# COMPASSION FATIGUE AND SECONDARY TRAUMATIC STRESS IN NURSES

By

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**Abstract**

Compassion fatigue and secondary traumatic stress are two risks associated with caring careers such healthcare and can result in a reduced ability to show compassion for patients. These can be juxtaposed by compassion satisfaction which can arise in similar situations but is characterized by increased ability to care and positive attitudes toward a caring role. While the literature currently describes these phenomena in depth, there are currently no emic case studies that show the conditions directly from a nurse's perspective. Two interviews were performed with hospice nurses to gain insight into the potential risk factors faced by nurses on a daily basis and what qualities or coping mechanisms may predispose them to dealing with stress and emotional situations in a more positive fashion. Several suggestions for interventions are identified as a result of these interviews.

**Keywords**

*Compassion fatigue, compassion satisfaction, secondary traumatic stress, nurses, hospice, case study, interview*

## Introduction and Statement of Relevance

In recent years, shortages in the nursing community have led to workplace environments that are less than ideal. Nurses have been finding themselves in situations where they are understaffed and overworked. This inevitably takes a toll on their ability to perform some of their most basic duties: to care, show compassion, and facilitate positive patient outcomes (Sabo, 2006). While nurses are trained to demonstrate the utmost compassion for their patients, this ability may be compromised when they are forced to deal with loss rapidly in order to keep up with a rising patient to nurse ratio. With 3.1 million nurses in the United States according to a 2008 survey by the American Nurses Association, there is a great need for a better understanding of the psychological risks faced by nurses (Fact, 2011).

## Review of the Literature

The concepts labeled compassion fatigue and secondary traumatic stress are prime examples of the psychological and emotional risks to nurses currently present in the literature. This literature review seeks to explore the current knowledge of compassion fatigue (CF) and secondary traumatic stress (STS) and their effects within the nursing profession. This will include an examination of the situations or triggers that may contribute to the onset of CF or STS, the symptoms experienced, and any current systems in place to assist nurses in dealing with CF and STS.

### *Defining Compassion Fatigue and Secondary Traumatic Stress*

Compassion is defined as a deep sense or quality of knowing or "awareness of the suffering of another coupled with the wish to relieve it (Radey, 2007, p. 207). Compassion fatigue, an experience commonly found within many healthcare professions, is a problem for

nurses because it inhibits their ability to perform basic caring functions involving compassion toward their patients. Slocum-Gori, et al. define it as the emotional cost of caring or a stress response that emerges suddenly and without warning and includes a sense of helplessness, isolation, and confusion (Slocum-Gori, 2013, p.173). It was similarly described as a phenomena characterized by physical and psychological exhaustion resulting from excessive professional demands that drain available personal resources (Leon, 1999, p.43). Current research can be a bit confusing though, in that there does not appear to be one simple, universal definition of CF. Adams et al. and other authors such as Figley define it as having a more intimate connection to trauma (Adams, 2007). In one article, it is defined as the formal caregiver's reduced capacity or interest in being empathic or "bearing the suffering of clients" and is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (Adams,2007, p.239).

Despite the incongruences in the definitions it is clear that certain symptoms and signs are characteristic of compassion fatigue. These can include lack of energy, burnout, emotional breakdowns, apathy, indifference, poor judgment, and becoming more accident prone (Coetzee, 2010). Other symptoms described are feelings of hopelessness & job dissatisfaction (Leon, 1999), languishing (Radey, 2007), distancing from suffering, anger, and difficulty bouncing back (Austin, 2009).

Coetzee and Klopper originally used the term "compassion fatigue" to describe the phenomenon of nurses losing the ability to nurture (Coetzee, 2010). So where does this phenomenon arise? Figley explained the onset of compassion fatigue as being the direct result of exposure to a client's suffering that is complicated by a lack of support in the workplace and at home. He also described poor self-care, previous unresolved trauma, the inability or refusal to

control work stressors, and a lack of work satisfaction as being contributors when speaking about CF in social workers (Figley, 1995). This statement seems to indicate that some features can be both contributors and symptoms. This is likely due to the idea that compassion fatigue can be present in varying degrees. Coetzee and Klopper propose a progression from "a state of compassion discomfort to compassion stress and, finally, to compassion fatigue" (Coetzee, 2010, p. 235). They claim that it is critical to gear interventions toward the earlier stages of compassion discomfort and stress to avoid permanent alteration of a nurse's ability to show compassion toward patients (Coetzee, 2010, p. 235).

Secondary traumatic stress seems to be defined a bit differently on its own, though its definitions resemble some of those used for CF. STS is defined as the emotions and behaviors that a person experiences as a result of being exposed to another person's traumatic experience (Von Rueden, 2010). It falls under the category of PTSD (Post Traumatic Stress Disorder) but is different in that a person suffering from STS does not have to be a direct participant in the traumatic event. Instead, interacting with or assisting people that were part of a large trauma can induce similar symptoms. In the context of nurses, it could be hypothesized that those involved in areas such as the emergency room are at a greater risk than other specialties as they are more likely to be exposed to such individuals. For example, those in emergency specialties frequently see victims of severe car accidents that can leave patients mangled. In large cities they are exposed to gang violence victims and cases of abuse. Many emergency rooms also are equipped to handle cases of sexual assault and rape, in which case the attending nurses and physicians are the first to hear victims' accounts of these deeply traumatizing events.

For those who face the risk of being exposed to people who recently experienced a trauma, it is important to recognize the signs and symptoms of STS. Symptoms of secondary

traumatic stress include flashbacks connected to the patient, troubling dreams, loss of sleep, intrusive thoughts (Adams, 2007), discouragement about the future, becoming upset by reminders of work or certain patients, loss of social interest, becoming more jumpy, and having gaps in memory about patients (Bride, 2004).

### *Connecting Compassion Fatigue and Secondary Traumatic Stress*

Despite the differences in individual definitions of the two experiences, CF and STS are often used as interchangeable terms in the literature. Coetzee and Klopper directly mention the use of compassion fatigue as a synonym for secondary traumatic stress and point out how this "is far removed from the original meaning of the term" (Coetzee, 2010, p.235). This is important because saying that these two experiences are the same implies that treatment and intervention could be the same. By separating CF and STS into two distinct categories, however, there is a question of whether treatment for one condition actually is interchangeable for the other or if more specialized plans should be considered. It is relevant to acknowledge that some of the symptoms reported in the current literature do overlap between CF and STS. These include feeling emotionally numb or hopeless, having a lack of energy, and increased irritability (Bride, 2004). These seem to be very limited, however, compared to the nature and amount of other, unrelated symptoms described in the literature for CF and STS. Compassion fatigue is described more as a loss of the ability to care for patients while secondary traumatic stress stems from indirect contact with trauma and the reliving or repressing of these events. It would seem then, that while compassion fatigue might be considered a possible symptom of secondary traumatic stress, secondary traumatic stress is a separate experience from that of compassion fatigue by itself based on the descriptions found in current literature.

Coetzee and Klopper's definitions of each experience do a good job of highlighting the differences. They define compassion fatigue as follows:

"Compassion fatigue is the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress. It evolves from a state of compassion discomfort, which if not effaced through adequate rest, leads to compassion stress that exceeds nurses' endurance levels and ultimately results in compassion fatigue. Compassion fatigue is a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost. All these states manifest with marked physical, social, emotional, spiritual, and intellectual changes that increase in intensity with each progressive state" (Coetzee, 2010, p. 237).

Juxtaposing this description is Coetzee and Klopper's (2010) definition of secondary traumatic stress is as follows:

"-a state of exhaustion and dysfunction (biologically, psychologically, and socially) that is manifested by recollections of traumatic memories that stimulate symptoms of post-traumatic stress disorder (PTSD) such as depression, generalized anxiety, avoidance/numbing of reminders, and persistent arousal associated with the patient. Secondary traumatic stress disorder results from prolonged exposure to secondary stress (compassion stress), where the person experiences a lack of relief from the burden of responsibility of the sufferer and the suffering and an inability to reduce the effects of secondary stress (compassion stress)" (Coetzee, 2010, p.238).

Coetzee and Klopper's use of the term compassion stress would indicate that they believe the two phenomena to be somewhat related in that they both are associated with a healthcare

workers ability to show compassion; however, they arise under different circumstances and have different associated concerns.

In fact, Coetzee and Klopper (2010) later explain:

> "Secondary traumatic stress disorder is similar to compassion fatigue, in that it shares the risk factor of contact with patients, although in STSD, the cause is due to prolonged exposure to the traumatic events and stories of others, while compassion fatigue is caused by the prolonged, intense, and continuous care of patients, use of self, and exposure to stress." (Coetzee, 2010, p. 239).

### *Addressing Compassion Fatigue and Secondary Traumatic Stress: Help and Interventions*

Due to the challenges presented by CF and STS for healthcare professionals, many hospitals and other medical facilities are recognizing the need for interventions and assistance for those experiencing symptoms. Smith uses the analogy of a kitchen sifter to describe how workers in the helping and healthcare fields deal with emotions that could lead to CF.

> "How do we process the emotions, thoughts and physical sensations that we experience upon hearing the stories of trauma and stigma that our clients share with us? Imagine this process as a kitchen sifter. As these histories are shared with us they go into the topside of the sifter. Then our self-care strategies work to turn the crank, refining and lightening the material, which passes through the underside, filtered of its deleterious effects upon us. If this process is effective then we do not experience overflow, the debilitating effects of compassion fatigue, the emotional numbing, difficulty sleeping, disturbing dreams, ceaseless rumination, memory gaps and the host of other symptoms that make up our understanding of how compassion fatigue impacts us as clinicians" (Smith, 2007, p.193).

What he seems to be describing here is the idea that healthcare workers and those exposed to difficult histories on a regular basis need to have some sort of mental system in place to work through and analyze the things they are experiencing. The first line of defense has to be the workers own mental filing system and coping strategies. The question in then, can this sort of ability be taught or is it an innate aspect of successful workers' personalities?

### *Compassion Satisfaction: The Brighter Side of Healthcare*

Compassion satisfaction is described by Coetzee and Klopper (2010) as, "the invigoration and inspiration that a nurse receives from connecting with and sharing in a patient's suffering, with the main focus being to relieve and alleviate the patient's pain through selfless use of oneself and one's skills and available resources" (Coetzee, 2010, p. 239). Cases of compassion satisfaction mimic those of compassion fatigue in that they seem to occur in workers exposed to the same risk factors; however, through some mechanism, these nurses gain a great deal of positive effects rather than accumulating negative responses and symptoms. What is different for the healthcare workers that experience compassion satisfaction from those that end up with compassion fatigue? In these situations, nurses maintain their ability to connect with their patients at an emotional level if not improve it. The difference may lie in the mindset of the nurses.

## Shortcomings in the Literature and Current Methods

Upon completion of the above literature review it becomes evident that previous studies were lacking in an important and valuable perspective. Few direct case study examples have been given to illustrate the phenomena of compassion fatigue, secondary traumatic stress, and compassion satisfaction. As the aforementioned conditions are very personal experiences it is

critical that the issues be examined from an emic approach – focusing on the perspectives of individuals who actually deal with them (Given, 2008, p.1). This insight may be crucial to development of prevention and treatment strategies along with a complete understanding of the symptoms and coping mechanisms that are triggered.

## Methods

This study sought to fill in the gap in the research by conducting one-on-one interviews with nurses. It was decided that hospice and emergency room nurses would be contacted due to the nature of the specialties. Hospice was selected due to the inherent exposure to death and dying that the nurses face. It was suspected that they might be more susceptible to compassion fatigue as a result, and that they would offer good insight as to how nurses deal with emotional situations. Emergency rooms were included due to the fact that they are unpredictable and can be hubs for trauma; both physical and emotional. The reasoning was that nurses in this line of work might be more vulnerable to secondary traumatic stress due to this exposure.

Once participants were obtained, one-on-one interviews were used to emphasize the emic perspective. These interviews were guided with a set of consistent questions but were flexible to allow the interviewer to seek clarity on certain topics or ask questions that were deemed relevant given the direction of the interview. A complete list of the questions used to guide the interviews is included in Appendix A. Each participant set up a time with the researcher over the phone for their interview, and was told that it was to last 30-60 minutes. Each interview took place over the phone and focused on the participant's experience as a nurse and the emotional side of their work. Prior to each interview, the nurses were informed that the interviews would remain

confidential and that any identifying information used in the research would be removed or altered. Each consented to this and agreed to have the interviews recorded.

Following completion of the interviews the recordings were examined, transcribed, and analyzed by the researcher. In analyzing the interviews the researcher was looking for general themes that emerged, in particular those related to the topics of compassion fatigue, secondary traumatic stress, or compassion satisfaction. Relevance to these topics was determined by discussion of signs and symptoms, triggers, or coping mechanisms similar to those described in the literature for CF, STS, and CS. These included descriptions of stressful situations and how they were handled, recurring emotions or experiences such as dreams, discussion of helpful or unhelpful resources at home and in the workplace, etc. Once identified, a list of themes was created and evidence for each was pulled from the interviews. These were then examined as a whole and conclusions were drawn regarding the presence of CR, STS, or CS for these nurses and implications were examined.

**Participants**

To recruit participants, the researcher identified various hospice facilities and hospitals with emergency rooms in the same city in the southwestern United States. Each was contacted by email (see Appendix B) or phone. No emergency room nurses responded. Two hospice nurses responded and agreed to participate in the study. Their interviews lasted 58 and 44 minutes, respectively.

The two nurses who responded each had differences in the lengths of their careers and the specific roles they filled in the hospice setting. They also had different backgrounds in the field of nursing. The first, ‘Barbara’, a female with 37 years of experience as nurse had also worked

in academic and administrative settings in addition to hospice. The second, 'Nancy' was a female who had only been a nurse for 5 years, and though she had previously been involved in bedside care in a hospice located in a different state, she was focused on the admissions side of hospice at the time of the interview. .

**Findings**

Upon analysis of the interview transcriptions, the following themes emerged.

1. Signs of compassion satisfaction (CS) were more common among the hospice nurses interviewed than were signs of compassion fatigue (CF) or secondary traumatic stress (STS). Certain situations can lead to symptoms characteristic of CF but they are often related to outside sources such as workload rather than patient care and are typically temporary.
2. Interactions with families of patients and with coworkers can be a major contributor to the occurrence of symptoms related to both CF and CS.
3. Prevention of negative emotional effects for nurses can be largely augmented by going into the career having already come to terms with one's own opinions on death and dying, ethical dilemmas, and personality traits.
4. Having the time and ability to effectively teach patients is an important part of how well nurses feel they have accomplished their job (and subsequently how high their level of job satisfaction is).
5. Keeping an awareness about putting patients first is more common in this sample than is letting emotions interfere with care. This can affect a nurse's level of self-care both in negative and positive ways.

It is important to acknowledge that these themes may not be all inclusive or completely representative due to the small sample size; however, they offer some interesting insight into the emotional experiences of hospice nurses, and possibly nurses in general.

### *Temporary Experiences with Compassion Fatigue Symptoms Do Not Detract from Overall Compassion Satisfaction*

One point that stood out in in the interviews was Barbara's description of what she describes as a very satisfying career that also had its downsides. One she briefly mentions is the physical toll that the work can have on a nurse's body due to the constant lifting of patients and moving around. She herself describes having had back surgery as a result of some of these tasks. She also describes the sometimes daunting task of keeping up with other requirements outside of patient care.

> *Barbara: Yeah, you're um, you know, you're responsible to Medicare, you're responsible to um, the financial people, you know they don't want you to have overtime and, uh, you're responsible for your electronic medical records, and uh… you-you've gotta balance um the care that you give with the requirements that you have to get done due to you know, just what's required.*

This suggests that some of the negative effects of the nursing career are derived, not so much from the emotions of patient interactions, but from heavy workloads.

However, in both Barbara's and Nancy's interviews, each nurse reported definite enjoyment of their career, distinct reasons for choosing nursing (in particular, hospice nursing), and evident satisfaction obtained through their work. Though one outside the field of nursing and hospice care might expect that the burden of dealing with the death and dying process on a daily basis could become depressing over time, this was not the case for either of these women.

When asked how she felt about her job and the work she does in the hospice setting, Nancy offered a response that clearly illustrates this idea.

> *Nancy: I personally love it. (laughs) When I, when I knew I was moving, I knew I wanted to stay in hospice. And uh, umm, I know sometimes families, and even though they're ever so grateful for your care, they also look at you and go how could you do this, isn't it depressing?*
>
> *Interviewer: Yeah.*
>
> *Nancy: And my thought is, I don't believe it's depressing, it's often times sad*
>
> *Interviewer: Okay.*
>
> *Nancy: But I believe I'm doing a service for people that-eh- I kinda say, we all know when we're born, there's nothing we know about us when we're born, we don't know if we'll be rich, poor, married, have children, travel the world, anything, we don't know. But we know we're gonna die one day.*
>
> *Interviewer: Right.*
>
> *Nancy: If you know you're gonna die, don't you wanna be able to choose that you die in comfort?*
>
> *Interviewer: Yes, yeah.*
>
> *Nancy: And I do feel that I offer that service to folks, to die a dignified and comfortable life. So I, I do love this work.*
>
> She reinforced this when asked if she felt negatively about her work in any way.

*Nancy: I don't think so, I think about a lot of the other nursing I see and I really do like hospice care. I-I couldn't see myself… doing any other field of nursing.*

She described her work as something she knew she wanted to do right out of nursing school. Her reasoning was that this specialty offered the opportunity to help patients in a unique and satisfying way that she felt sometimes wasn't possible in other areas of nursing.

*Nancy: Um and I-I'm kind of one of the unusual nurses that I never went and did floor nursing or any other kind of nursing first, I went straight into hospice,*

*Interviewer: Uh huh.*

*Nancy: Cause I think just in my, schooling I'd already seen the ki-the work I wanted to do to people.*

*Interviewer: Uh huh.*

*Nancy: Do things to them and they die ten hours later and last thing you did you shoved a hose up their nose and go lightly into their digestive track (laughs) like ugh, doesn't do it for me. So I think people-I think a lot of people just become drawn to hospice.*

*Interviewer: Ok*

*Nancy: You-you really are it's one of these things, when they say it's a calling, it really is. A lot of nurses come from ICU and ER and they get so tired after years of doing that kind of care and burning out from it and seeing bad results, they just think I wanna help people go comfortably. But people, you kinda have, I wouldn't encourage anyone to do it unless they thought they wanted to do it. Because you have to be comfortable I guess in some ways with your own mortality, knowing you're gonna die one day.*

One of the keys to Nancy's satisfaction with her job is the ability to know that what she does is worthwhile and tangibly so. She describes the experiences of other nurses in which they burn out more easily due to the feeling that their efforts are often futile. Rather than being burned out by death and dying, the knowledge that this outcome in inevitable and being able to do something to make it better actually buffers against the expected fatigue. This could have implications for other areas of nursing in that having tangible rewards for their efforts may go a long way in maintaining their job satisfaction and subsequently help to nurture their emotional wellbeing.

### *Interactions with Coworkers and Families of Patients and their Effects on Emotions*

Physical stains and balancing a difficult workload were not the only negatives Barbara described in her interview. Interactions with coworkers were described by both nurses. Barbara begins by describing the necessity of working in a team in the hospice setting.

> *Barbara: …And (clears throat) as a hospice uh, nurse, you know, you have to uh, pretty much coordinate all of the uh, the care er..uh physically, um, psychologically and, and spiritually. So, you know, th..it a hospice nurse doesn't work on her own she works as a team.*
>
> *Interviewer: Right.*
>
> *Barbara: So she works with the social worker, she works with the hospice aid, uh the bereavement counselor, the astro care (?), the volunteers, so it's really a, a team effort when you're talking about hospice care.*

She describes how this team can be a big factor in mitigating emotionally troubling situations.

*Barbara: …you get to rely on your team members and if have a really difficult case, the nice thing about it is is the social workers and the, the spiritual team have enough experience that they can also help to umm, kinda get the staff.. through difficult times too.*

*Interviewer: Right.*

*Barbara: Um, you know you get attached to patients and um, if you're at all human, you know, you think of the patient that you're taking care of as your, what if this was your mom or your grandma uh, or your grandfather and uh, you can't help but get emotionally, um attached at times. Oh, the spiritual care team, ca..also helps the staff as much as they help the patient and the family deal with death.*

Then, however, she describes situations in which the negativity of coworkers can have stressful effects. She describes a nursing stereotype that refers to nurses who, "eat their young", or from her descriptions are excessively difficult to the point that they actually try to make things difficult for other nurses.

*Barbara: the only other downside of nursing uh, that's a negative, is that there are a lot of nurses who are nurses that have no business being nurses.*

*Interviewer: Okay.*

*Barbara: Um, there is a saying in the nursing uh, community about nurses eating their young.*

…

*Barbara: Nurses, are.. some of the quirkiest, meanest, grumpiest, uumm, uha, people around. And it's a shame because "nurse" does not emit that, that would be the description but there are some nurses that are so cantankerous that they'll, they'll try, no what, no matter what field*

*they're working in whether it's hospice, critical care, obstetrics, emergency room, they'll try to ruin it for their coworkers just to be ornery.*

As a teacher for nursing student during part of her career, she felt it was a prevalent enough issue that she even made it a point to try and prevent the continuation of this behavior in future nurses.

*Barbara: one of the things I impressed on my students, especially the first quarter was I gave them a picture of what it was gonna be like, and if, they didn't think they were gonna cut it and uhh, y-you know today, was the day to make the decision to drop out of the nursing school, in the first quarter rather than waste their time and our time in uh, getting through and deciding to be um, cantankerous and ornery (laughs).*

When asked about any emotional experiences that she might take home with her after work (a sign of compassion fatigue and secondary traumatic stress described in the literature), she indicated that it was these interactions with coworkers, not those associated with patients, that stayed with her when she left work.

*Barbara: I don't think it's the patient um, things that you take home as often as the interaction between the uh, the professional staff and yourself that you take home more.*

*Interviewer: Okay.*

*Barbara: Like, you know, um, there-like I said there are people in the healthcare professional that should never have gone into the healthcare profession.*

*Interviewer: Right.*

*Barbara: Uh they're, they're non-supportive, and um sometimes they make it miserable for you and sometimes it's, it's, it's um easy to walk out the door and still be thinking about an interaction that you had, um, with uh-a coworker and not feeling uh, like it was right or fair uh, because you're on a different plane than they are.*

Nancy, however, made no mention of these negative interactions but described the just the opposite. Interactions with coworkers for her were only positive, and in fact, were described as the major coping mechanism used to deal with emotional situations in the workplace. Her descriptions go along more with the idea of a team network as Barbara referred to early on. In her first quote, she describes formal support groups that are available to employees at her hospice, especially in the instances of particularly emotional situations.

*Interviewer: …do you feel like you have a lot of support from the other nurses that you work with? Or from anybody I guess, um in your work setting. When things get..*

*Nancy: Oh yes! We-we-we not only um, there's some groups that get together in there that if you feel you want a little bit more personal, things that never leave that group, you can join some of the groups like that, e-just support groups. Um, they're led by some of the social workers. We do have social workers who are on board and sometimes you can really just, sometimes you really need to just vent things to them, and they're there and they listen all the time, the managers listen, we do have interdepartmental meetings where people can voice their concerns about things. And once in a while something really tragic happens and they do usually put together a group for everyone to kinda talk about it, uh on a rare occasion, there has been either a patient or a family member after a patient's death who's committed suicide and it kinda takes all of you by, you know it just takes your breath away.*

*Interviewer: Right. Yeah.*

*Nancy: And, you know they-they get together and they, there's a lot of talk and a lot of discussion and, and just lettin' again people, you know, vent their their thoughts and their feelings, I mean, get support from each other for it.*

However, she also describes a more informal support network, one in which venting and humor play a big role in mitigating any stress that the nurses may encounter. She not only brought this up once, but several times in the interview, reinforcing its significance for her.

*Nancy: Um, so I-I've got a good protectional, protection mechanism. And soiflhav- I do feel like something's been particularly stressful or I get a very difficult time with a family for whatever the reason may be, you know I'm going into all kinds of dynamics. Um, yeah, you come back to the unit there and the admissions office is usually only three or four of us and we can just, we can vent. So I'm, I'm one of those persons who gets it out quick, I don't take things home with me, I don't, I don't dwell on some of the things I see.*

*…*

*Nancy: …we can go and just blast it out back with the other people that have the same weird senses of humor (laughs)*

*Interviewer: (laughs)*

*Nancy: We can just kind of, you know, shake your head, question what's going on in these houses and just let it go.*

*Interviewer: (laughs)*

*Nancy: They-they always get resolved one way or the other so, like I said you just become the team that's resolving it, the doctor's involved, the nurses are involved, social workers are involved, so it's usually enough involvement of enough people that no one person takes the brunt of it. It gets resolved and… I let it go. So I'm not one to take home problems.*

*...*

*Nancy: N-Now you've got all the o-u-issues, now granted you that in the hands of social workers. That really is kind of where the social workers shine.*

*Interviewer: Yeah.*

*Nancy: I just kind of to get the people through the time while I'm there but then you have the social workers come in and deal with all this. But. So they're kind of our outlet, too. (laughs) We love our social workers.*

*…*

*Nancy: Yeah, we'll just go back and vent (laughs)*

*Interviewer: (laughs) yeah?*

*Nancy: We go back and vent. And there-there's a couple of the night nurses too who do the on-call stuff, you know they go out by themselves at one in the morning and say, they don't call me at one in the morning, but they'll call me up at ten o'clock at night going, "can I just vent to you?"*

*Interviewer: Aww.*

*Nancy: Like, yep. (Laughs)*

*Interviewer: (Laughs)*

*Nancy: And you just let em rant and rave about what's going on. (Laughs)*

*Interviewer: Right. It's a good system, to-I mean it works in everyday life with your friends and family.*

*Nancy: Uh huh. Uh huh. There's some nurses that click real well and just, can vent without, even though we might-it might sound harsh if somebody else was listening..*

*Interviewer: Right.*

*Nancy: We know we're just venting.*

*Interviewer: Yeah.*

*Nancy: You just have to get it off your chest, and when we're with those patients, we're present, we're there for them.*

These contrasting descriptions suggest that coworker interactions are very important to the emotional wellbeing of nurses and that this can work in either the positive or negative direction, potentially contributing to either compassion satisfaction or compassion fatigue.

It was interesting to note, though, that is not only interactions with coworkers that can have these effects. These nurses also bring up interactions with the families of patients as contributors to stress or satisfaction. Each mentions occasions in which family gratitude was evident.

*Nancy: …People always say, even if they've, I've actually meet people like at other things going on, like, "Oh my parents were in hospice, at so and so's hospice, I love my hospice nurse." They*

*always, I'd say 99.9% of the time love their hospice nurse. Love the hospice care. Um, people actually do get a lot of volunteers in hospice, and from what I understand, probably 50% of em come back to us cause someone died in our care and they wanna give back.*

*Interviewer: Aww, that's..*

*Nancy: So they're very grateful. Th-the other day, I brought someone to the unit, they were there for about two days, the family member died, the patient died, one of the family members came back looking for me and I wasn't there and a nurse called me up to t-one of my charge nurses called and said, you know Joanne, family so and so's here looking for you, he handed me a check but I didn't look at it, I just gave it to the secretary. She went back in a little bit later and she went, "That check was five thousand dollars."*

*Interviewer: Oh my..*

*Nancy: I guess this man donated five thousand dollars cause he was happy with the care after only two or three days with us, so. People are very grateful for the care we kinda get em through some hard times, and you know, everyone's got a little different way of-of sending their appreciation-we have a family who sets up Christmas dinner every year.*

*Interviewer: Awww.*

*Nancy: The patient died like eight years ago and this family still brings in Christmas dinner every Christmas. So people are very, very grateful for the work, I mean almost beyond what would ever be even thought of.*

*…*

*Barbara: You know, just, i-I've traveled to all fifty states and, in training in a high-tech uh, nursing that I helped to develop. Um, telehealth nursing which is monitoring patients over interactive video over phone lines. Well I've, I helped write the national standards for that and traveled to all fifty states.*

*Interviewer: Wow!*

*Barbara: And it ceases to amaze me, that when you, go out into the field in any state I go into, you just meet the most amazing people with the most amazing stories and, y-you know it just makes you, happy uh, to be able to impact uh, patients and their families because of how, h-what the patients and the families bring to the table just for, you know, for, for your personal um, growth i-you know as a person.*

*Interviewer: Right.*

*Barbara: Um, it's just um, it's an a-amazing journey really.*

However, just as with coworker interactions, interactions with family members can also take on a negative role in emotional wellbeing. Nancy describes several situations, which she refers to as "ugly deaths" in which family members contribute to the suffering of the patient which ultimately makes the nurse feel as though she may have let the patient and the family down.

*Nancy: Ugly deaths. That's what I call them, I'm sorry, the ugly deaths.*

*Interviewer: Okay.*

*Nancy: There's those deaths that you just can't get somebody comfortable, it may not be because we weren't able to do it, sometimes you get family members who just, they're just not*

*grasping what's going on, the person is dying, no question they're dying, they're dying soon, but the family member refuses to meditate. So you've got a patient who's got a lot of pain, or they've got a lot of restlessness, or a lot of shortness of breath, or they're dying what I call an ugly death. They're not comfortable. It doesn't matter how much you educate that family you just can't get em to understand….. the medication is not gonna kill em, the medication is gonna keep em comfortable, you need to medicate. And so you kind of feel like you've let somebody down, you've let the patient down, you've let the family down for not, for somehow not getting through to em, about gotta take care of the patient differently. Sometimes we just take the patient and go, "we're gonna go inpatient, okay?" Let us take-let's take care of em at the inpatient unit. Where we will medicate.*

*Interviewer: Yeah.*

*Nancy: But, so-so when you see somebody who's really struggling or they're at someone's house where the wife insisted that our caregiver, the hospice aid, take him to the bathroom for a shower, I'm like (laughs) I'm going he's got Parkinson's.*

*Interviewer: Yeah.*

*Nancy: We're into the last two days of life. I didn't, you don't say these things to people, but it's all running through your head, he's breathing up at 32, and you're like, I don't think you should be gettin him out of bed.*

*Interviewer: Yeah.*

*Nancy: And we can go (not sure what she says 34:31) there. "Oh no she needs to move" I'm like, you know, I (laughs)*

*Interviewer: (laughs)*

*Nancy: You know, (not sure what she says 34:38) we kind of laugh at these now, but you're kinda goin " what the heck!" Okay, and you try to explain to her, and finally when you realize all the nice little ways of dancing around it aren't working,*

*Interviewer: Yeah..*

*Nancy: you finally have to come right out and say, "He is dying a bad death" He's uncomfortable, he's in distress.*

*Interviewer: Right.*

*Nancy: We need to medicate him or he is gonna die in pain. And you-ha-you know you feel bad having to say straight out sometimes but they're not getting it and.. you know, and and the next thing you're gonna say to them is, you know, if you get him comfortable, he may just die. He's dying now but if we get him comfortable he may die and sure enough that patient, we got him comfortable and he died within two hours.*

*Interviewer: Right*

*Nancy: But the patients, the-the families just aren't grasping or they-they're… I think they have their own anxieties, their own fear, about it.*

*Interviewer: Right. Some sense of denial going on.*

*Nancy: Yes.*

*Interviewer: Yeah.*

*Nancy: Yes. And so you are, an-and that's-that's sometimes where these deaths are-are gruesome. When the families just can't come to grasps with…. We're-we're not over-medicating to kill him or anything we're medicating him to make him comfortable because he is dying.*

*Interviewer: Yeah.*

*Nancy: Yeah.*

*Interviewer: Oka..(cross talk)*

*Nancy: So yeah you get a couple of those and it affects you because you feel like you let everybody down (laughs)*

She describes situations in which families argue or bring outside issues into a room with a patient, interfering with their care. She describes this as one of the most draining parts of the job suggesting its possible significance to compassion fatigue.

*Nancy: (pause) I think more, I think the times that really only get stressful is when there's a lot of, unrest, or a lot of bad family dynamics.*

*Interviewer: Okay.*

*Nancy: Cause you can get, I mean, (clears throat) over in our inpatient unit we just have to actually say, you must take your argument out of this room,*

*Interviewer: Right.*

*Nancy: ..and not even out into the hall, you must leave the building. So when families are arguing over a dead, a dying person it's just kind of, it really just ticks us off (laughs) it's such an inappropriate time to be bringing up all your old baggage and all your old problems, we're trying*

*to come together for this person. I think that's very upsetting. Is when families, have just got serious psychiatric and psychosocial problems. And it spills over into our care, cause everybody just starts spending more time, trying to, how do you put it? (pause, sighs) Trying to contain that per-the bad energy or the bad, (sigh) the bad energy's all I can think from these other people and try to prevent it from affecting the sick person so much.*

*Interviewer: Okay.*

*Nancy: That-that takes a lot of energy and that's-ju-that's disturbing to all of us. You know we can police out the home and stuff and that, it-it just doesn't feel right. I don't know how to put it 'sept for it doesn't feel right.*

*Interviewer: Okay. You-you said that um, it was disturbing and I think you also used the word um, w-what was it you said uh, ii-well it-it was emotional for you to also see these families doing that, w-what kind of emotions are you referring to, you know what-what is that make you feel when you're having to deal with these families, as well?*

*Nancy: Well, your-p- you kinda feel like you're really not there to take care of the patient any longer, you're trying to quell problems between family members, while, y-you're trying to focus on the patient, trying to keep that patient comfortable, and you know that patient is hearing these problems and you can tell they're getting upset, and all you can do is try to speak reason with them, you try to get a hold of the social workers, depends on what's really going on. We've had occasions where police had to come to the house, which is really bad. But, you-you-you feel like you're really wasting your energy.*

*Interviewer: Okay.*

*Nancy: It feels like a waste of energy, and it is not even the right way to put it and I know that, because it's something you have to pay attention to. So I guess it's really not a waste of energy, but you just wish people would get along better at this point in time. It-it-it, it's a stressful time for everybody and you just, I don't know, wish people would put aside all their old baggage, like..*

*Interviewer: Yeah.*

*Nancy: .. so it drains your own energy.*

Nancy also gives an example of an extreme situation involving a family member who was angry about their loved one dying. Though no confrontation actually occurred, she describes the anxiety of wondering if the family member might have a violent reaction to them placing the patient in their inpatient unit. Though this situation did not end as badly as it could have, it is easy to see how nurses in these situations could be exposed to secondary traumatic stress. When patients are coming from homes in which violence is a possibility, they bring the possibility of exposing the healthcare workers to traumatic stories and situations that could affect them very deeply, even when they are not directly exposed to the violence themselves.

*Nancy: I think the most distressing one was when, and this was back up in Chicago, when, we had to bring someone to the inpatient unit, not that they were uncomfortable but it became a safety issue.*

*Interviewer: Oh wow.*

*Nancy: That the patient's husband was, was an ex-cop who, so now you know he's got guns..*

*Interviewer: Right.*

*Nancy: And he was angry at his wife for dying before him cause she was supposed to take care of him, he was making threats to the daughter. And eventually we actually came in and took her out from out from under him so to speak, so that's bad enough, now I wasn't involved in that part but now I'm on the inpatient unit going, so he's a cop? With guns? What if he shows up here with guns?*

*Interviewer: Oh god..*

*Nancy: He wants his wife back, what are you gonna do? Yea so there there's something to run in the back of your mind you realize some people can be unstable during this time and (sighs) you're worried about the extreme reactions some family members can have.*

### *How Exploring Personal Opinions Prior to a Nursing Career Can Buffer Against Negative Emotions*

A common idea that was brought up in both interviews was the idea that to succeed in hospice work, a nurse has to be in touch with her own opinions on death and dying. Nancy even makes it clear that she would not encourage just anyone to go into hospice. She describes it as something that an individual has to decide for themselves based on their level of comfort with their own mortality.

*Nancy: …But people, you kinda have, I wouldn't encourage anyone to do it unless they thought they wanted to do it. Because you have to be comfortable I guess in some ways with your own mortality, knowing you're gonna die one day.*

*Interviewer: Uh huh.*

*Nancy: Knowing, how do you wanna die. And so therefore you're comfortable helping other people, and educate other people on, the possibility of dying comfortably.*

*Interviewer: Right. Right. Um..*

*Nancy: So it i-it really something they have to be, in tune with themselves, I don't think anybody would-should uh, try to convince somebody to go into hospice care. (laughs)*

Barbara describes this as a necessity for dealing with emotional situation in the workplace. This may suggest that a healthy idea of one's own opinions on mortality may buffer against emotional strains in specialties such as hospice where mortality is an issue that comes up on a daily basis.

*Barbara: Um, the emotional toll isn't um, it, it, can be bad at times, but um, i..you have to really, as a hospice nurse and a nurse that deals with critically ill patients, you really have to have, be in touch with how you feel about the death and dying process.*

*Interviewer: Right.*

*Barbara: Cause if you're not in touch with your feelings, then it's not possible for you to be able to help somebody else through it.*

*Interviewer: Okay.*

*Barbara: Um, so the emotional side, as long as you're uh, uh pretty stable eh, nurse, and you've uh, thought through what you think about death and dying and, and things uh, you know that, that isn't so bad.*

She even goes one step further and suggests that taking some time to consider the possible ethical and moral dilemmas that one might face in their field prior to entering the workforce may be an invaluable advantage.

*Barbara: Um, is it just that they can't you know, bear to think that-that this person's gonna die, well everyone's gonna die sometime.*

*Interviewer: Right.*

*Barbara: And uh, they really need to if it's a, especially if it's a new graduate nurse, um, they really need to start doing homework now, on how they feel about different situations because in their lifetime as a nurse they're gonna come up against those situations and if ethically you've thought through some of those things it's gonna help um, blunt that, the trauma of some of the things that nurses have to go through. If you really thing th-ahead about those, about those things.*

*Interviewer: Okay.*

*Barbara: You know, when I did teach in the schools of nursing I had nurses um, take uh, a half an hour. And think about what they personally thought about death and what they saw w-how they saw themselves dying and you know uh, what they wanted if they were in pain and, and you know it's good to do those kinds of exercises ahead of time, you don't wanna wait til, the time that it-its happening to think about what you'd do if you were taking care of a prisoner that was under police guard who just shot a little girl at-you'll wanna be thinking about, are you gonna take care of this patient at that time. You wanna be thinking about what would you do if that happened ahead of time. Not at the time.*

She gives the following example to illustrate her point.

*Barbara: Oh yeah. And like I said if you, you have no business working in critical care or hospice if you haven't explored all your own feelings about what you think about taking care of a, somebody who shot a child.*

*Interviewer: Right.*

*Barbara: Now is not the time to be judging the person that you're taking care of. You're taking care of the patient because they need to be taken care of not because you're judging them and saying well they shot a child I'm gonna let him die. That's just not how it goes. Uh, you know, you-you took an oath to take care of um, a patient and uh, guess what you're not God, and so you don't get to judge the person that you're taking care of for no matter what um, reason. Uh, religion, sexual orientation, uh, criminality, it, nothing. You don't get to be the judge and the jury.*

*Interviewer: Right.*

*Barbara: You get to be the nurse who takes care of the patient according to how you were trained, and that's what you do.*

Nancy makes the point that having actually been through some of the situations that are being faced by patients and their families can immensely strengthen their ability to connect with families.

*Nancy: When they're deciding are we gonna extubate dad or not, I've extubated my father, I've extubated my uh, a sister-in-law, um, I've been with a sister-in-law's mother who was on home hospice and helped her through it, so. I actually can relate with people and I understand, they're fear, and I understand there can be anxiety of making these decisions.*

*Interviewer: Okay.*

*Nancy: Umm, and if they get real tearful, you can't help but well up yourself, I-I cry with them, myself, so.*

*Interviewer: Okay.*

*Nancy: And I think-I think they find it useful when I tell that I've been in the situation making the same decision.*

Having described at one point how a nurse can feel as though they let patients and their families down by not being able to ease some of the family's anxieties, this may play a key role in preventing some of those situations.

### *The Value of Being Able to Educate*

For any worker in any field, not having enough time to complete your tasks can be a frustrating situation. If not a part of the nursing field, one might not realize it, but teaching is a huge part of a nurse's daily schedule. Of course many things take large roles in a nurse's day, but being able to teach is one aspect that the nurses who participated in these interviews particularly enjoyed and gained a large part of their sense of accomplishment from. Nancy described teaching as being an integral part of her work in hospice admissions.

*Nancy: Umm, so much of my job is to go in and, inform them, and educate them what hospice care is, how we can help them, how we act as a support for them. We are kind of holistic so we do not only take care of the patient in terms of their comfort.*

She went on to describe how fulfilling this aspect of her job is. It is clear from her following statements that educating patients not only helps them to understand their disease

process but it gives the nurses a sense of accomplishment in knowing that they provided some comfort and decision-making power to their patient through the education process.

*Nancy: And I think that's what makes me… you know, I-I I think advocating them makes me feel the best. Or educating them, sometimes on their own disease process. I have been in seems (not sure what she says 41:16) that no one's told the people that they should tha-not only does she have cancer in her lungs but its moved everywhere. And they're like what do you mean its moved? Like are you telling me the doctors haven't told you these things? (laughs)*

*Interviewer: Wow.*

*Nancy: So you gotta take a deep breath and you kinda go okay, well tell me what you know, and okay well I'm looking at your papers here, and they're like can I see those? Yes, they're your notes, you may look at them. Sometimes you really educate them so that they can make a decision that's correct for them. You're giving them the power, to make an informed decision.*

*Interviewer: Okay.*

*Nancy: And I-I kinda like that. I-I a-I always tell people, I'm not here to make anyone sign for hospice, this is a choice.*

*Interviewer: Right.*

*Nancy: Well I-I think educating em as to what's really going on when they're thinkin-cause you know when people are so confused at what doctors are tellin em, five doctors walk in tell em something different. And they don't know what to think anymore. And you kinda come in and kinda help ground em, and educate em, and inform em they have choices.*

*Interviewer: Okay. Yeah, an-and that sounds like it would be very rewarding, to be able to do that for people.*

*Nancy: Well its (not sure what she says 42:27) telling em what they should do or what they HAVE to do.*

*Interviewer: Right.*

*Nancy: You tell em you can do that or you can do this.*

*Interviewer: You sort of empower them in a way.*

*Nancy: Yes, absolutely! It's absolutely giving power back to the-to the patient through, education.*

Barbara talked about this from the perspective of a time when she worked in a hospital setting. She describes how the lack of time can interfere with the ability to educate, and in the process deprive the nurse of a critical form of patient care.

*Barbara: But the thing that's in hospitals that you don't get to do enough of is teaching.*

*Interviewer: Okay.*

*Barbara: Um, and discharge planning and teaching uh, because you have all those um, uh, th-the paperwork requirements and uh, you know, doing rounds with the doctors. So you know, it'd be nice if um, if there was just uh, well they're making electronical-electronic medical records a lot easier you know, and faster at the bedside and it'd be, it'd be nice if you had just a little bit more time to, be able to feel like you could sit and hold somebody's hand for twenty minutes and not, most hospital situations, if you sat and held somebody's hand for twenty minutes and you've got eight to ten patients you'd be so far behind you wouldn't have, you would never catch up.*

*Interviewer: Right.*

*Barbara: So that, that extra step of, of more uh, personal care is sometimes missing because of how much you have to cram into a, into a ten or twelve hour shift.*

### *Putting Patients First*

One characteristic that stood out in both of these nurses was that despite whatever stress or emotional strain might be occurring they had an unshakeable mindset that they would never let that get in the way of their patient care. These nurses both approach their work from the perspective that their patients come first no matter what. Nancy, after describing how she would go to her coworkers and vent when something stressful was going on, summed up this idea of putting patients first with this statement.

*Nancy: You just have to get it off your chest, and when we're with those patients, we're present, we're there for them.*

She makes it explicitly clear that in her mind, nurses leave their problems at the door when they walk into a patient's room and they give that patient their all, even if that means getting things off their chest beforehand.

Barbara began talking about her patient perspective by sharing the advice she gives to new nurses about how to view patients.

*Barbara:…when I taught in the school of uh, nursing that's one of the things that I stressed to the new nurses that, when you're dealing with patient, it's not the heart attack in bed A. We're talking about a patient, who is, the mother of five kids with three dogs, and uum, needing to*

*know who's gonna pick up the mail today, and who's gonna get somebody to soccer practice, so it's always complex um, family, issues and it's not just a diagnosis that's sitting in that bed.*

*Interviewer: Right.*

*Barbara: It's um, uh-uh really a, a complex uh, person with, with um, happiness and problems like you and I deal with everyday.*

When asked if any of the negative experiences from her day ever carried over into her patient care, she responded with the following.

*Barbara: Not with the patient, no.*

*Interviewer: Okay.*

*Barbara: Um, you've gotta really be under control because your patient is already in a sickness you know, quote unquote circle.*

*Interviewer: Right.*

*Barbara: You've got something going on physically, uh, emotionally, spiritually, and to add any kind of burden into that is not a good thing.*

For her, patient care could become so much of a priority that her self-care often suffered.

*Barbara: Yeah, I mean, you have to protect your patient first you cannot let any of those, outside, um, influences influence their, worsening of their uh, physical or mental health.*

*Interviewer: Right..*

*Barbara: So you've gotta take control of the situation pretty quickly and um, if anything, nurses, will take care of their patients a-almost better than they'll take care of themselves.*

*Interviewer: Right. Um, so going off of that, that actually is related to one of my next questions, do you feel like that is something that maybe happened to you a lot? Where, you might have let your own self-care i-i-sort of go to the wayside um, as a result of caring for your patients?*

*Barbara: Well, I mean have you heard that nurses have the bladder of a camel? (laughs)*

*Interviewer: (laughs) I have heard that!*

*Barbara: (laughs)*

*Barbara:.. well there's a reason for that and like any of us that have worked in critical care, if you're in the middle of a cardiac arrest, now is not the time to go to the bathroom.*

*Interviewer: Right (laughs)*

*Barbara: So I can usually go ten to twelve hours without going to the bathroom including to this day..*

*Interviewer: Oh no! (laughs)*

*Barbara:.. even though I'm not working in critical care. Because you just, um, you're-you're umm, adrenaline in critical care especially is going so high that you just do things that you normally wouldn't do like not eat for ten hours, not go to the bathroom.. um, because you work ten hour or uh, eight hour shifts five days a week or even more*

*Interviewer: Right.*

*Barbara: Um, overtime, you tend not to go to the bathroom and you tend not to go to the dentist on a regular basis.*

Even when asked if her emotional and spiritual needs ever took a backseat as well, her response came back to the importance of patient care and how that is the priority.

> *Barbara: Um, n-no, no I mean, you-you keep it in your perspective that you know, you're there to uh, take care of your patient and uh, you know if things are that bad, I'd say, you have to get help anyway (laughs)*
>
> *Interviewer: Fair enough.*
>
> *Barbara: You know, you know um, rear its ugly head if you're sick or um, you know emotionally not.. being able to cope with something i-it's gonna, it's gonna show and it'll have to be taken care of one way or the other.*

**Discussion and Implications**

Through the interview process with Nancy and Barbara, it became clear that these two nurses fell largely into the category of compassion satisfaction. Though exposed to many risk factors cited in the literature that can contribute to compassion fatigue, these nurses describe overall positive emotions associated with their work. Coetzee and Klopper's (2010) description of compassion satisfaction cited in the literature review seems to describe the experiences of these two nurses almost exactly. They stated that compassion satisfaction was, "the invigoration and inspiration that a nurse receives from connecting with and sharing in a patient's suffering, with the main focus being to relieve and alleviate the patient's pain through selfless use of oneself and one's skills and available resources" (Coetzee, 2010, p. 239). Both nurses provided descriptions that would fit this definition. It should also be noted that neither of these nurses described symptoms synonymous with secondary traumatic stress; at least in the context where STS is listed as a completely different experience from CF. The only time that the interviewees

touch on an STS symptom is when they mention the experience of recurring dreams; however, as these are not associated with a particular patient or traumatic experience of a patient they can not necessarily be categorized with STS. The dreams described by the nurses are more associated with the time constraints of their daily work (for example, Barbara described a recurring dream in which it was already afternoon and she had not finished passing out her morning medications) and therefore may be more connected to everyday job stress. Nancy's dream comes the closest to potentially being related as she describes a recurring dream in which she can't find enough beds for patients; a similar dream to Barbara's when considered on its own, but she gives the context that these only happen in the midst of the ugly deaths in which she feels as though she let a patient down. Still, it would be a stretch to classify this as a warning sign of STS without other accompanying symptoms. Overall the only reasonable conclusion that can be drawn is that these two nurses are likely not experiencing STS based on their interviews, and at best it could be hypothesized that this could have a connection to the specialty in which they work (which would imply hospice nurses experience less STS if proven true). However, more studies would certainly need to be undertaken to further analyze these speculations and to identify which other nursing populations, if not this one, are more at risk for STS.

It is important to note that this study was performed on a very small scale with a limited specialty range, and therefore may not be indicative of all nurses' experiences. However, these descriptions are valuable in that they show firsthand the kinds of thought patterns and personality traits that may buffer against the stress and negative emotional demands of healthcare work.

So exactly what traits possessed by Barbara and Nancy led them to experience compassion satisfaction instead of compassion fatigue, especially given their thorough descriptions of various job stressors? One answer may lie in each nurse's understanding prior to

entering the field that they needed to examine their own opinions of difficult situations prior to trying to help patients through them. These nurses were not shocked or overwhelmed by the task of dealing with death and dying on a daily basis because they already had come to terms with how they felt about it. To recall, the definition of compassion was an awareness of the suffering of another coupled the wish to relieve it (Radey, 2007). These nurses consciously developed this awareness long before they were exposed to the suffering and knew how they would approach trying to relieve it when the time came. In both cases this was often augmented by direct experience caring for family members going through similar experiences as their patients. Barbara made the suggestion in her interview that this is something that nursing students should be given the opportunity to reflect on, even if it means giving them a long period of quiet time to reflect during class. There may be something to this suggestion. Asking students to begin the process of building up these opinions and understanding early may buffer against the emotional toll of the experiences once in the clinical setting.

In fact, providing interventions in nursing school, long before the nurses are faced with emotionally draining situations in the workplace may be the best preventative measure. In addition to having students consider their opinions on difficult situations, having them reflect on aspects of their own personalities that may either help or hinder them in their ability to care for patients under stressful conditions could be immensely helpful. The nurses themselves in this study credit much of their ability to appropriately channel emotional strains to their own inherent qualities. Identifying tendencies to hold on to emotions early may help students to begin developing their own coping mechanisms for when triggering situations arise. Students should also be encouraged to identify activities or practices in their lives that may contribute to stress relief and be challenged to maintain these. For example, Barbara spoke of the refreshing quality

of her church life and music. Nancy shared her love of massage and how it helped her to juxtapose her work life helping individuals going through the death process with having an ability to alleviate pain and improve quality of life for those still very much alive. Identifying activities outside of work that facilitate other interests and get nurses away from their stressful day-to-day work life could have rehabilitating qualities for them and these practices should be encouraged early in their career. The nurses interviewed also brought up the importance of being able to cry on the job. It not only helped them to release pent up emotions but aided in their patient and family member interactions by demonstrating human emotion and a genuine concern for what was going on. Nancy mentioned an interaction with a physician that made her come to realize that this is both an acceptable and helpful reaction to certain issues, but bringing this up to students outright may encourage them to abandon tendencies to hold on to difficult situations early on. In general, an open and up front dialog with nursing students needs to be facilitated to allow them to explore their opinions, personality traits, and tendencies so that they are better prepared for the emotional side of nursing and importance of self-care, in order to maintain a patient first attitude. As mentioned by Barbara in her interview, introducing these ideas to nursing students early may help improve the overall workplace environment by preventing both the emotional tolls on the individuals and the effects these can have on their coworkers, who for example, may become bitter and adopt a toxic attitude toward coworker interactions (become nurses who "eat their young").

An important benefit of pursuing a study more focused on the nurse's direct experience is that it begins to give more depth to the basic descriptions currently present in the literature for the risk factors and coping mechanisms associated with CF and STS. Though many current articles mention that job stress and excessive demands in the workplace can contribute to CF and

STS, these are broad terms that make it difficult to hone in on real everyday changes that could be made in the workplace to limit the risk for these conditions. These interviews begin to shed some light on these questions. An example of this is the need the nurses expressed to be able to effectively educate their patients and their families. While some of the literature does refer to how time constraints can add to a nurse's burden, the specific focus on the ability to teach could have important implications for interventions. Though not all challenges in terms of a nurses time constraints may be reasonably addressed, at least focusing in on this aspect of their day may have widespread effects on their overall job satisfaction; a key component in whether or not a nurse in the same conditions experiences compassion fatigue or compassion satisfaction. Changes have to be made at both the immediate care level and administrative levels to begin to shift the ideas of what should be prioritized for nurses to more fully encompass their ability to educate.

Another detail that arose was the role played by patients' families. Interactions with patient's family members as a negative experience is not necessarily intuitive, though as evidenced in both interviews, they can have huge impacts for nurses. The two nurses do mention the strong role social workers play in mediating these situations, but perhaps instituting stricter regulations and procedures for unruly family members should be considered. Another strategy that might be considered is to implement some sort of counseling for family members ahead of time that educates them on how to properly handle situations that arise in patient care and how to handle them appropriately before they occur. This could introduce them to how their disagreements may affect the patient and interfere with effective care, while making them aware of services offered to help them in these situations to hopefully prevent them from getting out of hand. In the positive sense, it seems that family members will provide positive interactions on

their own through the acts of gratitude they show, but more could be done to avoid the negativity that they can bring into a nurse's day. Included in this should be a consideration for coworker interactions which seem to have similar effects.

One surprising association made with helping patients' families was that both of these nurses described being able to help families as a major positive component of their day. They both expressed positive feelings associated with helping the patient and their families relieve some of the stress associated with their situation. In an article by Slocum-Gori, et al., (2011) it was concluded that nurses that participate more in relief of physical, emotional and/or spiritual pain and distress or providing psychosocial support to patients and/or families had a statistically higher probability of experiencing compassion satisfaction (Slocum-Gori, 2013). This suggests that this finding by Slocum-Gori et al. (2013) should not be considered as a direct, causal agent. From the interviews in this study, these tasks seem to actually improve the nurses' level of compassion satisfaction. The relationship between the two factors may be correlated but it would be necessary to identify what about nurses who partake in these tasks is increasing their risk of compassion fatigue, if not the tasks themselves as suggested here.

It also should be acknowledged that these interviews also pointed to policies and practices currently in place that are seemingly successful in buffering against symptoms of CF and STS. Both mention the ability to speak with a social worker or counselor if needed and the presence of support groups in the event of tragic situations. They both express positive opinions of these services and say that they help them to feel supported by their overall workplace administration. Continuation and maintenance of these systems should be highly encouraged, and if absent from certain facilities, should be considered for implementation. These already successful systems combined with additional policies and teaching objectives in nursing schools

may play a huge role in preventing additional emotional strains on those individuals who spend their days giving of themselves so selflessly for others.

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## Appendix A

Introduction:

Hi/Good afternoon/morning, I want to first of all thank you for meeting with me. My name is Jessica and I'm a senior in the honors college at the University of Arizona working on my honors thesis. I'm majoring in Family Studies and Human Development and looking to pursue a career in the healthcare field, possibly nursing, and so I was interested in some of the effects the job can have on individuals from an emotional standpoint. Do you have any questions for me?

Now that you understand a little bit about my goals I'd like to go through some questions with you about your experience as a _____ (insert, hospice, trauma, etc.) nurse. Would it be okay with you if I record the interview? However you're comfortable, I want to let you know that the interview will be kept confidential and that only I and my academic advisor, Dr. Susan Silverberg Koerner, will have access to it. Anything we use will be edited so that your name and any identifying characteristics will be indiscernible.

(*Interviewer note: remember to ask for clarification of words used such as "stressful"; i.e. What do you mean by stressful/What does stressful mean to you?)

1) Tell me a bit about what you do?
    a. What does a typical day at work look like for you?
2) What kind of patients do you tend to work with? (i.e., Older? Younger? Terminally ill? Trauma?)
3) How long have you been working in your field?
4) How do you feel about your job and the work you do with your patients?
    a. Do you ever feel negatively about work?
    b. Do you feel as though your work is rewarding?

i. How so? Could you expand on that for me?

5) Do you ever feel overwhelmed at work? Why? Example?
6) Could you describe some of the more stressful experiences you have had as a nurse?
7) What would you say is the most rewarding aspect of your work? Example?
8) Could you share an example with me of a time when something at work was particularly demanding?
    a. How about from an emotional standpoint?
    b. How about when working with patients?
    c. Do your feel as though you are faced with such challenges frequently?
9) Following this even did you feel supported? (either by having someone to talk to or through resources at work)
    a. Could you tell me more about this? or, Could you share an example?
    b. Do you feel as though your patients are grateful for the work you do, if not how would you describe their typical response toward you? (patients)
10) Do you feel like when something emotionally draining happens at work (could use, "such as the example you just gave me), that the event tends to affect you afterwards?
    a. How so?
    b. Does this carry over to how you interact with/relate emotionally to your patients?
11) So, looking back on when you first started off in your career, do you notice any change over time in how you are able to show compassion/empathize with your patients?
    a. Do you feel as though you sometimes get overwhelmed by the caring aspect of nursing?
    b. Does your current job meet the expectations you had going into the field?
12) Do you ever feel as though you carry work home with you? In other words, do aspects of work or patients' stories stick with you when you leave?

   a. How do they affect you? (i.e. do you ever have dreams, recollections, flashbacks, etc. about something that happened to a patient?)

13) How do you feel you engage in self-care? (that is, how do you attend to your own needs/maintain your own wellbeing outside of work or following a difficult day at work?)
14) What advice would you share with someone coming into the field in terms of dealing with issues regarding caring/compassion/emotions?
15) Is there anything else you would like to share with me or anything else you feel is important that I may not have asked you about?

Again, thank you so much for your time!

## Appendix B

To Whom It May Concern,

My name is Jessica Ackley and I am a senior in the honors program at the University of Arizona. Under the guidance of my faculty advisor, Dr. Susan Silverberg Koerner, I am currently working on a final thesis project that examines the concepts of compassion fatigue, compassion satisfaction, and secondary traumatic stress in nurses. I came to be interested in these topics because I am currently considering a career in the health care field myself and consider these to be important issues for both health care workers and the patients they care for. The project is a final culmination of my time at the University and is one of the last steps for me to complete my degree.

I am contacting your facility in hopes that some of the nurses may be interested in assisting me on this project. I am looking to conduct a onetime, recorded interview with several hospice and several trauma nurses to get a personal insight into the nursing career and its associated emotions. The interviews would only require 30-60 minutes of their time and could be conducted either at their workplace or at the University of Arizona campus. The interviews will be completely voluntary and confidential.

If any of the nurses at your facility would be interested in helping me on this, I would greatly appreciate their time. Please forward my contact information on to anyone who may be willing to work with me. I appreciate your time and thank you for passing on this request.

If there are any questions concerning the project or the interviews, you may contact me at any time at the number listed below.

Sincerely,

Jessica Ackley