

CONTINUING EDUCATION

EDUCATIONAL OBJECTIVES

After participating in this activity, clinicians should be better able to

- Identify the difference between burnout and compassion fatigue/secondary traumatic stress (CF/STS)
- Identify four risk factors for developing CF/STS
- List three coping mechanisms that help to manage or prevent CF/STS
- List four institutional interventions that can both prevent and treat CF/STS

Compassion fatigue in oncology nursing: A witness to suffering

Being able to recognize the symptoms and knowing how to manage and prevent the consequences are critical to personal and professional health.



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I had worked with Jane for several months during her frequent hospitalizations. She was just 40 years old and had widely metastatic vulvar cancer. Her pain was severe and difficult to control, despite epidurals and nerve blocks. The slightest movement was excruciating, yet she insisted on getting up to walk to the bathroom rather than suffer the indignity of a catheter. She had exhausted all treatment options, and her oncologist recommended hospice care. Desperate to live, Jane left the hospital and, with her husband Zach, drove several hours to get a second opinion at the Mayo Clinic. As they entered the hospital lobby to register, Jane had a stroke. She returned to our unit awake and alert but aphasic and paralyzed on her left side. Her death was imminent.

I sat by Jane's bed as her husband arrived. He held her hand. She opened one eye and started to try to speak, her speech garbled. Zach said helplessly, "I can't understand you, honey." Desperate to communicate, Jane began to repeatedly hit her chest with her fist and then point to Zach. She was becoming more agitated as we looked on helplessly, struggling to understand what she was trying to say. And then I finally got it. "Jane, are you telling Zach you love him?" She nodded vehemently, relieved to have finally gotten her message across. Zach, who was typically

stoic, broke down in tears. I left the room to give them privacy in this devastatingly sad moment, and also because I could not maintain my composure any longer. Watching Jane and her husband suffer through this long and painful journey, culminating in this final insult, had left a lasting mark on me.

DEFINITIONS AND DISTINCTIONS

Oncology nurses witness their patients' physical, emotional, spiritual, and existential suffering every day that they go to work. This repeated exposure to trauma can be a regular stressor for the caregiver. Although experienced oncology nurses may have learned how to deal more effectively with exposure to so much pain and suffering, tenure is no guarantee that a nurse will not suffer the physical and emotional symptoms that are commonly associated with compassion fatigue (CF), also known as secondary traumatic stress (STS). Understanding CF/STS, being able to recognize the symptoms of CF/STS, and knowing how to manage and prevent the negative consequences of this occupational hazard can be critical to the personal and professional health of the nurse.

Nurses drawn to the specialty of oncology are generally compassionate people. Radley and Figley define compassion as a “deep sense or quality of knowing or an awareness [among helping professionals] of the suffering of another coupled with the wish to relieve it.”¹ This empathic engagement is what contributes to job satisfaction, but it can also manifest as blurring of the boundaries between provider and patient and can leave the oncology nurse at risk for negative emotional and physical outcomes.

Compassion fatigue and *secondary traumatic stress* are used interchangeably and are defined by Charles Figley, PhD, a pioneer in the field of traumatology, as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person.”² Figley refers to compassion fatigue as “the cost of caring for others in emotional pain” and “an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper.”³ The symptoms of CF/STS, as listed in **Table 1**, are almost identical to the symptoms of posttraumatic stress disorder (PTSD). In PTSD, however, the person experiencing the symptoms is the same person who experienced the original trauma; whereas in CF/STS, the symptoms result from awareness of events happening to someone else.

An indirect connection to trauma is common to those who work in the field of oncology and who are regularly

TABLE 1. Symptoms of compassion fatigue

Reexperiencing the trauma event to the traumatized person
Recollections of event
Dreams of the event
Sudden and unexpected reexperiencing of the event
Distressing reminders of the traumatized person and event
Avoidance/numbing of reminders of event
Efforts to avoid thoughts and feelings
Efforts to avoid activities and situations
Psychogenic amnesia
Diminished interest in activities
Detachment/estrangements from others
Diminished affect
Sense of foreshortened future
Persistent arousal
Difficulty falling/staying asleep
Irritability or outbursts of anger
Difficulty concentrating
Hypervigilance for the traumatized person
Exaggerated startle response
Physiologic reactivity to cues
Adapted from Figley CR. ³

exposed to death and dying, grieving families, traumatic stories, severe physical pain, and strong emotional states, such as anger and depression in patients and family members. Being a witness to these situations may subsequently result in personal grief—and emotional and physical exhaustion in the nurse.

Other terms in the literature that may be familiar are *burnout*, *vicarious traumatization*, and *countertransference*. Research has demonstrated that although these constructs overlap, important differences exist in the etiology, prevalence, and symptoms related to each, and they are clearly distinguishable from CF/STS.⁴

Burnout usually develops gradually and intensifies over time, culminating in emotional exhaustion and demoralization. In contrast, CF/STS can develop acutely. Burnout is a defensive response to chronic dissatisfaction with work-related issues of inadequate support, short staffing, high workload, inadequate resources, and frustration with system issues. These demands and stressors eventually lead to feelings of hopelessness and

powerlessness to make a difference in the lives of those being served. Burnout may be a precursor to CF/STS.^{4,5}

Countertransference is the nurse's emotional reaction to the patient as the provider sees himself or herself in the patient and begins to overly identify with the patient. The risk in countertransference is that the nurse will attempt to express or meet his/her own personal needs through the client.² For example, a young oncology nurse whose father died of leukemia when she was in high school may struggle to work with patients of the same age and with the same diagnosis as her father. The professional role and the personal experience become blurred.

Vicarious traumatization refers to the health care provider's identification with the traumatized person beyond the experience of the usual symptoms of CF/STS. The identification occurs to such a degree as to cause an actual and potentially long-term or even permanent disruption to the provider's psychological frame of reference and how he or she views the world. The impact of vicarious traumatization changes affect, tolerance, perception of personal control and freedom, beliefs about self and others, sensory memory, imagery, and interpersonal relationships in the provider.^{5,6} For instance, a pediatric oncology nurse who decides against

- Younger nurses who are new to the field and are less experienced
- Nurses who have a history of personal trauma and have not worked through the issues related to the trauma
- Nurses who are working with large caseloads and/or long hours
- Nurses who are already experiencing professional burnout
- Nurses with inadequate training in effective communication or who are less competent in communication
- Nurses without adequate collegiate and personal support systems.

Not all health care providers who work with suffering patients develop CF/STS. King found a positive correlation between effective psychological coping and "hardiness," as characterized by feelings of control, commitment, and "change as challenge," along with strong functional and structural social supports. Oncology nurses are also at a lower risk of developing CF/STS if they have a realistic tolerance of failure and can accept and not feel responsible for the inevitable poor outcomes experienced by many of their patients.⁹

HEALTHY PROCESSING, HEALTHY COPING

Self care Prevention of CF/STS is key, and self care is a critical component of prevention. Self care includes attention to and care of physical, psychological, cognitive, interpersonal, behavioral, and spiritual aspects of the whole person. A study that examined the relationship between self care, compassion fatigue, burnout, and compassion satisfaction among hospice workers found that as compassion fatigue and burnout increased, the number of self care activities reported by the workers decreased.¹⁰ The study suggests the importance to oncology nurses of taking part in a variety of self care activities in preventing and managing the hazards of compassion fatigue. In addition, those health care professionals who reported high levels of emotional and spiritual self care and personal/professional balance had higher levels of compassion satisfaction.¹⁰

It is widely recognized in the literature that regular and vigorous physical exercise, along with nurturing interventions like massage, can help to reduce stress. Adequate sleep and good nutrition are crucial but easily neglected when life is fast-paced and stressful, and taking part in activities and hobbies that replenish the mind and spirit is equally important. In addition, assertiveness training, time management skills, working on improving personal communication skills, and becoming involved in community/social action activities can provide life skills that carry over to work.

Meditation and spiritual practice are important tools in understanding our response to watching others who are in

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having children of her own, based on her exposure to suffering in her patients and the fear of experiencing the same pain and anguish as a parent herself, is a victim of vicarious traumatization.

A final term used in the literature is *compassion satisfaction*. It is the satisfaction that is derived from doing work that helps others, and it has been found to protect against the development of CF/STS in helping professionals.⁵

WHO IS AT RISK?

Although very few validated reports are available on the incidence and prevalence of CF/STS in oncology caregivers, current research does not identify gender, employment status, specialty units, or educational preparation as contributing to the development of CF/STS.⁷ Helping professionals who appear to be at higher risk for compassion fatigue include the following:^{5,8}

pain and suffering and in maintaining self-integrity. Finally, self-reflection can help nurses to identify their own personal triggers that indicate stressed coping.¹¹

Reflection In addition to using self care and life balance as antidotes to the stressors that can lead to CF/STS, reflection can be used to provide more compassionate care in the face of suffering. Rita Charon, MD, a professor of medicine at Columbia University, has developed the field of *narrative medicine*, which is medicine practiced with the skills needed to recognize, absorb, interpret, and be moved to action by the stories of illness.¹² Providers who possess

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what Charon calls *narrative competence* are able to bridge the “divides” of their relation to mortality, the contexts of illness, beliefs about disease causality, and emotions of shame, blame, and fear. Charon challenges health care providers to move beyond withdrawal and detachment and toward a healthy and productive level of engagement with their patients that actually results not only in improved care for the patient but also improved coping of the provider in stressful circumstances.¹³

The health care provider can begin to process the emotional demands of the work by respecting the powers of sickness and dying. Charon states:

The most powerful response to suffering is compassion, that ability to experience with someone else what he or she is suffering and to accompany another on a journey of suffering. The compassionate witness will be able to recognize the pain in another and thereby to act on behalf of the one suffering. However, suffering does not automatically call forth compassion. Rather, the witness must work very hard to achieve that state.¹³

Charon describes three phases to increasing our ability to be compassionate. First is the ability to be a *silent witness*, to sit with the suffering person without words. The second phase is *expressive compassion*, which requires active listening and complete attention to both what the patient is saying and not saying. It is being able to put words to the patient’s feelings to help the patient tell his or her story and, in the process, be able to bring forth meaning for the patient. Finally,

once the story is heard, the listener can act to do what must be done, “medically, socially, and emotionally to lessen the suffering or even to end it.”¹³

Charon offers hope to healing professionals who fear the risks involved with working with such great suffering and have felt the effects of being compassionate persons:

Here in confrontation with serious illness, we have the opportunity to cross over that line that separates the sick from the well, to diminish the isolation that is the feared result of illness, and to accept without flinching the community of the sick. In giving this gift to our patients, we get a much greater gift in return: to become the person who hears, who understands and who gives in true compassion. We achieve new identities as persons who can give freely.¹³

Institutional support When the nurse develops symptoms of CF/STS, such as depression, anxiety disorders, sleep difficulties, substance abuse issues, and problems with relationships, it can have a lasting impact on physical and emotional health. This in turn affects organizations and employers by way of increased errors on the job, decreased efficiency, low morale, and high turnover. While recognizing and providing supportive interventions for those nurses experiencing CF/STS is critical, employers would be wise to consider incorporating preventive measures.¹⁴

Aycock and Boyle conducted a national survey to identify organizational resources that could help oncology nurses to cope with the phenomenon of CF/STS. Helpful interventions were identified and were presented as blueprints to be replicated in practice settings. They included the following:⁸

- Guidance in coping with suggestions for self care, including services through employee assistance programs
- For new hires, acknowledgment by managers of the inherent emotional stressors in order to “normalize” the experience and assurance of ongoing employer support
- Education and training in communication skills, conflict resolution, ethical issues, self care, and healthy coping
- Making prompt and timely supportive resources available to staff to allow for emotional expression (examples include on-site counseling in the form of staff support groups,

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critical incident debriefing, and routine daily rounds and patient care conference discussions)

- Pastoral care availability (often overlooked but identified as an important support by many of those surveyed)
- Retreats as an opportunity for informal interactive exchanges, team building, and artistic and narrative expression.

CONCLUSION

When the healing professional is overwhelmed by the emotional demands of the work, the most expedient and practical step may seem to be to retreat and withdraw. This is a natural response to pain. It is not the only option, however, and certainly not the healthiest response in the long run. The Compassion Fatigue Awareness Project Web site states: “Somewhere along your healing path, the truth will present itself: You don’t have to make a choice. It is possible to practice healthy, ongoing self care while successfully continuing to care for others.”¹⁵ In the myriad of challenges oncology nurses face every day, taking care of themselves should be at the top of the list and is essential in order to provide the best care to patients. ■

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REFERENCES

1. Radley M, Figley C. The social psychology of compassion. *Clin Soc Work J*. 2007;35:207-214.
2. Figley CR, ed. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York, NY: Taylor and Francis; 1995.
3. Gould J. Compassion fatigue: an expert interview with Charles R Figley, MS, PhD. *Medscape Psychiatry and Mental Health*. <http://www.medscape.com/viewarticle/513615>. Accessed September 7, 2010.

4. Meadors P, Lamson A, Swanson M, et al. Secondary traumatization in pediatric healthcare providers: compassion fatigue, burnout, and secondary traumatic stress. *OMEGA*. 2009-2010;60(2):103-128.
5. Collins S, Long A. Working with the psychological effects of trauma: consequences for mental health-care workers—a literature review. *J Psychiatr Ment Health Nurs*. 2003;10:417-424.
6. Sinclair HAH, Hamill C. Does vicarious traumatization affect oncology nurses? A literature review. *Eur J Oncol Nurs*. 2007;11:348-356.
7. Bush NJ. Compassion fatigue: are you at risk? *Oncol Nurs Forum*. 2009;36(1):24-28.
8. Aycock N, Boyle D. Interventions to manage compassion fatigue in oncology nursing. *Clin J Oncol Nurs*. 2009;13(2):183-191.
9. King L, King D, Fairbank J, Adams G. Resilience—recovery factors in post-traumatic stress disorder among female and male veterans: Hardiness, post war social support and additional stressful life events. *J Pers Soc Psychol*. 1998;74:420-434.
10. Alkema K, Linton JM, Davies R. A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *J Soc Work End Life Palliat Car*. 2008;4(2):101-119.
11. Najjar N, Davis LW, Beck-Coon K, Doebbeling CC. Compassion fatigue: a review of the research to date and relevance to cancer-care providers. *J Health Psychol*. 2009;14(2):267-277.
12. The Program in Narrative Medicine Page. <http://www.narrativemedicine.org/about/about.html>. Accessed September 7, 2010.
13. Charon R. Let me take a listen to your heart. In: Gordon S, Benner P, Noddings N, eds. *Caregiving: Readings in Knowledge, Practice, Ethics, and Politics*. Philadelphia, PA: University of Pennsylvania Press; 1996:292-305.
14. Stewart DW. Casualties of war: compassion fatigue and health care providers. *Medsurg Nurs*. 2009;18(2):91-94.
15. Compassion Fatigue Awareness Project. <http://www.compassionfatigue.org>. Accessed September 7, 2010.

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