

Helping Nurses Cope With Grief and Compassion Fatigue: An Educational Intervention

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Oncology nurses may experience intense physical and emotional exhaustion, identified in the literature as symptoms of cumulative grief and compassion fatigue, with significant consequences for both nurses and organizations. The first step in preventing these consequences is recognition. Organizations should provide nurses with resources including education, counseling, and opportunities to grieve. Nurses need to learn the importance of work-life balance, self-care strategies, and communication skills. Using recommendations from the literature, an educational intervention was designed with the purpose of providing nurses with knowledge, skills, and resources to practice effective self-care and recognize when assistance is needed. The program's objective was to help nurses develop the coping skills and inner resources necessary to maintain their emotional and physical health.

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Close, personal relationships often develop between nurses and patients with cancer throughout the course of treatment. When patients die, nurses may experience an overwhelming sense of grief and loss (Aycock & Boyle, 2009). Medland, Howard-Ruben, and Whitaker (2004) noted that many nurses ignore these feelings, and unrecognized and unaddressed grief may become chronic and cumulative (Aycock & Boyle, 2009; Marino, 1998).

Cumulative loss may contribute to the development of compassion fatigue, a term that has been used to describe the physical, emotional, and spiritual exhaustion resulting from caring for patients and witnessing pain and suffering (Aycock & Boyle, 2009). This exhaustion is often associated with the loss of ability to provide compassionate care (Joinson, 1992), a decrease in quality of patient care, and decisions to leave the workplace (Meadors & Lamson, 2008; Medland et al., 2004). Despite these significant consequences, few institutions offer support for nurses experiencing cumulative grief or compassion fatigue (Boyle, 2011; Shinbara & Olson, 2010).

The authors' institution is a 572-bed, Magnet®-designated community hospital in the northeastern United States. To date, no specific programs exist to assist nurses struggling

with cumulative grief or compassion fatigue. In an effort to support oncology nurses, group counseling in the form of a support group was provided in the past, but was discontinued because of attrition. A few years later, an attempt to integrate a remembrance ceremony into staff meetings failed, as nurses reported a preference for handling grief alone. The organization's employee assistance program (EAP) offers six free counseling sessions for employees who desire them, and the pastoral care department also offers supportive care on request. However, how many nurses use these services is not known.

Following a literature review, which revealed the importance of support for nurses frequently exposed to death and dying (Brosche, 2003; Dunn, Otten, & Stephens, 2005) and a concern for nurse's emotional well-being, a needs assessment was conducted in 2009. Because several years had elapsed since the remembrance ceremonies were discontinued, nursing leadership wanted to determine if nurses' feelings had changed regarding grieving preferences. The purpose of the assessment was to evaluate the assistance nurses preferred to effectively design a support program. After approval from the institutional review board (IRB), a survey tool was developed and distributed to nurses on the inpatient oncology unit (n = 32), and 21 nurses

responded. Nurses were asked if they preferred to handle grief alone or participate in group settings such as counseling or support groups. Fourteen nurses indicated a preference to grieve alone. Seven nurses indicated a preference for group support; however, six of those stated that informal sharing with a friend or close colleague was preferable to a larger group. With this information, and respecting nurses' preferences to grieve alone, a decision was made to explore interventions that would support nurses in the manner they wished to grieve and provide tools and resources to recognize and combat symptoms of cumulative grief and compassion fatigue.

Literature Review

Vachon (2001), described nurses as wounded healers. 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). Although caring and compassion are at the heart of relationships between nurses and patients, and can positively affect patient care, there may be a "cost to caring" (Boyle, 2011). Nurses grieve when patients die (Lally, 2005), and when this grief is recognized, addressed, and supported, nurses cope by finding meaning in the loss according to their worldview of life and death. This appropriately recognized grief facilitates the delivery of caring, compassionate patient care, and healthy relationships (Shinbara & Olson, 2010). However, unacknowledged grief has been described as a "powder keg," in that the effects of not recognizing and coping with it may "explode" at any time (Wakefield, 2000).

Another consequence of caring for suffering patients is the development of compassion fatigue. Radley and Figley (2007) describe compassion as the "awareness of the suffering of another coupled with the wish to relieve it" (p. 207). When nurses show compassion while caring for patients who are dying or suffering on a daily basis, a state of exhaustion often described as "running on empty," or compassion fatigue, may result (Austin, Goble, Leier, & Byrne, 2009).

Consequences of Unresolved Grief and Compassion Fatigue

Symptoms of cumulative grief may include physical illness, substance abuse, suicidal thoughts, apathy, poor self-esteem, depression, and anxiety (Brosche, 2003; Conte, 2012; Feldstein & Gemma, 1995). The effects of cumulative grief may cause nurses to detach emotionally, or overinvest in patients' lives, which may lead to the development of compassion fatigue (Boyle, 2011). The effects of compassion fatigue may include extreme weariness, poor performance, and multiple physical complaints. Emotional effects include lack of enthusiasm, depression, desensitization, irritability, feeling emotionally overwhelmed, and loss of ability to enjoy life (Coetzee & Kloppe, 2010). Physical complaints may include gastrointestinal disturbances, headaches, weight gain, and sleep disturbances (Aycock & Boyle, 2009; Showalter, 2010).

Bush (2009) identified symptoms of emotionally exhausted caregivers that are similar to those experiencing post-traumatic stress disorder, such as recurrent recollections, distressing

Organizational Responsibilities

- Allow time and opportunities for grieving—meditation areas, memory boards or books, and remembrance ceremonies.
- Ensure outlets for sharing emotional expressions, such as closure conferences, debriefings, retreats, professional counseling, and pastoral care.
- Offer education on grief theories, compassion fatigue, end-of-life care, and communication.

Personal Responsibilities

- Recognize feelings of grief and loss, allowing time to grieve.
- Identify ways to renew personal strength and well-being (e.g., spirituality, music, yoga, relaxation).
- Find activities that bring comfort and refreshment.
- Maintain physical health.
- Develop an appropriate work-life balance.
- Build positive relationships in personal and professional lives.
- Seek professional help when needed.
- Recognize the positive impact nurses have on patients and families.

FIGURE 1. Interventions for Recognizing and Combating Cumulative Grief and Compassion Fatigue

Note. Based on information from Aycock & Boyle, 2009.

dreams, and anxiety, as well as physical symptoms such as irritability, difficulty concentrating, and insomnia. Unresolved cumulative grief and compassion fatigue can have consequences for an organization in terms of increases in absenteeism, performance issues, decreased quality of patient care, interpersonal issues, and increased staff turnover (Aycock & Boyle, 2009; Coetzee & Kloppe, 2010; Shinbara & Olson, 2010; Showalter, 2010).

Coping With Grief and Compassion Fatigue

Strategies for preventing and managing the effects of cumulative grief also are recommended to prevent and treat compassion fatigue (Bush & Boyle, 2012). The literature calls for nurses to strive for work-life balance (Boyle, 2011; Radziewicz, 2001) and to practice "relentless self-care" (Wakefield, 2000, p. 245). Boyle (2006) stressed the need for nurses to make sustaining emotional health a "mandatory competency" (p. 11). Nurses need to find activities and practices that replenish, comfort, and rejuvenate the spirit (Bush, 2009). These activities may include exercise, family or religious activities, journaling, spirituality, or whatever promotes rest and comfort (Austin et al., 2009; Britt Pipe & Bortz, 2009; Showalter, 2010). Kearney, Weininger, Vachon, Harrison, and Mount (2009) noted the importance of establishing a method of shedding the professional role at the end of the day. Rituals such as putting away a stethoscope, changing clothes, or putting on music may help facilitate the transition between work and home.

Daily spiritual experiences, such as faith and religion, may protect nurses from the physical and emotional effects of cumulative grief and compassion fatigue and help nurses self-heal (Aycock & Boyle, 2009; Shinbara & Olson, 2010). Access to institutional pastoral care services is an important aspect of spiritual care and should be available to nurses. For some nurses, spiritual practices such as meditation, journaling, prayer, and quiet time may be therapeutic (Maytum, Heiman, & Garwick, 2004; Britt Pipe & Bortz, 2009). Holistic practices, such as yoga, tai chi,

meditation, Reiki, relaxation exercises, and music, are effective self-care strategies and may help nurses rejuvenate and self-heal (Brathovde, 2006; Showalter, 2010).

Acknowledging individual deaths by attending funerals and sending sympathy cards may help nurses grieve appropriately (Medland et al., 2004). Fetter (2012) described a remembrance tree developed by an inpatient oncology unit. The purpose of this project was to acknowledge individual patient deaths and facilitate sharing of memories, hopefully helping nurses find peace and closure.

Nurses often feel isolated and unable to share feelings of loss when patients die (Papadatou, 2000). This perception of inadequate emotional support may lead to decisions to leave the profession or the work setting (Shinbara & Olsen, 2010). Opportunities to discuss emotions may help nurses realize that these feelings are common and expected (Lally, 2005). Optimally, organizations will provide access to formal programs offering emotional support after multiple or difficult deaths, as well as opportunities to interact with other professionals (Papadatou, 2000). Examples of these opportunities include structured support groups, closure conferences, or debriefings. These interactions should be led by trained professionals and encourage staff to share helpful coping strategies with other team members (Keene, Hutton, Hall, & Rushton, 2010; Medland et al., 2004). Brosche (2003) described grief teams that are present at the time of death and shortly afterward to help support nurses. Access to professional counseling is recommended if nurses have difficulty dealing with grief feelings or have exhibited symptoms of compassion fatigue (Aycock & Boyle, 2009; Luquette, 2005). Aycock and Boyle (2009) recommend that EAPs provide counselors who are experienced with the needs of nurses experiencing cumulative grief and compassion fatigue. Professional counseling outside of the normal three to six sessions provided by EAP counselors or referral to a psychiatric nurse liaison may be necessary for some nurses (Boyle, 2011). Luquette (2005) recommends onsite counseling to promote close relationships with staff; however, this is not feasible in all institutions.

End-of-life education, grief theories, and strategies for coping with feelings of loss should be provided for nurses who consistently care for patients with cancer (Conte, 2012; Medland et al., 2004). Boyle (2011), along with Meadors and Lamson (2008), emphasized the importance of education in the areas of identifying, combating, and treating compassion fatigue. Communication skills, particularly those that help nurses learn how to ask for support and handle conversations with patients and families, are essential (Boyle 2000; Caton & Klemm, 2006).

Educational Program

The 2009 survey indicated that most nurses did not desire formal grief support, preferring instead to rely on informal support such as conversations with close colleagues or friends, as previously described by Spencer (1994). However, nursing leadership agreed that nurses may benefit from a program designed to provide the tools to recognize, avoid, and combat the effects of cumulative grief and compassion fatigue. The program goal was to help nurses develop strategies to stay physically and emotionally healthy, as recommended by Wakefield (2000). A three-

hour educational program titled "Running on Empty? How to Rejuvenate, Recharge and Refill" was designed. The title of the program was derived from Austin et al.'s (2009) description of nurse's feelings of exhaustion and weariness when constantly caring for dying patients. Because the stress of caring for these patients is not unique to oncology nurses, the program was offered to all hospital and outpatient nurses. Thirty-four nurses attended, with the class composed of inpatient and outpatient oncology, palliative care, and medical-surgical nurses. Continuing education credits were awarded by the Oncology Nursing Society. The program was divided into three one-hour sections: Cumulative Grief and Compassion Fatigue, Holistic Self-Care, and Spiritual Self-Care. Class content was based on recommendations from current literature concerning cumulative grief and compassion fatigue.

Cumulative Grief and Compassion Fatigue

The first step in recognizing and combating the symptoms of cumulative grief and compassion fatigue is acknowledgment. Definitions, significance, symptoms, and consequences of unresolved cumulative grief and compassion fatigue were presented. Steps in the normal grieving process were explored, using Worden's (1982) tasks for grieving. The impact of unresolved grief on patient care, as well as personal well-being, was emphasized (Showalter, 2010). Obstacles to healthy grieving, such as hiding grief reactions, insufficient time to process grief, inadequate social support from colleagues, and problems with facing individual mortality, were discussed (Papadatou, 2000). Saunders and Valente's (1994) exercises to help nurses examine individual thoughts concerning grief, bereavement, and mortality were distributed as handouts. Nurses were encouraged to identify personal obstacles to acknowledging grief, such as personality type, previous experiences with death and grief, and general coping strategies (Papadatou, 2000).

Strategies for survival were presented, including suggestions for transitioning from work to home (Kearney et al., 2009), developing social supports, using humor, and realizing the positive impact nurses have on patients' lives (Aycock & Boyle, 2009; Papadatou, 2000). Spirituality, faith, and religion were reviewed as ways to deal with grief and its effects (Shinbara & Olsen, 2010). Personal and professional priority setting was presented, with an emphasis on work-life balance, boundary setting, spiritual well-being, and self-care strategies (Bush, 2009). Nurses participated in an activity designed to help organize priorities in both personal and professional settings. Following suggestions from the literature, nurses were encouraged to develop positive, supportive relationships with each other, encouraging and recognizing the impact this may have on clinicians and patients.

Work-setting interventions identified in the literature were described. Programs identified in the literature, such as staff retreats, grief teams, support groups, get-togethers, and debriefings, were presented, and rituals such as funeral attendance, sending sympathy cards, and memory books were suggested as opportunities to grieve (Medland et al., 2004). The importance of obtaining professional help for unresolved grief and distress related to compassion fatigue was emphasized (Luquette, 2005). Contact information for institutional resources such

Implications for Practice

- ▶ Be aware that cumulative grief and compassion fatigue may significantly affect nurses' health, as well as patient care.
- ▶ Acknowledge the existence of cumulative grief and compassion fatigue.
- ▶ Maintain physical and emotional health by incorporating effective self-care strategies into one's routine.

as the EAP and pastoral care department was provided. At the end of the presentation, nurses divided into focus groups based on their work setting (inpatient, outpatient, or non-oncology area). Thoughtful discussions took place concerning nurses' experiences with grief and compassion fatigue, coping skills, and beneficial services from the organization. Although nurses had previously indicated a preference to grieve alone, it was evident from these discussions that nurses recognized the need for self-care and, therefore, felt more comfortable asking for help.

Holistic Self-Care

Many authors have emphasized the importance of self-care and work-life balance in preventing and combating cumulative grief and compassion fatigue. This session was dedicated to teaching nurses the importance of self-care and work-life balance. The concept of holistic health for the whole person—mind, body, and spirit—was introduced. Finding activities that refresh, rejuvenate, and satisfy was emphasized. The physiologic effect of stress and consequences on the body was included. Nurses participated in demonstrations of breathing techniques, guided imagery, simple stretches, and self-massage. The speaker for this session emphasized the benefit of therapeutic touch by encouraging participants to massage each other's hands while speaking to each other in a calm manner (Kunikata, Watanabe, Miyoski, & Tanioka, 2012). Nurses recognized the calming and soothing effects of this exercise and stated that it would be a therapeutic activity for each other and for patients. Strategies for incorporating self-care activities into a daily routine were presented, as well as the benefits of yoga, massage, and meditation (Showalter, 2010). The importance of basic self-care, such as adequate rest, sleep, and nutrition, was emphasized. Handouts containing instructions for stretching exercises and relaxation exercises were given to participants. In post-class evaluations, nurses stated they enjoyed this portion of the class and realized the importance of self-care activities.

Spiritual Self-Care

This session focused on self-awareness and meditation. The art and science of Reiki was presented and defined as a tool to promote spiritual health. The speaker for this class introduced and discussed chakras, or energy wheels, and how to use color and visualizations in self-healing. The focus of this session was to give nurses the tools to recognize and heal disturbances in energy fields to promote self-care and self-love, as advocated by Brathovde (2006). A demonstration and explanation of Reiki was given, with emphasis on releasing blocked energy fields in the body. The instructor's goal was to leave nurses renewed, refreshed, and with the ability to practice self-healing whenever

needed. Nurses reported feeling an ambience of peace and contentment in the room following this segment of the class and felt these skills would be beneficial for relaxation and self-healing.

Nurses were provided with a packet of handouts to use as resources for information and support. Literature provided by the authors' EAP included information on handling stress, humor in the workplace, and nutrition, as well as contact information. The Professional Quality of Life Scale (Stamm, 2012) was given to nurses for individual assessments of compassion fatigue and need for professional assistance. A compilation of holistic services available in the area was provided. Also included was an extensive reading list so that nurse could seek additional information in the areas of professional grief and compassion fatigue.

Implications for Practice and Conclusion

The purpose of this educational program was to equip nurses with tools and resources for self-care, as well as the ability to articulate helpful institutional resources. In post-class evaluations, nurses stated that they appreciated the focus on self-care and realized the need to make maintaining emotional health a priority. Nurses reportedly felt less isolated in the grieving process and were more likely to ask for help when needed.

The program presented the opportunity to discuss other activities to support nurses, including remembrances for patients, or professional assistance, such as group debriefings or grief teams. Additional educational interventions to help educate and support nurses may be explored to reach additional oncology and non-oncology nurses. Because staff turnover has occurred on the oncology unit since the 2009 study, an additional survey may be helpful to determine if nurses' grieving preferences and desire for support have changed. Additional support services in the form of closure conferences or grief teams could be facilitated if requested by nurses. Recognizing that this educational program is not a comprehensive solution to resolving the complex issues of cumulative grief and compassion fatigue, it is anticipated that nurses will feel better prepared to recognize the issues, commit to striving for better self-care, and recognize when professional assistance is needed.

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