THE LIVED EXPERIENCE OF SELF-COMPASSION AMONG

REGISTERED NURSES IN THE WORKPLACE

by

Caiocimara Braga McPhee

Dissertation Committee:

Professor Keville Frederickson, Sponsor
Professor Megan Laverty

Approved by the Committee on the Degree of Doctor of Education

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ABSTRACT

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Caiocimara Braga McPhee

The literature is replete with studies and information about registered nurse burnout, compassion fatigue, and turnover rates. Registered nurses enhance and bring benefits to the health care system, but stressful health care environments may contribute to their self-neglect and may adversely affect their decision to remain working at the bedside. Retention of registered nurses is necessary for the delivery of patient care. An investigation of self-compassion among registered nurses in the clinical workplace may help to understand how registered nurses deal with the pressures of the health care setting. In addition, there is a need for research to clarify what self-compassion looks like among nurses and how it may foster caring for themselves, nurse retention, and the delivery of quality patient care.

This qualitative study used a phenomenological method designed to illuminate registered nurses' experiences of self-compassion in clinical practice. Also, findings from this study will contribute to the body of knowledge of self-compassion in the context of

registered nurses. Van Manen's phenomenological research method of the six activities were used to guide the study. Nine registered nurses were interviewed about their experiences of being kind and compassionate toward oneself in the clinical work setting. Transcripts of the study participants' interviews were analyzed and four essential themes emerged that shed light on these nurses' experiences of self-compassion: (1) Transforming Time Famine; (2) Authentic Communication and Presence, (3) Collegial Cohesion, and (4) Evolution Toward an Ideal Registered Nurse. Most of the participants in this study shared stressful situations in the clinical workplace along with encouraging learning points through their stories of being kind to themselves in the workplace while caring for others.

DEDICATION

I dedicate this study to the profession of nursing. To all past, present—particularly the nurses who participated in this study—and future nurses, this work is dedicated to you. This study would not have been possible without the participants' stories of being kind to themselves at work while caring for others. I am deeply humbled by their heartfelt stories and by our profession and its mission to care for others. I pray this research stimulates all nurses, everywhere, to become mindful of compassion and kindness for oneself, and that this can also serve as a source of compassion toward others.

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INTRODUCTION

If your compassion does not include yourself, it is incomplete.
                                                    -Jack Kornfield, 1994, p. 28

Sheila is a registered nurse working as a geriatric visiting nurse. She is

experienced in her field, possessing three years of clinical work experience, and a model

of compassion. When making home visits to her elderly patients, she will bring them

treats, such as cookies or flowers, which she believes makes them feel cared for and

special. Laughter therapy is something Sheila uses to help elevate her patients' mood.

For instance, she might make the following joke, "I found my car in the parking lot,

which makes me feel like I won the lottery!" In addition, she is very attentive to situations

that may be embarrassing for patients, for example, when changing their soiled adult

undergarments. Stating something along the lines of "No need to be upset about this

because it happens to everyone, at some point," Sheila facilitates a feeling of common

humanity that may ease patients' discomfort.

Sheila is concerned about alleviating her patients' suffering and understands that

all human beings experience feelings of fear, shame, and distress. However, if Sheila is

late for a patient appointment or forgets to do something on her work checklist, she

chides herself with self-criticism. Her self-talk may include the following words: "You

are losing it!" "You call yourself a nurse!" "You let your patients down…they depend on you. "You are a pathetic nurse and shouldn't be taking care of others." or "You ought to be ashamed of yourself!" Sheila, on the other hand, would never talk to her patients this way. Although she is kind and understanding towards the patients she cares for, she is unkind to herself.

The above exemplar was adopted from Kristin Neff's (2015, p. 188) book, *Self-compassion: The Proven Power of Being Kind to Yourself.* It illustrates a nurse at work who demonstrated compassion toward patients but was non-compassionate with herself. This is not the only possible internal dialogue and behavior this nurse could have. Conversely, self-compassion for nurse Sheila after a challenging workday may look something like this:

> *Today was a stressful day at work. I plowed through it, hardly ate my lunch, and was late for every patient appointment. I'm exhausted, hungry, and need a shower. I did my best to provide compassionate care for my patients, but neglected my own needs throughout the workday. If I keep this up, I may end up experiencing burnout. Now, it's time to care for myself. I'll eat dinner, then go for a walk, and shower before retiring to bed early. Getting a good night's sleep will help to recharge my battery for another day at work. Tomorrow, I'll practice putting on my own oxygen mask before I help my patients put on theirs.*

The latter example above perhaps idealizes what may happen for a nurse upon reflection of a challenging workday. There is insufficient information in the literature to comprehend what self-compassion looks like among registered nurses (RNs) in the work setting. The scripted version offered possibly belies the complexity of the practice of self-compassion among RNs.

The purpose of this research was to understand self-compassion through the lived experience of RNs in the workplace while caring for others. Nurses around the globe

concern themselves with providing compassionate patient care, and patients and their families *expect* to receive compassionate care from their nurses (Hofmeyer et al., 2016).

Registered nurses work in stressful health care environments and are responsible for taking care of patients in fragile health. An understanding of how RNs offer kindness and understanding to themselves while caring for others in their daily work life may possibly shed light on how they deliver quality patient care in stressful workplaces and the value attributed to the outcomes their care generates, and the retention of nurses in health care work settings.

Given the complexity of RNs giving care and offering compassion to others, His Holiness the Dalai Lama (2003), a noted scholar and practitioner of compassion, stated the following:

> For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one's own feelings and to care for one's own welfare…. Caring for others requires caring for oneself. (p. 125)

Thus, if compassion for others should begin with compassion for one's self, self-compassion is worthy of investigation among RNs in practice. In turn, research on self-compassion in the literature suggests that nurses' compassion for self and their patients is synergistic (Beaumont, Durkin, Hollins Martin, & Carson, 2016; Duarte, Pinto-Gouveia, & Cruz, 2016; Heffernan, Quinn Griffin, McNulty, & Fitzpatrick, 2010; Mills & Chapman, 2016; Mills, Wand, & Fraser, 2015; Raab, 2014; Şenyuva, Kaya, Işik, & Bodur, 2014; Wiklund Gustin & Wagner, 2013). The literature suggests that RNs in the work setting require nurturing to put them in the best position to give quality care to their patients (Watson, 1979, 1999, 2015).

This study used a qualitative approach to address the gap in the body of knowledge and research about how RNs experience self-compassion at work while caring for others. Understanding RNs' lived-experiences of self-compassion in today's stressful health care arena can shed light on what it is like for them in stressful environments, which, given the forecasted nursing shortage, may impact the attrition of nurses.

Research findings have provided insights into RNs' perceptions of offering kindness and understanding to oneself. In turn, understanding this experience, among RNs when at work while caring for others, may potentially help to foster quality patient care delivery. Results of patients surveyed about their patient care experience through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) have a direct impact on medical/hospital care reimbursement (Press Ganey, 2015). This is important because the amount of quality care nurses provide to their patients has monetary value, which may impact health care institutions' bottom line.

Aim of the Study

The aim of this study was to shed light on the phenomenon of self-compassion among RNs employed in the workplace setting. Phenomenology, a qualitative research methodology, was utilized to conduct this study. Asking RNs to share their lived experience of being kind and gentle to themselves in the workplace while caring for others is an optimal way to gain understanding about this phenomenon in nursing. Participants were provided with an opportunity to tell their story. Analysis of data from RNs' personal stories uncovered essential themes for nurses. The goal of this research was to contribute to the body of knowledge in the literature. It was achieved by capturing the essences of self-compassion among RNs as it is lived as part of the art and science of

nursing. Consequently, illuminating RNs' lived-experiences of self-compassion offered

insights that have the potential for impacting patient care delivery and nurse retention in

stressful health care work environments.

Phenomenon of Interest

The phenomenon of interest is self-compassion. Neff (2003) operationally defined

the construct of self-compassion as:

> Being open to and moved by one's own suffering, experiencing feelings of
> caring and kindness towards oneself, taking an understanding, nonjudgmental
> attitude toward one's inadequacies and failures, and recognizing that one's
> experience is part of the common human experience. (p. 225)

The choice to be kind and gentle to one's self during times of stress, inadequacy, and/or

failure is available to everyone, but generally is an atypical response (Neff, 2003). The

analogy of putting on one's own oxygen mask first before helping someone else on the

airplane is one example often used to explain self-care.

The literature suggests that self-compassion is a precursor to self-care (Germer,

2009; Neff, 2015). To further explain this, Neff (2015) emphasized "when caregivers

have self-compassion they are more likely to" be aware of their own needs and "engage

in concrete acts of self-care such as taking time off, sleeping more, and eating well"

(p. 193). Consequently, with self-compassion, acts of self-care may be carried out

genuinely, without judging one's self or feeling guilty about caring for one's self (Neff,

2015).

Germer and Neff (2013) defined compassion as "an intimate awareness of the

suffering, by oneself and others, with the wish to alleviate it" and stated, "simply, self-

compassion is compassion turned inward" (p. 856). Neff (2003) claimed that self-

compassion is a way of being with one's self and recognizing, without judgment, the spectrum of one's own emotional states. Human beings experience a variety of emotions, such as sadness, pain, loss, sorrow, worry, stress, disappointment, love, joy, and the like. How people deal or cope with their feelings, in addition to situations that are beyond their control, may manifest in a variety of different ways. Beating ourselves up for being imperfect, or being gentle and kind to ourselves in times of stress and suffering, is one's personal decision. According to the literature, self-compassion may reveal itself in myriad patterns that are unique for each individual (Neff, 2015; Reyes, 2012).

Self-compassion in the literature is described as a beneficial way of relating to oneself and is inversely connected with stress, anxiety, and depression (Neff & Costigan, 2014). The practice of self-compassion may be regarded as a coping strategy for dealing with life's afflictions and may take on a variety of forms and characteristics. Experiential knowledge of hurt, pain, sadness, and suffering allows one to connect with one's humanness, possibly without criticism, and what it entails is to help individuals feel better and heal. Self-compassion among RNs may look different compared to the general population. Therefore, this study was needed to illuminate what self-compassion looks like among a variety of different RNs, what it entailed for the participants, and what meanings were revealed for nurses.

Context of the Phenomenon

The context for this phenomenon was RNs employed in the workplace setting. One way to understand the phenomenon of self-compassion in nursing is to understand it in the context of RNs who are employed full-time in a clinical workplace setting.

Since 2003, research on self-compassion and nurses in the literature consisted mainly of quantitative analyses. However, only one study utilized a qualitative approach. There is not enough research on self-compassion employing qualitative methods. This study intended to understand the basis of being kind to one's self and self-compassionate thinking and behavior among RNs directly from the source.

The literature suggests a positive correlation among self-compassion and empathy, emotional intelligence, empowerment, and resilience among nurses (Duarte et al., 2016; Heffernan et al., 2010; Mills et al., 2015; Stevenson & Allen, 2017). A sole qualitative research study, conducted by Wiklund Gustin and Wagner (2013), explored self-compassion as a source for compassionate care amid clinical nurse educators, which suggested:

> It is a way of becoming and belonging together with another person…both are mutually engaged…the caregiver compassionately is able to acknowledge both self and Other's vulnerability and dignity. (p. 175)

Reyes' (2012) one-of-a-kind concept analysis of self-compassion in the discipline of nursing suggested that self-compassion is:

> A state of being consisting of self-kindness, mindfulness, wisdom, and commonality that transforms suffering and results in actions that improve the individual's health and well-being as well as the health and well-being of others. (p. 84)

This phenomenon may not be well understood by nurses in practice, based on the limited qualitative research available on self-compassion among nurses and one concept analysis (Mills et al., 2015; Reyes, 2012).

A qualitative study using a phenomenological methodology to understand the lived experience of self-compassion among RNs in the clinical workplace setting is unique. The focus of this study was to address the gap in the body of knowledge and

research about how RNs experience self-compassion through qualitative inquiry. The qualitative hermeneutic phenomenological approach, which is an interpretive methodology, was used for the purpose of grasping a new concept, deriving answers to questions of meaning, and drawing meaning from life's experiences (Polit & Beck, 2017). This was an effective methodology to reveal what self-compassion means to study participants. Thus, shedding light on this phenomenon in the context of RNs in the workplace while caring for others provided insights into nurses being kind to and caring for themselves.

Justification for the Study

Nurses are respected health care professionals. Since 2002, according to Gallup polls, nurses have been voted number one among the most honest, trusted, and ethical professionals (Brenan, 2017). Conducting research that sheds light on the phenomenon of self-compassion among RNs may have potential financial outcomes. There have been suggestions that indicate the state of the nurse's well-being may influence the delivery of quality patient care (American Nurses Association, 2017; Bauer-Wu & Fontaine, 2015; Mills et al., 2015; Sharma & Jiwan, 2015; Watson, 1999, 2015). This care delivery is now related to hospital financial health care reimbursement. Nurses' self-compassion may also be related to workplace stress and nursing retention. However, to understand any of these relationships, there needs to be an understanding of how nurses are kind and understanding to themselves when at work caring for others.

Quality of nursing care is of concern through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which is administered to measure patients' experience of their hospital care. The survey questions include patients'

satisfaction with the quality of communication and treatment by nurses. The Centers for Medicare and Medicaid Services (2017) use the HCAHPS survey results, among other methods, to rank and reimburse providers and hospital facilities for up to 25% of medical care costs. Reimbursement for the delivery of quality patient care places value on the amount of compassionate care patients feel they receive from their nurses. Therefore, the value of conducting research on self-compassion among RNs suggests possible economic implications for the value-based purchase (VBP) of health care. According to Watson's (2015) theory of Human Caring, it is suggested that to ensure caring and healing for patients, self-care needs to be in place for the nurse.

A projected shortage of RNs in the United States is expected because of population growth, the aging Baby Boomer generation, and health care growth (American Association of Colleges of Nursing [AACN], 2017). Of additional concern are nurse turnover rates and their associated costs. One national study in the literature reported that roughly 15% of hospital-employed newly licensed RNs left their job within 1 year of being hired. This is significant given that it represented an estimated employer turnover cost of between $728 to $856 million annually (Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2012). One other study, conducted in the state of Florida, suggested that approximately 33% of newly licensed RNs surveyed (n = 533) had left their first job within 1.5 to 2.5 years after graduation and owed it mainly to work-related reasons (Unruh & Zhang, 2014). In addition, the literature suggests the average cost for the replacement of one RN is between $36,900 to $57,300 (Brewer et al., 2012; Richards, 2016; Sorenson, Bolick, Wright, & Hamilton, 2017). Therefore, the financial burden of nurse attrition on the delivery of quality patient care and workplace stress is high.

Based on extensive literature review, the phenomenon of self-compassion among RNs in the workplace setting has not been explored utilizing a phenomenological approach. Only one qualitative study available in the literature has examined clinical nurse educators. Therefore, this present unique investigation is needed because findings on RNs offering understanding and kindness at work to themselves would uncover insights that would not be revealed through a quantitative study. Subsequently, a perspective of RNs' self-compassion in clinical practice may conceivably impact economic implications associated with the delivery of quality patient care and VBP reimbursement as well as nurse retention in stressful workplaces.

Assumptions and Biases

It was my belief that RNs in the work setting would share that they lack self-compassion at work while caring for others. One assumption held was that RNs in today's health care work environments are stressed as they provide care for others. In addition, nurses hold themselves to the highest standard of competence from their very first entrance into nursing school. The expectation that they have and give of themselves and the extent of their sense of responsibility to others drive their work ethic. The literature suggests that RNs practicing in medical settings may not be supported to care for themselves. Thus, if health care systems are not in support of nurses caring for themselves, they may reinforce poor self-care while at work, which could then be transferred onto patients, families, and coworkers.

However, the assumptions and biases I held did not, in any way, imply that RNs deprive their patients of compassionate care. I believe nurses are dedicated to taking care of their patients. However, nurses may not well understand the concept of self-

compassion or perhaps perceive that their own well-being is possibly beneficial to quality patient care delivery. Study participants may perceive self-compassion as a selfish, uncaring, unprofessional act; they may think they do not have enough time to be kind to themselves in the workplace; or they may believe such behavior that is not condoned by the health care system. Registered Nurses may experience feeling judged by others, ashamed, embarrassed, not good enough, or guilty if they were kind and compassionate to themselves in the work setting.

Upon examination of my biases, I found one consisted of perceiving RNs who may not be kind and compassionate with themselves as possibly being somewhat limited when looking at the continuum of care holistically. Also, RNs may perhaps be in jeopardy of losing touch with humanistic nursing skills, such as compassion, in today's fast-paced health care environments. In addition, my bias was that humanistic self-understanding and care for oneself among RNs were likely being omitted. In turn, this perception may have clouded my ability to see nurses' coping in stressful workplaces.

Given the stresses of daily clinical nursing practice, I assume this may present challenges to moral self-respect and the preservation of integrity for nurses. For instance, occupational stress related to patients' end-of life issues, social injustice, disparity in health care, and violence in the workplace refers to a few of the challenges faced by nurses in the work setting. This idea assumed that research findings would potentially reveal ethical conflicts associated with RNs' practice. For example, a lack of self-compassion may potentially limit one's ability to advocate for oneself, one's patients and families, and even one's colleagues.

Academic nursing curricula use advanced technology, simulation, and online learning to teach technical and caring nursing skills to accomplish learning objectives in nursing schools. My bias was that these methods might decrease student nurses' amount of time in face-to-face interactions with human patients in a clinical setting during their nursing education. This may possibly impact RNs' opportunity to develop and practice self-reflection in real-life situations. One other assumption I held was that throughout the course of formal nursing studies, student nurses are not being taught or encouraged to pursue self-care and "being present with oneself." My biased perception assumed that this approach to nursing instruction could possibly affect RNs and negatively impact RNs' delivery of compassion for oneself in clinical practice. In turn, the potential for providing quality patient care and establishing the nurse-patient relationship may be affected.

Relevance for Nursing

Nurses in professional practice—over 3.6 million (Kaiser Family Foundation, 2017) to date—are respected and perceived as role models of the health care profession (Hassmiller & Mensik, 2017). As we advance into the "next era of healthcare" (Sanford, 2017, p. 143) and envision a collective movement toward a "…Healthy Nation," nurses are well positioned to become one of the prime leaders of this change (ANA, 2017). Sharma and Jiwan (2015) emphasized that nurse leaders need to cultivate an organizational environment of positivity, foster a culture that supports nurses' compassion for self to deliver compassionate patient care, and become encouraging role models for the next generation of leaders in nursing.

To develop a positive work atmosphere, some of the problems found in the health care field, such as stress in the workplace which may lead to nurse burnout and/or compassion fatigue, could be better understood. These issues may threaten the retention of RNs in the profession. Statistics and costs attempting to analyze these conundrums have been written about in the literature (Bauer-Wu & Fontaine, 2015; Griffiths et al., 2014; Van den Heede & Aiken, 2013). It is crucial to address nurses' coping with stress at work, given the predicted nursing shortage crisis (AACN, 2017). The American Nurses Association (ANA, 2017) declared that the health and well-being of American nurses is essential for the health of the nation.

The primary ethical component of nursing care, from Provision 1 in the American Nurses Association's Code of Ethics (ANA's COE), is compassion towards patients (Fowler & ANA, 2008). Heffernan et al. (2010) suggested that research on self-compassion among RNs in clinical practice is needed to understand how compassion is perceived for themselves. Provision 5 of the ANA's COE concentrates on the nurse as owing the same responsibility to self as to others (Fowler & ANA, 2008). The ANA's COE and the literature suggest that nurses' compassion for patients and compassion for oneself are possibly related (Heffernan et al., 2010; Watson, 2009, 2015).

Furthermore, RNs perhaps are unaware of the phenomenon of self-compassion. The limited available research in the literature lacks clarity about how self-compassion in RNs might look in professional practice (Mills et al., 2015). Self-compassion among RNs in clinical practice has been unexplored utilizing qualitative methodology. The ANA's (2017) Healthy Nurse, Health Nation™ campaign is building momentum to challenge nurses to take better care of themselves. Shedding light on this phenomenon using the

phenomenological method can reveal meanings for nurses. Study findings can reveal information with the potential to foster quality health care delivery and nurse retention in stressful workplaces. Hence, a perspective of self-compassion among RNs in workplace practice settings is needed.

Summary

The purpose of this qualitative study was to understand self-compassion in RNs in the workplace setting while caring for others. Phenomenology, a qualitative research methodology, utilizes interviews that encourage participants to share their lived experiences and tell their story. Insights and essential themes gleaned from the interviews will reveal meaning for nurses and may include potential economic implications for value-based health care reimbursement and nurse turnover in stressful workplaces. The next chapter discusses the historical aspects of caring, self-care, and compassion in nursing practice, including an evolution of self-compassion.

Chapter II

EVOLUTION OF THE STUDY

This chapter provides a historical context of professional nursing utilizing a review of the literature. Caring theories, women as professional caregivers, and nursing as a caring art and science are discussed. Self-care from the perspective of the Ancients and contemporary nursing is also included. A glimpse of compassion and compassion fatigue in nursing practice and the evolution of self-compassion from Eastern philosophy/psychology and neuroscience is presented as well. Lastly, the experiential context of the study offers insight into the researcher's epiphany to study the phenomenon of self-compassion.

Historical Context

Historically, caring in nursing began with Florence Nightingale, who is considered the founder of professional nursing, a woman who devoted her life to her chosen profession (Dossey, 2000). Her dedication to caring for others was steadfast, and she considered nursing "her calling" (Dossey, 2000; Nightingale, 1969). As the lady with the lamp, her reputation was well-known for compassionately walking the hospital wards at night to ensure that all of her patients were resting comfortably. In addition, she continually addressed her nurses with kind messages to "examine thyself" and offered encouragement to journal daily and practice the following:

Self-healing with quiet time, prayers, self-discipline, and becoming
aware moment by moment of how to deepen one's inner knowledge of the
interconnectedness with self, others, nature, and God. (Dossey, 2000, p. 305)

Caring

Caring is the core value of the RN's role and practice. While several nursing

theories offer insights about caring in nursing practice, two specifically are highlighted

based on their relevance to the evolution of the phenomenon of self-compassion.

The first, posed by Benner and Wrubel (1989) in *The Primacy of Caring*,

described *caring* as having persons, events, projects, and things matter to people. As a

result, the word *caring* sets up a relationship with "being connected and having things

matter works well because it fuses thought, feeling, and action—knowing and being"

(p. 1). Caring may also include a wide range of associations, for instance, from an

affectionate romance to parental love to a close friendship, from caring for one's pet to

caring about one's financial situation to caring for and about one's patient (Benner &

Wrubel, 1989). It entails not only what matters, but also what is important to an

individual, and along with caring arises an element of stress. "Relationships, things,

events, and projects do not show up as stressful unless they matter" (Benner & Wrubel,

1989, p. 1). In other words, if an individual does not care, an episode cannot be stressful.

The carefree person without plans and concerns may also be missing out on

belonging and possibly existing with meaning. Because of the extant element of stress,

caring also sets up a condition for coping. Coping that creates distance and avoidance

may be problematic because it may "cut people off from expressing their pain and fear"

(Benner & Wrubel, 1989, p. 2). Coping strategies may comprise of methods that do not

cure or remove loss and pain, but can be managed, such that "coping based on caring also allows for the possibility of joy, the satisfactions of attachment" (p. 3).

The second, posed by Jean Watson's (1979) *Nursing: The Philosophy and Science of Caring*, emphasizes *caritas* as a term for caring, or *carative* factors, which is central to caring for other human beings, stems from humanistic philosophy, and is founded on a continually evolving scientific base. As set forth by Watson, "The practice of caring is central to nursing" and "nursing is a caring profession" (p. 33). Nursing care can manifest itself in many different ways (similar to self-compassion). There are unlimited ways to describe and generate therapeutic results in nursing care (Watson, 1979). For example, the cultivation of humanistic values and kindness practices is possible through experiences that awaken compassion and other feelings, personal growth and development, meditation, study, travel, and the like. Since the essence of nursing is caring, nurses must treat themselves "with gentleness and dignity before" they in turn "can respect and care for others with gentleness and dignity" (Watson, 1999, p. 33). The nurse-patient relationship is unique and caring for others may be synergistic to caring for one's self.

A profession for women and caring for the other. Near the end of the 19th century, Nightingale's School of Nursing model was used to train nurses in Great Britain, the United States, and around the world (Dossey, 2000). Women are natural caregivers and, traditionally, nurses were predominantly women. Nurses were perceived to be selfless individuals, who were suited for and dedicated to the care of others. The expectation was, at the time, that nurses lived on hospital grounds and were on-call 24 hours in case of need (Baer, D'Antonio, Rinker, & Lynaugh, 2001). Thus, around-the-

clock caring and compassion toward others was expected of nurses who ran urban community hospitals and devoted their lives to serving sick patients. Conceivably, compassion for oneself was not attributed to nurses in the workplace while caring for others at that time.

Initially, the idea was that if women wanted to pursue nursing as a career, they would give up marrying and having a family to minister to the infirmed. However, Baer et al. (2001) noted that women, in the late 19th to early 20th century, who chose to pursue nursing as a vocation were perceived as liberated, and this afforded them self-actualization. White middle-class women were drawn to the profession and became "trained nurses" by the 1890s (Baer et al., 2001). In addition, the occupation of nursing offered minorities and immigrants work opportunities well before they materialized in other occupations and professions (Baer et al., 2001).

Nursing has been and continues to be a female-dominated profession (Hassmiller & Mensik, 2017). Some women were drawn to the profession of nursing based on their religious conviction, whereas for others it may have been reform and leadership opportunities (Baer et al., 2001). Furthermore, many were looking to learn new things and do important and meaningful work for which they would be compensated. On the other hand, at that time, an occupation which freed women from domestic and family dependence was considered progressive (Baer et al., 2001).

According to Gilligan (1982), the responsibility to care for one another stems from an awareness of connection between people. Through her work, Gilligan remarked that women are sensitive to the needs of others, have a relationship-oriented worldview, and embody an ethic of care. Responsibility toward others may be seen as "in what's

doing what's right for others, you're doing what's right for yourself…and not being any good to anyone unless I know who I am" (p. 53). A network of connections may be seen within the broader view of responsibility toward a societal connection, which may extend outward to the world. Nurses provide care to their patients and embrace the responsibility of helping others, but sometimes without taking care of themselves.

Giving care to others may involve self-sacrifice, such as giving to others even if that means hurting oneself. Gilligan (1982) noted that self-sacrifice may also be seen as a responsibility, along with a need to respond, because others are counting on you and you can help. However, hurting oneself in the process of helping others may, in turn, be harmful to others. For instance, thinking only about oneself without including everyone involved has moral consequences. Gillian provided an example of an ideal of self-sacrifice in a family situation consisting of "a family where everyone is encouraged to become an individual and at the same time everybody helps others and receives help from them" (p. 54). A moral responsibility to self is the same as a moral responsibility to others. Based on this concept, nurses giving care to others stand to benefit from being kind to themselves and performing self-care because it enables them to sustain a morally sound care ethic.

At present, the ratio of female to male nurses in the United States is 9.5 to 1 (Kaiser Family Foundation, 2017; Rappleye, 2015). The literature suggests that females have somewhat decreased levels of self-compassion compared to their male counterparts (Neff, 2011, 2003). On the other hand, women have increased "compassion for humanity, empathic concern, perspective taking and forgiveness than men" (Neff & Pommier, 2013, p. 170). Therefore, shedding light on the lived experience of self-compassion among RNs

in the workplace is needed. This may help to uncover themes and insights for nurses to better understand this phenomenon and possibly derive meaning for their practice.

Nursing as a caring art and science. Roberts (1925) described nursing during the early 20th century as a spiritual practice, whereby nurses who entered the profession were deftly chosen for their character and dedication to care for the infirmed. Then again, new nurses coming into the profession in the early to mid-1900s arrived when the aims of education were becoming centered on science and the national nursing organization's *The American Journal of Nursing* was being used as a text (Baer et al., 2001; Roberts, 1925).

By the 1920s and 1930s, the "demands of aseptic efficiency with their ideal of patient-oriented compassionate care" were troubling for nurses to reconcile with their primary role as caregivers (Lynaugh, 2001, p. 40). Less attention was being paid to learning courtesy, truthfulness, kindliness, generosity, and courage, with more emphasis granted to science, materialism, and commercialism. The expectation, at that time, was that the caring virtues would be learned from the lived example of others in the profession.

A better understanding of the past may further clarify enduring modern-day conundrums in nursing and health care. For instance, Roberts (1925) commented on the rigors of the work and noted that the idealism of some nurses was destroyed by the hospital system's overly developed routine or "factory method of mass production" (p. 737). In addition, a shift in the attitude of the nurse, whose real life was lived off-duty, was fixated on compensation and less on the comfort and happiness of the patient (Roberts, 1925). Hence, during the early part of the 20th century, there was a distinct

swing from the self-denying, self-sacrificing nurse to an economically valued, empowered, and assertive professional.

Care of Self

 The ancients' view. Care of self and knowing oneself is an ancient credo. The Greek phrase *epimeleia heautou,* and in Latin *cura sui*, means caring for the self (Foucault, 1997). Knowing oneself or self-knowledge, from the Greek *gnōthi seauton* (Foucault, 1997), was essential for care of self. The hyphenated word *self-care* is commonly used in modern vernacular. The Ancients were adamant about self-care practices and self-awareness. Care of self was viewed as a means of caring for the soul. Foucault (1997) in the *Hermeneutic* posited, "Attending to oneself is therefore not just a momentary preparation for living; it is a form of living" (p. 96). Socrates concerned himself with teaching his fellow citizens to care for themselves. He believed that educating others to do so, in turn, "teaches them to attend to the city-state itself" (Foucault, 1997, p. 94).

 The practice of self-reflection was an essential component of care of self and knowing oneself. Florence Nightingale (1860, 1969) reflected on her nursing practice and kept scrupulous notes of her day-to-day undertakings. Foucault (1997) offered the Roman emperor Marcus Aurelius' comment on *anakhōrēsis eis heauton*, which means "to come back inside oneself and examine the riches that one has deposited there; one must have within oneself a kind of book that one rereads from time to time" (p. 101). In addition, the analogy of the bee that returns to the hive to deposit the collected nectar was used to describe the information gathered from reading. Assimilating, and memorizing, the

material accumulated was important to the Ancients, to learn from and remember it, as an aesthetic care of the self.

      Contemporary view. The notion that self-care is a prerequisite to caring for others is made explicit in Watson's (2009) human caring theory and is synergistic with ancient philosophy. Thus, a therapeutic paradigm shift in health care may require an inside-out approach, whereby practitioners shift their awareness to intentional actions, while being fully present with one's self and doing something for the patient (Watson, 2009). A glance at applied ethics queries the character of an individual, "what kind of person should I be?" (Axtell & Olson, 2012, p. 193). For instance, in professional nursing practice, it may be beneficial to examine both internal and external attributes of the self, such as being and doing. Caring, loving, kindness, and personal connection may be ascribed to one's being. Administering medications, changing a dressing, and documenting on a patient's chart are actions that are consistent with doing. The question lies with how one chooses to conduct these acts, while simultaneously being with, or caring for, one's self (such as in the example of nurse Sheila).

      Modern-day professional nursing practice is oriented on the material, outwardly focused, and technology-driven performance. An external outcome focus may have affected the disregard of an inwardly focused self or soul in the practice of nursing. According to Watson (2009), the lack of human caring in nursing may be reflected, for example, in the nursing shortage, demanding institutional systems, overpowering technological advances, and task-oriented biomedical practices. Watson described a need for "radical change from within as an essential and necessary requirement" (p. 467) that may possibly sustain a caring ethic. Therefore, shedding light on the lived experience of

RNs' stories of kindness toward one's self at work may reveal insights and meaning for nurses in today's health care arena.

Compassion in Nursing

Compassion consists of a feeling or desire to relieve the suffering of others, although it is possible to have a compassionate thought without action and perform a kind act without compassion. In the context of nursing, compassion is a basic desire that is expressed in how nurses act and what they do—for instance, to assuage others' afflictions (Kenny, 2016; Reyes, 2012). In addition, nurses are unique service providers, often giving both emotional and physical care to patients, and they are ethically responsible for the delivery of compassion (Fowler & ANA, 2008; Hofmeyer et al., 2016). Thus, compassionate care is expected by patients.

Lynaugh (2001) suggested that nurses at the turn of the 20th century wanted to align their work with physicians, more closely following the principles of science and medicine. Consequently, individualized patient care needs became secondary to medical science, and care was guided by the decision of the physician (Baer et al., 2001). Seemingly, this created a conflict between the moral base of nurturing caregiving and the scientific base of nursing care. Rinker (2001) argued that "when rigidity overcame compassion it also undermined nurses' relationships with patients" (p. 40). Even so, patients benefit from and anticipate compassionate care from their nurse. Correspondingly, nurses' desire to give needed care, nurturing, and relief to patients' suffering is part of their responsibility (Bauer-Wu & Fontaine, 2015; Hofmeyer et al., 2016).

Pence (1983) raises the issue about whether compassion can be taught to medical students. The classic argument between Socrates and Protagoras about whether virtues are innate or taught was applied to the problem of teaching compassion. Pence commented on the process of education and the "claim that compassion is naturally picked up by students when they interact with suffering patients" (p. 190).

One other method identified for teaching compassion was role modeling. For instance, students become compassionate by observing other health care professionals who role model compassion when treating their patients or seeing how they respond when being reprimanded by their superior (Pence, 1983; Roberts, 1925). "Merely imitating compassionate behavior is not compassion because real compassion stems from deeper, internal attitudes and emotions" (Pence, 1983, p. 190).

Tenzin Gyatso, His Holiness the 14th Dalai Lama, posited that a sick patient in the hospital can tell if compassionate care (a warm human feeling, smile, or kind touch) or the lack thereof (a lack of human feeling, an unfriendly facial expression, impatience, or casual disregard) is being given. He commented further that it makes a difference in the quality of the patient's recovery because human beings, from the day they are born, crave human affection and compassion, love, and happiness. Gyatso (2003) emphasized that our deeper human values are "compassion, a sense of caring, and commitment" (p. 12). According to Gyatso (2003), "the ultimate source of that pleasant atmosphere is within the individual, within each of us—a good heart, human compassion, love" (p. 13).

Compassion fatigue. From a different vantage point, Sheppard (2016) posited that compassion fatigue is a "loss of satisfaction that comes from doing one's job well, or job-related distress that outweighs job satisfaction" (p. 53). These experiences may result

in physical or psychological distress and possibly be a consequence of caregiving (Benner & Wrubel, 1989). Nurses are vulnerable to compassion fatigue, which may lead to burnout. Emotional depletion, exhaustion, depersonalization, and diminishing one's personal accomplishments can lead to isolation. These are characteristics of burnout (Bauer-Wu & Fontaine, 2015; Kelly, Runge, & Spencer, 2015). Additionally, the ability of nurses to recognize compassion fatigue and burnout in themselves is limited (Gilligan, 1982). Kelly et al. (2015) claimed one other work-related consequence which nurses may experience is Secondary Traumatic Stress (STS). It occurs as a result of caring for those who have suffered from traumatic situations. Correspondingly, compassion fatigue can be the result of a combination of burnout and STS (Kelly et al., 2015; Sorenson et al., 2017). The literature suggests that self-care may be a way to stave off work-related stress and possibly burnout, compassion fatigue, and STS (Bauer-Wu & Fontaine, 2015; Kelly et al., 2015; Watson, 1999).

Evolution of Self-Compassion

Self-compassion originated from Eastern Buddhist philosophy. Suffering, failure, and imperfection are seen as natural components of life, as self-compassion and compassion for others are central to the Buddhist worldview.

An examination of human behavior suggests that compassion may be easier to impart to others than toward one's self. Kelly McGonigal (2016), a neuroscientist and psychologist, described that "we're wired to be critical of ourselves and compassionate toward others because we want to be accepted by the group" (p. 40). In addition, one's "emotional responses"—for example, guilt, shame, anxiety, self-criticism, and fear—are linked "to survival instincts" and are built into one's innate sense of self-preservation

(p. 140). Feelings such as anger may help to defend one's life, and sadness possibly will elicit support from others. Likewise, these reactions are thought to be triggered by the brain to facilitate coping with stress and suffering (McGonigal, 2016).

In contrast, this is not typically how one responds to another's misfortune, pain, or suffering. A compassionate response may be directed toward another who is ailing, yet for one's self, it may be similar to a sympathetic nervous system activation of the fight-or-flight response, or self-criticism. The exemplar of nurse Sheila (Chapter I, Introduction), who is kind to her patients but unkind to herself, provided an example of these two different instincts and two ways to respond.

Self-preservation and apprehensive behaviors are intended to protect one from immediate pain or to prevent future suffering. Science has yet to explain "why our self-defense instincts are more fear-based than nurturing; we just seem to be wired that way" (McGonigal, 2016, p. 141). Nevertheless, human evolution is beginning to progress toward self-compassion and understand the preventable suffering that results from this response, as opposed to self-criticism and unkind acts toward the self (McGonigal, 2016; Neff, 2015).

Summary of Caring, Care of Self, Compassion, and Self-Compassion Literature

Caring is central to nursing practice, relational, and an integral part of the nurse-patient relationship (Gilligan, 1982; Watson, 1979). Care of self and self-awareness were a way of life for the Ancients. The concept of self-care and self-compassion has traces of this heritage in contemporary nursing literature (Watson, 1999, 2009, 2015). Gilligan (1982) posited that an individual may not be of use to anyone unless one cares for and knows oneself. The preservation and continuation of the humanistic aspect of patient care

delivery in nursing practice may require encouragement for nurses to assimilate self-care and self-understanding (Henderson, 1964; Watson, 1979, 1999, 2015). Stories from RNs' lived experience of self-kindness, understanding, and compassion turned inward may enlighten nurses about the phenomenon and reveal meaning for practice.

Experiential Context

I have worked with very knowledgeable, expert nurses who exhibited compassion toward their patients but not necessarily toward themselves. This tendency for nurses to lean toward being compassionate to others but not as much to themselves has been both discussed and mentioned in the literature (Germer, 2009; Mills et al., 2015; Neff, 2015; Watson, 2009). For instance, I have witnessed staff nurses go through an entire 12-hour work shift without taking a meal break, yet seemingly accomplish their responsibilities to meet their patients' needs. I wonder how long nurses can sustain such practices until it becomes unhealthy.

Before I completed my formal education and obtained licensure as an RN, I was a patient care technician on a step-down cardiac unit. I vividly recall losing sight of myself in service to others. I initially enjoyed the feeling of not being preoccupied with my own thoughts or needs while tending to my patients' needs. In a way, it felt meditative and was soul-satisfying to me. In addition, I felt like a real nurse. Although I felt useful to the patients, eventually the suffering I was witnessing became burdensome. The medications patients received often helped to alleviate the physical manifestation of their symptoms, such as pain, but their emotional afflictions persevered. The medical treatments patients received did not always cure what ailed them.

The skills I learned in my formal nursing education courses and clinical rotations were helpful. However, they did not assist me in coping with the caliber of human suffering I was seeing. I began to feel sadness and guilt associated with my patients' distress. What did I have to complain about? My life was nirvana compared to the problems, pain, chronic diseases, illnesses, and distress my patients experienced.

At that time, the 1980s, the human immunodeficiency virus (HIV) was a new, unfamiliar, and lethal disease. Patients diagnosed with HIV admitted onto the unit where I worked raised fear and havoc among the staff. This, in part, was due to the paucity of knowledge and research about how HIV was transmitted and the belief that there was no cure for it at the time. I was struck with feelings of devastation for the patients I cared for who were diagnosed with HIV. Furthermore, the judgments, biases, and insensitive verbal comments made by the health care professionals I worked with were disheartening. In this instance, observing other professionals did not help me to cultivate compassion for patients.

My first patient, who died from HIV, was a male. I remember how difficult this was for me because I transferred my feelings about my brother, who had a substance abuse disorder, onto my dying patient. I used my faith and prayer to help me cope with this. I believe my own awareness about how I felt and responded to the suffering I was witnessing grew, and my feelings of compassion for patients deepened. This epiphany led me to begin to delve more deeply into "Who am I?" and "What am I doing here?" I was on a mission to understand myself in relation to my patients. I knew in my heart I could not fake feeling compassion for my patients. I deeply wanted to become an authentically compassionate nurse.

Through knowing, feeling, being with myself, and working to cultivate self-awareness, I also sought to better care for myself. This path toward self-discovery felt authentic. It led me to find and develop a Yoga and meditation practice, and eventually I found the American Holistic Nurses Association. The motivation for this study stems from my lived experience and journey of becoming a holistic nurse. Healing myself from the burden of the stress and pain I witnessed patients go through helped me to return eventually to school to earn a master's degree. Had I not done so, I would have left the nursing profession 5 years after graduating from a baccalaureate program.

Today, I am a holistic nurse and psychiatric-mental health nurse educator. I perceive a deficiency in the academic curricula for student nurses about self-care. The skills taught to undergraduate nursing students are predominantly medical and technical, directed toward the bio-medical model of patient care delivery, without regard for the nurses' needs. An assignment I have students complete before developing a patient care plan, during their clinical rotation, is a self-care plan. The rationale for this task stems from my own life and questions about "Who am I? What does my well-being look like?" Nursing students often describe their Aha! moment of needing healthy nutrition, adequate sleep, stress management, and physical movement, not simply for themselves but also for ways to help their patients identify their own needs. This exercise serves a dual purpose. It fosters self-awareness, encourages student nurses' self-care through the rigors of nursing school, and reinforces the practice of putting on one's own oxygen mask before helping others. In addition, it facilitates the students' ability to create individualized patients' plan of care with their patients, addressing them where they are.

Summary

This chapter focused on the historical context of the nursing profession, including caring, women as caregivers, nursing art and science, self-care, compassion, and compassion fatigue as related to the nursing practice. Care of self from the view of the Ancients and contemporary nursing was explored. Buddhist philosophy formed the foundation for self-compassion, and neuroscience depicted the evolutionary process of self-compassion. Finally, the experiential context revealed the researcher's lived experience and holistic quest for compassion. The next chapter delves into the methodology of phenomenology for the purpose of researching the phenomenon of self-compassion.

Chapter III

METHODOLOGY

Phenomenology

This chapter discusses the phenomenological method, its methodology, and its theoretical concepts. Historical and modern-day phenomenologists are introduced. A discussion of the rationale for choosing phenomenology, as the method of inquiry, to study the lived experience of self-compassion among registered nurses (RNs) is also included.

Introduction to the Phenomenological Approach

The methodology for this qualitative research design approach was phenomenology. Phenomenology is derived from the Greek word $\phi\alpha\iota\nu\omega\mu\epsilon\nu\omega\sigma$ (phainomenos), which means "to illuminate" or "to show" (Liddell, Scott, Jones, & McKenzie, 1996; Matua, 2015). Phenomenology and hermeneutic phenomenology are reflective disciplines, philosophies, and human science approaches rooted in philosophy (Cohen, Kahn, & Steeves, 2000; Matua, 2015; van Manen, 1997). While lacking theoretical concepts, phenomenology is, in and of itself, a philosophical approach based on philosophical schemes (Munhall, 2012).

Phenomenology embraces lived experience as a discovery of meaning for each human being and each perception of a specific phenomenon. One classical question

posed by phenomenologists is, What is this essence, or 'whatness,' of a phenomenon based on these individuals' lived experience and what meaning does it have? (Polit & Beck, 2017; van Manen, 1997). Thus, meaning is the primary focus of phenomenology. Phenomenologists search for subjective meanings of phenomena with a belief that implanted in people's lived experience are vital truths about life (Polit & Beck, 2017). Phenomenologists also believe that a person's perception, based on one's lived experience, contributes meaning to a particular phenomenon for that individual. Hence, the aims of phenomenological inquiry are to understand the perceptions that arise from lived experience and the interpretation of individuals' lived experience (Cohen et al., 2000; Munhall, 2012; Polit & Beck, 2017).

The phenomenological method is research that utilizes a phenomenological philosophy as a way to study lived experience and seeks to comprehend human experiences as they are "understood by the individuals who are having them" (Cohen et al., 2000, p. 3; van Manen, 1997). For the purpose of grasping a new concept, derive answers to questions of meaning, and draw meaning from life's experiences, phenomenology is an appropriate and relevant study approach (Cohen et al., 2000; Matua, 2015; Polit & Beck, 2017). An introduction to the historical phenomenologists, beginning with Husserl and Heidegger, then Merleau-Ponty, and lastly, the modern-day phenomenologist van Manen, is presented next.

The German philosopher and mathematician Edmund Husserl (1859-1938) was instrumental in the foundation of modern phenomenology (Cohen et al., 2000; Dowling, 2007). Husserl's views have been discussed in the literature as being influenced by the French mathematician Descartes, along with the Cartesian perspective of "I think,

therefore I am," whereby knowledge and the mind are important (Benner & Wrubel, 1989; MacDonald, 2000), although experiential knowledge was a source of meaning in Husserl's epistemology (Racher & Robinson, 2003). Husserl's (1964) phenomenological method was descriptive, and its tenets were based on *essences*, *objects*, *intersubjectivity*, *eidetic reduction*, and *intentionality* (Dowling, 2007; Moran, 1999; van Manen, 1997).

Returning to the nature or *essences* of "the things themselves" (Racher & Robinson, 2003, p. 471) was what Husserl considered "the consciousness and perception of the human world" (p. 471) and what makes *some thing* what it is—otherwise, it would not be that (Benner & Wrubel, 1989; Husserl, 1964). Husserl (1964) viewed the mind as directed toward *objects* or physical things, called *noema*. *Intersubjectivity* means to experience that which stems from an individual's private experience of or with *some thing* (Dowling, 2007). *Intentionality* is an association of thinking and *objects* which connects humans to the world (van Manen, 1997). Dowling (2007) noted that "the study of things as they appear" (p. 132) and attaining an "essential understanding of human consciousness and experience" (p. 132) of *some thing*, through description, supports *intentionality* (Husserl, 1964; Racher & Robinson, 2003). Husserl (1964) introduced the technique of *eidetic reduction*, or bracketing, to phenomenology. In order to access the essence of the phenomenon itself and understand and describe it, subjective ideas, personal perspectives, and theoretical constructs are openly made known and bracketed, or held deliberately at bay (Husserl, 1964; Polit & Beck, 2017; van Manen, 1997).

Martin Heidegger (1889-1976) was also of German descent and Husserl's apprentice (Cohen et al., 2000). His approach to the methodology of phenomenology was similar to Husserl's and stood "with human experience as it is lived" (Dowling, 2007,

p. 133). Heidegger (2008) further defined hermeneutic phenomenology to include the lived experience as "an interpretive process" (Dowling, 2007, p. 133). This ontological viewpoint, or understanding, was perceived as being in the physical world with an integration of the mind. This unified mind and body encompassed the meaning of *Being* from beings and used an interpretive and reflective thinking process as a source of knowing. One's consciousness and body are not separate, and "Being-in-the-world refers to the way human beings exist, act, or are involved in the world" (Dowling, 2007, p. 133; van Manen, 1997). This means how we are engaged in the world as woman, man, nurse, mother, father, doctor, teacher, and so forth (van Manen, 1997). In addition, both humans and the world are in a reciprocal process of co-creating, impacting, and changing each other simultaneously (Racher & Robinson, 2003).

Heidegger (2008) put forth three descriptions in hermeneutic phenomenology that are pertinent to the theory: (a) how to understand or make sense of the world in general, (b) how the individual goes about making sense of or understanding the world, and (c) *Daisen,* which in German means "to be there" or what it means for something to be, to comprehend being, or existence itself (Cohen et al., 2000; Matua, 2015; Salmon, 2012; Wilson, 2014). Understanding the world, being in and understanding the world, and wondering about one's own existence and *being* are all separate constructs yet they are connected (van Manen, 1997).

French-born Maurice Merleau-Ponty (1908-1961) was influenced by Husserl's and Heidegger's writings on phenomenology. He contributed to philosophy from his belief of lived experience pre-reflectively, with a fresh perspective, as if "re-learning to look at the world" for the first time (Merleau-Ponty, 1962, p. xx). As Merleau-Ponty

(1967) stated, "My perception is like a beam of light which reveals the objects there where they are and manifests their presence, latent until then" (p. 185). His goal was to shine a new light on one's pre-reflective experience, "which precedes knowledge" (Moran, 1999, p. 142), to gain new insights, as opposed to reflective experience or formed objective knowledge. This tries to clarify complex subjective perception and correct objective thought of distortions to thus reawaken a direct contact with the world where "the complex ambiguous 'milieu' in which human meaning comes to expression" (p. 402).

Merleau-Ponty's naturalistic outlook is dialectical and suggests that looking at the world, perceiving and interacting with it, is intertwined with being in the world (Moran, 1999). He contributed to the four *existentials* of the fundamental *lifeworld* structures of phenomenology that include: *spatiality*, or lived space; *corporeality*, or lived body; *temporality*, or lived time; and *relationality* or communality, or lived human relation (Dowling, 2007; Merleau-Ponty, 1962, 1967; van Manen, 1997).

From Max van Manen's (n.d.) internet website, one learns that he was born in the Netherlands in 1942 and became a professor. In 1967, he emigrated to Canada and obtained his citizenship there in 1973. Until his retirement in 2008, he taught research methods, pedagogy, and curriculum studies at the University of Alberta, and translated German and Dutch classical phenomenological pedagogical texts into English. Van Manen continues to be an avid researcher of phenomenology and pedagogy and is professor emeritus at the University of Alberta. His contribution to a phenomenological method, through the writing and research of "human science," has impacted the

educational, health care, anthropological, ethical, and other fields across the globe (van Manen, n.d.).

Through phenomenological human science, the meaning of a phenomenon and how one experiences it is sought (van Manen, 1997). With a focus on discovery, the generic question becomes, "What is this lived experience like?" (van Manen, 2017, p. 776). According to van Manen (1997), "the method of phenomenology and hermeneutics" (p. 30) is discovery-oriented and does not have a method. The utilization of *epoché,* which in Greek means to suspend judgment, and *eidetic reduction* or bracketing are critical tools orienting phenomenological meaning. Van Manen (2017) posited that "*epoché* opens up the space for the possibility of discerning phenomenological meaning and the reduction aims for phenomenological meaning to appear, give, or show itself" (p. 777).

Van Manen (1997) organized six methodological research activities to guide human science research:

1. turning to a phenomenon which seriously interests us and commits us to the world;

2. investigating experience as we live it rather than as we conceptualize it;

3. reflecting on the essential themes which characterize the phenomenon;

4. describing the phenomenon through the art of writing and rewriting;

5. maintaining a strong and oriented pedagogical relation to the phenomenon; and

6. balancing the research context by considering parts and whole (pp. 30-31).

Phenomenological research tries to evoke understanding of experience and "is used to answer questions of meaning" (Cohen et al., 2000, p. 3). Through language, meaning is derived. Meaning can also be conveyed non-linearly, non-cognitively, and often, in a nonverbal fashion. For instance, by means of tactile, esthetic, intuitive, kinesthetic, and discretionary abilities, communication can be conveyed and understood. The awareness of multiple means of communication is essential to carry out phenomenological research, especially since the world and language are enmeshed (Merleau-Ponty, 1962, 1967).

To undergo phenomenological knowledge inquiry, a beginner's mind is often a suggested prerequisite. One's ability to suspend previously acquired knowledge of accepted truth(s) grants permission, or opens the window of the mind, to uncover fresh possibilities of new understanding (Munhall, 2012). Being open to the process of discovery and cultivating an open mind allows for revelations to be unearthed, much like a garden bed with rich fertile soil is receptive to allowing a seed to be planted and, if nurtured, will thrive and grow. Eliminating preconceived perceptions opens the curious brain to inquire "What is this or that kind of experience like?" (van Manen, 1997, p. 9).

Lived experiences beckon us to delve more deeply into our nature and derive meaning from our quotidian reality. This tangible contact with the world allows people to gain insights into it, versus manipulating or assigning cause-and-effect theory to human existence. Learning about, or investigating, *lifeworld*, the world of lived experience, as put forward by Husserl, is both ancient and novel (Cohen et al., 2000; van Manen, 1997). There is a timeless component to it, whereby, in the past as well as today, humans use language and art to interpret their lived experiences and to bring people together. It has

the potential, time and again, to offer a different and creative lesson to draw from each time it is heard, seen, felt, or perceived. Phenomenology offers a refreshing and open point of view, like a breath of fresh air.

Rationale for Choosing the Phenomenological Method of Inquiry

The process of interviewing RNs was intended to shed light on what was extant in their stories and waiting to reveal itself. Phenomenological inquiry helped to clarify the poorly understood phenomenon of self-compassion among RNs. To understand the participants' lived experiences, a phenomenological hermeneutic research design was aptly suited for this study. One question was posed to each of the participants: "Tell me about a time when you were kind to yourself at work while caring for others." The use of an open-ended question encouraged the participants to share their story and not guide them in any direction, other than into their own thoughts. In addition, it was an opportunity for participants to reflect on their experience, return to that moment, freely describe the details of their thoughts and emotions related to the event, and tell their stories.

Thus far, studies on self-compassion in the literature have been predominantly quantitative. These studies suggest that a positive correlation between self-compassion and emotional intelligence, resilience, empathy, empowerment, and self-esteem exists (Heffernan et al., 2010; Mills et al., 2015). Only one study has explored self-compassion as a source for compassionate care among clinical nurse educators, using a qualitative phenomenological approach (Wiklund Gustin & Wagner, 2013).

A hermeneutic phenomenological qualitative study of self-compassion among RNs was thus unique. Phenomenological inquiry discovers distinctive possibilities of

existence and that which is yet to be known. This study thus contributes to the current literature related to self-compassion, particularly for nurses who may not be mindful of the phenomenon and what it looks like in professional practice. A collective understanding of the language unfolded and themes were identified that were derived from the individuals' stories.

Qualitative findings using a phenomenological research approach offer insights into the participants' perspectives, experiences, and essences of the concept of self-compassion being studied. They offer an in-depth view and shed light on the phenomenon as lived by RNs that would not otherwise be possible with other research approaches. Polit and Beck (2017) asserted that critical truths about reality, which are embedded in people's subjective, lived experiences, are revealed when people tell their stories. Last, but not least, phenomenological research can be of value when a particular phenomenon has been poorly defined or conceptualized, as in the case of self-compassion, and can give meaning to human existence when examined closely.

Summary

This chapter discussed the phenomenological method and included an introduction to its approach. Classical and contemporary phenomenologists Husserl, Heidegger, Merleau-Ponty, and van Manen, along with their philosophical contributions to phenomenology, were presented. The epistemological and ontological underpinnings of phenomenology, how things appear, show, or give themselves, were also provided. The rationale for choosing the method of phenomenology for this study of lived experience was posed. The next chapter then focuses on the applied method and van Manen's method of phenomenology.

Chapter IV

METHOD APPLIED

This chapter entails the method that was applied to conduct this hermeneutic phenomenological human science research. Van Manen's (1997) six activities are discussed. The description of the procedures used to carry out the study consists of participant selection, securing the setting, protection of human rights, data collection procedure, confidentiality and storage, and data analysis.

Van Manen's Method of Phenomenology

Van Manen's (1997) methodical structure of human science research was used to guide this study of the phenomenon of self-compassion among registered nurses (RNs). The research question that was answered using this methodology was "What is the lived experience of self-compassion among RNs in the workplace while caring for others?" According to van Manen (1997), pursuing human science research involves the "dynamic interplay among the six activities" (p. 30) or "methodological themes" (p. 31) as techniques to address a particular question or problem. Van Manen's six research activities are: turning to the nature of lived experience, investigating experience as we live it, reflecting on essential themes, writing and rewriting, maintaining a strong oriented relation, and balancing the research context by considering parts and whole.

Based on van Manen's (1997) recommended approach, the first activity, turning to the phenomenon, was driven by a deep-seated commitment toward a quest that I undertook to gain insights into a specific aspect of human existence. For this step, I approached the phenomenon of self-compassion among RNs with curiosity and wonder. Based on the literature, it is unclear what the experience of self-compassion looks like in this population. This research aimed to shed light on the lived experience among RNs of being kind and compassionate toward themselves to uncover meaning.

Van Manen's (1997) second activity, investigating experience as we live it, involves relooking at an experience with a fresh perspective in order to fully explore, or become full of, the lived experience of the phenomenon. Van Manen emphasized that the researcher needs to stand "in the fullness of life, in the midst of the world of living relations and shared situations" (p. 32). For this step, I conducted interviews to enable RNs to recall of a time when they were kind to themselves at work while caring for others. Taking participants back to the event and asking them to tell their stories uncovered insights. I kept a journal to bracket beliefs, examined my personal knowledge and experience of what was being studied, and came to terms with biases and judgment prior to and after each interview conducted.

According to van Manen (1997), the third activity, reflecting on essential themes, is a grasp of the true reflection of a particular experience that makes it special. This effort makes visible that which may be obscure, for instance, by placing a magnifying glass over the phenomenon or adjusting the lens to see clearly "what is it that constitutes the nature of this lived experience?" (p. 32). For this step, based on the study participants' stories, I conducted a thorough thematic analysis and derived themes. The themes

attempted to capture the phenomenon's meaning and facilitated understanding from the lived experience of RNs.

The fourth activity, according to van Manen (1997), which is the art of writing and rewriting, is the application of language and thought or *logos*. Van Manen stated that through the process of writing and rewriting, what is revealed is "letting that which is being talked about be seen" (p. 33). For this step, I listened to the audio recordings and read the transcripts of the recordings repeatedly to be able to understand the phenomenon from the participants' stories as well as to recall inflections and pauses related to the nuances during the interviews. Reflective writing and complete immersion with the data helped to uncover the meaning of the phenomenon of self-compassion among RNs in the workplace.

The fifth activity, according to van Manen (1997), which is maintaining a strong and oriented relation, requires that the researcher sustain a steadfast hold on the question, phenomenon, or notion being studied without wavering or getting sidetracked. An orientation to research and writing points to the awareness "of the relation between content and form, speaking and acting" (p. 151) and "research and vocation" (p. 135). For instance, my strong oriented relation toward the study participants' stories resulted in deep and rich meanings of their experiences and retained a strong relation to life as lived by the individuals. For this step, I thoroughly reviewed the literature to explore a broader awareness of self-compassion once the themes had been identified from the stories of the participants' lived experiences. An examination to support or refute the themes was carried out during this literature exploration phase.

Lastly, the sixth activity, according to van Manen (1997), is balancing the research context by considering parts and whole. This concerns the question, "What is this phenomenon in its whatness?" (p. 33). The aim during this phase is to maintain a keen focus through writing and reflecting on the participants' stories to create a clear representation of the reveal. To achieve this, a vigilant interchange between the part-whole relation of the study is important. This may be analogous with the painter's "preparation of a canvas for the imagery it is to serve" (p. 167). For this step, I examined the parts and holistic interaction of study findings through erudition and writing to understand the meaning of the experience of self-compassion as perceived by the RN participants.

Participant Selection

The population for this research study consisted of new graduate RNs in professional practice. Graduates from accredited schools of nursing who have successfully passed the National Council Licensure Examination—Registered Nurse (NCLEX-RN), were employed full-time in a health care institution as a licensed RN, and were from 6 to 36 months post-graduation met the inclusion criteria to participate in the study. Participants who had an Associate of Science in Nursing (ASN), a generic Bachelor of Science in Nursing (BSN), or a Diploma in Nursing were considered for inclusion in the study.

The rationale for selecting 6-36 months was based on Benner (1984), who provided insight into the proficiency of nurses who are novice, practicing from 0 to 12 months, and advanced beginners, practicing between 12 to 36 months post-graduation. Benner discussed how neophyte nurses are vulnerable and need support in their practice,

for example, setting priorities and practicing safely "to ensure that no harm comes to the patient and the new nurse" (p. 25).

The estimated sample size of 9-15 individuals for this study was the plan. The actual sample size was determined by saturation, which is when qualitative data collection has reached a sense of closure because new data reveal redundant information (Polit & Beck, 2017). After saturation, an additional two or three participants were interviewed to confirm saturation. To ensure that all themes were identified, a few more participants were interviewed to confirm theme consistency, reach data redundancy, and support the study's relevance. Not every essence was identified when interviewing a limited number of participants, yet common and/or similar themes began to show themselves in a redundant pattern. A sample of nine RNs were interviewed through this voluntary selection process. Thus, this facilitated my understanding of the lived experience of self-compassion among RNs in the workplace.

In this study, the participants represented three states, specifically the Southeast and Northeast regions, as well as the greater New York City metropolitan area. Recruitment methods included convenience sampling, snowball sampling, and distribution of flyers and business cards to advertise the study. Flyers about the study (Appendix A) and business cards (Appendix B) included the researcher's name and study and secure contact information (e.g., phone number and email address), established specifically for the study.

Convenience sampling, such as contacting peers and colleagues to recommend volunteers to participate in the study, was utilized to begin the research (Polit & Beck, 2017). Snowball sampling was also used to recruit participants for this study. Snowball

sampling consists of initial participants who have knowledge of the study (wave 1) and then recommend another group of subjects to participate in the study (wave 2), who then recommend more participants and so on (Heckathorn, 2011). The wavelike motion of sample subjects, like a snowball, builds one wave at a time into a large snowball propelled to roll down the mountain. According to Heckathorn, snowball sampling reduces selection bias and is appropriate for recruiting special and difficult-to-penetrate populations. Self-selection and peer recruitment, as in snowball sampling, provide a random mix of subjects and have the potential for a diverse representation of study participants to provide information-rich sources (Heckathorn, 2011; Polit & Beck, 2017).

I created business cards featuring my name, email, and phone number (Appendix B). To ensure privacy, a special email and phone number were created for the sole purpose of inviting potential participants to contact me for follow-up. When an interested individual called or emailed with interest in participating in the study, I described the study and inclusion criteria, and then emailed the demographic questionnaire (Appendix C) to determine their eligibility. The demographic questionnaire inquired about participants' age, year of graduation from the nursing program they attended, gender, race, and ethnicity (optional), nursing degree earned (ASN, BSN, Diploma), name of the undergraduate college or university attended, current nursing position, whether this was their first nursing position, name of hospital unit they worked in, whether they worked full-time, hours per week they worked in the position held, whether they had a previous career/profession before becoming a RN, and length of time they had worked full-time since graduating from nursing school. If an individual met all criteria (Appendix D), I scheduled an appointment for the face-to-face interview at a time and location convenient

for the participant. Skype or Zoom were two telecommunication application software

products used as alternatives for the in-person, face-to-face, interviews as convenient

ways to participate in the study. At that time, I also reviewed the informed consent

(Appendix E) and obtained verbal and written consent. Following this process, the

phenomenological interview began. In appreciation for participation in the study, upon

completion of the study, participants received a $25.00 Amazon gift certificate.

Setting

A private, quiet, and mutually agreed-upon environment was selected to interview

participants. This facilitated comfort and encouraged participants to share their

experience of self-compassion in the work setting. Written permission to audio-record the

interview was included in the consent form. The interviews were taped on an MP3 digital

voice recorder. Face-to-face interviews allowed for a better chance to observe body

language, facial expressions, and nonverbal communication. In this fashion, further

inquiry, if needed, regarding participants' nonverbal communication during the interview

was elicited.

Protection of Human Subjects

Institutional Review Board (IRB) approval from Teachers College, Columbia

University was obtained and full accordance of policies and procedures was met. The

IRB protocol number provided was included on all documentation. The key factors of

protection of human subjects included: voluntary participation for this study, ability to

terminate participation in the study at any time without consequences, encoded

recordings to ensure privacy, and transcription of audio recordings completed by the

1-888-TYPE-IT-UP service with transcribers who were Collaborative Institutional

Training Initiative (CITI) certified.

Data Collection Procedure

Demographic data included: gender, age, ethnicity, date of graduation, name of

school or university attended, work location, date of hire post-graduation, number of

hours working per week inclusive of shift type (i.e., 8-hour, 12-hour shift), length of time

working since graduation, nursing degree earned, current nursing position, place of

employment and unit, full-time employment, previous career/profession, and previous

nursing position, if any. All interviews were audiotaped. The opening prompt for this

interview was, "Tell me about a time when you were kind to yourself at work while

caring for others." This open-ended question was intended to allow the participants to

share their experience through storytelling. Follow-up questions were asked, each based

on the responses of the participants during the interview. These were intended to bring

the participants back to the moment of the experience to understand more fully what that

experience looked like.

Confidentiality and Data Storage

Adherence to strict confidentiality of data collection and storage of interviews and

transcriptions to protect participants' privacy for the study was followed and included: a

separate locked file cabinet kept in my home office to store participants' data; a secured,

locked, and coded computer to store all electronic data; and written notes, transcripts,

informed consents, demographic data, and audio recordings kept secure under lock and

key. Each participant was given a number and a pseudonym which were included on all

written documentation once the informed consent was filled out. A separate file, which was also locked and secured, was used to store the participants' real names and pseudo-identification codes. Safeguarding all the documents preserved confidentiality. After 5 years, the participants' information will be securely shredded, destroyed, and discarded.

Data Analysis

Audio recordings of the interviews were transcribed by a CITI-certified transcriber from the contracted service of 1-888-TYPE-IT-UP (www.1888typeitup.com). I then analyzed the transcripts by listening to the audio recordings, reading the transcripts, and dwelling with the information to uncover repeated themes or essences from the interviews. I also referred to my field notes to jog my memory about the participants' nonverbal communication, such as facial expressions, posture, and overall appearances during the interviews.

Data analysis began once the transcriptions had been returned and validated by listening to the interview recording side by side with the transcript to ensure that both matched. Then I shared each transcript with each participant to validate perceptions of accuracy and to record any additional thoughts about the interview. The next step was to dwell with the data. For this, I repeatedly read the transcripts while listening to the audio recordings to become aware of nuances, voice inflections, and other verbal clues. At this point, I read and reread the transcripts and identified and listed the meaning units. These meaning units were then clustered and synthesized into themes. The themes were reviewed and synthesized to develop essential themes. Finally, I synthesized the essential themes into an interpretive statement. During the course of data analysis and synthesis, I used my notes from the journal to record ongoing thoughts, responses, and the like in

order to expand my thinking about themes, essential themes, and the interpretive statement. To ensure that themes were identified, I sent all participants the themes and asked them to confirm not only the consistency of their statements with the themes, but also to comment on the themes as representing how they had experienced the phenomenon.

Rigor was established by discussing preliminary study findings with study informants to validate their experience and the consistency of meaning. In addition, I practiced diligent and earnest journaling before and after interviewing participants to examine personal biases, references, and preconceptions, and exercise reflexivity or critical self-reflection. This was conducted to best convey the reflective experiences of the RNs without any representation of myself or my experiences. Furthermore, I asked two other researchers to analyze the qualitative data and ensure reliable interview data accounts and use of bracketing. This assisted in further validating the participants' interview data and the thematic analysis. These steps were carefully taken to confirm qualitative data analysis credibility, which was important to convey the results and interpretations confidently and truthfully.

Summary

This chapter depicted the applied phenomenological method, according to van Manen's six activities, that was used to conduct this human science research. The detailed procedures for conducting the research were emphasized. Chapter V next examines the research findings.

Chapter V

FINDINGS OF THE STUDY

In this study, the phenomenon of self-compassion among registered nurses (RNs) in clinical practice was explored, described, and illuminated. Nine RNs, eight females and one male, were interviewed about their experience of being kind to themselves in the workplace while caring for others. The hermeneutic phenomenological method, according to Max van Manen (1997), was used to describe, interpret, and analyze the participants' lived experiences. This method was utilized in an effort to uncover meaning or themes and derive a collective understanding of the essences in order to put them into textual form. Van Manen posited that an individual's lived experience is personal, and unlike a material object or thing that can be fully described and made general, each person's experience is unique and no two are alike. With this in mind, I identified themes to try to explain or describe for the reader each participant's experiences and, by doing so, enliven his or her own lived experience.

Participants' Demographics

According to van Manen (1997), background information with descriptions about each participant and where he or she comes from promotes understanding of the experiences. The participants in this study worked in clinical hospital environments and were between 6 to 36 months post-graduation. Their stories consisted of situations that

took place while they were at work, either during or after their hospital orientation phase. All of the participants described having at least 6 months of nursing orientation with one or more preceptors (an experienced nurse). They also mentioned having completed from 6-12 months of a Nurse Residency Program, which is a hospital-based program that facilitates recent graduates to transition into clinical practice.

The participants' ages ranged from 24 to 48 years old. Four of the participants had a previous career outside of nursing. One participant, within the 36-month post-graduation timeframe, held more than one nursing position. Two worked in the Labor and Delivery unit; one in the Adult Medical-Surgical unit; two in the Neurosciences Intensive Care unit; one in the Intensive Care unit; one in the Medical-Surgical Oncology unit; and two in Pediatric/Pediatric Intensive Care Unit. See Table 1 for the participants' demographic information. Study participants were given pseudonyms so their actual names would not be used.

Individual Participants' Experiences

Amy

Amy's enthusiasm to participate in this study was evident the moment she initiated contact with me by email to arrange an interview. She heard about the study from a previous faculty colleague of mine, whom I contacted to help to recruit study participants and initiate the snowball sampling. Amy currently works as a staff nurse on a Medical/Geriatric unit of a large regional medical center. She has been working there for 36 months. This is Amy's first professional nursing position since her graduation in 2015. Prior to becoming a nurse, she was a school teacher.

Table 1

Demographic Information

Name	Age	Year Graduated	Number of Months as a RN	Hospital Unit	First Position in Nursing	Prior Career
#1 Amy	46	2015	36 months	Adult Medical Surgical Unit	Yes	Yes
#2 Betty	27	2016	24 months	Neurosciences Intensive Care Unit	Yes	No
#3 Carol	24	2015	36 months	Birthing Center/ Labor and Delivery Unit	Yes	No
#4 Diana	41	2016	24 months	Labor and Delivery Unit	Yes	Yes
#5 Evelyn	24	2015	36 months	Pediatric Intensive Care Unit	No	No
#6 Fran	27	2016	17 months	Intensive Care Unit	Yes	No
#7 Gina	48	2016	24 months	Medical Surgical/Oncology Unit	Yes	Yes
#8 Tom	31	2015	36 months	Neurosciences Intensive Care Unit	Yes	Yes
#9 Jackie	26	2018	7 months	Pediatric/Pediatric Intensive Care Unit	Yes	No

We conducted the face-to-face interview at a local coffee shop where Amy likes to frequent. It was summertime. She wore a skirt, with a solid color, short-sleeved blouse and closed-toe sandals. Her hair was shoulder-length and neatly coiffed. Amy's smile conveyed warmth and peacefulness. She was eager to hear my question ("Tell me about a time when you were kind to yourself at work while caring for others") and after she heard it, her facial expression was one of slight uncertainty. Amy paused for a moment, then stated:

> Kind to myself? Mm-hmm. Mm, I think it is, like, instead of keep going to… call to call and room to room, I just decide to go to the bathroom or to drink water. Sometimes I ignore that…and I just hold the bathroom visit, like, many hours, for six hours, seven hours sometimes, and I realize that I didn't drink for more than six hours or something like that, and I just really need that. But sometimes I really ignore that many hours until I feel really, dizzy or, too much pain for my bladder, stuff like that…. My rule is having five minutes outside of the building. But sometimes it happens only one time, sometimes happens zero. For example, yesterday, it happened zero times because my floor is fifth floor, and it's hard to go downstairs to fresh air…. So, when I have chance after the busy morning, between eleven to twelve, I try to go down with the elevator, really five minutes, breathing in, breathe out, a little bit of stretching, and come back. Then after, I feel much better.

Betty

Betty had a warm smile, displayed a calm demeanor, and articulated a desire to share her experiences. She learned about the study from another previous faculty colleague of mine. Betty contacted me directly by email. She expressed interest in the study because she would soon begin working toward earning a Master's degree to become a Nurse Practitioner.

Betty suggested that we meet at a Starbucks café near her home. She had long brown hair and wore casual attire consisting of light slacks, a short-sleeved top, and sandals. She has been working in the Neurological Intensive Care Unit (ICU) in a major

medical facility for 24 months. Although her first undergraduate degree was in psychology, nursing is her first profession, and this is her first professional position since graduation. Betty stated her mom is also a nurse. She explained that on the Neurological ICU where she works, "there will be great weeks and then there'll be weeks when everything goes wrong." Nevertheless, she emphasized that the nursing staff where she works is supportive as she began to tell her story:

> One thing I had trouble with in the beginning is, I would work through lunch, not take any breaks and stay late to finish charting and that just became a lot to deal with. So, one thing I have gotten a lot better at is talking to my neighboring nurses, making a plan for lunch. That has helped me stick to that. And it also helps that the nurses I work with are really supportive because, you know, if someone notices someone hasn't taken a break, they'll say "I'll watch your patients." You tell them everything they need to know. You feel safe leaving the patients with them. They'll say go take fifteen minutes and get a coffee or take lunch and don't come back until 30 minutes is up. That's probably how I would say I'm kind to myself at work.

Carol

Carol appeared vivacious and had a big smile upon arrival to the interview. She heard about the study from a faculty member whom she sees at the hospital where she works. Carol is a Labor and Delivery nurse on the Maternity Unit of a major medical center. She completed her undergraduate nursing studies in the spring of 2015 and has been practicing on the unit where she is currently employed for the past 36 months. Nursing is her first profession. Carol told me that both her mother and older sister are nurses and they are her role models.

Carol emailed me requesting to participate in the study. We scheduled to meet on a weekday morning at a mutually convenient Starbucks café. Carol wore a stylish grey/black stretchy athletic outfit with sneakers. Her light blonde hair was arranged high

up in a twisted knot. "It's my day off and after this interview, I'm headed to the gym,"

she excitedly stated. Carol shared her initial thoughts about being kind to herself when

she looked back at her experience as a new nurse:

> I try to be as patient with myself as possible, in caring for my patients. I think we have a profession where we have to give a lot of ourselves up for hours and hours at a time and I think that when I first started as a nurse, I didn't really take time to take care of myself. I think I gradually learned how important it was to just like, kind of, take a step back, take a break, eat something, drink something, all those things during those twelve hours. I think being patient with myself in making mistakes when caring for my patients. You know, giving myself some grace with that.

Diana

Diana radiated a strong caring presence that was apparent the moment her smiling

image appeared on the computer screen. She was the first study participant whom I

interviewed through Skype, a telecommunication application software product. Diana

learned about the study from Betty, who had posted it on a group chat forum, and emailed

me directly requesting to participate in the study. Nursing is a second profession for

Diana. She graduated in the spring of 2016. Her previous profession was in Information

Technology.

Diana had shoulder-length brown hair, which was partly down in back and partly

up in front, and she wore a V-neck t-shirt. She sat in a cozy-looking flowered lounge

chair with a window directly behind her. During the interview, she appeared content to

participate by readily sharing her story. Diana is a Labor and Delivery nurse and works

for a major medical center.

Diana shared a story that was "fresh in her mind from the week before, at work,"

when she cared for a patient with Intrauterine Fetal Demise (IUFD) at 29 weeks. She

stated, "It was a particularly difficult situation…. And that is never an easy situation to care for…it just takes a lot out of you emotionally." Reflexively, Diana described being kind to herself in this way:

> All of the stuff that I can typically handle on a day-to-day basis, I didn't have emotional space for because…I was giving that all to my patient. So, in terms of taking care of myself…I was able to articulate that. I mean, just being able to articulate, hey, I'm giving all this capacity to my patient, and I know it's difficult to expect myself to handle this other capacity [another patient assignment]. Just taking the time to take a deep breath, feel my feet on the ground, and just recognize the suck of the situation and my ability, you know, like, what's reasonable to expect of myself. That was a way that I cared for myself.

Evelyn

Evelyn was enthusiastic about participating in the study, especially because she was about to embark on her graduate studies to become a Pediatric Nurse Practitioner. She contacted me by email and we scheduled a Skype interview on a weekday morning. Evelyn learned about the study from one of the faculty members. She worked full-time on a Pediatric Intensive Care Unit (PICU). She graduated in the spring of 2015 and nursing is her first profession.

Evelyn wore her straight thin blonde hair loosely around her face, displaying its length just below the shoulders. She wore a white t-shirt, and the bare white wall before which she sat subtly framed her upper body on the computer screen. Her meek smile displayed gentleness and warmth. Evelyn looked refreshed and spoke with a soft and lucid voice. She revealed having recently moved into a new apartment to be closer to the university, where she will be studying, and her work setting. Evelyn candidly responded to my question about being kind to herself while at work, and shared her touching story:

I think, for me, in the PICU…we're really busy taking care of really sick patients, and then we don't really have the time to regroup and think about where we stand and what we're feeling about things…. One example of a patient that I took care of for many weeks…was a day that we were doing Brain Death Exams on him. And we were really busy because it was flu season, and my charge nurse decided to give me an admission…. And I had to sort of regroup, figure out what I was going to do about this situation that was going to be most beneficial for both of my patients, but also for me…. And I had to advocate for myself in that circumstance. And I think, for me, it kind of assisted in my ability to have closure and see this patient that I was taking care of from start to finish…. So…I'm very happy that I was able to do that…. I needed to be there, to have…the full circle experience with that patient.

Fran

Fran heard about the study from a doctoral student at another university. She contacted me by telephone, via a text message, and was animated about being interviewed through Skype to begin the study process. Fran lives and works in a large metropolitan area. She had been practicing as a nurse for 17 months and worked on an ICU. Fran was hired to work in the ICU as a new graduate nurse. Nursing is her first profession.

Fran dressed in bluish/green work scrubs for the interview. Her hair was wrapped up in a colorful brown and yellow printed headdress. She had a friendly smile and warm, big, round brown eyes. It was delightful to interview Fran because her experiences were shared openly and easily. Fran exuded a palpable sense of pride and respect for her chosen nursing profession. She conveyed a deep honor to be able to work in the ICU setting upon graduation from nursing school. Fran clarified that she worked hard to earn her nursing degree and is the first nurse in her family. When I asked her about her experience of being kind to herself, she described a stressful situation on the unit with a patient during her orientation period:

I was criticized for my age. My patient was in his forties, and he did not trust me at all because I was young…. It basically kind of made me feel like, no matter all…the hard work I've done up until this point to become an RN, I'm still going to be criticized based on my youth. So, in that instance, after I gave him his medication, I told him, oh, excuse me, I forgot something, I'll come back. I went to the bathroom and, I admit, I did tear up a little bit. So, I just basically washed my face…and dried my face, and I took a deep breath. And I want to say, maybe, I stayed there for a good five minutes, and then I basically just kept telling… myself that this will be fine.

Gina

Gina contacted me by email a few days after I had distributed study-related announcements and business cards at a university to current graduate nursing students. A nurse from one of the graduate programs inspired Gina to participate in the research. Gina was animated about the study when she contacted me and chose to meet in person for the interview. She had been working approximately 2 years on an Oncology Unit of a large hospital and this was her first nursing job since graduation from nursing school. Gina was previously a Social Worker before becoming a RN and was in the process of completing a Bachelor's degree in Nursing through an online program.

We met at a local Starbucks café close to her work. Gina had just completed her shift at work and was dressed in grey scrubs and white work sneakers. Her shoulder-length hair was highlighted and worn loosely. Gina had a caring smile and was eager to begin the interview. My impressions of Gina were that she is organized and efficient as a nurse. She spoke with a classic local accent and her answers were brief. She told me when she became a nurse, she had to think about her needs and make choices:

There was a holistic nurse, who used to come around…she would offer…five-minute massages, so—shoulder massages—or do some aromatherapy…we'd all be happy to see her, but yet it's like, oh, boy, I don't have time to step aside for ten minutes. Really, that's all it is…I don't have time. That's always a big thing. But I made time. And I went, and I saw her…. But I said, you know what, I'm allowed to take ten minutes. So, I told one of my co-workers. And of course, she

was like, fine, go ahead. It was more me thinking…what's going to happen if I leave the floor for ten minutes? People are usually very receptive in—you know, offering to help or are available to cover your patients while you're gone. But it was more me thinking, oh, boy, I can't get off the floor for ten minutes. But I was glad I did.

Tom

Tom found out about the study from Amy. He contacted me directly by telephone and was curious about the study. Upon learning more about the study from me, Tom was immediately drawn to participate. He had recently begun his studies toward a Master's degree in the Nurse Practitioner program at a local university. Tom had been practicing in the Neurological ICU setting at a large regional hospital since having graduated from nursing school in 2015. Nursing is a second profession for Tom and this was his first job as a new graduate nurse. His previous career was in retail.

An interview was scheduled via another telecommunication application software product called Zoom, which Tom preferred and requested to use. We met on a weekday morning for the interview. Tom wore a beige t-shirt and sat in a comfortable-looking taupe chair, with the kitchen of his apartment in the background. Chloe, his cat, was nearby. His hair was light brown, short and stylish. Tom's smile expressed a friendly and cheerful demeanor. He related, in general, times that were challenging in the work setting when dealing with individuals in authority. Tom described feeling "intimidated or made to feel condescended to and just sometimes made to feel really dumb." He added:

> But then, being kind to yourself…you're advocating for your patient. You wouldn't be going to them [the provider] unless you had…your own reasons for being concerned. And you're all on the same team. It's just that you have to recognize that they have their stressors too! But then, just being kind to yourself…it helps.

When asked to elaborate further on his experience, Tom commented on his thinking and perception of self that he saw as being kind to himself:

> You can be your own worst enemy, so if you can kind of figure out ways to feel a little bit better about yourself, be kinder to yourself…. I knew beforehand that I was, smart and kind, and funny. But, more importantly, I would list, all these negative things…. I'd just intensify the negative things whereas…to find those really good things about myself and really, accept them as true, you know, my truth. So that sort of, acknowledgment of one's own strengths, you know, and defeating your harshest critic, yourself, helped me in those moments where a provider or somebody in a position of power was being condescending to me.

Jackie

Jackie was a jovial and passionate new graduate nurse who recently completed orientation on her unit a few days before we met for the interview. She was currently working in the PICU of a large community hospital. A hospital Nursing Director was contacted to help with recruitment of study participants, which is how Jackie learned about the study. Jackie sent me a text message denoting interest to join the study and preferred an in-person interview. We met during a weekday afternoon, on her day off, at a Starbucks café which she frequents regularly on her way to work.

Jackie exhibited a congenial smile and was amiable and ready to get started with the interview. Her relaxed attire consisted of a comfortable grey sweatshirt with a loose, batik-print pair of pants and sandals. Jackie had highlighted blonde hair that was worn up in a ponytail initially, then half-way through the interview she let her hair down. She commented that she feels the hospital she works for "is good to us…we self-schedule…" and "they offer us Reiki." When I asked her to tell me about a time when she was kind to herself at work while caring for others, Jackie commented about some of her challenges as a new nurse:

When I first started working, I really didn't make time for myself to eat or pee. And I actually would get sick…UTIs [Urinary Tract Infections] and stuff…. It was my preceptor…I'm very lucky that we had a very good relationship, and I feel like she was my nurse mom. And she basically—didn't force me but, would…tell me, "You have to take breaks…you have to, and actually, like, you really are supposed to." So, I feel very kind to myself when I stop to do those simple things. It sounds like a simple thing, oh, you're going to just eat a yogurt quickly, but some days it's hard…. That's the truth…but sometimes you can't get off the unit to go [to Reiki]. That's the whole thing…I think the big thing is, being able to take those breaks…you're supposed to be able to, and I have to be in control of that for myself, to be like, I'm going to take a break now. But it's just hard sometimes. I don't know. It doesn't seem like it's the most important thing. That's the thing.

Thematic Analysis

The phenomenological method of van Manen (1997) illustrated the fourth activity as the art of writing and rewriting. Carrying out the steps in this activity was accomplished through scrupulous dwelling on and connecting with the participants' personal stories. The process involved deep reflection while reading the transcripts several times, along with reviewing my notes, listening to the audio-recorded interviews multiple times, then writing and rewriting, and lastly, visualizing the themes that emanated into interpreted meanings.

The entire analysis process, re-listening to the interviews and dwelling on and rereading the transcripts, took several months to complete. A spreadsheet was developed consisting of common ideas and participants' phrases from the interview transcripts that were placed into clusters of similar categories. The grouped words and phrases were examined to identify what theme they seemed to represent.

From most of the interviews, 14 possible meaning units emerged and were readily apparent. The meaning units were placed in a list. The analysis progressed with the detection of the theme categories, which were created directly from the participants'

specific quotes, then collated. As the end result, the essential themes revealed which aspects or qualities made the phenomenon of self-compassion among the participants working in the clinical setting while taking care of others what it is; what that experience is like; and without identifying it, the phenomenon could not be (van Manen, 1997).

The meaning units were identified by highlighting the common phrases or ideas with different colors. Several efforts were made to arrange and rearrange the phrases into the different clusters of ideas for a suitable match. The meaning units that were clustered were then merged into one-word themes. Thematic identification consisted of further revisions and changes to fine-tune the themes. The spreadsheet and the themes were given to my advisor and a qualitative research expert for review. A total of 14 themes, outlined meaning units, were identified. Four essential themes and 10 subthemes emerged. The 14 meaning units that arose were:

1. time,

2. communication,

3. team-based practice,

4. professionalism,

5. prioritization,

6. support,

7. relationship,

8. assertiveness,

9. self-esteem,

10. ethics,

11. care,

12. competence,

13. transparency, and

14. efficiency.

A table consisting of the essential themes and subthemes that emerged was constructed (see Table 2). I sent an email to the study participants with the themes and subthemes attached, requesting feedback, comments, concerns, and clarification related to the uncovered themes and subthemes. Several of the participants emailed me with no concerns. The responses I received from participants indicated approval, such as "I agree with the themes" and "I definitely agree with the themes." Table 2 contains the final essential themes and subthemes.

Table 2

Essential Themes and Subthemes

Essential Themes	Subthemes
Theme 1: Transforming Time Famine	I. Efficiency II. Take time for self and breathe
Theme 2: Authentic Communication and Presence	I. Transparency in practice II. Assertiveness matters III. Ethical accountability
Theme 3: Collegial Cohesion	I. Culture of reciprocity II. Social engagement
Theme 4: Evolution Toward an Ideal Registered Nurse	I. Empowerment II. Recognition of their growth and development

Establishing Rigor

A component of interpretive research entails establishing rigor. I established and maintained a strong relation to the phenomenological question of what it was like to be kind to oneself at work while caring for others. The use of our personal orientation is a foundation for phenomenological inquiry. Van Manen (1997) asserted that phenomenology captures personal and unique anecdotal stories that are related to our comprehension of things and how we comprehend ourselves. Through human science research and hermeneutic phenomenological reflection, a broader yet deeper awareness of the essence of thoughtfulness and understanding is possible. With this idea in mind, conscious engagement and a sense of knowing and direction opens the ability to "see" things that are happening in a situation mindfully, in that moment. As nurse educators and leaders, understanding and questioning the experiences of novice and advanced beginner RNs is critical for making necessary changes to ensure safe and sustainable practices.

The phenomenological texts are oriented, strong, rich, and deep. These four conditions are methodological requisites for phenomenological human science research, what give it power and credible validity, and are used as evaluative criteria. To orient oneself to the world of the participants, I spent time dwelling with the participants' stories by listening to the audio-recorded interviews, reading and re-reading the transcripts, reflecting on their experiences and words, and thereby developing a strong personal connection. This process allowed for a complete immersion with the deep and rich meanings of the reflected descriptions, which enabled me to emerge with the

essences of the participants' experiences. I utilized all of the four conditions, which enabled me to convey to the reader the evolution of the process.

Essential Theme 1: Transforming Time Famine

All of the study participants identified having some concern associated with managing time and often not having enough time to be kind to themselves while at work and to do everything. Transforming time famine describes how the participants realized that the time they spent at work involved lengthy, 12-hour shifts which, somehow, were still not enough. I had the impression that they were hungry for time. In addition, they expressed a continual attempt to develop and adjust their skills to accomplish their tasks; care for the patients, the patients' families, and themselves; and complete their documentation in order to be able to leave on time at the end of the shift. Each participant understood that the work time allotted to care for their patients and complete their tasks needed to be dealt with on a day-to-day basis. As such, it was a work in progress. Some participants described writing and creating prioritized lists about their shift activities, including conducting hourly rounds, planning ahead, and making an effort to use time to their advantage. Throughout most of the interviews, this theme presented itself repeatedly. The participants mentioned that time was always on their mind in being able to give quality care while not neglecting their own needs and being kind to themselves in the workplace.

Two subthemes were readily exposed: Efficiency, and Take Time for Self and Breathe. These were integrated to create the first essential theme, Transforming Time Famine.

Subtheme I: Efficiency. Betty verbalized how she was continually concerned about getting her work done on time as a new graduate nurse, but the key element for her was being aware that it takes time to develop this skill:

> You just have to take a step at a time and realize that all of these experiences are helping me…. It takes time to learn how to be efficient, and how to prioritize. I really learned how to use my resources and ask for help when I needed it.

The subtheme of efficiency revealed itself through the participants' examples of needing to be organized and good at what they were doing for their patients, and their desire to deliver quality nursing care. Patient care demands that RNs possess and execute many expert skills and qualities. The RN, through practice, learns how to efficiently balance the necessary duties and responsibilities, and perform them in a timely fashion (Benner, 1989).

Subtheme II: Take time for self and breathe. Diana expressed that consciously taking time for lunch to be with herself was a requisite. She described her thoughts and validated the rationale for reserving time to receive nourishment:

> Just taking my lunch was an act of care...you are deserving of a lunch break. I am worth my lunch. I mean, it is thirty minutes out of twelve hours. I am worth that time…that's just what I need…thirty minutes away, not talking to somebody…that is, like, sacred space to me…So what does it look like? It really is just leaving the unit. It's just a peaceful walk down to the cafeteria...it's an escape. I eat my lunch; I enjoy it.

Most of the participants shared how it is important to take time to care for oneself—to eat something, drink fluids, and eliminate waste during a 12-hour shift. The majority of the interviewees also contributed that it was in their patients' best interest for them to do so. For instance, Betty expressed that patient care is affected by her taking time for herself:

> Glad I did it. I don't regret taking a break. I have never once regretted, oh I shouldn't have taken my lunch break today…. I feel rejuvenated and ready to take on the next task, whatever that is…. Recognizing I need to step away…not think

about what's going on for thirty minutes…when I get back I end up being a better nurse than I would be if I just worked through lunch.

The notion that "taking time for lunch" or "go[ing] on a break" was a choice also came up for most of the participants. Interviewees expressed having the option to take their break or lunch time or not doing so. This personal preference is an integral component of this subtheme. Amy explained what it was like to take time away from the unit and why she felt the need to make that choice. She was keenly aware of when she did take time and when she did not take the time off the unit to breathe, and the difference between the two:

> My rule is having five minutes outside of the building…. We work inside the building constantly with very emotionally charged patients and families, so we need alone time…to breath out all those things…. I have the intention to give myself some short, but refreshing breaks…during my shift, such as stepping outside to breathe in and out in my favorite spot, an herb garden next to the cancer center; three to five minutes of break around eleven a.m. and/or three p.m.… But it does not go that way most of the time…. I know the value of a short break, giving me new energy to…my body, mind and soul…to be present and to provide compassionate care for my patients.

Essential Theme 2: Authentic Communication and Presence

All of the participants shared what it was like for them to be able to communicate effectively with members of the team, such as the charge nurse, provider, and staff. The necessity to work on communicating genuinely and confidently came through over and over. Being able to recognize and overcome the fear of saying something that may reveal they had a problem, made themselves sound foolish, or did not know something was common among the participants. Nevertheless, most of the participants related positive learning points through their stories of being kind to themselves in the workplace while caring for others.

Three subthemes came forth: Transparency in Practice, Assertiveness Matters, and Ethical Accountability. These were combined to produce the second essential theme, Authentic Communication and Presence.

Subtheme I: Transparency in practice. Carol described her difficulty with trying to communicate openly after she had made a mistake and needed to disclose it to the provider and the team:

> When I first made a medical error and gave a medication incorrectly, I kicked myself about it. You have this fear of telling the provider and communicating that. It is just so scary and intimidating. I gave the wrong dose of this medicine. It ended up not hurting anybody and it was a patient that could tolerate that dose…. We hear about these medical errors all the time and how dangerous they are. That they are a cause of death for a lot of Americans. It made me feel stupid. Made me feel less competent as a nurse…. The dosing information is right there. And yet, I overlooked it. I think maybe…I was on autopilot…. I was terrified for the patient, definitely! But also admitting to my mistake to the provider and the patient…it was something that could have caused harm, but didn't…but I used it as a learning opportunity…that's one of the times that I have cried at work. So, I think just kind of letting it out was probably good. Communicating the best that I could with my team…. They were very gracious.

What the participants described was a need to be straightforward and feel comfortable about communicating to the team and their patients. For example, in Betty's case, it was about the patients' safety:

> So now I'm upfront. If it's truly something I feel is not a safe situation…so that the patients are getting the care that they need, then I will speak up and say something to the charge nurse.

On the other hand, Tom described a thought-provoking situation about communicating under stress. He paused for a moment, then stated, "Do I really want to approach the provider about this situation?" He added:

> Hesitation comes into play when you've had a bad experience with a provider. It makes you feel like you're incompetent, basically. If I didn't have, you know…this problematic relationship with the provider, I would talk to them without hesitation.

Everyone has a responsibility to communicate to the team members, and doing so with

clarity and resolve, albeit challenging, came through as a continuous work in progress.

Subtheme II: Assertiveness matters. Amy shared a situation in the workplace

that was difficult for her to communicate clearly and to describe her needs during a

stressful time with the charge nurse about her assignment:

> They mostly…give [difficult assignments] to those nurses who never complain, very compliant and quiet nurses. That happens. And then some nurses just leave after, you know—[being] tired of those things.... But some people voice up…. So, one time, my co-worker…she wanted to talk to me because…she was the charge nurse. I was really [overwhelmed] given so heavy workload. Well, whenever she [came up to me], "Hi, are you OK?" Then I said, yeah, sure, I'm good. I'm good. But I just tried to explain to her that I am frustrated, but it was kind of very passive way. Like, oh, I have this much medicine, I have to give them—you know, I thought I showed that I'm very stressed out from…too much workload, but she didn't recognize it because I was very passive.... She wasn't sure I really needed help because I didn't use those words. Like, I need help. I cannot do this. Like that, I wasn't very clear about that…I should have been more assertive that way, but I always have a little bit of an issue with that, being assertive to the charge nurse.

From that experience, Amy stated she learned a very important lesson about

communicating in a confident manner, to assert herself, in order to get the help she

needed. Betty shared how she understood the need for proactive communication through

a situation she experienced and had discussed with her roommate, who is also a nurse.

She related what her roommate told her:

> People complain about assignments when they shouldn't even complain about assignments. If you feel like you did not sit down all day because it wasn't a safe situation, you can say that to someone. They want you to say that. That's going to make the situation better for everyone.

Subtheme III: Ethical accountability. Evelyn described a difficult experience

when she was preparing to conduct a final Brain Death Exam on a pediatric patient she

had been taking care of for a few weeks. The patient's family trusted and wanted her to

be in the room at the time of the exam. She contemplated her responsibilities and being present for the exam, and knew it was the right thing to do except that she had been assigned another patient in critical condition. In that moment, she made use of her clinical judgment and critical thinking, but she felt stressed, so much so she could not simultaneously be present to perform the Brain Death Exam and provide care for her newly assigned critically ill patient. Her decision was to uphold her professional integrity and responsibility by discussing the situation with the charge nurse:

> I need to start this Brain Death Exam. I've got a patient over here that…needs to be flat for the next four hours. But she's two [years old], and we are holding pressure…. I can't physically be in both of these places at once…

After Evelyn's conversation with the charge nurse, the critically ill patient was reassigned and Evelyn was able to conduct the final Brain Death Exam. She shared her thoughts about what may have happened had she not acted and sought consultation with the charge nurse, and also described the vital lesson associated with her being present for the exam:

> And I could have taken the other patient, I would just have not been present during the time that we did the Brain Death Exam…. But I wanted to know… what his end was going to look like…. I wanted to be there to see that the Brain Death Exam went the way that it did…. It was closure in that outcome of the patient. So it was hard, for many weeks, knowing what I knew and feeling the way I felt, that this patient was not going to make a recovery, while having a relationship with the family who was hoping for one. But I appreciate when we're able to do the Brain Death Exam…. It gives me kind of a sense of peace with when we withdraw care…

Diana articulated her experience through a very difficult work shift, caring for a patient with an intrauterine fetal demise (IUFD). She was aware of the special skills, necessary duties, and emotionally charged responsibility involved in caring for such a patient, including the depth of compassion and presence necessary to provide care in this instance:

The charge nurse needed to give me an assignment, she said…she's not really doing anything. No big deal. And I said, that's fine…I can only take her if she's going to sit. If we're going to do any active thing, I will not be able to take her.… I know I am personally operating throughout the day, with a fetal demise.… And it's a constant, am I doing the right thing? But they are going through an experience that, again, is going to be something they will always remember. It will be the only day they spend with their child. And that's profound to me. You don't ever expect to only spend one day with your child. You expect a whole lifetime—if the one thing that I can do is bear witness, that makes me feel—it's not about me, but it makes me feel—I don't know if the word is of use; of service doesn't sound right either. But it makes me feel pertinent. I don't quite have the vocabulary for it…

Essential Theme 3: Collegial Cohesion

Working in an environment that fosters support for its members, for instance, a sense of camaraderie and looking out for one another, was a constant theme throughout most of the interviews. The awareness of unity and caring in the workplace while being kind to oneself was expressed and understood by the participants as an exchange of mutuality and looking out for one another. The opportunity to feel cared about and to care for others in return within the workplace is inestimable. The majority of the participants contributed that one main reason for staying in their job was because of the people and the relationships they made at work. Betty shared that on her unit there is a resource nurse, "She'll come up and say, I got it! Tell me what I need to know. Go take your break. I'll cover for you."

Two subthemes emerged: Culture of Reciprocity and Social Engagement. These were synthesized to create the essential theme of Collegial Cohesion.

Subtheme I: Culture of reciprocity. Carol expressed what it was like to work with her preceptor and how it contributed to her professional attitude. In addition, the

support she needed she received as a new nurse, and it gave her reassurance during

stressful situations:

> I had a great resource in my preceptor. She's one of the people that I really admire a lot in my job. I think she's made me; she's helped me to be a better nurse.… That's part of the reason why I made the decision to work nights, as long as I did. As a new nurse on Labor and Delivery, I felt like the support on nights was so much better. I felt like people helped me and did things for me without me asking in stressful situations. I remember my first delivery…on my own. I called for help because I freaked out. Someone came right in and she didn't question all the things that I wanted to do. I wanted to reposition my patient, I wanted to give a fluid bolus, I wanted to alert the provider. And she jumped right in and helped me do all of these things, because you really need a hundred and fifty hands to do all the tasks that you want to do, in situations that stress you out like that. I appreciated that, for sure.

Tom described reaching out to another colleague whom he felt may be in need:

> I remember seeing another nurse who was behind me, in terms of experience, at the end of the day when she was doing her documentation, I could see that she was upset. And I took on a preceptor, mentor role, beginning at six months or so...informally. Nurses that I had precepted two years ago, you know, would say, you were the first person that made me ask myself, what next? So, really thinking ahead instead of being told what to do. I think I'm a good nurse and a good teacher, and there's independent verification of that.

Subtheme II: Social engagement. Gina explained how she bonded with the

nurses on her unit, "We would plan…once every maybe six weeks…to go out for dinner;

go for drinks. I went on a nursing conference with them." In addition, being able to plan

parties, such as a potluck dinner on New Year's Eve, and celebrate each other's birthdays

during their break time at work was fun and gave the participants something to look

forward to. Betty had an epiphany through her ability to connect with her peers on and

off the unit:

> I felt the other new nurses had it all under control.… Then I started talking with them and hanging out with them outside of work and they were all exactly the same as me, struggling, a lot…making those friendships helped a lot. Just being able to relate to other people.

Essential Theme 4: Evolution Toward an Ideal Registered Nurse

All of the participants discussed envisioning themselves in the future as expert and caring nurses as they shared stories about being kind to themselves. Betty expressed that she wanted to be good at what she does and wished she could fast-forward time to be just like the experienced nurses she worked with. Gina commented that she observed the seasoned nurses taking their break and admired how they went about their workday. The participants were all aware of their advanced beginner status, but embraced that they could imagine themselves being the experts. The opportunity to reflect back to the past, see themselves in the present moment, and visualize or project their potential for professional growth and development is what came through consistently in the interviewees' stories about self-kindness in the workplace while caring for others.

Two subthemes emerged: Empowerment and Recognition of Their Growth and Development. These were integrated to create the essential theme of Evolution Toward an Ideal Registered Nurse.

Subtheme I: Empowerment. Fran described a situation when she drew from her strengths to cope with a difficult patient situation. She recounted all the accomplishments and hard work she had done up to that point in her life, which made her proud of herself and her abilities:

> I know what I'm doing. I have to trust in my abilities as a nurse. I may be new; I may be young, but if I was able to go through all the obstacles of nursing school, passing the NCLEX-RN and getting this ICU job…. I told myself, I'm more than capable to take care of this patient and all other patients who are also going to possibly criticize me…also maybe not trust me initially. But I am going to do all in my power to, basically, prove them wrong and, you know, show them that I can be as great as the other veteran nurses, the ones who've been doing this for decades…So, while I may not meet their initial expectations, because they were expecting older nurses, I'm still going to apply the same amount of care that these older nurses have done for decades. Basically, I'm going to do the same thing that

they've done to their patients onto my patients as well, even though I don't meet their expectations initially. So, I think like that to myself.

Subtheme II: Recognition of their growth and development. Tom articulated the time when his preceptor asked him to assess his progress during his orientation in the hospital Neurosciences ICU setting. He was able to glance back to his experience from nursing school to where he was at that time, and described his progress:

> She [preceptor] asked me what I thought of myself…. And, the fact that I thought I had gone from, barely, knowing how to flush an I.V. to being able to manage drips and do, an accurate assessment and think critically, and safely…. Before she gave her own judgment…she agreed, that I had. You know, it helped…. I saw myself as being, a good nurse, and that was just reinforced over time by my patients, and families, and providers too! Though—it goes all the way back to, the [nursing school] lab. You would see where we're learning our foundational skills and—I didn't have to do a single redo there. I was always prepared, and I studied harder, and I'm smart. And so—sometimes you have to dig deep to find those qualities about yourself and remind yourself, why you're doing this, why you went into it in the first place; because I want to take care of people.

Interpretive Statement

An interpretive statement was created by synthesizing the four essential themes. This statement provides insight into the phenomenon of interest for this study. The interpretive statement reads: *The lived experience of self-compassion among registered nurses in the clinical workplace while caring for others is one of transforming time famine with authentic communication and presence, collegial cohesion, and evolution toward an ideal registered nurse.*

Summary

This chapter focused on the description of the phenomenological inquiry process into the lived experience of self-compassion among RNs in the workplace. This unique

group of RNs in clinical practice had not yet been studied concerning this. The experiences of self-compassion among RNs were explored through reflection during the interview process. The process entailed: achieving contact with the participants; interviewing them; keeping a journal of data; reading and rereading through a process of immersion and listening and re-listening to their stories; and identifying the themes, subthemes, and essential themes that the participants verified for clarity. Through the process of analysis, the participants' descriptions revealed the essences of meanings. The next chapter discusses the findings of the study.

Chapter VI

REFLECTION ON THE FINDINGS

Only from the heart can you touch the sky.
                                         - Mawlana Jalal-al-Din Rumi

This qualitative study was conducted to shed light on the lived experience of self-compassion among registered nurses (RNs) in the workplace. The phenomenological method, according to van Manen (1997), was used to examine the participants' experiences, describe each experience as it appears, and attempt to understand its interpreted meaning. Understanding these experiences has important value for the profession of nursing, especially for nurse educators, nursing leaders, and today's health care systems. This information will add to the body of knowledge of self-compassion in the literature and shed light on implications for health care delivery and nurse retention.

This chapter delves more deeply into the four essential themes or essences uncovered in this research. Chapter V described the following themes: (a) Transforming Time Famine, (b) Authentic Communication and Presence, (c) Collegial Cohesion, and (d) Evolution Toward an Ideal Registered Nurse. The context of the themes is clarified in this chapter through explanations defined by the literature and Watson's human

science/caring science theory, which was selected to conduct this study. In addition, the limitations, implications, and recommendations are provided.

Synthesis of Data

The focus of this study, self-compassion, is characterized by self-kindness, mindfulness, and common humanity (Neff, 2015). Neff (2003) defined self-compassion as "being open to and moved by one's own suffering, experiencing feelings of caring and kindness towards oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's experience is part of the common human experience" (p. 225). The literature supports self-care, mindfulness, self-compassion, and other strategies to help ease work-related stress (American Holistic Nurses Association, 2017; Cohen-Katz et al., 2005; Mills & Chapman, 2016; Mills et al., 2015; Neff, 2015; Raab, 2014). In this study, nine participants were asked to describe their experience of being kind to themselves at work while caring for others. They shared experiences such as stressful times of inadequacy as well as failure in clinical practice during their first 36 months of professional practice that challenged them as novice RNs. They also shared occasions in the workplace when they did things for themselves, such as taking time for oneself and breathing consciously.

Essential Theme 1: Transforming Time Famine

The term *Time Famine* began to appear in the scientific literature around the late 1990s (Robinson, 2017). The notion of time and how we use time, especially at work in western culture, is monochromatic or linear. It is measured by clocks, watches, in calendars in order to use time efficiently. In health care especially, time is money and

patients expect their nurses to get them their "medications on time" and spend "quality time" with them (Flaskerud, 2013). In addition, a few of the participants in this study shared that they often had to "stay overtime" to complete their documentation, had little to no "free" time for themselves, and especially did not want to "waste" time at work.

Overall, the participants verbalized being stressed about having too much to do and not having "enough" time to do it all in their stories of barriers to being kind to themselves at work while caring for others. According to the interviewees, the professional tasks and demands placed on them made them realize the importance of being organized and conscious of managing time to accomplish all their duties. Research on self-compassion appears to suggest that treating oneself kindly facilitates dealing with life's struggles and eases reactivity to negative events or situations by being flexible (Leary et al., 2007). This was confirmed by all the participants, who described the need to adapt and become efficient during a 12-hour work shift. For instance, creating lists on the computer and prioritizing the nursing tasks that needed to be done and when to do them were critical. Then, marking each item as done with a check mark was a strategy to maximize the use of their time.

Some of the participants in this study shared stories of feeling challenged in taking time for themselves while at work. Germer and Neff (2013) noted that with self-compassion, negative emotions are not pushed away nor are they replaced with positive ones; instead, negative feelings are embraced or acknowledged, and doing so generates positive emotions, such as optimism, happiness, and wisdom. A few of the stories shared by the participants revealed difficulty with self-kindness around meeting their own basic needs during a 12-hour work shift. For example, they described putting their patients'

needs or the tasks at hand first while postponing their break or lunchtime, at times eating something quickly or on the run, and delaying the use of the restroom to eliminate body waste. According to Cohen-Katz, Wiley, Capuano, Baker, and Shapiro (2004), compassion and caring in nursing practice is focused on the patient, but "self-care has not been socialized into nurses' ways of thinking or into their work environments" (p. 306).

The literature has implied that these types of self-neglectful behaviors may lead to nurse burnout and compassion fatigue (Beaumont et al., 2016; Boertje & Ferron, 2013; Cohen-Katz et al., 2004; Dyrbye et al., 2017; Laschinger & Leiter, 2006). A small number of the participants divulged being predisposed to infections, becoming physically ill, and feeling exhausted as a result of postponing meeting their own needs during long work shifts. On the other hand, studies on self-compassion (Heffernan et al., 2010; Neff, Kirkpatrick, & Rude, 2007) suggested that compassion for self is not just a beneficial way of relating to oneself and one's behaviors without self-criticism or punishment, but also of seeing one's weaknesses.

All of the participants, however, talked about times they did take their break or lunch and felt "refreshed" or validated that they "deserved" the break, nor did they regret leaving the unit to breathe and recharge themselves. The majority of the participants commented that taking time for themselves made a difference, and they felt better able to deliver patient care after they returned from a temporary respite off the unit. Neff and Costigan (2014) emphasized that acts of kindness toward oneself generate positive feelings about oneself, without self-judgment. By doing so, it is a beneficial way of relating to oneself and, therefore, to others.

Essential Theme 2: Authentic Communication and Presence

Communication is dynamic and complex in health care systems and nurses must possess this crucial core competency to maintain a safe environment for patients (AACN, 2008). All the participants in this study shared stories that described their awareness of how critical verbal communication is for everyone on the health care team as well as for patients and family members. Nurses are responsible for their patients by caring and advocating for them as well as negotiating to collaborate on their care with everyone on the interdisciplinary health care team. This requires an excellent ability to speak confidently and document clearly.

The word *authentic* is defined as worthy of acceptance or belief as conforming to or based on fact (Merriam-Webster, 2019a). For the purposes of this study, *authentic* was viewed as a behavior or characteristic that explained how participants carried out their verbal communication. In this study, participants imparted stories that reflected authenticity, optimism, and clarity in their communicative behaviors. Neff (2003) suggested that individuals who are self-compassionate "are likely to have a sense of true self-worth that is not contingent on meeting set standards but is based simply on being one's authentic self" (p. 241). Recent research has suggested that self-compassion seems to promote a sense of personal authenticity through reduced fear of negative evaluation and increased optimism (Zhang et al., 2019).

Participants articulated a recognition of their responsibility to be honest, assert themselves, and "speak up" to nursing management when there was a need to do so, and especially to uphold patient safety while providing patient care. The negative effects of ineffective communication can often result in patient harm, patient dissatisfaction, and

increased costs to the organizations (Zwarenstein & Reeves, 2002). At times, communication appeared to be challenging for the interviewees. They shared experiences of seeking help from preceptors and fellow colleagues to communicate effectively in situations when they had made a mistake, were faced with fear of consequences and judgments, had doubts about the health care providers' orders, and/or were in a relationship conflict with providers over the delivery of care.

In one study, participants were asked to describe their greatest weaknesses during mock job interviews. The findings corroborated with some of the findings in this study. Neff et al. (2007) reported that the study subjects were able to identify their weaknesses in the job interviews and related them to the shared human experience, with an understanding that all humans fail and make mistakes, but if they failed, they were not afraid to try again. Additional studies on self-compassion suggested that those who failed also demonstrated a reduced fear of failure (Neff & Costigan, 2014; Neff et al., 2007). In a similar way, the present study supported Neff et al.'s views. For example, when a participant disclosed having made a medical error, she was kind to herself by "being patient with myself" while also describing: "I was terrified for the patient…but also admitting to my mistake to the provider." What came through in several of the participants' stories was that lessons were learned from making mistakes, being candid about facing conflicts, and accepting responsibility. Participants continued to provide patient care with an understanding that "to err is human." According to the literature, acknowledging mistakes and problems in practice is a key component to improving safety in patient care delivery (Donaldson, 2008).

In several instances, participants shared that authentic communication was imperative for the delivery of ethical, safe, and quality patient care. The Nurses' Code of Ethics delineates the nursing profession's practice conduct (Fowler & ANA, 2008), whereas the nurse has an ethical responsibility for the patient and oneself. Participants, in those instances, shared stories of self-kindness that uncovered professional accountability for patients and their families as well as for themselves. Respect and dignity for patients and their families were preserved when participants described caring for parents who were suffering from the loss their child (van der Cingel, 2009). The experience and meaning of being with another in their loss were difficult to put into words, according to one participant. The philosopher Nussbaum (2003) would perhaps claim that this type of loss is an undeserved fate, and therefore sanction the necessity of feeling compassion. Yet participants articulated the need for them to be fully present not only with and for those families in their loss, but also with and for themselves. In this instance, the reciprocal shared experience of witnessing death possibly offers meaning to the common humanity element of compassion for self.

The word *presence* is defined as the fact or condition of being present (Merriam-Webster, 2019b). According to Hessel (2009), the concept of presence, as it relates to nursing practice, includes the connection experienced between both patient and nurse. A practitioner who is genuinely present, on purpose, with the patient is aware of "the sharing of the human experience, and the benefits of this connection are reciprocal" (p. 276). The participants' stories conveyed authentic presence, such as in the above example, and demonstrated respect for the human experience as they reflected on their own personal experiences of offering kindness to oneself while delivering patient care.

According to Parse (1995), true presence is "a special way of being with the other that recognizes the other's value priorities as paramount" (pp. 81-82). This unique and holistic way of being present with another places importance on the individual, his or her ideas and concerns, and his or her choices without judgment. The concept of presence is further looked at through Watson's (1999a) theoretical model to reflect on the essential theme, authentic communication and presence.

Essential Theme 3: Collegial Cohesion

Interpersonal relationships at work came through in the participants' stories of being kind to themselves and were strongly perceived as a positive experience for the majority of the nurses. Self-compassion has been positively linked to social connectedness and relatedness, which support basic human emotional needs (Heffernan et al., 2010; Neff, 2003; Neff et al., 2007). Participants spoke about being cared for and feeling supported during stressful times at work. For example, their colleagues spontaneously offered to cover for them while they took their break and also stepped in to help during stressful patient care situations. At times, participants disclosed a slight reluctance to take lunch and/or leave the unit, but their colleagues coaxed them to do so. Participants talked about covering for one another, and given their lived experiences, watching out for the newer nurses to ensure they were transitioning smoothly into their new role and acclimating to the unit. Some evidence (Neff, 2003; Yarnell & Neff, 2013) has suggested that individuals who are self-compassionate foster interpersonal conflict resolution by being able to compromise, which may be beneficial in bolstering and sustaining working relationships in stressful health care settings. Collegial relatedness may also foster improved teamwork and collaboration, and increase the

delivery of quality patient and family care (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014).

Socializing with colleagues at work and outside of work also brought value and meaning to participants' relationships with co-workers. What came through was the connections formed with the work group, which further developed during social events, such as parties on the unit to celebrate life events, birthdays, or get-togethers for a drink after work. Most, if not all of the participants, shared that getting along with their preceptors, other staff nurses, and providers was part of their decision to remain working on the unit and their assigned shift.

According to Li et al. (2014), survey study findings of nurse residents suggested that group cohesion was an effective protective factor in moderating the negative effects of nurses' exposure to unit stress, especially compassion fatigue and burnout. In addition, the study implied that organizational commitment fostered positive nurse outcomes, such as job and compassion satisfaction. Researchers from Australia who interviewed newly graduated nurses transitioning to acute care practice found that being part of a social group was about "fitting in" and the nurses' "perceptions of their success in establishing secure and meaningful social bonds" with their co-workers were very important to them (Malouf & West, 2011, p. 488).

Essential Theme 4: Evolution Toward an Ideal Registered Nurse

The participants in this study were fairly new to professional nursing practice, having been employed in the clinical setting from 6 to 36 months, yet they still held the ideals of why they entered the profession of nursing. As the participants shared stories of being kind to themselves at work while caring for others, they revealed positive ways in

which they related to themselves as RNs. This was consistent with the literature about the experience of individuals' self-compassion (Heffernan et al., 2010; Neff, 2015; Wiklund Gustin & Wagner, 2013). The participants described having trust in their abilities and skills during stressful times, which enabled them to see how much they had evolved, compared to when they were student nurses. Also, having objectively examined their inner critic, their strengths and weaknesses, and the lessons learned through their stories of self-kindness, the participants could apply perspective and recognition of their professional growth and development—how far they had come and how far they had yet to flourish (Cox, 2019; Jacobs, 2016).

In this study, participants shared their view of themselves in the future—for example, wanting to "fast-forward" time to turn into their image of the ideal experienced RN, like the ones they worked with and admired. Each participant shared a component of their perception of the ideal nurse: doing things right and on time, being able to take their lunch break, knowing the right words to say and things to do, and being knowledgeable and well liked. Holliday (1961) conducted a study to determine the characteristics of the ideal image of the professional nurse based on perceptions from Teachers College, Columbia University graduate nursing students. Their perceptions were compared to those of the hospital patients' perceptions of the ideal nurse. Interestingly, Holliday's results seemed to indicate there were similarities between the two groups—and in fact with the perceptions shared by the participants of the present study. For example, the nurse should be well liked, trained, and educated, gentle and friendly, competent, efficient, and communicative and cooperative; these were just a few of the perceptions that were similar to all studies.

In addition, all the participants in the present study articulated at the end of their interviews (when the recording stopped) how much they benefitted from reflecting on their professional experiences through the interview process. It is possible in reflection that the interviewees raised awareness of their progress and validated their future direction. It is interesting to note that three of the study participants were enrolled in graduate Nurse Practitioner programs, one was working toward earning her Bachelor's degree in nursing, and two actively discussed intentions to apply to graduate school.

This study may have offered participants an opportunity to gain perspective on their competency and capacity to act, earning the respect of others, observing continuous growth and change, and possibly supporting their self-awareness. Mitchell, Brooks, and Pugh (1999) suggested that empowered nurses display enhanced clinical performance, work effectively, deliver quality patient care, and tend to stay in their position. According to Bolden, Cuevas, Raia, Meredith, and Prince (2011), reflexivity in professional practice has the potential to foster personal and professional growth and development in new graduate RNs. Freire (2000) stated that "those who authentically commit themselves to the people must re-examine themselves constantly" (p. 60).

Thematic Statement Reflection Using a Theoretical Model

The essential themes were synthesized and resulted in the interpretive textual statement of self-compassion among RNs in the clinical workplace while caring for others. The statement is: *Self-compassion among RNs in the clinical workplace while caring for others is characterized by transforming time famine with authentic communication and presence, and collegial cohesion, which informs the (participants) evolution toward an ideal registered nurse.* Through significant reflection of the essential

themes, together with the interpretive contextual statement and an extensive literature search, Watson's theory of human caring/caring science emerged as a conceptual model that shed more light on this study's findings.

Watson's (1999a) theory of human caring/caring science contains views that are aligned with philosophy, ethics, and Eastern philosophy, and are spiritually and "phenomenological-existentially" oriented (p. x). One possible way to describe Watson's caring science, is a field of study rooted in the discipline of nursing, which is continuously evolving philosophically, ethically, and epistemically, while being informed by related fields (Fawcett, 2005; Watson, 1999a, 1999b). In addition, it may be seen as being situated in a worldview that is unified, non-dualistic, and relational.

The core concepts of Watson's (1999a, 2010) theory of human caring/caring science are: A Relational Caring for Self and Others; Transpersonal Caring Relationship; Caring Occasion/Caring Moment; Multiple Ways of Knowing; Reflective/Meditative Approach; Caring Is Inclusive, Circular, and Expansive; and Caring Changes Self, Others, and the Culture of Groups/Environments. The theory also encompasses 10 Carative Factors/Caritas Processes (essentially, guidelines for putting caring science into practice) which are:

1. Humanistic-Altruistic System Values,

2. Faith-Hope,

3. Sensitivity to Self and Others,

4. Helping-Trusting Human Care Relationship,

5. Expressing Positive and Negative Feelings,

6. Creating Problem-Solving Caring Process,

7. Transpersonal Teaching-Learning,

8. Supportive, Protective, and/or Corrective Mental, Physical, Societal, and Spiritual Environment,

9. Human Needs Assistance, and

10. Existential-Phenomenological-Spiritual Forces.

Relationship Between the Findings and Watson's Theory of Human Caring/Caring Science

Watson's theory of human caring/caring science was identified as a theoretical model that could add depth to the findings of this study. For the purposes of this study, Watson's theoretical construct was used to further understand and contextualize the question and the essential themes that emerged.

Theory of Human Caring/Caring Science—Theoretical Context

Watson's theory of human caring/caring science was introduced in 1979, and she continues to develop the theory further, making it a living theory (Cara, 2003; Fawcett, 2005). A comprehensive description of the applicable theoretical framework and core concepts in Watson's (1999a, 1999b; Watson Caring Science Institute, 2010) theory of human caring/caring science is provided here. Also, selected core concepts are discussed as they relate to the four essential themes of this study.

As previously mentioned, Watson (1999a) drew from many disciplines and philosophies which are rooted in her theory of human science/caring science (Fawcett, 2005). According to Watson, the theory of human caring/caring science encompasses the notion that time and space are not distinguished solely by external and internal linear perceptions, which may be viewed as constrained or limited. Therefore, one's awareness

consciously "shapes its own time and space," for instance, having the "capacity to coexist with past, present, and future all at once" (Fawcett, 2005, p. 558). One has the ability to "transcend" physical time, based on choice, such as controlling or subduing it with perceptions of the mind, imagination, and emotions (Fawcett, 2005). For example, an individual may be physically in one place, but one's mind may perhaps be elsewhere, such as in the past, present, or future—and any combination of the three may also be possible.

Essential Theme 1: Transforming Time Famine provides a reflection of an aspect of the overall framework of Watson's theory. For instance, time relates to Watson's theory construct and concept of transcendence of time, but not to the core concepts. The study participants realized they had to make choices to transform their thoughts of not having enough time at work. This was achieved by changing their perception of how to deal with all the tasks they needed to perform. Participants created lists, used computer and technology, and enlisted others to help them to become efficient. The participants decided to shift their consciousness or mindset away from lacking time. This perception transformed time famine to transcend time through becoming more organized as a way to allow time to be kind to themselves.

The participants' conscious decision to improve their situation by becoming efficient reinforced Watson's conceptual theory of shaping, or controlling, one's own time and space, transcending linear time, and accomplishing their work responsibilities in a timely fashion. Watson (1999a) seemed to imply that the mind has the ability to expand its awareness, tap into the realm of infinite potential, and transcend limitations caused by

less harmonious thoughts toward more harmonious ones that are mindful and kinder to oneself.

Core Concept: A Relational Caring for Self and Others

Watson's (Watson Caring Science Institute, 2010) Core Concept, A Relational Caring for Self and Others, may be seen in terms of "a field of connectedness" and is described in the theory of human caring/caring science as beings are united and "everything in the universe is connected" (Fawcett, 2005, p. 559). This core concept identifies caring in relationship to connectedness and consciousness, and is practiced interpersonally (Watson, 1999b). Caring also promotes the growth, knowledge, control, and healing of self, and holds safe space for oneself and others.

Within Watson's (1999a, 1999b) framework, the awareness of caring for oneself, such as reconnecting with one's inner landscape, being, and purpose, while creating opportunities to treat oneself with gentleness and kindness, may evoke self-healing. Embracing caring and healing for oneself may be understood as transformational. From this transformed place of expanded self-awareness and wholeness, one is then able to extend respect and care for others (Fawcett, 2005; Ledoux, 2015; Smith, Zahourek, Hines, Engebretson, & Wardell, 2013).

Essential Theme 1, Transforming Time Famine relates to Watson's Core Concept, a relational caring for self and others, such that participants' shift in perception toward oneself may have allowed them to tune into themselves and go within from a purely physical-material awareness to include consciousness and one's spirit. The participants' desire and ability to transform their hunger for time may have been the catalyst that allowed them to recognize the need to take time for themselves and to breathe. The

inspiration of breath is life-sustaining. Giving requires receiving. For example, if one's

basket is empty, there is nothing to offer anyone or anything from it (Cohen-Katz et al.,

2004). From an expanded state of awareness, beyond time and space, the participants

perhaps intuited the need to move toward a higher sense of self to achieve harmony with

one's mind, body, and soul. This also may explain how the participants perceived an

enhanced ability to deliver better care to their patients after taking time for themselves.

Core Concept: Transpersonal Caring Relationship

Watson's (1999a) Core Concept, Transpersonal Caring Relationship, holds the

nurse to a moral commitment, intentionality, and caring consciousness for the sake of

upholding human dignity. A human-to-human yet a deep soul connection is one principle

of this core concept to stimulate a sense of greater harmony and spiritual evolution.

Genuine communication and presence are just two aspects within the transpersonal caring

relationship that may bring "kinder and more helpful feelings for the human" (Fawcett,

2005, p. 561). Transpersonal caring may be viewed as an art form. This seems to impart

that the more one advances and adjusts one's art form toward sensations of human

kindness and helpfulness, "the more we can define ideal caring with reference to its

content and subject matter of nursing…" (Watson, 1999a, p. 70). Thus, moment-to-

moment human encounters offer conditions for seeing the context of an event, a coming

together of nurse (the caregiver) and the person (the recipient), to create a caring moment.

According to Watson (1999a), consciousness is energy and communication may

be viewed as an exchange of energy as well as an art form. Communication is a condition

of human life and a means of contact from human-to-human—and the world/nature

(Watson, 1999a). From Watson (1999a), one learns that entering into communication

requires an exchange, or an entry into a certain relationship, where not only words are transmitted back and forth, but sensations as well.

Three terms are used in the context of theory of human caring/caring science and notably in this core concept, transpersonal caring relationship, that are included here to facilitate clarity: *self, phenomenal field,* and *intersubjectivity*. *Self* is a "transpersonal-mind-body-spirit oneness, an embodied self, and an embodied spirit" and the perception of "I" or "me" and how "I" or "me" relates to others (Fawcett, 2005, p. 561). A *phenomenal field* is one's subjective reality or "being-in-the-world" and influences how one reacts in certain situations (p. 561). *Intersubjectivity* is a union of the human-to-human relationship. The nurse and the other are connected, share a phenomenal field, and based on their interaction and connection, are forever part of each other's history (Fawcett, 2005; Watson, 1999b, 1999a).

From Watson's (1999b) human science/caring science, three levels of presence are included and may be applied to the core concept of transpersonal caring relationship. First, there is physical presence, such as "physically being" there for the other—for example, body-to body contact. Second, there is psychological presence, such as "being with the other"—with a cognitive connection, for example, active listening, and therapeutic use of self, which is more in line with authentic caring presence. Third, there is therapeutic presence, which is strongly affiliated "with caring consciousness, mindfulness, intentionality, and transpersonal caring" (p. 226)—for example, meditating, centering, and openness.

Essential Theme 2, Authentic Communication and Presence, relates to Watson's Core Concept, Transpersonal Caring Relationship. Participants' stories of being kind to

themselves at work while caring for others revealed situations when they were honest and "spoke up" because they felt it was important. In addition, they were accountable for their professional ethical responsibility, and they did so with the three levels of presence for oneself and others. Also, the participants' self-awareness and authenticity of sensations, words, behaviors, cognition, and such facilitated their ability to communicate authentically in their professional practice.

The participants' stories of kindness toward oneself, according to Watson's (1999a) theory of human caring/caring science, seemed to imply they were authentically aligned with *self*. Thus, they were enabled to tap into their mind-body-spirt oneness as embodied beings and control the degree of sincerity and presence with which they "artfully" engaged; from that harmonious state, they were able to act morally and ethically.

**Core Concepts: Caring is Inclusive, Circular, and Expansive, and
Caring Changes Self, Others, and the Culture of Groups/Environments**

Watson (1999a) asserted that a human connection is beyond personal body-physical ego and has a spiritual dimension (Fawcett, 2005). This unified, non-dualistic, relational caring embodies a deeper, more spiritual or cosmic connection and includes the unique individuality of each human that radiates even further to a deeper sense of *self* and encompasses the environment, nature, and the universe. Caring science values *intersubjectivity*, described earlier, which refers to the human-to-human relationship or the connectedness of the nurse to others (Fawcett, 2005; Watson, 1999a). This connection is reciprocal and affected by each individual's *phenomenal field* when mutually present and unified in the moment. Both individuals, in the present moment and in the future, are co-participants in human becoming (Watson, 1999a). In this special bond, individuals are

held in "wholeness" with respect and a high regard for one's "being-in-the world" (Fawcett, 2005, p. 562).

Essential Theme 3, Collegial Cohesion, relates to both Core Concepts of Caring Is Inclusive, Circular, and Expansive, and Caring Changes Self, Others, and the Culture of Groups/Environments. This link was identified because participants in this study offered stories of kindness toward oneself that contained meaningful connections to their preceptors and co-workers and the support exchanged among them on and, at times, off the clinical unit. Within these two Core Concepts, a caring occasion may occur when the nurse and others engage in transpersonal connectedness during human-to-human transactions. This coming-together, or uniting of *phenomenal fields,* combined with their unique life histories, has the potential to reflect caring for each other (Watson, 1999b). Nurses understand what their lived experience on the clinical unit, caring for patients, is about. "We learn to recognize ourselves in others by engaging in a transpersonal caring moment" (p. 155). The consciousness of the study participants' connection to their co-workers, or group shared existence, such as their collegial human-to-human interactions, possibly elevated their relationships to a higher consciousness or mind-body-spirit dimension. This may be viewed as going beyond the *self* to the human spirit realm. Therefore, in the moment, during each encounter, a greater energetic field may be formed by the reciprocal caring exchange of the individuals (Fawcett, 2005; Watson, 1999b).

Core Concept: Reflective/Meditative Approach

The theme of evolution toward an ideal RN might be what Watson (1999a) suggested as a moral ideal for nursing. Human science/caring science calls for nurses to access "the inner depth of their own humanness and personal creativity" and comprehend

the condition of their own soul (p. 71). It is possible that the growth and development of nurses' human-to-human caring potential is infinite. Expansion of knowledge may increase the methods to achieve what Watson viewed as the ultimate goal of nursing: to protect human dignity and preserve humanity. Watson stated that personal and professional growth is continuous for nurses, and the greater depth of advanced practice of nursing is determined by the inclusivity of spiritual growth. Thus, an awakened nurse may recognize the transpersonal condition of the world.

Theme 4, Evolution Toward an Ideal Registered Nurse, relates to the Core Concept, Reflective/Meditative Approach. Participants in this study articulated stories of self-kindness at work while caring for others that revealed a recognition of their individual professional growth and development. According to Watson (1999a), nurses committed to their individual growth processes who treat themselves with kindness and dignity will, in turn, affect the care they deliver to others in the same way. In addition, a process that acknowledges one's growth and change is powerful (Fawcett, 2005). Ongoing caring for self—gaining more knowledge, self-control, even self-healing—may have an impact on helping others to do the same. Also, it is relevant to mention that during the time of the interviews, four of the nine study participants were enrolled in programs to further their nursing education and advance their careers.

Lastly, Watson (1999a) suggested that reflective practice, thinking or writing, among other modalities, allows the nurse "to reflect the self back upon itself" (p. 71). All of the participants in this study verbalized having benefitted from the opportunity to share their story. An opportunity to look back at their experiences, since graduation from nursing school and orientation for their first job in nursing, through the lens of being kind

to themselves at work may have facilitated a cultivation of sensitivity to self. Perhaps the 1-hour interview for each of the participants in this study enabled them to think their thoughts, feel their feelings, and possibly restore a sense of mind-body-spirit balance (Watson, 1999a).

Limitations of the Study

There are several limitations associated with this study. Generalizability is a challenge for all qualitative research studies and their findings. The findings, which are based on the stories of nine RNs represented in this study, are unique and specific to this group and therefore difficult to reproduce. Although I as the one researcher in this study conducted all the interviews, I identified my biases and kept a study journal to reflect on thoughts before and after each interview and to bracket assumptions about the interviewees' experiences. Likewise, participants reviewed the themes and another phenomenological researcher confirmed the themes. Nevertheless, it is possible that my own interpretations may have modified the RNs' responses given my preferences and background in holistic/mental health nursing.

The study participants consisted of eight females and one male. This is consistent with the low percentage of males represented in the female-dominated profession of nursing, but it is a limitation of the study nonetheless. Another potential limitation was that the RNs were in practice from 6 to 36 months. In addition, for the sake of convenience to allow some participants to partake in the study or because of distance in miles, four interviews were conducted using Skype or Zoom instead of in-person, face-to-face interviews. This may be considered a limitation, although in many research studies,

this is now an acceptable platform for data collection. Preferably, for consistency, all interviews should have been in-person, face-to-face, which is also more personable.

Implications

The aim of this study was to shed light on the phenomenon of self-compassion among RNs employed in the clinical workplace setting. Analysis of the participants' interview transcripts illuminated their experiences of being kind to themselves at work while caring for others. The concept of self-compassion in the literature, introduced earlier in this study (Duarte et al., 2016; Heffernan et al., 2010; Mills et al., 2015; Reyes, 2012; Wiklund Gustin & Wagner, 2013), is growing; therefore, several implications for the clinical and educational setting may be drawn from the findings of this study. Nurses are frontline caregivers and the nature of their work with patients is stressful; not surprisingly, burnout and compassion fatigue among nurses are on the rise. For example, the participants in this study made apparent that being kind to themselves by taking time for oneself and breathe in the workplace may imply that this is one way to create sustainability for nurses in clinical practice.

Communication in health care settings has value. The theme of authentic communication and presence emerged from participants stories of self-kindness and offered meaning and implications for hospital managers and administrators. The research findings from this study may imply that fostering nurses' sincere words and their presence or qualitative way of "being with patients" could potentially result in augmented hospital reimbursement rates. As mentioned previously in this research, patients provide feedback on surveys to rate how their nurses communicated with them in the hospital. These survey results through the Hospital Consumer Assessment of Healthcare Provider

and Systems (HCAPS) determine hospital reimbursement from the Centers for Medicare and Medicaid Services.

Based on the participants' stories of kindness toward self, positive collegial cohesion was revealed. The revelations entailed reciprocity in their work practices with co-workers and also influenced their decision to stay in their hospital positions. The findings from this study could imply that opportunities to bond with colleagues have meanings for clinical health care and academic settings. Studies have suggested that workers who feel a sense of connection with their colleagues at work do work as part of a team and tend to remain in their jobs (DeMeglio et al., 2005; Li et al., 2014). For instance, in light of the predicted nursing shortage, the implication of putting in place unit cohesion strategies may be worthwhile for the sake of nursing retention. It is also an important implication to consider as a cost containment measure in our current high-priced health care system (Van den Heede & Aiken, 2013). Moreover, the implications from this study could apply to academic environments needing to create strategies to support cohesion among student nurses for retention and graduation of new nurses to join the workforce. It can be implied that efforts to improve cohesion among nursing faculty, for the sake of retention, are also beneficial in light of a shortage of nurse educators.

I believe one of the most important implications of this study stems from what Cohen-Katz et al. (2004) examined about nurses who have not been socialized to think about caring for oneself and whose work environments are not conducive to taking time for oneself and to breathing. Improving nurses' awareness of compassion and kindness toward self in the workplace and strategies to support this type of behavior may imply benefits for nurses during long 12-hour shifts. The findings from this study imply that

nurse leaders, hospital administrators, and nurse educators need to understand that it is important in the long term to support nurses in taking time for themselves at work and breathing. Implications for improving work environments to develop and structure programs to adopt and reflect a nurturing culture that supports nurses in being kind to themselves could be advantageous. Schools of nursing could also benefit from the implications of this study to develop programs and weave into the curriculum opportunities to coach student nurses to be kind to themselves and take time to breathe, and to reduce stress (e.g., before taking exams).

The meanings of the participants' lived experiences of being kind to themselves at work while caring for others provided findings with meaningful and thought-provoking implications. The study findings could imply that time management, taking time for self to breathe, communication, teamwork, and reflecting on the ideal image of oneself in nursing practice are some of the qualities and characteristics of self-compassion that other nurses may also possess. In conclusion, the findings may also imply that self-compassion among RNs have by and large significant contributions for sustaining RNs in professional practice and quality patient care delivery.

Reflection on Researcher's Experience

While researching for a phenomenon to study, I came across the concept of compassion in nursing. I was intrigued. But what truly captured my attention was self-compassion. While carrying out this study, I have had several insights. As nurses, we know it is important to take care of ourselves while we are at work, but what keeps us from doing this? I wanted to dive more deeply to be able to understand how nurses perceived compassion for themselves. The participants in this study allowed me to peek

through their lenses to glimpse how they navigate their day-to-day work experiences. Some of them shared stories of when they were transitioning from being a nursing student to a newly graduated nurse, and the challenges they faced during that time. Their stories of being kind to themselves by managing time, communication, social support, and professional growth and development provided robust information for the nursing profession, particularly for nurse educators, hospital upper managers and administrators, and health care consumers.

I felt an incredible sense of courage as I interviewed each RN for this study. Their stories were filled with stress and challenges, but they embodied a sense of strength from the growth they observed in themselves, and how that strength transfers directly into the delivery of patient care. I was doubtful that this study would reveal what compassion for oneself looks like among RNs. After having disclosed that I did not believe I would find it, I felt sad. However, the element of surprise appeared upon completion of the last interview I conducted. I realized how this research had revived my belief in the new generation of nursing professionals. Learning and understanding the power of compassion for oneself through the participants' looking glass changed me. Reciprocally, the participants were awakened to how they were being kind to themselves in a way they never thought about before. Interviewees commented that talking about their experiences was helpful for them. My field of vision has broadened immensely, and I have learned so much from the study participants' personal stories.

Reading over the study journal I kept, I recalled relating to the nurses' stories and experiences of stress in the clinical workplace. My own struggles as a new graduate nurse surfaced. For example, I worked in a nursing home with elderly patients and I

remembered having to develop coping skills to deal with death and dying. It was difficult for me to care for dying patients and their families. The two participants' stories of taking care of patients—one with a fetal demise, and the other a pediatric patient being tested for brain death and their families—were heart-wrenching for me. Participants shared how they felt in those instances. I felt I had to validate how hard it was to "bear witness" to the suffering of their patients and their families. For me, I felt a moment of fragility as the researcher. I breathed in slow deep breaths and mindfully exhaled the sadness I sensed. This helped me to facilitate a safe space for participants to trust that their stories were being heard without judgment. Although it was a privilege for me, as a novice researcher, to be present, open, and receptive in listening deeply to the participants' experiences, perhaps my moment of fragility was a possible limitation of the study. However, I worked hard to trust the interview process, and wholeheartedly followed the six research activities that van Manen (1997) outlined.

Finally, it is my intention to continue to teach nursing students, professional nurses, and nurse leaders about the importance of caring for oneself. However, this study has sparked in me a desire to share these findings with fellow nurses, and to start the conversation about self-compassion for all nurses in the profession—perhaps for all health care professionals at large. We are currently facing some troublesome issues in the health care system of our nation. However, I now have renewed strength and am hopeful that this study will be a beacon of light for nurses. Perhaps it may instill yet one more kernel of optimism in others as well—to explore and educate our nurses about what self-compassion might look like for them.

Artistic Expression

The analysis and reflection in phenomenological research may include examples of interpretation that invoke the senses which may not be otherwise achieved solely by written words. For instance, the essence of a phenomenon may be stimulated through the visual sense by way of pictures and symbols. Clarification and illumination of unearthed themes may occur through a poem or a fictional story. Music or sound may strike an auditory link with the notion of the findings. The image below is an effort to shed light on the phenomenon examined here.

The image of a seed germinating from the soil emerges as a sign of growth and development, which illuminates the essence of self-compassion among RNs in the workplace while caring for others. Seeds may be interpreted as symbols of new life filled with potential and hope. Throughout the growth process, seeds—like the participants in this study—may encounter obstacles that could possibly make it difficult for them to grow. Similarly, kindness influences the seeds and may help them to flourish. Shedding light on the RNs' lived experience of self-compassion helped to examine and understand what that experience was like. Through the reflection process, the participants revealed being able to transform time famine, communicate authentically and with presence, establish collegial cohesion, and recognize their evolution toward an ideal RN.

Figure 1. Growth and development

The seeds of self-compassion already lie within you.
-Neff, 2019

Recommendations for Nursing Education

When I read about the phenomenon of self-compassion, I had an Aha! moment. I knew that it was what I wanted to study. As an educator and a holistic nurse, I have taught methods of holistic patient care and self-care to student nurses, new nurses, seasoned nurses, and executive nurses. Upon reflection on the research process and findings, a number of recommendations for nursing education emerged. I learned from the participants that many levels of support may need to be developed to further assist new graduate nurses in dealing with the stress of starting a new job, going through orientation, and beyond.

The construction of lesson plans with objectives and measured outcomes for a semester-long course would be ideal to offer to undergraduate and graduate nursing students. Initiating stimulating discussions to identify how they are kind to themselves is

one way to open the conversation for each class. Also, teaching breathing practices that can be done consciously, for example, when washing one's hands, anytime throughout the day, during times of stress, or when a moment of self-awareness or presence occurs, are beneficial to give kindness to oneself. It is important to formally integrate into nursing curricula concrete educational strategies for nurses to consciously manage their time and take time for oneself and breathe. Telling student nurses they need to be efficient and do self-care is insufficient. Watson (1999a) described three layers of presence that can be taught to student nurses and practiced in the laboratory, then implemented in clinical settings to support kindness toward oneself and others. All of these strategies would be components taught in the semester-long class.

Collegiality was a meaningful theme that emerged from the participants' stories of self-kindness, as it fosters teamwork and group cohesion. Strategies to work in groups need to be integrated, grounded, and reinforced into academic curricula and clinical settings to strengthen teamwork. This can also be included in the semester-long course, together with structured peer-group coaching programs for identifying self-compassion and kindness toward oneself as methods to create sustainability of the skills learned.

Therapeutic communication is typically taught in a separate course in undergraduate nursing curricula, but recently I heard there is a movement afoot to phase that out by weaving it into individual nursing courses. The rationale for this change is to create more time for additional simulation to teach technical skills. There is a risk associated with such an action and it needs to be thoroughly considered and discussed. For instance, compassion education was removed from medical school curricula because the idea was that it would be picked up by students in the clinical setting when treating

suffering patients. In fact, the study participants' stories revealed meaning that supported the need for authentic communication and presencing skills, which are critical for nurses to possess. In addition, findings from this study revealed that a nurse who is kind to oneself is also likely to be present for patients.

Lastly, there are over three million nurses in the nation, and they are all potential future leaders (Hassmiller & Mensik, 2017). The Institute of Medicine in 2010 made public the *Future of Nursing Education* report that recommended organizations should require evidence of nurses' preparation for participation in leadership teams. In other words, schools of nursing need to strongly create and implement curricula to teach student nurses at all levels skills for leadership, management, and teamwork. Self-compassion awareness needs to be included and discussed among nurse leaders. In addition, fostering the development of measurable and achievable goals to identify self-compassion and kindness toward oneself for future continued growth and development, and improved collegial camaraderie among RNs, is consistent with this study's findings.

Recommendations for Further Study

Despite the plethora of research that exists and continues to grow about self-compassion, the topic is still very recent within the context of professional nursing and nurses. There is insufficient data on self-compassion in the literature for nurses to fully grasp what self-compassion means for nurses in professional practice. This study revealed one possible meaning of the lived experience of self-compassion among RNs in the clinical workplace setting. Also, this research has paved the way for future studies in nursing, both in education and practice environments. More research is needed to identify the effect of self-compassion on nurses and patients and what can be gleaned from their

experiences. Are self-compassionate nurses better able to deliver compassionate care to their patients? Do patients perceive nurses who are compassionate toward themselves to be more compassionate when delivering care? The implications of future study findings for the nursing profession and other health care professionals at large are of great interest and value.

A recollection of my own experiences as a new nurse coping with patients' death and dying was triggered by the participants' stories of caring for parents who had lost their offspring. I would like to conduct a study to understand the lived experience of how nurses are compassionate with themselves when they are faced with caring for dying patients and their families.

Also beneficial would be replicating this study to include other different groups: RNs who have been practicing for more than 36 months; nurse leaders and nurse executives; male nurses only; and nursing professionals in different specialty areas. Do all these different groups have similar experiences of compassion toward oneself?

In addition, future quantitative studies may identify correlations between self-compassion in nurses and quality patient care and/or patient care satisfaction. A double-blind study could be implemented to test the effectiveness of self-compassion training for nurses.

A qualitative descriptive study of new RNs and expert RNs and their perceptions of compassion toward self could be examined to identify further meanings for the nursing profession. The exploration of self-compassion has only just begun to be explored among RNs.

Finally, a semester-long seminar on the application of self-compassion or kindness toward self in nursing practice would be an optimal mixed-methods study. First, an instrument to measure self-compassion, developed by Neff (2003), can be administered using a sequential design at the beginning and then at the end of the course. This would be used to determine if there was a difference in the participants' self-compassion measurement based on attending the class and learning the course content. Second, one qualitative question would be posed to class participants at the end of the class utilizing an interview or written narrative to describe a time when they utilized one or more methods discussed in class in the clinical setting. Thematic analysis would be used to identify themes from the interviews or written narratives. Comparisons can be made to determine any changes in self-compassion among participants pre- and post-taking the course, with interpretive integration of thematic findings. A synthesis of the two findings would then be made to develop an interpretive integration (Polit & Beck, 2017).

Summary

This chapter presented the synthesized data into a thematic analysis that was supported by using the literature and Watson's theoretical model of human caring/caring science. In addition, limitations of the study, implications, and recommendations for nursing education and future study were considered. Lastly, a reflection on the researcher's experience, including a visual display, were used as clarifying examples of the phenomenon of self-compassion among RNs in clinical practice.

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Appendix A

Flyer for Study Advertisement

<ins>*RN C<small>OMPASSION</small> S<small>TUDY</small>*</ins>

ARE YOU A Registered Nurse, or KNOW A RN, WHO WOULD LIKE TO PARTICIPATE IN A COMPASSION STUDY? I WOULD LIKE TO HEAR ABOUT YOUR/THEIR EXPERIENCE.

ALL INTERESTED PARTICIPANTS *PLEASE* CONTACT ME VIA EMAIL, TEXT, OR PHONE CALL

Email: <ins>RNcompassionstudy2018@gmail.com</ins>

Phone or text: 919-720-2966

CAI MCPHEE, RN, MS, AHN-BC, EdD(c)
TEACHERS COLLEGE, COLUMBIA UNIVERSITY

STUDY PROTOCOL #   18-377

Appendix B

Study Information Business Card

Appendix C

Demographic Data Form

Participant Number Code:

Today's Date:_____ Current Age:_____ Year of Graduation:_____

Optional: Race_____ Ethnicity_____

Gender:_____

Nursing Degree Earned: ASN_ BSN_____ Diploma_____

Name of Undergraduate College/University:

Current Nursing Position:_____

What Hospital Unit Do You Work In?_____

Full-time Employment In This Position: Yes_____ No_____

Number of Months Working Full-time Since Graduation From Nursing Program:_____

Is This Your First Professional Nursing Position: Yes_____ No_____

　　　　If No, What Previous Nursing Position(s) Were You In?_____

Did You Have a Previous Career/Profession Before Becoming a RN? Yes____ No_____

　　　　If Yes, What Was Your Previous Career/Profession?_____

Protocol #: 18-377

Appendix D

Inclusion Criteria for Eligible Study Participants

Criteria	Met
1. Registered Nurse (RN)	
2. Graduate of a Nursing Program: Associate Degree, Baccalaureate, Diploma	
3. Working as an licensed RN 6 – 36 months	
4. Working in Clinical Setting Full-time since graduation	

PROTOCOL #: <u>18-377</u>

Appendix E

Informed Consent

Teachers College, Columbia University
525 West 120th Street
New York, NY 10027
212-678-3000

Protocol Title: What is the lived experience of compassion among registered nurses in the workplace while caring for others?

Principal Investigator: Caiocimara B. McPhee, RN, MS, AHN-BC, EdD(c) Teachers College
919-720-2966, cbm2152@tc.columbia.edu

INTRODUCTION
You are being invited to participate in this research study called "What is the lived experience of compassion among registered nurses in the workplace while caring for others?" You may qualify to take part in this research study because you are a Registered Nurse working in the clinical acute care setting from 6 to 36 months, have successfully passed the National Council Licensure Examination – Registered Nurse (NCLEX-RN), are employed full-time in a health care institution as a staff nurse, you are over 21 years old, and graduated from an accredited Associate Degree, Baccalaureate, or Diploma Nursing program.

Up to fifteen people will participate in this study. This study will take 2 hours and 15 minutes of your time. Audio recording is part of this research study. If you decide that you don't wish to be recorded, you will not be able to participate in this research study.

This study has been "partially funded with a grant from The American Holistic Nurses Association (AHNA)."

WHY IS THIS STUDY BEING DONE?
This study is being done to understand what the phenomenon of compassion looks like in Registered Nurses in the clinical workplace setting while caring for others.

WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?
Participation in this study is voluntary. If you decide to participate, you will be interviewed by the principal investigator (PI). The interview will take place in a quiet environment and at a convenient public setting and time. The study will take about 2 hours and 15minutes of your time and will consist of 4-parts.

1. One audio-recorded interview (face-to-face or Skype) (1 hour). During the interview you will be asked about your professional experiences as a nurse;

2. After the audio recording of the individual is written down (e.g., transcribed) it will be emailed to you about one week after your face-to-face/Skype interview. You will then be asked to review your transcription, take notes, and identify any areas that surprised or gave you pause for reflection (30-minutes);
3. One follow-up email or audio-recorded phone call for verification of themes identified and connected to your statements will be discussed (30-minutes). You will be contacted up to 90-days after your initial interview to complete part three.
4. Lastly, you will be asked to complete a brief online survey that will ask you basic questions about your nursing profession and demographic questions. (15-minutes).

WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY?

This is a minimal risk study, which means the harms or discomforts that you may experience are not greater than you would ordinarily encounter in daily life while taking routine physical or psychological examinations or tests. However, there are some risks to consider. You might feel embarrassed to discuss situations that you encountered in your work experiences while caring for patients. **However, you do not have to answer any questions or divulge anything you don't want to talk about. You can stop participating in the study at any time without penalty. If problems such as mental health issues arise, the number of your workplace employee health will be provided where you can go to for help.**

The PI is taking precautions to keep your information confidential and prevent anyone from discovering or guessing your identity, such as using a pseudonym and de-identified code instead of your name and keeping all information on a password protected computer, encrypted phone, and locked in a file drawer. The master list identifying the subject is kept locked and separate from the list of codes. The company that will transcribe the audio recording of the interview is 1-800-TYPE-ITUP and they have a non-disclosure agreement to guarantee confidentiality of their work.

WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?

There is no direct benefit to you for participating in this study. Participation may benefit nurses and the profession of nursing to better understand the experience of compassion among registered nurses at work while caring for others.

WILL I BE PAID FOR BEING IN THIS STUDY?

In appreciation for your participation at the completion of all four parts of the study you will receive an electronic gift certificate worth $25.00 to Amazon.com. If you do not complete all four parts of this study you are not eligible for the $25.00 Amazon.com gift certificate. There are no costs to you for taking part in this study.

WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?

The study is over when you have completed all four parts (face-to-face interview, review of transcript, follow-up email or phone call to verify themes with your statements, and completion of the demographic survey). You may leave the study at any time, even if you haven't finished. However, if you decide to leave the study before completion of all 4 parts, the $25.00 Amazon.com gift certificate will not be issued.

PROTECTION OF YOUR CONFIDENTIALITY
The PI will keep all written materials locked in a desk drawer in a locked office. Any electronic or digital information (including audio recordings) will be stored on a computer that is password protected. Data will be kept for five years. After five years, the participants' information will be securely shredded, destroyed, and discarded.

For quality assurance, the study team, the study sponsor, the grant agency (AHNA), and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

HOW WILL THE RESULTS BE USED?
The results of this study will be published in journals and presented at academic conferences. Your identity will be removed from any data you provide before publication or use for educational purposes. This study is being conducted as part of the dissertation of the principal investigator.

CONSENT FOR AUDIO

Audio recording is part of this research study. You can choose whether to give permission to be recorded. If you decide that you don't wish to be recorded, you will not be able to participate in this research study.

_____I give my consent to be recorded

_____
                                                          Signature
_____I **do not** consent to be recorded

_____
                                                          Signature

WHO MAY VIEW MY PARTICIPATION IN THIS STUDY

____I consent to allow written and audio taped materials viewed at an educational setting or at a conference outside of Teachers College

_____
                                                          Signature

____I **do not** consent to allow written and audio taped materials viewed outside of Teachers College Columbia University

_____
Signature

> Teachers College, Columbia University
> Protocol # 18-377
> Consent form approved until: 5/28/2019

WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?
If you have any questions about taking part in this research study, you should contact the principal investigator, Caiocimara McPhee, at 919-720-2966 or at RNcompassionstudy.2018@gmail.com. **You can also contact the faculty advisor, Dr. Keville Frederickson at 914-773-3330.**

If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email IRB@tc.edu. Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 1002. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

PARTICIPANT'S RIGHTS

- I have read and discussed the informed consent with the researcher. I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at his or her professional discretion, such as not meeting study criteria.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue my participation, the investigator will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- Identifiers may be removed from the data. De-identifiable data may be used for future research studies, or distributed to another investigator for future research without additional informed consent from the subject or the representative.
- I should receive a copy of the Informed Consent document.

My signature means that I agree to participate in this study

Print name:_____

Date: _____

Signature:_____