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Original Article

Lived Experiences of Quiet Quitting Among ICU Nurses: A Sequential Explanatory Mixed Methods Study

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Abstract

Objective: To examine the relationships among quality of work life (QWL), compassion fatigue, psychological resilience, and quiet quitting among intensive care unit (ICU) nurses, and to explore the lived experiences of nurses who exhibit quiet quitting behavior.
Method: A sequential explanatory mixed-methods design was employed. In the quantitative phase, 400 ICU nurses from six public teaching hospitals in Kerbala and Babylon, Iraq, completed the QWL Scale, Compassion Fatigue Short Scale, Connor-Davidson Resilience Scale (CD-RISC), and Quiet Quitting Scale. Data were analyzed using mediation analysis with PROCESS macro. In the qualitative phase, 30 nurses were purposively selected for in-depth semi-structured interviews based on their quiet quitting scores. Thematic analysis was used to identify key themes.
Results: QWL was negatively associated with quiet quitting ($\beta = -0.38$, $P < 0.001$) and compassion fatigue ($\beta = -0.41$, $P < 0.001$), while compassion fatigue was positively associated with quiet quitting ($\beta = 0.42$, $P < 0.001$). Compassion fatigue significantly mediated the relationship between QWL and quiet quitting (indirect effect = -0.14, 95% CI: -0.19 to -0.09), accounting for 43.8% of the total effect. Psychological resilience moderated the QWL-compassion fatigue relationship (interaction $\beta = 0.18$, $P < 0.01$). Qualitative analysis revealed three major themes: erosion of professional identity and meaning, surviving versus thriving in the ICU environment, and the paradox of resilience.
Conclusion: Poor QWL was associated with quiet quitting through increased compassion fatigue, while psychological resilience appeared to serve as a protective factor. The qualitative findings provide rich contextual understanding of the processes underlying quiet quitting. Organizational strategies that improve working conditions, foster resilience, and restore professional meaning may help sustain nurses' work engagement and reduce quiet quitting.

Key words: *Compassion Fatigue; Intensive Care Units; Nurses; Occupational Stress; Psychological Resilience*

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Quiet quitting has attracted increasing attention in nursing research and is conceptualized as a phenomenon in which nurses perform their professional duties at a minimal level without physically leaving their jobs (1, 2). Unlike actual resignation, quiet quitting represents a form of work disengagement characterized by reduced psychological investment, limited initiative, and withdrawal of discretionary effort (3). Among healthcare professionals, nurses appear particularly vulnerable to this phenomenon, with recent evidence indicating that nurses experience higher levels of quiet quitting than other healthcare workers (4). Intensive care unit (ICU) nurses represent a particularly high-risk group for occupational stress and emotional depletion (5). By the very nature of their work, ICU nurses are required to manage patients' difficult treatment procedures, recognize and address their anxiety and suffering, and provide emotional support while delivering technically complex care (6). Sustained exposure to critical illness, death, and trauma renders ICU nurses susceptible to compassion fatigue, a work-related state of emotional, physical, and psychological exhaustion that develops after repeated exposure to the suffering of others (7). Research indicates that ICU nurses experience significantly higher levels of compassion fatigue compared to nurses in other clinical departments (8).

Quality of work life (QWL) has been identified as a critical factor influencing both compassion fatigue and work engagement among healthcare workers (9). Poor work environment and adverse working conditions significantly increase the risk of compassion fatigue, while positive work environments reduce stress and enhance job satisfaction (10). Recent evidence suggests that QWL is inversely associated with quiet quitting, with nurses reporting lower QWL demonstrating higher levels of disengagement (11, 12). Moreover, psychological resilience has emerged as an important protective factor in the relationship between occupational stress and negative work outcomes (13). Resilience refers to an individual's ability to adapt to, recover from, and cope with adverse circumstances (14). Studies demonstrate that psychological resilience reduces the negative impact of compassion fatigue on nurses' job satisfaction, turnover intention, and quality of care (15). Moreover, resilience has been shown to moderate the relationship between work environment challenges and compassion fatigue, with higher resilience buffering the negative effects of demanding work conditions (16).

The conservation of resources theory provides a useful framework for understanding the interrelationships among QWL, compassion fatigue, resilience, and quiet quitting (17). The theory proposes that individuals seek to obtain, retain, and protect valued personal and occupational resources. When resources are threatened, lost, or inadequately replenished, stress occurs. For ICU nurses, repeated emotional demands and poor working conditions may deplete energy, emotional capacity, and perceived control. Restricting work effort to formally required duties may represent an attempt to conserve remaining resources when QWL is poor and compassion fatigue is high. Conversely, psychological resilience may serve as a personal resource that buffers against resource depletion (18). Despite the growing interest in quiet quitting and its antecedents, most existing studies have relied exclusively on quantitative methods, examining these variables in isolation without capturing the rich contextual and experiential dimensions of the phenomenon (19). Quantitative studies can identify associations and test theoretical models, but they cannot fully explain the meaning-making processes, personal narratives, and contextual factors that shape how nurses experience and respond to occupational stress (20). Qualitative research, in contrast, offers the opportunity to explore these deeper dimensions, providing insights into the lived experiences of nurses who engage in quiet quitting.

Mixed-methods research, which integrates quantitative and qualitative approaches, offers particular advantages for studying complex organizational phenomena (21). The sequential explanatory design, in which quantitative data collection and analysis are followed by qualitative data collection to explain and elaborate on the quantitative findings, is especially well-suited for research that aims to understand both the extent and the nature of a phenomenon (22). In the context of quiet quitting, such an approach can reveal not only the statistical relationships among variables, but also the personal stories, contextual factors, and meaning-making processes that underlie these relationships (23). Recent literature highlights the importance of examining the complex behavior of quiet quitting using mixed-methods approaches to inform organizational interventions (2, 24). The present study addresses this gap by employing a sequential explanatory mixed-methods design to examine both the quantitative relationships among these variables and the lived experiences of ICU nurses who exhibit the quiet quitting behavior in Iraq. The following objectives guided this sequential explanatory mixed-methods study: quantitatively, we examined the relationship between QWL, compassion fatigue, psychological resilience, and quiet quitting among ICU nurses. Qualitatively, we explored how ICU nurses describe and make meaning of their quiet quitting experiences, what contextual and organizational factors shape these behaviors, how nurses experience and cope with compassion fatigue in their daily work, and what role resilience plays in their encounters with occupational stress and work engagement.

Materials and Methods

This study employed a sequential explanatory mixed-methods design. The design consisted of two phases: (A) a quantitative phase using a cross-sectional survey to examine the relationships among study variables and

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identify participants for the qualitative phase, and (B) a qualitative phase using in-depth semi-structured interviews to explore the lived experiences of nurses who exhibited varying levels of quiet quitting. The quantitative findings informed the purposive sampling strategy for the qualitative phase.

A. Quantitative Phase

Setting and Participants

The study was conducted in ICUs of six public teaching hospitals across two governorates in Iraq: three hospitals in Kerbala and three in Babylon. Data collection occurred between January and June 2026. A purposive sample of nurses working in the participating ICUs was recruited for the quantitative phase. Nurses were eligible if they had worked in an ICU for at least six months at the time of data collection and provided direct patient care. Nurses on administrative leave, maternity leave, or secondment during the data collection period were excluded. Participation was voluntary, and written informed consent was obtained from all participants. Sample size was determined based on recommendations for mediation analysis. Using the Monte Carlo power analysis for indirect effects with a desired power of 0.80 and $\alpha = 0.05$, a minimum of 258 participants was required. To allow for possible non-response or incomplete questionnaires and to ensure adequate statistical power for moderated mediation analysis, the target was increased to 400 participants. Therefore, a total of 435 nurses were approached across the six participating hospitals. Of these, 25 nurses were excluded because they did not meet the eligibility criteria. In addition, 10 nurses refused to participate in the study due to unwillingness or lack of time.

Measures

- Participants provided information on age, gender, marital status, educational level, years of ICU experience, work shift schedule, and hospital affiliation.
- QWL was measured using the QWL scale adapted and validated for professional service settings by Ishfaq *et al.* in Arabic (25). The scale operationalizes QWL as the gap between employees' expectations and their perceptions across seven distinct dimensions: physical work environment, organizational culture, relations and cooperation, training and development, compensation and rewards, facilities, and autonomy at work. Each dimension comprises four items, yielding a total of 28 items. For each item, participants rated two statements on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The first statement assessed participants' expectations regarding their ideal work environment, while the second assessed their perceptions of their actual work environment. The gap score for each item was calculated as the difference between the perceived score and the expected score (Perception - Expectation). The dimension-level score was computed as the average of the four constituent item gap scores, and the total QWL score was computed as the average of the seven dimension-level scores. Thus, the total QWL score represents the average discrepancy between expectations and perceptions across all seven dimensions, with a possible range of -4 to +4. A total score of 0 indicates that perceptions exactly match expectations; negative scores indicate that expectations exceed perceptions (dissatisfaction), and positive scores indicate that perceptions exceed expectations (satisfaction). For the purposes of interpretation and comparability with prior literature, higher (more positive) total scores indicate better QWL, while lower (more negative) scores indicate poorer QWL. We acknowledge that the gap-score approach has limitations, as the same numerical gap score can arise from different combinations of expectations and perceptions (e.g., a gap of -1 could reflect high expectations with moderate perceptions, or low expectations with very low perceptions). This scale has demonstrated strong psychometric properties, with Cronbach's alpha coefficients ranging from 0.775 to 0.808 for individual dimensions and 0.958 for the overall scale (25). In the present study, the scale demonstrated acceptable internal consistency (Cronbach's $\alpha = 0.91$).
- The Compassion fatigue short scale contains 13 self-reported items across two dimensions: job burnout (8 items) and secondary trauma (5 items). Items are rated on a 10-point scale from 1 (rarely/never) to 10 (very often), with a possible total score of 13-130. Higher scores indicate greater compassion fatigue. The scale has demonstrated adequate internal consistency in Arabic (26). In the present study, Cronbach's α was 0.89.
- The Connor-Davidson resilience scale (CD-RISC) was used to measure psychological resilience (27). The scale contains 25 items rated on a 5-point scale from 0 to 4, with a possible total score of 0-100. Higher scores indicate greater resilience. The CD-RISC has demonstrated excellent psychometric properties in diverse Arabic populations (28, 29). In the present study, Cronbach's α was 0.93.
- The Quiet-Quitting scale comprises nine items rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree), with a possible total score of 9-45 (1). Higher scores indicate greater quiet quitting. The instrument includes three dimensions: detachment, lack of initiative, and lack of motivation. The scale has demonstrated satisfactory internal consistency and factorial validity in Arabic populations (30, 31). In the present study, Cronbach's α was 0.87.

Data Collection

Self-administered questionnaires were distributed to eligible nurses during their working shifts. Participants completed the questionnaires voluntarily, and responses were handled confidentially. No identifying information was included in the analysis, and study results were reported in aggregate form.

Quantitative Data Analysis

Data were analyzed using SPSS version 27 and the PROCESS macro for SPSS. Prior to hypothesis testing, all statistical assumptions for mediation and moderated

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mediation analyses, including normality of residuals, homoscedasticity, and multicollinearity, were examined. Categorical variables were summarized using frequencies and percentages. Bivariate associations between continuous study variables were examined using Pearson's correlation coefficient. Internal consistency of the scales was assessed using Cronbach's alpha. Mediation analysis was conducted to examine whether compassion fatigue mediated the relationship between QWL and quiet quitting. Age, gender, ICU experience, and night shift variables were included as covariates in all primary models to control for potential confounding. The indirect effect was tested using bootstrapping, with 5,000 resamples to generate 95% confidence intervals. The indirect effect was considered statistically significant if the confidence interval did not contain zero. Moderated mediation analysis was conducted to examine whether psychological resilience moderated the relationship between QWL and compassion fatigue. The interaction term between QWL and psychological resilience was included in the model, and the conditional indirect effect was examined at different levels of resilience. All tests were two-tailed, and statistical significance was set at $P < 0.05$.

B. Qualitative Phase

Sampling and Participant Selection

Purposive sampling was used to select participants for the qualitative phase from the quantitative sample. Nurses were selected based on their quiet quitting scores on the Quiet Quitting Scale (possible range: 9-45). The quantitative sample had a mean quiet quitting score of 28.4 ± 6.2. The following score ranges were used to define the three groups: high quiet quitting = scores ≥ 34.6 (top quartile, corresponding to the 75th percentile and above), moderate quiet quitting = scores between 25.3 and 34.5 (interquartile range, approximately the 25th to 75th percentiles), and low quiet quitting = scores ≤ 25.2 (bottom quartile, corresponding to the 25th percentile and below). To ensure maximum variation in experiences, we initially aimed to recruit approximately 10 participants per group (30 total), which was considered a reasonable starting point based on the breadth of the research questions and the anticipated diversity of experiences. However, the final sample size was determined by data saturation, which was assessed continuously throughout data collection. This sampling strategy was designed to capture a range of experiences and perspectives. Additional selection criteria included willingness to participate in an interview, availability, and ability to articulate experiences clearly. Saturation was the guiding principle for determining sample size, and data collection continued until no new themes emerged.

Data Collection

In-depth semi-structured interviews were conducted by trained researchers in a private setting at the participants' convenience. An interview guide was developed based on the quantitative findings and the research questions. The guide included open-ended questions exploring participants' experiences of work engagement and disengagement, perceptions of compassion fatigue, experiences of QWL, and the role of resilience. Probes were used to elicit detailed narratives and contextual information. Interviews were conducted in Arabic, the participants' native language, and audio-recorded with consent. Each interview lasted approximately 45-60 minutes. Field notes were maintained to capture contextual information and non-verbal cues.

Qualitative Data Analysis

Audio-recorded interviews were transcribed verbatim and translated into English by bilingual researchers. Data were analyzed using thematic analysis following the six-phase framework, which included familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. A hybrid inductive–deductive approach was employed. The deductive component was guided by the study's research questions and the quantitative findings, which informed the development of the initial interview guide and the a priori sensitizing concepts (e.g., QWL, compassion fatigue, resilience, and quiet quitting). The inductive component allowed novel themes and subthemes to emerge directly from participants' narratives that were not anticipated by the quantitative framework or existing literature. This hybrid approach ensured that the analysis was both theoretically grounded and open to unanticipated experiential insights. Two researchers independently coded the data and identified themes. To assess inter-rater reliability, a subset of 20% of the transcripts was independently coded by both researchers, and Cohen's Kappa was calculated. The kappa coefficient was 0.84, indicating strong agreement between coders. Discrepancies were resolved through discussion until consensus was reached. Member checking was conducted by presenting preliminary findings to a subset of participants to verify the accuracy and resonance of interpretations. Specifically, eight participants were invited to participate in member checking, selected purposively to ensure representation across the three quiet quitting groups and to include both male and female nurses with varying years of ICU experience. The analysis was iterative, with emerging themes informing subsequent data collection and analysis. NVivo software was used to manage the data.

Trustworthiness

Trustworthiness was established using Lincoln and Guba's criteria. Credibility was ensured through prolonged engagement, integration of two distinct data sources from the quantitative survey and the qualitative interview within the sequential explanatory mixed-methods design, and member checking. Transferability was enhanced through thick description of the context and participants. Dependability was established through maintaining a clear audit trail and using multiple coders. Confirmability was ensured through reflexivity, with

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researchers maintaining reflexive journals and acknowledging their potential biases.

Integration of Quantitative and Qualitative Findings

Integration occurred at the interpretation stage. The quantitative findings provided a broad understanding of the relationships among variables, while the qualitative findings offered rich contextual and experiential insights. The qualitative findings were used to explain, elaborate on, and provide depth to the quantitative results. Joint displays were used to illustrate the integration of findings.

Ethical Considerations

Ethical approval was obtained from the Scientific Research Ethics Committee of the College of Nursing, University of Al-Ameed, and from the institutional review boards of participating hospitals. The study was conducted in accordance with the Declaration of Helsinki and its subsequent amendments. Participants were informed about the study purpose, the voluntary nature of participation, confidentiality safeguards, and their right to withdraw without penalty. Written informed consent was obtained from all participants. For the qualitative phase, specific safeguards protected participants' confidentiality from their employers: no identifying information was recorded; codes replaced names; data were collected privately; participation was never communicated to hospital administration; recordings were encrypted and deleted after transcription; identifying details were removed from reporting; and the consent process assured participants that withdrawal would have no employment consequences.

Results

Quantitative Findings

A total of 400 ICU nurses participated in the quantitative phase. As shown in Table 1, the mean age was 32.4 ± 6.8 years, with 56.5% aged 22-30 years, 30.5% aged 31-39 years, and 13.0% aged 40 years or older. The majority were male (68.8%), married (55.5%), and held a bachelor's degree in nursing (82.5%). Nearly half (47.8%) had 1-5 years of ICU experience, while 36.3% had 6-10 years, and 16.0% had 11 or more years. Most participants (58.2%) worked morning shifts, while 41.8% worked night shifts.

Table 1. Demographic and Professional Characteristics of Intensive Care Unit (ICU) Nurses Participating in the Study (N = 400)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	22-30	226	56.5
	31-39	122	30.5
	≥40	52	13.0
	Mean ± SD	32.4 ± 6.8	
Gender	Male	275	68.8
	Female	125	31.3
Marital status	Married	222	55.5
	Single	146	36.5
	Divorced	32	8.0
Educational level	Diploma	48	12.0
	Bachelor's	330	82.5
	Postgraduate	22	5.5
ICU experience (years)	1-5	191	47.8
	6-10	145	36.3
	≥ 11	64	16.0
Work shift	Morning	233	58.2
	Night	167	41.8
Hospital location	Kerbala	210	52.5
	Babylon	190	47.5

As shown in Table 2, QWL was negatively associated with quiet quitting ($r = -0.38$, $P < 0.01$) and compassion fatigue ($r = -0.41$, $P < 0.01$). Compassion fatigue was positively associated with quiet quitting ($r = 0.42$, $P < 0.01$). Psychological resilience was positively associated with QWL ($r = 0.35$, $P < 0.01$) and negatively associated with compassion fatigue ($r = -0.39$, $P < 0.01$) and quiet quitting ($r = -0.28$, $P < 0.01$). Quiet quitting also showed weak positive correlations with age ($r = 0.19$, $P < 0.01$), ICU work experience ($r = 0.16$, $P < 0.01$), and night shift work ($r = 0.12$, $P < 0.05$).

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Table 2. Bivariate Correlations Among Age, ICU Experience, Work Shift, Quality of Work Life, Compassion Fatigue, Psychological Resilience, and Quiet Quitting in the ICU Nurses

Variable	1	2	3	4	5	6	7
1. Age	—						
2. ICU experience	0.52**	—					
3. Work shift	0.28**	0.12*	—				
4. Quality of work life	-0.08*	-0.11*	-0.14*	—			
5. Compassion fatigue	0.06*	0.08*	0.11*	-0.41**	—		
6. Psychological resilience	-0.04*	-0.02*	-0.09*	0.35**	-0.39**	—	
7. Quiet quitting	0.19**	0.16**	0.12*	-0.38**	0.42**	-0.28**	—

Note. ICU = Intensive Care Unit. Work shift was entered as a binary variable (0 = morning, 1 = night). **P < 0.01; *P < 0.05 (two-tailed).

Mediation analysis was conducted to examine whether compassion fatigue mediated the relationship between QWL and quiet quitting, controlling for age, gender, ICU experience, and work shift (Table 3). Preliminary assumption checks confirmed that the data met the requirements for mediation and moderated mediation analysis. Residuals were approximately normally distributed, as indicated by non-significant Shapiro-Wilk tests (P > 0.05) and visual inspection of P-P plots. Homoscedasticity was supported by scatterplots showing even dispersion of residuals and a non-significant Breusch–Pagan test (P = 0.23). Linearity was confirmed through partial regression plots. All VIF values were below 1.5, indicating no multicollinearity concerns. The Durbin-Watson statistic was 1.92, indicating independence of errors. No influential outliers were identified (Cook's distance < 1.0 for all cases). None of the covariates were significantly associated with quiet quitting after the primary predictors were entered (all P > 0.05). The total effect of QWL on quiet quitting was statistically significant (β = -0.32, P < 0.001). QWL was significantly associated with compassion fatigue (path a: β = -0.38, P < 0.001), and compassion fatigue was significantly associated with quiet quitting (path b: β = 0.36, P < 0.001). The direct effect of QWL on quiet quitting remained significant when controlling for compassion fatigue (β = -0.18, P < 0.001). The indirect effect through compassion fatigue was -0.14 (95% CI: -0.19 to -0.09), indicating partial mediation. The proportion of the total effect mediated was 43.8% (indirect effect/total effect = -0.14/-0.32), indicating that nearly half of the association between QWL and quiet quitting was accounted for by compassion fatigue. The model explained 24% of the variance in quiet quitting (R2 = 0.24, adjusted R2 = 0.23). The pattern and magnitude of the indirect effect remained essentially unchanged after the inclusion of covariates, indicating that the mediation pathway was robust to potential confounding by these demographic and professional variables.

Table 3. Mediation Analysis of the Effect of Quality of Work Life on Quiet Quitting Through Compassion Fatigue Among 400 ICU Nurses

Path	Effect	SE	T	P	95% CI
Quality of work life → Compassion fatigue (a)	-0.38	0.05	-7.62	< 0.001	-0.48 to -0.28
Compassion fatigue → Quiet quitting (b)	0.36	0.05	7.20	< 0.001	0.26 to 0.46
Quality of work life → Quiet quitting (c, total)	-0.32	0.05	-6.40	< 0.001	-0.42 to -0.22
Quality of work life → Quiet quitting (c', direct)	-0.18	0.05	-3.60	< 0.001	-0.28 to -0.08
Indirect effect (a × b)	-0.14	0.03	—	—	-0.19 to -0.09

Note. All models controlled for age, gender, ICU experience, and work shift. CI = confidence interval (bias-corrected bootstrapped with 5,000 resamples); All P-values are two-tailed.

Moderated mediation analysis was conducted to examine whether psychological resilience moderated the relationship between QWL and compassion fatigue, controlling for age, gender, ICU experience, and work shift. None of the covariates were significantly associated with compassion fatigue after the primary predictors and interaction term were entered (all P > 0.05). The overall model was statistically significant (F (3, 396) = 51.33, P < 0.001, R2 = 0.28, adjusted R2 = 0.27). As shown in Table 4, the interaction between QWL and psychological resilience was statistically significant (β = 0.18, P < 0.01), indicating that resilience significantly moderated the QWL-compassion fatigue relationship. The index of moderated mediation was -0.06 (95% CI: -0.11 to -0.02), which did not include zero, indicating that the indirect effect of QWL on quiet quitting through compassion fatigue was significantly moderated by psychological resilience. Conditional

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effects of QWL on compassion fatigue were examined at three levels of resilience: low (one standard deviation below the mean), moderate (mean), and high (one standard deviation above the mean). The negative association between QWL and compassion fatigue was strongest among nurses with low resilience (β = -0.52, P < 0.001), moderate among nurses with average resilience (β = -0.38, P < 0.001), and weakest among nurses with high resilience (β = -0.24, P < 0.001). The conditional indirect effect was strongest among nurses with low resilience (indirect effect = -0.19, 95% CI: -0.26 to -0.13), moderate among nurses with average resilience (indirect effect = -0.14, 95% CI: -0.19 to -0.09), and weakest among nurses with high resilience (indirect effect = -0.09, 95% CI: -0.14 to -0.04). This pattern indicates that psychological resilience buffered the negative effects of poor QWL on compassion fatigue.

Table 4. Moderated Mediation Analysis Testing Psychological Resilience as a Moderator of the Quality of Work Life-Compassion Fatigue Relationship and Conditional Indirect Effects on Quiet Quitting Among 400 ICU Nurses

Predictor	B	SE	t	P	95% CI
Quality of work life (QWL)	-0.38	0.05	-7.60	< 0.001	-0.48 to -0.28
Psychological resilience (PR)	-0.24	0.05	-4.80	< 0.001	-0.34 to -0.14
QWL × PR interaction	0.18	0.06	3.00	0.003	0.06 to 0.30
Model R^2	0.28				
Conditional Effects of QWL on Compassion Fatigue at Different Resilience Levels					
Resilience Level	Effect	SE	t	P	95% CI
Low (M − 1 SD)	-0.52	0.07	-7.43	< 0.001	-0.66 to -0.38
Moderate (M)	-0.38	0.05	-7.60	< 0.001	-0.48 to -0.28
High (M + 1 SD)	-0.24	0.07	-3.43	< 0.001	-0.37 to -0.11

Note. All models controlled for age, gender, ICU experience, and work shift. CI = confidence interval (bias-corrected bootstrapped with 5,000 resamples).

Qualitative Findings

30 nurses from the quantitative sample participated in the qualitative interviews. Participants were purposively selected to represent high (n = 10), moderate (n = 10), and low (n = 10) quiet quitting scores. The mean quiet quitting score for the qualitative sample was 28.9 ± 6.8. The high quiet quitting group had a mean score of 37.6 ± 2.4 (range: 34.6-43.0), the moderate group had a mean score of 29.1 ± 2.9 (range: 25.3-34.5), and the low group had a mean score of 19.8 ± 3.1 (range: 11.0-25.2). The sample included 19 males (63.3%) and 11 females (36.7%), with a mean age of 34.2 ± 7.1 years (range: 23-48 years). Most participants were married (n = 18, 60.0%), held a bachelor's degree in nursing (n = 24, 80.0%), and had a mean of 9.4 ± 5.6 years of ICU experience (range: 1-18 years). 12 participants (40.0%) worked morning shifts, while 18 (60.0%) worked night shifts. Thematic analysis revealed three major themes and 11 subthemes that captured participants' lived experiences of quiet quitting, compassion fatigue, and resilience in the ICU context (Figure 1).

Theme 1: Erosion of professional identity and meaning

This theme captured participants' experiences of gradual loss of professional identity, sense of purpose, and meaning in their work. Participants described a progressive disconnection from their professional values and ideals. Subtheme 1a (the ideal nurse lost): Participants described entering nursing with a strong sense of purpose and commitment, only to experience gradual disillusionment. A participant with high quiet quitting scores reflected:

"When I graduated, I believed I could make a difference, that I was called to care. Now, I just go through the motions. The passion is gone. I don't even recognize the nurse I used to be." (Participant 12, High QQ, 8 years of ICU experience)

Subtheme 1b (meaninglessness in daily tasks): Participants described a shift from seeing their work as meaningful to viewing it as mechanical and devoid of purpose. A participant with high quiet quitting scores explained:

"Every day is the same. You stabilize one patient, and another comes in. You do your tasks, you check the boxes, but you don't feel you're truly helping anyone anymore. It's just routine." (Participant 18, High QQ, 6 years of ICU experience)

Subtheme 1c (conflict between ideals and reality): Participants described a painful gap between their professional ideals and the constraints of their work environment. A participant with moderate quiet quitting scores shared:

"I wanted to be a nurse who cared deeply, who made patients feel safe. But the system doesn't allow that. There's no time, no resources, no support. You become someone you don't recognize." (Participant 7, Moderate QQ, 11 years of ICU experience)

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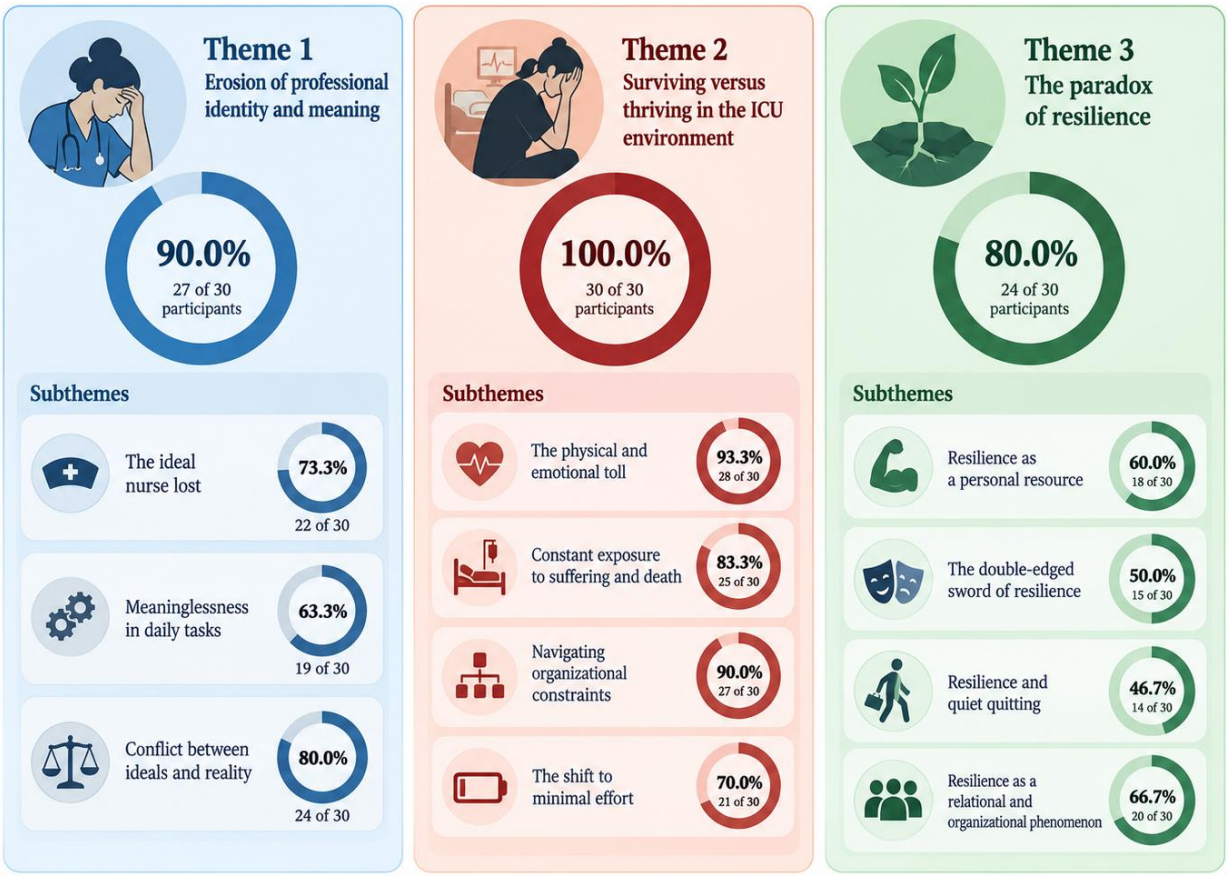


Figure 1. Overview and Prevalence of the Themes and Subthemes among Nurses Participating in Qualitative Interviews. Percentages Indicate the Proportion of Participants (n = 30) whose Narratives Reflected each Theme or Subtheme

Theme 2: Surviving versus thriving in the ICU environment

This theme captured the daily experiences of navigating the demanding ICU environment, with participants describing a shift from thriving to merely surviving. Subtheme 2a (the physical and emotional toll): Participants described the profound physical and emotional exhaustion associated with ICU work. A participant with high quiet quitting scores stated:

"It's like running a marathon every single day. You're physically drained, emotionally empty, and there's no time to recover. By the end of your shift, you have nothing left to give." (Participant 4, High QQ, 14 years of ICU experience)

Subtheme 2b (constant exposure to suffering and death): Participants described the cumulative burden of witnessing suffering and death, and the emotional armor they developed to cope. A participant with moderate quiet quitting scores reflected:

"You see so much pain, so much loss. You learn to become numb because if you feel everything, you won't survive. But that numbness takes away your ability to care deeply." (Participant 15, Moderate QQ, 5 years of ICU experience)

Subtheme 2c (navigating organizational constraints): Participants described the organizational barriers that made it difficult to provide quality care and maintain professional engagement. A participant with high quiet quitting scores explained:

"The system works against us. Staffing is never adequate, resources are scarce, and management doesn't listen. You want to do more, but the system doesn't allow it. Eventually, you stop trying." (Participant 22, High QQ, 9 years of ICU experience)

Subtheme 2d (the shift to minimal effort). Participants described the conscious decision to withdraw discretionary effort and protect their remaining energy. A participant with high quiet quitting scores stated:

"I used to go above and beyond. Now, I do what is required and nothing more. It's not laziness; it's survival. If I give any more, there will be nothing left of me." (Participant 9, High QQ, 7 years of ICU experience)

Theme 3: The paradox of resilience

This theme captured the complex and sometimes contradictory role of resilience in nurses' experiences of occupational stress. The paradox of resilience theme was endorsed by 24 of 30 participants (80.0%). Within this theme, ‘resilience as a personal resource’ was endorsed

by 18 participants (60.0%), 'the double-edged sword of resilience' by 15 participants (50.0%), 'resilience and quiet quitting' by 14 participants (46.7%), and 'resilience as a relational and organizational phenomenon' by 20 participants (66.7%). Subtheme 3a (resilience as a personal resource): Participants described resilience as an important personal resource that helped them persist and cope. A participant with low quiet quitting scores reflected:

"I've developed inner strength over the years. It doesn't make the challenges disappear, but it helps me face them with more hope and determination." (Participant 6, Low QQ, 12 years of ICU experience)

Subtheme 3b (the double-edged sword of resilience): Some participants described how their resilience enabled them to persist in adverse conditions, potentially at the cost of their own well-being. A participant with high quiet quitting scores explained:

"I was resilient for so long, I kept pushing through. But resilience isn't invincibility. After years of pushing, you crash. The crash is worse because you didn't allow yourself to acknowledge the pain earlier." (Participant 20, High QQ, 16 years of ICU experience)

Subtheme 3c (resilience and quiet quitting): Participants described how resilience interacted with quiet quitting, with some describing resilience as a protective factor and others describing how resilience enabled them to persist until burnout led to disengagement. A participant with moderate quiet quitting scores stated:

"Resilience helps you get through tough days, but it can also be a trap. You keep going when you should stop, you keep giving when you have nothing left. Eventually, you either burn out completely or you learn to protect yourself by pulling back." (Participant 13, Moderate QQ, 10 years of ICU experience)

Subtheme 3d (resilience as a relational and organizational phenomenon): Participants described how resilience was not solely an individual trait but was shaped by relationships and organizational factors. A participant with low quiet quitting scores reflected:

"My resilience comes from my team, from my family, from knowing that my organization values me. Resilience is not something you have or don't have; it's something that's fostered or broken by your environment." (Participant 3, Low QQ, 8 years of ICU experience)

Integration of Quantitative and Qualitative Findings

The integration of quantitative and qualitative findings revealed convergence, complementarity, and expansion. The quantitative findings identified statistically significant relationships among QWL, compassion fatigue, resilience, and quiet quitting. The qualitative findings provided rich explanations for these relationships, revealing the lived experiences and contextual factors that shape these associations (see Table 5).

Table 5. Joint Display Integrating Quantitative and Qualitative Findings on Quality of Work Life, Compassion Fatigue, Psychological Resilience, and Quiet Quitting Among ICU Nurses (N = 400 Quantitative; n = 30 Qualitative)

Quantitative Finding	Qualitative Finding	Integrated Interpretation
Quality of work life was negatively associated with quiet quitting (β = -0.38, P < 0.001).	Nurses described organizational constraints (staffing shortages, resource limitations, management indifference) that gradually eroded their professional identity and meaning.	Poor quality of work life creates conditions that erode professional meaning and engagement, leading nurses to withdraw discretionary effort as a survival strategy.
Quality of work life was negatively associated with compassion fatigue (β = -0.41, P < 0.001).	Nurses described the cumulative emotional toll of ICU work, compounded by organizational barriers that prevented adequate recovery.	Organizational constraints exacerbate the emotional toll of ICU work, creating conditions that foster compassion fatigue.
Compassion fatigue was positively associated with quiet quitting (β = 0.42, P < 0.001).	Nurses described becoming emotionally numb as a coping mechanism, eventually leading to a conscious decision to reduce effort and protect remaining resources.	Emotional depletion drives a protective withdrawal of discretionary effort, as nurses conserve resources for essential job functions.
Compassion fatigue mediated the QWL-quiet quitting relationship (indirect effect = -0.14, 95% CI: -0.19 to -0.09).	Nurses described a causal sequence: poor work conditions → emotional exhaustion → protective withdrawal of effort.	The qualitative narratives describe a perceived temporal and experiential sequence (from organizational constraints through emotional depletion to disengagement) that is consistent with the statistical mediation pathway. These accounts provide contextual depth regarding how participants experienced this process, but they do not independently validate the mediation effect.

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Quantitative Finding	Qualitative Finding	Integrated Interpretation
Resilience moderated the QWL-compassion fatigue relationship (interaction β = 0.18, P < 0.01).	Nurses described resilience as a complex, multi-dimensional resource shaped by both personal qualities and organizational conditions, with high resilience buffering the effects of poor QWL.	Resilience serves as a protective factor, but its protective effects are contextual and relational, not solely individual.
Quiet quitting was associated with age (r = 0.19, P < 0.01) and experience (r = 0.16, P < 0.01).	Experienced nurses described how cumulative exposure led to gradual disengagement and a pragmatic shift to "just doing the job."	The tendency toward quiet quitting may increase with cumulative exposure to occupational stress over a career.

The quantitative finding that compassion fatigue mediated the QWL–quiet quitting relationship was complemented by qualitative narratives describing participants' perceived experience of this process: from organizational constraints to emotional exhaustion to conscious disengagement. These narratives are consistent with the proposed mediation model and provide contextual depth, but they should be interpreted as experiential accounts rather than as independent evidence of a statistical mediation effect. In fact, the qualitative findings expanded understanding in ways not captured by the quantitative measures. The concept of resilience emerged as more complex and multi-dimensional than captured by the quantitative scale, with participants describing resilience as both a personal resource and a relational phenomenon shaped by organizational conditions. This suggests that resilience may be best understood as an interaction between individual and contextual factors.

Discussion

This sequential explanatory mixed-methods study examined the relationships among QWL, compassion fatigue, psychological resilience, and quiet quitting among ICU nurses, and explored the lived experiences underlying these relationships. The quantitative findings demonstrated that poor QWL was associated with quiet quitting through increased compassion fatigue, while psychological resilience moderated the QWL-compassion fatigue relationship. The qualitative findings provided rich contextual understanding of the processes underlying these relationships, revealing the erosion of professional identity and meaning, the shift from thriving to surviving in the ICU environment, and the paradoxical role of resilience. The finding that compassion fatigue mediates the relationship between QWL and quiet quitting is consistent with recent research (11, 32, 33) and extends it by providing qualitative evidence for the experiential pathway from organizational constraints through emotional depletion to disengagement. Danacı *et al.* (32) found that compassion fatigue partially mediated the stress of conscience-quiet quitting relationship, and the present study adds depth by revealing the meaning-making processes underlying this pathway. The moderating role of resilience in the QWL-compassion fatigue relationship aligns with recent research (34, 35) but adds nuance by revealing the complex and paradoxical nature of resilience as described by participants. While quantitative findings indicated that resilience buffers the negative effects of poor QWL, the qualitative findings revealed that resilience can also be a double-edged sword, enabling persistence under adverse conditions at the cost of personal well-being. This suggests that interventions aimed at enhancing resilience should also address the organizational conditions that require resilience in the first place.

The theme of erosion of professional identity and meaning extends the concept of quiet quitting by revealing the moral dimensions of work disengagement. Participants described a progressive loss of professional identity, a conflict between ideals and reality, and a sense of meaninglessness in daily tasks. This finding resonates with literature on moral distress and ethical disengagement in nursing (36-39), and suggests that quiet quitting may be partly understood as a response to moral injury experienced when organizational constraints prevent nurses from providing care in alignment with their professional values. The theme of surviving versus thriving captures the fundamental shift from professional engagement to protective withdrawal. This theme aligns with the conservation of resources theory, which proposes that individuals withdraw effort to conserve resources when resources are threatened or depleted (40, 41). The qualitative narratives reveal this as a conscious, strategic response to sustained resource depletion rather than simple disengagement. This finding has important implications for interventions, suggesting that addressing quiet quitting requires not only addressing individual factors but also restoring professional meaning and addressing organizational constraints. Furthermore, the paradox of resilience revealed in this study is particularly noteworthy. While quantitative findings indicated that resilience was protective, qualitative findings revealed that resilience could also enable persistence in adverse conditions at the cost of well-being. This complexity has been noted in recent literature (42), with studies suggesting that resilience interventions should be approached with caution if they inadvertently encourage nurses to tolerate toxic work environments. This finding suggests that organizational-level interventions to improve working

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conditions may be more important than individual-level resilience training for addressing quiet quitting.

The present findings also contribute to the conceptual clarification of quiet quitting as a distinct construct. While quiet quitting was moderately correlated with compassion fatigue (r = 0.42), the two are conceptually distinguishable: compassion fatigue is an affective state resulting from caregiving exposure, whereas quiet quitting is a behavioral strategy of effort restriction. The mediation model demonstrated that these constructs relate sequentially rather than being redundant, with compassion fatigue serving as one pathway through which poor QWL is associated with quiet quitting. Similarly, the moderate correlation between quiet quitting and compassion fatigue, combined with the distinct qualitative themes that emerged (e.g., erosion of professional identity, the paradox of resilience), supports the view that quiet quitting captures a unique behavioral phenomenon that warrants separate empirical and clinical attention.

An important contextual consideration is the predominantly male sample (68.8%), which contrasts with the female-dominated nursing workforce in many Western countries, but reflects the demographic reality of nursing in Iraq and other Middle Eastern countries. This gender distribution may influence our findings in several ways (43, 44). Female nurses may report higher compassion fatigue due to gendered caregiving expectations and differential emotional socialization. Thus, the lower proportion of female nurses may have attenuated overall compassion fatigue scores. Gender may also shape how poor QWL translates into quiet quitting, as male nurses in Middle Eastern contexts may face distinct professional pressures, career expectations, and work-life balance challenges. Additionally, the sources of resilience and willingness to seek support may vary by gender. Although our quantitative analyses did not stratify by gender, future research with more balanced samples should test for gender moderation to determine whether these mechanisms are universal or gender-specific and to inform gender-sensitive interventions.

The integrated findings of this study have several practical implications. First, organizational interventions aimed at improving QWL may have direct effects on reducing compassion fatigue and, in turn, quiet quitting. These interventions might include adequate staffing, manageable workloads, supportive supervision, and opportunities for professional development. Second, interventions aimed at fostering professional meaning and identity may help counteract the erosion of professional engagement. These might include regular opportunities for reflection, clinical supervision, and recognition of the value of nursing work. Third, while resilience is an important personal resource, interventions aimed at enhancing resilience should be complemented by interventions aimed at improving working conditions. It is insufficient to train nurses to be resilient in the face of poor work environments; efforts should also be directed at improving those environments. Fourth, the qualitative findings suggest that nurses who are quiet quitting are not lazy or uncommitted but rather are responding to sustained resource depletion. This reframing may help reduce stigma and encourage more compassionate organizational responses.

Limitation

Several limitations should be considered. First, the cross-sectional quantitative design prevents conclusions about causality. Second, the use of self-report measures may introduce social desirability and common-method bias, though the mixed-methods design mitigates this limitation by providing alternative data sources. Third, the qualitative findings are based on a sample from one region of Iraq and may not be transferable to other contexts. Fourth, the study focused on ICU nurses specifically; findings may not generalize to other nursing specialties.

Conclusion

This sequential explanatory mixed-methods study examined the relationships among QWL, compassion fatigue, psychological resilience, and quiet quitting among ICU nurses in Iraq. Quantitative findings demonstrated that QWL was negatively associated with quiet quitting and compassion fatigue, while compassion fatigue was positively associated with quiet quitting. Compassion fatigue significantly mediated the QWL-quiet quitting relationship, and psychological resilience moderated the QWL-compassion fatigue relationship. Qualitative findings revealed the erosion of professional identity and meaning, the shift from thriving to surviving in the ICU environment, and the paradoxical role of resilience. The integration of findings revealed the experiential pathway from organizational constraints through emotional depletion to disengagement, and highlighted the complex, relational nature of resilience. The findings suggest that poor QWL is associated with quiet quitting through increased compassion fatigue, while psychological resilience appears to serve as a protective factor. However, resilience should not be viewed solely as an individual responsibility; organizational conditions that foster or undermine resilience must also be addressed. Organizational strategies that improve working conditions, foster resilience, and restore professional meaning may help sustain nurses' work engagement and reduce quiet quitting. Addressing quiet quitting requires not only reducing occupational stress but also restoring the professional meaning and identity that sustain engagement in the demanding ICU environment. Future research should consider longitudinal designs to examine temporal relationships among QWL, compassion fatigue, resilience, and quiet quitting. Intervention studies would be valuable to test the effectiveness of organizational and individual-level strategies for

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reducing quiet quitting. Cross-cultural studies comparing quiet quitting across different healthcare systems and cultural contexts would provide insight into the influence of contextual factors. Research exploring the relationship between quiet quitting and patient outcomes would strengthen the case for addressing this phenomenon. Finally, research on the moral and ethical dimensions of quiet quitting, particularly in relation to professional identity and values, would extend the understanding of this phenomenon.

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Authors' Contribution
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