exist between age and coping strategies, personal stress, and the emotional toll being impacted by the pandemic (Table 10).

e) Level of Education and Compassion Fatigue

Earlier research indicated that those with higher levels of education (collapsed into college, undergrad and graduate school) versus those with lower levels of education (collapsed into college, undergrad and graduate school) were associated with compassion fatigue and mental health struggles (Kearney et al., 2021). One can speculate that those with higher levels of education would have more responsibility, and complexities of work based on that. However, for this study, a Chi-Square test of independence revealed no significant association between education and compassion fatigue with $X^2 = 2.460$, df = 4, p =.652 (Table 10).

f) Occupational Position and Compassion Fatigue

I explored occupational roles/positions (list them here for the reader) to test whether certain occupational roles/positions were associated with compassion fatigue that included participants' physical and mental health concerns. My literature review indicated that nurses are more likely to be impacted by levels of compassion fatigue and mental health struggles.

The occupational roles/positions were collapsed into three categories Nurse, Social Worker, and Other due to the small size of responses for occupational roles. A Chi-Square test of independence revealed no real significant association between their role/position and their experiences with compassion fatigue X^2=3.376, df= 4, p=.497 (Table 10).

A Chi-Square test of independence also did not reveal a significant association between their current role/position and if they felt that their physical and mental health was put in jeopardy during the COVID-19 pandemic: $X^{2=}$ 8.818, df = 4, p = .066 (Table 10) making this is borderline significant (p-value is between p > .05 and p < .10) Of the 16 social workers, eight (50%) stated they felt their physical and mental health was put in jeopardy. Of the 19 nurses, 16 reported that their physical and mental health were in jeopardy. The findings revealed that overall, there is no association between the role/position of healthcare workers and whether their physical and mental health were jeopardized during the COVID-19 pandemic (Table 10).

I wanted to further explore roles/positions in healthcare and women healthcare workers' experiences of compassion fatigue given my literature review demonstrated that nurses were more impacted than other healthcare workers. A one-way ANOVA was executed to test whether women healthcare workers' roles/positions are associated with compassion fatigue in their workplace. Results showed that there were no significant differences among the roles, (*F* (2, 41)= .224, < *p*= .80). Results revealed that Nurses (*n* = 19, M .84= SD=.375), did not have more significant levels of compassion fatigue than the Social Workers (*n* = 16, M=.75, SD=.447) nor did other employees (*n* = 9, M=.78, SD=.441). It would be important to explore differences in compassion fatigue among healthcare worker roles with a larger study sample.

Summary of Results

I engaged in descriptive analysis and in supplementary exploratory correlational and test of differences analyses to determine if I would find corroborating evidence for extant findings on women healthcare workers' experiences with compassion fatigue. As the pandemic was happening during and throughout my research, I wanted to compare what had already been studied as well as identify future studies that are warranted to address remaining gaps in this literature area. Supplementary analyses included exploring associations between reported levels of compassion fatigue with study participants' age, race, length of role, number of children, and role/position.

As highlighted throughout, due to this current study's small sample size, there were no statistically significant findings found. Furthermore, I assume that all study participants were impacted personally and professionally by the pandemic thus contributing toward limited variability in their responses to this study's survey questions. Participants' responses revealed the compounding and cumulative effects of the pandemic beyond their professional roles and the personal lives of women healthcare workers. Although numerous supplementary tests were conducted, I followed the statistician's recommendations to avoid data fishing. Due to this current study's small sample, no selected demographic characteristics were linked with women healthcare workers' compassion fatigue. However, descriptive study findings revealed that women healthcare workers experienced high levels of compassion fatigue during the COVID-19 pandemic and their experiences are unique and impactful.

Chapter VI: Study Findings - Qualitative Component - Follow-Up Interviews

Follow-up interviews were conducted with eight of the survey participants. As noted earlier, the interview questions were based on the survey responses. I aimed to pursue further and gather in-depth information. These research questions involved six major thematic categories: 1) The Impacts of the COVID-19 Pandemic on Participants Personal Lives, 2) Participants Experiences with Moral Injury, 3) Their Feelings of Guilt and Shame, 4) Supports Provided and Sought for their Well-Being, 5) Perceived Gaps and Limitations, and 6) Their Recommendations for Improving Systems and Supports.

Demographics of Interview Participants

The ages of the eight interview participants range from 22 to 58 years, with the mean age being 36.87 (SD=11.82). All participants identified as Caucasian. Seven of the eight participants were mothers, and two were pregnant during the pandemic (listed as mothers in the demographics), two were mothers of young children, and three were mothers of adult children. There was a range of how long participants were in their roles: two were at the beginning of their careers, four were in the middle of their careers, and two were close to retirement (Table 12).

There were a variety of professions represented. In the interviews, three participants were registered practical nurses with one working in long-term care, one in the hospital, and one in community mental health. Three were registered nurses with two nurses working in intensive care and one manager/clinical educator working in the hospital. Lastly, one participant was a community mental health social worker, and one was a case manager working in community mental health (Table 12).

Many participants ended up changing jobs either internally or externally. Most participants had switched careers due to stressors in their roles, and two switched jobs more than once. Some did this internally, while two of the nurses changed their professions more than once and others moved to external organizations. One participant changed their role three times during the pandemic, noting that she was in her previous roles for over 30 years.

Participants lived in a variety of locations. Seven participants worked in rural and urban settings or larger cities, and one travelled to care for Indigenous communities. Two of these individuals supervised or oversaw staff or programs, and one was a policymaker (Table 12).

In summary, I concluded that significant associations did not exist between the variables selected. This small sample size lacked in diversity of participant characteristics and yielded no statistically significant findings.

For many of the interviews, the participants' emotions were high when speaking of their experiences. The distress and pain were visible, and three of them cried through the emotions and discussed the PTSD-like aftermath of the pandemic.

The Professional Quality of Life Scale (ProQOL)

To begin each interview, I completed the ProQOL together with the participant. This scale is useful for professionals to self-monitor their satisfaction and use it as a prompt for self-care. I chose to administer this tool as it fits nicely with my research topic and questions as it explores both the negative and positive effects of helping others. After completing the ProQOL, we scored it together for learning purposes and then had a brief discussion about any feelings, insights, or thoughts they had after utilizing this tool. Participants were aware that this tool was used to stimulate conversation as opposed to being included in the research and stated they were fine with this. The ProQOL is a measure of compassion satisfaction (pleasure you derive from being able to do your work well), burnout (exhaustion, frustration, anger, and depression about work), and secondary traumatic stress (feeling fear of work-related primary or secondary trauma) within the last 30 days. Many of the interviewed workers' ProQOL scores were moderate (Table 13).

As I noted, given the small sample size of eight participants who were interviewed, this tool was used to stimulate conversation and dialogue with the participants and prompt them to think of things they may not have had in the past. Once they completed the ProQOL participants reflected on the stage of the pandemic that they were interviewed at and how different their present feelings and emotions are now following the height of the pandemic. Several of the participants stated that if this survey had been administered during the height of the pandemic or before they left their jobs, they would likely have scored high on the ProQOL. Many could see the effectiveness of the tool and how it could be useful for themselves or their peers. Few had been exposed to the ProQOL throughout their careers, while others found this was new information and noted it would be helpful for their leaders to engage in tools as such rather than just engaging in “how are you” conversations. As healthcare helpers are sometimes the last to view themselves in need of support, this process assisted them to self-identify challenges they may have been facing in their careers. Participant #2 who was visibly upset after completing the ProQOL stated that: "I felt guilty about how I responded to the questions, as this was not my experience in the past 30 years of my profession. My entire view of the field has changed so drastically, I found this heartbreaking".

The two oldest who were also in their careers the longest, appeared to be profoundly impacted by compassion fatigue. Both participants found it disheartening how their views about their professional roles had changed throughout their careers. One of these nurses (participant #1) fought back tears after commenting on her levels of compassion satisfaction stating: “I need to stay in this career to get my passion back, I loved being a nurse my whole life, and the pandemic and the ripple effects of the systemic issues has destroyed it for me.” In the interview, these two women were visibly distressed talking about their experiences and how a career they once loved—that was such a source of their passion and identity—had brought such sadness and anger. The ProQOL and my interviews challenged my assumption that younger workers would be more impacted by compassion fatigue during the COVID-19 pandemic, and this would be an interesting topic for future research.

Major Themes

The women had a clear idea of what compassion fatigue was, and all participants agreed that they had experienced varying levels during the different waves and stages of the pandemic. Different symptoms were highlighted, and many different themes were pulled from the survey to further expand on and summarize as captured below (i.e., derived either from participants' responses to survey questions with multiple response options, and their comments that were invited in response to open-ended questions on the survey). The themes derived from the data included: 1) The Impacts of the COVID-19 Pandemic on Participants Personal Lives, 2) Participants Experiences with Moral Injury, 3) Their Feelings of Guilt and Shame, 4) Supports Provided and Sought for their Well-Being, 5) Perceived Gaps and Limitations, and 6) Their Recommendations for Improving Systems and Supports. These themes became the structure of the eight open-ended questions, so we could expand on and seek clarity on these experiences.

Theme 1- The Impacts of the Pandemic on Participants Personal Lives

Participants discussed the effects of compassion fatigue and how it affected their personal lives. Several sub-themes were identified including emotional, mental health impacts, and physical impacts. Many participants also commented on the impacts on their family relationships and their spirituality.

a) Emotional and Mental Health Impacts of Compassion Fatigue

Participants discussed the effects of compassion fatigue and how it impacted their mental health and emotions. Anger, irritability, frustration, numbness, apathy, or feeling overly emotional or numb seemed to be common emotional responses stemming from working during the COVID-19 pandemic. Sadness and grief were also highlighted by all, as well as loss of identity. Participant #5 reported this explaining, "It was like Groundhog Day as every day was the same and they all just blended. It was hard to find purpose or meaning in anything. Depression crept up, as well as the inability to keep caring". Participant #8 shared her experiences noting:

> I am usually such a happy person to be around and pride myself on having a good balance for my mental health. My emotions were all over the place. I was either irritable, angry, or overly sensitive. I felt like I did not know who I was anymore, and I did not know how to regulate my emotions, nor did I have any outlets to move through my emotions. This is how I knew I was struggling.

A common reaction experienced by all of those interviewed was becoming angrier and more dispirited at work. There was understandable resentment for the way workers were forced to deliver care, and the frustrations were not directed at the patients or patients (that they had helped) but rather at the system at a larger level. Participant #3 noted, “I was irritable all of the time, I knew I was hard to be around, but I could not stop myself, I was mad at the world and everyone in my life felt it.”

Participant #6 who stated that she once loved being a helper and had a deep passion for helping others commented on her struggles:

> It was very emotional just walking into the building knowing everyone you were seeing was all alone and the connection you were able to give was minimal. Work didn’t feel meaningful anymore and we were just putting out fires waiting for the virus to potentially kill us all.

All participants noted that the services they provided were less effective due to a variety of factors. Participant #3 advised that:

> I became responsible for revamping everything, and this impacted all my relationships. I started to avoid my colleagues and family because all the information I was getting was leading me to believe if I did not do something, everyone was going to die, this left me cold and disconnected from others and my regular job duties went uncovered.

Six of the eight participants reported PTSD symptoms such as nightmares and flashbacks regarding specific patients or situations that they felt solely responsible for. Participant #7 noted, “I would have nightmares and restless sleep, I would worry about my patients consistently.” Many noted symptoms of depression, such as Participant #6 who reported, “I was just sleeping whenever I was not working and believed I was dipping into a depression.” Further, Participant #8 described that they would “jolt up in my sleep, with bad dreams almost nightly, I would have nightmares of the virus, killing everyone at work.”

Almost all reported that mental health impacts were keeping them in a heightened state of arousal and stress responses that impacted their ability to care for themselves. Participant #7 reported, “I significantly lacked self-care, as I did not know when this situation would end, leaving me in a constant state of fight or flight.” Participant #2 joked about having a “crying room” where staff went and had mental breakdowns during their shift when things became too much.

Feelings of responsibility also had a large mental health impact on many participants. Participant #3, a nursing manager, reported that “I felt responsible for everyone—patients/patients, their families, other staff, the entire hospital, and society.” Other aspects mentioned included bringing work home. Participant #2 stated, “Ask my partner, I am different, this is different”.

Participant #3 felt profound effects on her spirituality due to churches, cultural, and religious services being inaccessible for in-person attendance. This was a factor for her mental health, and she noted the severe impacts on her faith, highlighting:

> The impacts of my church being closed were detrimental to my mental health, given that it provided such a sense of community for me. The sense of community was taken from me in every capacity—at home, at work, and within my church. This left a void in my life and had implications for my mental health and well-being.

Three additional participants reported questioning their faith during the pandemic given what they were witnessing.

b) Physical Impacts of Compassion Fatigue

Participants highlighted the physical impacts of the compassion fatigue they were experiencing. Sleep was noted as an issue, with all eight participants reporting not being able to sleep adequately (either more or less). Participant #5 noted issues with her sleep explaining:

> Initially, my sleep was affected, and I did have a hard time sleeping before my shifts and during my shifts, because you just do not know what you are walking into, and you never look forward to going to work to watch the chaos.

Participant #7 discussed her issues with sleep noting that, “I was sleeping much less and just lacking purpose and meaning. My thoughts and worries kept me up almost every night.” Participant #3 noted that:

> I was sleeping more, just always feeling tired. Even after like 12-hour sleeps, I would just go back to bed, and nap all the time whenever I was not working. Before the pandemic I was like a 7 or 8 hour a night sleeper and that would feel great. This was my warning sign that I was struggling. I was also very forgetful about everything.

> Other participants noted needing to sleep with supplements such as sleep aids or alcohol.

Participant #8 spoke about her eating habits and self-care highlighting:

> I did nothing, I gained significant weight as I was working, eating for comfort, and just not taking care of myself, other than excessive showering, my physical appearance and self-esteem were at an all-time low and I had body pain due to stress and not doing anything.

Substance use concerns were noted by half of the participants. Using substances was noted as a struggle for some to cope with the inability to stop ruminating about their stress. Participant #2 advised that “before a shift, I needed to take medications to help with sleep, as anticipatory anxiety had taken over and impacted my ability to get a restful sleep.” She further advised that this was out of character for her. Many spoke of substances being used to cope with work, whether they were prescribed or purchased over the counter. Participant #2 noted that:

> Before needing to go in for a shift I would self-medicate as my anxiety was debilitating, and I was in extreme distress about what I was walking into, I would also use sleeping pills to excess. It was the only thing that got me rest.

Participant #6 was concerned about her urges to consume alcohol that were exacerbated during the pandemic, given that her mother had an alcohol use disorder. This participant reported, “I know that urges to consume alcohol are a trigger for me, and when I am well, I stay clear of alcohol.”

Participants noted that having urges to consume substances or increased substance use and having the urge to quit their jobs as common symptoms. Many also reported that when they left their jobs to start fresh, these feelings still did not go away (that was noted earlier in the literature review as effective for burnout, however, not compassion fatigue).

The negative side effects from the vaccine had one client very concerned as she was worried about the virus and torn on whether to proceed with the vaccinations. Participant #3 was pregnant, therefore, significantly stressed over the pandemic and stated, “I was worried about jeopardizing my health, my baby’s health, and this impacted me physically.”

There were additional physical demands placed on staff that made them more fatigued. Participant #4 reported that:

> Extra hours were an expectation of the role due to the staffing shortages, the lack of volunteers, and the significant amount of work that was needed. There was also so much more preparation to get ready for work and after work to cleanse—piling on the PPE—and after work—changing clothes and scrubbing yourself down. At my facility, many had reported skin issues due to the PPE, such as rashes and acne. Dehydration was also an issue, as well as urinary tract infections due to the inability to easily access the washrooms.

Three participants noted an increased risk to their physical safety from patients. Participant #7 reported that “our client’s complexity significantly increased, so we constantly felt our safety was in jeopardy, not only due to the pandemic but also increased violence, frustrations, and unwell patients.” Participant #8 echoed that noting, “patients’ complexities increased significantly: my safety felt in jeopardy due to all the concerns on top of the pandemic.” The participant working in elderly care noted confusion increasing for the elderly that resulted in more aggressive behaviours by them (e.g., lashing out at staff and other residents).

c) Impacts on Family

Participants discussed the effects of compassion fatigue on their families. As noted earlier, most participants interviewed were mothers (seven out of eight). Caregiving in many capacities was a significant cause of stress for them. For example, some had to learn how to support their children's online learning and navigate limited childcare options. Many felt guilt and shame regarding their emotional responses to their children due to their exacerbated stress levels. Participant #7 highlighted the changes to her parenting noting:

> Reflecting, I almost blamed my child for my additional stressors at times, I had to help them, worry about them, miss work for them, and be with them all the time, it was almost an unnatural way to live, stuck together with no outside contact.

Similarly, Participant #5 noted:

> I felt like I was failing my daughter, I couldn’t help her with school, and she fell quite behind, I would be napping all day because I couldn’t find childcare and was working night shifts, I wasn’t attentive, I wasn’t present, I just wasn’t the mom I know I am.

A few participants discussed the ever-changing demands and changes in their children's school and worrying that their children were falling behind. Participant #6 reported:

> I felt like I became such a terrible mother because I was unable to meet the ever-changing demands as a nurse who also needed to support teaching my daughter. I was doing extra shifts to help support my facility due to the shortages and needing to sleep most days. My daughter fell behind in her schooling, and I was so much more irritable and distant, I don’t even think I dealt with her struggles or was able to even care at the time.

Participant #2 reported that she was near the end of her career, therefore, her worries were more centred around her family members who were working during the pandemic. One of her adult children left the field during the pandemic after working hard to become a nurse. The participant had mixed feelings about this but then stated in the end, “I would rather have them exit the field than die by suicide due to the extreme psychological distress that he had been feeling.” One can only imagine how this mother felt—having initial pride that her child was following in her footsteps being replaced by fear for her child’s life due to the devastating state of healthcare.

Two participants noted they were also caregivers to elderly family members, and this came with stress and concern. Participant #7 noted, “My grandmother had significant reactions to the vaccine, and I had to care for her and support her and be her advocate, this came with stress and worry.” Participant #3 highlighted caregiving for the elderly in her family:

> It became my role to support the healthcare needs of my loved ones and help them navigate the system. I had to care for my partner's grandmother, who had concerning reactions to the vaccine. This impacted my work, as I saw the direct concerns of the vaccine yet needed to push forward the vaccine agenda in my professional role—regardless of my personal views, morals, and experiences.

Geographical distances came with exacerbated strain due to travel limitations for non-essential reasons. Participant #6 was in a different province from her partner and unable to visit she described:

> I ended my long-term long-distance relationship as we were unable to see each other during the pandemic, which caused significant conflict and issues in our relationship, and this ended up exacerbating my feelings of loneliness and isolation.

All participants reported that they felt isolated and disconnected from their families and co-workers for a variety of reasons. All participants feared they would expose their loved ones to the virus, and all reported that they felt irritable and angry that they were not present in their relationships. Participant #5 noted:

> It was so scary worrying about my family, I was so worried about bringing it home and killing someone in my family because I gave them COVID. I honestly hardly saw my family or friends for two years, I did not get to meet my niece until she was

> five months old, and I did not see my grandmother who I previously saw every day, it was so hard, and I feel I missed out on so much.

Across the province, there were restrictions on gatherings making it hard for individuals to connect. As travel was also limited, many were unable to connect with family members who resided far away. Participant #6 stated:

> I lived in another province and the travel restrictions were so tight, that I was unable to go home for what felt like an eternity, we connected over virtual means, but that was not the same, it was an extremely lonely time for me.

All participants reported feeling responsible for their family members in some capacity, and the majority noted that they were constantly asking them for updates on what was happening and seeking truth in the overwhelming news. Almost all participants reported at some point feeling the need to isolate from family and friends because they were simply done talking about COVID-19 or were feeling bad about how they were responding to things. Participant #2 reported:

> I whittled down my social circle quite a bit because I was done talking about what was happening at work. We would meet over Zoom and have drinks or try to connect, and everyone would just ask things like what was happening at work, whether was it real, how many COVID-19 patients were there, how many were vaccinated and not, and whether they were that sick. I would try to change the topic, but they always circled back, it was like no one had anything else to talk about. It would aggravate me so much that I just stopped connecting. It was like I could not escape the pandemic, no matter how hard I tried.

Additional warning signs that were highlighted were: feelings of frustration at work and home, irritability, a lack of patience with things that usually were not triggers, feeling anxious all the time about work, leaving work, and the state of the world, experiencing the urge to sleep more, not being able to sleep, or not being able to sleep without self-medicating especially on days before work, forgetting things all the time, and not being able to compartmentalize any longer.

Largely because of compassion fatigue, six of the eight participants switched jobs during the pandemic. They highlighted the cumulative and compounding effects of the pandemic that caused them to leave. Participant #2 stated, “I have been a nurse for the past 30 years, and the last few have been horrible, and I am determined to reignite that spark that I once had before I leave.” This was due to compassion fatigue, the pandemic, and some bullying she experienced within her place of employment. She believes the bullying was a result of all the stressors in the workplace and the toxic workplace culture that was a result. As quoted throughout, many left their roles due to internal issues. Participant #2 further noted, “I left jobs thinking that things would change and it’s like these feelings followed me.”

Healthcare workers started having negative thoughts at work that impacted and transformed their day-to-day work. Participant #1 reported often thinking, “Management does not care about the patients, so why should I?” This participant later highlighted that she had “thoughts of leaving the profession altogether.”

Again, most participants had switched careers during the pandemic due to stressors in their roles, and two did this more than once. Some did this internally, while others moved to another organization, one participant did this three times during the pandemic (participant #2), and she noted that “before the pandemic, I was extremely committed to my one role for much of my career, I never thought I would be leaving there.”

There were many reasons why employees moved around, and this was summarized throughout the questions posed in the interview. Participants had highlighted their negative experiences with their employers, or the love lost within their roles. It is important to note this given 75% (n = 6) of the participants expressed these experiences. Further studies are warranted that explore in greater depth these experiences.

Theme 2- Participants' Experiences with Moral Injury

Moral injury or distress is defined as an issue that occurs when workplace policies or routines conflict with one's beliefs about patient care (Mathieu, 2012). This can look like staff being told to do something that they fundamentally disagree with or that they are morally opposed (Mathieu, 2012). Many of the changes made to policy and practice were likely necessary. This section is not meant to place blame on policymakers or say that institutions were not doing this for safety, or that these measures were not necessary. Participants felt it important to highlight that they were in situations that were morally distressing because of the pandemic. During the pandemic with healthcare policies and routines changing rapidly, providers felt morally distressed and heartbroken in providing poor care, watching people die, and/or moving forward with an agenda that they were fundamentally opposed to (e.g., mandatory vaccinations). In some cases, participants could understand why this was happening, but half of them noted that watching someone fail to survive a critical illness without their loved ones around was one of the hardest things they experienced in their lives.

Participants discussed the effects of moral injury during the COVID-19 pandemic. Participant #1 reported that "before the breathing tube went in a patient, patients would often be allowed to make a phone call and make comments like, I hope I don't die." By not allowing family and loved ones to be present, Participant #1 commented, "This felt morally distressing as client-centred care was at the core of my values and these lonely deaths were quite painful and I experienced significant psychological effects for a long time after."

This was noted by another healthcare worker and her pain was visible when she discussed that many of her patients ended up dying. Participant #1 noted, “I spent my career watching people die but this sat differently for me, and I feel unable to shake it.”

Participant #2 cried when speaking of how patients were left in unchanged/soiled briefs that were utilized as an alternative measure to providing attentive care, as regular timely care could not be adequately provided. This participant stated:

> Patients should not be put in diapers because we are too busy to assist them to the washroom, or to turn them, how awful and degrading for them, I felt disgusted with this, however, knew there were limited options to provide better care, and this has stayed with me.

Participant #3 recalled seeing images in other countries in the beginning stages of the pandemic and trying to emotionally prepare for what was coming. She stated further that:

> This completely transformed everything I did and felt, and, looking back, I realized we were incapable of preparing for something of this magnitude, everything became terrible, and I morally struggled with the changes we were forced to roll out.

All workers reported experiencing moral distress with the care (or lack thereof) that was being provided to patients. Participant #4 was able to speak about the experiences of long-term care and she spoke about the depression and isolation that seniors had faced. This was due to the lack of connection they experienced throughout the pandemic. She estimated that about 90% of the clientele had low cognitive functioning or some form of communication impairment that vastly impacted their ability to understand what was happening. Although she noted that she was not disputing the reasons for the need to change all aspects of services, this participant felt it was morally distressing to isolate the elderly given that their mental health and quality of life were being severely impacted due to these changes. This healthcare worker highlighted her struggles:

> I remember walking into client rooms for brief periods in what resembled space suits. Many patients did not understand what was happening due to cognitive issues. Knowing that all support, volunteers, activities, and events were halted, and that people would be alone in their room for extended periods, was morally distressing and extremely sad. These patients were not able to experience the presence of children, comfort, or connection. They did not experience the sensation of touch throughout the pandemic.

Participant #4 described her present-day feelings noting that:

> It is hard to think about how, almost three years into the pandemic, an elderly person did not hold a baby or be around a child. The rooms in long-term care were about 10 by 10 which added to the feelings of isolation. Face masks were not effective for many patients, especially when dealing with patients who had hearing, visual, or cognitive impairments.

Although this healthcare worker said that they were aware of the safety components, they struggled with knowing the lack of quality of life these people were experiencing in potentially the last years of their lives. Participant #5 also noted that “long hours and expectations were overwhelming, everyone was just drained, and the standard of care people got was not the same, it was really sad to see.”

The participant’s facilities had virtual services available after the initial waves of the pandemic. In the beginning stages of the pandemic, in addition to being disconnected from loved ones, patients were not able to access some of the most important formal services that they previously had regular access to, such as dentists, pastors, elders, social workers/counsellors, activation, psychotherapy, and doctors. The lack of ability for workers to apply client-centred care and witnessing this went against their values and moral beliefs. Participant #8 discussed how services were delivered highlighting:

> We were only able to provide virtual services, with issues with remote communities, struggles with technology, and trust issues, this is not an effective way to only offer services. I worry that so many people just did not reach out and fear we will see the impacts of this for years to come, I worry about our future due to this.

All participants discussed the future of healthcare and the long-term impacts of people's inability to access services. They wondered what preventative screenings and measures have been missed, and they were also concerned about the devastating mental health impacts. Participant #5 noted:

> We couldn't provide anything but virtual care. People were not being screened for preventative health measures and lacked services such as dentists, doctors, and cultural support, and many things such as surgeries, hands-on care and assessments on top of many other things were extremely backlogged.

In thinking of moral distress when discussing a pandemic, I had considered that there would be varying ideas regarding mandated vaccinations. Three of the women viewed the forced vaccine mandate as morally distressing as they were forced to do something that they were strongly opposed to as well as needing to pressure their peers, colleagues, and people they serve to follow the same demands. Others struggled with not being allowed to provide the same level of care (and some no care at all) to those who were not vaccinated. Participant #8 noted:

> We pre-screened patients and kept track of their vaccination status. Those who were not vaccinated were not allowed into our building unless it was necessary, even though they needed connection more than anything in their lives and we were their only support. It was so sad, they refused to get the vaccine due to their concerns, phobias, or mental health issues, and would call us confused and crying wondering why we no longer cared about them, it broke my heart and felt so wrong.

The vaccinations turned out to be a topic that emerged throughout most of the interviews. People had valid reasons for getting vaccinated and others for their hesitation or inquiries. Participant #3 was pregnant and highlighted her experiences:

> I was trying to make an informed decision regarding the vaccines, going above and beyond to ensure that I knew all the risks. I was repeatedly threatened to be fired from my job, a job I had dedicated my life to. I was threatened for trying to navigate the well-being of my unborn child which was my first pregnancy. This moral distress had a significant toll on my and my family's mental health.

This worker ended up taking an early maternity leave before being what she believed would have been terminated, however, this has greatly impacted her throughout her maternity leave. This worker ultimately ended up leaving her position due to these stressors.

Another nurse highlighted the detrimental effects that firing employees over non-vaccination had on an already struggling system. Participant #1 reported:

> Extremely qualified, intelligent workers were forced to leave their places of employment due to their vaccination status, with nowhere to disperse the casework or workload. This put immense pressure on the remaining staff and created a culture of blame and bitterness.

Participant #3 spoke in detail about their concern about the vaccine:

> There was no clear pathway to report the adverse reactions of the vaccine and there was no adequate way of reporting my concerns. I felt that people were not being provided with all the data, it felt like everything was a lie.

This worker found it distressing and morally conflictual as they were forced to put forth an agenda that they did not believe in and genuinely believed was causing harm.

Theme 3- Participant Feelings of Guilt and Shame

Participants were all educated and spent considerable time learning to do their roles effectively and for some, it became connected to their identity. Participants discussed their feelings of guilt and shame in various facets of their lives, whether it be personally or professionally. These feelings were due to their personal and professional stressors. It was important to highlight this as a theme with Participant #6 noting:

> I was a brand-new grad and started in the pandemic, anything I was taught in nursing school looked so much different than the care we provided, and I don't think patients were getting the care they needed and deserved because everywhere was so strapped for staff, I felt so guilty about this, knowing they deserved so much better.

Emotions were high for three of the participants when the question arose about the experiences of grief and shame that workers had around the care that patients were receiving. Two interview participants who worked as Registered Nurses for almost 30 years spoke about not being able to connect with patients. Participant #1 highlighted how the structure of the hospital almost stigmatized people:

> We had the hospital separated into respiratory and non-respiratory sections, which made it almost like the clean and dirty side. I worry that we strategically tried to avoid the respiratory side as much as we could for our safety, and I feel so guilty about this now as they often needed us more.

Participant # 2 expressed extreme sadness after witnessing a client she cared for, for a tremendous amount of time soiling herself because she did not want to bother the staff in paging for support. This worker reported not being able to get over this and having almost PTSD-related symptoms stating:

> A patient I cared for deeply had soiled herself as she did not want to bother us because of everything that was going on. She did not want to page us, so she just sat

> in her urine, I never thought my level of care would get to this and I cannot get the picture of her sitting there out of my head, I cry often still when I think of her.

Many of the people interviewed spent substantial time in post-secondary education, and being a healthcare provider was their identity. The more seasoned nurses felt a loss of self and passion for a field that they had dedicated a significant portion of their lives to. This also highlighted a loss of personal identity along with their guilt and shame. Their career as a helper and a caregiver was something that had defined them for most of their lives. When this was impacted by the pandemic, some women felt that they lost a piece of their identity. The younger workers who were brand new graduates to the field struggled, but their self-reports of compassion fatigue were less debilitating. Two Registered Nurses (Participants #1 and #2) who were at the end of their career, struggled to speak at moments due to emotion during the interview. The interviews revealed that women who had dedicated their lives to the field and were at the near end of their careers held so much pain and resentment towards what they were witnessing. Participant #2 fought through her tears when she stated, "I need to love the field again before I retire," as her husband spoke in the background of how "this has changed her as a person and that he needs her to get out the field altogether." The COVID-19 pandemic has shifted perspectives on many issues that appear especially dependent on the age generation of healthcare workers.

Theme 4- Supports Provided and Sought for their Well-Being

Participants shared their experiences about how they managed self-care. For example, many participants had positive experiences with limiting their media exposure. Participant #4 recommended, "limiting Facebook, news, and any form of social media as those were triggering throughout the pandemic for me." Participant #3 also noted:

> I just stopped going on everything because I couldn't handle it anymore. It was just this ongoing cycle of COVID-19, and it would trigger me. It reminded me of what I

> am seeing daily as well as constantly keeping me in a state of fight or flight seeing what is potentially still to come, as they would show you the worst. I recommend limiting this as this helped significantly.

A survival strategy for one Registered Nurse (Participant #2) was, “taking a step back from people, given the issues regarding the pandemic and the freedom convoys, and the conspiracy theories.” She felt exhausted with being asked about what they were witnessing noting:

> I was drained, I felt like it was always something, the convoys, the protestors, the conspiracy theories, it was always just something, it was like nothing else existed, but COVID-19 and everyone was obsessed with it. I just took a step back from everyone and did my own thing and kept to myself and this changed things immensely for me.

Participant #8 also found that taking a step back from people and prioritizing their mental health was meaningful for them, however, they also noted that this perpetuated their loneliness stating:

> I kept to myself, work, home and over again. People had nothing to talk about and I did not have much to say, I made myself a priority and started creating outlets within my own home such as crafting, puzzles, and reading. I found some new hobbies and I eventually started looking forward to ‘me time’, I was much lonelier than pre-pandemic, but I got through.

Many participants also mentioned that it was helpful to have the interview space to discuss what they thought. Participant #1 noted that “having a safe space to navigate experiences, whether it is going to therapy, participating in research, or connecting with peer groups was beneficial.” Other participants echoed that experience noting using similar outlets. Participant #3 felt heard and valued discussing her experience and contributing to the solution when she stated, “This was helpful, having an unbiased voice hear me out and actually care about what I have to say.”

Participant #7 highlighted their experiences:

> I set up my home and space to ensure that I could have some outlets. I got things for exercise, got outside when I could and tried to incorporate work-life balance the best way I could. I needed to focus on something other than the pandemic.

Participants also shared advice they would pass on to others. These recommendations were on top of learning from the struggles they faced. Participant #6 noted that “avoiding increased substance use, making connections where you can, implementing regular self-care, and having appropriate sleeping and eating habits were crucial for my survival.”

Participant #2 had emailed after our interview advising that she had secured her therapist with whom, “talking through her experience, was so beneficial for my mental health.”

Theme 5- Perceived Gaps and Limitations

Participants were asked to highlight their negative experiences with specific systems. They highlighted their experiences with the government, their employers, and the public that they believed impacted their day-to-day work and contributed to their levels of compassion fatigue. These reported experiences were categorized as recommendations made for the government, their employer, and the public. In noting it is likely, not possible to make general recommendations for the public, these recommendations could potentially support in raising public awareness through campaigns or education that could be provided in the future.

a) Experiences with the Government

In speaking about the government, participants expressed many frustrations with how services, restrictions, and mandates were rolled out. Specific examples included vaccine rollouts, lack of compensation, employee legislation that was put in place (specifically Bill

124, that limited wage increases to 1% for three years), as well as policy and protocol adoptions that were changing quickly and were stressful for frontline workers. Many expressed frustration that they lacked support for dealing with the ever-changing demands.

Participants noted that the gratitude and false promises extended by government leaders felt like lip service and many found this irritating. Participant #2 stated:

> It was likely just selfish meaning behind the promises from the leaders, I feel like there was an agenda to be met and that none of the policymakers understood patient care or services.

b) *Experiences with Their Healthcare Employer*

There was a mix of individual experiences with employers. Two participants highlighted how they felt their employer was supportive and how meaningful it was for them to receive that support from their employer. On the other hand, other participants experienced a lack of understanding and support. A few participants interviewed felt that their employers did not meet their needs. Participant #6 commented, “that the only support we were offered was for internal staff members to provide counselling services that none of us were comfortable with.”

Several workers expressed feeling tension with their employers when they needed to request time off from their work. They felt they were exposing themselves to the virus, however, if they needed sick time/isolation time or needed to support their children, it was met with judgement or resistance from their employer. Many felt that they were challenged with the impossible task of needing to prove that the virus was from their place of employment. Participant #8 discussed the false messaging that healthcare workers received stating, “We were continually told family first, ask for what you need, only to be penalized and guilted when the topic of sick time or requests were made to our employer.” Participant #7 noted:

> We were told to somehow prove we caught the virus from work if we needed additional time off over our COVID days, like how is that even possible? I dealt directly with COVID patients so strong likelihood I got it from there, then the response would become, what did I do wrong, was I not gowned, safe, following the process, it seemed surreal dealing with this while being sick on top of it all.

Daycare and school measures were strict, and children were often sent home for several days at a time. Some employers were inflexible with working from home, therefore, healthcare workers who were parents had to use their sick time, vacation, or unpaid time to support their families. Looking to others for childcare support was a daunting task, as healthcare workers did not want to expose their children or loved ones to COVID-19, therefore, there were limited options available to them. Participant #7 further reported:

> My boss did what they needed to do for their family or life but when it came to staff, we were guilted when we needed to do anything for our families, my child was constantly sent home from daycare, and I would get eye rolls whenever I needed to leave to deal with things, almost made to feel like I was lying, it was maddening.

Many healthcare workers discussed that their employers lacked the compassion and understanding that they needed. Participant #4 discussed feeling the after-effects of contracting COVID-19 for extended periods reporting that, “I was given 10 days to isolate and then had to go back to work, even though the effects of the virus lasted about 60 days for me.” This experience was also explained as being exacerbated due to staffing shortages experienced in all systems of health care.

The lack of timely and effective critical incident debriefing was noted as a common issue. Participant #6 discussed losing a patient who their team was very close to due to an unrelated health complication when she stated, “Our management kept pushing off debriefing or discussions, and people felt they were expected to just carry on with everything they dealt with." Workers described feeling like management did not take the time or care to genuinely see how people were doing.

Last-minute redeployments were seen as significantly stressful. Participant #4 noted that "schedules needed to be changed at the last minute, which affected many areas of life and placed staff in roles they were unprepared to do or were not necessarily comfortable in."

There were also issues with people being pushed through schooling quickly and thrown into the field. Interview #2 reported that "nurses were sometimes seen as just warm bodies in rapid turnovers due to lack of experience, adequate training, and orientation." There was also an increase in paperwork and liability. Participant #4 noted:

> I had major concerns that there were more forms to fill out than humanly possible, care was limited because no one had time, cold meals were delivered, people were going unturned and untoileted, and specific staff members were left having to do everything.

Participant #7 spoke in detail about how senior management was a major problem:

> Our manager had a "do as I say, not as I do" mentality and allowed themselves to do whatever was needed to support themselves and their family while having very different demands and expectations for their staff. One hundred percent of the staff who left that organization left solely due to the response of our leader and the truth is people don't leave organizations, they leave bad management, and ours was the worst.

Participant #3 noted how inadequate staffing was the issue highlighting that:

> Staff shortages and redeployments put additional pressure on the remaining staff members, and no work was pivoted, leaving staff bitter and burnt out and creating an extremely toxic working environment.

Participant #7 who worked in community mental health further reported:

> Our manager found it seemingly brave to remain open and navigate the pandemic, not closing any of our programs, whereas many felt that this was irresponsible, I believe our manager had their agenda for this which was frustrating given it ultimately put everyone more at risk.

Other healthcare workers had positive experiences and felt that their employers tried to meet their demands with regular check-ins and conversations. Participant #6 reported that:

> I had food and resources delivered to my home by my employer when my family was sick and needed to isolate. This made me feel that my employer genuinely cared for my family's well-being, and this meant more than anything.

Participant #4 also noted:

> I do feel that I was very supported by my managers, just by simply asking how we were doing, if there was anything we needed, and accommodating working from home, I think they tried their very best and honestly cared about us and this made me stay and appreciate my job more than anything.

These experiences, the positive and the negative, highlight how impactful employers can be on the mental health and well-being of their staff.

c) Experiences with the Public

Many participants felt immense responsibility in their roles as frontline staff during the pandemic. A few highlighted their experiences with the public. They felt the pressure of trying to save the world from something that they had limited control over which was very distressing. They felt the pressure to do their job was exacerbated due to the unrealistic expectations of the public. Participant #2 noted:

> Heroes do not do things for pay, we worked hard to get where we are, many of us getting master's degrees, to say we are heroes is creating this unrealistic expectation that we can fix everything, so much was not within our power and control, that

> language minimizes and dismisses everything. Stopping the pandemic was everyone's responsibility.

All participants interviewed reported that hearing people say that "COVID-19 is fake and watching people suffer or die was distressing." Participant #1 stated, "I wanted to invite those non-believers for a tour of what I was seeing, I wish it was fake news." Healthcare workers felt helpless to debate these things, and many just gave up or significantly distanced or isolated themselves from others as discussed throughout other themes.

Participant #6 lived in a small community and discussed the judgement they would feel when in the grocery store in work clothing stating:

> I felt like I was getting dirty looks and being judged as if I was carrying the virus because I was working all the time this was necessary to do, and I felt like people viewed me as a carrier for simply trying to live my life.

Participant #8 spoke about seeing the protests and the anger in the news:

> Although my community was not impacted by this, it was so disheartening to see the protests and the anger centred in places that were already in so much distress like hospitals. I cannot imagine feeling all the things I was feeling about going to work, then having to walk through an angry group of people, never mind if my loved ones were in there needing care.

Theme 6- Recommendations for Improving Systems and Supports

Participants had many recommendations for how to support frontline healthcare workers. These recommendations were categorized according to those for government policymakers, management, and on how to educate the public.

a) Recommendations for Government Policymakers

Participants suggested several specific recommendations for government policymakers including, providing housing for staff so that they did not have to go home to their families and put them at risk. The older and more experienced nurses discussed the need to stop fast-tracking new nurses, with Participant #2 stating, “We do not need a warm body, we need skilled clinicians, as patient outcomes are drastically affected by this.” Participant #2 felt healthcare workers went from “heroes to zeros”. Several other participants stated that they went from being praised to feeling like nothing. Participant #2 remarked further:

> I believe this was led by statements from government leaders in press conferences and when disseminating information to the public. I hope that if this were to happen again, the hero mantra would not be used, as it dismissed our entire experience.

The discrepancy in wages, such as where personal support workers and travel nurses saw an increase in wages, created wage divides and subsequent serious animosity where tensions already existed. Participant #3 recommended, “equitable raises across the board to not further silo professions.” *Bill 124, Protecting a Sustainable Public Sector for Future Generations Act 2019,* was an extreme concern for all participants who thought that the government should re-evaluate similar bills moving forward. The goal of Bill 124 was to cap public sector wage increases at one percent for a period of three years to help eliminate the deficit. Participant #8 discussed the bill as follows:

> This Bill created so much divide between agencies that had multi-disciplinary teams, there was friction between who got it and who did not that further siloed teams and created a toxic workplace culture. There also seemed to be no clarity on when it was coming or how it was going to be rolled out, that also created friction between management and staff.

Participants requested more clear information on changing restrictions and information from one source. A common theme of concern was the way the restrictions were handled, as they seemed rushed and without logic, constantly making people pivot when there was already so much happening. The participants expressed the need for more concrete direction, "here is where to find this, this is what you need to do, step by step" (participant #8). They believed that this would be beneficial for all, given that many healthcare workers were too overloaded with information, and it was hard to sift through this on top of everything else. In the beginning stages, many found that PPE was a problem, and advised that society needs to be better prepared.

Other participants found positive support in what the government had created. Participant #5 reported:

> I had a very positive experience with the low-barrier online support lines and programs that were created for free access. I would recommend making these more available and having these free resources ongoing because they have helped me and my colleagues through the pandemic times.

There was a struggle with mandatory vaccinations. Whether they were in support of the vaccine or not, all participants discussed the issues of the vaccine mandates. Participant #2 highlighted, "We lost so many staff members when we were already struggling, this killed healthcare."

b) Recommendations for Management

Participants highlighted some recommendations they had for their management. Participant #4 noted positive interactions with her leadership when she stated, "my managers checked on me regularly, asking if I needed things, and when needed they allowed me to work from home." After completing the ProQOL, some participants thought the ProQOL would be a useful tool in facilitating conversations with their staff and helping to inform them when making workload, leave, and support decisions.

Other recommendations offered by participants were about providing structured debriefings, and updates, and having someone to support healthcare workers with clear direction. More sick days were recommended, especially for childcare purposes. One critical recommendation by participants was for managers to respond with less judgment. Four of those interviewed felt like managers only reached out to them when it was disciplinary. They recommended management talk to their staff not only when there is an issue. Participants also had ideas on advocacy for supporting people when they are at home, contracting someone to deliver things to people, and checking on and supporting staff and families who potentially got sick while working. One participant described that little thing became big things that really mattered such as having access to therapy dogs in the workplace, a quiet room and a comfort cart. She suggested that it would be beneficial to have regular huddles where staff can communicate information, ask questions, share ideas and resources, check on staff, and have a platform for dialogue. Participant #8 highlighted that:

> Some organizations just pushed through and kept everything open, thinking that this made them braver than others and that they were able to offer better care. I think more clear guidelines should have been enforced throughout the system rather than being left up to individual organizations to meet their own needs. I believe this caused an increase in judgements and silos against organizations, with everyone being very critical of who was doing what, what restrictions they were implementing or not, how they were offering services, and when they came back into office. Negativity and bitterness took over, and it seemed more linked to organizations trying to recruit each other’s staff. This should be evaluated in an ongoing internal and systematic process.

c) Recommendations to Improve Public Awareness

Although as noted earlier, it is not easy to make recommendations for the public, many felt impacted and wanted a voice on their experiences with how things were handled. Participants felt that their recommendations can be used for education to foster public awareness about compassion fatigue in the future.

When discussing their feelings of responsibility and how they were viewed in their role, Participant #5 reported, “We went from heroes to zeros overnight, and no one can fathom our experiences.” Many found it frustrating to be in the spotlight and have the additional responsibility of feeling like they needed to “save the world” from something they had little control over. The hero mentality was a trigger for Participant #1 who said:

> We are not heroes, as we are professionals who worked hard to get our degrees to do an extremely hard job. Stating we are heroes just expects us to rise to the challenge no matter what. We are human beings, and that needs to be recognized.

The protests outside the hospital were also flagged as disheartening. Participant #7 made a request for individuals to rethink those measures by stating:

> Things were hard enough for many having to walk in and do their work, knowing that there were angry people outside did not help that and a hospital should be a safe place, I hate that patients and families had to be exposed to that.

Through my research and my dissemination of findings, I hope that those reading about women healthcare worker’s experiences can develop an informed understanding of the ripple effects of the pandemic (e.g., how it affected us all) and how we should respond if there were another large-scale crisis My appreciation of these study findings is that we all were dealing with the effects of the pandemic the best way we knew how, and in reflection, we could all be more compassionate to one another.

Chapter VII: Discussion

This study explored the personal and professional experiences of compassion fatigue among women healthcare workers during the 2020–2022 COVID-19 pandemic. Informed by standpoint feminism, I used a mixed methods approach, involving a quantitative component (survey conducted with 44 participants) and a qualitative component (semi-structured interviews conducted with eight participants). Through various analysis techniques, I identified many interesting findings of compassion fatigue among study participants. In this chapter, I discuss and interpret these findings, situating them within the existing body of literature. I conclude by providing implications for future practice.

Preliminary themes were identified from the findings of the quantitative survey. I used the themes to formulate follow-up questions for my semi-structured interviews with eight participants. The results from the survey and the interviews revealed that the pandemic contributed to the levels of compassion fatigue experienced by women healthcare workers. There were six themes and related sub-themes arising from participants' responses to this study's open-ended survey questions and qualitative interview questions that include: Theme 1) The Impacts of the Pandemic on Participants' Personal Lives with subthemes of, The Emotional and Mental Health Impacts of Compassion Fatigue, The Physical Impacts of Compassion Fatigue, and the Impacts on Family; Theme 2) Participants' Experiences with Moral Injury; Theme 3) Participants Feelings of Guilt and Shame; Theme 4) Supports Provided and Sought for their Well-Being; Theme 5) Gaps and Limitations with sub-themes of, Participants Experiences with the Government, Their Healthcare Employer, and Their Experiences with the Public; and Theme 6) Recommendations for Improving Systems and Supports with sub-themes of Recommendations for Government, Recommendations for Management and Recommendations to Support with Public Awareness.

As found in this study, women healthcare workers experienced compassion fatigue due to the nature of their work, which often involved caring for others in distressing situations. Quantitative findings revealed that despite evidence of a variety of demographic characteristics in this study's sample, there were no statistically significant differences found in participants' experiences of compassion fatigue. Although the ProQOL was not analyzed due to the number of participants being minimal (n = 8), the information was still relevant to the findings as many conversations were stimulated throughout using this tool. Based on participants' quantitative and qualitative responses, it was apparent that all women healthcare workers surveyed in this study had experiences of compassion fatigue. Qualitative findings suggested that there are significant impacts of the pandemic on women healthcare workers' personal and professional lives, mental health, and ability to provide care that warrants ongoing study in larger study samples. The findings also highlight the urgent need for healthcare organizations and policymakers to recognize and act on the impact of the pandemic on women healthcare workers. Larger systems need to create and provide adequate tailored interventions, resources, and support based on women workers' needs, situations, and experiences as described in this study's findings.

Mathieu (2012) highlighted that most helpers experience compassion fatigue at some point throughout their careers, and this is often exacerbated in turbulent times. My findings were consistent with this literature noting that women healthcare workers experience compassion fatigue, and the consequences were impactful on various areas of their lives.

As noted earlier in this paper, women's unpaid family work is devalued. The responsibility for childcare and housework (and many additional pressures) often falls solely on women and most single-parent homes are headed by women.

When analyzing my survey data, I noted no significant differences in experiences of compassion fatigue based on their demographics. I invited women with experiences of compassion fatigue to further be interviewed to explore their concerns more in-depth, therefore naturally all those surveyed were impacted. Based on the literature review I conducted, I did not find research supporting a differential vulnerability based on race. There was limited diversity amongst my participants as most of the women identified as Caucasian. My literature review did not go into detail on this topic due to the limited implications for my research. Ideally, future research with larger sample sizes and more diversity among participants would allow for a more accurate picture.

Research on compassion fatigue gives indication certain demographics are more impacted by compassion fatigue. I explored this to see if it was consistent with my findings. It was noted by Galanis et al. (2020) that those with higher levels of education would be more impacted by levels of compassion fatigue. My findings did not indicate that education had an impact on their levels of compassion fatigue. I was surprised by the finding that individuals with higher education would be more impacted, as I believe that people with less education would have fewer tools and information to utilize in high-stress situations. However, in using critical thinking, one could assume that higher levels of education would lead to potentially having additional responsibilities, and specialties, therefore dealing with more complexities of patients, oversight, duties, or decision-making that could further exacerbate stressors.

Galanis et al. (2020) also noted in their research that younger women would be more impacted and prone to compassion fatigue. My survey did not highlight this given all women were impacted; however, the follow-up interviews contradicted these findings. When the eight women were able to expand and articulate their thoughts, the older women (who happened to be nurses) were more impacted. Doing the interviews allowed women to reflect on their experiences and highlight what happened more in hindsight further emphasizing the strength of a mixed methods approach. My findings through the interview were that the younger woman’s role was seemingly not yet as connected to their identity. It appears they likely did not understand how drastically healthcare services had changed or been impacted, thus, allowing them to pivot more easily. This led to more curiosities given this is contradictory to what I found in my literature review.

Although the younger women were undoubtedly impacted, there was not such an emotional charge or catastrophic impact. What I witnessed in the older participants' interviews were tears, and an inability to speak at times, whereas the young women were very matter of fact. Anand (2021) also found that helping professionals aged 20-30 would be the most impacted. Throughout the interviews, the older more experienced participants were visibly distressed, disheartened and drastically impacted. While interviewed they spoke about the career they once loved so deeply, which was such a source of their passion and identity, being now replaced with such sadness and anger. The conversations during the ProQOL highlighted their feelings of guilt and shame of responses while completing this tool. This can also raise questions as to whether nurses are more impacted, which should be explored with larger sample studies. This was difficult for me to determine, as there are many other factors to consider.

The survey did not clearly articulate whether mothers were more impacted nor did the number of children impact their responses. The earlier research highlighted that this was a factor and gave several reasons why this was the case. As almost all interview participants were mothers (n = 7) it would be hard to determine whether their experiences were unique to being mothers given there were many other factors. Several factors of being a caregiver came with heightened stress discussed by participants. The stressors included (but were not limited to) an increase in needing to support their children with online schooling, more complex childcare responsibilities due to daycares being closed, children consistently sent home due to symptoms, and not having childcare assistance. The intersectionality of concerns likely made some interview participants more impacted. Therefore, I would recommend future research to investigate this in more depth.

The survey results that everyone was impacted met my expectations given what I was seeing in my community. This was also linked with my own experiences of compassion fatigue, as a women essential worker in healthcare over this period. The literature review I completed before beginning my research also led me to believe that this may be the result.

Theme 1. The Impacts of the Pandemic on Participants' Lives

Research suggests the pandemic has impacted workers, most notably women healthcare workers (Anand, 2021). The symptoms and struggles stretched across many different facets of participants' lives personally and professionally. The many concerns that were flagged in the research were echoed by this study's participants. Sub-themes were created to highlight their unique emotional, mental, and physical impacts, as well as stressors on their families.

a) Emotional and Mental Health Impacts of Compassion Fatigue

Research notes that the pandemic exacerbated many psychological concerns for individuals. There was a plethora of emotional and mental health impacts of compassion fatigue for both survey and interview participants that were consistent with the literature. These emotional and mental health symptoms impacted the participants' personal and professional lives in various ways such as lack of control, loss of self, various escalations in many emotions, and influenced their spirituality.

Jones et al.'s (2021) research shows that the COVID-19 pandemic created a "perfect storm" for compassion fatigue. These authors found that the lack of control and chaos had major impacts on individuals' mental health. The concerns that this study's participants discussed were consistent with Jones et al.'s findings where participants felt a lack of control and consumed by the chaos.

Also highlighted by several participants was a loss of identity, a loss of connection, as well as a spectrum of different emotions, such as feelings of numbness, sadness, and anger Mathieu's (2012) description of the common psychological and emotional signs and symptoms of compassion fatigue can include dread of working with certain patients, feelings of professional helplessness, depersonalization, disruption of worldview, problems with intimacy, distancing, negative self-image, depression, reduced ability to feel sympathy or empathy, cynicism, and resentment. These symptoms along with the experiences of avoidance were echoed throughout the interviews.

In line with the research findings, there were elevations in mood such as an escalation of anger, irritability, depression and anxiety symptoms, and feeling in a heightened state of arousal (Jones et al., 2021). Interview participants highlighted many PTSD symptoms such as flashbacks, constant worry, and feelings of immense responsibility for others. Interview participants experienced a significant loss of connection, profound impacts on mental health and constant worry. These symptoms impacted their behaviours, and many reported not liking the way they were responding in different areas of their lives (Pal et al. 2020)

b) Physical Impacts of Compassion Fatigue

Physical impacts can be a consequence of exacerbated stress, personally and professionally. There were many physical impacts of compassion fatigue evidenced in the responses of this study's participants to survey and interview questions which is consistent with the existing literature. These included physical and behavioural symptoms that were caused by stressors due to the pandemic. For participants, this included issues with sleep, increased substance use, self-medication for coping with symptoms, somatic concerns, and body pain. The Crisis Prevention Institute (2021) highlighted the various physical signs and symptoms of compassion fatigue, such as issues with sleep and behaviours. Many of this study's participants noted significant sleep disturbances (sleeping more or less), fatigue, and nightmares. Mathieu (2012) also highlighted that individuals will experience many physical symptoms that impact their mental health, such as exhaustion and insomnia because of compassion fatigue.

Interview participants in this study further discussed coping mechanisms that they used to mitigate these symptoms, such as struggling with secretive addictions and self-medication. Mathieu (2012) mentioned increased substance use as a behavioural symptom that was consistent with my research. Some form of substance use being exacerbated was noted by all interview participants, with half (n = 4) identifying this as a significant concern. They highlighted repeatedly their need to self-medicate to control their anxiety to promote good sleep. They also described that they have large urges to consume alcohol when stressed, noting it was not characteristic of them. Based on the increased use of substances, withdrawal symptoms may also have affected this study's participants' day-to-day functioning. Additional somatic complaints were also present such as stomach issues, headaches, and brain fog. Other researchers have described how stress can manifest in the body and can cause somatic concerns among individuals (i.e. headaches, brain fog, etc.) (Mathieu, 2012).

Due to the staffing shortages, additional physical demands were placed on healthcare workers. Participants in this study also noted feeling physically exhausted from the additional preparation and precautionary steps required to work. This study's participants were not clear if the physical pain they were experiencing was due to the additional demands or because of these additional stressors which likely constrained their ideas for effective coping strategies.

c) Impacts on Family

There were many impacts on participants' families due to compassion fatigue that were highlighted by participants in both their responses in the survey and during the interviews. The impacts on family included exacerbated stressors due to needing to care for others, needing to balance work-life stress, feeling disconnected, feeling isolated, and experiencing guilt on how they were responding to loved ones.

As noted, almost 88% (n=7) of the interview participants were mothers at the time of interview or had other family members to care for. Their home life was impacted as well as their work-life balance and ability to handle stress. The women interviewed discussed this as a concern. They were not only expected to care for their children at home but also support them in their online learning. Online schooling was a new role for many of the study participants and challenging for many healthcare workers who were mothers. Participants reported feeling upset and guilty about how they were responding to their children by being overly emotional or negligent of their needs. This new role was not one that many had previously experienced and posed an additional stressor to balancing everything else.

One healthcare worker noted in the interview that she worried tremendously about her adult child’s (who was working as a nurse) mental health. The immense worries and struggles individuals face in all facets of their lives, such as those noted above must be explored. This mother was so concerned about her child’s mental health during the pandemic she mentioned thinking he would die by suicide due to this. We need to consider the pandemic's ripple effects and how it impacted individuals emotionally, physically, spiritually, psychologically and how their parenting or family life, potentially suffered the consequences of this distress. Given that there was a lack of connection, significant isolation and other concerns, people were not able to engage in meaningful visitation with loved ones therefore likely exacerbated their concerns for their loved ones.

Many study participants noted feeling isolated and disconnected and needing to care for many individuals (e.g., children and elderly relatives) on top of their careers as professional caregivers. Others expressed their struggles in needing to be the expert for their family by providing information. Participants highlighted feelings of guilt and shame regarding how they were behaving and responding to loved ones. Mellins et al. (2020) discussed the issues in coping with the pandemic as well as juggling at-home responsibilities and roles. As noted earlier, many study participants were upset with the way they were responding to the ever-changing demands in their lives and caregiver pressures. There were also many geographical stressors due to pandemic-related restrictions and some relationships ended due to this. Also important to note were the restriction-related impacts on relationships that study participants felt that they had changed and had become distant and cut off from loved ones.

As noted in related research, while changing jobs is effective in overcoming burnout (mostly related to low job satisfaction), it is not effective in dealing with compassion fatigue (which influences a profound shift in one’s worldview) (Mathieu, 2012). This study’s findings also revealed that changing roles to overcome compassion fatigue was ineffective for study participants that is consistent with previous research. Many participants noted they did this to improve their work-life balance and respond better to loved ones. Consistent with Mathieu’s (2012) findings, this study’s participants noted changing roles either within or outside their organization but experienced the return of familiar symptoms that were almost immediate. These findings support what is highlighted in the literature about additional complications and stressors of being a caregiver (to children or elderly individuals) during turbulent times and the impact it has on levels of compassion fatigue.

Theme 2- Participants’ Experiences with Moral Injury

Extant research suggests that the pandemic has had a major impact on workers’ experiences with moral injury (Mathieu, 2012). Working in a field where healthcare workers often need to place the well-being of others before themselves can seem admirable but can come with drastic consequences. This can come with professional and personal issues due to a variety of policies, procedures, and experiences. Some examples were mandated vaccinations, not being able to provide the same level of care to the unvaccinated in some settings, not allowing loved ones to be present at the end of someone's life, having patients remain in unchanged/soiled briefs because they did not have time to change them, diminished quality of life for elderly, and lack of access to supports.

Moral injury (distress) is an internal conflict that occurs when policies or routines conflict with one's beliefs about patient care (Mathieu, 2012). This can look like staff being told to do something that they fundamentally disagree with or that they are morally opposed to (Mathieu, 2012). Factors such as shifting allocations, watching younger healthier patients dying, triaging patients beyond their normal scope and feeling undermined and unsupported by their organization and government were impactful on their moral distress (Rabin et al, 2023).

As discussed earlier; moral injury can impact care providers' relationships with their clients. The way providers feel about themselves, their ability to provide care as well as whether they experience an internal conflict with policies, procedures and services can impact them significantly in their professional roles.

Similar to what Mathieu (2012) found, many of the healthcare workers that I interviewed described that compassion and empathy were at the very heart of the work they did, and many cared for their patients quite deeply. Participants' levels of compassion fatigue impacted how they felt about themselves, their work, and their ability to handle their lives. This study's findings revealed that there were experiences of moral injury due to compassion fatigue described by participants in both their responses to the survey and interview questions that were consistent with the literature (Mathieu, 2012). Feelings of moral injury and distress have significant impacts on levels of compassion fatigue (Mathieu, 2012).

Participants felt morally distressed over ways they needed to provide care as well as not always agreeing with the way they were forced to deliver services. As Pal et al. (2020)

highlighted in their study, many healthcare workers in this current study experienced extreme psychological distress from decisions they had to make under immense pressure. This was also relevant in the way they provided care (i.e., leaving patients in unchanged/soiled briefs, not being able to treat the unvaccinated, or not being able to provide care that they would usually provide to patients). There were immense feelings of anger, betrayal, resentment, powerlessness and a lack of trust in leadership which heightened their distrust of all systems (Rabin et al., 2023). Participants expressed their concerns with how services were being delivered and not meeting the needs of patients with diminished cognitive abilities or mental health concerns.

The experiences of moral injury can impact individuals personally when they experience negative emotions such as guilt, shame, or anger, about things they have done that they fundamentally disagree with. Also, when healthcare workers put the needs of those they were supporting professionally before their families, this came with drastic home-life consequences. This behaviour also trickled over into their family lives and exacerbated struggles with how they were providing care to their children and treating their families. This is especially catastrophic when it conflicts with how they think they should be behaving. Many of those interviewed described taking these feelings and internal conflict home with them and projecting these feelings onto their loved ones which were often them isolating.

Mandatory vaccinations also were a point for debate by study participants and were associated with their feelings of helplessness. Participants described their experiences of moral injury about mandatory vaccinations as some felt that they were pushing forward an agenda which they did not necessarily agree with.

Theme 3. Participant Feelings of Guilt and Shame

Research suggests that the pandemic had and continues to have major impacts on healthcare workers’ feelings of guilt and shame, both in their professional roles and personal lives (Anand, 2021). Healthcare worker participants in this current study described their experiences of guilt and shame due to compassion fatigue in both their survey and interview responses that is consistent with the literature (Anand, 2021). This was explored on both personal (i.e., how they were responding to family) and professional (i.e., in their provision of patient care) levels.

The personal experiences were linked to how study participants were treating and responding to their family and loved ones due to all their work stressors. This includes how they were responding with anger, their short temper, feelings of avoidance as well as their behaviours due to the mental health and physical symptoms they were experiencing (e.g., substance use, isolation, avoidance etc.). There was likely shame around how they were coping with increased substance use and other problematic behaviours which perpetuated the isolation.

The professional experiences were linked to how study participants were providing care or a lack of care, as well as what they were witnessing their patients experiencing. Anand (2021) flagged survivors' guilt as a concern for secondary trauma and this was evident with interview participants in this current study. This resonated mostly with Participant #1 who talked about ill patients who would pass away due to the virus with limited support around them. Both younger and older interview participants had expressed their experiences of guilt and shame regarding the care that was being provided however this varied a bit across this study's findings. New graduates reported that they were not able to provide the care they had learned to provide while in school. The older and more experienced participants felt guilt about the lack of connection with patients which was the main source of their passion for their roles. Emotions were high with their experiences with guilt and shame, and, how they were no longer passionate or feeling effective in their roles. Survivor guilt would be another important topic that warrants ongoing research considering many study participants feel profound loss, and it would be interesting to see if the feelings of guilt and shame were more deeply connected to compassion fatigue.

The feelings of guilt and shame trickled over into personal and professional lives given these symptoms do not resolve regardless of whether the healthcare workers left or stayed in their current workplace. Many interviewed in this current study felt like they were ineffective in many of the roles they were in and how they were responding.

Theme 4. Supports Provided and Sought for their Well-Being.

It is unclear what supports were available to the study participants who completed the survey. However, this was explored further with those who completed the interview. I asked this as a theme question as it was clear from this current study as well as from participants' responses in related studies that healthcare workers are not likely to reach out for services for a variety of reasons discussed later. Additionally, based on my interviews, I am aware of a shared feeling that healthcare workers were no longer interested in talking about the pandemic and they wanted to isolate themselves and internalize what was happening during the pandemic. This could plausibly be linked to the deterioration of their mental health, their experiences of guilt and shame, and not wanting to burden their family with their experiences. This study's participants shared many coping strategies that include their engagement in healthier ways of dealing with stress such as limiting media, having a better sleep, and embracing better eating habits.

Internalization and isolation were noted as barriers to reaching out, as well as other struggles impacting their ability to want to engage in a dialogue about their struggles. The participants identified their support systems as key factors in their well-being, but as previously noted, many issues were internalized rather than addressed.

Participants highlighted how they were lacking self-care, and some solutions discussed were to find a safe place to take a step back and isolate. As the Crisis Prevention

Institute (2021) highlights, many healthcare workers do not typically seek help for their symptoms of compassion fatigue as they believe it is normal for the role that they are in. Kearney et al. (2021) also captured various reasons why women do not reach out for help such as their inability or unwillingness to seek support, their perceptions of a lack of accessible services, the cost to attain professional support or consultation, being too busy, or a sense of embarrassment. Although the participants I interviewed did not go into significant details as to why they did not connect with supportive others, most reported feeling lonely and isolated and none seemed to relate to formal support. Anand (2021) highlighted an emphasis on feelings of helplessness and hopelessness that were consistent with what my participants felt; therefore, this is likely another factor to examine in future studies. On the other hand, participants also described that they did not reach out for support because they were just so burned out and were just done with it all. Study participants described that they did not want to think about or discuss COVID-19 at all anymore.

In contrast, one participant found that utilizing the services had a positive effect on them. Jones et al. (2010) provided evidence that is consistent with the positive effects of accessing support systems such as the Department of Health’s list of on-call social workers in Texas who were available in the medical school. Effective programs like this should be modelled and explored for future use across healthcare workplaces. About half of the interview participants in this study also felt that discussing this with me and participating in a meaningful dialogue during the study was beneficial.

Theme 5. Perceived Gaps and Limitations

As highlighted at the beginning of the literature review, the main gaps in the existing research literature are about frontline women’s experiences with system support and resources. This study’s participants highlighted that there were many gaps and limitations in their workplace supports and resources that I was not able to corroborate due to the paucity of existing evidence that exists on this issue. What was highlighted by this study's participants, however, was how specific systems responded, how this impacted their day-to-day work, and how the system contributed toward their levels of compassion fatigue. The systems that participants addressed included the government, their healthcare employer, and the public.

a) *Experiences with the Government*

This study's participants described their many experiences with the government. They expressed their frustrations about services, restrictions, mandates, and how pandemic plans were executed seemingly without forethought and input from healthcare workers. Furthermore, they highlighted the false promises, and the toxic environment created by this governmental decision-making (such as the wage discrepancies across healthcare organizations). Galanis (2020) stressed the importance of ensuring that individuals can cope with devastating events through adequate support and relevant, informed guidance from the government, individual organizations, and other macro systems. Galanis et al. (2020) stressed the need to focus on ongoing preparedness and planning that the participants also discussed.

b) Experiences with their Healthcare Employer

Participants highlighted many different experiences, both positive and negative, with their healthcare employer. Participants expressed concerns about their employer not meeting their needs as well as not engaging in compassion, understanding, support, and meaningful debriefing while perpetuating tension surrounding necessary time off. Also important to note was how last-minute redeployments impacted healthcare workers in this study. In this study, there was only one participant who wanted to capture the positive experiences they had with their employer.

Consistent with the Crisis Prevention Institutes (2021) findings, there were issues with morale within these systems that created a toxic workplace culture. When multiple people within the same organization are experiencing compassion fatigue, they either feed off one another or emotionally detach from the organization (Crisis Prevention Institute, 2021). Examples of this were evident in this study's interviews where one participant described the bullying that she was experiencing in her workplace. Another study participant highlighted how she segregated or identified respiratory patients and non-respiratory patients as "the clean and the dirty patients." This participant experienced this as the behaviour of individuals who were engaging in toxicity and when there were no managers available to mitigate this behaviour. Participants believed that these issues needed to be dealt with at a managerial level to ensure a better working environment. These types of behaviours were also identified by study participants as the ripple effect of poorly managed organizations.

Although there were several negative experiences, one interview participant was able to discuss the positive experiences they had with their employer. This participant focused on how small-scale gestures such as check-ins and conversations were impactful supportive measures. This participant felt the genuine gestures meant more than anything, and the literature backed how important supervision and connection are during a pandemic (Galanis et al. 2020)

c) Experiences with the Public

Participants described many different experiences they had with the public. These responses were addressed from a "lessons learned" framework. Interestingly, many study participants noted that their recommendations for the public may not be sustainable.

Several participants noted feelings of judgement and unrealistic expectations placed on them by the public. These perceptions were linked with how the government portrayed healthcare workers by using terminology such as the hero language. The unintended consequences of this messaging were that healthcare workers felt pressured to live up to the enormous task of needing to "save the world." This exacerbated mental health concerns due to the already immense pressures placed on healthcare workers and many things that were beyond their power and control during the pandemic and beyond. The government's heroic language became a large source of contention and put additional pressure on healthcare workers. All the healthcare workers who were interviewed reported finding that type of messaging unattainable. This exacerbated healthcare workers' feelings of guilt and shame and perpetuated many of their other concerns with their struggles during the pandemic.

The anti-vaccination rallies, protests and conspiracy theorists made many workers feel devalued and angry with the public. Many of those interviewed highlighted the devastating loss they were experiencing within their systems, only to be met on their way out of the building with public anger and protests. All the above-noted concerns contributed to healthcare providers further isolating themselves and likely prevented them from reaching out for help.

Theme 6. Recommendations for Improving Systems and Supports

The Crisis Prevention Institute (2021) highlighted how helpers who were affected by compassion fatigue are often the last to recognize what is happening and may need others to help them realize it. This is why screening, support, early intervention, resources, and services are critical. All the women interviewed in this current study struggled independently and were further isolated. The recommendations provided in earlier literature for improving systems and supports were linked to women's experiences and resonate with my study's findings. Galanis et al. (2020) argued the need to screen workers early for mental illness and support those who require it, develop training and protocols, expand training, have stand-by supports, as well as support flexibility and adaptability to meet workers' needs. As discussed, many of this study's participants were isolated, engaged in self-medication, and had significant mental health concerns.

a) Recommendations for the Government

Participants had many recommendations for the government. Gupta et al. (2020) highlighted the need for support, resources, and policies to be tailored to meet women's needs. This study's participants highlighted their unique needs and wants. Two participants discussed the need for housing for frontline workers who faced continual virus exposure. This was so they would not bring the virus home to their families. Additional recommendations were not fast-tracking new graduates, not using hero language, ensuring there are equitable wage increases across the workplace employee sector, clear and consistent dissemination of information, and support lines in place (such as described in the study conducted by the Department of Health Social Work in Texas, in the United States (Jones et al., 2021). Lateef (2020) noted the need to learn from the unpreparedness and develop more appropriate support systems that were consistent with what this study's participants recommended.

b) Recommendations for Management

Mellins et al. (2021) noted the need for healthcare leaders to strengthen existing efforts to support mental wellness and prevent potential emergent challenges in the workplace. Study participants had many recommendations for management. These recommendations included providing support for structured debriefings and engaging in regular updates for healthcare workers. They also reiterated how support and check-ins would be significantly helpful. Tsamakis et al. (2021) similarly noted that effective supervision was key for fostering wellness with an emphasis on tailoring decisions made to meet the unique needs of each healthcare worker. Regular meetings and structured debriefings centred around compassion fatigue, stress and anxiety (both formally and informally) were recommended by the Crisis Prevention Institute (2021). The women interviewed in this current study felt that they were lacking support and connections such as those listed above and had many recommendations for moving forward by management.

c) Recommendations for the Government to Support Public Awareness

The Crisis Prevention Institute (2021) expressed the need to educate helpers on compassion fatigue and invest in intervention programs and public awareness**.** Many recommendations for public awareness were similarly highlighted by this study's participants. The most ardent recommendation was for the government to provide the public with more education and effective campaigns that do not further exacerbate the stressors on the system. The women in this current study highlighted how important it was for everyone to be working together on the same page. Tsamakis et al. (2021) also discussed how it is crucial to foster an informed public through training, workshops, and awareness.

Study Strengths

The mixed-methods design allowed me to combine quantitative data gathered from the online survey with the specific qualitative reports of experiences of interview participants with compassion fatigue during the pandemic. This provided a more thorough perspective on the experiences of essential women workers. The survey allowed me to obtain important quantitative information from many women healthcare workers, and the semi-structured interview component allowed me to explore participants' experiences in greater depth making a valuable contribution toward reducing gaps in the literature on this issue.

The study was also feasible to execute. Online surveys offer some important advantages, such as reaching a wide audience across a large geographical area and within a brief period, making them a convenient, quick, and inexpensive form of data collection (Carey, 2012). This allowed me to complete my thesis research in a timely manner. The project was also feasible because of my existing relationships with many healthcare-related and professional organizations in Ontario that aided in my recruitment of study participants. Other organizational bodies assisted me in recruiting a more representative sample of healthcare workers that included colleges and universities in Ontario, as well as agencies such as CMHA Ontario. Some employers also agreed to send my survey to their staff members, and some posted it on their agency media page that I am very thankful for.

Additionally, there were significant strengths in conducting one-on-one interviews with women participants. The in-depth interviews allowed me to capture women's firsthand experiences and encouraged women to elaborate on their experiences utilizing a feminist standpoint. In conducting these interviews, I was able to follow up on important themes that were identified in participants' survey responses and obtain thick, rich, and detailed information about women's perceptions and personal experiences with compassion fatigue. These interviews were the most powerful part of the journey for me and allowed me to witness a firsthand recount by women healthcare workers about their experiences when they used their own words without the fear of rebuttal from their employers or colleges. It appeared that women participants were unapologetically and authentically themselves in these interviews as they freely expressed themselves knowing that it was confidential.

Study Limitations

With any research there are limitations, and several limitations arose during mine. The main one was a small study sample (n = 44). As discussed in the methodology, there were also issues encountered with using Qualtrics that negatively impacted my data collection of survey responses from participants. These included technical issues with the data as discussed earlier with issues arising after question 14. Additionally, I would have liked to have analyzed more data obtained from the ProQOL tool. However, only 18% (n = 8) of this study's participants completed this tool in the follow-up interview. As well, there were many organizations and regulatory bodies that were not accessed to assist with recruitment due to proposed fees for dissemination of the survey. More can be learned by expanding and exploring the experiences of women from other organizations across the province regarding their working experiences during the COVID-19 pandemic.

There was limited cultural diversity in my sample therefore I was unable to adequately address the cultural impacts of Compassion Fatigue. Some questions could have been elaborated on more effectively (I am a new researcher therefore more in-depth questions would have yielded more results). In hindsight, I should have asked for participants' ages directly rather than an age range as this would have given me a more accurate picture of the mean age. I also should have asked specifically where they were located given many selected multiple places thus, not making it clear where many lived and worked. Also, I would have liked to centre on was on gendered norms of caregiving, and I wish I had gathered more information on women's family and caregiving responsibilities as we know personally and economically this can exacerbate existing stressors, putting more pressure on women. Women captured a lot of struggles with work-life balance and navigating the many roles they had as now helpers, caregivers, and home school educators. Managing the wellbeing of self and others during a heightened state of arousal had many consequences and all women surveyed and interviewed felt the impacts. It would also be important to get more diversity in participants and highlight the compounding effects of the pandemic (i.e. increase in domestic violence as highlighted in the literature review, parenting struggles, and the gender gap).

There were several participants' perspectives that I was not able to capture as these healthcare workers had experienced challenges in attending the scheduled interviews that later conflicted with the time demands of their roles. For instance, I had two physicians wanting to be interviewed however, when it came to scheduling, they were unable to. I am wondering how many others across the province were stretched too thin or too burned out to share their important perspectives.

Previous research indicated some similarity in results, however, given that my study was being conducted at the height of the pandemic, there was not a significant amount of local data with which I could compare my study findings. However, from the data gathered through this study, some recommendations and conclusions can be made to improve the conditions of healthcare workers as our province and systems recover from the pandemic.

Significance of the Study

The significance of this study is that we are living through a global pandemic and the effects of traumatized frontline workers can have catastrophic impacts on the future of healthcare as discussed throughout. In addition, by exploring the experiences of frontline workers through the COVID-19 pandemic we can better inform systems of care to support their staff both in general practice and prepare for additional high-level events or pandemics. Without deeply exploring how our current systems impact frontline workers who are entrusted with the care and support of others, we will not be able to improve our ability to provide care and support in the future.

In many countries, women comprise approximately 70% of the health and social care workforce (Gupta et al., 2020). In Canada, women comprise of approximately 82% of essential healthcare workers (Statistics Canada, 2021). The pandemic has impacted most professions in some capacity, whether through shutdowns, changes in service delivery, or exposures to the virus. These concerns can lead to long-term consequences such as increased burnout, compassion fatigue, decreased retention, and compromised patient care. Individuals in frontline healthcare services are most frequently women who are the most notably affected by the pandemic. These frontline helpers have faced unimaginable pressures and stress throughout the ever-changing waves of the pandemic that warrant ongoing investigation. Additional stressors were noted in women helpers who had a friend or loved one infected with COVID-19 and this experience increased burnout rates. It will be important to explore how women’s personal lives were impacted and contributed to their levels of compassion fatigue (Galanis et al., 2020). The findings demonstrate the need for future research to create concrete strategies to support these frontline workers.

Although compassion fatigue is not a new concept, nor is it new to the profession, as discussed throughout this paper, it has been exacerbated immensely by the pandemic. Systems will need to grow, adjust, provide support, and provide professional learning. Daily developments are being made as we continue to navigate and learn through the pandemic. It will require work to return to how life was in pre-COVID times, and healthcare workers will need to heal, learn, and create change in the post-COVID-19 era.

While healthcare workers continue to somewhat maneuver through the ever-evolving pandemic or the aftereffects, mental health concerns and other illnesses that were neglected due to the lockdown will need to be a focal point of our attention (Luxbury, 2020). Many have flagged massive disruptive change as having potential impacts measuring up to the Great Depression or the aftermath of WWII (Mathieu, 2012). The long-term effects of the pandemic, lockdowns, isolation, and trauma will not be known for several years.

During the time frame of conducting this research and analysis, changes were occurring daily in terms of restrictions, contraction rates, vaccinations and system improvements, and fewer fatalities connected to the illness. However, the emotional and mental impacts that frontline women healthcare workers have endured have meant that they cannot rebound as quickly as commercial businesses. The work and stress that has been the daily reality for these workers has deeply impacted them. Just as the effects of other trauma exposures do not subside quickly, these women workers will also require time to rest and heal, however, at a precarious time when our healthcare system is facing critical staffing shortages across the country. The well-being of the frontline staff in our healthcare systems is critical to the system’s overall effectiveness. We must investigate the impacts, explore solutions, and proactively work to improve the working conditions for those in caring roles.

Regarding the interviews, participant #1 stated, “I feel like I have not been able to have a voice and a platform to bring this forward, I like that this was an open dialogue and a willingness to consider our perspective, the people who lived this, so thank you.” For all the interviews, the emotions were raw, and the experiences were traumatic and distressing. Participant # 4 highlighted: “this has been a good experience to get off my chest with someone actually interested in listening and learning to make improvements rather than just listening from the goodness of their heart, so thank you, I feel heard.” This participant even reached out via email to let me know that due to this, she is now doing her own therapy and is ready to heal.

Chapter VIII: Dissemination of Findings, Summary, Recommendations, and Conclusion

As there is limited information specific to the experiences of women healthcare workers with compassion fatigue during COVID-19, it will be important to share my research findings widely. I also identified many gaps, limitations, recommendations for improvements, and future ideas that policymakers and practitioners may want to explore. In this chapter, I discuss the dissemination of my findings and highlight my summary of study findings and recommendations for future research, and conclusions.

Dissemination of Findings

The thesis will be shared through the University of Manitoba M Space, that will distribute my thesis. I will also disseminate a summary of my study findings to all agencies and regulatory bodies that assisted with recruitment and who agreed to share it with their staff. As I received a grant for this research, I intend to publish in academic journals, including the *Canadian Social Work Review*, the *Journal of Social Work, and the Women's Health Collective of Canada* or similar journals. I would also like to provide academic presentations at any relevant women's health or social work conferences.

Summary and Recommendations

On May 5, 2023, the WHO declared COVID-19 as no longer qualifying as a global emergency. However, the WHO also noted that it is still a global health threat, over three years after it devastated our globe (WHO, 2023). Although the study yielded important information about women healthcare workers' lived experiences during the pandemic with COVID-19, as highlighted previously, it was not without its limitations. Since research and services need to be tailored to the unique needs of women healthcare workers, further studies are warranted to help them navigate the consequences of the waves of pandemic effects as we continue to learn more about its long-term effects in the post-COVID-19 era. Women participants in this current study reported feeling unheard and under-supported during the pandemic. There are recommendations for practice, research, education, and policy.

Practice Recommendations

I have several recommendations to improve future practice. One of the most common issues identified in this study was the impact of the lack of regular, ongoing support for healthcare workers in the workplace. Employers need to ensure that they are utilizing support lines or debriefing processes to effectively support their staff. Another recommendation is for healthcare leaders to access and disseminate evidence-informed recommendations on how to foster gender-specific interventions that address the unique experiences of women healthcare workers in the workplace.

As we recover from the pandemic, although our fear of the disease may ease, we are left with tired and overworked professionals. It will be critical to improve clinical supervision and consultation that will support frontline workers in being able to access the support that they need from their systems to effectively continue in their role as a caregiver.

It will also be important to address potential obstacles to implementing these changes such as resource constraints, and resistance to change within healthcare agendas. However, we need to take immediate action to ensure that gaps in appropriate support provision do not get missed or overlooked to protect and preserve healthcare. It will be especially important for organizations to ensure that workplace wellness is a priority.

Research recommendations

I have several recommendations for future research that were based on what survey participants believed was important, the literature review and gaps that I found as well as my findings from completing this study. Several research recommendations were regarding the topic and research methodology.

Research Topic

Ideas for future research are to explore large numbers of healthcare workers to gather more experiences. It would be important for future research to explore the consequences of the pandemic, and to explore retention strategies given job vacancies presently flood the system. Considering contemporary healthcare worker shortages, immediate research is warranted that examines reasons why healthcare workers leave their roles, move to other places of employment, or leave the healthcare practice field altogether. As the system is struggling and there is a mass exodus from the healthcare field, it will be important to understand this. We also need to collect permanent data on what is successful, explore what more is needed, and monitor progress as this is crucial in making improvements.

We need to explore planning tools to support the diagnosis, implementation, and evaluation of large-scale crisis. We need to evaluate and ensure evidence-based interventions are available to support those impacted pre-, during and post-crisis. Future research should explore the effectiveness of different interventions to support healthcare workers and prevent compassion fatigue during pandemics and other high-stress situations.

Another area that should be explored is the reasons why healthcare workers did not reach out for the mental health or medication they may have needed especially as noted they found it helpful when they talked through their experiences, and many were actively engaged in self-medication. Several participants felt that talking about their experience was therapeutic and were encouraged to further explore this as they believed they had repressed this as a form of survival. In the interviews I conducted, many of the women engaged in self-medicating as a means of coping that should be explored for future research to help, support, and educate. Although my research helps paint somewhat of a picture of women's experiences, further research will need to continue to explore this as one can wonder if participants were still in shock by what they were experiencing.

Research should explore expanding on their experiences with having multiple roles and how this impacted their levels of compassion fatigue and other mental health concerns. This would include future investigative work that builds on this current study’s findings that contradicted currently held views that younger workers are more significantly impacted by compassion fatigue.

Research Methodology

There are several recommendations for future research methodology. This could involve ongoing systematic research that needs to be conducted with larger study samples. Future studies need to be carefully designed to capture their voices to make meaningful changes to their support in healthcare workplaces as this will be crucial in repairing and sustaining the healthcare profession for the future.

The timing of the survey was peak pandemic when there were still so many unknowns, changes, and uncertainties with the pandemic, whereas the interviews took place when things were not as catastrophic. Through the interviews, more in-depth information was able to be shared and patients were able to provide more intimate details of their experiences allowing me to get a more fulsome picture. The experiences of the women healthcare workers revealed that, through both quantitative and qualitative methods, there was an exacerbation of compassion fatigue experienced by them throughout the pandemic.

This study’s findings revealed the need for ongoing investigative work with a larger study sample of women who can address ongoing questions derived from remaining uncertainty about women healthcare workers’ experiences with compassion fatigue during and post-pandemic. Nonetheless, this study’s descriptive findings revealed that women experienced compassion fatigue during the COVID-19 pandemic. Women’s qualitative responses highlighted systemic issues, internal processes, and policies and procedures that need to be re-evaluated to more effectively structure organizations to be healthy workplaces, where workers are better able to provide support and care to their patients and patients.

Education Recommendations

I have several recommendations for future education and training. Incorporating professional learning focused on compassion fatigue, personal wellness, support toward each other in the workplace, and establishing healthy work-life balance would benefit individual organizations in supporting their staff to achieve their missions, thus improving the landscape of healthcare in Ontario. There will be a need to foster workshops and conferences with those who are achieving success and invest in prevention, intervention and postvention services.

Policy Makers Recommendations

I have several recommendations for policymakers. The first recommendation is for the government to have consistent, clear messages from one source to avoid chaos and confusion. Second, political leaders need to foster the public's understanding of healthcare workers' risk for compassion fatigue as affected by crisis events like the COVID-19 pandemic through 'raising awareness' campaigns and education. Third, there needs to be screening for mental health concerns within staff and for healthcare managers to have ongoing, meaningful conversations and support readily available for those in need. Next, the government should support programs/services with uniquely trained professionals who are readily available during an emergent large-scale crisis. An effective example of such support service is the call line program in Texas that is manned by uniquely trained Social Workers (described earlier). Additionally, the government should ensure equitable wage raises are provided to healthcare workers to avoid further silos across workplace sectors. Employers need to be trained in compassion fatigue and create environments that foster safe conversation, understanding, compassion, flexibility, and support wherever possible.

After completing additional research and understanding the gaps and deficits, the government could research and explore mandating services to establish compassion fatigue screening with knowledge and evidence-based practices. It would also be beneficial to ensure there is a legislated mandate with core funding for staff, research and development on mental health concerns brought on by the pandemic (and other large-scale crisis).

Further, this study's findings revealed that mandatory vaccinations impacted healthcare worker retention and their perceptions of service delivery resulting in their moral injury. Thus, the impacts of how policies on mandatory vaccinations were executed as well as how these policies were perceived and implemented by healthcare workers are warranted for ongoing investigative work.

The study's findings have crucial implications for healthcare organizations, policymakers, and future research. Healthcare organizations and policymakers must recognize the impact of compassion fatigue on healthcare workers' personal lives and provide them with adequate support and resources to cope with their experiences. My recommendations are consistent with those that the women provided. Unfortunately, as noted in compassion fatigue research, they were only able to see these things in hindsight or learn from their own negative experiences. The hope is that this study's findings as well as ongoing research will shed light on this issue.

Conclusion

This study explored personal and professional experiences with compassion fatigue among women healthcare workers during the 2020–2022 COVID-19 pandemic. Through the survey and in-depth interviews with healthcare workers, six themes emerged: the impacts of the pandemic on participants' personal lives, participants' experience with moral injury, participants' feelings of guilt and shame, support provided and sought for their well-being, perceived gaps, and limitations, and finally, recommendations for improving systems and supports.

The healthcare system is amid a crisis involving the retention of healthcare workers impacted, at least partially, by the COVID-19 pandemic. Evidence indicates that many healthcare workers’ psychological well-being was impacted by the pandemic and that they confronted challenges with support provided (or not) to them. This study’s findings make an important contribution to the literature in this area. This study’s findings suggest that women healthcare workers had unique experiences with compassion fatigue due to a variety of internal or external factors that warrant further examination in a larger study. What stood out in my study findings is how many resources could have been (or were) effective in hindsight. At the time of this study’s interviews, women participants were able to reflect on what they needed or what they benefitted from in terms of support and resources during the pandemic. As also identified in existing literature, because of their dual caregiving roles (both personally and professionally), women experienced greater levels of compassion fatigue and were impacted in different ways due to their circumstances during the pandemic. This study’s qualitative findings help to expand our appreciation of the clear impact that the pandemic had on women healthcare workers’ levels of compassion fatigue. The study also highlighted the gaps in research and data-driven recommendations for future research. I hope this research has meaningful impacts on health care and contributes to future research on this important topic. I also hope that I was able to capture women participants’ unique experiences with compassion fatigue and shed light on what they have been through during and continue to experience in the post-pandemic era.

References

Anand, S. (2021, June 12). The pandemic's compassion fatigue. *The Hindu*. https://www.thehindu.com/society/covid-19-volunteers-face-compassion-fatigue-in-india-mental-stress/article34790774.ece

Brindle, A., Fridinger, C., & Pety, J. (2021). *Compassion fatigue during the COVID-19 pandemic.* Penn State College of Nursing. https://scholarsphere.psu.edu/resources/87313fa1-6d99-4919-aa82-ae913c39b28e

Carey, M. (2012). *Qualitative research skills for social work theory and practice.* Routledge.

Chaudhury, S., & Samudra, M. (2020). COVID-19 lockdown: Psychological effects. *Medical Journal of Dr. D. Y. Patil Vidyapeeth*, *13*(6), 580–584. https://doi.org/10.4103/mjdrdypu.mjdrdypu_230_20

Chaudoin, K. (2020). *The pandemic leads to compassion fatigue and burnout for health care workers.* Lipscomb University. https://www.lipscomb.edu/news/pandemic-leads-compassion-fatigue-burnout-health-care-workers

Creswell, J., & Creswell, J. (2018). *Research design: Qualitative, quantitative, and mixed methods approach* (5th ed.).

Crisis Prevention Institute. (2021). *Compassion fatigue: Could it be compromising your profession?* https://www.crisisprevention.com

DePasquale, N. & Chappell, N. L. (n.d.). Double-Duty and Triple-Duty Caregivers. In *Encyclopedia of Gerontology and Population Aging* (pp. 1519–1524). Springer International Publishing

Hesse-Biber, S., & Flowers, H. (2019). Using a Feminist Grounded Theory Approach in Mixed Methods Research. In *The SAGE Handbook of Current Developments in Grounded Theory* (pp. 497–516).

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC health services research*, *18*(1), 120. https://doi.org/10.1186/s12913-018-2915-2

Galanis, P., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2021). Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis. *Journal of Advanced Nursing*, *77*(8), 3286–3302. https://doi.org/10.1111/jan.14839

Geoffrion S., Lamothe J., Morizot J., Giguère C-É. (2019). Construct Validity of the Professional Quality of Life (ProQoL) Scale in a Sample of Child Protection Workers. *Journal of Traumatic Stress*, *32*(4), 566–576. https://doi.org/10.1002/jts.22410

Gupta, N., Balcom, S. A., Gulliver, A., & Witherspoon, R. L. (2021). Health workforce surge capacity during the COVID-19 pandemic and other global respiratory disease outbreaks: A systematic review of health system requirements and responses. *The International Journal of Health Planning and Management*, *36*(S1), 26–41. https://doi.org/10.1002/hpm.3137

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches.* Jossey-Bass.

Hesse-Biber, S. N. (2012). *Handbook of feminist research: Theory and praxis* (2nd ed.). SAGE. https://doi.org/10.4135/9781483384740

hooks, b. (2014). *Feminism is for everybody: Passionate politics* (2nd ed.). Routledge. https://doi.org/10.4324/9781315743189

Jones, B. L., Phillips, F., Shanor, D., VanDiest, H., Chen, Q., Currin-McCulloch, J., Franklin, C., Sparks, D., Corral, C., & Ortega, J. (2021). Social work leadership in a medical school: A coordinated, compassionate COVID-19 response. *Social Work in Health Care*, *60*(1), 49–61. https://doi.org/10.1080/00981389.2021.1885567

Kearney, A., Hamel, L., & Brodie, M. (2021). *Mental Health Impact of the COVID-19 Pandemic: An Update. Medical Benefits, 38(9), 3–4. https://web-p-ebscohost-com.uml.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=0&sid=df4c6989-3497-4d4f-86a4-35ecdf2c18f8%40redis*

Kronsell, A. (2005). Gendered practices in institutions of hegemonic masculinity: Reflections from feminist standpoint theory. *International Feminist Journal of Politics*, *7*(2), 280–298. https://doi.org/10.1080/14616740500065170

Kushida, C.A., Nichols, D.A., Jadrnicek R., Miller R., Walsh J.K., & Griffin K. (2012). Strategies for De-identification and Anonymization of Electronic Health Record Data for Use in Multicenter Research Studies. *Medical Care*, *50*(7), S82–S101. https://doi.org/10.1097/MLR.0b013e3182585355

Lateef, F. (2020). Face to face with coronavirus disease 19: Maintaining motivation, psychological safety, and wellness. *Journal of Emergencies, Trauma and Shock, 13*(2), 116–123. http://doi.org/10.4103/JETS.JETS_27_20

Maqsood, A., Shah, R., Sarfaraz, S., Irfan, A., Faisal, A., & Fatwani, H. (2020). Healthcare workers knowledge, practice, and stress level amid the COVID-19 pandemic. *Pakistan Armed Forces Medical Journal*, *70*(1), 244–250. https://www.pafmj.org/index.php/PAFMJ/article/view/4883

Mardare Amini, M. (2022). *Statistical portrait of women and girls by the relative remoteness of their communities, series 3 : health and well-being*. Statistics Canada.

Mathieu, F. (2012). *The Compassion Fatigue Workbook: Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization (1st ed.).* Routledge Taylor & Francis Group. https://doi.org/10.4324/9780203803349

Mellins, C. A., Mayer, L. E. S., Glasofer, D. R., Devlin, M. J., Albano, A. M., Nash, S. S., Engle, E., Cullen, C., Ng, W. Y. K., Allmann, A. E., Fitelson, E. M., Vieira, A., Remien, R. H., Malone, P., Wainberg, M. L., & Baptista-Neto, L. (2020). Supporting the well-being of health care providers during the COVID-19 pandemic: The CopeColumbia response. *General Hospital Psychiatry*, *67*, 62–69. https://doi.org/10.1016/j.genhosppsych.2020.08.013

Morris, T. (2006). *Social work research methods: Four alternative paradigms*. SAGE.

O'Connor, D. B., Aggleton, J. P., Chakrabarti, B., Cooper, C. L., Creswell, C., Dunsmuir, S., Fiske, S. T., Gathercole, S., Gough, B., Ireland, J. L., Jones, M. V., Jowett, A., Kagan, C., Karanika-Murray, M., Kaye, L. K., Kumari, V., Lewandowsky, S., Lightman, S., Malpass, D., . . . Armitage, C. J. (2020). Research priorities for the COVID-19 pandemic and beyond A call to action for psychological science. *The British Journal of Psychology*, *111*(4), 603–629. https://doi.org/10.1111/bjop.12468

Pal, S., Kalra, S., & Jain, S. (2020). COVID-19 pandemic mental health and coping strategies. *Journal of Clinical and Diagnostic Research*, *14*(12), YE01–YE04. http://dx.doi.org/10.7860/JCDR/2020/45839.14298

Patton, M. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Sage.

Plichta, S.B., & Kelvin, E.A. (2011). Munro's statistical methods for health care research: (6th ed.).

Professional Quality of Life [ProQOL] (n.d.). *Professional Quality of Life.* (ProQOL).

Retrieved from https://proqol.org/

Rabin, S., Kika, N., Lamb, D., Murphy, D., Stevelink, S. A. M., Williamson, V., Wessely, S., & Greenberg, N. (2023). Moral Injuries in Healthcare Workers: What Causes Them and What to Do About Them? *Journal of Healthcare Leadership*, *15*, 153–160. https://doi.org/10.2147/JHL.S396659

Sayilan, A., Kulakac, N., & Uzun, S. (2020). Burnout levels and sleep quality of COVID-19 heroes. *Perspectives in Psychiatric Care*, *57*(3), 1231–1236. https://doi.org/10.1111/ppc.12678

Tsamakis, K., Tsiptsios, D., Ouranidis, A., Mueller, C., Schizas, D., Ternitotis, C., Nikolakakis, N., Typos, G., Kympouropoulos, S., Lazaris, A., Spandidos, D., Smyrnis, N., & Rizos, E. (2021). COVID-19 and its consequences on mental health (Review). *Experimental and Therapeutic Medicine*, *21*(3), 244–244. https://doi.org/10.3892/etm.2021.9675

University of Manitoba. (n.d.). *Governing documents: Research*. https://umanitoba.ca/governance/governing-documents-research

World Health Organization. (2021). *Coronavirus disease (COVID 19) pandemic*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Table 1

Survey Participant Demographics 100% (44)

Variable	Frequencies (100)
Gender	Women 98% (43) Nonbinary 2% (1)
Marital status	Legally married 70% (31) Divorced 4.5% (2) Common law 7% (3) Separated but still married 2% (1) Never legal married 14% (6) Engaged 2% (1)
Race	White 70% (31) South Asian (e.g. East Indian, Pakistani, Shi Lankan) 14% (6) Latin American 4.5% (2) Southeast Asian (e.g. Vietnamese) 7% (3) Indigenous, First Nation or Metis 4.5% (2)
Number of children	0 children 29.5% (13) 1 child 20% (9) 2 children 29.5% (13) 3 children 11% (5) 3 children 9% (4)
Age (years)	18-25 years 9% (4) 26-35 years 27% (12) 36-45 years 36% (16) 46-55 years 20% (9) 56-65 years 4.5% (2) 66-75 years 2% (1)
Education	Technical or applied college diploma 29.5% (13) University bachelor’s degree 29.5% (13) University graduate degree 29.5% (13) Other 11% (5)
Role	Nurse 43% (19) Social Worker 36% (16) Physician 7% (3) Other 14% (6)
Position	Frontline 77% (34) Management 20% (9) Other 2% (1)

Characterize your employment.	Full time 79.5% (35) Part time 14% (6) Casual/on call 4.5% (2) Other 2% (1)
How long in your current role	Less than a year 16% (7) 1-2 years 20% (9) 3-4 years 20% (9) 5-10 years 18% (8) Over 10 years 25% (11)
Where do you work?	City or urban centre14% (6) Small city or town (population <100,000) 61% (27) In rural northern community 25% (11) Other 2% (1)

Table 2

Trends in Compassion Fatigue 100% (44)

Q: 14 Trends in Compassion Fatigue	Percent (100)		
Please read the list below and select the trends in compassion fatigue you have noted in your professional practice since the start of COVID-19 (select all that apply).	Yes	No	Don't know
a. Increased personal levels compassion fatigue at your work	79.5% (35)	20.5% (9)	0
b. Deterioration of mental health and well-being of patients	91% (40)	9% (4)	0
c. Deterioration of mental health and well-being of staff	95% (42)	5% (2)	0
d. Deterioration of mental health and well-being of workplace culture	89% (39)	11% (5)	0
e. Impact on work life balance	86% (38)	14% (6)	0
f. Don't now	0	0	0
g. none	0	0	0

Table 3

Workplace Alterations

Q: 17 Workplace alterations	Percent (100)		
In what ways has your workplace had to alter its service delivery model within the context of COVD-19? (Select all that apply).	yes	no	Don't know
a. Working from home	50% (22)	50% (22)	0
b. Cancelling non-priority programs and projects.	70% (31)	30% (13)	0
c. Cancelling community outreach programs	45% (20)	55% (24)	0
d. Limit use of communal space	84% (37)	16% (7)	0
e. Reduce agency/program capacity to maintain social distancing	57% (25)	43% (19)	0
f. Cleaning and sanitizing common spaces	93% (41)	37% (3)	0
g. Cancellation of services	50% (22)	50% (22)	0
h. Spend agency funds on personal protection equipment	70% (31)	30% (13)	0
i. Spend agency funds on new technology to facilitate virtual services delivery	45% (20)	55% (24)	0
j. Discontinue volunteer programs.	50% (22)	50% (22)	0
k. Discontinue donation programs (i.e., clothes, toiletries)	32% (14)	68% (30)	0
l. Work additional hours/overtime	52% (23)	48% (20)	0
m. Decrease in work hours	2% (1)	98% (43)	0
n. Cancel/amend fundraising activities	27% (12)	73% (32)	0
o. Workplace did not alter services	0% (0)	100% (44)	0
p. Other	7% (3)	93% (41)	0

Table 4

Compassion Fatigue Impacts on Work 100% (44)

Q:18 Impacts on work	Percent (100)		
How have these changes impacted you and your ability to do your work? [select all that apply]	Yes	No	Don't know
a. The changes at my workplace have left me more stressed and overwhelmed.	64% (28)	36% (16)	0
b. The changes in my home/personal life have left me more stressed and overwhelmed.	57% (25)	43% (19)	0
c. I am worried for my physical safety/health (i.e., contract COVID-19 at my workplace)	30% (13)	70% (31)	0
d. I have had to take time off work due to illness or mandatory self-isolation.	59% (26)	41% (18)	0
e. I've been temporarily laid off and/or have had my hours reduced due to funding cuts.	0% (0)	100% (44)	0
f. I am worried for our patients'/service users' physical safety/health.	68% (30)	32% (14)	0
g. I have had to focus my attention to the changes required of our organization to deal with COVID-19 and have had less time to connect/work with my patients/service users.	68% (30)	32% (14)	0
h. Because I am working from home, it is difficult to separate my home and work obligations, leaving me feeling stressed and overwhelmed.	82% (36)	18% (8)	0
i. I have had to learn to use new technology, adding to my workplace stress.	23% (10)	77% (34)	0
j. Because I am working from home, I feel disconnected from my co-workers/colleagues.	16% (7)	84% (37)	0
k. I encounter difficulties connecting with other agencies.	50% (22)	50% (22)	0
l. I've had to provide services to patients/service users that are beyond my scope of practice/responsibility (e.g., completion of CERB applications)	34% (15)	66% (29)	0
m. the changes did not impact my ability to do my work.	2% (1)	93% (43)	0
n. Other (please specify)	7% (3)	93% (41)	0

Table 5

Top Three Challenges 100% (44)

Q: 19 Top three biggest challenges	Percent (100)		
What are the biggest challenges you have encountered providing services within the context of COVID-19 [select the top 3 challenges]	Yes	No	Don't know
a. Inability to meet the complex needs of patients and supporting families.	70% (31)	30% (13)	0
b. Lack of personal connection due to service delivery by remote means (i.e., phone, video conference)	36% (16)	64% (28)	0
c. Confusion around public health orders/health directives and how this translates to the workplace.	61% (27)	39% (17)	0
d. Technology related challenges (i.e., internet connectivity, lack of equipment)	32% (14)	68% (30)	0
e. Logistical challenges associated with working from home (i.e., inadequate workspace)	11% (5)	89% (39)	0
f. Lack of collaboration with other service providers	45% (20)	55% (24)	0
g. Adapting to new policies/procedures to manage COVID-19	61% (27)	29% (17)	0
h. Delays in services delivered through my facility.	41% (18)	59% (25)	0
i. Delays in the family court process	2% (1)	98% (43)	0
j. Decreases in staffing	70% (31)	30% 13)	0
k. Lack of financial resources	18% (8)	82% (36)	0
l. Uncertainty about the future of service provision	17% (12)	73% (32)	0
m. dealing with angry patients and families due to challenges they are facing.	55% (24)	45% (20)	0
n. Risk of physical harm	17% (12)	73% (32)	0
o. Did not experience challenges.	0	0	0
p. Other (please specify)	0	0	0

Table 6

COVID-19 on Personal Life 100% (44)

Q: 22 COVID-19 on personal life	Percent (100)		
How has COVID-19 impacted your personal life? [select all that apply]	Yes	No	Don't know
a. Had to work from home.	34% (15)	66% (29)	0
b. Had to homeschool children and/or provide care for children.	45% (20)	55% (24)	0
c. Had to care for others (i.e., family, relatives, neighbors)	20% (9)	80% (35)	0
d. Experienced health concerns for myself, children, and family	48% (21)	52% (23)	0
e. Experienced increased financial concerns/burden	34% (16)	66% (28)	0
f. Experienced moral distress or concerns with professional/personal boundaries	68% (30)	22% (14)	0
g. At times, I felt uncertain about my future in this profession.	50% (22)	50% (22)	0
h. Experienced increased stress	86% (38)	14% (6)	0
i. Experienced burnout	79.5% (35)	20.5% (9)	0
j. Felt isolated from family, friends, co-workers.	79.5% (35)	20.5% (9)	0
k. Experienced mental health issues (i.e., anxiety, depression, etc.)	59% (26)	41% (18)	0
l. Experienced lack of sleep or trouble sleeping.	59% (26)	41% (18)	0
m. Experienced relationship difficulty with spouse/partner	43% (19)	47% (25)	0
n. Experienced relationship difficulties with co-workers	29.5% (13)	70.5% (31)	0
o. It has not impacted my personal life.	2% (1)	98% (43)	0
p. Other (please specify)	2% (1)	98% (43)	0

Table 7

Impacts of COVID-19 100% (44)

Q: 23-40 Impacts of COVID-19	Percent (100)		
Questions	Yes	No	Don't know
23. Did you have patients die either directly or indirectly related to COVID-19?	45.5% (20)	43% (19)	11% (5)
24. Did you get sick, or have loved ones who were sick with COVID-19?	79.5% (35)	21.5% (9)	0% (0)
25. Did you feel you had enough breaks, work life balance?	23% (10)	77% (30)	9% (4)
26. Do you feel the policy adaptations, clear consistent messaging from the leaders of your organization?	20% (9)	75% (33)	5% (2)
27. Did you have time off?	57% (25)	43% (19)	0% (0)
28. Were you redeployed?	30% (13)	70% (31)	0% (0)
29. Did you feel safe at your work?	66% (29)	29.5% (13)	4.5% (2)
30. Do you feel your workplace supported your changing needs during the pandemic?	57% (25)	34% (15)	9% (4)
31. Did anyone check on your physical or mental health	31% (14)	66% (29)	2% (1)
32. Did you feel you had adequate support during the pandemic?	39% (17)	52% (23)	9% (4)
33. Did you have the appropriate personal protective equipment to safely do your job?	93% (41)	7% (3)	0% (0)
34. Did you feel that you were in situations where your physical and mental health were put in jeopardy during the COVID-19 pandemic?	70% (29)	32% (14)	2% (1)
35. Did you have primary caregiving responsibilities in caring for children or elderly that impacted your work?	57% (25)	43% (19)	0% (0)
36. Did your employer support the ever-changing demands of your caregiving responsibilities?	27% (12)	48% (21)	25% (11)
37. Were your coping strategies with personal stress and emotional toll impacted by Covid-19?	89% (39)	4% (2)	7% (3)
38. Did the pandemic impact your home and personal responsibilities?	73% (32)	25% (11)	2% (1)
39. Did you experience compassion fatigue and mental health struggles during the pandemic?	93% (41)	2% (1)	4.5% (2)
40. Was your perceived stress, emotional toll, and coping strategies impacted during the COVID-19 pandemic?	93% (41)	2% (1)	4.5% (2)

Table 8

Work Preparedness, Beginning of Pandemic

Question 20. Please rate your agreement with the following statement: At the beginning of the pandemic (March 2020), my workplace was well equipped to provide support services to patients within the context of COVID-19.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	a. Strongly disagree	10	22.7	22.7	22.7
	b. Disagree	11	25.0	25.0	47.7
	c. Agree	13	29.5	29.5	77.3
	d. Strongly agree	5	11.4	11.4	88.6
	e. Don’t know	5	11.4	11.4	100.0
	Total	44	100.0	100.0	

Table 9

Work Preparedness, Present

Question 21. Please rate your agreement with the following statement: my workplace is currently well equipped to provide support services to patients within the context of COVID-19.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	a. Strongly disagree	6	13.6	13.6	13.6
	b. Disagree	2	4.5	4.5	18.2
	c. Agree	26	59.1	59.1	77.3
	d. Strongly agree	10	22.7	22.7	100.0
	Total	44	100.0	100.0	

Table 10

Pearson Chi-Square Tests

1. Marital Status and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.225[a]	2	.199
Likelihood Ratio	3.841	2	.147
Linear-by-Linear Association	.127	1	.722
N of Valid Cases	44		

a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is .30.

2. Race and Compassion fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.197[a]	4	.185
Likelihood Ratio	5.150	4	.272
Linear-by-Linear Association	.015	1	.902
N of Valid Cases	44		

a. 6 cells (66.7%) have expected count less than 5. The minimum expected count is .14.

3. Number of Children and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	7.154[a]	6	.307
Likelihood Ratio	7.137	6	.308

Linear-by-Linear Association	1.460	1	.227
N of Valid Cases	44		

a. 8 cells (66.7%) have expected count less than 5. The minimum expected count is .20.

4. Age and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.097[a]	6	.797
Likelihood Ratio	4.010	6	.675
Linear-by-Linear Association	.157	1	.692
N of Valid Cases	44		

9 cells (75.0%) have expected count less than 5. The minimum expected count is .09.

5. Levels of Education and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.637[a]	6	.356
Likelihood Ratio	6.617	6	.358
Linear-by-Linear Association	.087	1	.768
N of Valid Cases	44		

a. 9 cells (75.0%) have expected count less than 5. The minimum expected count is .11.

6. Current Role (Frontline/Management) and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.376[a]	4	.497

	Value	df	Asymptotic Significance (2-sided)
Likelihood Ratio	4.128	4	.389
Linear-by-Linear Association	.256	1	.613
N of Valid Cases	44		

a. 6 cells (66.7%) have expected count less than 5. The minimum expected count is .20.

7. Length in Role and Compassion Fatigue

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.690[a]	4	.793
Likelihood Ratio	2.310	4	.679
Linear-by-Linear Association	.056	1	.812
N of Valid Cases	44		

a. 6 cells (66.7%) have expected count less than 5. The minimum expected count is .18.

8.Position and Work Life Balance.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.334[a]	2	.189
Likelihood Ratio	5.291	2	.071
Linear-by-Linear Association	2.260	1	.133
N of Valid Cases	44		

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is .82.

9. Occupational Role and Physical and Mental Health in Jeopardy.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	8.818[a]	4	.066
Likelihood Ratio	8.193	4	.085
Linear-by-Linear Association	4.359	1	.037

N of Valid Cases	44		

a. 4 cells (44.4%) have expected count less than 5. The minimum expected count is .20.

10.Race and Coping Strategies.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.171[a]	4	.530
Likelihood Ratio	3.207	4	.524
Linear-by-Linear Association	.769	1	.381
N of Valid Cases	44		

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is .41.

11.Current Role (Frontline/Management) and Feelings of Safety

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.312[a]	2	.519
Likelihood Ratio	1.104	2	.576
Linear-by-Linear Association	.965	1	.326
N of Valid Cases	44		

a. 6 cells (66.7%) have expected count less than 5. The minimum expected count is .27.

12.Age and Work Life Balance

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	11.611[a]	6	.071
Likelihood Ratio	13.270	6	.039
Linear-by-Linear Association	.001	1	.979
N of Valid Cases	44		

a. 9 cells (75.0%) have expected count less than 5. The minimum expected count is .36.

Table 11

ANOVA Tests

Test #1

Descriptive

14. Please read the list below and select the trends in compassion fatigue that you have noted in your professional practice since the start of COVID-19 (March 2020 – present). [select all that apply] - Selected Choice a. Increased personal levels compassion fatigue at your work

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
nurse	19	.84	.375	.086	.66	1.02	0	1
social worker	16	.75	.447	.112	.51	.99	0	1
other	9	.78	.441	.147	.44	1.12	0	1
Total	44	.80	.408	.062	.67	.92	0	1

Tests of Homogeneity of Variances

		Levene Statistic	df1	df2	Sig.
14. Please read the list below and select the trends in compassion fatigue that you have noted in your professional practice since the start of COVID-19 (March 2020 – present). [select all that apply] - Selected Choice a. Increased personal levels compassion fatigue at your work	Based on Mean	.932	2	41	.402
	Based on Median	.224	2	41	.801
	Based on Median and with adjusted df	.224	2	39.898	.801
	Based on trimmed mean	.932	2	41	.402

Test #2

ANOVA

14. Please read the list below and select the trends in compassion fatigue that you have noted in your professional practice since the start of COVID-19 (March 2020 – present). [select all that apply] - Selected Choice a. Increased personal levels compassion fatigue at your work

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.077	2	.039	.224	.801
Within Groups	7.082	41	.173		
Total	7.159	43			

Multiple Comparisons

Dependent Variable: 14. Please read the list below and select the trends in compassion fatigue that you have noted in your professional practice since the start of COVID-19 (March 2020 – present). [select all that apply] - Selected Choice a. Increased personal levels compassion fatigue at your work

Tukey HSD

(I) professional_role	(J) professional_role	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
nurse	social worker	.092	.141	.792	-.25	.44
	other	.064	.168	.923	-.34	.47
social worker	nurse	-.092	.141	.792	-.44	.25
	other	-.028	.173	.986	-.45	.39
other	nurse	-.064	.168	.923	-.47	.34
	social worker	.028	.173	.986	-.39	.45

Test #3

Descriptive

22. How has COVID-19 impacted your personal life? [select all that apply] - Selected Choice k. Experienced mental health issues (i.e., anxiety, depression, etc.)

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	Upper Bound	Minimum
18-25	4	.50	.577	.289	-.42	1.42	0
26-35	12	.75	.452	.131	.46	1.04	0
36-45	16	.56	.512	.128	.29	.84	0
46+	12	.50	.522	.151	.17	.83	0
Total	44	.59	.497	.075	.44	.74	0

22. How has COVID-19 impacted your personal life? [select all that apply] - Selected Choice k. Experienced mental health issues (i.e., anxiety, depression, etc.)

Tukey HSD[a,b]

age	N	Subset for alpha = 0.05 1
18-25	4	.50
46+	12	.50
36-45	16	.56
26-35	12	.75
Sig.		.743

Means for groups in homogeneous subsets are displayed.
a. Uses Harmonic Mean Sample Size = 8.348.
b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Test #4

ANOVA

22. How has COVID-19 impacted your personal life? [select all that apply] - Selected Choice k. Experienced mental health issues (i.e., anxiety, depression, etc.)

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.449	3	.150	.587	.627
Within Groups	10.188	40	.255		
Total	10.636	43			

Multiple Comparisons

Dependent Variable: 22. How has COVID-19 impacted your personal life? [select all that apply] - Selected Choice k. Experienced mental health issues (i.e., anxiety, depression, etc.)

Tukey HSD

		Mean Difference			95% Confidence Interval	
(I) age	(J) age	(I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
18-25	26-35	-.250	.291	.826	-1.03	.53
	36-45	-.063	.282	.996	-.82	.69
	46+	.000	.291	1.000	-.78	.78
26-35	18-25	.250	.291	.826	-.53	1.03
	36-45	.188	.193	.766	-.33	.70
	46+	.250	.206	.622	-.30	.80
36-45	18-25	.063	.282	.996	-.69	.82
	26-35	-.188	.193	.766	-.70	.33
	46+	.063	.193	.988	-.45	.58
46+	18-25	.000	.291	1.000	-.78	.78
	26-35	-.250	.206	.622	-.80	.30
	36-45	-.063	.193	.988	-.58	.45

Table 12

Participant Demographics Interviews 100% (44)

Variable	Percent (100)
Gender	Women 100% (8)
Marital status	Married 75% (6) Common law 12.5% (1) Single 12.5% (1)
Race	Caucasian 100% (44)
Number of children	0 Children 12.5% 12.5% (1) 1 Child 50% (4) 2 Children 25% (2) 3 Children 12.5% (1)
Age (years)	Minimum age: 22 maximum age: 58 mean: 36.87 SD: 11.82 (22, 24, 29, 32, 38, 42, 50, 58)
Level of education	College 50% (4) University 50% (4)
Length in career	Beginning 25% (2) Middle 50% (4) End 25% (2)
Role position title	RPN 37.5% (3) RN 37.5% (3) Social Worker 12.5% (1) Case manager 12.5% (1)
Position	Fulltime 100% (8)
Characterize employment position	Managers 25% (2) Frontline 75% (6)
Primary area of work	Community mental health 37.5% (3) Hospital 37.5% (3) Long term care 12.5% (1) Nurse educator (hospital) 12.% (1)

Table 13

ProQOL Results 100% (8)

Question	**1 = Never**	**2 = Rarely**	**3 = Sometimes**	**4 = Often**	**5 = Very Often**	**Missing**	**Total**
1. I am happy.	0	2	1	5	0	0	8
2. I am preoccupied with more than one person I [help].	0	0	12.5% (1)	0	87.5% (7)	0	8
3. I get satisfaction from being able to [help] people.	0	25% (2)	12.5% (1)	50% (4)	12.5% (1)	0	8
4. I feel connected to others	0	0	25% (2)	75% (6)	0	0	8
5. I jump or am startled by unexpected sounds.	0	37.5% (3)	25% (2)	37.5% (3)	0	0	8
6. I feel invigorated after working with those I help.	12.5% (1)	12.5% (1)	50% (4)	25% (2)	0	0	8
7. I find it difficult to separate my personal life from my life as a helper.	12.5% (1)	0	37.5% (3)	0	50% (4)	0	8
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	25% (2)	25% (2)	25% (2)	25% (2)	0	0	8
9. I think that I might have been affected by the traumatic stress of those I help.	0	0	37.5% (3)	37.5% (3)	25% (2)	0	8
10. I feel trapped by my job as a helper.	12.5% (1)	0	50% (4)	25% (2)	12.5% (1)	0	8
11. Because of my work, I have felt “on edge” about various things.	0	25% (2)	12.5% (1)	12.5% (1)	50% (4)	0	8
12. I like my work as a helper.	0	12.5% (1)	37.5% (3)	37.5% (3)	12.5% (1)	0	8
13. I feel depressed because of the traumatic experiences of the people I help.	12.5% (1)	12.5% (1)	25% (2)	50% (4)	0	0	8
14. I feel as though I am experiencing the trauma of someone I have helped.	1 or 12.5%	2 or 25%	2 or 25%	37.5% (3)	0	0	8
15. I have beliefs that sustain me.	0	0	6 or 75%	25% (2)	0	0	8
16. I am pleased with how I can keep up with helping techniques and protocols.	0	25% (2)	37.5% (3)	37.5% (3)	0	0	8

17. I am the person I always wanted to be.	12.5% (1)	12.5% (1)	50% (4)	25% (2)	0	0	8
18 My work makes me feel satisfied.	0	25% (2)	62.5% (5)	12.5% (1)	0	0	8
17. I feel worn out because of my work as a helper.	0	0	0	62.5 %(5)	3 or 37.5%	0	8
18. I have happy thoughts and feelings about those I help and how I could help them.	0	25% (2)	25% (2)	50% (4)	0	0	8
19. I feel overwhelmed because my case load seems endless.	0	0	12.5% (1)	12.5% (1)	75% (6)	0	8
20. I believe I can make a difference though my work.	0	25% (2)	12.5% (1)	50% (40)	12.5% (1)	0	8
21. I avoid certain activities or situations because they6 remind me of frightening experiences of the people I help.	0	37.5% (3)	37.5% (3)	12.5% (1)	12.5% (1)	0	8
22. I am proud of what I can do to help.	0	25% (2)	37.5% (3)	37.5% (3)	0	0	8
23. As a result of my work, I have intrusive, frightening thoughts.	25% (2)	12.5% (1)	37.5% (3)	25% (2)	0	0	8
24. I feel “bogged down” by the system.	0	0	0	25% (2)	75% (6)	0	8
25. I have thoughts that I am a “success” as a helper.	0	25% (2)	0	75% (6)	0	0	8
26. I can’t recall important parts of my work with trauma victims.	12.5% (1)	25% (2)	50% (4)	0	12.5% (1)	0	8
27. I am a very caring person.	0	12.5% (1)	12.5% (1)	50% (4)	25% (2)	0	8
28. I am happy that I chose to do this work.	12.5% (1)	25% (2)	25% (2)	37.5% (3)	0	0	8

Appendix A

Definition of Compassion Fatigue for the purposes of this study:

Compassion is defined as the feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering (Mathieu, 2012). Compassion is different from empathy, which means suffering together and fully engaging in others' suffering (Mathieu, 2012). Fatigue is defined as extreme tiredness resulting from mental or physical exertion or the state of being weakened under repeated stress (Chaudoin, 2020). Although there are varying definitions of compassion fatigue (and of compassion), it is often described as the "cost of caring for others," and it affects those directly working with others, such as nurses, social workers, police officers, personal support workers, and many other direct helping professions (Mathieu, 2012, p. 8). Compassion fatigue is the physical, emotional, and spiritual result of chronic self-sacrifice or prolonged exposure to difficult situations, which renders a person unable to love, nurture, or care for/empathize with another's suffering (Chaudoin, 2020). Compassion fatigue is an occupational hazard, and most helpers who care for their patients will eventually experience it firsthand (Mathieu, 2012). Compassion fatigue is known as "the death by a thousand cuts, meaning that the gradual erosion of the pain and suffering we are exposed to will catch up with us over time (Mathieu, 2012, p. 9)." Most helpers will experience some form of this throughout their careers, and it impacts how we feel about ourselves, the work we do, and our ability to handle our lives.

Appendix B

Online Survey Questions

This study considers the experiences healthcare workers in Ontario within the context of COVID-19. As such, there are specific criteria associated with participating in the study. The next three questions will assess your eligibility to take part in the survey.

1. Have you worked in frontline healthcare (mental health) during COVID-19, meaning providing direct care for patients or patients (March 2020 – present)?

   a. Yes

   b. No

2. Do you work in Ontario, Canada?

   a. Yes

   b. No

3. As this study is specific to woman as healthcare workers here is a list of terms to describe gender. Please check all terms that currently apply to you.

   a. Women

   b. non-binary

   c. Trans woman

   d. Two- spirit

   e. Prefer not to say

   f. Other

   g. Ineligible

Demographic Information

4. What is your marital status?

   a. Legally married (and not separated)

   b. Widowed

   c. Divorced
   d. Common law
   e. Separated but still legally married.
   f. Never legally married
   g. Other
   h. Engaged
   i. Common law

5. What is your culture/race?
   a. White
   b. South Asian (e.g., East Indian, Pakistani, Sri Lankan)
   c. Chinese
   d. Black
   e. Filipino
   f. Arab
   g. Latin American
   h. Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai)
   i. West Asian (e.g., Iranian, Afghan)
   j. Korean
   k. Japanese
   l. Indigenous, First Nation or Metis
   m. Other (please specify)

6. How many children do you have?
   a. 0
   b. 1
   c. 2

  - d. 3
  - e. 4
  - f. More than 4

7. What is your age?
   - a. 18-25
   - b. 26-35
   - c. 36-45
   - d. 46-55
   - e. 56-65
   - f. 66-75
   - g. 75+

8. What is your level of education?
   - a. Less than a high school diploma
   - b. High school diploma or equivalent
   - c. Technical or applied college diploma.
   - d. University bachelor’s degree
   - e. University graduate degree
   - f. Other (please specify)

9. What is your role/position title?
   - a. Nurse
   - b. Nurse practitioner
   - c. Healthcare aid
   - d. Personal support worker
   - e. Physician
   - f. Paramedic

   e. Social Worker
   f. Other healthcare provider (please specify)

10. What best describes your position? (Select one)
   a. I am in a front-line staff position.
   b. I am in a management position.
   c. I am a student.
   d. I am support staff.
   d. Other (please specify)

11. How would you characterize your employment?
   a. Full-time
   b. Part-time
   c. Casual/on call
   d. Student
   e. Other (please specify)

12. How long have you worked in your current role?
   a. I am a student.
   b. Less than 1 year
   c. 1-2 years
   d. 3-4 years
   e. 5-10 years
   f. Over 10 years

13. Would you say you primarily work: [check all that apply]
   a. In city or urban center
   b. In a suburb near a large city
   c. In a small city or town (population <100,000)

d. In a rural (non-northern) community

e. In a rural northern community

f. In a First Nations community (i.e., on-reserve)

g. Other (please specify)

14. Preliminary research indicates that COVID-19 has impacted experiences of compassion fatigue in several ways. Please read the list below and select the trends in compassion fatigue that you have noted in your professional practice since the start of COVID-19 (March 2020 – present). [select all that apply]

a. Increased personal levels compassion fatigue at your work.

b. Deterioration of mental health and well-being of patients

c. Deterioration of mental health and well-being of staff

d. Deterioration of mental health and well-being of workplace culture

e. Impacts on work life balance

f. Don’t know.

15. Is there anything else you’d like to add regarding the impact of COVID-19 on compassion fatigue? [open-ended question]

Service Provision within the Context of COVID-19

16. Did your organization alter its practice during the COVID-19 pandemic?

a. Yes

b. No

c. Do not know.

17. In what ways has your workplace had to alter its service delivery model within the context of COVID-19? [select all that apply]

a. Working from home.

b. Cancelling non-priority programs and projects.

c. Cancelling community outreach programs

d. Use of virtual means (i.e., phone, video conference) to deliver supports.

e. Limit the use of communal spaces

f. Reduce agency/program capacity to maintain social distancing.

g. Cleaning and sanitizing common spaces.

h. Cancellations of services

i. Spend agency funds on personal protection equipment (PPE)

j. Spend agency funds on new technology to facilitate virtual service delivery.

j. Discontinue volunteer programs.

k. Discontinue donation programs (i.e., clothes, toiletries)

l. Work additional hours/overtime

m. Decrease in work hours

n. Cancel/amend fundraising activities.

o. Workplace did not alter services.

p. Other (please specify)

18. How have these changes impacted you and your ability to do your work? [select all that apply]

a. The changes at my workplace have left me more stressed and overwhelmed.

b. The changes in my home/personal life have left me more stressed and overwhelmed.

c. I am worried for my physical safety/health (i.e., contract COVID-19 at my workplace)

d. I have had to take time off work due to illness or mandatory self-isolation.

e. I’ve been temporarily laid off and/or have had my hours reduced due to funding cuts.

f. I am worried for our patients’/service users’ physical safety/health.

g. I have had to focus my attention to the changes required of our organization to deal with COVID-19 and have had less time to connect/work with my patients/service users.

h. Because I am working from home, it is difficult to separate my home and work obligations, leaving me feeling stressed and overwhelmed.

i. I have had to learn to use new technology, adding to my workplace stress.

j. Because I am working from home, I feel disconnected from my co-workers/colleagues.

k. I encounter difficulties connecting with other agencies.

l. I’ve had to provide services to patients/service users that are beyond my scope of practice/responsibility (e.g., completion of CERB applications)

m. Other (please specify)

19. What are the biggest challenges you have encountered providing services within the context of COVID-19 [select the top 3 challenges]

a. Inability to meet the complex needs of patients and supporting families.

b. Lack of personal connection due to service delivery by remote means (i.e., phone, video conference)

c. Confusion around public health orders/health directives and how this translates to the workplace.

d. Technology related challenges (i.e., internet connectivity, lack of equipment)

e. Logistical challenges associated with working from home (i.e., inadequate workspace)

f. Lack of collaboration with other service providers

g. Adapting to new policies/procedures to manage COVID-19

h. Delays in services delivered through my facility.

i. Delays in the family court process

j. Decreases in staffing

k. Lack of financial resources

l. Uncertainty about the future of service provision

m. dealing with angry patients and families due to challenges they are facing.

n. Risk of physical harm

o. Did not experience challenges.

p. Other (please specify)

20. Please rate your agreement with the following statement: At the beginning of the pandemic (March 2020), my workplace was well equipped to provide support services to patients within the context of COVID-19.

a. Strongly disagrees.

b. Disagree

c. Agree

d. Strongly agrees.

e. Don’t know.

21. Please rate your agreement with the following statement: my workplace is currently well equipped to provide support services to patients within the context of COVID-19.

a. Strongly disagrees.

b. Disagree

c. Agree

d. Strongly agrees.

e. Don’t know.

22. How has COVID-19 impacted your personal life? [select all that apply]

a. Had to work from home.

b. Had to homeschool children and/or provide care for children.

c. Had to care for others (i.e., family, relatives, neighbors)

d. Experienced health concerns for myself, children, and family

e. Experienced increased financial concerns/burden

f. Experienced moral distress or concerns with professional/personal boundaries

g. At times, I felt uncertain about my future in this profession.

h. Experienced increased stress

i. Experienced burnout

j. Felt isolated from family, friends, co-workers.

k. Experienced mental health issues (i.e., anxiety, depression, etc.)

l. Experienced lack of sleep or trouble sleeping.

m. Experienced relationship difficulty with spouse/partner

n. Experienced relationship difficulties with co-workers

o. It has not impacted my personal life.

p. Other (please specify)

23. Did you have patients die either directly or indirectly related to COVID-19?

a. Yes

b. No

c. Don’t know.

24. Did you get sick, or have loved ones who were sick with COVID-19?

a. Yes

b. No

c. Don’t know.

25. Did you feel you had enough breaks, work life balance?

a. Yes

b. No

c. Don’t know.

26. Do you feel the policy adaptations, clear consistent messaging from the leaders of your organization?

a. Yes

b. No

c. Don’t know.

27. Did you have time off?

a. Yes

b. No

c. Don’t know.

28. Were you redeployed?

a. Yes

b. No

c. Don’t know.

29. Did you feel safe at your work?

a. Yes

B. No

c. Don’t know.

30. Do you feel your workplace supported your changing needs during the pandemic?

a. Yes

b. No

c. Don’t know.

31. Did anyone check on your physical or mental health?

a. Yes

b. No

c. Don’t know.

32. Did you feel you had adequate support during the pandemic?

a. Yes

b. No

c. Don’t know.

33. Did you have the appropriate personal protective equipment to safely do your job?

a. Yes

b. No

c. Don’t know.

34. Did you feel that you were in situations where your physical and mental health were put in jeopardy during the COVID-19 pandemic?

a. Yes

b. No

c. Don’t know.

35. Did you have primary caregiving responsibilities in caring for children or elderly that impacted your work?

a. Yes

b. No

c. Don’t know.

36. Did your employer support the ever-changing demands of your caregiving responsibilities?

    a. Yes

    b. No

    c. Don’t know.

37. Were your coping strategies with personal stress and emotional toll impacted by Covid-19?

    a. Yes

    b. No

    c. Don’t know.

38. Did the pandemic impact your home and personal responsibilities?

    a. Yes

    b. No

    c. Don’t know.

39. Did you experience compassion fatigue and mental health struggles during the pandemic?

    a. Yes

    b. No

    c. Don’t know.

40. Was your perceived stress, emotional toll, and coping strategies impacted during the COVID-19 pandemic?

    a. Yes

    b. No

    c. Don’t know.

41. Is there anything else you’d like to share about your experience(s) working in healthcare during COVID-19? [open-ended question]

42. Would you like a copy of the report once completed?

    a. Yes

    b. No

    Please writer email address if yes

    Email address

43. Would you be willing to participate in follow up interview via zoom if selected? Note: Interviews are first come first serve therefore even if you select yes, you may not be contacted for a follow up interview.

    a. Yes

    b. No

    Please write email address or phone number and I will follow up with you.

    Email address:

    Phone number:

Appendix C

Script Recruiting Service Provider Survey Participants

Hello Frontline Healthcare worker,

My name is Regan Dearborn. I am a Master of Social Work student writing my graduate thesis under the direction of my advisor Dr. Kendra Nixon (Faculty of Social Work at the University of Manitoba). I am contacting you to request your assistance with a research project I am working on as part of my master's thesis. The title of the research is "Women Healthcare Workers, Compassion Fatigue, and the COVID-19 Pandemic" which is a study being conducted across Ontario focusing specifically on women in healthcare. We are interested in learning about women's experiences providing support services within the context of COVID-19. You will see from the survey, there are a few inclusionary criteria questions at the beginning which clarifies how this study will be defining women, the times you would have needed to be working during the pandemic, as well as that you must be a resident and working in Ontario.

The study includes a survey of healthcare workers in Ontario (who are over the age of 18 years as of date completing the survey). The survey includes questions related to background/demographic information, professional and personal experiences in being a healthcare worker in the context of COVID-19, and suggestions for ways to improve the working conditions and support healthcare workers. The survey will take approximately 15 - 20 minutes to complete and the results will be kept strictly confidential. This research has been approved by the Research Ethics Board at the University of Manitoba. The study is voluntary and your decision to participate or not will in no way affect their employment. The final portion of the survey will include information inviting participants to take part in an interview. Interested participants will be asked to provide their contact information for subsequent follow-up to schedule an individual interview. Participant contact information will be de-linked from the survey responses and there will be a small compensation for completing the follow up interview.

For purposes of maintaining confidentiality, we will not share with your employer if you decide to participate (or not) in the study. Here is the link to the survey https://cssrp.ca1.qualtrics.com/jfe/form/SV_6Ga8QfgTl0r4LFI

Please feel free to contact me with any questions regarding the study.

We truly appreciate your value time.

Regan Dearborn

Principal Investigator- Regan Dearborn moorer3@myumanitoba.ca
Advisor- Dr. Kendra Nixon kendra.nixon@umanitoba.ca

University of Manitoba

Appendix D

Script Recruiting Agency Survey Participants

Hello [Association/Agency],

My name is Regan Dearborn. I am a Master of Social Work student writing my graduate thesis under the direction of my advisor Dr. Kendra Nixon (Faculty of Social Work at the University of Manitoba). I am contacting you to request your assistance with a research project I am working on as part of my master's thesis. The title of the research is "Women Healthcare Workers, Compassion Fatigue, and the COVID-19 Pandemic" which is a study being conducted across Ontario focusing specifically on women in healthcare. We are interested in learning about service provider's experiences providing support services within the context of COVID-19. You will see from the survey, there are a few inclusionary criteria questions at the beginning which clarifies how this study will be defining women, the times they would have needed to be working during the pandemic, as well as that they must be a resident and working in Ontario.

The study includes a survey of healthcare workers in Ontario (who are over the age of 18 years as of as of date completing the survey). The survey includes questions related to background/demographic information, professional and personal experiences in being a healthcare worker in the context of COVID-19, and suggestions for ways to improve the working conditions and support healthcare workers. The survey will take approximately 15 - 20 minutes to complete and the results will be kept strictly confidential. This research has been approved by the Research Ethics Board at the University of Manitoba. Staff will be informed that participation in the study is voluntary and that their decision to participate or not will in no way affect their employment. The final portion of the survey will include information inviting participants to take part in an interview. Interested participants will be asked to provide their contact information for subsequent follow-up to schedule an individual interview. Participant contact information will be de-linked from the survey responses and there will be a small compensation for completing the follow up interview.

Would you be able to email the survey link your staff? Of course, it is up to your staff if they would like to participate in the study. For purposes of maintaining confidentiality, we will not be able to share with you if they decide to participate (or not) in the study. https://cssrp.ca1.qualtrics.com/jfe/form/SV_6Ga8QfgTl0r4LFI

Please feel free to contact me with any questions regarding the study.

Thank you for your time.

Regan Dearborn

Principal Investigator- Regan Dearborn moorer3@myumanitoba.ca
Advisor- Kendra Nixon kendra.nixon@umanitoba.ca

Appendix E

Interview Questions:

1. The following questions are optional but will be helped to establish context for the remainder of the interview. If you are comfortable, please share:

a) Your age:

b) Your professional title:

c) Your area of practice:

d) Workplace location (community, hospital etc.)

2. Can you share how the experiences working in your healthcare role during the COVID-19 pandemic had an impact on your personal life (family, social, emotional)?

3. Did you experience moral injury? (Moral injury as the distressing psychological, behaviour, social and sometimes spiritual aftermath of exposure to an events).

If so, can you elaborate?

4. Can you share if you had experiences of guilt and shame around client care or services that were offered during the COVID- 19 pandemic?
5. Can you speak of the supports you had to care for your own health during the pandemic?
6. Looking back, can you share what were the warning signs that your mental health was being impacted (if it was impacted)? (So, we can help others recognize it earlier)

7. In your opinion, how could responses to the pandemic and associated working conditions have been improved by:

a. The government?

b. Your employer?

c. Your direct manager?

d. And the public?

8. From your experiences in working in healthcare during the Covid-19 pandemic, what recommendations would you have for improving the supports available to frontline staff.

Appendix F

Consent form for survey

Principal Investigator and contact information: Master of Social Work Student University of Manitoba: Regan Dearborn moorer3@myumanitoba.ca
Research Supervisor and contact information: Professor at University of Manitoba: Kendra Nixon Kendra.Nixon@umanitoba.ca

This consent form, which you can take a screenshot of for your records and references, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This research is on women as essential workers in healthcare and the impact of compassion fatigue during the COVID-19 pandemic. A brief survey will be completed (about 15-20 minutes). The interview will take place virtually on zoom. Participation is voluntary and will not affect employment. There will be no compensation provided. The goal is to understand their experience and then advocate for changes to better support women in these roles in the future. There are minimal risks to the participant as the information is confidential. I will offer supports in case participants become distressed as they could be potentially sharing traumatic elements of compassion fatigue or pain and loss experienced during the pandemic. I have a script in case this happens.

The information will be confidential and stored in Qualtrics and transferred through SharePoint which will be password protected. I will have direct quotes from participants however, they will be identified as “A social worker” or “a doctor.” There will be a list of free available resources in case the participants become distressed, Once the survey is completed the participant is unable to withdraw their information from the study as it is non identifiable, and we will be unable to link information back. Risks associated with participation are minimal and are like those associated with many email and social media websites such as Hotmail and Facebook which have a certain element of risk for privacy and security. The summary of results will be sent to participants in March 2023 and the research will be disseminated on MSpace. I will leave a section on the form where they can leave their email address or mailing address (whichever you prefer) to provide it to them once complete. The confidential data will be kept for approximately 5 years and destroyed on October 2027.

I hope to publish my findings in academic journals and at conferences (both academic and professional). I will also share the study results more broadly with service providers and women frontline healthcare workers who are interested by writing a report that will be disseminated to various professional associations. My hope is that this information and research will support staff and assist organizations in understanding what these workers went through, what they need, as well as how they can be supported in the future.

By checking agree at the end of this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study up until it is submitted and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. You can do this by exiting the browser and not submitting the survey. Once your information is submitted, we will not be able to omit your information from the survey as there is no way to link it back to you. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

. -----------------------Check below if you are agreeing to the above information: -----------------

_____ I agree

University of Manitoba

Updated: December 4, 2020

Appendix G

Consent form for interview

Principal Investigator and contact information: Master of Social Work Student, University of Manitoba, Regan Dearborn moorer3@myumanitoba.ca
Research Supervisor and contact information: Professor University of Manitoba, Kendra Nixon Kendra.Nixon@umanitoba.ca

This consent form, which you can take a screenshot of for your records and references, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This research is on women as essential workers in healthcare and the impact of compassion fatigue during the COVID-19 pandemic. The interview will be completed over a Personal Health Information Protection Act (PHIPA) complaint zoom account. The interview will be recorded from beginning to the end of the interview by both video and audio. Participants must consent to being recorded, or arrangements can be made for note taking if there are expectational reasons they do not want to be recorded. The recordings will be transcribed through the software and manually by the Principal Investigator. The PI will use the zoom's auto transcription feature and do it manually. The recordings will be deleted after it is transcribed, and the person interviewed will never be identified by name rather by occupation i.e., a nurse stated. The Principal Investigator and the advisor will have access to this information in SharePoint. The data will be stored and transferred using UM cloud service SharePoint. The advisor will also have access to all data. The PI will have direct quotes from participants however, they will be identified as "A social worker" or "a doctor." The ProQOL will also be used at the beginning of the interview as an evidence-based tool to measure levels of compassion fatigue.

Once the interview is completed, transcribed and the recording is deleted, the participant is unable to withdraw their information from the study as it is non identifiable, and we will be unable to link information back. The interview participant can stop the interview at any time by exiting or requesting it to end and the information thus far in the interview will be deleted and not used in the study. The interview will take approximately 1.5 hours. The PI will request that the participant let them know if they are choosing to exit so that it is not confused with technical issues. The participant can exit at any time they choose during the interview and the information will be omitted if requested. Participants can also withdraw from the research up until transcription and the recording is deleted as there will be no way to link back information after this time. The summary of results will be sent to participants in March 2023 and the research will be disseminated on MSpace. Participants can also leave their email or mailing address at the end of the survey and the information will be sent to them. The confidential data will be kept for approximately 5 years and destroyed on October 2027. An honorarium of $40 will be provided to those who participated in the interview. An honorarium receipt will be provided to participants who completed the interview, and they will need to sign it. This data will be identifiable as participants will need to sign the form. This data will need to be stored in SharePoint for 7 years as per CRA requirements being deleted October 2029. This is in case the PI gets audited; they PI will have to provide them with the receipt and used for no other purposes.

The goal is to understand the experiences of women in healthcare and then advocate for changes to better support women in these roles in the future. There are minimal risks to the participant as the information is confidential. In the case that a participant does become distressed, I will offer supports as they could be potentially sharing traumatic elements of compassion fatigue or pain, and loss experienced during the pandemic. There will be a list of free available resources in case the participants become distressed as well as the opportunity to debrief after the interview. The PI hopes to publish findings in academic journals and at conferences (both academic and professional). The PI will also share the study results more broadly with service providers and women frontline healthcare workers who are interested by writing a report that will be disseminated to various professional associations. The hope is that this information and research will support staff and assist organizations in understanding what these workers went through, what they need, as well as how they can be supported in the future.

By checking agree at the end of this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study up until the interview is completed, transcribed, and video deleted and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. For the interview your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

. -----------------------Check below if you are agreeing to the above information: -----------------

_____ I agree.

Please check below if you agree to being recorded during the interview (note the PI and the advisor will have access to the recording).

---------I agree

University of Manitoba

Updated: December 4, 2020

Appendix H

Script for Debriefing and Offer of Counselling Services

Participating in research interviews and speaking about personal experiences whether it be related to compassion fatigue, or the pandemic can be distressing sometimes. Are you feeling upset and distressed? We can take a break and/or you can stop the interview at any time? Would you like to stop the interview?

> *If "yes",* thank you for participating in our study. Would you like us to use the information we have gathered so far?
>
> > *If "yes":* Thank you again for participating in our study. I encourage you to contact a crisis counsellor if you continue to feel upset or distressed. Sometimes sharing your thoughts and feelings with professionals knowledgeable can be helpful. Would you like me to provide you with a list of names and numbers of agencies that you could contact for assistance?
> >
> > *If "no"*: All of the information you have provided so far, including contact information sheet, informed consent form, demographic information, and this audio recording will be destroyed immediately.
>
> If "no", we can carry on with the interview whenever you are ready.

End of interview: Thank you again for participating in our study. I encourage you to contact a counsellor if you continue to feel upset or distressed. Sometimes sharing your thoughts and feelings with professionals knowledgeable in the field can be helpful. We are providing all women who participate in an interview with a list of names and numbers of agencies that you could contact for assistance now or in the future, (For telephone interviews – the list was sent to you with the consent form).

Appendix I

Free counselling resources

1. Wellness Together Canada

Wellness Together Canada is a free mental health and substance use website to support people across Canada and Canadians living abroad, with immediate text support, information and videos on common mental health issues, mental wellness programs you can do on your own and with coaching, monitored communities of support and individual phone, video, and text counselling. Learn more: **1-866-585-0445**

WELLNESS TOGETHER Canada | Mental Health and Substance Use Support

WELLNESS TOGETHER Canada | Mental Health and Substance Use Support

WHO IT IS FOR: All Canadians

2. Together All

Together All is a free, safe, online peer-to-peer mental health community that is accessible 24/7 to help those experiencing anxiety, depression, and other common mental health issues. Commissioned by over 250 organizations globally, Together All is an online service that provides access to millions with anxiety, depression, and other common mental health issues through online peer-to-peer support.

togetherall

WHO IT IS FOR: All Ontarians aged 16+

3. BounceBack Ontario

BounceBack Ontario is a free skill-building program managed by the Canadian Mental Health Association (CMHA) Ontario. It is designed to help adults and youth 15+ manage low mood, mild to moderate depression and anxiety, stress or worry. Delivered over the phone with a coach and through online videos, you will get access to tools that will support you on your path to mental wellness.

WHO IT IS FOR: All Ontarians aged 15+

4. Crisis Services Canada

Crisis Services Canada is a 24/7 national network of distress, crisis, and suicide prevention line services. This service is available across Canada via toll-free phone, or text in English. Our toll-free phone service is also available in French. This means anyone in Canada that is thinking about, is or has been affected by suicide, can reach out across a variety of media, and feel supported 24 hours a day, 7 days a week. **Call** 1.833.456.4566 **Text** 45645

WHO IT IS FOR: All Canadians

5. LGBT Youth line Ontario

LGBT Youthline Ontario is an Ontario-wide peer-support for lesbian, gay bisexual, transgender, transsexual, two-spirited, queer, and questioning young people through text and live chat with peer support volunteers. Their services are available from Sunday to Friday from 4:00 PM - 9:30 PM. **Text** 647-694-4275 **Live Chat** www.youthline.ca/
Email askus@youthline.ca

WHO IT IS FOR: LGBTTQQ2SI individuals across Ontario.

6. Distress Centres of Greater Toronto

Distress Centres of Greater Toronto offer free, 24/7 support to individuals in crisis and/or experiencing emotional distress. Services are available via hotline, online chat, and text. They are Canada's oldest volunteer-delivered crisis, emotional support, and suicide prevention + intervention + postvention service agency.

Distress Centres
of Greater Toronto

Call 416-408-4357 (24/7 support)
Text 45645 (texting available from 4 pm – 12am
WHO IT IS FOR: Individuals living in the GTA

7. AbilitiCBT

AbilitiCBT is an internet-based cognitive behavioural therapy (iCBT) program that you can access from any device, any time. It is free to anyone in Ontario or Manitoba. Cognitive behavioral therapy is one of the most effective forms of therapy. It works by helping you understand and change the thoughts, feelings and behaviors that are causing you problems. AbilitiCBT works the same way, but virtually. AbilitiCBT's user-friendly platform makes it convenient to get help when you need it, where you need it.

AbilitiCBT

WHO IT IS FOR: All Canadians

8. Good2Talk Helpline

Good2Talk provides confidential support services for post-secondary students in Ontario and Nova Scotia. Students can receive information and referrals about services and supports for mental health, addictions, and well-being on and off campus and speak anonymously with a professional counsellor.

Call 1-866-925-5454
Text GOOD2TALKON to 686868

WHO IT IS FOR: Post-secondary students in Ontario/Nova Scotia

8. Ontario Caregiver Helpline

The Ontario Caregiver Organization (OCO) exists to support Ontario's 3.3 million caregivers, ordinary people who provide physical and emotional support to a family member, partner, friend, or neighbour. We support caregivers by being their one point of access to information, so they have what they need to be successful in their role.

Text 1-833-416-2273
Live chat www.ontariocaregiver.ca

WHO IT IS FOR: Caregivers in Ontario

10. Kids Help Phone

Kids Help Phone is a free, national, 24/7 e-mental health service providing counselling, information and referrals text and phone-based support. Kids Help Phone also provides information on how to access community support services for youth.
Call 1-800-668-6868
Text 686868
Questions & inquiries www.kidshelpphone.ca/get-involved/contact-us/

WHO IT IS FOR: All kids, teens, and young adults across Canada.

11. MindBeacon

The MindBeacon Therapist Guided Program is 100% covered by the Government of Ontario to support all Ontario residents through stress and mental well-being concerns during COVID-19. There are no appointments to keep - you complete the therapy when it works for you, through secure message-based therapy that is always guided and supported by a Registered Ontario Therapist.

At MindBeacon, your therapist will guide you through a 12-week program. They will personally select readings, exercises, and activities to help you develop new skills. There are no face-to-face appointments - instead you have access to unlimited secure text-based messages that they'll always respond to within a couple days.

Email help@mindbeacon.com
Questions & inquiries www.mindbeacon.com/ontario

WHO IT IS FOR: Everyone in Ontario

NEED ADDITIONAL HELP NAVIGATING SERVICES?
There are multiple services and organizations that specialize in helping Canadian's navigate the mental health service. A short list of them can be found below. It is important to note that depending on the severity of your symptoms, your family doctor can refer/connect you to other mental health services. If you are in crisis, please call 911. Mental health *is* health, it is important to seek help if you need it (the world is a brighter place with you in it).

Family Navigation Project is a free program that provides help to youth, 13 to 26 years old experiencing mental health and/or addiction issues, and their families navigate the system more easily, to find and gain access to resources, such as service providers and treatment centres.
Connex Ontario provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness, or gambling. They are funded by the Government of Ontario. Their system navigation and information services are live-answer 24/7, confidential, and free.
Ontario 211 connects people to the right information and services. Dial 211 to find out about or get connected to community, health, and social services across Canada.

Appendix J

Honorarium Payment Form

An honorarium is a payment for services for which custom or propriety forbids a price to be set. It is a “thank you” gesture of goodwill and appreciation. It is not a previously agreed upon payment for services.

These services are not ongoing or continuous.

Name:
SSN:
Address:
Service
Rendered:
Date of Service:
Compensation:

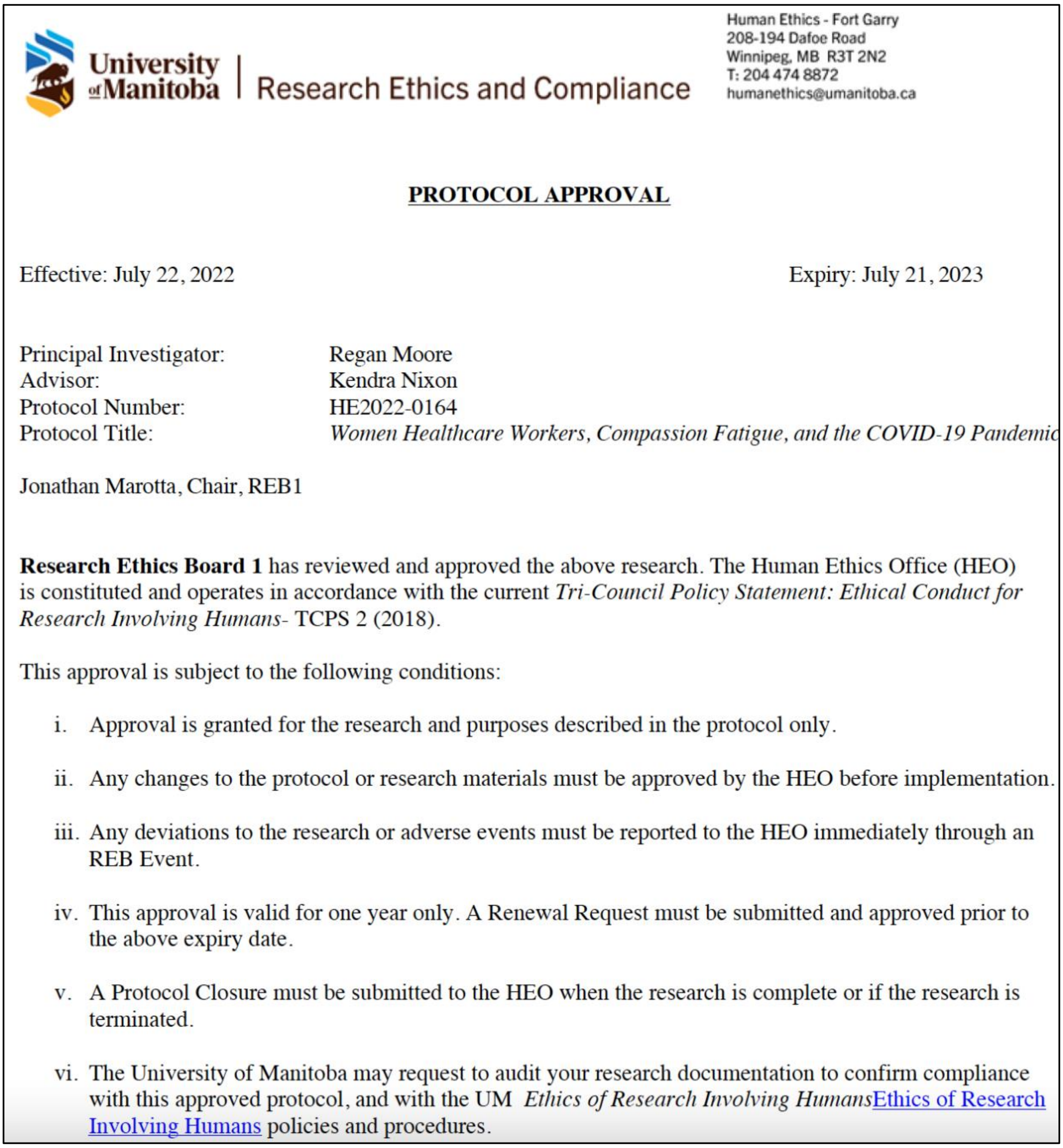
I certify that the above services were completed, that the compensation hereby approved for payment is appropriate to the service performed, and that the payment is a “thank. you” gesture of goodwill and appreciation.

Signature of Project Director

Date

Rev 4/0

Appendix K



University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

PROTOCOL APPROVAL

Effective: July 22, 2022 Expiry: July 21, 2023

Principal Investigator: Regan Moore
Advisor: Kendra Nixon
Protocol Number: HE2022-0164
Protocol Title: *Women Healthcare Workers, Compassion Fatigue, and the COVID-19 Pandemic*

Jonathan Marotta, Chair, REB1

Research Ethics Board 1 has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans-* TCPS 2 (2018).

This approval is subject to the following conditions:

i. Approval is granted for the research and purposes described in the protocol only.

ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.

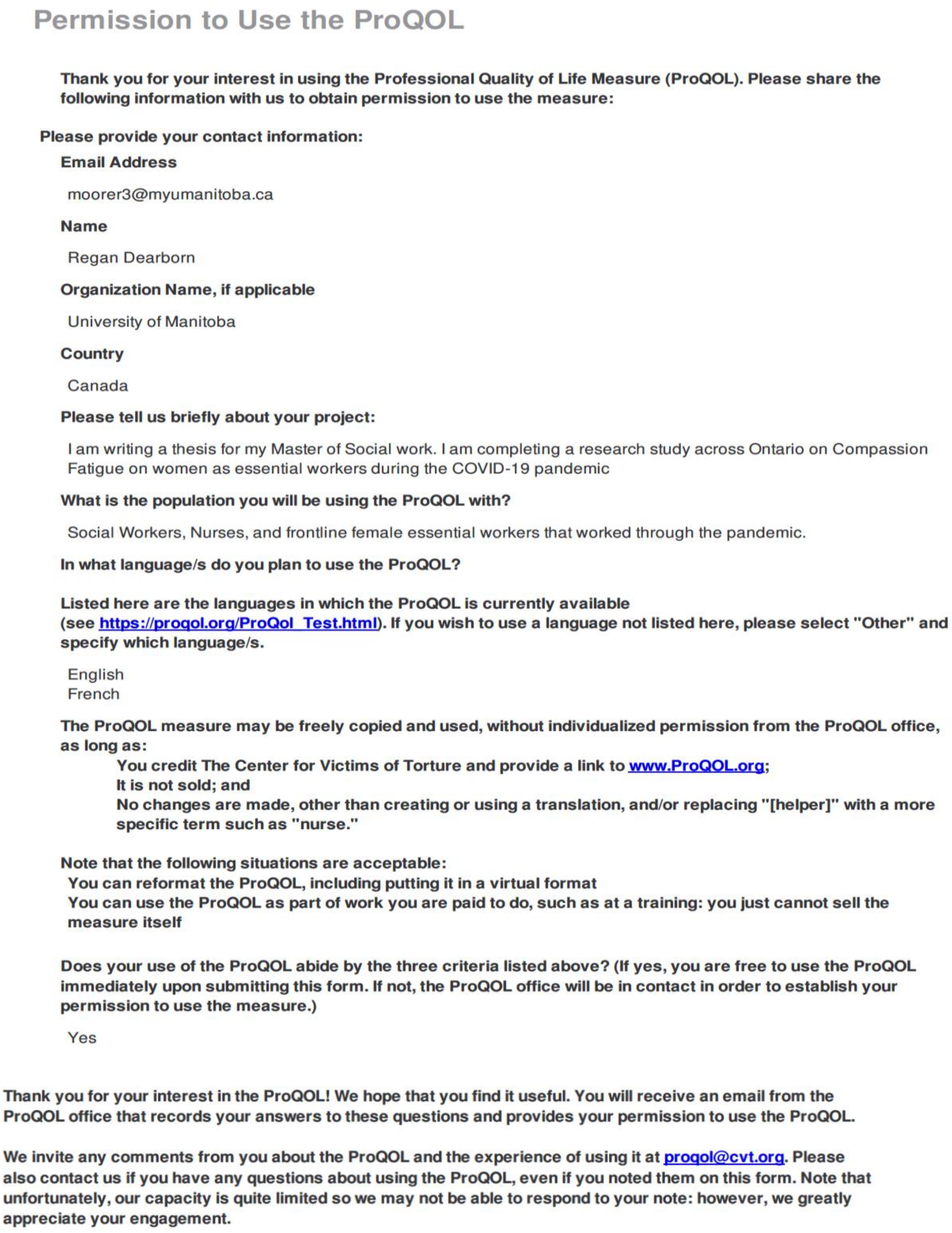
iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.

iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.

v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.

vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans*Ethics of Research Involving Humans policies and procedures.

Appendix L



Permission to Use the ProQOL

Thank you for your interest in using the Professional Quality of Life Measure (ProQOL). Please share the following information with us to obtain permission to use the measure:

Please provide your contact information:

Email Address

moorer3@myumanitoba.ca

Name

Regan Dearborn

Organization Name, if applicable

University of Manitoba

Country

Canada

Please tell us briefly about your project:

I am writing a thesis for my Master of Social work. I am completing a research study across Ontario on Compassion Fatigue on women as essential workers during the COVID-19 pandemic

What is the population you will be using the ProQOL with?

Social Workers, Nurses, and frontline female essential workers that worked through the pandemic.

In what language/s do you plan to use the ProQOL?

Listed here are the languages in which the ProQOL is currently available (see https://proqol.org/ProQol_Test.html). If you wish to use a language not listed here, please select "Other" and specify which language/s.

English
French

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

You credit The Center for Victims of Torture and provide a link to www.ProQOL.org;
It is not sold; and
No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."

Note that the following situations are acceptable:
You can reformat the ProQOL, including putting it in a virtual format
You can use the ProQOL as part of work you are paid to do, such as at a training: you just cannot sell the measure itself

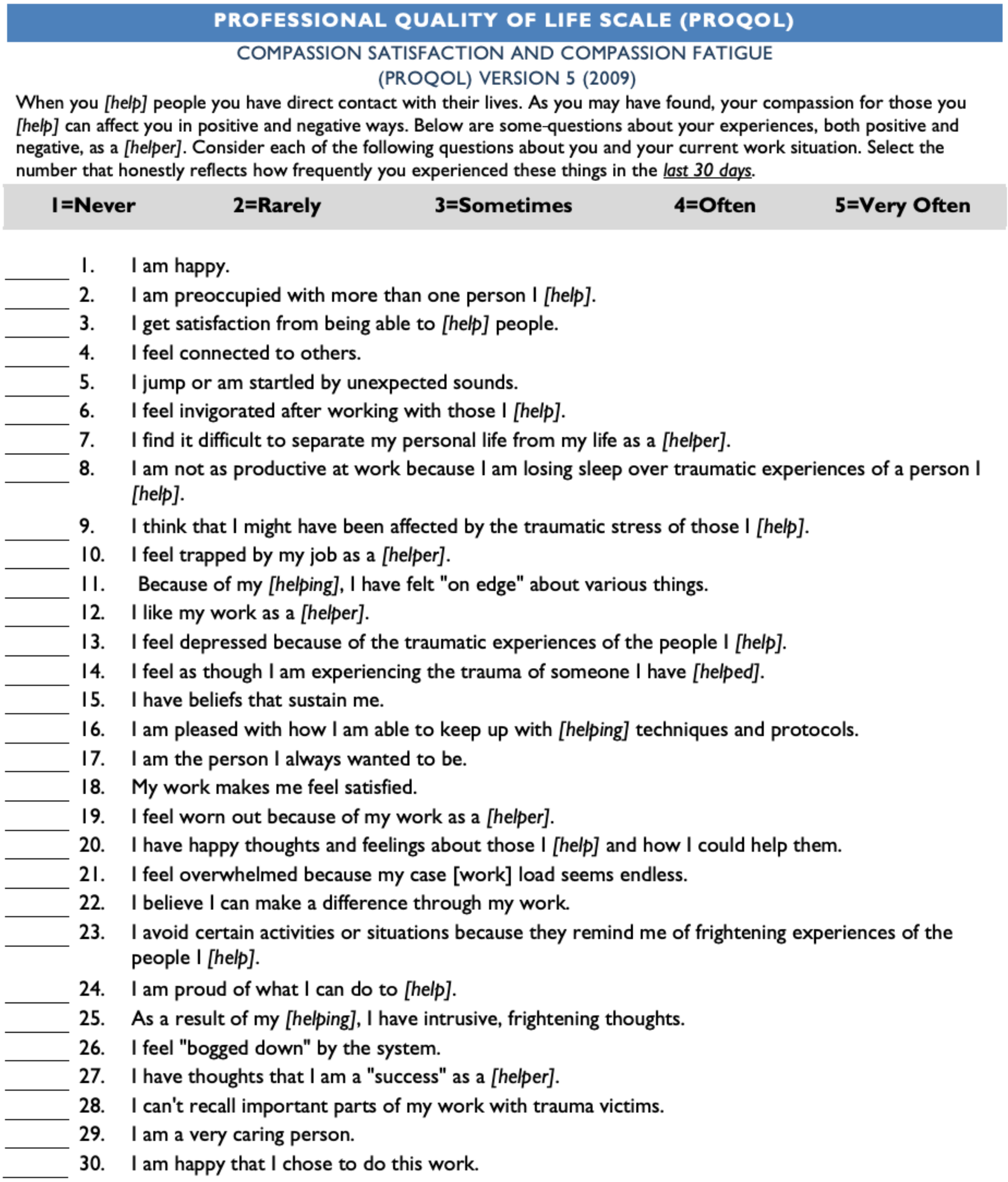
Does your use of the ProQOL abide by the three criteria listed above? (If yes, you are free to use the ProQOL immediately upon submitting this form. If not, the ProQOL office will be in contact in order to establish your permission to use the measure.)

Yes

Thank you for your interest in the ProQOL! We hope that you find it useful. You will receive an email from the ProQOL office that records your answers to these questions and provides your permission to use the ProQOL.

We invite any comments from you about the ProQOL and the experience of using it at proqol@cvt.org. Please also contact us if you have any questions about using the ProQOL, even if you noted them on this form. Note that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we greatly appreciate your engagement.

Appendix M



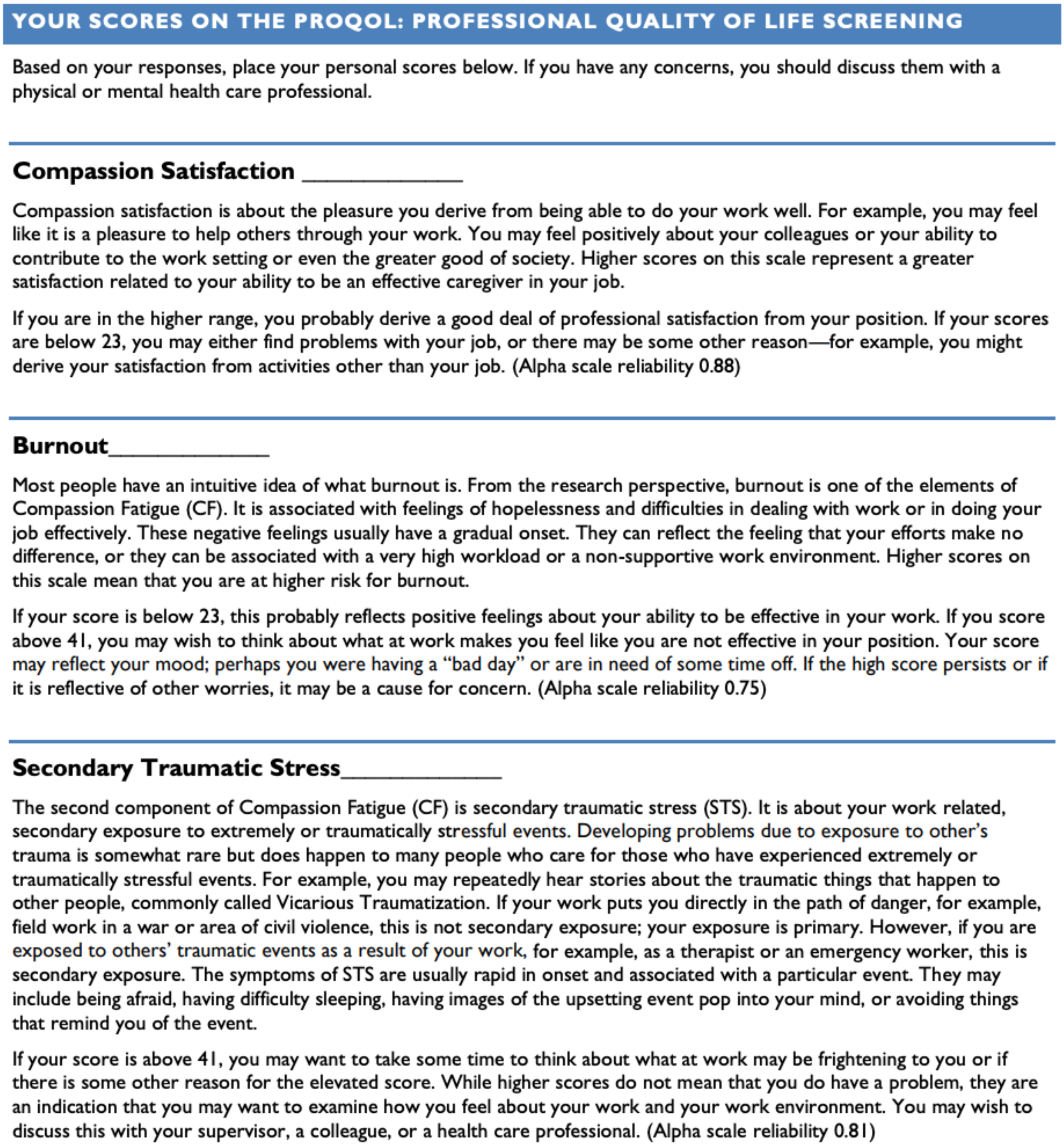
PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	**2=Rarely**	**3=Sometimes**	**4=Often**	**5=Very Often**

______ 1. I am happy.
______ 2. I am preoccupied with more than one person I *[help]*.
______ 3. I get satisfaction from being able to *[help]* people.
______ 4. I feel connected to others.
______ 5. I jump or am startled by unexpected sounds.
______ 6. I feel invigorated after working with those I *[help]*.
______ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
______ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
______ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
______ 10. I feel trapped by my job as a *[helper]*.
______ 11. Because of my *[helping]*, I have felt "on edge" about various things.
______ 12. I like my work as a *[helper]*.
______ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
______ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
______ 15. I have beliefs that sustain me.
______ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
______ 17. I am the person I always wanted to be.
______ 18. My work makes me feel satisfied.
______ 19. I feel worn out because of my work as a *[helper]*.
______ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
______ 21. I feel overwhelmed because my case [work] load seems endless.
______ 22. I believe I can make a difference through my work.
______ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
______ 24. I am proud of what I can do to *[help]*.
______ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
______ 26. I feel "bogged down" by the system.
______ 27. I have thoughts that I am a "success" as a *[helper]*.
______ 28. I can't recall important parts of my work with trauma victims.
______ 29. I am a very caring person.
______ 30. I am happy that I chose to do this work.



YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____________

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout_____________

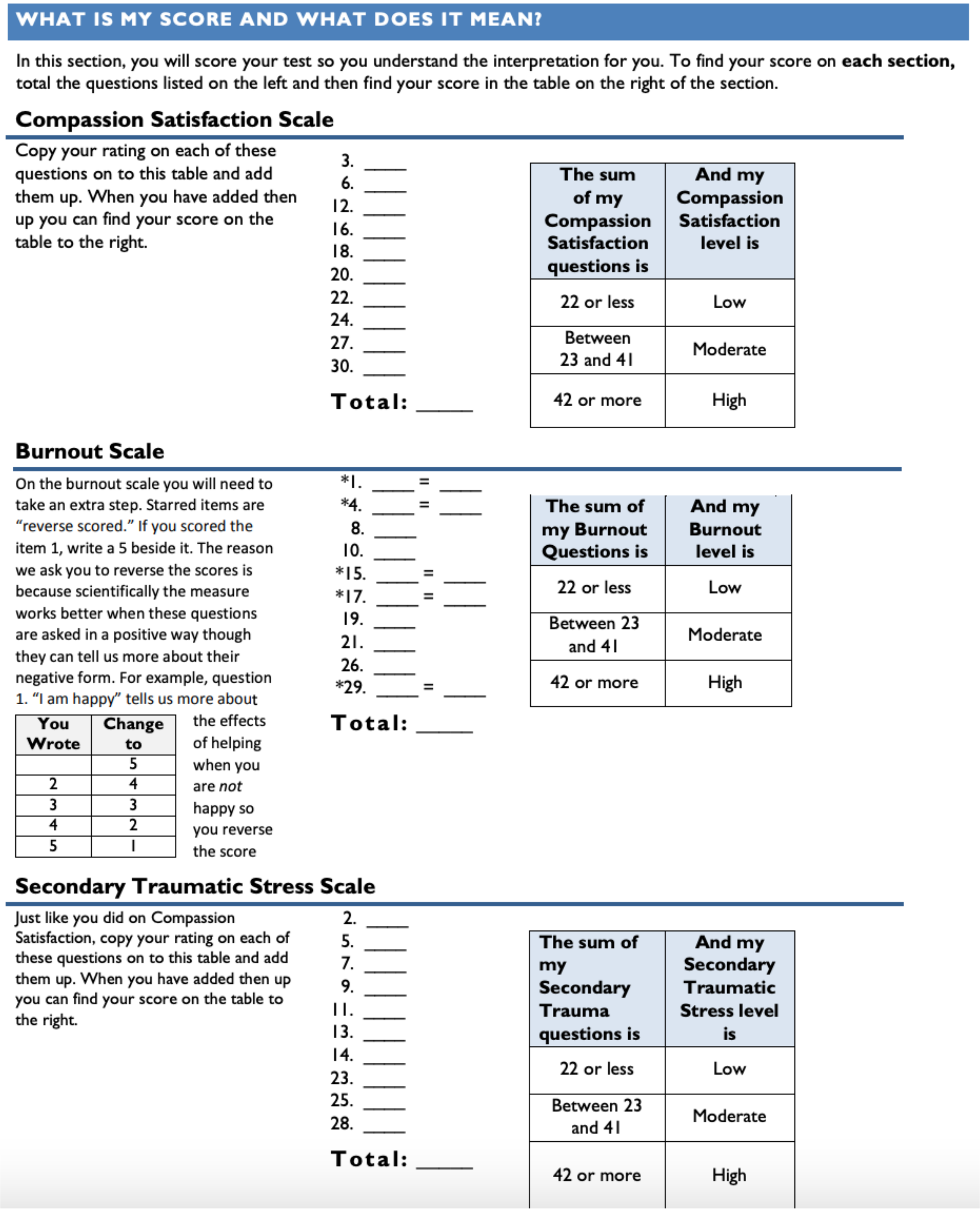
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress_____________

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)



WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are “reverse scored.” If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

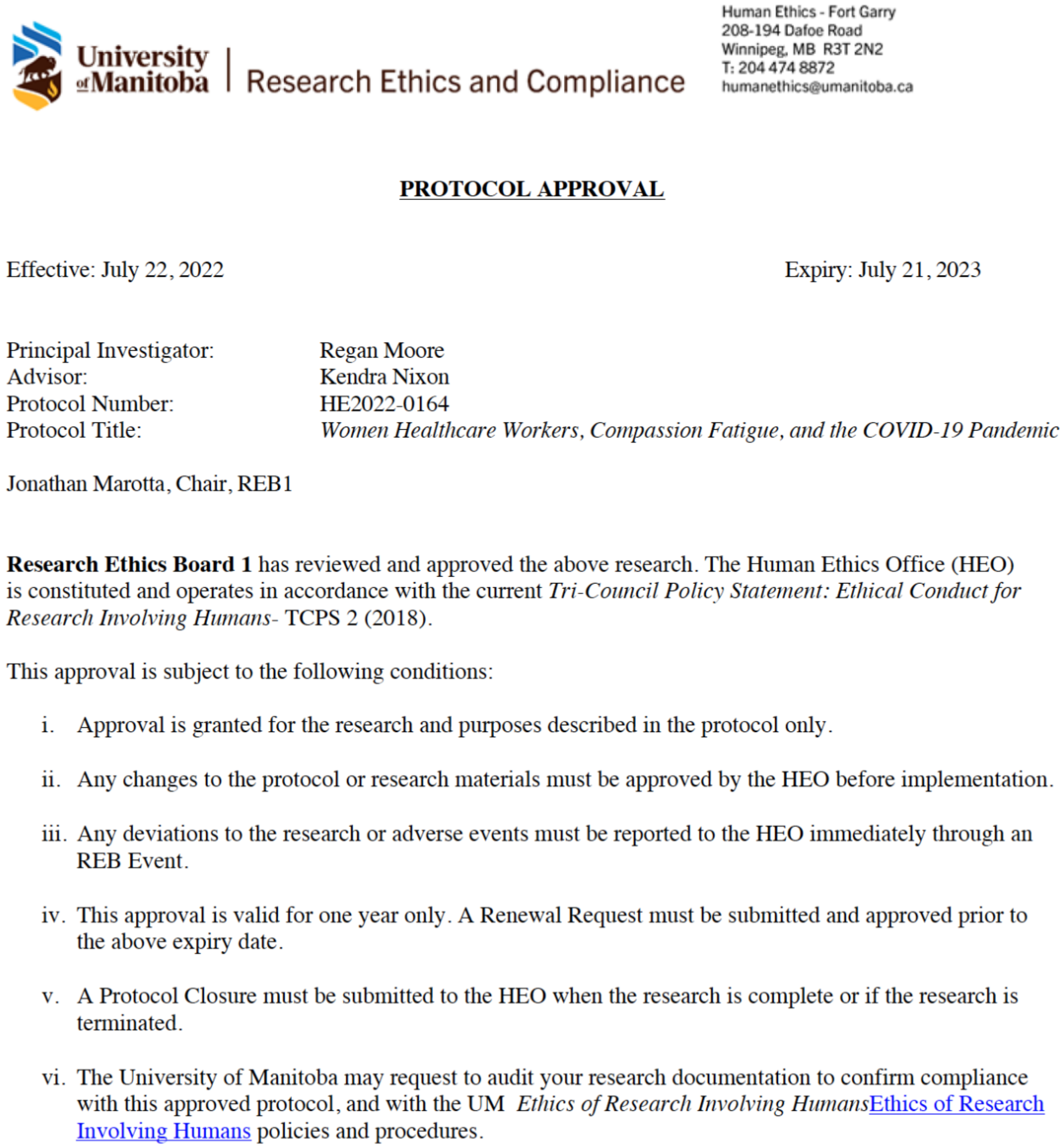
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Appendix N



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PROTOCOL APPROVAL

Effective: July 22, 2022 Expiry: July 21, 2023

Principal Investigator:	Regan Moore
Advisor:	Kendra Nixon
Protocol Number:	HE2022-0164
Protocol Title:	*Women Healthcare Workers, Compassion Fatigue, and the COVID-19 Pandemic*

Jonathan Marotta, Chair, REB1

Research Ethics Board 1 has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans-* TCPS 2 (2018).

This approval is subject to the following conditions:

i. Approval is granted for the research and purposes described in the protocol only.

ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.

iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.

iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.

v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.

vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans*Ethics of Research Involving Humans policies and procedures.