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Reflections on the Emotional Hazards of Pediatric Oncology Nursing: Four Decades of Perspectives and Potential

Deborah A. Boyle, MSN, RN, AOCNS, FAAN [a,*], Nancy Jo Bush, DNP, RN, MA, AOCN, FAAN [b]

[a] Advanced Oncology Nursing Resources, Huntington Beach, CA, United States
[b] University of California Los Angeles School of Nursing, Los Angeles, CA, United States

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ABSTRACT

Theoretical Principles: Pediatric oncology nurses are particularly vulnerable to emotional distress. Responsible for the oversight of a child's care, these nurses sustain close interactions with multiple patients and families over time, many of whom are coping with life-limiting diagnoses. The world of pediatric oncology nurses is one where tragedy is routinely witnessed thus demanding self-care and healing across a continuum.
Phenomenon Addressed: The aim of this article is to outline and review the emotional sequelae of pediatric oncology nurses' work and to suggest interventions to support well-being in light of prolonged caregiving. Three major categories that are addressed include the aspects of clinical practice that influence caregiving, the risks of burnout, compassion fatigue, moral distress and grief, and interventions to counteract these phenomena.
Research Linkages: Future-nursing research should focus upon the development of validated, psychometrically sound measurement tools to assess nurse-specific variants of burnout, compassion fatigue, moral distress, and nurse grief. Qualitative research should investigate the relationship between personal variables, workplace and team characteristics, age and experience, and their influence on the predominance of burnout, compassion fatigue, moral distress, and nurse grief. Lastly, the phenomena of resiliency demands further study.

Introduction

While practicing in the specialty of pediatric oncology is a rewarding profession, it is also inherently stressful (Campos de Carvalho, Muller, Bachion de Carvalho, & de Souza, 2005; Cantrell, 2007; Hecktman, 2012; Meadors & Lamson, 2008). Despite evidence characterizing dramatic advances in the field, one in five children with cancer will die of their malignancy (Ries et al., 2013). Even for survivors, the burden of morbidity and reduced quality of life following treatment remains a persistent problem (Kirch et al., 2016).

A summary from an Institute of Medicine and American Cancer Society joint workshop on comprehensive cancer care for children and their families, stated that families coping with childhood cancer often are left impoverished emotionally, physically, and financially (National Academies of Sciences, Engineering and Medicine, 2015). Parents are especially affected. They may experience chronic sorrow as a corollary of coping with their child's illness over time (Coughlin & Sethares, 2017). As the frontline providers of care, pediatric oncology nurses are continually exposed to these psychosocial ramifications. Yet, the majority of nurses enter this field ill equipped to assess and respond to the affective sequalae inherent in this specialty.

Pediatric oncology is considered a high-risk nursing specialty due to the emotional vulnerability experienced by staff practicing in this field (Rushton, Batcheller, Schroeder, & Donohue, 2015). Patient and family needs are often intense and prevail within an atmosphere of continuous uncertainty and fear of dying. This highly charged context of nurses' work is omnipresent. Multiple role expectations (i.e., care provider, educator, facilitator, translator, supporter, advocate) add numerous responsibilities to the nurses' list of expected proficiencies (Newman, 2016). Thus, occupational stress becomes a given for pediatric oncology nurses.

All health care providers require proficiency in communication. It should be as exemplary as one's physiological acumen and skill mastery. Due to the affective implications of caring for children with cancer, it is a central, core skill within pediatric oncology (Brand, Fasciano, & Mack, 2017; Hecktman, 2012; Montgomery, Sawin, & Hendricks-Ferguson, 2017; Snaman et al., 2016). Yet, the absence of a significant emphasis on communication skill training in undergraduate education positions pediatric oncology nurses in a precarious emotional state (Hendricks-Ferguson et al., 2015). Most nurses gain skill 'on the job', either role modeling seasoned colleagues or learning from mistakes. While this style of learning may help with basic skills, it has its limitations. Nurses may struggle with finding the right words, hesitate bringing up sensitive topics, and disengage from emotion-laden conversations (Bowden et al., 2015). Additionally, the risk for burnout, compassion fatigue,

* Corresponding author.
E-mail address: deboyle@cox.net (D.A. Boyle).

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moral distress and nurse grief will prevail. Research addressing the nature of these work-related sequelae in pediatric oncology nursing has been nominal as has the identification of interventions to counter them.

The aim of this article is to outline and review the emotional impact of pediatric oncology nurses' work and to suggest interventions to support well-being in light of prolonged caregiving. A review of the literature was performed using Pub Med, CINAHL, Psych Info and Google Scholar using the search terms pediatric oncology nurse stress, burnout, compassion fatigue, moral distress, grief, resilience, family, coping and interventions within pediatric settings. Three major constructs evolved from the literature review: 1) Aspects of practice that influence nurse caregiving, 2) Specific risks for burnout, compassion fatigue, moral distress and grief, and 3) Potential interventions to counteract these phenomena.

Aspects of Practice Contributing to Emotional Distress

The emotional distress associated with pediatric oncology nurses' practice can be categorized within four overarching themes: 1) Challenging skill requirements, 2) Ineffective coping, 3) Difficulties dealing with problematic family scenarios, and 4) Acquiring blurred interpersonal boundaries. Each of these contributes to the nature and intensity of the emotional distress experienced by pediatric oncology nurses.

Challenging Nursing Competencies

Nurses who choose the specialty of pediatric oncology must have a broad set of skills to care for a complex, at-risk patient population. Often responsible for the administration of highly adverse chemotherapy, pediatric oncology nurses are particularly concerned about administering treatment in a safe manner, avoiding medication errors, adequately managing toxicities and anaphylaxis, and preventing extravasation (Gibson et al., 2013). Nurses must also monitor and manage other sequelae such as the surgical and radiation therapy experiences (inclusive of anxiety and toxicity management) and symptoms evolving at the end-of-life (Mechtel & Stoeckle, 2017). Being proficient in psychological interventions (i.e., distraction, deep breathing, relaxation, emotional support) during a child's procedural intervention or treatment is another expectation of pediatric oncology nurses (Weinstein & Henrich, 2013). Since these young patients are frequently fragile and gravely ill, pediatric oncology nurses must engage in timely critical thinking particularly around the anticipation of potential untoward effects (Hecktman, 2012). This has been noted especially within the context of pediatric hematopoietic stem cell transplantation (Gallagher & Gormley, 2009; Morrison & Morris, 2017). Most pediatric oncology nurses highly regard their role as patient/family advocate. This often entails lobbying for needed interventions and clarifying the plan of care. Additionally, managing conflict becomes part of the nurses' advocacy role as competing professional views may leave the family confused and frustrated. Therefore, a multifaceted range of nursing expertise is necessary to optimally care for this pediatric population.

Coping Issues

A common pediatric nurse stressor is the feelings of helplessness in the face of patient pain and suffering. It also prevails when nurses witness the anxious uncertainty families often endure over months and years of aggressive therapy. Suppressing feelings of frustration and anger when care is considered futile, and repeatedly administering painful procedures may also elicit moral questioning and at times, guilt (Mukherjee, Beresford, Glaser, & Sloper, 2009). Novice nurses are particularly vulnerable to these work-related stressors (Latimer et al., 2017; Meyer, Li, Klaristenfeld, & Gold, 2015). This is attributed to fewer or less mature adaptive coping skills in young staff. Several studies have documented deficits in pediatric nurse communication skills that offer evidence for the need for additional education.

An investigation of the grief experienced by the multidisciplinary team after the death of a child identified that nearly two-thirds of nurses (59%) did not feel comfortable providing emotional support to families of dying children (Plante & Cyr, 2011). In another study of cancer nurses' experience in providing palliative care to children, nurses revealed that communication was the hardest skill to master (Pearson, 2013). Nurses acknowledged that they felt inept in knowing what to say, how to say it, and determining what the family needed and wanted in terms of psychosocial support.

Difficult Family Scenarios

As the primary hands-on provider of oncologic care of the child, nurses are expected to be competent in a range of supportive skills. Parents expect comfort from nurses during their child's life-threatening illness. They desire a partnership focused on hope and one that is characterized by 'fighting together' to achieve the child's survival (Conway, Pantaleao, & Popp, 2017; Mooney-Doyle, Dos Santos, Szylit, & Deatrick, 2014). Therapeutic communication rendered by nurses requires the provision of developmentally appropriate counsel for the sick child, eliciting the patient's and family's concerns and needs, engaging in goals of care discussions, and mediating conflict that may evolve within the family or with the multidisciplinary cancer team. For the nurse caring for multiple patients and their families, providing psychosocial support becomes a daunting task. This is due to the overall numbers of family members within the support networks, limited time, a lack of skill, and a priority on physical care interventions.

Certain family scenarios require more than the basic provision of emotional support. It is estimated that 40% of lay caregivers of children with cancer meet criteria for acute distress disorder within the first two weeks following diagnosis (Steele, Mullins, Mullins, & Muriel, 2015). For a subset of these caregivers, this disorder continues throughout the course of the child's illness. Anxiety and depressive symptoms are also prominent (Muscara et al., 2015; Vernon, Eyles, Hulbert, Bretherton, & McCarthy, 2016). Parents with pre-existing mental health problems or those with poor parenting skills pose unique needs that require specialized support (Kearney, Salley, & Muriel, 2015). Additionally, nurses may be required to interact over time with angry, distrustful, confrontational, rude and demanding parents (Dix, Gulati, Robinson, Syed, & Klassen, 2012; Klassen, Gulati, & Dix, 2012). Other families are characterized by considerable social stress. Examples include families with little available support, those not speaking English as their primary language, single parents, families where parents are separated, divorced or remarried, and unemployed parents with no health insurance (Gil, Hooke, & Niess, 2016; Kazak & Noll, 2015). The provision of support to high-risk families requires a skill set that most non-psychiatrically trained nurses have never received formal training in.

Internal nurse stressors may occur concomitantly. Nurses may struggle with existential questioning or exhibit anger towards team members whom they feel have rendered less than optimum care to the family. In some instances, nurses become surrogate parents which then presents a unique relationship paradox (Morrison & Morris, 2017). Nurses may find themselves identifying with parents and empathizing with parents' dual struggles of helping their child cope, while simultaneously having to manage their own fears that their child will die (Bjork, Wiebe, & Hallstrom, 2009). Within the context of long-term professional relationships, when a child dies, nurses may unconsciously feel that they failed the child's parents.

Blurred Boundaries

Associated with the affective domain of pediatric oncology nursing, is the common issue of emotional boundaries. Particularly in pediatric palliative care, boundary issues emerge as a highly recognized component of practice that requires ongoing scrutiny (Erickson & Davies, 2017). Within this construct, the perimeters defining the professional