Interventions to Manage Compassion Fatigue in Oncology Nursing

Nancy Aycock, RN, BSN, OCN®, CHPN, and Deborah Boyle, RN, MSN, AOCN®, FAAN

Work-related stress emanating from close interpersonal contact with patients with cancer and their families may result in physical, emotional, social, and spiritual adversity for oncology nurses. The negative result of this cumulative distress has historically been referred to as burnout. However, this dated term does not truly depict the result of the longitudinal workplace ramifications of sadness and despair on nursing staff. This article proposes that the phrase compassion fatigue replace the outdated notion of burnout in describing this phenomenon. Although not clearly and uniformly described in the literature, this occurrence is seen regularly in clinical practice and is conceptually known by nurses. Limited information is available about interventions to manage compassion fatigue; therefore, a national survey was conducted to identify resources available to oncology nurses to counter this phenomenon. Participants provided information about the availability of interventions in three major categories: on-site professional resources, educational programs, and specialized retreats. The availability of resources ranged from 0%–60%. Survey findings, along with narrative comments by respondents, provide relevant information for oncology nurses and their employers. By recognizing the perils of inattention to this frequent nursing phenomenon and the scope of existing workplace options that may augment nurse coping, oncology nurses’ recognition and management of this entity may be enhanced. Organizations also may be encouraged to periodically inventory their support and lobby for workplace interventions to manage this critical work-related issue.

Oncology nurses play a vital role in the physical, emotional, and spiritual care of patients with serious, life-threatening illnesses. Although many nurses perceive their work as a calling, few enter oncology nursing prepared for the emotional sequelae that emanate from their close relationships with patients and their families. Numerous clinical scenarios can elicit intense emotional distress in oncology nurses.

One significant challenge is reacting to the death of patients with whom the nurse has long-standing professional friendships (McCaffrey, 1992). These patients are identified as special and, therefore, have generated more than the usual interpersonal connection. Then, when the patient dies, the deep rapport established between the nurse, patient, and family members may transform into overwhelming grief. Moral distress evolves when workplace barriers prevent nurses from carrying out what they believe to be ethically appropriate courses of action (Elpern, Covert, & Kleinpell, 2005). Nurses who experience ethical or moral distress (particularly over time) acknowledge the presence of frustration, tension, and dissatisfaction with the profession, often generated from nurse and physician conflict over patients’ goals and expressed wishes (Gutierrez, 2005; Taylor, 2002). Traumatic emergencies, such as acute carotid erosion or disseminated intravascular coagulation, can prompt feelings of professional futility, particularly when patient death follows the emergent event. Situations in which family chaos is apparent may overextend nurses’ skill in therapeutic communication. Attempts by

At a Glance
- The nature of work-related stress for oncology nurses may lead to compassion fatigue.
- Oncology nurses provided relevant information about the availability of interventions to manage compassion fatigue.
- Oncology nurses and their employers have a responsibility to recognize the existence of compassion fatigue and implement management interventions.

Nancy Aycock, RN, BSN, OCN®, CHPN, is the palliative care coordinator at St. Dominic Hospital in Jackson, MS, and Deborah Boyle, RN, MSN, AOCN®, FAAN, is the Magnet coordinator at Banner Good Samaritan Medical Center in Phoenix, AZ. The authors were participants in the 2007 Clinical Journal of Oncology Nursing Writing Mentorship Program. No financial relationships to disclose. (Submitted November 2007. Accepted for publication August 24, 2008.)

Digital Object Identifier:10.1188/09.CJON.183-191
nurses to reduce interfamilial adversity may be ineffective and solicit feelings of helplessness. Difficult clinical scenarios such as these can leave nurses physically, emotionally, and spiritually drained. Unless interventions are available and used to counter the emotional component of oncology nursing, nurses may experience physical and emotional exhaustion.

**Evolving Conceptual Domains**

Emphasis has historically been placed on nurses and physicians emotionally detaching themselves from patients and families, particularly those with a poor prognosis or who are dying (Quint, 1966). This professional expectation gradually changed as the humanistic element of patient suffering and isolation surfaced in the late 1960s. Although it was recognized long before it was researched, burnout became the historic term of choice to identify this phenomenon with nurses and physicians (Freudenberg, 1974). Defined as a prolonged response to chronic job-related emotional and interpersonal stressors, burnout was characterized by emotional exhaustion, depersonalization, and lack of perceived personal accomplishment (Sabo, 2006). Burnout ultimately resulted in healthcare professionals treating patients and others in an uncaring manner (Gaskill, 2000; Maslach, Jackson, & Leiter, 1996). This process frequently ended with staff leaving the nursing field.

Almost 30 years have passed since this phenomenon was first addressed in the oncology nursing literature and two decades since the first book was written about burnout in nurses who care for the critically ill and dying (Cox & Andrews, 1981; Donovan, 1981; Jenkins & Ostchega, 1986; McElroy, 1982; Newlin & Wellisch, 1978; Vachon, 1987; Yasko, 1983). However, few definitive works have been undertaken since that time to clearly delineate or manage the phenomenon.

Terminology has abounded in the literature in an attempt to better characterize the phenomenon. Nomenclature such as secondary traumatic stress disorder, moral distress, vicarious trauma, and others have been used. Although all describe corollaries of this “wear and tear” syndrome, each term depicts only a part of the entire paradigm (see Figure 1). The term compassion fatigue, however, most closely captures all of the elements of this phenomenon in oncology nurses.

Joinson (1992) was the first to use this descriptor in the professional healthcare literature. A less caustic and negative term than burnout, compassion fatigue was referred to as deep physical, emotional, and spiritual consumption accompanied by significant emotional pain (Pfifferling & Gilley, 2000). Resulting from intense nurse caring and identification with patient suffering, compassion fatigue ultimately leads to emotional exhaustion (Papadatou, 2000). Pessimism and cynicism evolve from self-perceptions of personal inadequacy in optimally managing patients’ illness trajectories (Keidel, 2002). Contradictory feelings of immense caring for patients in tandem with negative attitudes toward self can result in emotional overextension. Augmenting this may be the presence of death anxiety on the part of the nurse (Chen, Ben, Fortson, & Lewis, 2006; Defnier & Bell, 2005).

Vachon (2006) stated that providing nursing care to dying patients also can trigger the nurse’s own personal death awareness and professional death anxiety. The nurse’s personal death awareness is impacted by life experiences, spiritual beliefs, cultural and social exposures, and experiences with death. Professional death anxiety occurs when the nurse, with few resources of support, encounters fear about his or her own death and mortality. Cumulative loss also plays a significant role in the prevalence of compassion fatigue. Such loss requires the nurse to experience frequent anticipatory and normal grief reactions. Consequently, impaired role performance occurs.

Distinguishing factors between burnout and compassion fatigue remain controversial. Sabo (2006) postulated that burnout evolves gradually when differences between expectations of the individual and the organization are in conflict. A common example of this relates to staffing. The nursing staff may perceive that they need more RNs to provide optimum patient care, whereas, at the same time, the organization cites financial issues that limit such appropriation. Staff members often try to persevere over time but ultimately leave the employer because of physical and emotional overextension. The longitudinal process is a common defining characteristic of burnout and compassion fatigue (Bush, 2009).

Figley (1995) suggested the coexistence of compassion fatigue in the presence of burnout, and that the phenomena were not distinct entities. Although burnout frequently results in less empathic responses to patients, withdrawal from emotion-laden clinical scenarios, and leaving one’s clinical position, compassion fatigue may result in more emotional giving that ultimately leaves the employer because of physical and emotional overextension. The longitudinal process is a common defining characteristic of burnout and compassion fatigue (Bush, 2009).

Research of this phenomenon has transitioned over time (Medland, Howard-Ruben, & Whitaker, 2004). Initial research focused on defining burnout and its prevalence among people working in human services roles. In the 1980s, additional queries focused on resources available to employees to manage stress in the workplace. In the 1990s, the concept of burnout was extended to other occupations, and the construct of compassion fatigue was posed as a more suitable label. During the 2000s, more sophisticated research expanded the burning discussion.
research methodologies were identified (Maslach, Schaufeli, & Leiter, 2001). Limited investigation of the health consequences of compassion fatigue are available (Sabo, 2006). What has been clinically recognized, however, are physical and emotional exhaustion and illness (Radziewicz, 2001); nurse symptom distress such as headaches, increased blood pressure, fatigue, weight gain, stiff neck, disrupted sleep, and anger (Brown, 2006); and increased incidence of cardiovascular disease, diabetes, gastrointestinal conditions, and immune dysfunction (Warshaw, 1989). General symptoms of emotional overextension can affect a person’s physical, psychological or emotional, behavioral, and spiritual function (see Figure 2). In the absence of interventions to modulate the reactions to stress, these symptoms may lead to maladaptive coping mechanisms, physical and psychological exhaustion, lack of initiative, and physical illness (Radziewicz).

In today’s tumultuous healthcare domain, the loss of mature, knowledgeable nursing staff is significant to the entire organization. Retention issues impact not only nurse availability at the bedside, but also the availability of educators and mentors for novice nursing staff, particularly in the development of critical thinking and problem-solving. Even with tenured staff, lack of skill development to manage compassion fatigue may impact retention and staff engagement in the work setting. Interventions to manage stressors must be identified.

Survey Process

Oncology nurses’ experiences with compassion fatigue are not clearly defined. Because compassion fatigue has been empirically described as pervasive and known by oncology nurses, a national survey was undertaken to identify available workplace resources to counter compassion fatigue.

Based on themes from the literature describing resources that can assist with burnout and compassion fatigue (i.e., changes in the work environment, work support, and educational interventions), the survey tool was designed to address three major categories: accessibility to on-site professional resources, provision of educational programs, and retreat availability (Maslach et al., 2001). The questionnaire allowed participants to check the resources available in their area and provide comments as desired. Minimal optional demographic information was requested from participants. A letter describing the purpose of the survey accompanied the questionnaire, including the opportunity for sharing what had or had not worked to minimize compassion fatigue. Because this was considered an educational survey, institutional review board approval was not required.

Initially, a group of five oncology nurses representing diverse roles (i.e., academia, outpatient chemotherapy, inpatient oncology, radiation oncology, and palliative care) participated in a pilot survey. The group was asked for feedback concerning the ability to understand instructions, the ease of survey completion, and the time required for survey completion. Only minor changes in wording were suggested. The pilot group identified that the questionnaire took less than five minutes to complete. This information was added to the accompanying letter.

A national response to the survey was a major goal of this initiative. The letter and questionnaire were e-mailed to 231 chapter presidents of the Oncology Nursing Society (ONS). At a minimum, at least one questionnaire per chapter was requested to be completed and returned within three weeks. A reminder e-mail was sent the week questionnaires were due. Participants were given the option of returning the questionnaires via e-mail, fax, or traditional mail service.

Survey Results

Sixty-two (27%) of the ONS chapters receiving the survey provided at least one response. A total of 103 responses were received. Frequency results are presented in Table 1. Narrative comments were grouped according to theme. The availability of interventions ranged from 0%–60%. No participants reported mandatory participation requirement in the End of Life Nursing Education Consortium (ELNEC) courses, whereas 62 (60%) reported availability of an employee assistance program (EAP).
Table 1. Availability of Interventions for Compassion Fatigue

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-site professional resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee assistance program</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>Pastoral care</td>
<td>51</td>
<td>50</td>
</tr>
<tr>
<td>Counselor or psychologist</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>None offered</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Psychiatric clinical nurse specialist</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Support group</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Education addressing workplace-related coping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None offered</td>
<td>46</td>
<td>45</td>
</tr>
<tr>
<td>Periodic in-services</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Optional ELNEC course</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Continuing education series of classes</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Topic integrated into orientation</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Online educational resources</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Mandatory ELNEC course</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Off-site retreat to promote renewal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None offered</td>
<td>84</td>
<td>82</td>
</tr>
<tr>
<td>Yearly voluntary retreat</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Episodic retreat</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Yearly mandatory retreat</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

N = 103
ELNEC—End-of-Life Nursing Education Consortium
Note. Because more than one intervention may be available in the workplace, n values may total more than 103 and percentages may total more than 100.

On-Site Professional Resource Availability

Survey participants who verified that an EAP program was in place to assist them with workplace issues also reported that the number of sessions and fees varied per institution. Most organizations limited appointments for counseling to three free sessions annually. Discounted services were offered to the employee beyond the three visits. This finding most likely gave testimony to the large percentage of respondents who were employed by acute care facilities and outpatient centers associated with these facilities. This statement also is supported by the fact that the second-highest resource was the pastoral care department, a discipline that often is integrated into medium- and large-sized hospital settings.

Although 23 oncology nurses (22%) reported having access to a staff counselor or psychologist, respondents identified a significant barrier for their use being the extensive lag time between request and scheduled time for appointments. Psychiatric or psychiatric liaison clinical nurse specialists are not routinely available in the workplace; however, when they were, it usually was limited to large institutional settings. Only 12 participants (12%) listed this as a resource for them in the workplace. Other sources of support were case managers and master’s-prepared oncology social workers. Several respondents commented that, although no organized support services existed in their facility, nurses frequently relied on collegial support. Five nurses (5%) reported having exposure to support groups. When a group was initiated, several respondents noted that they were rarely continued over time. Attrition was associated with poor overall attendance and unease related to group participation. Eighteen respondents (17%) reported that no professional support was available.

Other on-site professional resources identified as helpful were employee wellness programs; employee health screenings; adequate staffing; and role model, preceptor, or mentor programs. Several respondents identified opportunities for interdisciplinary teams to provide support to each other through debriefing or discussion of difficult patient situations they currently were encountering. Others reported that their hospital provided monthly rounds for staff based on the Schwartz Center Rounds concept. The rounds foster an open, supportive environment for all healthcare professionals to meet and discuss end-of-life issues, bereavement support needs, and their feelings about difficult clinical situations (Lally, 2005). Some chapters reported hosting patient celebrations or memorial services on a routine basis as a source of support for family and staff. Respondents also identified the national and local constituents of ONS as providing support through information exchange and novel idea generation.

Educational Programs

Forty-six survey participants (45%) did not receive an opportunity for knowledge and skill development in coping, adaptation, and emotional self-care. Thirty-one participants (30%) received sporadic continuing education regarding these issues. Of the 103 respondents, none of their employers made education about nursing care of the dying (i.e., ELNEC courses) a mandatory requirement for readying nurses for practice. However, 18 (17%) reported an optional ELNEC course as a resource. Eleven nurses (11%) cited the availability of online education, a single class integrated into orientation, or an educational series focusing on nurse coping. On average, about one or two in-service training or programs were available to staff yearly.

Specialized Retreats

Retreats to address the psychological toll of professional caregiving and to promote emotional renewal rarely were a coping resource for respondents. Of the respondents who said that their institutions did offer specialized retreats, several stated that, over time, attendance was insufficient to continue the program. Another respondent stated that, although retreats were not available in her area, nurses were encouraged to attend other retreats. On their return, the nurses were positively influenced by the experience and exhibited renewed professional specialty commitment. Ten survey respondents (10%) had a voluntary yearly retreat available to them, six (6%) reported the availability of episodic retreats, and three (3%) reported a mandatory yearly retreat. Qualitative comments noted on the survey described the immense value nurses found in their retreat experience. However, they also revealed that numerous colleagues did not share their enthusiasm. Average retreat attendance varied between 5-120 participants. Retreat locations included sites such as a local education center, a beach house, a secluded mountaintop conference center, a temple, the campus of the work facility, or a rustic resort on a river. The retreats were structured in a variety of formats. Creative group experiences that cultivated teamwork, hearing motivational and inspirational presentations, offering educational topics along with more psychosocial-themed activities, providing massages, engaging in outdoor events, and the inclusion of humor and door prizes all were described. Some of the retreat experiences provided contact hours for education.
Discussion

Interventions to counter the emotional ramifications of providing nursing care over time to patients with a life-limiting diagnosis have been cited. Although these interventions are currently only available to a relatively small subset of oncology nurses, results of this survey indicate that existing blueprints exist for colleagues to replicate in their practice settings. The following discourse delineates considerations for intervention planning based on the qualitative findings from the survey.

Considerations for Intervention Planning

Guidance: Wakefield (2000) stated “For nurses who are regularly faced with caring for dying patients, grief is like a powder keg that nurses may not be aware that they have been challenged by grief, but the effects of grief can be explosive and cause problems for practitioners at any time. Despite this, nurses are expected to carry on as normal once a patient has died. The notion of grief being like a powder keg is certainly appropriate for those nurses who have developed a close relationship with the patient as a result of having nursed them over an extended period of time” (p. 247).

Some guidance in coping may prevent this powder keg from exploding. Self-reflection by oncology nurses can aide in intervention planning. Brown (2006) suggested the following key questions:
• What needs to change in our setting to enhance a more healing environment?
• Would you feel rested or comfortable if you were one of our patients?
• Should we have a quiet space for breaks?
• Do you find yourself tense or relaxed when you work?
• Does the environment create a relaxed or technological aura?

To avoid compassion fatigue or burnout, nurses can benefit from integrating self-care practices into their daily life (Henry & Henry, 2004). Multiple strategies for avoiding burnout have been delineated by Welsh (1999) (see Figure 3). Nurses experiencing physical and emotional fatigue should identify ways to renew their strength and well-being. Oncology nurses may find it helpful to build upon non-clinical strengths. Some may find this renewal in their religious faith. Others may use music or art as beneficial support mechanisms (Lally, 2005). Another important aspect of self-care includes nurses not neglecting their own physical health while caring for others (Brown-Saltzman, 1994). Balance in life is important for professional oncology nurses’ survival (Lally), and nurses should recall what brought them to the nursing profession in general and to oncology nursing in particular (Nelson, 2007). This alone may foster renewal of commitment to the profession.

Resources available to staff: A thorough review of literature that details the relationship between the level of occupational work support and positive outcomes, such as low turnover rates, decreased absenteeism, and lower patient mortality, may help support requests for resource contracting and procurement (Aiken, Smith, & Lake, 1994; Barnard, Street, & Love, 2006). This may be particularly helpful for ambulatory private practice settings where existing internal recourse is negligible.

According to Maslach et al. (2001), the most effective interventions for dealing with burnout are a combination of changes in managerial practice and educational interventions. Organization support and adequate staffing are two identified strategies to deal with heavy physical and emotional workloads (Barnard et al., 2006). However, because of the current and projected nursing shortages, enhanced manpower may never reach the preferred status. Therefore, nurses must consider, despite what the norm was in the past, what can be delegated and what is essential for the highly specialized oncology nurse to provide. The presence of moral fatigue and its associated energy depletion may deter nurses from even considering how to resolve this issue.

Intervention delineation: A menu of options should be created so that intervention individualization is available for each nurse. This approach acknowledges that oncology nurses are a heterogeneous group with individual preferences. For a variety of reasons, some nurses may not desire emotional support. However, many subsequently engage in these activities once they hear, firsthand, how the experience transpired for peers.

Some survey participants mentioned the helpful nature of attending funerals. Papadatou (2000) stated that some nurses find attending the funeral of a deceased patient as a method of closure. Signing sympathy cards for family members or attending hospital memorial services can serve the same purpose for nurses who cannot attend the funeral. One nurse commented that a media- tion area (quiet space) was available. Another mentioned a memory wall of patients. Acknowledging the variety of grief reaction expressions where some nurses cry, withdraw, or contemplate about their experience with the patient is another approach. Unfortunately, and most commonly, oncology nurses ignore their own grief when caring for patients (Medland et al., 2004).
Acknowledgment: When hiring new staff, the nurse manager or interviewer should make it clear that emotional distress will most likely occur but that options to manage the distress are available. This normalizes the reality of the emotional response many encounter, particularly with patients and families who engender special connectedness. Of note is the inclusion of statements within the Hospice and Palliative Nursing: Scope and Standards of Practice (Hospice and Palliative Nurses Association and the American Nurses Association, 2007), which address the need for optimal emotional attention for individuals and the interdisciplinary team (see Figure 4).

Training: All orientation programs and core courses that provide formal overview of competencies required of oncology nurses should include education and training in communication skills, conflict resolution, ethical issues, and self-care. In essence, communication competency should be viewed as being equally important as central venous catheter care and chemotherapy administration. Similarly, proficiency in the nursing care of the dying should be mandated for all oncology nurses. Just as nurses ensure that knowledge and skills are in place to anticipate and identify oncologic emergencies, so should nurses be confident that nursing expertise is evident to optimize the dying experience for patients and their families. Humor should be integrated into programs for its stress-reducing nature (Ekedahl & Wengstrom, 2006). Laughter, except at another’s expense, may assist in addressing self-care needs in a palatable and practical manner (Cohen, Brown-Saltzman & Shirk, 2001).

Symptoms and risk factors: Overwhelming exhaustion, feelings of depersonalization, and a sense of lack of personal accomplishment are symptoms of compassion fatigue. Nurses who bring high expectations to a job have been found to be at risk for burnout or compassion fatigue (Bush, 2009). Other vulnerable populations include younger employees (aged 30 years or younger) who are still relatively new to their careers. How gender affects this phenomenon is unclear. Being married has been noted to be a positive variable, resulting in less susceptibility compared to nurses who are unmarried or single (Maslach et al., 2001).

Allow for emotional expression: Ideally, an on-site counselor is preferred because of the close proximity and relationship that has been established with staff (Luquette, 2005). Whether during rounds, patient-care conferences, or debriefing sessions, discussing feelings that emanate from relationships with patients and families allows nursing staff to recognize that they are not alone in their experience (Lally, 2005). This parameter for discussion should become part of the ongoing meeting agenda, much like medication review or discharge planning is the norm.

If the need can be documented, ask if a member of the EAP office in your setting can be dedicated to clinical care issues. This allows for EAP personnel to direct their expertise to the stress associated with grief and loss for the staff, rather than marriage or children difficulties, for example. Also, communicate to EAP management that delayed communication back to the nurse requiring assistance, or the availability of only protracted appointments, will not meet the needs of staff.

Pastoral care: In some cases, lobbying for dedicated time from pastoral care staff to provide support for nurses must be negotiated. Pastoral care staff and nurses often hear much in common from patients that are not shared with families or physicians; therefore, they have a natural bond in striving to optimize patients’ experiences. Only 51 respondents (50%) reported the availability of pastoral care resources. Lobbying for volunteer support from priests, ministers, rabbis, or even parish nurses within the community often results in numerous offers to collaborate. Their response often is, “We didn’t realize there was a need.”

Pastoral care can offer some unique programs that nurses find therapeutic. Chaplains and pastoral care staff can offer a “blessing of hands” for staff. This offers ceremonial recognition of the important work professional caregivers provide. Employees are approached by chaplaincy staff and have their hands blessed and a simple prayer said for the continued gift of giving to others. Other options include the “Tea for the Soul” approach. This program is part of the University of California, Los Angeles, Medical Center’s approach to providing support to staff. Chaplains bring a cart filled with herbal teas, cookies, quiet music, and their presence to talk about distressing workplace frustrations and sadness (Gaskill, 2000). Note that the intervention is brought to the nurses rather than the nurses going to the offering.

Retreats: Although few survey respondents had retreats available to them for support, many cited an intense interest in having them as a resource. Retreats are a beneficial option to explore (Brown-Saltzman, 1994). Ideally offered in a relaxed setting, retreats can provide an opportunity for informal interactive exchanges, art, journaling, storytelling, and team building. If the retreat includes all disciplines on the cancer care team, it can clarify role ambiguity and more clearly delineate team member responsibilities and expectations within the patient experience (Medland et al., 2004). Unlike on-site support groups in which participants anxiously anticipate a call or being required in the clinic for other duties, the distancing that retreats provide allows for intense focusing on the personal aspects of oncology nurses’ work. One survey participant detailed the hospital’s attempt to provide a retreat experience for all oncology nursing staff. Five separate retreats were offered, allowing all shifts (most importantly the night shift, which often is excluded) to participate.

Program planning: Discussing the logistics of the program with the targeted participants will clarify timing, scheduling,
and preferred format of the offering. They also can help market the program. One survey respondent described that, even when resources were available, they were not communicated well to staff and required nursing staff to search out available options for support. During a busy work day, having time for this searching will most likely be the first task omitted.

**Strategies:** In the absence of formalized education and skill building during the initial phase of oncology nursing role maturity, continuing education targeting strategies to enhance nurse coping are essential. Multiple efforts versus a single approach are required to achieve this intervention. Formal psychosocial-educational classroom experiences can be augmented by the use of self-help materials in written or electronic format (Llouette, 2005). As one of the responders noted, “Education is not the cure-all answer for this dilemma. Educational interventions may enhance the nurse’s ability to cope with job demands, but it doesn’t necessarily decrease the potential for burnout.”

**Peer support:** Peer support likely is the most common resource for nursing staff and it alone may have a positive impact on nurse retention (Barnard et al., 2006). Peer support may include active listening, which is a therapeutic communication strategy (Gaskill, 2000). For example, an oncoming nurse may ask the nurse she is following about the details of the death of a patient they both knew (Papadatou, 2000). This dialogue may decrease the sense of isolation each nurse may experience and cultivate a sense of community concerning mutual grief. On the other hand, peer support may not always be therapeutic. In an attempt to render emotional support to a peer, challenging one’s colleague to reflect on their attitudes and feelings may not occur. Therefore, the practice of repeating usual responses—and not necessarily the most therapeutic—may prevail, particularly during a difficult patient and family scenario. Peer support is a vital option for emotional expression; however, it should not be the sole venue for personal reflection about communication strategies.

**Limitations**

Several limitations of the survey were apparent. The study of compassion fatigue requires an extensive and methodologically sound investigation, which was not the goal of this initiative. Although the sample size of 103 was adequate, the response rate of 27% limited the ability to generalize the findings. Some ONS chapters were not able to respond to the survey because they did not hold summer meetings when the survey was distributed. For future surveys, although definite outcome data is preferred, self-report of oncology nurse perception about the helpfulness of available strategies on their emotional response to their work would be of interest. Although some did provide this in the narrative comments section, it was not routinely addressed. Another important consideration for future surveys would be a quantification of how often strategies were used by staff and whether or not this response differed by nursing role or position held. Clearly, more scientifically rigorous work should be conducted on this issue.

**Conclusion**

The foundation of cancer nursing is grounded on a platform of workplace-generated emotional adversity (Boyle, 2000). This adversity emanates from multiple expectations that include providing highly effective emotional care to patients and families in the absence of formal education-fostering knowledge and skills to do this (Boyle, 2002, 2006). Because of the nature of their work, oncology nurses have an increased risk for compassion fatigue. Sharing available strategies for oncology nurses to combat workplace-induced emotional sequelae can provide helpful information for novice and seasoned oncology nurses.

The stress that emanates from close interpersonal relationships with patients and families is exacerbated by other current realities, including the complex state of finance-driven health care, expectations to provide care to patients with escalating patient acuity in conjunction with shortened length of stays, the increasing nursing shortage, increasing consumer expectations regarding care, and the strain of dealing with death, which complicate and intensify workplace-related emotional duress on nursing staff (Barnard et al., 2006). Oncology nurses who feel isolated, overloaded, unappreciated, and who are in denial about the impact of work on their emotions have higher incidence of compassion fatigue and, ultimately, turnover (Medland et al., 2004). Oncology nurses and the organizations that employ them must realize and act on the emotional ramifications of the profession to reduce the incidence of compassion fatigue and subsequent turnover.

Because of known links between nurse working conditions and the health outcomes for patients and nurses, identifying
how to build supportive work environments that prevent professional burnout is important (Barnard et al., 2006; Leiter & Spence Laschinger, 2006). If the level of organizational stress does not change, stress management alone cannot provide resolution of the emotional compromise induced by the work setting. Optimally, organizations should provide preventative and proactive support services instead of stress or crisis responses (Barnard et al.). Attributes of a healing environment include a workplace that promotes peace of mind, body, and spirit (Brown, 2006), which should be the predominant goal of hospice organizations as they acknowledge the inherent emotional sequelae of working with the dying. For work to be positive, employees should find their efforts fulfilling and able to be completed within the allotted time (Leiter, 2005).

In an effort to decrease compassion fatigue, organizations must step up and provide better environments for nurses (Taylor, 2002). Although numerous strategies can be considered, addressing the personal nurse experience can be actualized by providing on-site counseling for staff, a visible sign of administration’s value of the nurse (Luquette, 2005). Additionally, education and retreat participation may augment setting-specific counseling. Interventions identified in this survey provide templates for enhancing the work environment for oncology nurses as they pertain to emotional skill enhancement. Additional research in this area could be beneficial. A critical sense of urgency prevails as the number of novice nurses dwindle and the majority of seasoned nurses approach retirement age (Medland et al., 2004). Responses such as “hang in there” or “everyone else seems to be handling it okay” without the availability of professional resources to aide nurses in distress will continue to fail in providing necessary training and support to a cadre of nurses experiencing compassion fatigue. Ideally, oncology nurses should have the opportunity to work in a supportive work environment with a reasonable workload. However, in the absence of deliberative attention to the need for interventions that address compassion fatigue, ideal, holistic oncology nurse functioning will remain compromised. Periodic inventory of available resources followed by implementation of pertinent interventions would positively influence the individual nurse and the organization and have a positive impact on care provided to patients and their families with the ultimate result of decreasing compassion fatigue and high turnover rates.

Author Contact: Nancy Aycock, RN, BSN, OCN®, CHPN, can be reached at naycock@stdom.com, with copy to editor at CJONEditor@ons.org.

References


Receive free continuing nursing education credit for reading this article and taking a brief quiz online. To access the test for this and other articles, visit http://evaluationcenter.ons.org. After entering your Oncology Nursing Society profile username and password, select CNE Listing from the left-hand tabs. Scroll down to Clinical Journal of Oncology Nursing and choose the test(s) you would like to take.