

Compassion Fatigue: Are You at Risk?

Nancy Jo Bush, RN, MN, MA, AOCN®

E.P., a 34-year-old oncology staff nurse, felt like she was losing control of her life. She felt a sense of dread and fatigue each morning when her alarm went off. How could she make it through one more day trying to balance her family life, her job, and caring for her mother, whose senile dementia was gradually worsening every day? E.P. could not really remember the last time she felt energetic and positive, nor could she pinpoint when she began to feel so overwhelmed.

E.P. had been married for 13 years to her college sweetheart. He was in sales and worked out of the home, which, she felt, often added to the chaos of their lives. Their children came soon after marriage and were now embarking on adolescence—a daughter, 12, and a son, 10. The children seemed to fight continuously for inconsequential reasons, and her daughter was beginning to challenge E.P. in every arena: clothes, music, friends, homework, and curfew. E.P.'s husband played a passive role in their childrearing, and E.P. often did not feel supported when she attempted to set guidelines or expectations for the children. Caring for her mother was adding additional stress and her only sibling lived out of state and was not available to assist her in handling the physical, emotional, or financial aspects of their mother's care.

E.P. had studied nursing in college and began working immediately after graduation. She worked in general medical-surgical units initially; looking back, she remembered being enthusiastic and eager to go to work every day. Nursing was not just a job for her. E.P. felt that nursing was a profession and, at one time, she had hoped to further her education and become a nurse practitioner. She did not plan to become an oncology nurse but worked the float pool for several months and soon found that her work with patients with cancer and their families was rewarding. E.P. enjoyed the challenges of working in a specialty area, learning new skills, and felt that the environment reinforced the ideals that made her enter the profession in the first place: empathy,

compassion, caring, and making a difference in the lives of her patients and their families.

The years passed quickly—her children kept her outside life very busy, her colleagues at work became her dearest friends, and she had started to take classes to get a master's degree in oncology nursing. She worked 12-hour day shifts that initially made her feel like she could juggle family, work, school, her mother's care, and, if possible, some time for herself to continue jogging, her favorite form of exercise. Her first semester was a difficult transition and, at times, she felt overwhelmed by the amount of reading and studying required. Her husband and her children did not seem to understand the demands of her studies, and their expectations of her remained the same. Her husband did not understand her desire to further her education; he would express his feelings that "a nurse is a nurse; just a nurse." Unexpectedly, rearing her daughter began to feel more, not less, demanding. At times, E.P. felt that her daughter would challenge her on every occasion and keep their relationship at arm's length. She missed feeling close to her daughter but tried to understand her need for independence. Her son seemed unaffected by any family crisis that would occur but he would fight with his sister, refuse to do homework, and had to be constantly reminded to do his chores around the house.

The hospital environment and work demands also were making E.P. feel "down." The nursing shortage had increased the nurse-patient ratio, so, most days, she came home feeling physically and emotionally drained. It was hard for her to rationalize going to school when she could no longer practice nursing at the bedside with the time to care for her patients and their families as she once had. The inpatient oncology population also was becoming more acutely ill, and the nursing staff was experiencing more deaths, family grief, and loss, without a balance of caring for patients who were being treated in outpatient settings or who were survivors. As hospital finances

became worse, other resources, such as social services and advanced practice nurses, became scarce. Gone were the days of support groups on the unit for the staff or educational programs at work to help the nurses feel competent with technological changes and the demand for new skills. Over time, E.P. began to feel that nursing was a job, not a profession, and not supported or recognized for the hard work, both emotional and physical, that oncology nursing demanded.

E.P. began to feel a sense of hopelessness and helplessness when it came to making any changes in her home or work environment. She would stay up late to study and, even with eight hours of sleep on a weekend night, was constantly fatigued. Her husband and children said that she was "irritable" and always distant. When she would visit her mother, she would leave feeling depressed; as if her mother was dying slowly in front of her. At work, E.P. continued to feel emotionally close to her patients and their families but, unknowingly, she was unable to leave their grief and issues at work. She began to wake up at night dreaming about a patient or fearing that a patient she cared for would die before she got back to work in the morning. Several nightmares included fears of injury to her children resulting in their own death. Months had passed since she had gone jogging, and she was unable to concentrate on her studies, often finding herself sitting for hours preoccupied with feelings of fear or anxiety. She began to feel incompetent at work, at home, and with her studies. E.P. felt angry at her husband for his lack of understanding and support in all areas of her life and she would shutter if he attempted to show any signs of affection or intimacy. She felt her life was like a roller coaster out of control and that no one, not even her own friends and colleagues, could keep her on the track. As her isolation increased, so did her loneliness. Feelings of despair would erupt when a patient or family member was in despair, and she began to feel their loss as her loss, too.

What Is Compassion Fatigue?

Lewin (1996) described compassion as a complex emotion that allows caregivers to hold and sustain themselves in emotional balance while holding patients' despair in one hand and their hopefulness in the other. Compassion requires an inner conviction and resiliency—a passion of personal ethics, personal beliefs, and a personal way of being. Lewin explained that compassion requires us to ask who we are, what we wish to be, what are our joys and commitments, and what values do we hold dear and defend? He described compassion as the core value of the caregiver's work, and that the essence of compassion is what gives nursing its soulfulness, staying power, and healing resources. Poignantly, Lewin encapsulated what all nurse caregivers come to know, "Our patients instruct us in so much that is painful, but our patients lead us to love, appreciate, and enjoy so much that we would not otherwise have known to cherish. We come to care about what they care about because they care about it and we care for them" (p. 25).

Compassion fatigue is a term first coined by Joinson (1992) to describe the unique stressors that affect people in caregiving professions (e.g., nurses, psychotherapists, ministers). Joinson envisioned compassion fatigue as a unique and expanded form of burnout, not only environmental stressors of the workplace negatively affecting nurse caregivers but the patient's physical needs (e.g., pain, discomfort) and emotional needs (e.g., fear, anxiety) contributing to nurses becoming tired, depressed, angry, ineffective, and, at the end of the continuum, apathetic and detached. Compassion fatigue and burnout in the nursing profession often have been addressed in the specialty of palliative care when nurse caregivers must come to terms with their own grief and loss related to caring for dying patients (Mulder, 2000). Joinson addressed the cost of compassion fatigue (evidenced in the case study). Nurse caregivers may feel as if they are working two jobs, giving of themselves all day at work and returning home to nurture and care for family, constant stress eating away at the commitment and the foundation on which the career was built. As a result of compassion fatigue, somatic complaints range on a continuum from headaches to depression, and emotional symptoms range from irritability to anger. If un-

addressed, isolation, withdrawal, and detachment occur. Compassion fatigue is a complex phenomenon that escalates gradually as a product of cumulative stress over time, often when caregivers ignore the symptoms of stress and do not attend to their own emotional needs.

How Is Compassion Fatigue Differentiated From Similar Theories Such as Burnout?

Burnout is a well-known construct and is experienced by oncology nurses beginning with the continual changes and increased demands of the healthcare and work environment, such as cutbacks, cost-containment, and demands to do more with less. The phenomenon of burnout has been well researched over the past 30 years and appeared in the literature prior to the concept of compassion fatigue. Burnout has been described as having feelings of failure, being worn out, or becoming exhausted by excessive demands on energy, strength, or resources (Freudenberger, 1974). Burnout manifests as physical, psychological, and behavioral reactions: emotional exhaustion, diminished caring, and a profound sense of demoralization (Maslach, 1993). The literature on burnout shows that committed professionals such as E.P. begin their careers with energy, involvement, and efficacy, and emotional exhaustion is viewed as the main component of burnout, with involvement becoming cynicism and efficacy becoming ineffectiveness (Lederberg, 1998; Maslach, Schaufeli, & Leiter, 2001).

Vicarious traumatization is a term closely related and often used interchangeably with compassion fatigue. The stresses experienced by oncology caregivers are twofold and intertwined. Inherently, the heart of oncology care is the relationships that develop between caregivers and patients and their families. To be truly effective in oncology care, in the process of helping others heal through the trauma of a cancer diagnosis and treatment, the nurse must give of himself or herself from a deeply personal and spiritual level. The empathic engagement that takes place between nurse and patient must maintain a fine balance with appropriate emotional boundaries to safeguard the mental health of both. A risk for oncology nurses, and other nurse caregivers in trauma centers, intensive care units, and burn units, is that after prolonged exposure to trauma and loss, the caregivers begin to integrate the emotions, fears, and grief of their

patients, ultimately increasing their own stress and emotional pain (see Figure 1). The construct of vicarious trauma posits that the psychological distress that incurs over prolonged exposure to trauma actually changes the cognitive schema or perspective of the caregiver related to such life issues as intimacy, trust, safety, self-esteem, and control (Saakvitne & Pearlman, 1996). Nurses experiencing vicarious traumatization no longer feel grounded in the world around them; they begin to question the meaning of life, risk losing a sense of purpose, and pervasive hopelessness may set in (Figley, 2002; Larson & Bush, 2006). As the case study demonstrates, E.P. began to feel a sense of hopelessness and ineffectiveness in her ability to change the circumstances of her life. Figley (1999) described this phenomenon as the cost of caring.

Secondary traumatic stress incorporates the concepts of compassion fatigue and vicarious trauma caused by empathic engagement, but the subsequent emotions and behaviors may result in an acute stress disorder or symptoms similar to post-traumatic stress disorder (PTSD). According to the American Psychiatric Association (2000), "any person who has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" (p. 426) is a criterion for the diagnosis of PTSD. Another criterion is that the person's response can involve intense fear and hopelessness. E.P. began to fear for the safety of her own family during nightmares that concerned death and dying. Many experiences reported by emotion-

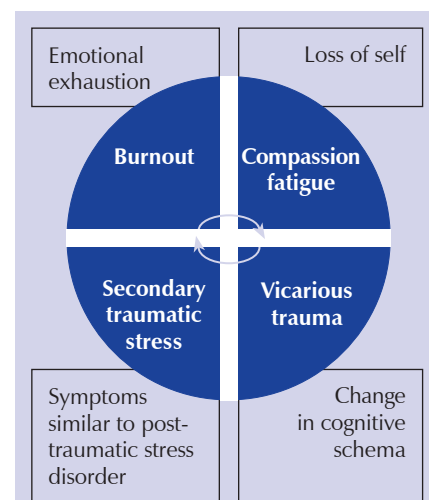


Figure 1. The Risks of Empathic Engagement

ally exhausted caregivers are similar to the experiences of people with acute stress response or PTSD: recurrent recollections, distressing dreams, psychological distress (e.g., anxiety), reminders of the event or death of the person being cared for, in addition to physical symptoms including irritability, difficulty concentrating, and insomnia (Figley, 1999). The individual's experience in relation to the traumatic event, combined with a lack of personal and supportive resources to cope, exacerbate the feelings of fear and loss, challenging the person's belief system, faith, and trust in others and themselves (Figley).

Who Is at Risk?

All caregivers are at risk for emotional exhaustion from their work and in any level or all degrees described by the constructs proposed in the literature (Badger, 2000). Figley (1999) stated that "The capacity for compassion and empathy seems to be at the core of our ability to do the work and at the core of our ability to be wounded by the work" (p. xv). Stamm (1999) warned that we may begin our careers with the illusion that we will be protected from the pain and loss of those we care for by our educational preparation and our "white coats," believing that our educational training, our clinical work, our research, or our teaching will help us keep our balance and objectivity. Figley (1999) stressed that compassion fatigue, vicarious trauma, and secondary traumatic stress are natural, predictable, treatable, and unpreventable consequences of working with suffering and traumatized patients.

Stress and coping theories commonly assert that it is not the stressors themselves but how the individual responds to them that influences stress and coping responses (Lazarus & Folkman, 1984). Adaptive coping responses are viewed as action-oriented, problem-solving approaches. Ultimately, can the nurse identify and feel effective to modify, adapt, and change within the work environment to meet the challenges? If not, the chronic stress, disillusionment, and frustration may lead to ineffective coping responses and use of defensive mechanisms such as avoidance approaches (e.g., withdrawal, apathy, food or substance abuse). E.P. began to withdraw from her husband in addition to feeling disappointment about her children's lack of support. Personal stressors, a lack of adequate

support systems, and personal trauma will all place the nurse caregiver at a higher risk for compassion fatigue.

Understanding the countertransference between the caregiver and the patient is important when speaking about vicarious trauma or secondary traumatic stress. In psychodynamic therapy, countertransference is the emotional reaction to the patient by the therapist because of a process by which the therapist sees oneself or one's past experiences played out by the patient. The issue is the risk of overidentifying with the patient or attempting to meet one's personal needs through the patient (Figley, 1999, 2002). In the case study, E.P. is experiencing anticipatory grief related to her mother's illness, cognitive deterioration, and imminent death.

Research has identified that organizational stressors, such as the workplace, role ambiguity, and workload, contribute to nursing burnout. Prolonged exposures to stressful environments that consist of low staffing and a lack of administrative and colleague support keep nurses in a constant state of alertness and isolation that eventually create physical and mental exhaustion (Cohen, 1995; Duquette, Kerouac, Sandu, & Beaudet, 1994; Medland, Howard-Rubin, & Whitaker, 2004). Studies on sociodemographic factors have not demonstrated that gender, employment status, specialty units, or educational preparation contribute to burnout. Interestingly, age has been found to be positively correlated with burnout, with younger nurses being most vulnerable, possibly because they are unprepared for role ambiguity, heavy workloads, and changing environments (Duquette et al.). In a review of research to identify workplace stress associated with oncology caregivers, identified stressors included physician- and coworker-related stress, organizational and environmental factors, inadequate resources, and emotional stress (e.g., observing suffering), ethical issues, low self-esteem, and death and dying (Medland et al.).

Nurses who are idealistic, highly motivated, and committed also are at high risk to experience burnout and compassion fatigue, possibly the result of the cumulative losses they experience that cause disappointment and despair or if they perceive that they are not moving toward their care goals and do not feel effective in changing the environment to do so. For these reasons, idealistic, highly motivated, and highly empathic helpers often are the first to burn out, as does a bright flame by virtue of its intensity (Larson, 1993). On-

cology nurses who work in palliative care are at an increased risk for compassion fatigue and secondary trauma because they experience multiple deaths within a short period of time. The associated grief and loss can lead to depression and chronic grief reactions (Vachon, 2001). Vachon has described oncology caregivers as "wounded healers." In a personal journal of her experiences in palliative care medicine, Mulder (2000) described the healing and wisdom gained amidst the suffering of palliative care and reflected on the adage, "healer, heal thyself."

Compassionate Care for the Self

Stebnicki (2008) stated, "In traditional Native American teaching, it is said that each time you heal someone you give away a piece of yourself until, at some point, you will require healing" (p. 3). Empathic engagement is essential to the healing process in disciplines such as nursing, medicine, and psychotherapy. Stebnicki stressed that caregiving professionals must prepare their minds, bodies, souls, and spirits to become resilient in working with patients at intense levels of interpersonal functioning. Stebnicki expanded upon the fatigue syndromes and has coined the term "empathy fatigue." He investigated the interaction of variables that influence empathy fatigue, including caregiver personality traits (e.g., resiliency), coping resources, age, developmental experience, and, ultimately, the inter-relationship between the caregiver's mind, body, and spiritual development. Stebnicki emphasized that empathy is a way of being and a form of communication; that caregivers develop the skills of empathic engagement is essential: positive beliefs about themselves as well as their patients, a healthy self-concept, embracing values that respect other people and cultures, and the capability to listen to and understand the needs of others.

To avoid end points of the continuum between emotional overinvolvement with patients to the other extreme of emotional distance or burnout, the key may be compassionate care for the self and "balanced" empathy (Larson & Bush, 2006). What may contribute to the long-term coping resources of many oncology nurses is what they learn from the patients themselves. Oncology nurses learn about courage and resiliency from many of their patients who transform their adversity into challenge and who find hope in often hopeless situations (Larson & Bush). Nurses must be as

compassionate, understanding, and forgiving of themselves as they are for their patients and loved ones; balancing their giving to others with giving to themselves. Welsh (1999) called this "practicing responsible selfishness." As highly motivated and committed caregivers, nurses must engage in activities that comfort, restore, and rejuvenate empathic caring. Hill (1991) proposed that, for caregivers to be most helpful to their patients, they must use reflection and inner awareness to attend to the emotional needs of their inner lives. A shared "duality" of time and life exist with patients—the existential concerns and the blessing and burden of searching for life's meaning. Both are central themes in the lives of patients experiencing cancer and nurses experience the illness through empathic engagement. The patient with cancer often asks, "Why me?" and the oncology caregiver often asks "Why not me?" (Hill).

Empathy can be viewed as a double-edged sword, an honorable personality trait and a point of vulnerability at the same time (Larson & Bush, 2006). The compassionate qualities that attract oncology nurses to their profession are the same ones that make them vulnerable to burnout, vicarious trauma, or secondary traumatic stress over the long haul. Preventive self-care strategies are essential ingredients for professional survival and also are necessary for personal growth. Only when nurses take time to heal themselves can they be truly available to aid in the healing of others. The major preventive self-care tasks are well understood by the majority of nurse caregivers: exercising, relaxation, maintaining adequate sleep and nutrition, and reaching out for support from others. Why are these strategies so difficult to maintain on an ongoing basis? It may be because

the strategies are straightforward and simplistic and do not touch upon the deeply spiritual needs that are essential for self-care. Prevention and treatment of compassion fatigue must begin with care for, protection of, and healing of the spirit (see Figure 2). Nurses should continue to work with compassion, vulnerability, and tenderness but learn how to manage sadness in growth-enhancing rather than destructive ways. Nurses should be alert to countertransference reactions and symptoms of vicarious trauma, such as overinvolvement or withdrawal. Learn to set boundaries and limits; learn to reach out for support from coworkers, peers, family, and friends. Apply action-oriented, problem-solving behaviors to find solutions to the stressful healthcare environment and how to deliver the best quality care with the resources available. Do your best—what Larson and Bush (2006) called practicing the art of the possible. Lastly, learning forgiveness and self-love is inherent in healing and preventing compassion fatigue. Being gentle, kind, and patient with themselves is one way nurses can effectively cope. Nurses should treat themselves with the empathy and compassion that they give others.

Nancy Jo Bush, RN, MN, MA, AOCN®, is an assistant clinical professor in the School of Nursing at the University of California, Los Angeles. No financial relationships to disclose. Bush can be reached at nancyjobushrn@aol.com, with copy to editor at ONFEditor@ons.org.

Digital Object Identifier: 10.1188/09.ONF.24-28

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Badger, J.M. (2000). Understanding secondary traumatic stress. *American Journal of Nursing*, 101(7), 26–32.
- Cohen, M.Z. (1995). The meaning of cancer and oncology nursing: Link to effective care. *Seminars in Oncology Nursing*, 11(1), 59–67.
- Duquette, A., Kerouac, S., Sandu, B.K., & Beaudet, L. (1994). Factors related to nursing burnout: A review of empirical knowledge. *Issues in Mental Health Nursing*, 15(4), 337–358.
- Figley, C.R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 3–29). Lutherville, MD: Sidran Press.
- Figley, C.R. (2002). *Treating compassion fatigue*. New York: Brunner-Routledge.
- Freudenberger, H.J. (1974). Staff burnout. *Journal of Social Issues*, 30(1), 159–165.
- Hill, H.R. (1991). Point and counterpoint: Relationships in oncology care. *Journal of Psychosocial Oncology*, 9(2), 97–112.
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116–121.
- Larson, D.G. (1993). *The helper's journey: Working with people facing grief, loss, and life-threatening illness*. Champaign, IL: Research Press.
- Larson, D.G., & Bush, N.J. (2006). Stress management for oncology nurses: Finding a healing balance. In R. Carroll-Johnson, L. Gorman, & N.J. Bush (Eds.), *Psychosocial nursing along the cancer continuum* (pp. 587–601). Pittsburgh, PA: Oncology Nursing Society.
- Lazarus, R.A., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Lederberg, M.S. (1998). Oncology staff stress and related interventions. In J.C. Holland (Ed.), *Psycho-oncology* (pp. 1035–1048). New York: Oxford University Press.
- Lewin, R.A. (1996). *Compassion: The core value that animates psychotherapy*. Northvale, NJ: Jason Aronson.
- Maslach, C. (1993). Burnout: A multidimensional perspective. In W.B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 19–32). Washington, DC: Taylor and Francis.
- Maslach, C., Schaufeli, W.B., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422.
- Medland, J., Howard-Rubin, J., & Whitaker, E. (2004). Fostering psychosocial wellness in oncology nurses: Addressing burnout and social support in the workplace. *Oncology Nursing Forum*, 31(1), 47–54.
- Mulder, J. (2000). Transforming experience into wisdom: Healing amidst suffering. *Journal of Palliative Care*, 16(2), 25–29.
- Saakvitne, K.W., & Pearlman, L.A. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. New York: W.W. Norton.
- Stamm, B.H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.). Lutherville, MD: Sidran Press.
- Stebnicki, M.A. (2008). *Empathic fatigue: Healing the mind, body, and spirit of professional counselors*. New York: Springer.
- Vachon, M.L. (2001). The nurse's role: The world of palliative care nursing. In B.R. Ferrell & N. Coyle (Eds.), *Textbook of palliative nursing* (pp. 647–662). New York: Oxford University Press.
- Welsh, D.J. (1999). Care for the caregiver: Strategies for avoiding "compassion fatigue." *Clinical Journal of Oncology Nursing*, 3(4), 183–184.

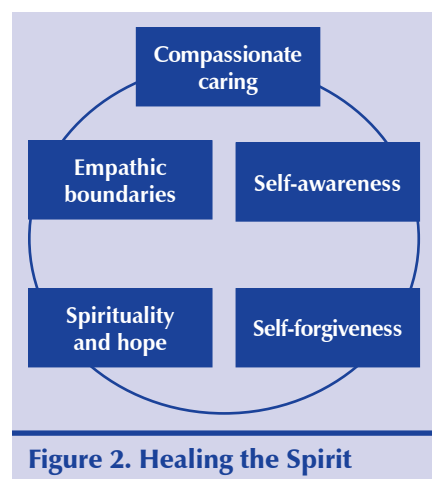


Figure 2. Healing the Spirit

Clinical Highlights: Compassion Fatigue

Definition

Compassion fatigue refers to an emotional state with negative psychological and physical consequences that emanate from acute or prolonged caregiving of people stricken by intense trauma, suffering, or misfortune. Compassion fatigue occurs when emotional boundaries become blurred and the caregiver unconsciously absorbs the distress, anxiety, fears, and trauma of the patient (also termed countertransference). The cumulative effects of untreated compassion fatigue can have a negative effect on personal and professional psychological, physical, social, and work-related health. Depending upon empirical research and the discipline, compassion fatigue also has been interchangeably described as burnout, vicarious traumatization, secondary traumatic stress, and empathy fatigue.

Pathophysiology

Stress and coping theories commonly assert that the appraisal of a situation as stressful or threatening and individuals' perceptions of their ability to cope with the situation ultimately determine their response. If caregivers appraise their personal-life or work-environment demands and exceed their abilities to cope effectively, ultimately, they may be functioning in a constant state of alertness such as "fight or flight" stimulation. If chronic stress continues, individuals may use ineffective coping strategies to self-medicate their emotional and physical pain with defensive or avoidant strategies (e.g., alcohol or substance abuse, risky behaviors, isolation or withdrawal) or become apathetic, cynical, angry, or depressed.

Risk Factors

Caregivers who inherently demonstrate the ability to show compassion and express empathy are at the greatest risk for compassion fatigue when exposed to cumulative grief and loss in their work (Figley, 1995). Oncology nurses enter the field to be healers but are faced with multiple losses, trauma, and grief despite their best efforts. The oncology nursing specialty forces nurses to face the same existential issues confronting patients and serve as a constant reminder of their own mortality and the fragile hold on life (Hill, 1991). Sociodemographic variables,

such as stressful work environments, lack of social support systems, and personal life stressors and experiences, also may leave a caregiver more vulnerable.

Clinical Presentation

Symptoms of compassion fatigue can occur on a continuum from acute to chronic and affect seven domains: cognitive, emotional, behavioral, personal relations, somatic, work performance, and spiritual (Figley, 2002). Cognitive symptoms may include decreased concentration, low self-esteem, and apathy. Emotional symptoms may range from feelings of anxiety, guilt, and anger to feelings of powerlessness and helplessness. Often the most noticeable behavioral symptoms include irritability, moodiness, appetite changes, and sleep disturbances. Relationships suffer when an individual experiences compassion fatigue. Symptoms of withdrawal, mistrust, and isolation serve to exacerbate the loneliness the nurse is experiencing. Somatic complaints may range from generalized aches and pains to impaired immunity. All of the symptoms can have a negative effect on work performance, including exhaustion, low motivation, absenteeism, and detachment or apathy. The nurse may start to question the meaning of life, his or her own purpose in life, and question the very belief systems, values, and commitment that provide feelings of emotional safety and trust.

Treatment

Hill (1991) proposed that, for caregivers to provide healing to their patients, they must use reflection and inner awareness to attend to their spiritual lives. Each individual nurse must learn to recognize his or her own coping mechanisms and to find a balance of mental and physical health. Buffering factors to prevent compassion fatigue include the use of problem-solving coping strategies, hardiness, and social support. Effective coping includes positive reappraisal, self-control, and seeking support from others. Certain individuals demonstrate personality traits such as openness to change or challenge, a capacity to commit to personal goals, and feeling control over themselves and their situations (Duquette, Kerouac, Sandu, & Beaudet, 1994). Social support in the workplace that protects against compassion fatigue includes the support of colleagues and

superiors. Nurses often feel that identifying their own emotional needs are signs of weakness or failure. By expressing and sharing emotional angst with colleagues, friends, and family, the nurse has the opportunity to problem-solve and reflect. Reaching out to others also helps the nurse normalize feelings and let go of self-blame and guilt. In cases of cumulative grief and what Levine (2005) terms "unattended sorrow," psychotherapy is a very effective treatment for healing.

Implications for Nursing

Nurses heal with compassion and empathic engagement with their patients and, "... we must bear loss as deeply as we cared" (Levine, 2005, p. 15). Oncology healthcare professionals at all levels must support each other, respect the contributions of all involved in oncology care, and reach out to others, particularly nurses in need of nurturing and renewal. Nursing research is required to identify the most pressing variables affecting the occurrence of compassion fatigue and delineate the association between personal stressors, professional stressors, and workplace stressors that contribute to specific negative behaviors and somatic complaints. The information could be used in educational programs to prepare new oncology nurses for the exposure to suffering and to provide treatment programs and supportive measures to prevent what Levine calls "the wounding of hope" (p. 27).

References

- Duquette, A., Kerouac, S., Sandu, B.K., & Beaudet, L. (1994). Factors related to nursing burnout: A review of empirical knowledge. *Issues in Mental Health Nursing*, 15(4), 337-358.
- Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.
- Figley, C.R. (2002). *Treating compassion fatigue*. New York: Brunner-Routledge.
- Hill, H.R. (1991). Point and counterpoint: Relationships in oncology care. *Journal of Psychosocial Oncology*, 9(2), 97-112.
- Levine, S. (2005). *Unattended sorrow: Recovering from loss and reviving the heart*. New York: Holtzbrinck.