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Beyond Burnout: Nurses' Perspectives on Chronic Suffering During and After the COVID-19 Pandemic

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Abstract

Nurses around the globe have been impacted psychologically and emotionally during and after the COVID-19 pandemic. The purpose of this study was to describe nurses' perspectives on the concepts of compassion fatigue, second victimhood, burnout, and moral injury. Eight nurses were interviewed either individually or in groups of two. Data were analyzed using conventional content analysis. The following themes were identified: waves of compassion fatigue, traumatization within second victimhood, never the same after chronic burnout, moral injury: nurses couldn't do their best, and connections across concepts. Results showed nurses were most familiar with burnout and compassion fatigue, which remain chronic struggles. Second victimhood and moral injury were more distinct experiences related to traumatic or morally distressing events and likely contributed to experiencing burnout or compassion fatigue. Nurses' suffering heightened during the COVID-19 pandemic and remains prominent three years later. Future research and interventions are urgently needed globally to reduce workplace stressors and promote nurse well-being.

Keywords

nurses, well-being, burnout, compassion fatigue, moral injury, second victim, Southeastern USA

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Introduction

The nursing profession around the globe has been significantly affected psychologically and emotionally by the COVID-19 pandemic because of staff shortages, increased workloads, an increased risk of contracting COVID-19, moral and ethical patient dilemmas, and experiences of grief and loss, all while providing care to patients during and after the COVID-19 pandemic (Aiken et al., 2023; Moreno-Mulet et al., 2021; National Council of State Boards of Nursing [NCSBN], 2023). The nursing profession has been one of the most impacted groups of healthcare workers from the COVID-19 pandemic, experiencing significant psychological and emotional consequences due to their jobs (NCSBN, 2023; Mira et al., 2021; Moreno-Mulet et al., 2021). Registered nurses (RNs) provide more direct patient care than other healthcare professional groups and often work 12-hr shifts in understaffed or under-resourced settings (Institute of Medicine [IOM], 2011; Maunder et al., 2021).

Throughout the COVID-19 pandemic, many concepts have been utilized to describe the psychological and emotional experiences of nurses, including four concepts included in this study: compassion fatigue, second victimhood, burnout, and moral injury (also known as moral distress) (Mira et al., 2021; Moreno-Mulet et al., 2021). Compassion fatigue refers to the emotional and physical fatigue experienced by social service professionals using empathy when caring for patients (Newell & MacNeil, 2010). Second victimhood refers to individuals who provide patient care and are personally or professionally traumatized after challenging events (S. D. Scott, 2023). Burnout refers to chronic workplace stress that includes the following three dimensions: energy depletion or exhaustion, increased mental distance from their work, and reduced professional efficacy (World Health Organization [WHO], 2019). Moral injury refers to suffering that violates an individual's moral values or beliefs leading to reduced moral capacity and psychological distress

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(Rushton et al., 2022). Recent literature on nurses' experiences during the COVID-19 pandemic has focused predominately on burnout, characterized by three main components: emotional exhaustion, depersonalization, and reduced personal accomplishment (Bisesti et al., 2021). Published research has not adequately addressed other psychological and emotional concepts that are used to describe the COVID-19 pandemic's impact on nurses. There is limited literature that describes these concepts specifically from nurses' perspectives and experiences; this work aims to fill that gap. This study included the four aforementioned concepts due to their prominent utilization in the literature and their relationship to nurses' COVID-19 pandemic experiences. Mental health conditions, such as anxiety, depression, or post-traumatic stress disorder (PTSD), were not chosen as concepts as they may require a medical diagnosis. There is a critical need for a deeper knowledge of nurses' perspectives on psychological and emotional experiences related to the COVID-19 pandemic to inform how researchers, healthcare leaders, and organizations understand nurses' ongoing struggles to collectively work to improve nurses' well-being (Galehdar et al., 2020; Munn et al., 2021).

Without understanding and addressing the suffering nurses have experienced during and after the COVID-19 pandemic, there are long-term risks to the mental health of the entire nursing profession, as well as risks for patient safety and poor patient and healthcare system outcomes (Bodenheimer & Sinsky, 2014; Mira et al., 2021; Moreno-Mulet et al., 2021; Munn et al., 2021; Rassin et al., 2005; Schelbred & Nord, 2007). In the United States (U.S.), the trajectory of the nursing profession is at risk of losing up to 900,000 RNs, one-fifth of total RNs, by 2027 due to COVID-19 pandemic stress, burnout, or retirement (NCSBN, 2023). The Future of Nursing Report 2020-2030 (2021) emphasizes that research must focus on understanding the physical, emotional, and mental challenges the nursing profession has faced during and after the COVID-19 pandemic to aid in developing the most appropriate support programs and resources to ensure nurse health and well-being while reducing future staff turnover (National Academies of Sciences, Engineering, and Medicine, 2021). Importantly, the International Council of Nurses (2023) identifies nurse burnout and staffing shortages as a global emergency that deserves immediate attention internationally after the devastating effects from the COVID-19 pandemic (Buchan & Catton, 2023). This study aimed to describe nurses' perspectives on psychological and emotional concepts impacting the nursing profession during and after the COVID-19 pandemic and how they relate to these concepts.

Methods

Design

This study utilized a qualitative descriptive design and inductive approach to ensure rich and in-depth data were captured from participants regarding the phenomenon of interest (Sandelowski, 2000, 2010). The epistemological underpinnings guiding this qualitative descriptive approach included using an inductive process to develop knowledge regarding the phenomenon of interest and subjectivism that highlights the participants' individual perspectives and experiences as well as the researchers' perspectives conducting the analysis (Bradshaw et al., 2017).

Sample and Setting

Participants were eligible if they were registered nurses (RNs) and provided care to patients during the COVID-19 pandemic between March 2020 and September 2022. This timeframe is the estimated time when U.S. restrictions for the COVID-19 pandemic were implemented. Participants were eligible if they worked at one of two community hospitals part of an academic health system and level one trauma center in the southeastern United States. This study focused on RNs to understand the perspectives of nurses in direct care roles at the patients' bedside (American Association of Colleges of Nurses [AACN], 2023), thus advanced practice registered nurses were not eligible for the study.

Recruitment

A purposive sample of nurses were recruited for participation via a flyer in a digital nursing newsletter with the assistance of the fourth author (DA). All study recruitment materials and procedures were reviewed by the Duke Health Institutional Review Board (IRB, Pro00111167) and the study was determined to be exempt from ongoing IRB review.

Data Collection

Due to the COVID-19 pandemic and scheduling challenges, three small group interviews ($n=2$) and two individual interviews were conducted. Group interviews were selected to encourage participants' ability to discuss with one another and build upon each other's comments to elicit rich details about the problem or phenomenon (Marshall & Rossman, 2014). Interviews lasted approximately 60 to 90 min, were video and audio recorded, transcribed verbatim, and occurred virtually via a secure Zoom meeting. Participants provided verbal consent at the beginning of the interview after reviewing the consent form via email sent prior to the interview. Participants received a $40 Amazon gift card for remuneration.

The first author (MP) conducted the interviews and began with a brief description of the study's purpose, allowing time for questions, participant introductions, and guidelines for the interview. An interview guide (Appendix A) was created, reviewed, and revised by the first (MP) and last (AW) author before finalizing. The interview guide aimed to elicit a discussion of four psychological and emotional concepts of

Table 1. Concept Definitions.

Compassion fatigue	*"the overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering" (*Newell & MacNeil, 2010, *p. 61)*
Second victimhood	*"individuals working within an environment who are offering/providing care and are personally or professionally traumatized by exposure to a complex acute or chronic clinical case/event" (*S. Scott, 2022*)*
Burnout	*"a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed and characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism/cynicism related to one's job, and reduced professional efficacy" (*WHO, 2019, *para. 4)*
Moral Injury	*"[moral injury] refers to a type of moral suffering characterized by exposure to circumstances that violate one's moral values and beliefs in ways that erode integrity, moral capability, perception of basic goodness, and create distress on a psychological, behavioral, social, or spiritual level" (*Rushton et al., 2022, *p. 713)*

interest: compassion fatigue, second victimhood, burnout, and moral injury. These four, common and overlapping concepts, were chosen due to their prominent use in healthcare and current scholarly literature; the third author (SS) is an expert in second victimhood and especially helpful in defining that concept.

Participants were provided with a definition of each concept during the interview. The definitions are shown in Table 1 in the order they were presented to the participants. These definitions were chosen based on their comprehensiveness and detailed descriptions for participants to refer to share their perspectives. It is pertinent to highlight that the second victim definition presented to the participants was formulated by an individual renowned for their expertise in second victimhood research. This previous version was recently updated in 2023 to "*individuals working within an environment offering/providing care and are professionally/personally traumatized by exposure to a challenging clinical case/event*." (S. D. Scott, 2023, p. 272). Open-ended questions on participant experiences were asked regarding each concept to understand the impact of working with patients during the COVID-19 pandemic; all participants were asked the same questions. The first author (MP) asked follow-up questions and probing questions to follow participants' direction during the interview to elicit detailed information based on responses to questions. Field notes were captured during interviews to assist in contextualizing any verbal and nonverbal observations and were analyzed with the transcripts to enrich the study findings.

Data Analysis

Conventional content analysis was used to analyze the data (Hsieh & Shannon, 2005). The three phases of content analysis were conducted: (1) data preparation; (2) data organization; and (3) data reporting (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). In the first phase, the data were prepared by the first author (MP) (Elo & Kyngäs, 2008). The transcripts and field notes were reviewed and edited against the recording and read multiple times, line-by-line, to ensure coding captured all pertinent manifest content from interview findings (Elo & Kyngäs, 2008; Miles et al., 2020, p. 86). In the second phase, the data were organized by the first author (MP) to group data that was related to concepts of interest in the study (Elo & Kyngäs, 2008). An inductive coding approach was used, which led to the creation of descriptive codes that were connected to the participants' language and rich description (Hsieh & Shannon, 2005). Meaning units were words and sentences from the transcripts that were contextualized to create codes using the participants' own words and then codes were aggregated according to similarities to develop themes (Graneheim & Lundman, 2004). A codebook with code names, definitions, and quotation exemplars was created; the codebook was revised iteratively throughout analysis (Glesne, 2016, p. 198; Turner, 2014). NVivo 14 was used for coding the data and creating and managing the codebook (Lumivero, 2023). In addition to the first author (MP) reviewing all transcripts, 20% of each transcript were reviewed by two authors independently, each author reviewing 10% of each transcript. The two authors were the second (TO) and last (AW) author, with the second author (TO) having expertise in qualitative methods and data analysis and the last author (AW) having qualitative experience while working in a supervisory role throughout the study process. Data were organized into themes associated with each concept with an additional theme identified for concept connections. Preliminary findings were reviewed and final themes were agreed upon with consensus from all three authors reviewing authors (MP, TO, and AW, respectively). An audit trail was kept during the analysis process to track all analytical decisions made. In the third phase, data were reported in finalized and agreed upon themes to present the study's results (Elo & Kyngäs, 2008).

Trustworthiness

The authors acknowledged their personal and interpersonal reflexivity during the research process through conscious awareness, reflection, and appraisal of possible subjective influence when evaluating and analyzing data (Olmos-Vega et al., 2023). The authors have between several years to decades of qualitative, clinical, and nursing research experiences from various specialties; the authors all identify as female and ages range from 30s to 60s. None had personal

relationships with any of the participants. These potential author characteristics have been acknowledged during the data analysis process. Credibility, transferability, dependability, and confirmability were utilized to enhance rigor and trustworthiness during the conduct of the study. Credibility involves prioritizing internal validity while including thick description and member reflections (Tracy, 2010). To enhance credibility, multiple researchers provided peer examination on data analysis, findings, and conclusions to ensure member reflections were detailed and concrete. Transferability relates to how study findings can be applied to other situations or scenarios (Lincoln & Guba, 1985). To prioritize transferability, thorough descriptions and detail were offered regarding study methods for potential of application to other clinical settings and the nursing profession. Dependability prioritizes consistency of findings, examining both the process of conducting the research and product to ensure findings are supported by the data (Hoepfl, 1997). To enhance dependability, details of the research methods were carefully recorded and presented in this manuscript. Lastly, confirmability prioritizes the direct viewpoints of participants to ensure their voices directly shape the study findings (Lincoln & Guba, 1985). To prioritize confirmability, an audit trail was maintained to record the data analysis process and decision-making among the research team.

Results

Eight nurses were interviewed between November 2022 and April 2023. Nurses reported having between one and 20 years of nursing experience. At the time of the study, nurses reported working in the following specialty areas in their current roles: inpatient neurology/oncology/palliative care ($n=2$), inpatient general surgery ($n=1$), inpatient medical-surgical (n=1), intensive care unit (ICU) ($n=1$), COVID-19 progressive care ($n=1$), ambulatory surgery ($n=1$), and nursing education ($n=1$). One nurse left the inpatient float pool for ambulatory surgery, and a second nurse left ambulatory surgery for a nursing educator role between 2020 and 2023. The results of nurses' perspectives of each concept are presented below as themes in the order they were presented to the nurses: waves of compassion fatigue, traumatization within second victimhood, never the same after chronic burnout, and moral injury: nurses couldn't do their best. The fifth theme, concept connections, is described last. Within each theme, we discuss nurses' perceptions on: (1) personal connections with the concepts; (2) thoughts about the definition of the concepts; (3) beliefs about the names of the concepts; (4) consensus about the concepts; (5) familiarity with the concepts; and (6) resonance of the concepts.

Waves of Compassion Fatigue

In the theme, waves of compassion fatigue, several nurses related to the definition of compassion fatigue presented to them in Table 1, specifically the chronic need for empathy while caring for patients that can lead to emotional fatigue and physical fatigue. Nurses were familiar with the concept of compassion fatigue and thought the definition of compassion fatigue was sensible and self-explanatory. Nurses highlighted that their experiences with compassion fatigue fluctuated throughout the COVID-19 pandemic, which was perceived to correlate with waves of COVID-19 infections. For example, one nurse stated that "*compassion fatigue comes in waves*" and another explained it "*can be like a spectrum*." Nurses expressed being extremely emotionally fatigued from caring for patients without replenishment, so much so that they began feeling numb as they set their emotions aside and choose not to deal with them as a coping mechanism. The emotional burden of caring for COVID-19 patients led to weight loss and poor nutrition in one nurse. Compassion fatigue was an experience that nurses felt compiled or snowballed, particularly when experiencing grief and other emotions during end of life care throughout the COVID-19 pandemic. Nurses were exposed to increased rates of death and dying during the COVID-19 pandemic. One nurse explained that compassion fatigue became specifically challenging when witnessing patients struggle:

> *With this compassion fatigue I have suffered with it a lot. Especially with the COVID patients seeing them struggling for their lives, difficulty breathing, especially with family members in the room it makes the situation a little bit worse – RN 02*

A nurse discussed that although physically exhausted, compassion for patients increased during the COVID-19 pandemic after watching patients endure the unknown while navigating illness from COVID-19 infection. Another nurse felt that the "compassion fatigue" concept implied a negative connotation, as if the nurse did not have any compassion left for patients. In contrast, another nurse believed compassion was sustained for patients during the COVID-19 pandemic. From these various perspectives, there was no consensus among nurses regarding how nurses related to the definition of compassion fatigue.

Traumatization Within Second Victimhood

In the theme, traumatization within second victimhood, some nurses were familiar with the second victimhood concept definition after experiencing traumatization from acute and chronic clinical events. They discussed feelings of fear, guilt, and worry related to the unknown and how these emotional responses were an indication of being personally traumatized as a second victim. The word "traumatized" stood out most to nurses due to the extent and magnitude of the COVID-19 pandemic on the entire nursing profession. The second victimhood concept was new to several nurses. It required explanation, such as historical context regarding second victims who either were part of a medical error or traumatic

patient event (Wu, 2000). However, two nurses did not see themselves as victims, with one not understanding how the patient is a victim when nurses are doing their best to provide care. Despite the description and lack of personal connection to the concept, one nurse described understanding for other nurses who may relate to second victimhood:

> *Victimhood is complex. . . I don't think I've ever really thought of myself or I thought [of] nurses as a victim. I never kinda pull those layers. . . I'm sure there are some folks because there is some really interesting cases out there, but I don't think I can relate to the victimhood. – RN 05*

Of the nurses that did relate to second victimhood, they also discussed its possible relationship to Post-Traumatic Stress Disorder (PTSD), with one nurse disclosing having been diagnosed with and currently being treated for PTSD. This nurse (RN 03) in particular, related to second victimhood the most of all concepts and stated, "*I still get a little bit of anxiety when I hear the word 'COVID' on the news or just out in public*" and "*If someone says the word vaccine I get, I immediately get tense*." Furthermore, a second nurse described feeling like a second victim from interacting with a nurse after having coded her husband in the ICU:

> *I still have to see the nurse that I know that I coded her husband. . . For the longest time after, like he passed, when she would see me, she would just like literally go the other direction. And I'm going to go the other direction. So I think that's a hard thing, because he was young. We're all basically the same age. – RN 08*

In addition to nurses as second victims, several nurses thought that second victimhood could be extended to their family and friends during and after the COVID-19 pandemic. For example, family members were impacted by watching the nurse be increasingly more exhausted and fragile, while taking additional precautions to avoid infection risk. Lastly, nurses felt troubled by feeling obligated to endure the stress of caring for patients during the COVID-19 pandemic, leading to distress and career changes:

> *Do I still feel like a second victim sometimes? Yes, because COVID has caused our nursing career to completely change. I chose to be a nurse. I chose the field I wanted. I didn't choose what has happened since COVID. So um that to me still gives me the idea that I am a victim and my career has completely changed because of COVID. - RN 01*

Never the Same After Chronic Burnout

In the theme, never the same after chronic burnout, most of the nurses in this sample were familiar with the concept of burnout, as well as the following indicators from the burnout definition: the chronic workplace stress, energy depletion or exhaustion, increased mental distance from one's job, cynicism, and negativism. Burnout was the most well-known concept among all nurses, and many nurses felt that burnout is just "*part of nursing*" and that it will be experienced by all nurses at some point in their career. Of all four concepts, burnout is the only concept that all nurses resonate with to some extent. The reduced professional efficacy component of burnout was understood the least by nurses, as nurses related this component to "professionalism," which nurses believed they maintained despite the stress of the COVID-19 pandemic that led to challenges with completing nursing tasks with confidence.

Emotional stories shared by nurses related to burnout were mostly connected to physical and mental exhaustion. Many nurses described reaching a "*breaking point*" where they either decided, in an effort to reduce their burnout, they must work fewer hours, spend less time in patient rooms, mentally or emotionally check out, or switch nursing roles. Specifically, two nurses did switch roles during the COVID-19 pandemic. Nurses recognized that challenges with staffing, including short staffing and high nurse-patient ratios contributed to nurses' burnout and led to patient safety risks that changed the quality of care provided to patients.

Several nurses felt strongly that burnout must be prevented before it occurs and that nurses may never be the same after experiencing burnout. One nurse said this simply, "*burnout is the end result*" after enduring hardships at work. Nurses described burnout as something that is chronic and "*increases over time*." Even though nurses were interviewed from late 2022 to early 2023, burnout still resonated the most out of all the concepts with nurses interviewed, which aligns with the chronic nature of burnout described by nurses. Nurses expressed that large-scale change across the profession is necessary to effectively mitigate burnout, as it has continued to increase throughout the COVID-19 pandemic and beyond. Although burnout was frequently reported and quickly related to by nurses, their responses were often direct and confident in connection to the concept.

Moral Injury: Nurses Couldn't Do Their Best

In the theme, moral injury: nurses couldn't do their best, several nurses related to the moral injury definition presented to, suggesting their experiences included events that violated their moral and ethical values in ways that led to distress and diminished their capacity to provide care to patients. However, this concept was new to other nurses, required additional explanation, and was not easily grasped. For example, one nurse initially felt this definition meant that a nurse had pushed their religious or moral beliefs onto a patient when they should not have. Limited discussion regarding integrity and social and spiritual levels were discussed with the concept. However, one nurse was unaware of moral injury before participating in this study but resonated with this concept the most after talking through the definition; this nurse described several former experiences with

moral injury, having been given language to describe prior violations of her moral and ethical values.

Nurses felt they could not provide the care they desired based on their values and beliefs due to workload and time limitations. For example, nurses were consumed by donning and doffing additional PPE during the COVID-19 pandemic leading to less time providing care to their patients. Additionally, one nurse reflected on patients' wishes not always being followed thoroughly. The initial wave of the COVID-19 pandemic led to an increased need for ICU treatment for cases of severe infection, but patient and family preferences for specific lifesaving treatments were not always prioritized when there was a sense of urgency to initiate intensive care, leading to moral injury for the nurse. Concerns regarding COVID-19 infection prevention, constantly evolving organizational policies and practices, and public health were also tied closely with nurses' moral injury. Prior to the COVID-19 pandemic, nurses were used to strict policies and procedures related to infection prevention and PPE use, however, this changed during the pandemic and led to moral injury:

> *Well, the first thing I think about is when we had to reuse like N95s, and like PPE. And I remember. . . they're saying, you know, we have to reuse this for like a week, and you know, when you're working as a nurse for so many years, and you are taught sterile technique. . . you would never reuse like a dirty anything. And then here we are reusing an N95 for 5 days and then we get a new one. So when I think of moral injury, that's what comes to my mind. – RN 05*

Concept Connections

Nurses discussed each concept individually but concepts were often discussed together as nurses described their experiences and how the nursing profession has been impacted during and after the COVID-19 pandemic. The most well-known and commonly experienced concepts were burnout and compassion fatigue. Mental and physical exhaustion were at the forefront of nurses' experiences and related to increased workloads and staffing challenges. Although compassion fatigue was the first concept discussed, burnout was quickly integrated into the nurses' language when describing their emotional and physical fatigue experienced from burnout:

> *The emotional part just gets pushed to the back, and it becomes just more physically, just like just trying to get the work done and get everything going. So, then you get fatigued, and then kind of burnt out. – RN 03*

While discussing burnout, a few nurses discussed that their burnout led to reduced compassion for patients but that both concepts went hand-in-hand. This revelation was related to nurses' exhaustion and staffing challenges, and presents the chronic nature of experiencing both burnout and compassion fatigue overtime:

> *. . . we've been very short staffed and the hospital has put out all kinds of incentives for people to work extra shifts. . . and I found myself working more and more because it was great to make the money. But then again, you just get tired and frustrated and you go into work, and you realize that you're not happy to be there, and you're exhausted, and you don't feel very much compassion. You're just doing your job, and you're not being the best nurse that you could be. . . At some point, I just stopped signing up for extra shifts. RN - 07*

Furthermore, second victimhood was discussed prior to burnout, but the connection between the two co-occurring concepts was evident, as a nurse (RN 02) shared: "*the* second *victimhood is really real. It's not only [from] the COVID patients. We have people with different diagnoses. So, taking care of all the patients has been stressful and the burnout is real*." Considering moral injury (also known as moral distress) another nurse (RN 06) found that "*moral distress was causing me to have compassion fatigue and burnout,"* highlighting the chronic nature of both burnout and compassion fatigue after experiencing morally distressing events.

As nurses reflected on all four concepts, several nurses expressed that these concepts may occasionally be discussed in the clinical setting, most commonly burnout, but the concepts are often used differently and may not be fully understood by nurses. Nurses stated that these concepts should be discussed more, as several nurses were unaware of one or more of the concepts, with two nurses identifying most with a previously unaware concept. This realization was unsettling to one nurse (RN 03) who stated, *"You know I don't think that's a coincidence, because if we knew about it, we would have done what we can to take care of it."* With nurses asserting that burnout is chronic and challenging to recover from, most nurses agreed that drastic change is needed to improve working conditions and provide more support resources to promote the well-being of nurses.

Discussion

This study aimed to describe nurses' perspectives on four psychological and emotional concepts, including compassion fatigue, second victim, burnout, and moral injury, and how these nurses relate their experiences during and after the COVID-19 pandemic and its impact to these concepts. Nurses provided in depth insight into their personal connections with the concepts, thoughts about each definition, beliefs about the names of the concepts, consensus about the concepts, familiarity with the concepts; and resonance with the concepts. Overall, the most relatable concept from nurses' perspectives was burnout. Due to this study being conducted up to three3 years after the start of the COVID-19 pandemic, the chronic and ongoing nature of burnout was evident and

significant. In our study, nurse burnout was often discussed in connection to experiences related to lack of staffing, increased workloads, and risks to patient safety, which have been noted as worsening global challenges in healthcare after the COVID-19 pandemic (Grant et al., 2023). The ongoing struggles that nurses are enduring with burnout cannot be underscored enough.

Compassion fatigue was found to be conceptually related to burnout based on nurses' perspectives, and this connection was likely related to emotional and physical fatigue. Nurses discussed fluctuations or waves in compassion fatigue during the COVID-19 pandemic, and burnout tended to increase over time. Both burnout and compassion fatigue have been shown to have chronic features in the literature (Foli, 2022), and this was mirrored among nurses in our sample. Additionally, nurses who work in specialty areas, such as ICU or oncology, may be more prone to ongoing stressors, like burnout (Bakker et al., 2005; Ekedahl & Wengström, 2007), which aligns with several nurses' experiences with continued burnout who work in the aforementioned specialty areas. In addition, two nurses in the present study who switched roles during and after the COVID-19 pandemic did so due to enduring chronic burnout.

Second victimhood and moral injury were more distinct experiences and related to particular cases, events, or experiences while practicing that later seemed to lead to chronic psychological and emotional manifestations like burnout and compassion fatigue. For example, several nurses recollected emotional memories of patients who suffered or couldn't be saved, and these memories left lasting impressions on nurses years later when reflecting on the COVID-19 pandemic. Second victimhood was often related to the discussion of traumatic events and memories and moral injury was usually associated with discussions of morally or ethically distressing events; both concepts elicited longer, detailed storytelling from nurses to describe such distinct experiences. However, some experiences and stories shared by nurses included events that were both traumatic (representative of second victimhood) and morally or ethically distressing (representative of moral injury), suggesting that these concepts may be interwoven. Due to nurses' experiences with traumatic and morally or ethically distressing events, similar to second victimhood and moral injury, it can be suggested that compassion fatigue and burnout develop chronically after such cumulative experiences. Recent studies of hospitalists found that both second victimhood experiences and moral injury may be predictors of burnout during the COVID-19 pandemic (Chandrabhatla et al., 2022). If nurses related to these concepts, each may be experienced sequentially, as a recent concept delineation found that morally injury events may lead to second victimhood, which may then be followed by burnout or compassion fatigue as a possible manifestation of chronic suffering (Powell et al., 2024); this assertion aligns with nurses' perspectives in this study regarding burnout being the ending point after experiencing a compilation of traumatic events.

An important contribution to the literature from this present study involves the individual connection each nurse felt to the concepts they related to, particularly with distinct experiences with second victimhood or moral injury. Nurses either felt they strongly associated with second victimhood or moral injury or did not, likely highlighting the personal identity related to these specific terms. For example, two nurses specifically did not relate to being considered a second victim. The second victimhood concept assigns a hierarchy and ranking to each victim, with the patient being the first victim and the nurse as the second victim; the rank order and use of the word "victim" may be challenging for some nurses to relate to or want to identify with (Dekker, 2013, p. 13). However, it is important to recognize that several nurses in this study felt that they were indeed traumatized and that they were a victim. Nurses' connection to the concept showed how personal and individualized a nurse's relationship is with their psychological and emotional experiences. Nurses in this study who related to these concepts suggested they would have taken action if they had understood sooner; their actions could lead to behaviors that act as protective factors, like resiliency (Lluch et al., 2022). Lastly, nurses who did not identify with a specific concept were still found to have a broad understanding of how another nurse could experience such a concept, showing empathy and compassion for their colleagues.

Although the present study focused on these four concepts, numerous other concepts and mental health conditions must be considered. Additional concepts discussed in the literature include workplace stress, secondary traumatic stress, and vicarious trauma (Newell & MacNeil, 2010; Sabo, 2011). Researchers have identified some concepts as synonymous, while others have found directional connections between various concepts. Figley (1995) first identified compassion fatigue as a type of burnout or a kind of "secondary victimization." Other literature suggests that secondary traumatic stress is closely related to compassion fatigue and burnout with no specific delineations between the three concepts noted (Malliarou et al., 2021). In addition to these numerous concepts, mental health conditions are often prevalent in nurses who have experienced distress during and after the COVID-19 pandemic, including anxiety, depression, and PTSD (Draze, 2022). The overall connections among and timing of experiences defined by these concepts and mental health conditions remain largely unknown and have not been studied in large samples of nurses. These concepts and conditions co-exist, overlap, and fluctuate in individual nurses identifying with them. Each concept or condition likely does not exist in isolation, and the overlap in concepts may also be due to the use of specific concepts by nurses because of how they as an individual relate the term and definition to their experience. Although workplace stress, or job stress, has largely been discussed as a broad

concept that includes burnout and depression (Centers for Disease Control [CDC], 2007), the catastrophic mental health effects on nurses during and after COVID-19 pandemic suggests the impact may be greater than the term or symptom of "stress" suggests. Recent literature aiming to delineate concepts, such as compassion fatigue versus burnout, recommended that these concepts are part of a larger experience named "occupational trauma" which points out distinct trauma occurring from one's occupation (Powell et al., 2024). The ongoing psychological consequences for nurses in the aftermath of the COVID-19 pandemic led to the creation of the Middle Range Theory of Nurses' Psychological Trauma, which is one of the first visual representations of the various traumas nurses may experience (Foli, 2022). Future research of nurses' experiences has the potential to expand upon this theory and knowledge of the broad scope of nurses' trauma. Understanding the full scope of nurses' trauma may provide healthcare organizations and leaders the detailed information needed to provide adequate support resources that can address specific concepts nurses may be challenged by.

A strength of this study is its contribution to the literature through qualitative data collection centered on nurses' perspectives related to psychological and emotional concepts during and after the COVID-19 pandemic. Findings from this study may guide future research focused on additional psychological and emotional concepts, such as including interview questions aimed at understanding the participants' perceptions, beliefs, familiarity, and resonance with a particular concept. Discussion of these concepts and detailed reflections may allow nurses to reflect on and process their experiences. Furthermore, the chronic nature of continued nurse suffering is at the forefront of this study's findings and pertinent to the future well-being of the nursing profession. Although the study sample was small, a sufficient range of perceptions were captured for each concept leading to meaningful insights (Thorne, 2020). The few concepts chosen for discussion may have not accurately captured all potential experiences of nurses across varying practice specialties and settings, and the discussion of specific concepts may have led to nurses' aligning their experiences to fit a concept. Lastly, considering the interview timepoint of late 2022 and early 2023, there is potential for recall bias as nurses reflected on events that occurred up to three3 years previously at the beginning of the COVID-19 pandemic.

Findings from this study suggest that some nurses may be experiencing chronic psychological and emotional consequences due to their occupation and changes to support the nursing profession are needed. Our findings showed that nurses' suffering is felt prominently at the individual level, even though events that trigger suffering come from both organizational and individual factors; these findings suggest that solutions focused on nurse well-being after the COVID-19 pandemic must target both individual and organization level issues. Individually, nurses have historically desired and needed support at the individual level and support from trusted peers to cope with traumatic events and experiences at work may be a beneficial solution (Burlison et al., 2017). The Future of Nursing Report 2020-2030 (2021) asserts that organizations and healthcare leaders must initiate support programs and resources to promote and sustain the nursing profession after the COVID-19 pandemic (National Academies of Sciences, Engineering, and Medicine, 2021). Recent literature from Aiken et al. (2023) emphasizes that nurses' struggle since the COVID-19 pandemic is closely related to organizational factors, including insufficient nurse staffing, increased workload, and poor work environments impacting patient safety. The American Nurses Association (ANA) asserts that mandated nurse to patient ratios via new legislation and regulation are appropriate solutions alongside the inclusion of direct care nurses on staffing communities to provide their experience and advocacy when staffing decisions are made (ANA, 2022). Globally, the International Council of Nurses (2023) has reported that up to 80% of nurses are experiencing psychological distress after the COVID-19 pandemic, but resiliency training cannot be the sole focus for recovering healthcare systems globally; governments and healthcare organizations must take immediate action to implement solutions and policy change that support and empower nurses to be effective in their roles to rebuild the health of global nations (Buchan & Catton, 2023). Considering recent literature, there is a need for a multi-pronged approach to support nurse well-being at the individual level and within the organizations where nurses work.

In conclusion, findings from this study suggest that nurses can experience traumatic events that are long lasting and require intervention strategies tailored to the organizational and individual level. Furthermore, staffing challenges, increased workloads, and poor work environments described by nurses in this study must be addressed as these issues impact nurse retention during and after the COVID-19 pandemic. Organizations and healthcare leaders must prioritize the development and testing of sustainable solutions that address both organizational and individual factors to support the nursing profession's needs. Urgent efforts from organizations and healthcare leaders around the globe are critical to stabilize and reduce the chronic suffering nurses continue to endure after the COVID-19 pandemic.

Appendix A

Interview Guide

Background:

- For us to get to know each other, could you each please tell me a little about your nursing background and role in the health system.
- In the interest of time, I am going to start with more specific questions related to your experiences during

the pandemic caring for patients. What has your overall experience been caring for patients with COVID-19 in the last two2 years?
- How has your experience changed over the last two2 years with patients with COVID-19?

Compassion Fatigue:

Definition—the overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering

- What do you relate to in this definition while caring for COVID-19 patients in the last 2 years?
- What are your thoughts or feelings about the concept name?
- What experiences during the COVID-19 pandemic and with COVID-19 patients has led you to relate to this concept?

Second Victimhood:

Definition—individuals working within an environment who are offering/providing care and are personally or professionally traumatized by exposure to a complex acute or chronic clinical case/event

- What do you relate to in this definition while caring for COVID-19 patients in the last 2 years?
- What are your thoughts or feelings about the concept name?
- What experiences during the COVID-19 pandemic and with COVID-19 patients has led you to relate to this concept?

Burnout:

Definition—a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed and characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism/cynicism related to one's job, and reduced professional efficacy

- What do you relate to in this definition while caring for COVID-19 patients in the last 2 years?
- What are your thoughts or feelings about the concept name?
- What experiences during the COVID-19 pandemic and with COVID-19 patients has led you to relate to this concept?

Moral Injury/Moral Distress:

Definition—MI refers to a type of moral suffering characterized by exposure to circumstances that violate one's moral values and beliefs in ways that erode integrity, moral capability, perception of basic goodness, and create distress on a psychological, behavioral, social, or spiritual level

- What do you relate to in this definition while caring for COVID-19 patients in the last 2 years?
- What are your thoughts or feelings about the concept name?
- What experiences during the COVID-19 pandemic and with COVID-19 patients has led you to relate to this concept?

Conclusion:

- Of these concepts, which one resonates with you the most?
- Do you think these concepts are well understood and utilized?
- What benefits do you see in the clinical setting from understanding these concepts experienced by nurses?
- How have your experiences with COVID-19 patients and during the COVID-19 pandemic changed the way you will practice or your outlook as a practicing nurse in the future?
- Are there any additional experiences you have had that we haven't covered?

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