Compassion Fatigue

Exploring early-career oncology nurses’ experiences

Brooke A. Finley, BSN, RN-BC, and Kate G. Sheppard, PhD, RN, FNP, PMHNP-BC, FAANP

BACKGROUND: Oncology nurses have a higher risk and rate of compassion fatigue (CF) compared to professionals in other specialties. CF exhibits tangible negative outcomes, affecting nurses’ health and professional practice.

OBJECTIVES: Early-career oncology nurses’ unique CF experiences lack thorough scientific exploration. This secondary analysis seeks to qualitatively augment this paucity and illuminate targeted interventions.

METHODS: Open-ended interviews were conducted with five early-career inpatient oncology nurses. Subsequent transcripts were explored for CF themes secondarily using thematic analysis.

FINDINGS: Themes indicate that early-career oncology nurses enjoy connecting with patients and families, but over-relating, long patient stays, and high patient mortality rates trigger CF. Symptoms include internalizing patients’ and families’ pains and fears, being haunted by specific patient deaths, feeling emotionally depleted, assuming that all patients will die, and experiencing burnout, physical exhaustion, and hypervigilance protecting loved ones.

KEYWORDS
compassion fatigue; burnout; secondary traumatic stress; emotional saturation

DIGITAL OBJECT IDENTIFIER
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RECOGNIZING THE EFFECTS OF THE DARK, DEPLETING SIDE of oncology nursing may provide insight as to why compassion fatigue (CF) risks and rates are comparatively higher in this specialty. Emanuel, Ferris, von Gunten, and Von Roenn (2011) found CF symptoms in 37% of oncology nurses, and Potter et al. (2010) found that 44% of inpatient oncology nurses experience burnout, one component of CF. In addition, oncology nursing has a 31% turnover rate versus an average of 13% in all other specialty areas (Achenbach, 2010). Contradictory to need, oncology nurses also have a substantial lack of resources for emotional intervention and mental health support in the workplace, as 47% of oncology nurses did not have any coping skills training and 17% of oncology nurses had no on-site resources for mental health support (Aycock & Boyle, 2009). With the substantial increases of novice and oncology nurses leaving the profession; estimated cancer-related patient deaths; and resulting need for recruiting, retaining, and supporting oncology nurses, these figures warrant urgent attention (Achenbach, 2010; Flinkman, Isopahkala-Bouret, & Salanterä, 2013; Toh, Ang, & Devi, 2012; World Health Organization, 2017). Oncology nurses, particularly novice and younger nurses who demographically have higher CF risk, must have their vulnerabilities and experiences with CF recognized and understood to guide the creation of tailored interventions to aid in workforce retention and satisfaction (Davis, Lind, & Sorensen, 2013).
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(Boyle, 2011; Coetzee & Klopper, 2010; Stamm, 2010). CF can be exhibited any time in nurses’ career, as internalizing trauma and workplace issues is highly individualized and situational, occurring anytime vulnerability and situational stimulus occur (Boyle, 2011; Stamm, 2010). Each shift with CF has the potential to be a stressful, baneful endeavor, resulting in negative psychological and behavioral outcomes affecting nurses and their practice.

CF creates a complex manifestation “with marked physical, social, emotional, spiritual, and intellectual changes that increase in intensity” (Coetzee & Klopper, 2010, p. 237) and, when unresolved, perpetuates feelings of hopelessness, sadness, general despair, and social isolation (Aycock & Boyle, 2009; Lombardo & Eyre, 2011). CF is markedly deleterious in the clinical setting, as nurses who have CF have higher practice errors, increased patient mortality, and higher infection rates, ultimately reducing patient safety and care (Boyle, 2011; Fetter, 2012; Lombardo & Eyre, 2011; Potter, Deshields, & Rodriguez, 2013; Romano, Trotta, & Rich, 2013). Although the literature conceptualizes CF and its outcomes, the foundation of oncology nursing can be enriched with a greater understanding of this pervasive psychological burden faced by oncology nurses and how to address it head-on.

Methods
In the parent study, qualitative phenomenologic interviews were conducted with 16 hospital-based RNs at a level I trauma facility in Nevada. Participants worked in emergency, trauma intensive care, medical intensive care, neurology, and oncology units. The parent study received institutional review board approval from the trauma facility and the University of Arizona in Tucson prior to recruitment. Data for the secondary analysis came from transcripts of the face-to-face, in-depth, semistructured interviews with five oncology nurses.

Interviews began with an open-response question, such as, “Tell me about CF.” After, focused questions were used to gather specific details pertaining to meaning, experience, and events that influenced CF experiences. Participants were interviewed once to capture unfiltered responses and avoid exploitation. Interviews averaged one hour, and a $25 gift card was given to participants for their time. Interviews were conducted until saturation of themes was reached and additional information regarding CF ceased to be contributed, including experiences unique to the oncology specialty. Each participant record was kept anonymous with a first-name pseudonym.

Data Analysis
After being read three times, transcripts were deductively analyzed using Stamm’s (2010) CF framework for commonalities; common phrases, words, and ideas were highlighted and noted for initial impressions (Smith & Firth, 2011; Stamm, 2010; Vaismoradi, Turunen, & Bondas, 2013). Initial impressions were categorically organized and assigned in vivo codes or direct quotations for interpretive accuracy (Smith & Firth, 2011). Next, themes were created using codes that have analytically been grouped together using critical thinking and descriptive explanations (Smith & Firth, 2011).

Qualitative research trustworthiness can be addressed by establishing credibility, dependability, confirmability, and transferability (Graneheim & Lundman, 2004; Vaismoradi et al., 2013). Credibility is defined as the confidence gained from gathering quality data and analyzing it appropriately (Graneheim & Lundman, 2004). In the current study, credibility is demonstrated by using thematic analysis, an appropriate method to analyze the qualitative data gathered via in-depth interviews conducted by an experienced qualitative researcher. Dependability is defined as minimizing inconsistencies that can arise during data collection, largely related to the interviewer’s skill and interviewee selection (Graneheim & Lundman, 2004). The principal investigator’s extensive CF research background, selection of interviewing staff from a high-risk CF hospital, and doctoral credentials in psychiatric nursing make the data dependability high.

Trustworthiness is increased with confirmability, or validation of the findings from qualified professionals that collectively conclude that respective results are consistent with reality (Graneheim & Lundman, 2004). Specific themes found from this secondary analysis were confirmed and consistent with the parent project analysis. Trust is established with transferability, or how applicable the structure and findings of a study are in other settings or research studies. To facilitate transferability, participants’ characteristics are outlined in Table 1. By addressing trustworthiness, this secondary analysis may fill a void in the literature by describing oncology nurses’ experiences with CF.

Findings
All participants were female early-career nurses with seven or fewer years in the specialty, each holding a different role on the unit. Six themes were discovered, along with respective positive and negative CF coping mechanisms that highlight oncology...
nurses’ unique CF experiences. To stay true to the data, participants’ quotes were purposefully not altered and filler words were kept, indicating pause needed for expressing difficult, complex ideas and emotions when speaking about CF.

**Theme 0: I Did Not Pick Oncology, But It Did Pick Me**
Appropriately coded as Theme 0, symbolizing the absolute beginning, all participants, who have only been in the specialty from 0-7 years, stated that they did not seek employment in oncology but chanced upon it through practicum experiences. This could have been attributed to the negative reputation of oncology nursing inducing STSD described by an orienting nurse. “Oncology was the floor I was most scared of ’cause I was like, ‘How could you handle, you know, how depressing, how horrible.”

**Theme 1: Forming and Losing Long-Term Connections With Patients and Family**
Over-relation to patients and families elicited symptoms of STSD in oncology nurses, whereas the long-term care given to patients was cited as the main reason why nurses failed to maintain boundaries because they felt attached to patients’ outcomes and families. The nurses repeatedly stated that patients for whom they were continuously primary nurse had a lasting emotional impact. Most attributed this to the long-term care that they provided to one person, sometimes spanning months and years of readmissions. When patients were dying and eventually died, nurses re-lived moments and feelings that corresponded to losing someone close and expressed signs of STSD.

I took care of a 35-year-old for six months, and he had gastric cancer, and, you know, I was his primary nurse, so three days a week, I took care of him, and he was sick . . . and we all knew he was not going to make it . . . . It’s just, you feel like all your emotions are spent, but you still have them.

In addition, the families reached out to and relied on nurses for emotional support, particularly after patient deaths and occasionally after care was transferred. This dependence and over-relation traumatized nurses.

I had to talk to her after, her mom. I didn’t have to, but I thought, I’ve been taking care of her for eight weeks. . . . I need to be the one to go tell her that she didn’t make it, and that was hard. I remember just sobbing and sobbing.

Nurses somatically over-related to patients, as they hypervigilantly associated patient symptoms mirroring their own bodily pain, or those of loved ones, to cancer. One participant said, “You start to get scared because, oh my gosh, I feel like, oh, I have a cough, I betcha I’ve got lung cancer now.”

**TABLE 1.**
**SAMPLE CHARACTERISTICS (N = 5)**

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>n</th>
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<tr>
<td>Age (years)</td>
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<tr>
<td>25–34</td>
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<td>35–44</td>
<td>2</td>
</tr>
<tr>
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<td>Years in oncology</td>
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<tr>
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<td>2</td>
</tr>
<tr>
<td>4–7</td>
<td>3</td>
</tr>
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</tr>
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</tr>
<tr>
<td>Unit role</td>
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<tr>
<td>RN</td>
<td>3</td>
</tr>
<tr>
<td>Advanced practice oncology nurse</td>
<td>1</td>
</tr>
<tr>
<td>Unit educator and charge RN</td>
<td>1</td>
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</tbody>
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**Theme 2: Grief, Loss, and Endless Suffering**
The first patient who newer nurses primarily cared for posed an increased risk for secondary traumatic memories because knowledge and experience with healthy boundary-setting was limited. One participant said, “My first year or two in nursing was hard with those situations, and now, I mean, they still make me tear up.” Nurses expressed the rarity of sending patients home; they had to watch most continuously suffer before they eventually died. In addition, inspiring follow-up with survivors rarely occurred, leading to nurses assuming that all their inpatients with cancer would die.

You know, 90% of the time, our patients come in healthy, and we watch them deteriorate, and a lot of ’em, you know, don’t come back, so do, did they, are they in remission, or do they pass away? I don’t know.

Consistently, when a primary nurse had a patient profile of a younger person with children who unexpectedly got diagnosed and subsequently died of cancer, this created a long-lasting memory for the nurse and the perspective that life was not fair.
Theme 3: Burnout Is All in a Day’s Work: Expectations, Disappointment, and Exhaustion

One burnout experience included feeling overstretched with crisis situations, making nurses “extremely angry and frustrated” with unrelenting workplace demand and stress. Nurses felt guilt for not providing high-quality care because they felt they did not have enough time for important human–human interaction, such as small requests and talking to patients. Nurses expressed interprofessional conflicts with oncologists when patients were perceived to be dehumanized by the medical model, reducing them to a diagnosis or research participant. Nurses felt unheard when advocating for patients’ best interests for palliative care, having to instead deliver extremely painful, aggressive treatments that disrespected individual patients’ perceived needs. After work, nurses felt exhausted, isolated themselves at home, and wanted sleep. They would sometimes be too tired to eat and barely had enough energy to shower.

Theme 4: All Your Emotions Are Spent, But You Still Have Them

Themes of psychological STSD were the most frequently cited symptoms regarding Stamm’s (2010) model, resulting in numbing emotions. Instinctually rejecting sharing emotional connections with patients was a concern of the nurses. One participant said, “There are some days where I do feel like I’m not as compassionate, but not that I’m not compassionate.” Nurses expressed guilt that they could not feel deeply for patients anymore but admitted that this was a defensive move “. . . ‘cause it’s certainly less exhausting than when you go [to] that point with your families and your patients.”

Theme 5: What I Do Here Makes Me a Better Person

Oncology nurses expressed that they felt high intrinsic rewards, or compassion satisfaction; helping individuals in times of need was something that restored their sense of purpose and provided internal joy. According to one participant, “I feel like I’m doing good for the community and for other people.” All nurses expressed that their patients with cancer were special and that their patients were different than others because they got a second lease on life, giving them an extra appreciation for nursing care and presence.

Positive Coping

Spending time with friends and family and honoring self-care practices (e.g., exercise) created happiness outside of work. In addition, vacations were crucially refreshing to nurses. Coworker support buffered stress and created meaningful relationships. Coworkers were considered the only ones who truly related to workplace trials and frustrations. Turning off work thoughts was a healthy way to compartmentalize work and prevent negative overlap in nurses’ personal lives. Some nurses also sought professional help, such as therapy, to process unresolved professional trauma.

Negative Coping

Overindulging in alcohol and staying out late at night, resulting in sleep deprivation, were examples of poor self-care outside of work. When stressed, nurses would forgo eating or binge-eat unhealthy foods, which would usually be done at a computer desk while charting. Nurses expressed being stuck in mindsets that did not serve them, including being a “perfectionist” and becoming “jaded.” These fixated identity descriptions lead to self-loathing and wanting to be normal but not knowing how to achieve normalcy.

Discussion

Inpatient oncology has a special patient demographic, one that brings great interpersonal rewards to nurses but also fosters long-term connections with patients at high risk for mortality and their families. Nurses bemoaned becoming purposefully emotionally disengaged when caring for patients and their families but felt it was necessary to avoid feeling psychological pain, which they continued to carry with them, early in their nursing careers. As a result, this phenomenon was interpreted as not being able to handle more emotions, not that nurses did not care anymore. This warrants changing CF to a more appropriate, semantically accurate term, such as “emotional saturation,” that is also less stigmatizing (Sheppard, 2015).

Limitations

The sample size of five oncology RNs from a single level 1 trauma facility in the Southwest limits the generalizability of the results. In addition, this population is solely female and had seven or fewer years of experience in the oncology nurse profession. However, newer oncology nurses expressing CF symptoms garners support for timely CF education and intervention.

Personal Interventions

Fostering spirituality, personal reflection, meditation, guided imagery, and diaphragmatic breathing was found to alleviate emotional exhaustion, which was a common CF symptom in the current study (Luquette, 2007). Spirituality is cited as one of the most effective buffers against CF but was not mentioned in the results of the current study and may be an area of further exploration (Neville & Cole, 2013). One self-help anxiety-management
strategy is using stress inoculation training mobile applications that develop emotional regulation coping skills. They were demonstrated to reduce stress in an innovative study by Villani et al. (2013). Another self-help intervention is a web-based, 3D, virtual reality application called Second Life (www.secondlife.com). It is a peer storytelling platform for grief expression and coping (Rice, Bennett, & Billingsley, 2014; Villani et al., 2013). Self-care tailored to an individual’s needs—identified in the current study as taking vacation time and enjoying time off alone or with family and friends—was shown to be protective in the current study and in others (Neville & Cole, 2013; Pfaff, Kowalski, & Ansmann, 2013).

Workplace Interventions
Based on Theme 0, nurses not seeking oncology employment, understanding this reality and interesting nurses in oncology through practicum experiences can help with recruitment. Enticing new graduates and retaining novice oncology nurses can be enhanced with internship programs that increase professional support, potential, and clinical skills (Childress & Gorder, 2012). Internship and preceptorship program quality can be enhanced by initiating preceptor training programs for high-quality mentoring (Kang, Chiu, Lin, & Chang, 2016).

Effective oncology-tailored interventions mitigating the recognized CF symptoms in the current study include prevention and educational seminars, intervention workshops, and grief resolution ceremonies (Edmonds, Lockwood, Bezjak, & Nyhof-Young, 2012; Emanuel et al., 2011; Fetter, 2012; Houck, 2014; Popkin et al., 2013; Potter, Deshields, & Rodriguez, 2013; Potter et al., 2013; Poulsen, Sharpley, Baumann, Henderson, & Poulsen, 2015; Traeger et al., 2013; Wittenberg-Lyles, Goldsmith, & Reno, 2014). Lastly, following the interdisciplinary guidelines set forth by the National Consensus Project for Quality Palliative Care, nurses can use the COMFORT™ Communication Project as a resource for effective holistic palliative care communication when navigating the morally and ethically challenging area of palliative care patient advocacy (Goldsmith, Ferrell, Wittenberg-Lyles, & Ragan, 2013).

Nursing management should use authentic leadership, or transparent and ethical behavior that encourages openness, and create a supportive professional environment that will retain new graduate nurses and support seasoned nurses (Fallatah & Laschinger, 2016). Initiating support groups within units for peer support has shown benefits and would expand the identified positive coping mechanism of empathetic working relationships found in the current study (Luquette, 2007; Wittenberg-Lyles et al., 2014). In addition, creating a space in the hospital setting dedicated for nurses to rejuvenate has also proven to reduce stress and may address the issue of creating a safe space to relax, eat a meal, and get grounded in the self (Romano et al., 2013).

Conclusion
Exploring the complex nature of CF among early-career oncology nurses can set a precedent in guiding tailored solutions and providing hope for resolution. Many employable, existing interventions effectively address symptoms of CF in this population.

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REFERENCES


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