THE EXPERIENCE OF WITNESSING PATIENTS' TRAUMA AND SUFFERING
FOR ACUTE CARE NURSES

by

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Abstract

Research has shown there are many stresses that nurses endure as a result of their work and workplace environment. Burnout and stress are common issues that have been proven to be quite prevalent in the nursing world. More recently, compassion fatigue is starting to be studied as part of the struggles that many nurses face. This study is an initial attempt to describe the experience of witnessing patients’ trauma and suffering for acute care nurses to see if this could also be an aspect of the stress. Phenomenological reduction of the data yielded several themes: A witnessing of a traumatic event and/or prolonged witnessing of suffering; a group of common effects as a result of the witnessing, distancing and guilt secondary to the effects; change in self; and finally what nurses do to cope and what they feel would help aid further coping. Recommendations for resources and further research are made.
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For all nurses who struggle in silence.
INTRODUCTION

As a result of being a part of and witnessing traumatic experiences for my clients as a registered nurse in the acute care setting, I began to wonder what the potential effects of these experiences were on myself. At the same time I gradually noticed that working as a nurse seemed to affect many of my colleagues around me in a negative way. I noticed changes over time in the way nurses around me seemed to relate to their work and their patients. They were at times distant and detached – and it seemed to be a way of coping with the frequently intense emotional situations they were experiencing. It was common to hear nurses talking about trouble sleeping and not being able to leave the experiences of the shift in the hospital when they went home. Furthermore, it was clear there were often stark differences in the way newly graduated nurses and experienced nurses interacted with their patients and spoke about their jobs. It seemed as though hopelessness and an acceptance of how negative the world was, were largely apparent in the conversations I overheard from the experienced nurses. On top of all of this, I witnessed large numbers of sick calls and would often hear nurses claiming they could just not do another shift.

These things led to me to wonder about the effects of experiencing patients’ trauma and suffering upon nurses responsible for their care and whether these effects are lasting. My questions led me to research a phenomenon related to work related stress in the helping professions and I found a relatively new body of knowledge was being developed using a variety of titles. Whether it was secondary traumatization, vicarious traumatization or compassion fatigue, the literature proved to me that there are, in fact, lasting effects from witnessing trauma and suffering and that perhaps this is what I was witnessing in the nurses
around me. Research and theorists were cautioning that, in the words of Figley (1995), there really is a cost to caring. The literature also led me to explore the similar constructs of burnout and occupational stress and it became apparent that these too could be potential explanations of the changes I had witnessed in my colleagues and experienced in myself as a nurse. The question became whether what I was seeing was a result of the better-known terms of 'stress' and 'burnout', or the new construct of 'compassion fatigue' discussed above, or something completely different.

1.1 Purpose of the Research

I carried out a study that investigated the experience of witnessing patients’ trauma and suffering for acute care nurses. It was my primary focus to provide a rich description of this experience as well as an understanding of acute care nurses’ coping strategies, and the resources that are used (and could be used) to facilitate functioning in their everyday lives. My goal was to describe the meaning of the lived experience of witnessing patients’ trauma and suffering among acute care nurses.

1.2 Study Rationale

Research was showing there are lasting effects in populations of nurses as a result of their work responsibilities and environment, however studies had not been done to determine what the experience of witnessing patients’ trauma and suffering is for acute care nurses. I questioned whether the themes that would emerge would point to compassion fatigue, or burnout or stress as they had in prior nursing literature. I knew that much more needed to be
known about this experience for acute care nurses in order to properly support them so they can continue to care for their patients.

The majority of time and effort in the research to date had been put into what to call the effects of witnessing other people's trauma and suffering as well as the prevalence of these effects. Collins and Long (2003) state that no matter what the term used to classify the phenomenon, the effects of working with those who have experienced trauma and suffering appear to be the same. More in-depth personal knowledge of the phenomenon was needed in order to address its effects in the workplace.

1.3 Research Questions

The following two questions guided my research:

1. What is the meaning of the lived experience of witnessing patients' trauma and suffering among acute care nurses?

2. How have acute care nurses been coping and what would be helpful in facilitation of their coping?
2 REVIEW OF THE LITERATURE

2.1 Terms Defined

2.1.1 Stress

Lazarus and Folkman (1984, p. 21) contend "stress is a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." They state that "the judgment that a particular person-environment relationship as stressful hinges on cognitive appraisal" (Lazarus & Folkman, 1984, p. 21). Therefore it can be said that stress comes about when an individual interprets their environment through cognitive appraisal requiring more resources than they are able to give.

2.1.2 Burnout

Maslach, Schaufeli and Leiter (2001) state there are three parts that combine to form burnout: (a) overwhelming exhaustion, (b) cynicism and detachment from one's job and (c) feelings of inefficacy or lack of accomplishment. According to the research on burnout, of these three parts, exhaustion is the central factor as well as the most widely reported symptom of burnout. Maslach et al. (2001) report that people begin to detach themselves from their work once this exhaustion sets in as a way of coping. This emotional exhaustion comes about over time as a result of prolonged interaction with one's work environment and can be quite influential to one's interactions in the work environment.
Burnout has been found to be associated with higher levels of absenteeism and job termination and for those who continue at work, productivity, effectiveness, satisfaction and commitment often decrease (Maslach et al., 2001).

2.1.3 Compassion Fatigue

While the above terms are quite well known to most people, compassion fatigue is a relatively new term to the world of psychology and health care. There has been a long-standing belief in the world of psychology that there are many potentially negative effects as a result of experiencing trauma. For years, however, it was thought only individuals who had been directly traumatized experienced these negative effects (Figley, 1995). This began to change in 1980 with the publication of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1983) (DSM III) which included a section on Post Traumatic Stress Disorder (PTSD) and stated in its criteria that even the knowledge of another person’s traumatic experience has the potential to be traumatizing (Figley, 1995). It was acknowledged that bearing the distress of others who are in harms way could lead to PTSD (Figley, 2002). Following this, it wasn’t until almost 10 years later that research began to be published looking at what the effects of knowing about another person’s trauma were and how it could be classified. This was apparent in Arvay and Uhlemann’s (1996) research where they state the progression of terms published began with “secondary victimization” formulated by Figley in 1989 followed by “vicarious traumatization” published by McCann and Pearlman in 1990, then, “secondary traumatization” presented by Herman in 1992, and finally “compassion fatigue” coined by Figley in 1995.
The different terms used in the literature to talk about the phenomena of being vicariously affected by other people’s trauma and suffering while undoubtedly related, have been defined in distinct ways. The three main terms discussed in the literature are “secondary traumatization,” “vicarious traumatization” and “compassion fatigue.”

Secondary traumatization has been defined as the “natural consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person” (Stamm, 1995, p. 10). It is manifested by a group of symptoms that are nearly the same as those exhibited in Post Traumatic Stress Disorder (Stamm, 1995).

Vicarious traumatization alternatively refers to enduring psychological effects that are a result of the therapist’s exposure to the traumatic experiences of clients. McCann and Pearlman (1990) posit that the individual’s cognitive schemas or world beliefs are altered by the accumulative process of hearing the traumatic stories of clients. Lastly, compassion fatigue is used as an alternate title for secondary traumatic stress and, as stated by Figley (1995), is used in helping professions by practitioners because it is more positively received.

It can be seen that the definitions of these terms are quite similar and so it is not surprising that there is a lack of clarity between them and confusion in the literature. Baird and Kracen (2006) suggest this lack of clarity is due to the fact that research on these constructs is quite new. The question becomes whether these terms are in fact different and how research can assist in clarifying them?
Many of the researchers have talked about the overlap and confusion with regard to the domains surrounding these constructs (Arvay & Uhlemann, 1996; Arvay, 2001; Buchanan, Anderson, Uhlemann & Harwitz, 2007; Collins & Long, 2002; Jenkins & Baird, 2002; Baird & Kracen, 2006) and have attempted to present these constructs’ similarities and differences.

Pearlman and Saavitine (1995) describe vicarious traumatization as causing profound disruptions in the therapist’s sense of identity, worldview and spirituality. They ascertain that many aspects of the therapist’s life are affected including such things as psychological needs, beliefs, interpersonal relationships and tolerance. It is all encompassing and changes the self of the therapist and their experience in the world (Pearlman & Saavitine, 1995). Pearlman and McIan (1995) found that vicarious traumatization’s manifestations arise from the interaction of the work situation over time and personal characteristics of the therapist, such as personal trauma history, current stressors, personal support and one’s interpersonal style. Just as secondary traumatic stress has a relationship with posttraumatic stress disorder, vicarious traumatization also seems to be related to the domain of PTSD. McCann and Pearlman (1990) found that changes in the therapist’s memory system and cognitive schemas could result in PTSD-like symptoms, such as intrusive images and negative emotional reactions.

Secondary traumatization has been described as a syndrome of symptoms that are nearly identical to PTSD. Symptomatology includes a stressor, re-experiencing of the traumatic event (e.g., through dreams), avoidance of reminders of the event and persistent arousal
Like vicarious traumatization, secondary traumatization has contributing factors, such as (but not limited to) personality traits of the helper, history of psychiatric symptoms, identification with the individual and how that affects their stress appraisal, characteristics of the occupational context and finally supports in the helper's life (Figley, 1995). Some of the commonly reported manifestations of secondary traumatization include recollection, sudden re-experiencing or dreams of the distressing event, efforts to avoid thoughts, feelings and activities that remind the individual of the distressing event, detachment from others, diminished interest in significant activities, difficulty sleeping and concentrating, as well as irritability (Stamm, 1995).

It is clear from the explanations above that these constructs do share many common themes, but also appear to be slightly different. Arvay (2001) ascertains that vicarious traumatization and secondary traumatization differ with respect to their foundations. While vicarious traumatization is based on a constructivist self-development theory, and secondary traumatization emerged from diagnostic criteria for PTSD, she feels they describe the same concept. Jenkins and Baird (2002) support this notion positing secondary traumatization and vicarious traumatization are similar with respect to observed symptoms being a result of experiencing other people's trauma and suffering, but are conceptually distinct. Secondary traumatization puts its emphasis on emotional and social phenomena, where as vicarious traumatization’s main focus is cognitive symptomatology.

Due to the above descriptions and the support by researchers on the similarity of these concepts I have chosen the term, which I feel best suits my research and more importantly
the population I wish to work with. Given that Figley (1995) states he has found the term “compassion fatigue” tends to be less derogatory as well as better received by nurses, this is the title I chose for the purpose of my research. Compassion is defined by the American Heritage Dictionary (2006) as “a deep awareness of the suffering of another coupled with the wish to relieve it.” As a nurse, I feel this exemplifies much of what we do and what governs our desire to nurse, further making this the appropriate definition to use.

It is quite apparent that each of the terms discussed above could be a likely result of witnessing a patient’s trauma and suffering for a nurse. They each take into consideration negative influences that occur within a person’s work environment and display potential symptoms that can result.

2.2 Theoretical Basis

2.2.1 Stress Theory

Lazarus and Folkman’s (1984) Transactional Theory of Stress and Coping provides a clear basis with which to look at stress. They propose that individuals are constantly appraising the environment around them in attempt to pull out meaning and significance in order to categorize interactions with their environment related to their well being. The amount of stress felt is a result of a two-part cognitive appraisal. The first, primary appraisal, is the evaluation of whether a situation is irrelevant (has no implications for well-being), benign-positive (preserves or enhances well-being) or stressful (could lead to harm/loss, threat or challenge). Secondary appraisal is one’s evaluation of their coping abilities and options. They posit that if a person is highly attached to the outcome (i.e., strongly committed) that
helplessness (not having resources to cope) can be devastating to them. Lazarus and Folkman (1984) add that there is also a possibility of reappraisal, which is a new found evaluation as a result of novel information made available to the person.

The emotional state of the person greatly influences the way in which one appraises the situation and therefore acts upon it. If an individual feels they have little control or that their resources are depleted in some way, then it is likely they will fail to notice their full coping capabilities (Lazarus & Folkman, 1984). This can undoubtedly result in a vicious cycle that could leave the individual at risk for suffering from stress. Stress has been linked to a number of illnesses (Lazarus & Folkman, 1984) and can have a wide variety of psychological effects on an individual. Social functioning (how an individual is able to fulfill their roles, their satisfaction in their interpersonal relationships and the skills they possess to function in their social life) and morale (emotions related to a person’s appraisal of their coping ability – the way in which one assesses a situation greatly affects how they foresee their role abilities with respect to a situation) are two of the main aspects of a person that are closely related to stress and have been shown to affect a person’s psychological state, even leading to such things as depression (Lazarus & Folkman, 1984).

Much of a nurse’s work involves assessment of situations and planning in order to implement the correct treatment. As they are already in this frame of mind, it would be logical to think that perhaps this is how they are dealing with the stresses of their job as well. Given the large demands put on nurses in today’s health care system, as well as the chronic shortage of nurses, it is likely that often nurses’ resources are depleted, which could then put them at a
further disadvantages with respect to coping, (as talked about above) as well as suffering from the outcomes of experiencing stress.

2.2.2 Burnout Theory

As stated earlier, research shows that exhaustion, detachment from one’s job and feelings of lack of accomplishment combine to result in the phenomenon of burnout (Maslach et al., 2001). Maslach et al. (2001) also contend that burnout results from prolonged interpersonal and emotional stressors on the job and that workers become burned out in defense of the unmanageable feelings they are left with as a result of their work. In relation to the population of people studied in this research, it has been found that those working with people (who suffer from burnout) begin to see their clients as objects in an attempt to make the demands of their job more manageable (Maslach et al. 2001).

In the research it has been discovered that there are a wide variety of symptoms related to burnout making it sometimes difficult to distinguish it from other conditions. Some of the symptoms that can result from suffering burnout are fatigue, sleep difficulties, gastrointestinal symptoms, anxiety, depression, pessimism, issues with interpersonal relations, inability to concentrate and withdrawing (Stamm, 1995). It is clear that burnout can be all encompassing and is also a very likely challenge that many nurses who are struggling with their work demands could face.

While the above has similarities to compassion fatigue, Figley (1995) has found that burnout emerges gradually whereas secondary traumatization can appear quite suddenly, with little
warning, and with it carries a sense of confusion, hopelessness and isolation, which is distinct from burnout. Many others have supported this notion that burnout is, in fact, distinct from secondary traumatization (Arvay, 2001; Benoit, Veach & LeRoy, 2007; Stamm, 1995).

2.2.3 Compassion Fatigue Theory

Figure 2.2 Compassion Stress and Fatigue Model Figley (2002)

Figely (2002) presents his model for compassion fatigue stating that all of the variables in Figure 1 work together to form risk for compassion fatigue. At the heart of this model is an empathetic ability and emotional energy. Figley posits that these are essential in working with suffering as well as establishing and maintaining an effective relationship. There is a cost to being compassionate and these variables form a casual model that is predictive of compassion fatigue. It has been found that a sense of achievement (or satisfaction) and disengagement are factors that lower or prevent compassion stress. This disengagement
involves a conscious effort to let go of the thoughts, feelings and experiences that result from
witnessing other people’s trauma and suffering (Figley, 2002).

The literature and theory on compassion fatigue has grown mostly out of research on trauma
therapists and focuses on the integral factor of the relationship between a therapist and their
client. Figley (2002) breaks down the model of compassion fatigue and the centre of this is
always the relationship. He states first and foremost that an empathetic ability is primary to
helping others, but this also puts caregivers at risk of suffering the negative effects of caring.
He further describes that one must possess empathetic concern, make an effort to decrease
the suffering they come into contact with (empathetic response) and have direct exposure to
the emotional energy of suffering. It is clear that in order for compassion fatigue to occur,
there must be a significant relationship that includes empathy between two people. This
empathetic relationship is something I strongly believe is also characteristic of the nurse-
patient relationship. Morse, Bottorff, Anderson, O’Brien and Solberg (1991) speak of this
nurse-patient relationship and state that the empathetic model of communication has been the
model used by nurses as well as taught by nurse educators for quite some time. Welch
(2005) also reflects on this nurse-patient relationship stating it has been found to include
trust, mutuality, congruence and authenticity. While the context of the relationship between
a nurse and patient is not one like that found in a therapy session between a therapist and
client, there are still many moments over the course of a patient’s time in hospital where
nurses connect with them and provide support and compassion, much like a therapist. Figley
(1995) states that professional work, which focuses on the relief of suffering of others, is
undoable without absorbing some of that suffering. This is also supported in the nursing
literature, where it has been found that in confronting other people’s suffering, nurses
themselves suffer (Morse et al., 1991). Nurses also contend that it is not possible to avoid
pain and still be compassionate (Morse et al., 1991).

Each of the above theories share hypothesis as to how interactions with one’s environment
(workplace) can affect an individual’s psychological well-being. These are very logically
argued theories and have all been shown to result in nurses who struggle with the demands
put upon them. My intention in talking about these theories was to use them as a foundation
for evidence that work environments and relationships can impact nurses. My main interest
was to focus on the unique stories regarding workplace stress from the nurses themselves.

2.3 Review of the Research

2.3.1 Stress and Nurses

It is not uncommon to hear nurses talking about the struggle of getting through 12-hour shifts
due to fatigue and stress. On top of this, in the era of “best practice” and the ever-changing
medical technology, nurses are also faced with having to stay current and continually master
new skills. Stress is often something that is just assumed to be “a part of the job” when it
comes to nursing, but what are the effects of this stress on nurses’ mental and physical health
and also their practice at work?

Chen, Chen, Tsai and Lo (2007) studied role stress and job satisfaction in nurse specialists in
Taiwan with 129 nurses. A cross-sectional design was used and the participants were given a
questionnaire that comprised a variety of pre-existing measures. Kahn’s five-dimension
model of role stress was used to measure role stress, while McCloskey and Mueller’s satisfaction scale measured the nurses’ job satisfaction and Costa and McCrae’s five-factor model was used to measure personality. Hierarchical regression was used to analyze the data and results indicated that role stress accounted for one quarter of the variance of job satisfaction. Role ambiguity and overload were found to be the highest predictors of job dissatisfaction and personal characteristics and training were also responsible for the variance of job satisfaction. Nurses indicated that increased role ambiguity decreased their satisfaction with professionalism, interaction, demand/reward and control/recognition. They also reported that as role overload grew, dissatisfaction in demand and reward increased as well. Finally, role ambiguity and role overload decreased job satisfaction, however role competence increased satisfaction with interactions.

Ross-Adjie, Leslie and Gillman (2007) looked at emergency room nurses and what occupational stressors are significant to them. They administered a three-part questionnaire to 156 emergency room nurses asking them to give demographic information first, then rank 15 workplace stressors taken from the literature and, finally, provide qualitative information regarding their experiences (if any) with debriefing following a stressful event at work. The top five stressors were found to be violence in the workplace, heavy workload and poor skill mix, mass causality, death or sexual abuse of a child and dealing with high acuity patients. The question regarding debriefing showed that nurses think debriefing is very useful following a stressful event and should be encouraged.
Hallin and Danielson (2007) conducted a qualitative study looking at the experiences of daily work, strain and stimulation for a group of 12 registered nurses with six years’ experience. Interviews were carried out and content analysis was used to analyze the text. The interviews were opened with a broad question asking about the participant’s experience of daily work. Minimal encouragements were then used to carry the interview and deepen the detail of the participants’ responses. Following their content analysis, a main theme of balancing strain and stimulation was found, with two related sub-themes of a stressful work situation and a stimulating work situation. Stressful work situation themes included being insufficient, being unsure of oneself and not enough contact with patients. Stimulated work situation themes included encountering patients and qualified health care staff as enriching, having situations under control and having the skills needed to be independent. Through the participants’ stories, it became apparent that there is a fine balance between strain and stimulation and that shifts move between the two. It also indicated that the participants felt increases in patient loads decreased the nurses’ ability to prioritize, plan and manage work.

2.3.2 Burnout and Nurses

Burnout is a phenomenon that has been widely studied, especially in the field of nursing. There is no question that burnout is very commonly experienced by many nurses in different settings all over the world.

Poncet, Toullic, Papazian, Kentish-Barnes, Timsit and Pochard (2007) carried out a study with 2,497 nursing staff in various Intensive Care Units (ICUs) in France. The participants were given questionnaires that included a demographic section, the Maslach Burnout
Inventory (MBI) and the Centre for Epidemiological Studies Scale for Depression. The results showed 32.8% of the participants suffered from severe burnout syndrome, 12% showed signs of depression and that there were a variety of factors that affected the levels of severe burnout syndrome. There was no significant difference in rate of burnout according to nursing rank, but there was a higher risk of burnout in teaching hospitals, and the risk of burnout was also higher in younger nurses. On the other hand, nurses who were able to have the holiday time they wanted had a lower risk of burnout, and positive relationships with fellow employees were also associated with a lower risk. Finally, having to care for and make decisions regarding life-saving or end of life treatment was associated with higher levels of burnout.

Ericson–Lidman and Strandberg (2007) used narrative interviews with nurses whose coworkers had developed burnout (and were on leave as a result) to study their perceptions of the signs preceding their workmates’ burnout. The 15 participants were all female and were chosen for the convenience sample by their nurse managers. The analysis of the interviews yielded five main themes which were struggling to manage alone, showing self sacrifice, struggling to achieve unattainable goals, becoming distanced and isolated and showing signs of falling apart. It is apparent from the interviews that there is a theme of them seeing their coworkers putting too much of themselves into their work and setting unrealistic goals. The authors suggested that some of these signs might be hard to recognize and interpret, as they are characteristics that are often encouraged in nurses.
Spooner-Lane and Patton (2007) conducted a survey using a cross-sectional design with 237 nurses who were mostly working in surgical care. Their focus on the determinants of burnout in public health nurses was measured using various items and measures from other pre-established tests. Wolfgang's health professions stress inventory was used to measure perceptions of job specific stressors, while role stressors were measured using the occupational roles questionnaire subscale from Osipow and Spokane's occupational stress inventory. Perceptions of support received at work were measured using items from various social support scales and, finally, Maslach's burnout inventory was used to measure emotional exhaustion, depersonalization and personal accomplishment. Results from the surveys showed there were moderate levels of emotional exhaustion, moderately high levels of depersonalization and moderately low levels of personal accomplishment. Full-time nurses showed more emotional exhaustion than those who were part-time or casual, while role overload, job conflicts and role boundary were found to be the main determinants of emotional exhaustion. Younger nurses in this sample were found to have higher depersonalization with role boundary and professional uncertainty as the main causes of depersonalization. Finally, role boundary and role ambiguity were the main influential factors of reduced personal accomplishment.

### 2.3.3 Compassion Fatigue and Nurses

Given the commonalities between a therapeutic relationship and the bond that nurses and their patients share, it would seem logical to assume that nurses too could be put at risk for suffering the effects of witnessing their patients' trauma and suffering, much like therapists working in the field of trauma. This risk is certainly supported in the literature.
Benoit, Veach and LeRoy (2007) carried out a study with 12 genetic counselors using focus groups to find out about their experiences of compassion fatigue. Their results showed that such things as delivering bad news, dealing with difficult patient issues such as terminal illness, emotionally investing in patients and being unable to help (i.e., change the outcome) put them at risk for compassion fatigue. These are all situations that nurses frequently encounter.

Within nursing literature, researchers postulate that exposure to people dying and sacrificing one’s own needs for the needs of a patient are factors that increase the risk for compassion fatigue (Frank & Karioth, 2006). Abendroth and Flannery (2006) add high patient loads, stress and life demands, and excessive empathy leading to blurred personal boundaries to this list. Schwam (1998) states that when nurses are subjected to the aftermath of traumatic events it can lead to them questioning their abilities when the outcomes are negative. Dealing with these situations on a daily basis and in multiple numbers (given the typical patient load of a nurse), it is clear that nurses are being put at extreme risk for suffering the effects of compassion fatigue. It is also obvious from the statements above that there are many factors that influence this risk for nurses which increases the complexity of the situation. Added to this is the unfortunate fact that there has been limited research on nurses and compassion fatigue thus far. Sabo (2006) states that most research has focused on patients and the pathology of their ailments in relationship to health care providers and that there has been little research carried out on the consequences for nurses of witnessing other people’s trauma and suffering (Sabo, 2006). This is especially true when it comes to acute
care nursing. To date, there has not been a study examining the effects of caring and the consequences of being exposed to suffering when it comes to acute care nursing as all studies have focused on nurses working in sub-acute settings.

In 2004, Maytum, Heiman and Garwick carried out a descriptive qualitative pilot study with 20 experienced nurses who worked in various non-acute care settings with chronically ill children and their families. They used an interview format consisting of open-ended questions in three categories: education and work experience, experience with compassion fatigue and burnout and triggers/causes of compassion fatigue and burnout. One week prior to the interviews they were all given a patient-family scenario as well as working definitions of compassion fatigue and burnout to use as a starting point for the interviews. They found that unreasonable policies, staffing shortages, general health care system dysfunction, lack of support at work and not being able to give a desired standard of care due to unreasonable workloads, were the main triggers of compassion fatigue.

Frank and Karioth (2006) studied 117 public health nurses who provided assistance to hurricane victims three to four months prior to the study. The researchers used a survey method where participants were asked to write about their feelings at the time of the disaster and then complete a compassion fatigue self-test answering in terms of how they were thinking and feeling at time of the hurricane. They were then asked to write about their thoughts and feelings in the present and fill out another compassion fatigue self-test using their current state for the information. They found that 27% of their sample was at risk for compassion fatigue.
Finally, Abendroth and Flannery (2006) looked at the prevalence and the relationship between nurse characteristics and compassion fatigue risk in 216 hospice nurses using the Professional Quality of Life Compassion Satisfaction and Fatigue Subscales: Revision III. In their sample of registered nurses and licensed practical nurses, nearly 80% were found to be at moderate to high risk of compassion fatigue. Results showed that such things as stress, a tendency to put others needs before one’s own, trauma, anxiety and life demands were all variables that increased the participants’ risk of compassion fatigue. While all of these studies have increased the knowledge base about compassion fatigue and nurses, there is still a long way to go and many different groups of nurses that must be researched.

There is quite a lot of support in the literature suggesting expansion of the breadth of knowledge around compassion fatigue (Abendroth & Flannery, 2006; Adams, Boscarino & Figley, 2006; Buchanan et al., 2007; Frank et al., 2006; Sabo, 2006). One of the rationales that points strongly towards increasing this knowledge as well as creating greater awareness of this phenomenon is the fact that it has the potential to impact helping professionals’ quality of work (Arvay, 2001). Collins and Long (2003) support this notion stating that professionals who are affected by compassion fatigue are at a higher risk of making poor professional judgments, which can also be said about those suffering from burnout or experiencing stress (Lazarus & Folkman, 1984; Maslach et al. 2001). Not only can these constructs negatively affect those who are around trauma and suffering, but also the effects extend into all of the people that are touched in the professional’s life. When it comes to nursing, there is even less known than with other populations, such as therapists. Researchers are voicing their concerns regarding this and are agreeing that there is a need for
more studies to be carried out with nurses (Abendroth & Flannery, 2006; Adams et al., 2006; Frank et al., 2006; Saho, 2006).

Frank et al. (2006) states that research must be done to understand how to prevent compassion fatigue in nurses as well as what should be done to decrease the risk factors involved. They also posit that this research should include more ethnically diverse as well as more male nurses. Abendroth and Flannery (2006) state the need for studies to be done with nurses from more varied settings and stress that qualitative studies are needed to provide a greater depth to the understanding of compassion fatigue. As stated above, to date there has been nothing examining nurses in the acute care setting which comprises 63.2% of the nurses currently registered in Canada (CIHI, 2006). With the chronic shortage of nurses that is widespread in Canada, it was imperative that more be done to examine possible reasons for this. Compassion fatigue may be a piece in this puzzle that has not yet been recognized due to lack of information known about it. Given the fact that no research had been done with acute care nurses surrounding compassion fatigue, it is imperative that studies be done to look at how nurses experience witnessing their patients’ trauma and suffering and if there are lasting effects such as compassion fatigue. The cost of caring is taking its toll on nurses and because of their invaluable role in our health care, something must be done to learn more about this in order to put proper resources and programming in place.
3 METHOD

3.1 Research Design: Why Hermeneutic Phenomenology?

Hermeneutic phenomenology is the study of lived experiences and is based on the belief that one best understands people from the experiential reality of their world (van Manen, 1998). It works to make meanings recognizable and attempts to describe experience as we live it rather than through abstract theories. Its intent is to do this with depth and richness, through a lens of mindful, caring wonder about the project of living (van Manen, 1998). It is a method that works to go beyond core concepts and is thought to be most useful for interpreting contextualized human experiences (Wojar & Swanson, 2007). Hermeneutic phenomenology is based on the premise that people cannot remove themselves from the contexts that shape their choices and give meaning to their lived experience (Wojar & Swanson, 2007).

These above statements are ones I feel capture my intent in doing this research. Nursing itself is a very concrete and hands-on profession and I believe that the only way to properly capture aspects of it is by looking at it in these experiential terms. Nurses, in general, do not work from abstract theories, but live nursing in their everyday lives. I believe this method allows for accurate, holistic interpretation of nurses and nursing work because so much of what makes a nurse is tied to personal values and attributes (therefore making it impossible to remove the person from their experiences as might be done in other methods of interpretation). It was my goal to capture the essence of the experience of witnessing patients' suffering and trauma for nurses through listening to their stories and experiences of doing just that. It was time to explore this topic with acute care nurses and uncover the meaning of this lived experience for them. I also feel that interpretive phenomenology is the
appropriate method to be used for this research given the fact that this aspect of nursing has not been looked at in the literature to date. An exploratory method was needed to start to lay the groundwork for beginning to understand what this experience is like for nurses. By richly describing the experiences of the participants in detail, I was able to paint a picture of a phenomenon that has been overlooked within nursing literature. I hope it will help to spark an interest in this topic and become the impetus for future research to be carried out in nursing and counselling literature. Finally, the data collected from this study is from the mouths of nurses and can therefore be used to increase awareness and understanding within the nursing world about a common experience that acute care nurses share on a whole.

One final reason why I feel hermeneutic phenomenology was a good fit for this research project is connected to my experiences and myself as a researcher. Given the fact that I am a nurse and have had my own experiences with this phenomenon, it was important for me to use a method that would address this and allow an understanding that I did enter this research with these experiences. Wojar and Swanson (2007) state that hermeneutic phenomenology researchers enter a situation with familiarity and background information from their own world and that this is what makes interpretation possible. They feel that hermeneutic understanding is made up of a blending of meanings coming from both the researcher and the participant. I went into each interview with an understanding of the dichotomy of my experiences and the participants (as talked about in orienting to the phenomenon), but I knew that the background knowledge I have would inevitably be a part of the interpretation process.
3.2 Sample Procedures

3.2.1 The Sample

The five participants in this study were registered nurses who have at least one year of acute care nursing experience (all were still currently working full-time in acute care at the time of interview) and self reported either current or past stress as a result of witnessing patients' trauma and suffering as per the selection criteria. All of the nurses had under 10 years experience with the majority working for less than 5 years. They were all female and four of the five nurses were under 35. They were all working in a busy acute care teaching hospital in Vancouver, British Columbia.

3.2.2 Recruitment Procedures

The main method of recruitment ended up being snowball sampling and all of the participants became known to me through my work as an acute care nurse. I distributed e-mail invitations and displayed posters inviting the nurses to participate in interviews if they self reported having witnessed a patient's trauma and suffering and as a result felt present or past stress related to it. These invitations and posters made it known that the study was being carried out, and all of the participants approached me directly or after speaking with other nurses.

3.3 Orienting to the Phenomenon

van Manen (1998) postulates that one cannot simply try to forget what it is that one already knows in order to bracket their experiences. He posits that it is better to make explicit your understandings, beliefs, biases, assumptions and theories than hold them at bay. Prior to
carrying out my interviews and following each one, I recorded my thoughts, feelings and experiences surrounding witnessing patients' trauma and suffering in a journal to aid bringing clarity to my biases and assumptions as well as the theory that underlies them. I felt this better allowed me to enter each interview in a place where I was open to each participant's individual experience and did not let my personal experience cloud these interactions.

3.4 Data Collection Procedures

3.4.1 The Interview

One-hour interviews were scheduled with each participant at a convenient private location for them, usually their home. The interview began with a conversation about confidentiality (and the limits to it), how and where the data would be stored, the general outline of the study and their right to withdraw their participation at any time followed by the signing of the consent form.

I began the interview by asking the question, “what has been your experience of witnessing your patients' trauma and suffering?” If the participant struggled with this, I asked them to try to think of a particular situation where this happened and invited them to describe what the situation was like for them. I used minimal encouragers to prompt further and more in-depth exploration of their experiences during the course of the interview. I then asked, “how are you coping and what would be helpful in facilitation of further coping?” and used the same steps as above if the participant struggled. Each interview was audio taped for future transcription. The interviews were each approximately 1 hour in length.
At the end of each interview, I gave each participant contact information for counselling resources available to them through Vancouver Coastal Health as well as in the local community in the event that the interview brought about any unsettling or new emotions for them that they felt they needed to talk about. I informed the participants that I would be contacting them at a later date following my data analysis in order to review my results to ensure they match their experience.

3.5 Transcription Process

Following the interviews, each was transcribed verbatim from the audio recordings. I was unable to transcribe each directly following the interview, but I reviewed each audio prior to the next to familiarize myself with the information that was collected before and with some of the general themes that emerged. As with orienting myself to the phenomenon, I felt that doing this helped to make explicit what was a part of the prior interview allowing me to enter each subsequent one with openness to its own uniqueness.

3.6 Data Management

3.6.1 Security Issues

Demographic information, audio recordings of the interviews and transcribed sessions were kept on a secure laptop, which required a password for entry (only known to myself and my supervisor). Any hand-written notes were kept in a locked filing cabinet on campus in my supervisor’s office. All demographic information was kept separate from the transcribed interviews and analysis of the data.
3.7 Role of the Researcher

As mentioned above, I am an acute care nurse and therefore it is only logical to assume that I would have some biases and hunches as to how I foresee the participants may experience this phenomenon. My impetus for doing this research is strongly connected to the fact that I believe that witnessing patients’ trauma and suffering can profoundly affect nurses. I have experienced witnessing my own patients’ suffering and trauma and realize without doubt that it has affected me in many ways. While I do not think I currently suffer from continuous stress as a result of this aspect of my work, I do think that there have been times when I have struggled. I realize that these personal experiences may result in biases on my part and so I continually did my best to make myself aware of these thoughts, feelings and assumptions and set them aside while interviewing and analyzing my data (as talked about in the section on orienting to the phenomenon).

I feel that my role in the research process was to provide a medium for the participants’ stories to be listened to and told. I initially provided adequate information to my participants regarding my expectations of them. I ensured that I provided a safe and comfortable environment for them to share their experiences with me and tell me their stories. I was non-judgmental, supportive and appreciative of the honor that I had in being given the opportunity to hear their experiences. Furthermore, I provided resources to them to further explore and discuss their experiences if they felt they needed to. Following the collection of the participants’ experiences I ensured their stories were portrayed in a respectful and accurate way and appropriately utilized the information given to me by staying true to the task of richly and accurately describing the participants’ stories.
3.8 Data Analysis

3.8.1 Phenomenological Reduction

Following the completion of all the interviews, I used phenomenological reduction to reflect on the text of each interview and look for themes or structures of experience. van Manen (2002) states that the aim of the reduction is to re-achieve a direct contact with the world as it is experienced as opposed to how it is conceptualized. He feels that reduction is used to bring into focus and provide clarity to the uniqueness of a phenomenon the researcher is oriented to. van Manen finally states that reduction cannot be explained in terms of a procedure but that it should be more like bringing attentiveness to work to understand the meaning of the participants' lived experience. For the purpose of my research I will combine two of the three potential guidelines to promote attentiveness described by van Manen (1998).

3.8.1.1 Holistic Reading of the Text

I first reviewed the interview transcriptions as a whole and pulled out the phrases that captured the fundamental meaning of the text. I then condensed this initial analysis into a couple of pages in an attempt to present the general overall picture of each experience told.

3.8.1.2 Detailed Reading of the Text

I then read through the text looking at every single sentence or sentence cluster that revealed something new about the experience. These meaning units were highlighted and coded using appropriate phrases. I then compiled all of these coded meaning units to describe the experience for the individual. Finally, I compared and contrasted this description of the experience with the initial pages formed by the holistic reading of the text.
3.9 Criteria for Trustworthiness

3.9.1 Member Checking

Once I completed the above two steps for each of the transcripts, I compiled all of common themes, and described them with bulleted points for ease of reviewing for the participants. I then mailed them to the participants and asked for their feedback, thoughts and feelings about whether it was representative of their experience.

There were three criteria that allowed me to know my findings were trustworthy. I asked the participants for comments on the resonance, comprehensiveness and pragmatic value of the themes by asking the following questions:

1. Do these themes resonate for you; do they correspond closely to your experience of witnessing your patients’ trauma and suffering?
2. Do these themes present a comprehensive representation of your experience of witnessing your patients’ trauma and suffering?
3. In your opinion, do these themes represent information that holds practical value for nurses?

All of the participants made no changes to the initial themes and voiced agreement that the information was representative of the experience. These agreed upon themes were used to create a final description of the experience.

One participant added as an aside that since leaving the area of nursing she was working in at the time of the interview she is much happier and has been feeling less stress. She attributes this to it being an area that is better suited for her interests, being in a smaller community
based hospital and also a work environment/administration that is much more supportive of its staff.

3.9.2 Expert Review

Once I had a final set of themes, I shared them with a nurse who has extensive experience with nursing asking for her feedback. She is very familiar with nursing research and also the struggles that nurses face and commented on the above three questions. She agreed that the themes were closely related to her personal experience of witnessing patients’ trauma and suffering, noting that it reminded her of similar personal experiences as a nurse such as her first code, feelings of stress and hardening to the realities of nursing. She felt that the themes were a comprehensive picture of the experience of witnessing patients’ trauma and suffering voicing that it accurately captured the reality of nursing. Finally she agreed that the study holds pragmatic value for nurses expressing that it validates the experience of nurses and nursing and that in her opinion the themes would resonate for nurses in all areas of nursing.

3.10 Ethical Considerations

Due to the sensitive nature of the construct being studied, there was the risk that the participants would experience negative emotional and psychological effects as a result of talking about their experiences with witnessing their patients’ trauma and suffering. New awareness or insight as well as reminders of traumatic experiences could have resulted from the interview process. Due to this, I provided the participants with contact information for Vancouver Coastal Health employee resources as well as community resources that are
available to them in the event that they feel they need someone to talk to or support in
dealing with their experiences following the interviews.
4  RESULTS

After reviewing the transcripts, it became apparent there were five main themes that were prominent in the participants’ experiences for the first question (what has been your experience of witnessing your patients’ trauma and suffering?), and two main themes for the second question (how are you coping and what would be helpful in facilitation of further coping?). The themes seem to arise in the form of a process and therefore I will present them in the order in which they occurred in the participants’ experiences. The first part was witnessing a traumatic event and/or prolonged witnessing of suffering within an acute care environment which led to a group of common effects. From there, there were two responses to the effects, which were distancing (both at home and at work) and guilt. The final part to the process was that of a change in self. For the second part regarding coping, the two themes were what the nurses are doing to cope and what they think would be helpful for further coping. Below is a summary of the themes which is followed by a more detailed description of each theme individually.

1. Witnessing within an acute care environment:
   - Traumatic Codes and/or deaths
   - Being around patients with chronic/terminal illnesses and their families
   - Seeing little success
   - Lack of control and power at work
   - No support from management
   - Not enough time to do everything that should/could be done – lack of resources
   - Lack of respect/mistreatment from patients and families
An expectation that nurses will deal on their own with issues and/or not be affected

Stress as a norm at work

2. Effects:

- Stress
- Feeling overwhelmed
- Re-visiting of situations at work (flashbacks, dreams, analyzing)
- Feelings of depression
- Taking it home with you
- Trouble sleeping
- Anger
- Irritability
- Anxiety
- Emotional and physical exhaustion

3. Distancing as a means to cope:

- Becoming detached
- Trying not to listen to patients stories/take on too much
- Not wanting to be vulnerable
- Disinterest in normal activities outside of work
- Distancing from family and friends
4. Guilt
   - Related to distancing
   - Over not being able to make things better
   - Due to not being able to do things how you would like/do more
   - Self blame when negative things happen

5. Change in Self:
   - Become hopeless
   - Change in perspective on life
   - Negative outlook
   - Decrease in empathy

6. Coping:
   - Talking (with nurses other nurses most helpful)
   - Exercise
   - Enjoyable activities outside of work
   - Moving to another area of nursing

7. Recommendations for coping:
   - Debriefing – both regular and after critical incidences (during work hours)
   - A supportive place to talk to other nurses/another nurse
   - Support from management
4.1 Theme 1 – Witnessing Within an Acute Care Environment

The first theme that was a part of each of the participants’ experiences of witnessing their patients’ trauma and suffering was that of a traumatic event and/or prolonged witnessing of patients’ suffering within an acute care environment. Some spoke of a specific event that led to various effects and each spoke of prolonged witnessing of suffering and trauma that resulted in effects.

One participant (DB) shared her experience of a patient she had been caring for, for quite some time, and struggling to get the care for him that she thought was needed:

I open up the curtain and just boom, he’s dead! I just could see his face, even to this day I can still see his face . . . it was awful, it looked really bad . . . it was the worst image you could have in your mind ever. It was horrible and I was just in shock and I just closed the curtain and was like oh my god, he’s dead.

Another participant (SP) spoke of a code that she was a part of and the experience of being in the room while the patient is being worked on:

. . . The most traumatic part was that the family was present and so it was so overwhelming. You could see the emotion on everyone’s face in the room, the healthcare providers were trying not to cry themselves and being the nurse that was looking after the patient for the last couple of days I just felt awful about the whole situation.

Three of the participants expressed that they could still remember things like their first code. They could describe every detail, from conversations to sights and smells, and still thought about whether they could have done anything differently.
While those particular experiences were shocking and traumatic for the nurses, what is interesting is that those nurses who spoke only of prolonged witnessing of suffering also had similar effects. SH and LS described their experience of caring for patients with chronic or terminal illnesses:

SH: I really have no words to comfort those patients, I don’t know what to tell them and I find it very depressing and very frustrating. I feel sometimes going to work that I need something different, I need to see some success, someone getting better, someone carrying on with their life, there are days where it’s really, really hard.

LS: Just to have to watch him suffering and knowing that he was declining was hard. I find that it’s often harder to deal with the family suffering, I think just because with patients if they are suffering or in pain you can get them medications and you can get them things to comfort them whereas with the family there’s not really too much that you can do other than just listen and try and support them.

Participants spoke of the challenges of seeing little success with their patients and that it was hard to see the same “case” over and over. They described changes in themselves after caring for patients time and time again who did not get better or who were in the same situation as many before them. Another part of the experience that seemed to bring about change was a lack of respect from some patients and their families. DB described how experiences such as this lead to changes in her:

Those events are not the only things that hardened me on that unit, it was also the way that people treat you and the disrespect that you get from patients and families... it made me feel like I work really hard, I try and do my best and this is what I get? So I’m not going to be too nice because if I am too nice you get eaten basically, you have to be a little bit tough...
Another aspect of this theme that was consistent with most of the nurses was that of a lack of control at work. They described frustrations at not being able to do anything about patient outcomes as well as system pressures and demands.

Something that seemed to significantly impact the experience of witnessing trauma and suffering was that it was occurring within a specific context of an acute care environment. This environment brought about certain challenges that each of the nurses described in different ways. They spoke of lack of time and resources as well as how there seems to be a norm or culture of “stress” and that often this “stress” influences how they can care for their patients, and their subsequent experiences. LS described her experiences:

All of the little things that we were taught to do for our patients, there is just no way in the real world that we can do it; it adds to it because at the end of the day quite often I walk out of there thinking I’ve done the bare minimum, I’ve kept them alive, I’ve done the things that absolutely need to be done but I haven’t done anything in my mind to really help them. I’ve just kind of maintained where they are at.

There are so many demands and you’re pulled in so many different directions and you want to do everything that you can for your patients but there’s just no time.

This participant’s experience shows evidence of stress as spoke of in Lazarus and Folkman’s research (1984). The context that she describes is one that exceeds her resources and endangers her well-being. This aspect of the nurses’ experiences was closely related to feelings of guilt which will be discussed later in the results.

The next part of this theme was described as a lack of support from management as well as an expectation that nurses will either not be affected or will deal independently with their issues. It seemed from their stories that nurses felt management on a whole does not address
many of the issues they come up against, but especially the emotional ones. CM voiced her experience and how it has led to her leaving full-time work in acute care:

I think that another reason why I've left in addition to the stress, is the feeling of having no support. It feels like the hero model like everyone is expected to feel that stress... it's the culture, it feels like you're supposed to feel that way, if you don't feel that way you're not doing your job, so I don't feel like there is anything that they do to make it not so stressful.

All of the nurses described this lack of support from management and felt that it was a very significant issue that made the situations they deal with more difficult. Different nurses had suggestions as to what might be helpful from management, which I will discuss later.

4.2 Theme 2 - Effects

The second theme that emerged was that of various effects that seemed to come about as a result of witnessing patients' trauma and suffering within an acute care environment. While each participant experienced these themes in different ways and secondary to different experiences, there was a list of effects that seemed to be experienced at one time or another for all. Each of the participants spoke of being stressed and feeling overwhelmed along with physical and emotional exhaustion quite often while at work. These things coupled with witnessing suffering and traumatic events seemed to lead to effects that were longer lasting than the ones at work and significantly affected their life outside of work. LS described what it is like when she takes work home with her:

I would quite often be distracted. I wasn't able to focus completely just because my mind would keep going back to that. I couldn't detach myself from it even when I was at home, I was constantly talking to my husband about it, I don't know if I was
trying to unload it from myself or what I was doing... it’s almost like it consumes you in a way.

They all described situations at work staying with them, sometimes for years after the fact. There was a common thread throughout all of the stories told, that their patients and work become a part of them. In addition to distraction and being pre-occupied with events that occurred at work, the nurses spoke of more serious effects, especially following particularly traumatic events. SP described her experience following a traumatic code:

I could not sleep for three weeks after, I was feeling extremely depressed and not really eating and you know, the general signs of depression... I reflected on it and then realized what triggered it. I felt so bad for that family and their situation that it was just extremely overwhelming for me and I didn’t know how to cope at the time.

With the traumatic experiences on an emotional level, it’s really hard a lot of the time to cope... it looks like trouble sleeping, irritation, anxiety and physical symptoms. I’ll wake up at night with heart palpitations and not able to breathe or I’ll have really bad panic attacks. I’m not sure if it’s completely related to work but work definitely plays a factor in those emotions I’m having.

This participant’s description denotes possible compassion fatigue symptoms as described by Figley (1995).

Another common experience for the majority of the nurses interviewed was that of flashbacks to traumatic events. DB describes what this is like for her:

It just sort of comes when you least expect it, you’ll suddenly start thinking [about an event]... and all of the thoughts and feelings that you had at that time...
In addition to trauma like responses, all of the participants confided that they often felt unusually irritable and had feelings of depression both at work and home. Some spoke of anger and anxiety that comes as a result of the issues and events that they experience at work. As SH told in her story:

"I just want to scream sometimes! I think it's not supposed to be like this, she's too young to leave and not to have all of these opportunities. Nursing teaches you to support, to provide comfort and I don't know what to tell these people . . . medically you give them something for pain or anxiety, you medicate them and then you have the room and you want to cry."

It became very clear in the participants' narratives that there was something else that was going on secondary to feeling tired and stressed as a result of a busy work environment. LS stated that:

"It's not the fact that we're on our feet 12 hours a day running around like crazy; it's the fact that we have all of these psychosocial and emotional issues. You can't rest and recover from that; it kind of becomes a part of you; it's hard. I find I don't have as much of me to give when I get home because I'm spent."

This description sounds like the emotional exhaustion that Maslach et al. (2001) speak of as an element of burnout.

The effects described by all of the participants mirror stress, burnout and compassion fatigue symptoms as described by Lazarus and Folkman (1984), Maslach et al. (2001), Figley (1995) and Stamm (1995). The participants made it very clear that nursing is not just a job, but also something that becomes a part of you. Each described struggling with the above effects at various times over their careers, some to the point of questioning whether to continue work as a nurse.
4.3 Theme 3 – Distancing as a Means to Cope

The third theme that surfaced in participants’ stories was one of two responses the nurses seemed to have as a result of the effects they experienced. Each of the nurses spoke of distancing themselves, all at work, and the majority of them at home with their families at different times. They described this as sometimes the only way of coping, however they were also clear that they did not like to have to cope in this way. SP and LS shared their experience with this:

SP: I just kind of withdrew, I started not getting as attached, I was being a little bit more withdrawn with conversation with patients and getting to know them because I was afraid that if I got to know them better that I would witness something else that was traumatic and have the same sort of problem [effects].

LS: Sometimes I just feel like I don’t have anything left, I’m almost at the point where I just try and cut myself off, I try not to listen to personal stories and whatever because I can’t, I can’t know . . .

They described the distancing and detaching of themselves as a way to not be vulnerable and this was not only with patients. The majority of the nurses also spoke of distancing themselves from their family and friends, especially when they were working a set of shifts. The common reason for this seemed to be that it was too much to handle, that work was taking so much of them; they could not or did not want to deal with anything else. LS and SP describe what this is like for them:

LS: When it’s really bad I just shut off completely from everything I do, I just kind of retreat into myself and I don’t really feel anything. I don’t socialize, I don’t do anything, I just kind of sit and try and work through it on my own.
... It's not that I don't care, it's just I feel like I just can't deal with it and so I just kind of go numb.

SP: I withdrew at work and at home, not wanting to go out and do anything, just kind of staying at home and not wanting to do even the activities that I like to do at home.

There was quite a lot of guilt that went along with the practice of distancing as a means of coping for the nurses. They felt that "distancing" and "numbing out" were often the only ways that they could get through their day and still function and it came about after the nurses had experienced being vulnerable, were emotionally impacted by their work and then could not find other ways to cope. CM described what this is like for her:

After a while there is no way to effectively cope with it except detaching yourself and when you detach yourself it makes you feel like a bad person.

It's just too much to handle, you can't, if I ask all of my five patients [about psychosocial information] I would just have the heaviest heart, I wouldn't even be able to cope with that [and] I wouldn't be able to function.

It was clear from hearing the nurses' stories that the practice of distancing created negative effects and was not seen as the answer for dealing with the effects of being affected by their work as a nurse but more an act of desperation. DB shared her thoughts:

... I don't want to get into all the details of their entire life story because it's going to be too hard. I'm going to have to care and then I'm going to have to think about it . . .

This distancing used as a way to avoid the negative feelings and effects that they have experienced at other times when they have not distanced, as well as detachment from significant others are both symptoms of compassion fatigue as cited by Stamm (1995). Distancing, numbing out and having feelings of guilt are well documented in the trauma
literature as common effects of secondarily witnessing the trauma and suffering of another, it appears that acute care nurses are not immune to these effects.

4.4 Theme 4 - Guilt

The fourth theme that was prominent in the participants' stories and was another response to the effects was feelings of guilt. As touched on above, a lot of this guilt is related to the distancing that takes place for the nurses in an attempt to cope with the often-painful experiences they have. There seemed to be a realization at some point, for all of the nurses interviewed that they did not like what was happening and who they were becoming as nurses. These feelings were having an impact on their personal identities as nurses and as human beings. This place of dissonance was one that brought about much angst for the nurses. DB expressed her struggle with this:

I don't want to become an evil nurse or a mean nurse or a non-caring person that is task oriented - you just do your job and you don't want to think about the emotional part. I don't want to be like that, I want to be caring so it started to make me feel like I'm not a good person.

The participants were very aware of the fact that they were not doing "good nursing" in these times and were not being the nurse that they knew they could be and were, deep down. They spoke of the pain, stress and frustration that results from opening themselves up to their patients' stories, forming relationships and from giving all of themselves as just too much.

Another part to this guilt was the fact that they were. All of the nurses spoke about the lack of time and unreasonable demands put on them as sources of stress, exhaustion and frustration and also components that decreased the quality of care that they could give their
patients. This brought about strong feelings of guilt and sadness for the acute care nurses.

LS shared:

I feel like I’ve let [patients] down and like I’ve let myself down because I know I could do so much more for them if I had the time. I feel bad because so often I have to tell people no if they want something, I have to, and you know they are sick and you know it’s hard. It’s difficult because you want to do so much more than you’re physically capable of doing. You just want to do better and make everyone comfortable.

I feel bad because some patients get 100% of me and then if somebody happens to catch me on an off day where I’m feeling overwhelmed or whatever I feel terrible because . . . I’m probably not doing all that I could for them.

The third part that became apparent in this theme was the guilt that all of the nurses felt related to their general lack of control over patient outcomes and the fact that their patients, who are people they care about, were having awful experiences in hospital. Three of the nurses shared their experiences of feeling helpless:

SP: I feel like well if all of these other people are suffering do I deserve to be happy myself?

CM: You feel guilty that they are in that situation and you can’t give them any real solutions or answers.

. . . I just wish there was more that we could do because it seems like so often people just come in and get worse . . .

SH: I feel sad and I feel frustrated because we can’t really help [the patients] much, I feel that it’s just not fair, many times I just feel it shouldn’t be this way . . .

There was a common experience of feeling guilty that bad things were happening to people who didn’t deserve to be sick or battle with illnesses, this adds another layer to the struggles that the nurses interviewed go through each day. At the root of the guilt that was described by the nurses seemed to be a strong desire to nurse at a standard that they are not able to

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reach whether it be due to coping mechanisms secondary to the emotional effects, system constraints or general frustration at not being able to stop negative things from happening to other human beings.

4.5 Theme 5 – Change in Self

The participants’ stories, in terms of their experience of witnessing patients’ trauma and suffering in an acute care setting, described a process of distancing, feeling guilty, frustrated and helpless which eventually led to an internal dissonance. This dissonance between their beliefs about nursing and their actual lived experiences in their acute care setting finally led to changes in their sense of self. The majority of the nurses had a realization that not only were they enduring situational effects along with longer-term manifestations secondary to what they were witnessing, but they also noted changes in themselves as a person. Since being interviewed, three of the nurses have moved to other areas of nursing and each of them spoke of how these changes were part of the impetus for leaving. Some expressed feelings of hopelessness and a negative outlook while others talked of a decrease in empathy. SP and CM speak of this hopelessness:

SP: When I first started I was all “gun hoe” and solid as a rock, nothing bothered me and then after time seeing all of these things all the time for almost two years now it’s like oh! There is always new people, always new things, always getting sicker and you’re just sitting there and you’re like, ‘is there ever an end?’ Sometimes it seems so hopeless for some of these people and I think that’s starting to wear on me.

CM: After a while I started to see the same kind of situations, patients not getting better, patients suffering and I felt like I didn’t have the power to do anything about it and so I went from being a little less hopeful to disillusionment.
DB told her experience of feeling a decrease in empathy:

I think I’ve become hardened, I don’t think I’m as empathetic as I was before and I think I was becoming like them [other nurses], I was changing . . . you see the same thing over and over again and it’s like you don’t want to feel that.

Common to all of the nurses experiencing these effects was the notion of not wanting these changes to be permanent. They spoke about the impact on self as a change in their ability to be empathetic and a disillusion with the profession of nursing. Their beliefs about core aspects of self-as-nurse were being challenged. The dissonance between former beliefs about nursing and the type of nursing they were now experiencing created a great deal of personal stress.

Not all of the changes the participants spoke of were negative. The majority of the five nurses also expressed positive effects in terms of taking the knowledge they have and their experiences and using them as encouragement to live their lives in a positive way. SH spoke of this in her interview:

I try to be more conscious about what we have, like good health, or relatively good health, still being able to get up and walk and do your job and enjoy life. I try to cherish that more, try to just do what I can to keep that life as it is and try to teach my children and other young people that I find don’t appreciate life and health . . . I try to make some change for me [and] for my own family whether it’s exercise, decent food, or just finding some sort of balance. [I do this] because [work] is really sad, it’s frustrating, it’s depressing and I find that if I want to do this job and if I want to carry on with my life I need to find some sort of balance and that’s what I try to do in thinking and applying all that knowledge and what I see, all the experience that I [have], I find [I] have a different perspective on life.
Whether negative or positive it was clear that all of the nurses felt that their job created changes in them as a result of their experiences. While there were positive changes for some, all shared struggling with the negative changes.

4.6 Theme 6 – Coping

The second question I asked the nurses I interviewed was about their coping strategies. I wanted to know how they coped with all of the struggles talked about above, and what would be helpful in facilitation of further coping. Unanimously they all expressed that the most helpful thing in terms of coping was talking to other nurses. They explained that this was due to the fact that only nurses could fully understand situations that others, such as their family members, could not. Three of the nurses spoke about this:

SP: I find I have to debrief a lot in order to deal with the emotions of work. Just like talking to people, I talk a lot because if I don’t then I cry a lot more, sleep a lot less and eat a lot less.

SH: I talk to people I work with because they’ll understand, not just because they happen to be there but I think because we are in the same situation they will understand.

DB: I talk until it’s out of my system, I talk to my friends [nurses] until I can breathe. I talk to my husband too but it’s easier to talk to people who understand the situation.

Three of the five nurses also talked about exercise being helpful in coping as well as ensuring that they did enjoyable activities outside of work. They explained that this not only took their mind off what they experienced at work but also reminded them of the good things in life.
As discussed earlier, three of the five nurses have since changed their area of nursing and spoke of this as a necessary thing to cope for them. Each expressed sadness and frustration at having to do this but nonetheless knew that it was absolutely needed. One of these nurses talked about her experiences:

[I cope by] leaving and going casual, changing my shifts to casual was a huge coping thing because I feel like I can't deal with it anymore and if I do stay full time then I'm just going to become the most horrible jaded nurse and person.

Four of the five nurses spoke about having thoughts of leaving their current area of nursing - or nursing as a profession all together. While the other nurse still shared in the hardships and struggles of her colleagues, she described coping differently then the rest. She used the coping mechanisms talked about above but the unique difference in her experience was that she spoke of changing herself in response to situations that come along. SH shared:

Maybe it's just me personally, whatever happens I've tried not to fix the situation, I've tried to fix myself and find ways for me to cope . . . maybe it's a cultural thing and maybe it's a generational, I'm not sure.

SH also spoke of her experiences with teaching students and shared what she tells them:

. . . First you have to be ready, maybe not born for the job but not everybody can be a nurse and you have to know that you can't to this job for the money . . . you have to learn to work as a team . . . you can't do it on your own . . . find something [and area] that's appealing and that you can cope with and that you can manage . . . find a venting mechanism . . .

Some of the other nurses shared their experiences and said they felt supported by their colleagues and talked about working together, but that in the end it was still often not enough. What was clear from the nurses' stories was that they are all "coping", but there is
still something missing. They realize that they need more support, which will be discussed in the next theme.

4.7 Theme 7 – Recommendations For Coping

The final theme that arose for the question of coping was that of what would be helpful for the nurses in further coping. In line with the above theme, they all expressed that having somewhere to talk to someone who would understand, preferably at work and during work hours, would be the most helpful. They voiced a need for debriefing, both after critical incidences and on a regular basis. Each explained that talking to nurses was easiest and most beneficial because they were the only ones who could really understand. SP, DB and LS explained their thoughts:

SP: It would be nice if there was someone to talk to where it would be OK to describe the situation. It’s really hard with confidentiality . . . it’s hard for anyone else to understand if you can’t describe exactly what you saw.

DB: We should have [debriefing] open to us right away, Employee and Family Assistance Program is great . . . but it would be nice if they could just come to where we work.

I think I do need that kind of support where someone would say it’s OK to feel bad! That you don’t have to buck up . . . that it’s normal to blame yourself . . .

LS: It’s nice to have debriefing at work, just some of the situations that we come across I don’t see how anyone is expected to handle that on their own.

I almost feel like if I talk to somebody at work and we have a debriefing or something at work I feel like they can actually understand more and share in whatever it was that I went through, whereas my husband doesn’t understand.

Each of the nurses agreed that the experiences that they have on a daily basis at work are too much to handle independently. They feel more needs to be done in the workplace to provide
nurses with emotional support. The participants felt this support needs to happen on work
time and be easily accessible following incidences, but also as a routine support. LS shared
her experience of a debriefing that she was a part of in the past at work.

I think it would be nice to have kind of a routine thing where we can just go and kind
of unburden ourselves, you know even if it’s just a couple of times a year, just to have
somebody . . . I still remember the way we all felt or the way that I felt at least
walking out of there [after a past debriefing] and listening to other people and talking
it was almost like we had new life . . . I felt like I could breathe and it was just like
finally I’ve gotten all that out and now I can start to fill up again.

LS and the others questioned why debriefings and other support like debriefings are not
available to them. They felt it is clearly something that would be very helpful in making an
inevitably challenging workplace more manageable.
5 DISCUSSION

5.1 Conclusion

After reviewing the literature along with the experiences the participants shared in their interviews, it is quite clear that the experience of witnessing patients' trauma and suffering as an acute care nurse is multifaceted and complex. The themes that emerged seemed to create a process whereby the experience of witnessing either a traumatic event or enduring prolonged witnessing of patients' suffering over time within an acute care environment, led to certain effects and then responses to those effects. While each of the participants' stories were unique, there were many common threads that point to a collective experience within the individual narratives. The review of the literature examined stress, burnout and compassion fatigue as potential constructs that could be a part of the nurses' experiences. Following analysis of the participants' stories, it is quite clear that all three of these constructs could very well be a part of this multi-layered phenomenon.

The participants spoke of the unique context of health care and more specifically acute care, as a very significant aspect of this experience. It is one that I think sets the scene for an already challenging situation and increases the fragility of the nurses and the experiences they share. In the review of the literature, Lazarus and Folkman (1984) spoke of stress and the fact that it comes about when an individual interprets their environment through cognitive appraisal as requiring more resources than they are able to give. After listening to the participants, it certainly sounds like this definition of stress is also a very accurate description of an acute care nursing environment. It would be logical to assume that stress is very much a part of this experience for nurses and their cognitive appraisal of resources is something
that is continually occurring. Coupled with this appraisal is the reality that resources are more often than not lacking, which does lead to stress and anxiety for the nurses (as told in their stories) much like Lazarus and Folkman's (1984) research suggests. Lazarus and Folkman (1984) state that if someone is highly committed to the outcome, but experiences a lack of resources and therefore inability to cope, it can be devastating to them. If anything became clear in the experiences of the nurses that were interviewed, it was their commitment to their patients and the relationships that are formed. While this commitment is very much an integral part of the nurse patient relationship, it is one that puts the nurses at serious risk for stress given the chronic lack of resources in health care today. The many accounts of stress and feeling overwhelmed in the nurses' stories are proof of this. The nurses spoke candidly about a continual lack of resources. Whether that was in the form of time, other nurses or support, all brought about much stress for the participants. This lack of resources spoke about by the participants supports stress research carried out with nurses by Chen et al. (2007), Ross-Adjie et al. (2007) and Hallin and Danielson (2007), which was highlighted in the review of the literature.

Chen et al. (2007) found that role ambiguity increased stress and therefore decreased job satisfaction which was not a part of the nurses’ experiences with respect to witnessing their patients’ trauma and suffering. Their results also indicate that role competence led to increased job satisfaction which was touched on in the experiences that were a part of this study, supporting the above research.
Ross-Adjie et al. (2007) found that the top five causes of stress for the nurses in their study were violence in the workplace, heavy workload and poor skill mix, mass causality, death or sexual abuse of a child and dealing with high acuity patients. While heavy workload and dealing with high acuity patients were talked about by the participants, the other stressors were not. Some of this is likely due to the fact that none of the nurses in this study work in an emergency room setting or with children and therefore are less likely to come into contact with the factors spoke about above. What was supported by the present study was the results indicating the usefulness of debriefing in the workplace.

Hallin and Danielson (2007) showed that stress came about as a result of the nurses feeling insufficient, being unsure of themselves and not having a desired amount of contact with their patients. They also found that feeling qualified, under control and having the skills to be independent was stimulating for the participants as opposed to stressful. All of these themes are ones that were a part of the results of the present study.

Some of the participants referred to a “culture of stress” and an environment that encourages its professionals to be stressed and even rewards them for it. They shared that if they weren’t stressed and pushed to the limit they would be frowned upon in the workplace. This context is what sets the stage for nurses to do the work they do and if it is already flawed to the extent that it is and putting this extreme stress on the nurses, then it is no wonder they would be struggling with more serious emotional effects from their work in this stressful environment.
The next construct that was discussed in the literature review as a potential component of nurses' stress was burnout. Burnout has been widely studied in nursing and health care literature and has definitely been proven to be a chronic issue that plagues many healthcare professionals. The literature states that exhaustion, detachment from one's job and feelings of lack of accomplishment are the main tenants of burnout (Maslach et al., 2001). All three of these aspects of burnout are very visible in the experiences described by the participants. All five nurses described feeling emotional and physical exhaustion frequently at work, which was often secondary to the stressful environment of acute health care. Maslach et al. (2001) speaks of exhaustion being the central component of burnout and that it leads people to detach themselves from their work by depersonalizing others. Detachment or distancing is very much a part of the nurses' experience of witnessing the trauma and suffering of their patients as described in the results section. While the nurses describe exhaustion and detachment and often times the two constructs together, it does not seem as though exhaustion is the central reason for nurses' detachment. This being said, it is definitely a part of it and as the nurses also speak of feeling as though they are not doing enough or a lack of accomplishment, burnout does seem to be a likely aspect of the nurses' experience along with management of stress.

While the accounts from the participants were not as detailed with respect to burnout as the burnout studies cited in the review of the literature, they do exhibit information that supports many of results found by previous burnout researchers. Poncet et al. (2007) found that those working in teaching hospitals and younger nurses were at higher risk of developing burnout. The nurses in this study work at a teaching hospital, the majority of them were under 35
years of age and all showed signs of burnout, this is supportive of the above study’s findings.

Ericson-Lidman and Strandberg’s 2007 research looking at the signs preceding burnout yielded themes of struggling to manage alone, self sacrifice, struggling to achieve unattainable goals, becoming distant and showing signs of falling apart. All of these symptoms were prevalent in the nurses’ narratives again backing the burnout literature.

Spooner-Lane and Patton (2007) speak of part time and casual nurses struggling less with burnout and younger nurses struggling more with depersonalization. Given that one of the nurse’s ways of coping was to change her main employment area and decrease to casual hours in acute care, this may show supportive evidence of the above findings. Furthermore, as the nurses in this study were all quite young and spoke of distancing as a means to cope, this may support the results with respect to depersonalization spoke about above.

What was not touched on in the present study in terms of burnout literature was influences of holiday time, positive work relationships and decisions regarding end of life care (Poncet et al., 2007) (with the first two factors as relievers of burnout and the last as an element that increases the risk of burnout) as well as job conflict and issues with role boundaries and ambiguity (Spooner-Lane and Patton, 2007) all being things that increase the risk of burnout.

The research shows that burnout symptomatology has many similarities to the effects the nurses interviewed described. Stamm (1995) speaks of troubles sleeping, anxiety, depression, pessimism, withdrawing and issues with concentration as all signs of burnout, all of these things are aspects of the nurses’ stories. This gives strength to the argument that burnout may be something the nurses in this study are experiencing, however it does not
sufficiently describe the experience. There seems to be more to it. Not only did the effects sometimes occur quite suddenly (which is not an aspect of burnout), but there was also at times confusion and hopelessness that came with the effects, which is how Figley (1995) distinguishes burnout from compassion fatigue.

The third construct that was reviewed in the literature was compassion fatigue. I spoke of this phenomenon and its novelty in nursing research as a potential aspect of the experience of the nurses who were to be interviewed. As stated above, there has been very little research to date with nurses and compassion fatigue and therefore there is minimal knowledge surrounding this construct in this context. Through studies with other populations of people, researchers have been able to carve out a process by which compassion fatigue occurs as well as common effects associated with it. Along with stress and burnout, the results from this study also show evidence in support of compassion fatigue being a component of the nurses’ experience. Compassion fatigue has been defined as the “natural consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person” (Stamm, 1995, p. 10).

As was talked about earlier in this paper, compassion fatigue has been found to have almost identical symptoms to PTSD. Figley (1995) speaks of a stressor, re-experiencing of the traumatic event, avoidance of reminders of the event and finally persistent arousal. The nurses interviewed described stressors as traumatic events or prolonged witnessing of suffering, which began a process of effects and responses to these effects. One of the
prominent responses to the effects was persistent arousal in the form of anxiety, feelings of stress, trouble sleeping and sometimes struggles with focusing or concentrating. The nurses described avoidance of patients and their stories, as they were reminders of past negative experiences and the emotions they felt in response to those situations. Stamm (1995) lists the common reported indications of compassion fatigue as recollection, sudden re-experiencing or dreams of the distressing event, avoidance of thoughts, feelings and activities that are reminders of the distressing event, detachment from others, diminished interest in activities, troubles sleeping and concentrating and irritability. All of these manifestations were described in the experiences of the nurses interviewed, which is evident in the results section.

Past nursing research found that exposure to death, sacrificing one’s own needs (Frank & Karioth, 2006), high patient loads, stress and life demands, stress, trauma, anxiety (Abendroth & Flannery, 2006), questioning of ability (Schwam, 1998), unreasonable policies, staffing shortages, system dysfunction, lack of support and not being able to give a desired standard of care (Maytum et al., 2004) were all factors that increase the risk of compassion fatigue. Each of these constructs were components of the participants’ stories which is supportive of the literature and points to the fact that they likely are at great risk of suffering from compassion fatigue. Excessive empathy leading to blurred personal boundaries which was talked about by Abendroth and Flannery (2006) was not spoke of in the present study.

Stamm (1995) states that for compassion fatigue to occur, one must have empathetic concern as well as an empathetic response in the form of attempting to decrease the suffering that
they come into contact with, as well as have direct exposure to suffering. All of these conditions are undoubtedly met as evidenced by the experiences that the participants shared. Throughout all of the stories told, empathetic concern for the patients was at the forefront along with a desire and continual attempts to decrease the suffering that they cannot avoid coming into contact with. This further suggests the nurses are, in fact, at risk of suffering from compassion fatigue much like the research has shown their colleagues in sub-acute care to be. What is even more worrisome is that the nurses interviewed are also showing signs and symptoms of compassion fatigue, suggesting this is perhaps something they are already struggling with.

5.2 Recommendations for Future Research

There is strong evidence pointing to all three of the constructs reviewed in this thesis being a part of this experience for acute care nurses. The nurses in this study described components of stress and burnout, which is not surprising given the breadth of knowledge and research that has already proven these phenomena to be present in the nursing world. More importantly, what needs to be focused on is the fact that compassion fatigue also seems to be a significant part of these nurses’ experiences. Burnout and stress have been researched in the past and have been proven to be prevalent in many nurses’ experiences, however compassion fatigue has not and therefore needs to be examined more closely.

Given that prior research has documented many negative effects in other populations as a result of compassion fatigue and that the nurses in this study are showing signs of this phenomenon, research must not stop here. Studies including measures for compassion
fatigue are a must in order to clearly say this construct is a part of the nurses' lived experience and to properly tailor support for the acute care nurses.

Future research must include larger sample sizes as well as a more diverse population including both male and female nurses and more variety with respect to age and ethic background. As this study had a sample size of 5 participants that were all female with the majority coming from similar backgrounds and mostly under 35 years of age. Further research altering these components would be beneficial in increasing the generalizability of this study.

Researchers should also look at workload and different areas of nursing within acute care and outside of it, to see if these factors influence the experience of nurses. Perhaps future studies might also look at the relationship between age or experience and the prevalence of effects as well as coping, in response to witnessing patients' trauma and suffering. It may not be a coincidence that the majority of the nurses in this study are relatively new in their nursing careers. Related to this, it can also be seen that the nurse with the most experience approached coping with her job in a different way than the rest. She herself suggested this might be due to cultural or perhaps generational influences, which supports the fact that these aspects need to be examined in future research. Finally, once supports are put in place, studies following the effects of providing nurses with varying support should be carried out in order to understand how to best help acute care nurses manage the struggles of their work.
5.3 Implications for Practice

The questions on coping shed light on some of the things that nurses consider to be helpful in terms of coping with the struggles of their job. What was clear, however, given the effects they are experiencing along with their accounts of the necessity for further resources for coping, is that the things they are doing are not enough. All of the participants shared that what they first and foremost feel they need is the opportunity to talk to someone who understands what they are going through. They strongly voiced a lack of support from administration. In terms of implications for counselling and healthcare, this request for support is huge. Through my experience as a nurse and from hearing the experiences of the participants, it is clear that health care is largely an environment that does not support its staff emotionally and fosters a context where its professionals feel as though they cannot show emotion or psychological struggles with their work. For this reason, nurses may be hesitant to speak of their hardships, especially to someone who they feel will not understand. With respect to this study, I believe the fact that the nurses knew of me (as I am a nurse in a similar environment) made them more open to talking to me about their experiences as they knew I would have a better understanding of what they go through. This further supports the notion that nurses need someone to talk to that will understand the context of health care and, more importantly, the culture of nursing.

So what does this mean for health care and the counselling profession? I feel that resources must go into increasing the support that is available to nurses in acute care settings. The information provided above shows more than enough proof that bearing witness to suffering and trauma is taking a major toll on nurses, to the point where many consider leaving the
profession. There needs to be counselling professionals who have backgrounds in health care and/or are very familiar with current nursing and health care culture readily available to nurses in their workplace. I would also suggest that unit managers be trained in basic counselling skills to give them the tools to aid in management of crisis situations. In saying this however, I do not believe that the role of “counsellor” should be put on the shoulders of the managers as this is something that requires much more time and specialized focus than they are able to provide given their other duties. Ideally, I feel that there should be a counsellor to every area in the hospital on the units on a daily basis as a constant support for nurses to help them in dealing with their struggles. Group sessions and/or debriefings led by counselling professionals on a routine basis would also be of huge benefit as this would allow the nurses to talk to their colleagues who will undoubtedly understand them more than anyone else, in a safe environment.

In an already strained health care system, I realize that paying one more professional may seem like an unreachable request. I believe, however, that providing nurses with the support they have voiced they need will decrease other costs in the system (i.e. sick calls and overtime pay) offsetting this new expense. One nurse (DB) interviewed shared her thoughts on this:

   ... If they want people to keep becoming nurses or staying nurses ... they’re going to have to provide that support... I think that people need to know that we are human ... we care for all of these people and it wouldn’t hurt to have people care about us too.

It is no secret that there is a very serious shortage of nurses in health care today. Given statements like the one made above, perhaps this is a piece to the puzzle of why not as many
people are going into nursing or staying long term in the profession. If taken care of, nurses will be happier and healthier and therefore more able to do their job to the best of their ability. For a system that focuses on caring for people in their times of sickness and need, it is not one that takes care of itself and the staff within it.

In conclusion, many potential ideas and theories have been presented throughout this research as information and tools that could be used to improve the issues that have been brought forth in the nurses’ stories. While perhaps the answers are still not clear, in the end, what is clear is that nurses are struggling and have asked for help. It is my hope that this preliminary study on this topic will bring to the forefront the fact that nurses’ emotional wellbeing is being put at serious risk as a result of their work and workplace environment. I also would like this research to begin to aid in the normalization of emotional issues in healthcare and begin a dialogue whereby health care professionals and can openly talk about their struggles without shame or embarrassment. As helping professionals, we need to work harder at supporting each other so that we are all able to continue to do the jobs that we are passionate about.
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HEY NURSES...
Is work making you STRESSED?

Is witnessing patient’s suffering taking its toll on you?
Are you experiencing stress because of it?
Have you felt stressed in the past due to this aspect of your job?
DO YOU WANT TO TALK ABOUT IT?

Researchers in the Department of Education and Counselling Psychology and Special Education at the University of British Columbia are conducting a study looking at the experience of witnessing patient’s trauma and suffering for acute care nurses.

To participate you must have at least one year of acute care nursing experience, have felt or currently feel stress as a result of this aspect of your job and be willing to participate in a one hour interview as well as give brief feedback via phone. All participants will remain anonymous.

**Principle Investigator:** Marla Buchanan, Ph.D., R.Psych
Department of Education and Counselling Psychology and Special Education
University of British Columbia

**Co-Investigator:** Mary Walsh BNSc., RN.
Counselling Psychology Masters Student
University of British Columbia

If you feel you meet the criteria and are interested in participating please contact Mary via e-mail at: marywalsh6@gmail.com
Title of the Project: The Experience of Witnessing Patient’s Trauma and Suffering for Acute Care Nurses

Principle Investigator: Marla Buchanan, Ph.D., R.Psych
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Co-Investigator: Mary Walsh BNSc., RN.
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Purpose: to richly describe, for the purposes of increasing knowledge around, the experience of witnessing patient’s trauma and suffering for acute care nurses.

Study Procedures: you will be asked to participate in a one hour interview where you will be asked to share you experiences as an acute care nurse with stress resulting from witnessing your patient’s trauma and suffering and how you have been coping. You will also be asked to provide feedback regarding the themes collected in the study, their representation of your experience and your feelings regarding participation. This will be done via phone conversation following completion of all of the interviews.

Potential Risks: there is a possibility that you may experience negative emotional affects as a result of talking about your experiences with witnessing your patient’s trauma and suffering. New awareness or insight as well as reminders of traumatic experiences may result from the interview process. You will be provided with contact information for counseling resources available to you through Vancouver Coastal Health as well as community resources that are available to you in the event that you feel you need someone to talk to or support in dealing with your experiences following the interviews.

Potential Benefits: talking about these experiences may help to provide positive insights for your personal growth and self-learning. Your experiences will be documented and used to further knowledge in nursing literature regarding the stresses that nurses are faced with as a result of their work responsibilities. If you wish you will be provided with the results of this study, please provide the researchers with a mailing address/email where this may be sent.

Voluntary Participation: participation is completely voluntary and you are free to withdraw your participation at any time with out explanation and free from negative implications. Choosing to withdraw from this study will have no negative
implications with regards to your employment.

Confidentiality: the interviews will be audio-taped for the purpose of transcription and analysis of the information collected. Both the hard copies of the audio-tapes and transcriptions will be kept in a locked cabinet at UBC in Dr. Buchanan’s office and any electronic copies will be stored on a password protected computer. Your identity will be kept strictly confidential as all documents will be identified only by code number. In the final write up of the research all participants will not be identified by name. Your employer will not have access to any of the information that is collected at any time including knowledge of your participation.

Contact for information about this study: If you have any questions or desire any further information with respect to this study you may contact Dr. Buchanan or Mary Walsh at the above telephone numbers.

Contact for concerns about the rights of research subjects: If you have any concerns about your treatment or rights as a research subject you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

I ________________________________, consent to participate in this study conducted by: Dr. Marla Buchanan and Mary Walsh. I understand the nature of this project and wish to participate. I understand the limits to confidentiality and that participation is voluntary allowing me to withdraw my participation at any time.

Signature ____________________________________________

Participant

Date ________________________________
Dear Member,

I’ve been busy interviewing, transcribing and trying to make sense of all of the amazing experiences that each of the participants shared. I have condensed all of the information into some main themes that I hope are a fair and accurate representation of the collective experiences of all of the participants.

I have enclosed these themes and would greatly appreciate it if you could review them and respond by answering the following questions:

1. Do these themes resonate for you; do they correspond closely to your experience of witnessing patient’s trauma and suffering?

2. Do these themes present a comprehensive representation of your experience of witnessing patient’s trauma and suffering? Is there anything that was missed?

3. In your opinion, do these themes represent information that holds practical value for nurses?

Please remember, not everything may apply to your experience – these themes are based on the collective experience of everyone I interviewed. Having said that, if there is something crucial that you feel is missing, don’t hesitate to let me know and I will incorporate it.

If you could give me a quick phone call at your convenience sharing your thoughts regarding these themes I would really appreciate it. Even if you feel that you have no further information to add, please call and let me know that too. If I don’t answer, leave a message with your feedback or let me know if and when you would like me to call you back. My number is: (778) 836-2376.

If you could also provide me with your full name, number of years nursing and an alias that I can use in the write up of my research to represent you that would be great.

Thank you so much,

Mary
Themes: The Experience of Witnessing Patient’s Trauma and Suffering

1. Traumatic event and/or prolonged witnessing of patients trauma and suffering within an acute care environment:
   - Traumatic Codes and/or deaths
   - Being around patients with chronic/terminal illnesses and their families
   - Seeing little success
   - Lack of control and power at work
   - No support from management
   - Not enough time to do everything that should/could be done – lack of resources
   - Lack of respect/mistreatment from patients and families
   - An expectation that nurses will deal on their own with issues and/or not be affected
   - Stress as a norm at work

2. Effects:
   - Stress
   - Feeling overwhelmed
   - Re-visiting of situations at work (flashbacks, dreams, analyzing)
   - Feelings of depression
   - Taking it home with you
   - Trouble sleeping
   - Anger
   - Irritability
   - Anxiety
   - Emotional and physical exhaustion

3. Response: Distancing
   - Becoming detached
   - Trying not to listen to patients stories/take on too much
   - Not wanting to be vulnerable
   - Disinterest in normal activities outside of work
   - Distancing from family and friends

4. Response: Guilt
   - Related to distancing
   - Over not being able to make things better
   - Due to not being able to do things how you would like/do more
   - Self blame when negative things happen

5. Change in Self:
   - Become hopeless
   - Change in perspective on life
   - Negative outlook
   - Decrease in empathy

Themes: Coping

1. What is used to cope:
   - Talking (with nurses other nurses most helpful)
   - Exercise
   - Enjoyable activities outside of work
   - Moving to another area of nursing
2. What is needed to facilitate coping:
   - Debriefing – both regular and after critical incidences (during work hours)
   - A supportive place to talk to other nurses/another nurse
   - Support from management
CERTIFICATE OF APPROVAL - FULL BOARD

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR:</th>
<th>INSTITUTION / DEPARTMENT:</th>
<th>UBC BREB NUMBER:</th>
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<tr>
<td>Marla Buchanan</td>
<td>UBC/Education/Educational &amp; Counselling Psychology, and Special Education</td>
<td>H08-00384</td>
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INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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Other locations where the research will be conducted:
Participants will be given the option of completing the interview at either their own home or in Dr. Buchanan's lab at UBC.

CO-INVESTIGATOR(S):
Mary Walsh

SPONSORING AGENCIES:
UBC Faculty of Education

PROJECT TITLE:
The Experience of Witnessing Patient's Trauma and Suffering for Acute Care Nurses

REB MEETING DATE:    CERTIFICATE EXPIRY DATE:
March 27, 2008      March 27, 2009

DOCUMENTS INCLUDED IN THIS APPROVAL:

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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair