



Wounded healers during the COVID-19 syndemic: Compassion fatigue and compassion satisfaction among nursing care providers in Greece

Evdokia Missouriïdou RN, MSc, PhD¹  | Polyxeni Mangoulia MSc, PhD¹ | Vassiliki Pavlou MSc¹ | Emmanouel Kritsotakis MSc¹ | Evangelia Stefanou MSc¹ | Polyxeni Bibou MSc¹ | Martha Kelesi MSc, PhD¹  | Evangelos C. Fradelos MSc, PhD²

¹Department of Nursing, Faculty of Health and Caring Professions, University of West Attica, Egaleo, Greece

²Department of Nursing, University of Thessaly, Larissa, Greece

Correspondence

Evdokia Missouriïdou, RN, MSc, PhD, Department of Nursing, Faculty of Health and Caring Professions, University of West Attica, St. Saint Spiridonos, Egaleo, Athens 122 43, Greece.

Email: emis@uniwa.gr

Abstract

Purpose: The aim of this study was to investigate compassion fatigue (CF) and compassion satisfaction (CS) in nursing care providers in COVID-19 units.

Methods: A mixed-method study with 105 nurses.

Results: 23% of participants reported high CF risk while 77% expressed high to moderate potential for CS. Adequate preparation/education, clear and accountable leadership, and team sharing of feelings, experiences, and responsibilities during the transition in the COVID-19 unit helped participants to deal with overwhelming anxiety which if unattended could bring about frustration and long-lasting feelings of powerlessness.

Practical Implications: In the face of the present and future pandemics, there is a clear need to prepare healthcare organizations and nursing care providers to cope with the emotional content of public health emergencies while protecting themselves and avoid absorbing unmanageable emotions.

KEYWORDS

burnout, compassion fatigue, compassion satisfaction, emotional work, nursing, secondary posttraumatic stress, spirituality, trauma

1 | INTRODUCTION

The word “pandemic” etymologically joins the ancient greek words “pan,” meaning “all,” and “demos,” meaning “the people,” and was chosen by WHO to describe the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-Cov-2) outbreak to denote a Public Health Emergency of international concern. On the other hand, the term “syndemic” constitutes a portmanteau of the Greek words “synergy” and “epidemic” and is credited to the anthropologist Merrill Singer, who focused his attention on the social and ecological conditions that created such phenomena and contribute to acknowledging that the pursuit of a purely biomedical solution to COVID-19 is deemed to fail (Horton, 2020). Indeed, the COVID-19 pandemic has shattered the

daily routine, business, schools, and lifestyle of the globe (Coroiu et al., 2020; Kristeva, 2020), caused an unprecedented economic crisis that is advancing before us and can not yet be assessed (Horton, 2020) while claiming the lives of millions of people and inflicting suffering and disenfranchised grief to the latter's affected family members (Stroebe & Schut 2021). Amongst this dramatic landscape, frontline nurses come to provide compassion.

Compassion lies at the core of health and social care. It transcends empathy, that is the affective and cognitive capacity to understand the other person's inner state by adding the motivation and/or courage to do something to relieve or prevent suffering (Sinclair et al., 2017). Lanara (1991) in her book “Heroism as a nursing value – A philosophical perspective” explains why compassion for the

suffering patient as a person in a cure-orientated healthcare system requires heroism, passion for social justice, and zeal for righteousness. She analyzed Jesus' parable of the good Samaritan as a description of caring for the suffering patient with trauma, that is a "first-aid" incidence at a roadside (in Luke 10:30–35). The Samaritan (foreigner) bound up the wounds of a battered, blood-spattered helpless victim of cruel robbers pouring in oil and wine (i.e., a common remedy of ancient times). He carried the suffering individual to an inn despite the loss of time, fear of robbers, becoming dirty and other types of sacrifice required to help, in sharp contrast to Levitt (i.e., priest) who passed by indifferently although his mission was to serve compassionately those in need. Lanara (1991) concludes that serving those in need in a complex society is a difficult intellectual and spiritual achievement emphasizing the decision-making processes, intelligent love, and sacrifice (i.e., personal time, energy) implicated in daily nursing care (pp. 154–155). Standing by the suffering patient and facing pain and human misery requires moral courage in dealing with internal and external barriers to care and persistence in building resilience to emotional situations (Missouridou, 2017). On the other hand, compassion fatigue (CF) describes the "cost of caring" for the suffering individual (see Figure 1) in nursing and other disciplines (Cavanagh et al., 2020). Frontline healthcare workers in COVID-19 settings have been reported to be at risk for various mental health problems (Liu et al., 2020; WHO, 2020) and CF (Alharbi et al., 2020; Ruiz-Fernández et al., 2020).

Contextual factors surrounding COVID-19, such as the ease of transmission, lack of immunity among global populations, delayed testing, limited medical equipment, the uncertainty of the pandemic trajectory and the general level of anxiety within the community all combine to place increasing pressure on health and welfare systems (Centers for Disease Control and Prevention, 2020). Disasters—including disease outbreaks and epidemics—require a high level of emergent healthcare response that is often instituted without a focus on the psychological well-being of those providing the response (Albott et al., 2020). The combination of witnessing physical suffering and death along with the immediate threat to one's own safety has been reported to induce many negative feelings in frontline nurses (fear of being contagious and infecting loved ones or about their own death in isolation and burial without religious rites and ceremonies,

grief and guilt) as well as elevated mental health scores (Ardebili et al., 2021; Kackin et al., 2021). On the other hand, nurses in COVID-19 settings, despite increased responsibility due to performing tasks previously assigned to other clinical team members such as physicians, dietary staff, and respiratory therapists (Jia et al., 2021; Schroeder et al., 2020), also report positive emotions (confidence, calmness, relaxation, happiness and psychological growth which may lead to compassion satisfaction (CS; see Figure 1) and personal and professional psychological growth (Chen et al., 2021; Schroeder et al., 2020). Nonetheless, to the authors' knowledge, there has been no study focusing exclusively on the CF and CS of frontline nurses in COVID-19 settings. In Greece, Blekas et al. (2020) reported moderate stress among healthcare professionals working in COVID-19 settings but did not distinguish among the variety of professionals from different disciplines.

This study aims to add to the literature because, to the best of the authors' knowledge, there has been no study previously investigating CF and CS among frontline nurses during the COVID-19 pandemic. The aims of the study were fourfold: (1) to investigate the level of risk for CF for greek nursing care providers (2) to examine their levels of CS (3) to explore the possible effects of personal and work-related characteristics on levels of CF and CS and (4) to describe the experiences of front-line nursing care providers providing care in COVID-19 settings.

1.1 | Theoretical framework

The present research employed the theoretical model of CF and CS developed by Stamm (2005, 2010) to explain the consequences of working with traumatized individuals. The origins of the model lie in the seminal work of Charles Figley and Beth Hundall Stamm who in the 1980s and 1990s attempted, among multiple other researchers, to refine the concepts of CF and secondary traumatic stress (STS) and developed the Compassion Satisfaction and Fatigue Test, the first self-help instrument focusing on CF. This instrument was later revised and evolved into the Professional Quality of Life Scale (Stamm, 2010).

According to the Compassion Fatigue and Satisfaction Theory, CF is composed of two subsets of symptoms: Job burnout (BO) and

Term	Definition of Term
Compassion fatigue	The overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering (Figley, 2002).
Compassion Satisfaction	An individual's sense of achievement regarding his or her efforts to help another person (Figley, 1995).
Burn-out	A syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed and characterized by three dimensions: (a). feelings of energy depletion or exhaustion, (b). increased mental distance from one's job, c feelings of negativism or cynicism related to one's job, and (c). reduced professional efficacy (ICD-11).
Secondary Traumatic Stress	The natural and consequential behaviors and emotions that result from exposure to trauma experienced by a significant other or client and the stress that emerges from wanting to help (Figley, 1995).

FIGURE 1 Definition of terms

STS symptoms. Stamm (2010) defines BO as lingering feelings of hopelessness and fatigue that interfere with the professional's ability to perform effectively at work. Symptoms of BO may include feelings of being trapped, overwhelmed, "bogged down," and unsatisfied with one's work. On the other hand, STS is defined as being "preoccupied with thoughts of people one has cared for." Professionals report feeling exhausted, trapped, "on edge" or "infected" by other's trauma (Stamm, 2010, p. 21). Symptoms may include fear, sleep difficulties, intrusive images, and avoiding listening to other's traumatic narratives. However, the Compassion Fatigue and Compassion Satisfaction Theory does not solely focus on the negative consequences of helping others but also attempts to capture the positive feelings derived from compassionate help, that constitute the dimension of CS. Instead of developing fatigue due to exposure to suffering and traumatization, professionals may develop high morale and resiliency in adversity while experiencing pleasure and a sense of personal fulfillment and satisfaction.

1.2 | Cultural considerations

The first COVID-19 case was diagnosed in Greece on February 26, 2020. Contact tracing was initiated on the first and all subsequently confirmed cases, with all contacts being tested and isolated. On March 23, a nationwide restriction of movement was enforced, whereby citizens could leave their house only for specific reasons and with a special permit. Despite the economic costs of the devastating measure of lockdown, the epidemic curve was successfully flattened. According to the National Public Health Organization (2020), Greece had 126,373 confirmed cases and has suffered 3785 deaths (mean age of death, 79 years) on December 15, 2020. A second national lockdown measure announced on November 7, seems to successfully, for now, curb the epidemic curve. Nonetheless, the impact of the COVID-19 pandemic in Greece is better understood in relation to its current socioeconomic status.

The Greek society has suffered a decade of austerity (Stylianidis & Souliotis, 2019) while the necessary, but at the same time socially disruptive measure of nationwide lockdown, appears to have a great impact on the well-being of individuals, families, and young people (Marketos, 2020). Furthermore, the public health system was challenged by the rise in migration due to the Syrian Civil War and the overpopulated Reception and Identification Centers with minimal healthcare capacity serving as camps. By December 2020, 37,012 asylum seekers and migrants have been accommodated in Greek island migrant camps which have a housing capacity of 6095 people posing urgent questions regarding the living conditions and healthcare provision for this vulnerable population (General Secretariat for Information and Communication, 2020). Furthermore, profound cutbacks in the National Health Care System during the last decade as well as pre-existing staff shortages constitute a major challenge to adequate COVID-19 care provision by healthcare professionals. At the moment, 1082 intensive care beds are available while the Greek government announced that by the end of the year 234 more intensive care beds will be available.

2 | METHODS

In our mixed-methods study, a convergent parallel design was employed to investigate CF in nurses working in COVID-19 units (Creswell & Plano Clark, 2017). In this design, quantitative and qualitative data are collected at the same time, analyzed separately, and then the results are mixed during the interpretation of the data. During this last phase, the researchers looked for convergence, divergence, contradictions, or relationships between the qualitative and quantitative results. When used in combination, quantitative and qualitative methods complement each other and permit for a more robust analysis. Through this complementarity, the researchers sought to have the qualitative data enhance and elaborate on the quantitative findings.

2.1 | Procedure and ethical considerations

Data were collected between May 2020 and October 2020 at COVID-19 units of two public hospitals in Athens, Greece. Questionnaires were distributed to nursing care providers who worked full time. Overall, 105 nursing care providers completed the questionnaire (85% participation rate). The study was conducted after review and written approval by the Administration and Scientific Society of the hospitals. The researchers informed the head nurse of each unit about the purpose of the study and then the head nurse informed the nursing staff. Furthermore, all participants were informed of their rights to refuse or to discontinue their participation, according to the ethical standards of the Helsinki Declaration of 1983. Participation in the study was contingent on individual verbal consent. An anonymous self-administered questionnaire was then distributed to nursing care providers (registered and assistant). Upon questionnaire completion, semi-structured interviews were conducted with five participants from two COVID-19 units who were available during that shift for an interview. The interviews' duration was approximately 30 min. An introductory question (What motivated you to work in a COVID-19 unit?) generated lively discussions about participants' experiences. This was followed by specific questions: Can you describe your experience in a COVID-19 unit? What are the advantages and the challenges of working in a COVID-19 unit? Can you describe some of the difficulties you encounter in your work in the COVID-19 unit? How do you cope with these difficulties? What are the advantages of working here? Questions were open-ended, with probes facilitating rich accounts.

2.2 | Measures

2.2.1 | Functional assessment of chronic illness therapy spiritual wellbeing scale 12

The Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale-12 non-illness (FACIT-Sp-12) was used to assess nurses' spirituality over the last 7-day period. This 12-item scale is used to

measure three dimensions of spirituality (“meaning,” “peace,” and “faith”), and provides a total score. Responses are given in a 4-point Likert scale ranging from 0, which corresponds to “not at all,” to 4, which corresponds to “very much.” Higher scores in the total scale and in the three domains indicate higher spirituality. The Cronbach alpha coefficient of the Greek version of FACITsp-12 was 0.77 for the total questionnaire, 0.70 for the “meaning” subscale, 0.73 for the “peace” and 0.87 for the “faith” subscale (Fradelos et al., 2016).

2.2.2 | Traumatic Life Event Questionnaire

The Traumatic Life Events Questionnaire (TLEQ) is a self-report questionnaire assessing the occurrence of a range of potentially traumatic events (Kubany et al., 2000). The TLEQ records detailed information about lifetime trauma history, including both impersonal (natural disaster, car accident, etc.) and interpersonal events (being attacked, while growing up: physically punished, witnessing family violence, being physically harmed by an intimate partner, unwanted sexual contact). Participants indicated a “yes” or “no” response to 16 potentially traumatic events. Prior studies have established good psychometric properties of the TLEQ (Kubany et al., 2000). The Cronbach alpha coefficient of the Greek version of TLEQ in the present study was 0.66 for the total questionnaire.

2.2.3 | Professional Quality of Life Scale

The Professional Quality of Life Scale (ProQOL V) is a 30-item self-report measure on a 5-point scale (from never to very often) and consists of three discrete scales: CS, BO, and CF/STS that do not yield a composite score (Stamm, 2010). The Greek translated ProQOL version was employed for the purpose of the study (Missouridou et al., 2020). The Cronbach's alpha value was found to be 0.67 for CS, 0.68 for BO, and 0.84 for CF.

2.3 | Data analysis

A descriptive analysis was used to identify samples' characteristics. Quantitative data was entered into SPSS v23 for analysis. *T*-tests and multiple linear regression analysis were used to explore the possible effects of personal and work-related characteristics on levels of CS, and CF/STS. Variables with $p \leq 0.05$ were considered significant.

As regards qualitative data, inductive content analysis was used to explore participants' experiences in COVID-19 units following the principles of conventional content analysis (Hsieh & Shannon, 2005). The steps implicated in this process include: (a) reading repeatedly data to achieve holistic understanding, (b) deriving codes using the exact words that capture key concepts, (c) attaching labels to emerging codes, (d) organizing codes into subcategories and categories, (e) developing a tree diagram which organizes codes, sub-categories, and categories into a hierarchical structure, (f) developing

definitions of codes and categories, and (g) identifying key themes emerging from categories. To ensure the credibility of findings, three researchers read independently participants' answers, and a consensus was reached on the identified themes, categories, and sub-categories. Confirmability of results was enhanced by data triangulation (Begley, 1996) and researcher triangulation. A reflective approach entailed thinking through any preconceptions about the data and any preliminary understandings borne out by the data (Barry et al., 1999).

3 | RESULTS

3.1 | Demographic and work-related characteristics

One hundred and five nursing care providers (73 registered and 32 assistant nurses) completed the questionnaire. The sample was predominantly female (83%) and married (51%). The mean age was 37.9 ± 10.5 years. All registered nurses had a Bachelor's degree in nursing. Nineteen registered nurses (18%) had also acquired a Master of Science in nursing. The demographic characteristics of the sample are presented in Table 1.

Table 2 presents the work-related and personal characteristics of participants. The majority of respondents (70%) described their working environment as very good or excellent while 89% thought that the staff always/most of the time worked as a team. Interestingly, 60% reported that they had never felt a desire to leave the unit or that it did not concern them although their placement at the COVID-19 unit was not their choice. Participants considered their physical health as very good (77%) but a considerable number of them reported having experienced one or more traumatic events in their life course (see Table 2). The most common traumatic life events were the death of a loved one (42.9%), injury or illness of a loved one (41%), natural disaster (29.5%), and car accident (21.9%) or any other accident (16.2%).

3.2 | Integration of quantitative findings

Based on the norms provided by Stamm (2010), the average scores for the sample were “moderate to high” for CS (36.81 ± 6.77 , top 25% cut point = 42), “moderate to low” for BO (23.20 ± 4.87 , bottom 25% cut point = 22) and “almost low” for STS (22.46 ± 6.76 , bottom 25% cut point = 22). The majority of participants (according to *t* scores) reported a moderate potential for CS (56.2%) and moderate risk for BO (46.7%) and STS (51.4%). 22% and 28% of participants reported high risk for CF nad BO, respectively, while a considerable percentage of participants (77%) expressed moderate or high potential for CS. The ProQOL frequencies are presented in Table 3, whilst the descriptive statistics of study instruments are presented in Table 4.

CS was correlated positively with meaning ($r = 0.31$, $p < 0.001$), peace ($r = 0.29$, $p < 0.05$), faith ($r = 0.28$, $p < 0.05$) and spirituality total

TABLE 1 Demographic and professional characteristics of the sample (N = 105)

	n	%
Sex		
Male	18	17.1
Female	87	82.9
Marital status		
Single	47	44.8
Married	54	51.4
Widowed	1	0.9
Divorced/separated	3	2.9
Job position		
Registered nurse	73	69.5
Assistant nurse	32	30.5
Educational level		
Secondary education	34	32.4
University education	52	49.5
Post-graduate education	19	18.1

($r = 0.42$, $p < 0.001$). BO was correlated negatively with meaning ($r = -0.26$, $p < 0.05$), peace ($r = -0.39$, $p < 0.01$), and spirituality total ($r = -0.37$, $p < 0.01$). STS as expected was found to correlate positively with traumatic life events ($r = 0.25$, $p < 0.05$) and negatively with peace ($r = -0.30$, $p < 0.05$). Also, BO was found to correlate positively with STS ($r = 0.45$, $p < 0.01$) and negatively with CS ($r = -0.37$, $p < 0.01$). No statistically significant correlation was found between CS and STS.

Teamwork (always vs. most of the time) was found to correlate with higher levels of CS ($F_{2,102} = 4.22$, $p = 0.017$; $t = 2.91$, $p = 0.004$) and lower levels of BO ($F_{2,102} = 6.33$, $p = 0.003$; $t = -3.45$, $p = 0.001$). Participants with secondary education (vs. university education: $F_{2,102} = 3.42$, $p = 0.037$; $t = 2.74$, $p = 0.007$) had also higher levels of CS. Marital status ($F_{3,101} = 2.74$, $p = 0.047$) and workplace environment ($F_{3,101} = 4.10$, $p = 0.009$) were found to correlate with BO. Divorced participants (vs. single: $t = 2.34$, $p = 0.047$ and married: $t = 2.49$, $p = 0.016$) had lower levels of BO, while those who described the workplace environment as good (vs. excellent: $t = -3.05$, $p = 0.004$ and very good: $t = -2.76$, $p = 0.007$) had higher levels of BO. Statistical significant differences were observed across gender ($t = -2.24$, $p = 0.027$) and physical health status ($F_{3,101} = 2.82$, $p = 0.043$). STS scores were higher among women and those who described their physical health as good (vs. excellent: $t = -2.27$, $p = 0.028$ and very good: $t = -2.92$, $p = .005$). T-test analysis results for ProQOL subscales (t scores) are presented in Table 5.

Nurses with higher scores in meaning ($p = 0.024$) and faith ($p = 0.040$) were found to have higher levels of CS, whilst lower peace was found to correlate with higher BO ($p = 0.007$) and STS ($p = 0.001$). Also, the existence of traumatic life events (total number

of traumatic events, regardless of their intensity) was found to be associated with higher levels of STS ($p = .0044$). These independent variables explain the 29.3% of CS, 26.2% of BO, and 29.1% of STS variability. The independent variables (traumatic life events and spirituality) were adjusted for demographic and work-related characteristics. The multiple linear regression analysis results for ProQOL subscales are presented in Table 6.

3.3 | Integration of qualitative results

Reported experiences varied greatly among participants due to differences in environmental and personal characteristics and motivation. Some participants entered a COVID-19 unit with enthusiasm having chosen to work in it. Others would not choose to work in this particular field if they had an option for fear of infection of themselves, their families, or patients. Three of the participants had been tested positive for SARS-Cov-2. One overarching theme described their experiences and perceptions of working in a COVID-19 unit: The transition into knowledge as a valuable journey from fear to CS at later stages. Learning how to care for suspected and confirmed COVID-19 infection while surviving the challenges of the field appeared to be the central organizing element of participants' experiences of caring for individuals carrying the dual burden of illness and cumulative suffering implicated in the quarantine experience. Overall, three categories and seven sub-categories emerged regarding their perceptions and feelings toward CS (Table 7).

3.3.1 | Category 1: Fear and heroism

This category comprised two sub-categories: (a) feeling overwhelmed and inadequate and (b) being an ostracized hero.

Feeling overwhelmed and inadequate

Participants described feelings of fear, inadequacy, and exhaustion at the beginning of working in a COVID-19 unit. Some participants described feeling powerless in the landscape of an unknown disease, insufficient protective supplies, and shortage of staff. Other participants reported being stressed or scared of the high disease transmission capacity and contact with colleagues diagnosed as having COVID-19 which might result in being infected and infecting others. Participants who cared for vulnerable individuals in their families emphasized many ways that their personal life was influenced, for example, overwhelming stress, guilt feelings, and exhaustion. The perception of being adequately trained, clear communication of guidelines and precautionary measures appeared to alleviate their worries and protect them against fear and intense stress during their transition into a COVID-19 unit.

"I was scared mostly at the beginning and not so much for myself but for others. I was afraid that we may not do the right thing, that we may not operate properly because there was a lot of different information from many sources. These were the sources of my

TABLE 2 Perceived work-related and personal characteristics (N = 105)

Characteristics	n (%)			
	Excellent	Very good	Good	Poor
Working environment	16 (15.2%)	58 (55.3%)	25 (23.8%)	6 (5.7%)
	Always	Most of the time	Sometimes	Rarely
Staff works as a team	55 (52.4%)	38 (36.2%)	10 (9.5%)	2 (1.9%)
	Never	Doesn't concern me	At some point	Soon/as soon as possible
Desire to leave the Unit	35 (33.3%)	28 (26.7%)	28 (26.7%)	13 (18.4%)
	Excellent	Very good	Good	Poor
Physical health	33 (31.4%)	48 (45.8%)	18 (17.1%)	6 (5.7%)
	Yes	No		
Personal choice of work in unit			10 (9.5%)	95 (90.5%)
Choice of nursing career again			64 (61%)	41 (39%)
Traumatic Life Events Questionnaire (TLEQ)				
Natural disaster			31 (29.5%)	74 (70.5%)
Car accident			23 (21.9%)	82 (78.1%)
Any other accident			17 (16.2%)	88 (83.8%)
Combat			3 (2.9%)	102 (97.1%)
Death of loved one			45 (42.9%)	60 (57.1%)
Injury/illness of loved one			43 (41%)	62 (59%)
Serious illness			5 (4.8%)	100 (95.2%)
Witness armed robbery			7 (6.7%)	98 (93.3%)
Victim of physical assault			6 (5.7%)	99 (94.3%)
Witness of physical assault			7 (6.7%)	98 (93.3%)
Threat of death/assault			10 (9.5%)	95 (90.5%)
Childhood physical assault			6 (5.7%)	99 (94.3%)
Domestic violence			8 (7.6%)	97 (92.4%)
Intimate partner violence			5 (4.8%)	100 (95.2%)
Sexual abuse			2 (1.9%)	103 (98.1%)
Sexual assault			15 (14.3%)	90 (85.7%)

TABLE 3 Professional quality of life frequencies (t scores, N = 105)

	Compassion satisfaction	Burnout	Compassion fatigue
High	22 (21%)	30 (28.6%)	24 (22.9%)
Moderate	59 (56.2%)	49 (46.7%)	54 (51.4%)
Low	24 (22.9%)	26 (24.8%)	27 (25.7%)

anxiety. I was certainly afraid of getting infected but I thought that a lot of people get infected since there is a high infection capacity. The important thing is not to have any complications. That's the point." (I4)

"It is much more difficult when you have a family. We have colleagues who are mothers of three young children. They did not permit them to take any paid leave for family reasons. We were scared at first until we saw how it goes. In the beginning, we did not even have any ventilation... The biggest obstacle is the lack of equipment. You do not have tubes, masks, disposable shoe covers and you have to put plastic bags on your feet..." (I1)

Being an ostracized hero

Stigma and self-isolation constituted dimensions that participants had to deal with in everyday life. Colleagues, family members, and friends' fear of being infected by front-line nurses was so intense to the extent they withdrew, kept participants at a distance, or

TABLE 4 Descriptive statistics of study instruments

	Min-max	Mean ± SD	Cronbach's alpha
TLEQ			
TLEQ	0–12	2.34 ± 2.14	0.66
TLEQ intensity	0–10	6.09 ± 3.76	
ProQOL			
Compassion satisfaction	10–59	36.81 ± 6.77	0.67
Burnout	12–34	23.20 ± 4.87	0.67
Compassion fatigue	8–42	22.46 ± 6.76	0.83
Spirituality			
Spirituality total	16–47	32.38 ± 6.73	0.76
Meaning	6–16	13.64 ± 2.36	0.70
Peace	2–16	9.75 ± 2.94	0.65
Faith	0–16	9.06 ± 4.33	0.87

Abbreviations: ProQOL, Professional Quality of Life Scale; TLEQ, Traumatic Life Events Questionnaire.

avoided any type of contact to protect themselves. At the same time, participants chose to separate themselves from others as a way of self-quarantine so as to avoid feelings of guilt and self-blame in case any of their family members or patients were infected by the virus.

“Some people regard us heroes and others send us into exile. My husband feels very proud of me! He is a police officer working for the greek security protective forces. But we do not have any vulnerable family members and we keep distances from everyone...” (I3)

“At the hospital, everyone avoided us in the beginning and kept us at a distance. We also faced racism, intensely, in our families. At the same time, we put ourselves in isolation in our families. I personally slept on a sofa in the living room in order not to get in touch with my mother because she was in a high-risk group. Anyway, we tried to put ourselves in self-quarantine so as to protect those around us. Even in our social circle, there was racism. My friend, for example, asked me not to visit her. She told me “no, don't come!” because I worked in a COVID-19 unit. All the others who were around made room for me to pass. We faced that, yes. And I think we will face it again, but okay it does not scare us. At least it did not affect me. (I5)

3.3.2 | Category 2: Learning to care in the context of a team

This category comprised three sub-categories: (a) trust in protocols and hospital management, (b) self-motivation, and (c) containing feelings and experiences.

Trust in protocols and hospital management

Participants described how the COVID-19 pandemic affected the way their hospital operated. Regular wards were modified into COVID-19 units while human resource management and organizational changes aimed at contributing to faithful implementation of protocols and guidelines released by the national health commission. According to participants, in several units, appointed managers held post-graduate or even doctoral degrees while staff had previous experience in meeting the criteria of infectious disease units. Socialization tactics and participation in COVID-19-training familiarized newly appointed nurses with organizational policy and values. At the same time, new personnel worked in couples with experienced nurses to reflect on practice together, receive feedback through discussion and learn through practice. Participants emphasized the importance of colleagues' feedback in processes of experiential learning, exploring, drawing on previous experience, reading, being informed regarding managing airways, tubes, positioning, medication, nutrition, contaminated, semi/non-contaminated areas, isolation measures, and other important issues in COVID-19 care. Overall, differences in applying the guidelines between units allowed for staff choices and accountability tailored to specific circumstances.

“Protocols help greatly and we follow them faithfully.” (I1)

“We (i.e., nurses) are responsible to dress all personnel. We are responsible for infection control in the hospital setting.” (I2)

Self-motivation

Participants described different levels of motivation in relation to working in a COVID-19 unit. Nonetheless, educational preparation and group cohesion enhanced their self-motivation and boosted their self-confidence.

“Being here is a great opportunity. I am very lucky. We all put our knowledge and do something good. The job would not work out if we were not so combatworthy.” (I3)

“I was brought here because of my experience in the pulmonology clinic. But I do not want to leave the COVID-19 clinic. I'm quite happy.” (I2)

“I like action... I like tension and I don't like open units. COVID-19 is something new, you work with patients who are ‘dangerous.’ There is something intriguing in all this. It is not like in the ward, I take the trolley, I put on antibiotics and then I take them out. Here work has another meaning. This does not mean that the other work is not important, by no means, it is important but it's just lost.” (I4)

Sharing feelings, experiences, and responsibility in the context of the group

According to participants, clear and accountable leadership, respect for other team member's contributions, and hard work resulted in feeling more closely connected to their colleagues in comparison to other units they had previously worked at. Sharing feelings, thoughts, and experiences with others were experienced as comforting and helpful as well as cultivating a feeling of “camaraderie.”

TABLE 5 T-test analysis results for ProQOL subscales (t scores)

Grouping variables	Compassion satisfaction			t	p
	m ± SD				
	Secondary education		University education		
Education level	53.66 ± 9.66		48.12 ± 8.59	2.74	0.007
Team work	52.50 ± 10.93	Always	46.67 ± 7.25	2.91	0.004
			Most of the times		
Burnout					
	m ± SD			t	p
	Single	Married	Divorced		
Marital status	50.39 ± 10.08	50.38 ± 9.48	36.58 ± 2.36	2.34 (sin-div)	0.047 (sin-div)
				2.49 (mar-div)	0.016 (mar-div)
Team work	46.93 ± 9.66	Always	53.82 ± 9.44	-3.45	0.001
			Most of the times		
Workplace environment	44.95 ± 12.13	Excellent	49.06 ± 9.24	-3.05 (ex-g)	0.004 (ex-g)
			Good	-2.76 (vg-g)	0.007 (vg-g)
Secondary traumatic stress					
	m ± SD			t	p
	Male		Female		
Gender	45.28 ± 8.66		50.97 ± 10.02	-2.240	0.027
Physical health	48.61 ± 11.08	Excellent	48.41 ± 8.79	-2.27 (ex-g)	0.028 (ex-g)
			Good	-2.92 (vg-g)	0.005 (vg-g)

Abbreviation: ProQOL, Professional Quality of Life Scale.

“Our infectious disease specialists here are very good and they are always by our side. It is very important to have a doctor by your side at all times because you know that no matter what happens you are covered. They get dressed and come in with us and they are next to us, just like the infectious disease specialist is there for anything and that is what makes me feel safe.” (15)

“One colleague is watching the other. If someone makes a mistake we help him. It is simple, but it helps. We keep the area of our unit clean, if someone enters from a ward, they will not enter the unit. Our colleagues tell us ‘you make me feel safe as a guest.’ Similarly, I feel safe in here. We know each other. I know we will talk and find a solution. Experience does not matter. As long as the new colleague has critical thinking. (12)

3.3.3 | Category 3: Compassion satisfaction

This category comprised two sub-categories: (a) satisfaction from meaningful nursing care and (b) personal/professional growth and self-care.

Satisfaction from meaningful nursing care

Understanding the challenges during the process of COVID-19 care, participants felt a powerful urge to help the COVID-19 patients and described the satisfaction they get as “meaningful” (13) and “unique” (15). Oral hygiene, wound care, assistance with nutrition, fluid, and elimination needs were described as means to relieve the emotional burden of quarantined patients and their traumatic experience of isolation.

“When you come in and talk to them, it is a great reward. Especially when you see them walking away from the hospital. It is the gratitude we receive, our reward, our recognition by the patients...” (12)

“Patients want constant contact. Isolation triggers their psychological problems. They want to hear you and see you all the time” (15)

Personal/professional growth and self-care

According to participants, enhanced personal accomplishment facilitated personal growth. They also described that they gradually acquired a strong sense of personal identity and self-knowledge which was described as important in the encounter with patients. Having more confidence both in themselves and in their role enabled

them to feel more effective in their care. The value of peer support was emphasized by most participants. Peer supervision and education were sought as opportunities for self-reflection, support, and empowerment.

"I have calmed down here at this clinic. We have a manager who listens to his staff, he understands. The colleagues are all great. I did not have this anywhere else." (I3)

"After 10 years of working at the ICU, I got tired mainly psychologically, not physically. It's a heavy work. I cannot stand it. During the 7th year, I asked to be moved, but they did not move me. So I had no motivation to come here. At first, there was fear but after some time I did not want to leave. Still, I have not recovered from that psychological burden of working at the ICU. Fortunately, things are fine here so it does not bother me. I feel safe. And of course, I do my job in the best possible way." (I4)

TABLE 6 Multiple linear regression analysis results for ProQOL subscales adjusted for demographic and work-related characteristics

Compassion satisfaction			
Predicting factors	B (SE)	p	95% CI
Constant	26.98 (6.05)	<0.001	14.951–39.023
Meaning	0.59 (0.26)	0.024	0.082–1.116
Faith	0.30 (0.14)	0.040	0.015–0.598
$R^2 = 29.3\%$, $F = 4.293$, $p < 0.001$			
Burnout			
	B (SE)	p	95% CI
Constant	34.123 (4.65)	<0.001	24.873–43.372
Peace	-0.46 (0.16)	0.007	-0.797 to -0.130
$R^2 = 26.2\%$, $F = 3.686$, $p = 0.001$			
Secondary traumatic stress			
	B (SE)	p	95% CI
Constant	19.801 (6.448)	0.003	6.977–32.625
Peace	-0.830 (0.23)	0.001	-1.293 to -0.368
TLEQ	0.621 (0.30)	0.044	-0.017 to 1.225
$R^2 = 29.1\%$, $F = 4.252$, $p = 0.001$			

Abbreviations: ProQOL, Professional Quality of Life Scale; TLEQ, Traumatic Life Events Questionnaire.

TABLE 7 Themes, categories, and sub-categories

Theme	Categories	Sub-categories
The transition into knowledge: The long journey from fear to compassion satisfaction	Fear and heroism	Feeling overwhelmed and inadequate Being an ostracized hero
	Learning to care in the context of a multidisciplinary team	Trust in protocols and hospital management Self-motivation A team approach to sharing feelings, experiences, and responsibility
	Compassion satisfaction	Satisfaction from meaningful nursing care Personal/professional growth and self-care

4 | DISCUSSION

The aim of the present study was to investigate the levels of CF and CS of nursing care providers and to describe the emotional costs as well as the rewards of working in a COVID-19 unit. Findings suggest that 23% of participants reported a high risk for CF and 77% expressed high to moderate potential for CS. Nurses with higher scores on faith and meaning reported higher CS while nurses with traumatic events in their life course scored higher in STS. All participants described the transition into knowledge as a strenuous but worthwhile journey from fear to CS. Adequate preparation/education, clear and accountable leadership, and team sharing of feelings, experiences, and responsibilities during the transition in the COVID-19 unit helped them to deal with overwhelming anxiety and fear as well as undue optimism and misperceptions, which if unattended could bring about frustration and long-lasting feelings of powerlessness.

Overall, the results of the present study are similar to those of Buselli et al. (2020) conducted during the present pandemic and other studies included in the meta-analysis of Cavanagh et al. (2020) and conducted before the COVID-19 pandemic. A possible explanation is that, despite the high transmission capacity of the SARS-Cov-2 (three of the participants in the present study had been tested positive), the present pandemic is associated with a significantly lower death rate and disease burden in comparison to SARS and MERS (Munster et al., 2020). Furthermore, the BO element of CF is influenced greatly by organizational factors (Stamm, 2010). In the present study, quantitative results point to participants' satisfaction with the organizational climate in their working context while qualitative results point to the impressive readiness of nursing management in preparing and educating nurses to protect their patients and themselves in times of crisis. Participants also embraced organizational and group values and followed the National Health Service Guidelines in the mission to safeguard the nation from the invisible enemy creating the pandemic.

As regards the positive aspects of work in COVID-19 units, more than three-quarters of the participants reported moderate and high CS while ninety percent of participants had no desire to leave the COVID-19 unit, described their working environment as very good and thought that the staff most of the times worked as a team. These unexpectedly high scores in CS constitute a protective shield of frontline nurses since professionals with high CS and moderate BO

and CF reflect a “positive reinforcement profile” (Stamm, 2010). Individuals with this profile, despite the moderate scores in CF, carry no significant concerns about being able to accomplish their work. Furthermore, higher levels of CS are found to be correlated with lower scores in stress, anxiety, and depression (Li et al., 2020) and in relation to an organizational climate characterized by trust, collaboration, respect, and shared responsibility, echoing principles of clinical governance (American Nurses Credentialing Center, 2020), point to a good person-environment fit (Inoue et al., 2021).

Furthermore, the qualitative results of the present study reveal participants' feelings of satisfaction and self-accomplishment when describing how they overcame the fear experienced during their transition into the COVID-19 unit. Through the strenuous journey of learning to provide compassionate care in a COVID-19 unit while protecting themselves, they acquired a strong sense of personal and professional identity. Additionally, through the struggles associated with assigning meanings to traumas they are exposed to, professionals may have the opportunity to grow beyond their pre-exposure level of psychological functioning (Chen et al., 2021). In this way engaging in an empathic relationship with COVID-19 patients may lead to opportunities for growth and a new appreciation of life, spirituality, and relationships despite the initial intense emotional impact (Lin et al., 2020). In the present study, faith and meaning were correlated with CS, a finding echoing the recommendations of Cruz et al. (2020) which suggest that spirituality may contribute to CS increase and CF decrease.

Another important result of the present study is that nurses with traumatic life events scored significantly higher in ST in comparison to the rest participants. Similarly, Rossi et al. (2012) found a significant positive association between professionals' history of trauma and CF. It appears that professionals' emotional reactions can be partly a result of their own personal history when exposed to the stress and the tensions present in their interactions with traumatized individuals (Missouridou, 2017). Missouridou (2017) stresses that self-awareness, acknowledgment of personal loss history and unresolved issues as well as acceptance of personal limitations constitute necessary equipment for a “wounded healer” in a genuine encounter with those in need. In this way, spirituality (Timmins & Caldeira, 2017) could be a precious compass in the long-term journey of resolving feelings of grief and loss and of building a strong professional identity.

5 | LIMITATIONS

Certain limitations of the present research should be taken into account. A major limitation of the study is that it may have been too early to see the real impact of the pandemic on frontline nurses. Galanis et al. (2020) have found that longer working time in quarantine increases nurses' BO. Furthermore, the sample was drawn from only two public hospitals and therefore no generalizations can be made to other healthcare contexts in Greece or internationally. Additionally, the small sample size of the qualitative data and the

analytic method employed partly due to the need for actionable information and timely integration of mixed-method results in the context of a public health emergency did not allow for in-depth exploration of participants' experiences.

6 | IMPLICATIONS FOR PSYCHIATRIC NURSING PRACTICE

As the second wave of the pandemic disrupts our family and social lives and there are predictions for following waves in the future, the findings of this study indicate the need for the development of educational and supportive interventions to prepare nursing care providers to cope with the emotional content of their work in the face of the present and future pandemics. Although CF scores in the present study were average, they certainly suggest a potential for an increase in CF if not mitigated. Psychiatric-mental health advanced practice nurses can support frontline nurses and contribute to providing mental health crisis interventions (Lesley, 2020). Screening nursing care providers and targeted interventions to those with high scores on CF and other mental health outcomes may protect both “wounded healers” and functioning healthcare systems stretched to their limits. Severe depressive and acute stress symptoms related to unacknowledged CF should be clinically evaluated. Additionally, organizational support and a supportive workplace culture (American Nurses Credentialing Center, 2020) are crucial to enable nursing care providers to talk about their feelings of frustration and grief in COVID-19 healthcare settings since they often do not feel prepared to provide care in the context of a public health emergency (Albott et al., 2020). Adequate preparation before entering the field and continuous education may empower nurses in actualizing their valued role and societal mission.

Care during the emotionally laden moments of COVID-19 treatment may be a source of suffering, anguish, and stress for nursing care providers but also an arena of personal maturity and self-actualization. “The doctor is effective only when he himself is affected” (Jung, 1989, p. 134). During a journey of self-healing, wounded healers have the courage to alleviate the other's suffering only to discover the way out of Plato's cave (Choder-Goldman, 2020), which is the process of transforming mute, immobilizing, and incomprehensible trauma and loss into knowable, expressible and meaningful experience facilitating personal and professional development and formation of profoundly authentic identities. In times of an international workforce crisis, nursing care providers should be adequately prepared to face the dynamics of trauma to understand the nature of suffering experienced when individuals and families face the dual burden of COVID-19 and stigmatized isolation and thus be able to help them restore purpose and meaning while at the same time protect themselves from absorbing or internalizing unmanageable emotions which may lead to CF (Missouridou, 2017). Caution is needed not to develop a dependency on the social and emotional intensity of the working milieu to meet unmet and social intimacy needs. Ultimately, the present syndemic invites contemporary human

beings to reconstruct their lives and the way they relate to others and to think over personal and collective assumptions. Furthermore, it constitutes a challenge for organizations that give precedence to moral obligations to patients, families, and the public over corporate and commercial values and “wounded healers” who have the courage to pour “oil and wine” in the wounds of those in need.

ACKNOWLEDGMENTS

The authors owe gratitude to the Coordinators of the Post-graduate Programme “Wounds and Ulcers, Care and Treatment” of the Nursing Department, University of West Attica, Greece.

DATA AVAILABILITY STATEMENT

Data are available on request from the authors.

ORCID

Evdokia Missouridou  <https://orcid.org/0000-0002-0401-1749>

Martha Kelesi  <http://orcid.org/0000-0003-0292-7005>

REFERENCES

- Albott, C. S., Wosniak, J. R., McGlinch, B. P., Wall, M. H., Gold, B. S., & Vinogradov, S. (2020). Battle buddies: Rapid deployment of a psychological resilience intervention for health care workers during the coronavirus disease 2019 pandemic. *Anesthesia & Analgesia*, 131, 43–54. <https://doi.org/10.1213/ANE.0000000000004912>
- Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *Journal of Clinical Nursing*, 29, 2762–2764.
- American Nurses Credentialing Center. (2020). *Pathway to excellence and pathway to excellence in long-term care application manual*. <https://www.nursingworld.org/continuing-education/ce-subcategories/pathway/>
- Ardebili, M. E., Naserbakht, M., Bernstein, C., Alazmani-Noodeh, F., Hakimi, H., & Ranjbar, H. (2021). Healthcare providers experience of working during the COVID-19 pandemic: A qualitative study. *American Journal of Infection Control*, 49(5), 547–554.
- Barry, C. A., Britten, N., Barbar, N., Bradley, C., & Stevenson, F. (1999). Using reflexivity to optimize teamwork in qualitative research. *Qualitative Health Research*, 9(1), 26–44.
- Begley, C. (1996). Using triangulation in nursing research. *Journal of Advanced Nursing*, 24, 122–128.
- Blekas, A., Voitsidis, P., Athanasiadou, M., Parlapani, E., Chatzigeorgiou, A. F., Skoupra, M., & Diakogiannis, I. (2020). COVID-19: PTSD symptoms in Greek health care professionals. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(7), 812–819.
- Buselli, R., Corsi, M., Baldanzi, S., Chiumiento, M., Del Lupo, E., Dell'Oste, V., & Carmassi, C. (2020). Professional quality of life and mental health outcomes among health care workers exposed to Sars-Cov-2 (covid-19). *International Journal of Environmental Research and Public Health*, 17(17), 6180.
- Cavanagh, N., Cockett, G., Heinrich, C., Doig, L., Fiest, K., Guichon, J. R., & Doig, C. J. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. *Nursing Ethics*, 27(3), 639–665.
- Centers for Disease Control and Prevention. (2020). *How coronavirus spreads*. <https://www.vdc.gov/coronavirus/2019-ncov/prepare/transmission.html>
- Chen, R., Sun, C., Chen, J. J., Jen, H. J., Kang, X. L., Kao, C. C., & Chou, K. R. (2021). A large-scale survey on trauma, burnout, and posttraumatic growth among nurses during the COVID-19 pandemic. *International Journal of Mental Health Nursing*, 30(1), 102–116.
- Choder-Goldman, J. (2020). A Conversation with Grigoris Vaslamatzis. *Psychoanalytic Perspectives*, 17(1), 120–128.
- Coroiu, A., Moran, C., Campbell, T., & Geller, A. C. (2020). Barriers and facilitators of adherence to social distancing recommendations during COVID-19 among a large international sample of adults. *PLOS One*, 15(10):e0239795.
- Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.
- Cruz, J. P., Alquwez, N., Mesde, J. H., Almoghairi, A. M. A., Altukhays, A. I., & Colet, P. C. (2020). Spiritual climate in hospitals influences nurses' professional quality of life. *Journal of Nursing Management*, 28(7), 1589–1597.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (Psychosocial stress series, no. 23)*. Brunner/Mazel.
- Figley, C. R. (2002). *Treating compassion fatigue (Psychosocial stress series, no. 24)*. Brunner-Routledge.
- Fradelos, E. C., Tzavella, F., Koukia, E., Tsaras, K., Papathanasiou, I. V., Aroni, A., & Zyga, S. (2016). The translation, validation and cultural adaptation of functional assessment of chronic illness therapy-spiritual well-being 12 (facit-sp12) scale in Greek language. *Materia Socio-Medica*, 28(3), 229–234.
- Galanis, P. A., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2020). Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis. *medRxiv*.
- General Secretariat for Information and Communication. (2020). *The national situational picture on the refugee/immigration issue on 13th December 2020*. <https://infocrisis.gov.gr/11468/national-situational-picture-regarding-the-islands-at-eastern-aegean-sea-13-12-2020/?lang=en>
- Horton, R. (2020). Offline: COVID-19 is not a pandemic. *The Lancet*, 396(10255), 874.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, 15(9), 1277–1288.
- Jung, C. G. (1963). *Memories, dreams, reflections*. Crown Publishing Group/Random House.
- Inoue, M., Kunie, K., Takemura, Y., Kida, R., & Ichikawa, N. (2021). The influence of learning circumstances and on-the-job opportunities for professional growth on perceived person-environment fit among hospital nurses: A longitudinal study. *Journal of Nursing Management*, 29(4):776–784.
- Jia, Y., Chen, O., Xiao, Z., Xiao, J., Bian, J., & Jia, H. (2021). Nurses' ethical challenges caring for people with COVID-19: A qualitative study. *Nursing Ethics*, 28(1), 33–45.
- Kackin, O., Ciydem, E., Aci, O. S., & Kutlu, F. Y. (2021). Experiences and psychosocial problems of nurses caring for patients diagnosed with COVID-19 in Turkey: A qualitative study. *International Journal of Social Psychiatry*, 67(2), 158–167.
- Kristeva, J. (2020). In the current state of war, it is our most inner selves that we must save. *European Journal of Psychoanalysis*. <http://www.journal-psychoanalysis.eu/in-the-current-state-of-war-it-is-our-most-inner-selves-that-we-must-save/>
- Kubany, E. S., Leisen, M. B., Kaplan, A. S., Watson, S. B., Haynes, S. N., Owens, J. A., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment*, 12(2), 210–224.
- Lanara V. A. (1991). *Heroism as a nursing value—A philosophical perspective*. Athens, Greece: Evniki.
- Lesley, M. (2020). Psychoanalytic Perspectives on Moral Injury in Nurses on the Frontlines of the COVID-19 Pandemic. *Journal of the American Psychiatric Nurses Association*.
- Li, Z., Ge, J., Yang, M., Feng, J., Qiao, M., Jiang, R., Bi, J., Zhan, G., Xu, X., Wang, L., Zhou, C., Pan, Y., Liu, S., Zhang, H., Zhu, B., Hu, Y., Hashimoto, K., Jia, Y., Wang, H., ... Yang, C. (2020). Vicarious

- traumatization in the general public, members, and non-members of medical teams aiding in COVID-19 control. *Brain, Behavior, and Immunity*, 88, 916-919.
- Lin, J., Ren, Y., Gan, H., Chen, Y., Huang, Y., & You, X. (2020). Factors associated with resilience among non-local medical workers sent to Wuhan, China during the COVID-19 outbreak. *BMC Psychiatry*, 20, 417.
- Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: A qualitative study. *The Lancet Global Health*, 8(6), e790-e798.
- Marketos, N. (2020). Living with coronavirus. *Hellenic Systemic Thinking and Family Therapy Association Journal*, 17, 7. <https://hestafta.org/systemic-thinking-psychotherapy-journal/issue-17/living-with-coronavirus/?lang=en>
- Missouridou, E., Pavlou, V., Kasidi, K., Apostolara, P., Parissopoulos, S., Mangoulia, P., & Fradelos, E. (2020). Translation and cultural adaptation of the professional quality of life scale (ProQOL V) for Greece. *Materia Socio-Medica*, 32(3), 187-190.
- Missouridou, E. (2017). Secondary posttraumatic stress and nurses' emotional responses to patient's trauma. *Journal of Trauma Nursing*, 24(2), 110-115.
- Munster, V. J., Koopmans, M., van Doremalen, N., van Riel, D., & de Wit, E. (2020). A novel coronavirus emerging in China—Key questions for impact assessment. *New England Journal of Medicine*, 382(8), 692-694.
- National Public Health Organisation. (2020). *Daily report of COVID-19 infection containment on 15th December 2020*. https://eody.gov.gr/20201215_briefing_covid19/
- Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, 200(2-3), 933-938.
- Ruiz-Fernández, M. D., Ramos-Pichardo, J. D., Ibáñez-Masero, O., Cabrera-Troya, J., Carmona-Rega, M. I., & Ortega-Galán, Á. M. (2020). Compassion fatigue, burnout, compassion satisfaction and perceived stress in healthcare professionals during the COVID-19 health crisis in Spain. *Journal of Clinical Nursing*, 29(21-22), 4321-4330.
- Schroeder, K., Norful, A. A., Travers, J., & Aliyu, S. (2020). Nursing perspectives on care delivery during the early stages of the covid-19 pandemic: A qualitative study. *International Journal of Nursing Studies Advances*, 2, 100006.
- Sinclair, S., Beamer, K., Hack, T. F., McClement, S., Raffin Bouchal, S., Chochinov, H. M., & Hagen, N. A. (2017). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative medicine*, 31(5), 437-447.
- Stamm, B. H. (2005). *The Pro-QOL Manual: The Professional Quality of Life Scale: Compassion Satisfaction, Burnout & Compassion Fatigue/Secondary Trauma Scales*. Baltimore, MD: Sidran Press.
- Stamm, B. H. (2010). *The concise ProQOL manual*. 2nd ed. Pocatello, ID: ProQOL.org.
- Stroebe, M., & Schut, H. (2021). Bereavement in times of COVID-19: a review and theoretical framework. *OMEGA-Journal of Death and Dying*, 82(3), 500-522.
- Stylianidis, S., & Souliotis, K. (2019). The impact of the long-lasting socioeconomic crisis in Greece. *BJPsych International*, 16(1), 16-18.
- Timmins, F., & Caldeira, S. (2017). Understanding spirituality and spiritual care in nursing. *Nursing Standard*, 31(22), 50-57.
- World Health Organization. (2020, March 18). *Mental health and psychosocial considerations during the COVID-19 outbreak*. <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>

How to cite this article: Missouridou, E., Mangoulia, P., Pavlou, V., Kritsotakis, E., Stefanou, E., Bibou, P., Kelesi, M., & Fradelos, E. C. (2021). Wounded healers during the COVID-19 syndemic: Compassion fatigue and compassion satisfaction among nursing care providers in Greece. *Perspectives in Psychiatric Care*, 1-12. <https://doi.org/10.1111/ppc.12946>