
The Experience of Witnessing Patients' Trauma and Suffering Among Acute Care Nurses L'expérience de témoin des traumatismes et de la souffrance des patients chez les professionnels en soins infirmiers actifs

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ABSTRACT

A large body of research provides evidence of workplace injuries to those in the nursing profession. Research on workplace stress and burnout among medical professionals is also well known; however, the profession of acute care nursing has not been examined with regards to work-related stress. This qualitative study focused on acute care nurses' workplace stress, as 5 acute care nurses described experiences related to witnessing patients' trauma and suffering. Through the use of phenomenological analysis, five main themes emerged from the interviews, revealing a more in-depth understanding of nurses' experiences in acute care settings. These themes were (a) shock and prolonged witnessing of suffering, (b) long-term effects, (c) distancing as a coping strategy, (d) feelings of guilt and helplessness, and (e) dissonance in core beliefs about self. The results are discussed in terms of coping strategies and recommendations for counsellors working with health care professionals.

RÉSUMÉ

De nombreuses recherches ont permis de démontrer l'existence de blessures au travail chez les personnes qui exercent la profession infirmière. La recherche dans le domaine du stress et de l'épuisement professionnel en milieu de travail chez les professionnels des soins médicaux est aussi bien documentée; cependant, la profession infirmière en soins actifs n'a pas fait l'objet d'analyses sur le plan du stress lié au travail. La présente étude qualitative est centrée sur le stress en milieu de travail des personnes exerçant la profession infirmière en soins actifs; 5 professionnels en soins infirmiers actifs ont décrit des expériences liées au fait d'assister au traumatisme et à la souffrance des patients. Suite à une analyse phénoménologique, les thèmes principaux ressortis des entrevues permettent une compréhension plus approfondie des expériences vécues par les professionnels infirmiers en milieu de soins actifs. Les thèmes sont : (a) choc et constat prolongé de la souffrance, (b) effets à long terme, (c) distanciation comme stratégie d'adaptation, (d) sentiments de culpabilité et d'impuissance, et (e) dissonance au niveau des valeurs essentielles de soi. Les résultats sont discutés du point de vue des stratégies d'adaptation et des recommandations à l'intention des conseillers travaillant auprès des professionnels des soins de santé.

It is well known that nursing is a profession that poses a variety of risks. Exposure to infectious diseases, violence, and physical injury are among the common factors that place nurses at risk for work-related injuries (Abendroth & Flannery, 2006; Chen, Chen, Tsai, & Lo, 2007). However, the psychological and emotional effects of nurses' work are not as well known (Frank & Karioth, 2006; Hallin & Danielson, 2007). Using personal observations within acute care hospital settings, the investigators of this study noticed changes over time in the way nurses related to their work and their patients. Nurses were at times distant and detached, which appeared to be a way of coping with the frequently intense emotional situations they were experiencing.

Observations on acute care hospital wards also revealed a common occurrence of hearing nurses talk about trouble sleeping and feeling unable to leave the experiences of their shift in the hospital when they went home. Large numbers of sick calls were also witnessed, and acute care nurses would often claim they could just not do another shift. These observations led the researchers to wonder about the effects upon nurses who experience patients' trauma and suffering.

Various labels have been used to describe the relatively new body of knowledge related to workplace stress in the nursing profession. They include *compassion fatigue* (Abendroth & Flannery, 2006; Benoit, Veach, & LeRoy, 2007; Figley, 1995; Frank & Karioth, 2006; Maytum, Heiman, & Garwick, 2004), *generalized stress* (Hallin & Danielson, 2007), and *burnout* (Chen et al., 2007; Ericson-Lidman & Strandberg, 2007; Poncet et al., 2007).

A review of the literature revealed that three constructs could provide a theoretical understanding of the stress experienced by acute care nurses: generalized stress (Lazarus & Folkman, 1984), workplace burnout (Maslach, Schaufeli, & Leiter, 2001), and compassion fatigue (Figley, 1995, 2002). In this article we review these three psychological constructs but acknowledge that there could be other theoretical underpinnings that describe acute care nurses' experiences.

The purpose of this study was to understand acute care nurses' experiences of job-related stress. The study's primary focus was to provide a rich description of nurses' experiences of witnessing patients' trauma and suffering on an acute care ward. The following phenomenological question guided the research: What is the lived experience of witnessing patients' trauma and suffering among acute care nurses?

In the following review of the literature, the authors discuss the three main theoretical constructs that have relevance to our understanding of the current study on acute care nurses' experiences of witnessing the trauma and suffering of their patients. However, the researchers were open to the possibility, before commencing the study, that the phenomenon under investigation may or may not reveal whether these constructs had relevance in the participants' experiences as acute care nurses.

REVIEW OF THE LITERATURE

Stress

In Lazarus and Folkman's (1984) Transactional Theory of Stress and Coping, the authors proposed that individuals are constantly appraising the environment in an attempt to discern the meaning and significance of events in order to categorize interactions within their environment related to their well-being. According to Lazarus and Folkman, the amount of stress felt is a result of a two-part cognitive appraisal. The first, a 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). The secondary appraisal is one's evaluation of coping abilities and available options.

Stress has been linked to a number of illnesses (Lazarus & Folkman, 1984) and can have a wide variety of psychological effects. Social functioning and morale are two of the main factors that are closely related to stress and have been shown to affect a person's psychological state, possibly leading to depression (Lazarus & Folkman, 1984).

Chen et al. (2007) studied role stress and job satisfaction among 129 nurse specialists in Taiwan. Role ambiguity and overload were found to be the highest predictors of job dissatisfaction, whereas personal characteristics and training were responsible for the variance in job satisfaction. Ross-Adjie, Leslie, and Gillman (2007) investigated occupational stressors that were significant to emergency room nurses. The top six stressors were violence in the workplace; heavy workload and poor skill mix; mass casualty; death; sexual abuse of a child; and dealing with high acuity patients. Their research findings also revealed that emergency room nurses thought that debriefing was very useful following a stressful event and should be encouraged.

Hallin and Danielson (2007) conducted a qualitative study on the experiences of daily work strain and stimulation for a group of 12 registered nurses, each with 6 years of experience. Stressful work situation themes included feeling insufficient, being unsure of oneself, and not enough contact with patients. Stimulating work situation themes included experiencing patients and qualified health care staff as enriching, having situations under control, and having the skills needed to be independent. It became apparent that there is a fine balance between strain and stimulation and that nursing work can shift between these two constructs. The participants felt that increases in patient loads decreased their ability to prioritize, plan, and manage work.

Burnout in the Nursing Profession

Maslach et al.'s (2001) theory on burnout stated that there are three components to job-related burnout: (a) overwhelming exhaustion, (b) cynicism and detachment from one's job, and (c) feelings of inefficacy or lack of accomplishment. According to the findings in their research, exhaustion was the central factor as well as the most widely reported symptom of burnout. Maslach et al. reported that,

as a way of coping, people begin to detach themselves from their work once this exhaustion sets in. In the majority of cases of burnout, emotional exhaustion comes about over time as a result of prolonged interaction with the work environment and influences one's interactions in the work environment. Maslach and colleagues also contended that burnout results from prolonged exposure to interpersonal and emotional stressors presented in the work environment and that workers become burned out in defence of the unmanageable feelings.

The research confirms that there are a wide variety of symptoms related to burnout, sometimes making it difficult to distinguish from other conditions. Some of these symptoms are chronic fatigue, sleep difficulties, gastrointestinal symptoms, anxiety, depression, pessimism, issues with interpersonal relations, inability to concentrate, and withdrawing from stressful situations (Stamm, 1995).

Poncet et al. (2007) carried out a study with 2,497 nursing staff in various intensive care units in France. The results showed that 32.8% of the participants suffered from severe burnout syndrome, 12% showed signs of depression, and that a variety of factors affected the levels of severe burnout syndrome.

In Ericson-Lidman and Strandberg's (2007) narrative study, nurses whose co-workers had developed burnout (and were on leave as a result) were asked to share their perceptions of the signs preceding their workmates' burnout. The analysis of the narrative interviews yielded five main themes: (a) perceptions of co-workers struggling to manage alone, (b) showing self sacrifice, (c) struggling to achieve unattainable goals, (d) becoming distanced, and (e) showing signs of falling apart.

In another burnout study, Spooner-Lane and Patton (2007) conducted a survey using a cross-sectional design with 237 nurses who were mostly working in surgical care. Results showed 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 did those who were part-time or casual, while role overload (an expansion of one's expected responsibilities), job conflicts, and role boundaries (constraints on one's scope of practice) 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 (unclear definitions of one's responsibilities) were the main influential factors of reduced personal accomplishment. The above research studies confirm that burnout is in fact a serious issue within the nursing profession and one that has been proven to be common in a variety of nursing environments.

Compassion Fatigue

Compassion fatigue is a relatively new term in psychology and health care that arose in research carried out with trauma therapists. A variety of research over the last 15 years has examined the effects of knowing about another person's trauma and how to classify these effects. Figley (2002) coined the term "compassion fatigue" as an alternative term for secondary traumatization, as he believes that this term is more positively received by helping professionals.

In explaining this phenomenon, Figley (2002) stated 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 stated that one must possess empathetic concern, make an effort to decrease the suffering of others (empathetic response), and yet have direct exposure to the emotional energy of suffering. Figley (1995) explained that professionals who focus on the relief of the suffering of others are at risk of absorbing some of that suffering.

Symptomatology of secondary traumatization include a stressor, re-experiencing of the traumatic event (e.g., through dreams), avoidance of reminders of the event, and persistent arousal (Figley, 1995). Some of the commonly reported manifestations of compassion fatigue 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; and irritability (Figley, 1995; Stamm, 1995).

Figley (1995) found that although burnout and compassion fatigue share similarities, burnout emerged gradually whereas secondary traumatization could appear quite suddenly, with little warning, causing a sense of confusion, hopelessness, and isolation. Other researchers have supported this notion that burnout is, in fact, a construct distinct from secondary traumatization or compassion fatigue (Arvay, 2001; Benoit et al., 2007; Stamm, 1995).

To date, there has not been a study examining the effects of caring and the consequences of being exposed to suffering among acute care nurses. All previous studies have focused on nurses working in sub-acute settings. Maytum et al. (2004) carried out a descriptive qualitative pilot study in the USA with 20 experienced nurses who worked in various non-acute care settings with chronically ill children and their families. 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 onerous workloads were the main triggers of compassion fatigue.

In another study, Frank and Karioth (2006) surveyed 117 public health nurses in Florida who provided assistance to hurricane victims 3 to 4 months prior to the study. They found that 27% of their sample was at risk for compassion fatigue. Abendroth and Flannery (2006) investigated 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. Results showed that 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.

A search of a number of databases (CINAHL, PsycINFO, PubMed, Medline, and OVID) revealed that very little research on the experience of work-related stress among nurses in acute care settings had been conducted. An examination of acute care nurses' lived experiences of witnessing the trauma and suffering of their patients was at the heart of this phenomenological investigation.

METHOD

Phenomenologists work to make meanings recognizable and attempt to describe experience as lived 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, 1990). This method of research was chosen for this study because of the paucity of research on this topic among acute care nurses. Little is known about the lived experiences of nurses in this health care setting. A qualitative method was needed to lay the groundwork for beginning to understand this experience for this nursing population.

In this study, the researchers used a descriptive phenomenological research design with a focus on describing human experience and understanding the lived experience under investigation among a selected group of participants. Phenomenology relies on hermeneutic analysis—a process of reading and re-reading the interview texts and dwelling on the phenomenon under study until themes begin to emerge.

The researchers focused on the lived experience of acute care nurses' work-related stress. In using this methodology, it is considered important for the research interviewer and the research analyst to bracket their personal experiences of the topic and to hold at bay the theoretical knowledge gained through the research process. This was achieved in this study by interviewing the research interviewer about her experience as an acute care nurse to explicate her knowledge of the topic and her personal experiences as an acute care nurse. The researchers kept a research journal and used reflexivity to bracket prior knowledge or experiences that could influence the phenomenological reduction. For example, experiences regarding the research interviewer's first patient death and her experience of burnout and stress reactions on the ward were detailed in writing and bracketed when interviewing the participants and analyzing the participants' transcriptions.

Participants

The 5 participants in this study were registered nurses who had 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 less than 10 years nursing experience with the majority working for less than five years. The participants were all female (aged 25, 25, 30, 31, and 40; $M = 30.2$). The participants were all working in a busy acute care teaching hospital in Vancouver, British Columbia.

Phenomenological Interviews

One- to three-hour, in-depth, open-ended, unstructured interviews were scheduled with each participant and conducted by the first author in the participants' homes. After gaining research ethics approval and informed consent, each interview was initiated with the following invitation: "Can you describe for me your

experience of witnessing patients' trauma and suffering on the acute care ward where you work?" Probes and queries were made only to clarify the meaning or content of their experience. The participants led the direction of their interview. Following Polkinghorne's (1989) phenomenological method, the research interviewer was cautious and aware of not imposing her knowledge or experience into the interview process. The interviews ended after the fifth participant, as no new information was evident in the last interview. It is common in phenomenological research to have a small sample size of 5 to 7 participants.

Data Analysis

The researchers followed a 6-step process of phenomenological analysis as outlined by Polkinghorne (1989) and Colaizzi (1978). Each reading of the interview texts had three phases: (a) dividing the transcript into units by content domains, (b) articulating the essential meaning of each unit, and (c) clustering the meaning units into themes that constitute a general description of the phenomenon (Polkinghorne, 1989). The 6-step process of analysis (Colaizzi, 1978; Polkinghorne, 1989) was conducted as follows:

1. The researchers transcribed verbatim each interview transcript.
2. Each transcript was read orally with the research interviewer reading the participant's words and the other research team member reading the interviewer's words.
3. A discussion of the text discerned themes, and thematic structures emerged from the readings of the text.
4. Exemplary quotes were noted from each text that supported the theme under discussion.
5. The researchers summarized each interview text and identified the main themes in each participant's text by noting the significance of each theme as it pertained to the research question.
6. The researchers conducted a member check of each participant's text and returned the thematic analysis to each participant for verification.

Additionally, the researchers provided a summary of the main findings to an expert peer reviewer—an acute care nurse with extensive nursing and research experience—who reviewed the findings and verified their trustworthiness and comprehensiveness. The themes that emerged are descriptions of the lived experiences for five acute care nurses who experienced work-related stress as a result of witnessing patients' trauma and suffering. Each participant was given a pseudonym to protect her anonymity in this study.

RESULTS

Five main themes emerged during the phenomenological reduction that exemplified the participants' experiences of witnessing patients' trauma and suffering on an acute care ward. The themes seemed to arise in the form of a process (the first

experience, followed by further experiences in which effects became conscious and more serious) and therefore are presented in the order in which they occurred in the participants' experiences. The themes are (a) shock and prolonged witnessing of suffering, (b) long-term effects, (c) distancing as a coping strategy, (d) feelings of guilt and helplessness, and (e) dissonance in core beliefs about self.

Shock and Prolonged Witnessing of Suffering

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 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 stressful effects.

I open up the curtain and just boom, he's dead! I can 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." (Diane, age 31)

Three of the participants expressed that they could still remember and visualize their first code (a life-threatening emergency call). They could describe every detail, from conversations to sights and smells, and still wondered about whether they could have acted differently.

While particular events were shocking and traumatic for the nurses, they also spoke of prolonged witnessing of suffering that had similar effects. One participant's description illustrates the difficult experience of caring for patients with chronic or terminal illnesses:

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 life. There are days where it's really, really hard. (Susan, age 40)

The daily stresses of seeing patients deteriorate and witnessing their prolonged suffering took a toll on the nurses in this study.

Another aspect of the experience that added to the stress of witnessing the trauma and suffering of patients was a perceived lack of respect from some patients and their families. Diane described how experiences such as this led to changes in her way of being a care provider:

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 ...

All of the participants experienced shifts in their ability to be compassionate in times of duress. The participants also spoke about how the lack of time and resources undermined the values they held as nurses—what they were taught about nursing in their training. They spoke of a norm or culture of stress currently present within acute care nursing and how often this stress influenced how they cared for their patients. As Linda (age 30) described her experience:

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 ... 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 [the stress] 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.

This participant's experience shows evidence of stress as described by Lazarus and Folkman's (1984) research. The context that she describes is one that exceeds her resources and endangers her well-being. Common to the participants' stories was a theme of struggle to maintain/achieve a sense of accomplishment, as well as concern for the lack of resources within the work context and how that subsequently affects their level of performance as acute care nurses. These experiences are commensurate with the research on stress and burnout.

Long-Term Effects

Being stressed and feeling overwhelmed, coupled with witnessing suffering and traumatic events, led to effects that impacted the participants' lives outside of work. In this theme, participants described symptoms that resemble the effects of compassion fatigue. Linda described what it was like when she returned home from work:

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.

All participants described situations at work staying with them, sometimes for years after the event. They struggled with depression, sleep disturbances, panic attacks, anxiety, and guilt. Sarah's (age 25) description of her experience following a traumatic code illustrates these serious psychological and physical effects:

I could not sleep for three weeks after [the event]. 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) (such as intrusive imagery and sleep disturbances, anxiety, depression, avoidance of reminders, and heightened startle responses).

Another common experience for the majority of the nurses interviewed was that of flashbacks to traumatic events, another element common to the experience of compassion fatigue. As Diane stated: "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 ... come back."

In addition to trauma-like responses, all of the participants confided that they often felt irritable and had feelings of depression both at work and home. 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. Linda 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 emotionally.

This description is similar to Maslach et al.'s (2001) description of one of the main elements of burnout—emotional exhaustion; it is also evident in the literature on compassion fatigue.

Distancing as a Coping Strategy

The third theme that surfaced in participants' stories was distancing oneself as a coping strategy. All of them spoke of distancing themselves at work, and the majority of participants also spoke about isolating and distancing themselves at home with their families. They stated that this was the only way to cope with their feelings; however, they were also clear that they did not like using this coping strategy.

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].
(Sarah)

They described this distancing and detaching of themselves as a means to protect themselves from the effects of witnessing patient trauma and suffering.

The majority of the nurses also spoke of distancing themselves from their family and friends, especially when they were working a set of shifts. They expressed that work was too much to handle, that it was taking too much from them, and that they could not or did not want to deal with anything else. Linda stated: "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." Cathy (age 25) offered this comment: "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." Susan phrased it this way: "It's just too much to handle ... 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."

The strategies of distancing and detaching one's feelings as a way to avoid negative feelings are symptom descriptions for both compassion fatigue (Figley, 1995; Stamm, 1995) and burnout (Maslach et al., 2001). 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.

Feelings of Guilt and Helplessness

All of the nurses spoke about the lack of time and unreasonable demands put upon them as sources of stress, exhaustion, and frustration. They described workplace demands that decreased the quality of care they could give their patients. This brought about strong feelings of guilt and sadness for these acute care nurses.

One important aspect in this theme was that all of the nurses felt a general lack of control over patient outcomes. They expressed concerns that their patients, who were people they cared about, were having awful experiences in the hospital. Institutional demands and limited resources created a context in which acute care nurses felt helpless, guilty, overburdened, and frustrated. As Linda explained: "I feel sad and I feel frustrated because we can't really help 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, which added another layer to their workplace stress. At the root of their guilt was a strong desire to nurse at a standard that they were not able to reach because of two main factors: an inability to cope with the psychological and emotional stress and system constraints within the health care setting. As one nurse stated: "if somebody happens to catch me on an off day where I'm feeling overwhelmed, I feel terrible because I'm probably not doing all that I could for them."

Dissonance in Core Beliefs About Self

There seemed to be a realization at some point, for all of the nurses interviewed, that they did not like what was happening to them and who they were becoming

as nurses. Their feelings of disconnection were having an impact on their personal identities as nurses and women. 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, being frustrated, and feeling 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. Diane shared 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.

All participants shared that they were changed by their experiences in acute care nursing by being disillusioned with the profession and by decreases in their ability to be empathic. This dissonance between former beliefs about the nursing profession and the lived experience of acute care nursing created a great deal of personal distress. They all struggled with the negative changes within themselves, but some saw these struggles as lessons learned on how to have a more balanced life, how to develop better coping strategies, and how to enjoy life more and adopt a different perspective about their career as nurses. A common belief among all participants was the hope that these changes in self would not remain permanent.

DISCUSSION

After reviewing the literature and the experiences the participants shared in their interviews, we believe it is quite clear that the experience of witnessing patients' trauma and suffering as an acute care nurse is multifaceted and complex. In our review of the literature, we examined stress, burnout, and compassion fatigue as constructs that could be related to our participants' experiences.

As Lazarus and Folkman's (1984) model of stress suggests, acute care nurses' cognitive appraisal of workplace stress and their inability to cope due to a lack of resources and lack of control over their work environment created a great deal of stress for the nurses in this study. As in previous studies on workplace stress in nursing (Chen et al., 2007; Hallin & Danielson, 2007; Ross-Adjie et al., 2007), our participants confirmed that unmanageable patient workloads, stressful work environments, and a lack of resources to deal with the demands placed upon them caused serious stress in their lives, both at work and at home.

The literature on burnout states that exhaustion, detachment from one's job, and feelings of lack of accomplishment are the main features of burnout (Maslach et al., 2001). All three of these aspects of burnout are very visible in the experiences described by the participants. All 5 nurses described feeling emotional and physically exhausted frequently at work, which was often secondary to the stressful environment of acute health care.

Maslach and colleagues (2001) claim that emotional exhaustion is 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 our participants' experience of witnessing the trauma and suffering of their patients in acute care health settings. Our findings support the research found in previous studies on burnout in sub-acute care populations (Ericson-Lidman & Strandberg, 2007; Poncet et al., 2007; Spooner-Lane & Patton, 2007).

In addition to stress and burnout, the results from this study also show evidence of compassion fatigue among our participants. Figley's (1995) model of compassion fatigue outlines three main stressors: 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 with the experience of a shocking event followed by stressors leading to symptoms of compassion fatigue. One of the prominent responses was persistent arousal in the form of anxiety, feelings of stress, trouble sleeping, and sometimes struggles with focusing or concentrating.

The participants described avoidance of patients and their stories, as these were reminders of past negative experiences. 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; troubles concentrating; and irritability. All of these manifestations were described in the experiences of the acute care nurses interviewed.

In current nursing research, it has been found that exposure to death, sacrificing one's own needs (Frank & Karioth, 2006), high patient loads, stress and life demands, trauma, anxiety (Abendroth & Flannery, 2006), 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 increased nurses' stress. Each of these factors was a component of our participants' stories.

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 of others, as well as having direct exposure to suffering. All of these conditions were met as evidenced by the experiences that the participants shared. This further suggests that acute care nurses are, in fact, at risk of suffering from compassion fatigue similar to the research findings among colleagues in sub-acute care settings (Abendroth & Flannery, 2006; Frank & Karioth, 2006; Maytum et al., 2004).

Recommendations for Future Research

Given that prior research has documented many negative effects in other caregiver populations as a result of compassion fatigue, burnout, and job-related stress and that the nurses in this study are showing signs of these phenomena, research must continue to address these topics. Survey research would be beneficial to our

understanding of the breadth of the problem of compassion fatigue, burnout, and stress among health care providers. Future research needs to 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 ethnic background.

As this study had a small, homogeneous sample of 5 female participants with similar socioeconomic and cultural backgrounds, further research would be beneficial. There are relationships that also need to be investigated such as differences in effects based on age, experience, and type of work setting. It may not be a coincidence that the majority of the nurses in this study were relatively new in their nursing careers; however, it cannot be claimed in this study that age was a main factor in the experience of compassion fatigue, burnout, and stress among these nurses due to the small sample size in this phenomenological study.

Recommendations for Nursing Practice and Counselling Practitioners

Our findings support the need for more funding within nursing to address the emotional and psychological costs to nurses who provide empathetic care to their patients. The evidence is clear that there is a personal price to pay from witnessing the trauma and suffering of patients in acute care. Counsellors working in health care settings could provide individual counselling, group interventions, and psychoeducation regarding job-related stress. Our participants stated that counselling practitioners in both private practice and health care settings needed to understand the unique context of acute care nursing.

The nurses in this study had recommendations for counselling practitioners and hospital administration. First, they wished to be able to share their experiences and feelings with others who have “first-hand” experience, an indication that group interventions would be beneficial to this population. They requested that debriefing, such as Critical Incident Stress Management (CISM), consistently be made available on shift, which would require support from administration for coverage to enable them to debrief traumatic experiences with professional counsellors within their health care setting.

An excellent example of the provision of individual counselling sessions, group interventions, and critical incident debriefings is at the Centre for Practitioner Renewal, a counselling service for health care providers at St. Paul's Hospital in Vancouver, British Columbia. The centre provides critical incident debriefing and provides ongoing counselling services to hospital personnel. This initiative has been successful in addressing the psychological and emotional needs of nurses and doctors as well as the costs to hospital administration for staff sick leaves.

Second, the nurses recommended that the culture of nursing needs to be changed by creating a safe work environment where feelings of detachment, guilt, and inadequacy could be voiced and addressed through professional counselling and support. Third, they argued that manageable patient workloads are imperative to the health and well-being of nurses and in the prevention of stress, burnout, and compassion fatigue in their workplace. This final issue needs to be addressed by hospital administrators and nurses' union representatives.

Workplace supports such as counselling and critical incident debriefing need to be put into place along with evaluation studies to understand how best to help acute care nurses manage the stress of their work. CISM is an intervention protocol used in hospitals and in organizations where there are emergency responders. It involves a group meeting to debrief a critical incident that may cause distress among personnel involved. For a more thorough description of critical incident debriefing strategies and the efficacy of this intervention, refer to the work of Jeffrey T. Mitchell (e.g., 1999, 2003, 2008) or visit CISM International's website at www.criticalincidentstress.com.

It is no secret that there is a very serious shortage of nurses in health care today. The Canadian Nurses' Association claims that there will be a shortage of almost 60,000 full-time equivalent registered nurses in Canada by 2022 (Canadian Nurses' Association, 2009). If we take a closer look at nurses' experiences, we see stress, burnout, and compassion fatigue as possible explanations for their short-term careers. Although not all aspects of nurses' stress are clear, what is evident from our findings is that nurses are struggling and are asking for support from their administration and peers. It is the authors' hope that this preliminary study will bring the issues to the forefront and that change within health care is on the horizon.

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