A Psychotherapeutic Exploration of Nurse Experience in Oncology Wards

By

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Abstract

The aim of this study was to explore the experience of working as an oncology nurse from a psychotherapeutic perspective. To do this a qualitative study was carried out. Five nurses with at least 2 years' experience were interviewed using semi structured interviews. This was transcribed and analysed using thematic analysis allowing 3 themes to emerge from the data. The findings suggest that oncology nursing is emotionally taxing work but is also experienced as being extremely rewarding. Patient and peer relationships are of particular significance. To create the best conditions for a positive experience there are steps the nurse can take individually in terms of self-care. There are also ways management and the hospital system can operate to minimise anxiety for the nurse. It is in everyone's interest to achieve this as it will likely lead to better health for the nurse and a better standard of care provided.

Chapter One: Introduction

1.1 Background and Context:

Cancer is the second leading cause of death globally and is responsible for one in six deaths in the world (World Health Organisation [WHO], 2018). Approximately 40,000 new cases of cancer are diagnosed in Ireland each year and this number is rising (Irish Cancer Society [ICS], 2017). In Ireland over 8,000 people die from cancer each year and it is the second most likely cause of death after circulatory diseases such as heart disease and stroke (National Cancer Control Program, 2017). Cancer care is labour intensive but without highly trained and educated staff ongoing improvements in cancer care would not be happening. Nurses comprise a third of all healthcare workers and play a variety of essential roles in cancer care (National Cancer Strategy, 2017).

The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, 2018). To be healthy means more than to be absent of disease. Good mental health and good social structures are as important as being physically well in overall health. This is highlighted in the government mental health policy document A Vision for Change which states "that mental health is broader than an absence of mental disorders; that poor mental health affects our ability to cope with and manage our lives…and that mental health is an essential component of general health, which it underpins." (The expert group on mental health [TEGOMH], 2006). In this context, it is important that any significant ongoing stressors which are faced are managed in order to maintain

good health. Work related stress would fall into this category as it is something that is faced on a consistent basis. This is especially relevant when working in a field such as oncology nursing where there is a particular vulnerability to stress due to the nature of the work (Woonhwa and Kiser-Larson (2016).

Sinclair (2011) points out that there has been extensive literature exploring the spiritual and existential impact of death and dying on patients and family members but there has not been the same focus on the impact of working as a carer in this environment. Medland et al (2004) tell us that the affective dimension of oncology nursing is important to consider when thinking about the nurse's wellbeing. This is the psychological and emotional aspects of being an oncology nurse. Nurses require nurturing and emotional support if they are to treat patients effectively. Menzies-Lyth's (1990) study showed that nurses are at high risk of experiencing significant work-related stress. Russell (2016) explains that oncology nurses are exposed to a high level of stress while caring for critically ill patients and must manage this stress while also managing the patients care and treatments. Florio, Donnelly, and Zevon (1998) identify common stressful factors as including relationships with other team members, administering intense cancer treatments, death of patients, and dealing with highly demanding patients and families. Woonhwa and Kiser-Larson (2016) point out that nurses frequently ignore their emotional experiences with patients possibly due to unawareness of the link between work and their own health. This can lead to ineffective coping mechanisms which can result in burnout or compassion fatigue. In this way, the nurse's health suffers and the level of care they can provide is also compromised.

Menzies-Lyth (1990) highlights the fact that there is a significant unconscious element to the anxiety and stress experienced by oncology nurses due to objective situations they face, such as patients and their families suffering, evoking unconscious phantasy situations. Dartington (2010) explains that no-one is immune to vulnerability and this feeling is often caused by external forces that can't be controlled. Meier (2011) tells us that emotional investment is high when working with cancer patients because of the close relationship that tends to form between patient and carer. Due to this close relationship it can be extremely stressful to try to maintain a sense of composure when a patient is dying (Wakefield, 2000). Vachon (1998) says in order to allow nurses to be effective care-givers who can contribute to high quality patient care there must be a dual approach of helping them to develop personal coping strategies and cultivate collaborative working relationships.

Post-White (1998) says that meeting the needs of the care-giver is the first step in providing optimal care for others. This highlights why it is so important for oncology nurses to be aware of their mental health and have the training and support necessary to maintain this health. Vachon (1998) suggests that the most important coping strategy for nurses is the development of a team philosophy, support, and team building. Woonhwa and Kiser-Larson (2016) tell us that functional coping strategies will include creating boundaries around work life balance, having fun with co-workers, and using humour at work. Vachon (1998) also outlines personal coping strategies such as developing a sense of control and pleasure in the work and maintaining a healthy lifestyle. The system can also operate in a way that reduces

anxiety for the nurse. Dartington (2010) explains that the nurse must have a clear understanding of their role and responsibilities with clear procedures, training and supervision. This must be facilitated through supportive management.

1.2 Aims and Objectives:

It seems clear that nurses work in an environment which presents emotional challenges which could be a risk to the nurse's health if not acknowledged and managed. This can have the knock-on effect of affecting the nurses work performance and in turn standard of care being provided. The majority of the research in this area has focused on the patients experience and research focused on nurses has tended to be quantitative which is limited in exploring the real lived experiences of nurses. The aim of this research is to explore the experience of working as an oncology nurse looking at working with vulnerability and the unconscious processes involved. To begin a literature review of existing research was performed. This review informed the interview questions that were asked in five interviews with experienced oncology nurses. The research design is outlined in the methodology chapter. The interviews were then transcribed and analysed using thematic analysis to identify the three main themes in the data. These themes are presented in the findings chapter. The themes were then reviewed in relation to the existing research as outlined in the literature review. Finally, the conclusion chapter examines the limitations of the study, recommendations for further study, and the broader implications this research has.

This qualitative study aims to look at the experience of working as an oncology nurse from a psychotherapeutic perspective. Some of the objectives it aims to achieve:

- examine personal experiences of oncology nurses in the Irish healthcare system

- explore challenges and work-related stress as identified by participants

- critically evaluate supports and personal strategies utilised by nurses to manage work-related stress

Chapter Two: Literature Review

2.1 Introduction:

This literature review will look at the literature dealing with the impact of working as an oncology nurse. Firstly, the nurse's role in the hospital and the impact this has on them will be discussed. Then the stress inherent in the work and the emotional labour the nurses do on behalf of others will be explored. The anxiety provoked by the job due to the real situations experienced by the nurses evoking phantasies from their internal world and how they defend against these phantasies will be examined. The impact this can have on the dependency relationship will be outlined along with how early attachment relationships will affect the nurse's capacity to handle stressful situations and relationships.

It will then be shown how being part of a hospital system can impact on the nurse's stress levels and some of the measures that can be taken organisationally to minimise this stress and anxiety. The causes of this stress and the potential health problems resulting from it will be presented before the risk of burnout and compassion fatigue are outlined. The need for self-care and education to combat these risks will then be discussed in the context of the nurse's health and their ability to perform their job. Following this the coping strategies used by nurses to defend themselves will be looked at. This will include defences the individual uses to defend against anxiety and systematic defences in which the environmental factors can be managed in a way that reduces the anxiety experienced by the group. Finally, some of the supports that may be effective when a nurse is feeling overwhelmed or struggling in the work will be included.

2.2 Working with Loss:

Menzies-Lyth (1990) describes the main role of a hospital as taking care of ill people who cannot be taken care of at home. Nurses have most of the responsibility for doing this as they provide continuous care for patients twenty-four hours a day. This means that nurses bear a large amount of the stress caused by patient care. Oncology nurses are in constant contact with sick people, many of whom may never recover from their illness. Each person responds to this situation differently but in coping with their situation it helps to have someone to talk to about their illness (Cefrey, 2004). The nurse often provides this support meaning that as well as being in constant contact with severe physical illness nurses also must deal with psychological stress of other people such as these patients, colleagues, and patients relatives. This increases stress levels for the nurse as they not only have to manage their own stress but can also have others stress projected into them. Patients and their relatives may do this to protect themselves from the emotional burden of dealing with illness, passing on the stress they cannot manage (Menzies-Lyth, 1990).

Nurses face the reality of suffering and death as a regular feature of their job. They are in close physical contact with these patients which can make the libidinal and erotic wishes aroused by this difficult to control. Phantasy situations in the unconscious are simulated by the objective situations encountered in a nurse's work stimulating the early situations and accompanying emotions leading to the intense and complex anxiety a nurse may experience (Menzies-Lyth, 1990). The ego needs to protect itself from the anxiety provoked by destructive feelings originating in the death drive. When the baby is frustrated and directs all its rage at the breast it becomes scared that the

object will retaliate. It protects itself from this by splitting the object and itself into good and bad parts and placing all its badness into the external object, this is the paranoid-schizoid position (Klein and Mitchell,1991). Many people are drawn to the caring professions out of an often unconscious need to make reparation. This arises from guilt or concern and is an attempt to heal emotional wounds in the internal world. This can be achieved by helping others but there is risk that this need to help can become compulsive (Dartington, 2011).

In the hospital setting nurses may unconsciously link the patients and their relatives suffering with the suffering of the people in the nurse's phantasy world leading to increased anxiety for the nurse. Patients may also experience strong libidinal and erotic feelings evoked by the care they receive. These feelings may lead to the patient making the nurses lives more difficult as the positive feelings they have towards the nurses for the care they receive is complicated by feelings of resentment due to their dependence on the nurses and envy of the nurse's health and skills (Menzies-Lyth, 1990). For dependency to exist there must be a relationship and in this context, it is the relationship between the potential to give support and the emotion evoked by being provided that support (Dartington, 2010). Similarly, relative's feelings towards the nurses can be conflicted with positive feelings mixed with negative feelings of implied inadequacies as they can't take care of their loved one themselves (Menzies-Lyth, 1990). Mature, healthy dependency is a necessary acceptance of an individual's limitations, that everyone needs relationships at different times. Mature relationships, a person's capacity for trust and reliance on others as well as self-reliance is rooted in their attachment relationship history (Dartington, 2010).

The ability to handle stress is largely informed by childhood attachment. A secure attachment relationship in childhood allows the child to learn to regulate their emotions and become more resilient. An insecure attachment can lead to finding situations more stressful and responding to these situations in more uncontrolled way (Wallin, 2007). This is particularly relevant for nurses because becoming stressed in the workplace can lead to inhibited decision making (Totton, 2006). Dartington (2010) points out that the tendency for an individual to be seen as a unit of productivity by the hospital system adds to stress at work. The individual is viewed as a cog in the wheel that can methodically produce optimal functioning ignoring the fact that they are a human being that is being impacted by the things they are experiencing. Stokes (1994) explains that there are various factors that are essential in a team functioning which help in mitigating against the individual feeling like they are not valued or feeling fulfilled in their work. These include having a clear definition of aims and purposes, well defined sub-tasks and the authority and resources to perform those tasks, an acceptance that anxiety is inevitable in any activity that is difficult or upsetting and that this anxiety needs to be contained by management, and that there should be a reliable and pleasant working environment where the primary task of the team and the organisation to carry this out are regularly reviewed. Where this primary task is the delivery of positive intervention in a caring relationship conventional measures of success and efficiency may not be appropriate and a different measure of what success means must be adopted (Dartington, 2010).

2.3 Vicarious Traumatisation:

Dartington (2010) says no-one is immune to vulnerability with this feeling usually being evoked by external forces we can't control. Vachon (1998) outlines three main causes of stress for health care professionals working with critically ill and dying patients. These are issues around their relationships with clients and their families, around their occupational role and feelings of control, and their work environment. Woonhwa and Kiser-Larson (2016) add to this that there is a risk of long term stress due to unresolved grief and loss experienced as many nurses supress feelings of grief in the workplace. Dartington (2010) says that the biggest disadvantage the vulnerable person has is in reminding others of their own vulnerability. Florio et al. (1998) conducted a study on the causes and severity of work related stress among 59 oncology nurses. The study explored the nurse's perception of stress and looked at the coping strategies used to manage this stress. It found a strong correlation between the most frequently experienced stressors and the most intensely experienced stressors. These stressors included organisational factors, observing patient and family suffering, and physician related stress. This fits in with other studies findings in relation to work related stress for oncology nurses which suggest that things such as administering intense cancer treatments, dealing with the death of patients, poor relationships with medical staff, ethical and moral issues around the work, interpersonal conflicts with colleagues, and finding a good work life balance are causes of stress which can lead to significant negative effects.

There is a consensus in the research that working as an oncology nurse has the potential to be extremely stressful which can lead to health problems if not

acknowledged and managed adequately. Woonhwa and Kiser-Larson (2016) identify some of these potential health problems as headaches, backache, excessive nervousness, sleep disturbances, feelings of continuous stress, and a lack of pleasure in general life. This is as a result of work related stress but can also be the result of nurses frequently ignoring the emotional toll of caring for patients with cancer. This may be due to a lack of understanding of how these experiences can impact their health or because of ongoing long-term stress. This lack of awareness has the potential to result in ineffective coping strategies leading to negative emotions like feelings of failure and depression. This potential for chronic mental health problems is a very real risk with oncology nurses prone to burnout and compassion fatigue due to the nature of the work.

Tuna and Baykal (2014) tell us that burnout can develop due to exposure to long term stress. It is a psychological syndrome in response to long term chronic stress in the workplace. Russell (2016) used a quantitative study of 61 nurses to investigate what is perceived to be the main causes of burnout and what can be done to prevent suffering from it. This assessed emotional exhaustion, personal accomplishment, and depersonalisation elements which impact on someone's potential to experience burnout. It found that there is a statistically significant association between burnout and things like nurse to patient ratios and interactions with patient's family and friends. When these factors increase burnout, it was found that nurses may behave in a manner that lacks compassion as they become detached from providing care in a supportive and compassionate way. The impact on nurses experiencing burnout could be decreased by improving various factors. Improving nurse to patient ratios decreased the impact of burnout as did collaboration among staff and adequate resources and

supplies. Adequate sleep and rest was another important factor as was maintaining behaviours such as self-care and being able to separate work from home life. It was found that education around this self-care is important in avoiding burnout.

Figley (2002) explains that the act of being compassionate and empathic to others suffering leads to suffering for oneself. Compassion fatigue reduces the sufferer's capacity to bear the suffering of others. It is a state of tension where the individual is preoccupied with a traumatized patient. Traumatic events are re-experienced, with an avoidance or numbing of persistent arousal associated with the patient. Abendroth and Flannery (2006) tell us that stress and burnout can be precursors to compassion fatigue. Lack of support while dealing with work related stress and trauma can lead to psychological distress. It is suggested that unhealthy levels of empathy can blur professional boundaries which can leave nurses at high risk of compassion fatigue. It was found that nurses who sacrifice their own needs for their patient's needs had greater levels of financial stress, headaches, and hypertension than nurses who did not. These self-sacrificing nurses also reported other health problems resulting from physiological stress. Along with this these nurses who over identify with patients unintentionally, vicariously experienced their patients pain and anxiety. The impact this stress has on nurses is exacerbated when the nurses don't practice self-care. It is highlighted that compassion fatigue is a preventable and treatable phenomenon which is worthwhile addressing. Reducing the risk can have a significant positive effect on the nurse's health and quality of life and result in increased patient family satisfaction. It seems apparent from the research that stress, burnout, and compassion fatigue are a risk for nurses which if not addressed through self-care and other supports can escalate. It would suggest it is appropriate to provide nurses with education, ongoing

support, and an appropriate work environment to mitigate this risk. By doing this the nurses physical health and psychological health can be maintained at a good level. This is important for the nurse's wellbeing but also because if a nurse is overly stressed it can affect their cognition and ability to do a good job (Corner and Baily, 2009).

2.4 Strategies to Defend Oneself:

Wakefield (2000) says that maintaining a sense of composure when a patient is dying of cancer is extremely stressful and emotionally taxing. Woonhwa and Kiser-Larson (2016) describe coping strategies of nurses as fitting into one of two groups, functional or dysfunctional. Functional patterns include setting appropriate boundaries at an individual, group, and institutional level. This would mean things like separating work from spare time, developing new tasks in oncology units, and using humour at work. Oncology nurses may also use coping strategies such as venting emotions and colleague support. Dysfunctional coping patterns are characterised by a lack of boundaries and a lack of colleague support. Where there are boundaries there needs to be management of the system regulating the transactions between the inside and outside of the system. Through ego-function the individual manages their boundary between their inner and outer worlds (Dartington, 2010).

Menzies-Lyth's (1990) study observed the nurses in the hospital projecting their infantile phantasy situations into current work situations. They experienced current objective situations as a mixture of objective and phantasy leading to painful feelings associated with their phantasies being experienced. This is a common method of

managing anxiety where objective situations symbolise the phantasy situations allowing the person to reduce their anxiety by mastering this objective situation. Yalom (1980) explains that if we can change a fear of nothing into a fear of something then we can then do something about this real thing thus reducing anxiety. These anxieties can be defended against in functional or dysfunctional ways. When things are not seen as all good or all bad the depressive position has been reached where parts of something we want to possess can be contained alongside something we want to reject (Dartington, 2010).

Environmental factors also play an important role in supporting the caregiver in their work. Collaborative work relationships, support groups, and institutional polices are ways in which the environment can provide support. Most importantly the individual must feel they are part of a team with a philosophy, support, and team building. This sense of being supported by being part of a team leads to improved patient care and staff retention (Vachon (1998). In order to defend against anxiety, the individual must have supportive management with a precise understanding of their role and responsibilities with clear procedures, training and supervision (Dartington, 2010). Menzies-Lyth (1990) describes how the members of a social organisation will develop socially structured defence mechanisms to defend themselves against anxiety. This is a way for the individual to externalise their psychic defence structures by giving them substance in objective reality. These defence mechanisms develop over time through collusion between members of the group. This is often an unconscious process. Once the defence mechanism is established it becomes an external reality meaning that all members must adapt to it. The groups effort may be directed at satisfying the needs of the group (Stokes, 1994). As it is an open system it is judged on its ability to process

inputs from its environment and produce outputs and because it is a system there is an interdependence between the different members. This means change in one area will affect other areas which can lead to resistance to change in the organisation. It is possible that there is a conflict between the desire for containment and the desire to make a difference (Dartington, 2010).

Vachon (1998) outlines personal and environmental coping strategies which are important for managing work related stress. Effective personal coping strategies include developing a sense of competence, control, and pleasure from the work. It is suggested that having control over aspects of practice, developing a personal philosophy of illness, death, and where the individual fits in their professional role is also important. Finally support from family and friends and maintaining a healthy lifestyle help to reduce the risk associated with work related stress. It is important that whichever of these strategies are used that the caregiver must develop ways to care for themselves if they are to continue to effectively care for others. Woonhwa and Kiser-Larson (2016) tell us that nurse leaders and educators should develop interventions such as exercise and support groups, counselling resources and stress management classes. Verbalisation of feelings and expression of grief should also be encouraged to help nurses to cope with work related stress. Wenzel, Shaha, Klimmek, and Krumm (2011) outline suggestions from participants in their study that individualised support, and the creation of meditation rooms or quiet spaces could help them to cope with stress while also identifying support for their education and careers and opportunities to attend conferences as being important.

2.5 Conclusion

The literature highlights the demands placed on an oncology nurse working in this challenging environment. It shows the risk to the nurse's health and how their work performance may be affected if the stressful aspects of their job are not acknowledged and managed adequately. However, the majority of the literature is focused on quantitative research which is limited in exploring the real lived experiences of nurses working in oncology. It is the aim of this study to explore from a psychotherapeutic perspective the impact of working as an oncology nurse.

Chapter Three: Methodology

3.1 Introduction

This chapter explains the rationale behind using qualitative research methodology for this study. First the research design will be outlined, followed by a description of why the sample was chosen and how it was recruited. The choice of semi-structured interviews as the method of data collection will then be explained before the use of thematic analysis as the method of data analysis for this study is justified. Finally, the ethical considerations of the research and how they were addressed will be outlined.

3.2 Research Design

A qualitative research methodology was used in this research project. Qualitative research is interested in detailed readings of qualitative material. This allows the understanding of process rather than addressing causal relationships or measuring the size or extent of something. A qualitative approach is applicable when looking at an individual's experience allowing an understanding of the impact of this experience on the individual to be developed (Harper and Thompson, 2012, p.5). Qualitative research works as a discovery tool. This tool is used to follow the data wherever it may lead to extend the possibility of understanding of a subject. Its aim is to understand the subject rather than to test or agree with existing theories (McLeod, 2003). This research project aimed to explore the experience of nurses working in oncology wards making a qualitative approach the appropriate choice of methodology. The focus was on the

individual's subjective experiences and analysing these experiences from a psychotherapeutic perspective in order to gain a better understanding of the role and the impact it has on the individual.

3.3 Sample

Table 1. *Demographics of Participants*

Name (Pseudonym)	Age	Gender	Years' Experience
Liz	40 – 45	Female	15 – 20
Mary	25 – 30	Female	0 – 5
Ann	35 – 40	Female	10 – 15
Sandra	40 – 45	Female	20 – 25
Vicky	30 – 35	Female	10 – 15

The sample consisted of five female nurses that currently work on oncology wards in Irish hospitals. Demographic information is contained in table 1. Participants were selected based on the criteria that they were currently working as an oncology nurse and that they had at least two years' experience of doing this job. This was to try to ensure a broad view of the role with the hope that interviewing nurses that have at least two years' experience would provide a range of experiences in dealing with different circumstances and events that are part of the work. The sample contained nurses with a range of experience working on oncology wards in both public and private hospitals.

The sample included nurses who worked on in-patient wards and in day wards where the patient would come in for treatment and go home again afterwards on the same day.

3.4 Recruitment

The recruitment process began by making contact with an oncology nurse known to the researcher. Potential interested participants were then identified through this nurse. Other oncology nurses that were willing to participate were found through other contacts of the researcher. This separate person helped to recruit further participants in order to increase the pool that the sample will be selected from. Once identified permission was requested to obtain nurses contact details to contact them directly and send them an information sheet (see Appendix 1) which outlined the study and explained what was being asked of the potential participants.

3.5 Method of Data Collection

Face to face semi-structured interviews were used in this study. The main purpose of semi-structured interviews is to get a description of the central themes of a person's experience and attempt to understand them. This type of qualitative interview can also be a positive experience for the interviewer in giving an insight into the rich subject matter it allows the interviewee to reveal (McLeod, 2008). The nature of the in person one to one semi-structured interview is such that a rich exploration of the interviewees

experiences can be facilitated through interpersonal communication such as prompting and awareness of body language (McLeod, 2003).

The interview questions for this study were compiled with the main themes of the literature review in mind but aimed to be open enough to allow new themes to emerge (see Appendix 3 for Interview Schedule). This allowed in-depth data to be gathered in a structured and consistent way which was suitable for thematic analysis while allowing the flexibility to explore the individuals experience in an open way. All interviews were recorded with the participants permission and later transcribed verbatim for analysis. The interviews ranged in time from forty minutes to an hour and fifteen minutes and the following topics were covered:

- How the participants became interested in becoming an oncology nurse
- The participants experience of working in the field
- The challenges the participants face in doing the work
- What, if any, personal strategies or supports the participants utilise to manage their stress

3.6 Method of Data Analysis

Thematic analysis was used to analyse the data. The concept of theme is comfortably understood by those reading research papers and delivering analysis of an interview in a thematic way allows the researcher to stay close to the subject's experience (McLeod, 2012). Thematic analysis is an empirically driven approach to examining

observable data. It identifies patterns of meaning in the data containing manifest and latent material. These patterns are themes which can be coded and analysed. Manifest content is when the subject explicitly talks about a particular subject while latent material refers to when a subject is talked about implicitly. Themes are patterns of explicit and implicit content and manifest themes may point to a latent level of meaning. Themes can also be divided deductive or inductive. A deductive theme is drawn from a theoretical idea that the researcher brings to the work while an inductive theme emerges from the raw data itself. There is value in both these findings and qualitative work allows both to be explored. The knowledge of previous work allows similarities to be observed while the data which focuses on personal experience allows themes that differ from previous findings to emerge (Joffe, 2012). In thematic analysis material is coded and these codes are examined to find common themes (McLeod, 2012).

In this study the transcripts were read a number of times to become more familiar with the material before being analysed in a more systematic way. In this systematic process the data was coded to organise it into different groups relevant to the research question. Patterns and themes then emerged from these coded groups of information and the most relevant and significant themes were explored in the findings and discussion sections of this study. This allowed each individual interview to be analysed to identify themes within the data which informed the research findings and discussion of the study.

3.7 Ethical Considerations

Ethical approval for this research was given by the Dublin Business School ethics committee. The most common ethical issues include confidentiality and avoidance of harm to participants (McLeod, 2012, p.33). McLeod (2012, p.171) explains that informed consent requires three criteria to be met. The first is that the person giving consent must be competent in making an informed and rational decision about their participation. The second is that the person is given adequate information about the research, particularly about the risks involved. Finally, it is important that the consent is voluntary. These criteria were met by providing participants with relevant information in a written document (see Appendix 1). This document informed the participants of the purpose of the study and what was involved in taking part. The participants were made aware that their participation was anonymous and voluntary. They were informed they were free to decide what to disclose in their interview and to withdraw from the study at any time. The participants were made aware that they have a right to see the completed research document. Finally, the participant's identity is protected by the use of pseudonyms and their interview recordings, which are stored on a password protected hard drive, are only accessible to the researcher. These recordings will be destroyed on completion of the study. Having been provided with this information in advance the participants were then given a consent form (see Appendix 2) to review and sign before the interviews took place. The information and consent form were reviewed in person to ensure all was understood and to allow any questions to be asked, this allowed informed consent to be given. The researcher kept one copy of this signed consent form while the participant was provided with another copy.

Chapter Four: Findings

4.1 Introduction:

Research data was collected through five semi-structured interviews with oncology nurses. This data was then interpreted and analysed from a psychotherapeutic perspective from which three themes emerged. These themes came from the personal experiences of the participants and were chosen as they were the most prominent common themes running through the five interviews. The themes are:

1. Managing Vulnerability
2. Death anxiety and identification
3. Impact of the hospital system

These themes will be outlined and explored in the following section with vignettes from the interviews used to illustrate and support the themes chosen.

4.2 Theme One: Managing Vulnerability:

The relationship the patient has with the oncology nurses that look after them is at the core of the overall care the patient receives. While their primary duty is to complete tasks and administer treatments, their role can be more holistic than that and given the right circumstances the relationship can be rewarding and beneficial to both nurse and patient. The nurse spends more time with the patient than any other professional in the hospital and this can allow a relationship to form which is therapeutic in itself and also allows the nurse to act as an advocate for the patient within the multi-disciplinary

team. The participants in this study see this relationship as being fundamental to the care they provide but also have an awareness that this relationship must have boundaries in order to protect themselves emotionally and to ensure the level of care the patient receives is not compromised.

All participants in this study agreed that the most rewarding aspect of the work is building relationships with patients and looking after them. It is understood that success in these circumstances does not necessarily mean recovery from their illness but can also mean giving the patient the best care possible at the end of their life. Liz explained that it's very rewarding when people you've built a rapport with over time do well.

> **Liz:** *I liked looking after them. I found it very interesting and I found that you know was rewarding when people did do well in their cancer treatment…You've built a good rapport with these patients as well because they were coming in for treatments and you got to know them really well where with their surgical units and other medical wards you didn't get as close as, you know, you didn't get to know them as well.*

Sandra outlines how even when the outcome is not what was hoped for there are still positives that can be taken from the experience.

> **Sandra:** *…sometimes it's positive feedback even though we have a non-desired outcome, because at least the patient and their family know that we've left no stone unturned. I think if the patient and the family know that we've been on that journey with them and looked for every possible way of getting their cancer under control, then their likelihood and their ability to reach a point of acceptance is much more likely.*

This shows how the participants have learned to focus on what they can control as a coping mechanism for the difficult circumstances they often find themselves dealing with. In doing this they try to protect themselves from the potential negative emotional impact of the work in order to sustain themselves in the work. This is also a way to protect themselves from the unconscious anxieties provoked by the work.

The participants were united in their view that the relationship and the trust that can be built through developing the relationship is crucial in providing a high level of care. Three of the participants said that in order to be a good oncology nurse you must enjoy being in a relationship and be a people person. These nurses also highlighted how much they enjoyed this aspect of the work and found being appreciated by these patients to be very rewarding. Ann says that you must build a trusting relationship as the nature of the care you are providing requires the patient to share intimate details about their life.

> **Ann:** *You would have to discuss very intimate details like maybe having sex or fertility issues. You have to have trust. I suppose you can build up a relationship in that respect because there's no boundaries. You have to advise them, you have to empower them, you have to give them all the information, and build up a relationship that way.*

Vicky outlines how enjoying spending time with people is an important characteristic in being a good oncology nurse.

> **Vicky:** *You have to be a certain kind of person to go into it. You'd have to be very patient, empathetic. I suppose, to be a nurse in the first place, you have to be all those things, but to be an oncology nurse-- There's some people that just shouldn't be nurses. They're not people-orientated at all. They're not chatty, they're not friendly.*

Mary tells us that the job is not just about providing a service.

> **Mary:** *…for someone to let you in that much and when at the end of the day, I suppose you're just there to give them their chemotherapy but it's so much more than that.*

There is an awareness here of the therapeutic importance of the relationship as part of the patients care. It's seen as a requirement to enjoy getting to know people and to have the personal qualities needed to engage in this way. This suggests that there is a particular type of person who has the necessary characteristics to be a nurse which the participants see themselves as being.

The participants were also at a consensus that for these relationships to be appropriate and effective, proper boundaries must be maintained. In doing this the nurse can maintain their position as an empathetic care giver and avoid the risk of closing themselves off emotionally. It is agreed that if these boundaries are not maintained it can have a negative impact on the nurse and the patient in terms of their emotional well-being and the quality of care that is given and received. Sandra explains how she maintains the boundary between her work and home life:

> **Sandra:** *...my approach is that, give it 100% while I'm here, but then take the uniform off, whether I have a shower when I get home, or whether I cycle home. Let that be your process of, yes, that's behind me now, and now I'm on my day-to-day life that's separate... I think I've always got it clear in my mind and my empathy is coming from picturing it being my brother, my father, my mother, my sister that's where the empathy is routed but to remind myself that it isn't my family and that I have a very different role to play here compared to the role that I would take on if it was my brother, my father, my brother, my sister.*

Vicky talks about a patient who was well liked by all the staff leading to boundaries being blurred and many of the staff becoming overly close to her leading to problems when the patient died.

> **Vicky:** *People got very upset in the ward. There's a really bad morale on the ward for a long time. People were very upset. Then other patients that are newly diagnosed they can sense there's something wrong.*

This shows the importance of boundaries but also shows the difficult line that nurses try to tread. They must be capable of being emotionally engaged but not too much or in an uncontrolled way. This asks a lot of the nurses and their ability to do this successfully seems to be more reliant on the individual's personal characteristics and maturity than anything else. The ability to do this may be rooted in childhood attachment and how strongly developed the persons sense of self is developed.

4.3 Theme Two: Death Anxiety and Identification

All participants spoke about difficulties and stress caused by their role as an oncology nurse and that this has impacted their private lives. While it was highlighted that attitudes to showing emotion have changed all participants agreed that there are times when you can't be upset as it's part of the job and the impact it has on the individual seems to be considered less important than getting on with the work and getting the job done. Four of the nurses said that you do not stop and think, you just keep going. All the nurses talked about finding situations where they had a particularly strong bond or identification with a patient who died or had a bad prognosis, such as similar age or life stage, to be particularly challenging. At times there is a suggestion that the nurses may compromise their own wellbeing by trying to give the patient "the best care possible." While the nurses all aimed to perform as best they could at all times, four of the nurses described occasions when they wanted to go "above and beyond" for certain patients. These were patients who for various reasons such as being a similar age provoked deep anxiety in the nurse. These experiences affect the nurse's attitudes to their own life with two of the nurses talking about how inspiring they find it to work with these patients and two nurses talking about how they try to live their life in the moment and enjoy it as much as they can as a result of the suffering and fragility of life they have seen.

Liz outlined the impact patients can have and how attitudes to showing this impact have changed.

> **Liz:** *…there's patients I have cried about, there's patients I have thought about, they say you should leave it at the gate, but I don't think, in reality I don't think that is possible. So, I think that's easier said than done, that to detach and you know, kind of nursing was always kind of you know you have to take a*

professional stand back. You know type of attitude. You know it's impossible when you've built up a rapport with patients and there's going to be certain patients that you're going to have a very strong bond, a strong attachment with. And I don't think it's considered unhealthy now, years ago it was considered unhealthy to get... Now there is instances where some people get too much a strong bond and that can be unhealthy.

Ann talked about the difficulty of dealing with a patient getting bad news and the need to get on with things, which can lead to feeling burnt out, in the absence of other ways of dealing with it.

Ann: *Well, you try to leave it at work, but you're human. Sometimes it is really extremely difficult when somebody's gotten bad news, you've built up a rapport and what do you do? You just get on with it, I suppose. As time goes on you get more burnt out, you have a heavier heart and it is more difficult, but what do you do? Maybe perhaps we should seek counselling, I don't know.*

Mary describes a time when she had a patient of a similar age and background who she wanted to give the best care possible. The death anxiety provoked by identifying with the patient led Mary to try to do everything in her power to save the patient.

Mary: *I just wanted to make sure everything was done right for her. Not that I don't trust my staff, I completely do, but I just wanted to make sure that she got the best care. I knew I would have gone above and beyond for her. I just wanted to make sure that she had that, probably wasn't a great idea.*

Vicky explained the need to control your emotions for the good of the patient and how being around death can affect your attitude to life.

Vicky: *Patients, they can't be picking you off the ground crying. It's okay to be a little bit sad or whatever but you need to be in control and you need to manage, you have other patients.*

And

Vicky: *It's just, you'd see mortality and you worry a lot. Then, you have this live life to the full thing to the point that maybe you're a bit self-destructive.*

In terms of the support they receive in the work all participants highlighted peer support as the most common and an important source of support. This is relied on in

the absence of formal structured supports from the institutions the nurses work in. This lack of formal support was spoken about by three nurses while one nurse pointed out that this situation works when you get on well with your peers but could be a much bigger issue if you did not have good relationships and became isolated. Three nurses talked about how a good manager can make a big difference to the atmosphere in the workplace and to how supported you feel in the work. It was also highlighted by three of the nurses that there is still a stigma about showing vulnerability as this can be seen to show you are not suitable for the work. Mary explains how nurses support each other and how it would be good if there was a more structured support system.

> **Mary:** *It's always talked about how there isn't enough psychological support for nurses. There isn't enough debriefing. We do it ourselves, but we don't have anyone leading it. We're just lucky because we all get on so well and we can do that ourselves, but there's nothing. We all wish there was. Even once a month or once every couple of months. They were trying to set it up but there's nothing regular. There may have been one workshop ever since I started was three years ago.*

Beyond not offering formal support it also happens that due to low staffing levels that a nurse may not get the space needed to get over a traumatic event in the work. Vicky had this experience when one of her patients died in an unexpectedly sudden and traumatic way.

> **Vicky:** *I remember the next day coming to work. We were short-staffed actually, and they were telling me who my patients were. They were like, "You're looking after 4, 5, 6, B, and C." I said, "Can I not look after the patient in room B because that's where he died?" There was a friendly new patient, newly diagnosed with the same condition. I said, "Can I not just--." Then, they couldn't. They were like, "No. There's no one else." I had to walk into that room.*

For Liz the manager is the most important source of support and can have a profound effect on the whole ward.

> **Liz:** *I think that your main support comes from your, from your manager on the ward really. If you've a poor manager poor clinical nurse manager on the ward, it brings the ward down, we have an extremely, Orla would be an*

extremely excellent manager and a very good leader on the wards or would, you know stand up for staff.

Liz also points out that even though it is changing there is still a stigma around showing vulnerability which could be an issue if there were formal supports as nurses may be reluctant to use them.

> **Liz:** *...it's important for them if they are struggling to be able to go to the manager but see not all managers are approachable. And then you do have that, "oh well she's cracking up" or you know "is there something wrong with her" but yeah and it's, to a certain degree it can be frowned upon. It can be. But I think we have moved a little bit but there's still more to go.*

There is a feeling that the nurses can feel uncontained in the work at times for various reasons. This in turn affects their capacity to engage in the work in a way that feels rewarding to them because in order to do this they must feel capable of being available in the relationship. These relationships can often provoke anxiety in the nurses, so they need a secure base in order to feel safe entering into it in an embodied way. When the nurses feel contained through having a good manager or through peer support they feel more resilient and their ability to enjoy the work improves.

There was agreement that there are large parts of the role that are extremely rewarding that act as a counter balance to the stressful parts of the job. All the participants said that knowing your role, generally and in relationship with patients, and giving good care which includes giving treatments, controlling pain, and giving the patient a good death gave them a sense of meaning and value in their work. Sandra talks about the importance of knowing your role in sustaining yourself in the work.

> **Sandra:** *...we play an even more important role in looking after the patients that we cannot cure and cannot make their disease go away than what we do for those that achieve getting on with the rest of their life. I think if you can be a constant and not shy away from those difficult situations, then that's part of what's important about the role. If I didn't think I could do that, I probably*

wouldn't have stayed there that long-term. I couldn't cope with only being there for the good outcomes and shying away and avoiding the difficulties.

Ann explains how giving someone a good death can be rewarding and how spending this time with a patient is a privilege.

> **Ann:** *Even though it's an upsetting time, it's an amazing thing to do for somebody, to be on that journey with them and to look after them through that. It's actually very special to give that to them and their families, to look after them. It's a privilege to be with them in their hour of need. With the good news, of course, when the disease is controlled, or the tumour burden is decreased, that's fantastic. But also, it is actually rewarding the whole journey through.*

4.4 Theme Three: Impact of the Hospital System

Due to the necessity of the nurse performing their role (irrespective of the emotional impact of the difficult situations they sometimes experience in order to keep the system running), there are times when the nurses felt reduced to objects by the hospital system. Within the hospital system, the nurse is seen as a good object if they are performing all their tasks and getting all their work done. Their individuality and desire for relationship with the patient, and the benefits this can bring for nurse and patient, are seen as being of secondary importance. Their training advocates a holistic approach to treating patients and this creates a conflict for the nurse when due to inadequate staff levels or other reasons, patient to nurse ratios mean they are not given the time to provide the care they would like. This leaves the nurses open to at times destructive projections which they are left to manage with their own internal resources.

All the nurses talked about times they were used by the system to ensure all tasks were done in a way that wasn't necessarily ideal for them personally. Liz talked about a time when the hospital was particularly short staffed, and nurses were moved around.

> **Liz:** *There's was a lot of shortages here. There was a lot of nurses being pulled from the wards. It's caused a lot of distress, a lot of stress on the people that really didn't want to go the other place, that they want to give the care that they could. They wanted to work on the specialty that they had chosen, that they trained in. So, there was a lot of, there was a lot of a lot of people were just say very upset in that it was just so short staffed. There was massive shortage of nurses and nurses being pulled right, left, and centre. It was demoralizing to deploy these specialized nurses into the likes of accident and emergency. There was a lot of tension.*

Ann explains that although you have the desire to treat the patient in a holistic way this is not possible due to the priority given to tasks and the pressure to get all this work done.

> **Ann:** *I suppose each nurse if they weren't allocated as many patients could be a much less stressful environment, you could give more time to each individual. I suppose the whole holistic approach. This is what you're taught from the get-go but realistically, you don't have that time.*

The nurse's role as typically being the member of staff who has the closest relationship with the patient and acts as the patients advocate with other members of staff means they can sometimes be viewed as objects by other members of staff, patients and their families. All the nurses talked about experiences they had that suggested this dynamic was active. The emotional needs of this group can lead to splitting and seeing the nurse as a good object or bad object. The nurse acts as an auxiliary ego having these emotions projected onto them. This has an emotional impact on the nurse which varied depending on the emotion being projected and the person experiencing it. Mary talks about a time when a patient with a very difficult prognosis was viewing her as a good

object that could keep her safe leading her to look after her most of the time which she

wouldn't typically do with one patient.

> **Mary:** *I just really liked her, and I just really clicked with her. She said that she felt really safe with me looking after her. I suppose we built some of that trust in our relationship, so I ended up looking after her for the most of her treatment.*

Sandra talks about a time a patient's family member got very angry after bad scan

results and directed that anger at her.

> **Sandra:** *You have to depersonalize it and just let it be water off a duck's back. There's no point in dwelling on it but I think maybe my younger self would've been a lot more likely to be defensive in that situation, and I suppose experienced teaches you that, but there's no point.*

Ann describes how difficult it can be to feel upset yourself but have to supress that

feeling and hold hope for the patient.

> **Ann:** *When you see somebody deteriorate before your eyes and you see the scan and you see the result, you just go, "Oh, no." That's just so difficult because you know you're going to have to pick up the pieces. You have to stay strong for them and you can't be upset. Naturally enough, but it's very difficult for times.*

Sometimes a threshold is reached where the nurse doesn't have the capacity to take on

any more emotional baggage or may feel the emotion they are being asked to contain

is inappropriate in how it's expressed.

> **Vicky:** *You get a lot of emotions with the diagnosis. For the most part, people are lovely, but you get people taking out their anger on you. You know it's not personal, but you do reach a threshold of-- you get defensive maybe and upset. It's being professional all the time but at the end of the day, you don't want to be spoken to a certain way.*

All the nurses talked about the emotional challenge of dealing with death and dying.

There was a consensus that this becomes more manageable with experience and how

the process of becoming familiar with this part of the work is handled is important.

Experienced nurses must at times contain younger or more inexperienced nurse's

anxiety as part of their work. Three nurses talked about the importance of introducing inexperienced nurses to dealing with death in a gradual controlled way. This increases the emotional load these more experienced nurses are carrying and can also make them reluctant to show their own vulnerability for fear that it will have a negative impact on their younger colleagues. All the nurses talked about the need to educate more inexperienced nurses on the importance of boundaries in managing their emotions and sustaining themselves in the work. Vicky describes the process of getting a young nurse familiar with dealing with patients that have died.

> **Vicky:** *...you have first years crying, and you have to be there for them, and I was that soldier. I've had to take student nurses out, or often if they're too afraid to go in, if it's a nice family I'll say to them, "do you want to come in for a minute?". Because sometimes the younger you're exposed the better but maybe just for a minute or maybe lay out the body if they didn't know the person, which might be easier.*

She goes on to tell us how important it was for her that this was done as a gradual process when she was going through this phase.

> **Vicky:** *My training I was very lucky I was very well supported. Things that were scary or intimidating like doing CPR, the exposure was very gradual, and I never felt like I was put in the deep end, I always felt safe.*

While Sandra explains that it is more experienced nurses job to explain to newer nurses the importance of boundaries in maintaining emotional well-being during difficult experiences.

> **Sandra:** *I've become more and more well equipped at going, "I can't do anything about that now. I'll pick up, and I'll get back at giving 100% come Monday again if it's weekend or come the following morning if it's a week day." I think unless you get to the point of doing that, then there's a lot of over burdening that can happen and people can burnout. I think it's an important thing for us to instil and give colleagues younger than us coming through.*

Chapter Five: Discussion

5.1 Introduction:

The aim of this research was to explore from a psychotherapeutic perspective the experience of working as an oncology nurse. This qualitative study looked to:

- • examine personal experiences of oncology nurses in the Irish healthcare system

- • explore challenges and work-related stress as identified by participants

- • critically evaluate supports and personal strategies utilised by nurses to manage work-related stress

The findings suggest that the relationship between the nurse and patient is seen as central to the patients care and is one of the most rewarding aspects of the work for the nurse. While engaging in and ideally enjoying this relationship are seen as being vitally important to the standard of care provided, having and maintaining boundaries is seen as equally important. There is an understanding that due to the nature of cancer it will not always be the case that there will be a desired outcome for the patient. In this context success is giving the patient the best possible care and if the point is reached where no further treatment is possible giving the patient a good death becomes the focus. In this way anxiety is managed by focusing on what can be controlled and trying to accept what cannot. Work stress has affected all the participants at times and impacted on their private lives. This happened in particular when issues arose around a patient they particularly identified with.

It can be difficult to be in this situation as there is a suggestion there is a stigma around showing vulnerability which three participants said has improved but still exists. Peer support is seen as important during these times. Other important factors in feeling supported include having a good manager, good staff-patient ratios, knowing your role and having the ability and resources to do it. Due to the necessity of the hospital system functioning, nurses sometimes had to make serving their function and ensuring that tasks were completed their priority over their well-being. This is the nurse being used as an object by the system and they also describe being seen as bad and good objects by patients, their families, and other staff at various times.

5.2 Managing Vulnerability:

The relationship the nurse has with the patient is at the centre of the care the patient receives. The nurse spends more time with the patient than any other professional at the hospital and so often forms an attachment to the patients they care for. All participants in this study saw the relationship with the patient to be fundamental to the care they provide and one of the most rewarding aspects of the work. All nurses agreed that when you had formed this relationship with a patient you want to give them the best care possible. This would mean ideally that the patient would be cared for until they recovered from their illness but due to the nature of the work there is agreement that sometimes this means keeping the patient as comfortable and pain free as possible. If the patient reaches a point where they are given a prognosis that they will not recover from their illness the focus then turns to giving the patient a 'good death'. This is a coping strategy where the nurses are focusing on what they can control as a way to

manage the anxiety from dealing with unpredictable circumstances. As Sandra points out, if the nurse and the rest of the medical team do everything within their power when working with a patient there can still be positive feedback in the event of an undesired outcome. The patient and their family are more likely to reach a place of acceptance if they feel that all options have been exhausted and this allows them to continue seeing the nurse as the good object for the care they have provided. For the nurses it means that they can protect themselves from undesired emotions caused by unconscious phantasies evoked by the undesired outcome which was outside their control. These findings fit in with previous research which says that nurses are generally given most responsibility for the patient's day to day care (Menzies-Lyth, 1990). This leads to situations where phantasies in the unconscious are simulated by the objective situations the nurse is facing which can result in complex anxiety for the nurse (Menzies-Lyth, 1990). This may lead to splitting the object into good and bad parts to manage this anxiety but in this study the participants seem to have found a way to avoid doing this by accepting desired and undesired outcomes as being possible and to a large extent outside their control, this suggests the depressive position has been reached where the good and bad aspects of the whole can exist together as part of one object (Klein and Mitchell, 1991). This also fits in with the suggestion in the literature that in this work conventional measures of success and failure may not be appropriate and a different measure of what success means must be adopted (Dartington, 2010).

The nurses all saw it as being necessary to build trust with the patient due to the intimate nature of the care they were providing. The patient must share intimate details about their life in the course of their treatment and all the nurses talked about seeing

and helping patients during extremely vulnerable moments. There was a matter of fact attitude to these experiences and a belief that it was important to maintain your composure and stay professional for the good of the patient being taken care of. There may also have been a desire to master these situations and feel in control as a way to manage the unconscious anxiety they felt. This coping mechanism is reflected in the literature which says that an individual can project their phantasy situations onto objective work situations (Menzies-Lyth, 1990). This gives the nurse the opportunity to turn the fear of nothing into a fear of something, this fear of the objective thing can then be acted on, reducing anxiety (Yalom, 1980).

All the participants spoke about the importance of boundaries in their work relationships in terms of managing work related stress. It was seen as being extremely important to manage this as it was agreed that a lack of appropriate boundaries can increase stress significantly which can negatively impact health and work performance. The nurses all spoke about ways in which they set boundaries between their work and private life such as not engaging with patients on social media and trying to switch off and leave work at work at the end of the day. Other important factors mentioned for coping included exercise, eating healthily, having good management and peer support. The nurses all spoke about times when they had a closer attachment to a patient than usual. This caused increased stress and highlights the need and difficulty of managing the boundary in the relationship with the patient. The capacity to manage this is rooted in childhood attachment relationships and emotional resilience is also developed during this process. The importance of coping strategies and the coping strategies utilised by the participants in the study are similar to what the literature suggests. Woonhwa and Kiser-Larson (2016) outline functional coping

patterns as including setting appropriate boundaries, separating work from spare time, venting emotions, and peer support. These were all mentioned by the participants as being vital to sustain themselves in the work.

5.3 Death Anxiety and Identification:

The participants all highlighted the difficulties and stress caused by their work as an oncology nurse and times when this has impacted on their private life. Although all nurses agreed that it is now accepted that to show emotion is normal and healthy there still seemed to be an element of stigma around the idea of showing this vulnerability. This may have been due to the pressure to perform with four of the nurses talking about having to not think and just keep going to complete the work that needed to be done. This denial of vulnerability may also be a denial of death believing that they are not affected and can continue unconcerned however Ann talked about finding it difficult to do this at times and how attempting to do so can lead to feeling burnt out. This may have been what Dartington (2010) was talking about when he said that the individual can sometimes be seen as a unit of productivity by the hospital system. This ignores the impact that some of these work experiences can have and the stress it causes which the literature suggests could lead to burnout in the long term (Russell, 2016).

All the nurses talked about times when they established a strong connection with a patient due to identifying with them in some way such as similar age or similar life stage. When a patient like this died or received a bad prognosis it was particularly

difficult to deal with and all nurses described times when their own well-being was negatively affected when trying to give these patients the 'best care possible'. This again seems like an attempt to control their own death anxiety provoked by caring for someone with whom they identified so much. If they can provide the best care possible then they might be able to save this patient and themselves. However, when this proves to be impossible due to circumstances outside their control the impact can be overwhelming. This informs the nurses view that managing boundaries is vital to their own emotional well-being and providing a consistently high level of care. This desire to give the best possible care often at the cost of the nurse's own well-being is a common issue (Abendroth and Flannery, 2006). The awareness the nurses in the study have that it is important to manage this issue and have clear boundaries is consistent with the literature which says that unhealthy levels of empathy can blur professional boundaries and leave the nurse vulnerable to compassion fatigue (Abendroth and Flannery, 2006). This is important because it can have serious negative impacts on the nurse's health and ability to provide a high standard of care if left unaddressed (Corner and Baily, 2009).

Peer support was chosen by all participants as their most important source of support. Peer support and good management are highlighted in the literature as being imperative to supporting the caregiver in their work which when in place can contribute to improved patient care and staff retention (Vachon, 1998). Three of the nurses talked about the lack of formal support during difficult times and how this can leave them feeling isolated and uncontained. Three of the nurses brought up the importance of a good manager in a well-functioning team. It was highlighted that even in a good team with good individuals, a good manager is needed to make the staff feel

safe. This evokes the idea of a secure base in attachment theory where if the individual being cared for feels that there is a secure base to return to then this allows them to take more risks and be more engaged in the relationship. Wallin (2007) explains that in order to feel safe in exploring different experiences and in relationship the individual must have a secure base. In childhood this is provided by the primary care giver while in the hospital system this could be seen to be provided by good management and a secure supportive team environment. As well as a lack of formal supports four nurses talked about times when they had to continue working after they had experienced a particularly traumatic experience. These nurses suggested that it would have helped them if they could have had a short amount of time off or even not have to work in certain rooms for a few days, but this could not be accommodated as the system functioning as required is seen as of paramount importance and the system did not have the capacity to do this built into it. Dartington (2010) talks about an open system being judged by its ability to process inputs and produce outputs. In order to do this the system relies on its members working as an interdependent unit. There are also aspects of the work and the hospital system which the participants experienced as fulfilling and acted to contain and reduce anxiety. All agreed giving good care, good treatments, and a good death gave a sense of meaning and fulfilment in the work. These findings are consistent with the literature.

5.4 Impact of the Hospital System:

The nurses training advocates a holistic approach to caring for patient's which the nurses value but at times can't deliver due to the demands of the hospital system. All

nurses described times when they had to work in a way that wasn't ideal for them personally but was necessary to ensure all tasks were completed to keep the system running. In this scenario the nurse's individuality and desire for relationship and to do the best job they possibly can with the skills they have learned are made subservient to the needs of the system. This creates a conflict for the nurse as providing the best care possible is one of the ways of protecting themselves from anxiety. In this situation the system is increasing the anxiety of its members which is likely to reduce efficiency in the long run as well as potentially leading to health risks for the nurse. There was however agreement that the majority of the time the role is rewarding and that these times outweigh the difficult moments. The participants suggest that the system contributes to creating an environment where this is possible by making sure the nurses have a clear idea of their role in the system and their role in the relationship with the patient, as well as the opportunity to work in the speciality they have trained in. Stokes (1994) outlines the importance of having a clearly defined purpose, well defined sub-tasks, and the ability and resources to perform those tasks as being important factors in feeling valued and fulfilled in the work. Dartington (2010) also highlights supportive management, a precise understanding of one's role and responsibilities, and good training and supervision as being important. This fits in with the findings of this study as when these criteria were met participants reported feeling their work had a sense of direction and meaning. However, during times when management was not of the standard required or when staff shortages led to nurses having to work in areas they were not trained to specialize in they reported high levels of stress and dissatisfaction with their work.

The nurse can sometimes be seen as an object by patients, their families and other members of staff due to their role in the system. The nurse has the closest relationship with the patient and often becomes their advocate on the multi-disciplinary team. All nurses talked about experiences in work relationships where they felt they were playing a role for the other person. This included times when they were holding hope for the patient or times when they had to act as a container for the family's anger when faced with a bad prognosis. There were also times when the nurses fulfilled this role for other members of staff who sometimes can use the nurse to contain their unwanted emotions. In these situations, the nurse is acting as an auxiliary ego and is carrying others anxiety for them. This can have a large emotional impact on the nurse. Their ability to manage this and have an awareness that these incidences are not about them varies depending on personal characteristics and experience. Dartington (2010) points out that a mature dependency relationship should exist between carer and patient. This is an acceptance of an individual's limitations which are apparent when suffering from illness. The ability to engage in this type of relationship is informed by the individuals attachment history (Wallin, 2007). This means that some patients and some nurses or other colleagues will have a better capacity for this than others and those that do not will be more likely to revert to more primitive defences (Menzies-Lyth, 1990). This can lead to the nurse being used as an object when others project emotions they cannot bear into the nurse, this may be a good object such as holding hope for the patient or providing good care, or it may be a bad object such as holding patient or family anger following a bad prognosis or colleagues stress when they are overwhelmed and can't contain it themselves. This is a big emotional burden for the nurse which if not managed could lead to burnout and compassion fatigue (Russell, 2016).

All nurses talked about the obligation they feel to help young and inexperienced nurses in learning to manage working with death and dying. This included how to deal with the relationship with the patient and their families during this period and also the task of dealing with a dead body. Three of the nurses talked about finding this a very difficult part of the work when they first started but became more comfortable with it with experience. Three of the nurses mentioned the help they have received during this stage and their feeling that they should pass on this support. Vicky suggests that it may be easier to have a student nurse work on the body of a person they did not know first as this would be easier. This could suggest that the idea of death is being avoided because having never known the person alive it is easier not to think about their death. As well as containing these younger nurse's death anxiety the more experienced nurses also attempt to protect the younger nurses through advocating for things such as maintaining their boundaries. This serves the purpose of helping the younger nurses and also protecting the productivity for the system. This is added stress for the more experienced nurses, but it also provides them with a sense of accomplishment as they can see the younger nurses grow and develop under their care. This desire to set boundaries and contain the difficult aspects of the work while offering colleague support is consistent with factors which contribute to functional coping strategies for nurses (Woonhwa and Kiser-Larson, 2016). This serves two functions for the nurses as it gives them a sense of meaning in their work and also maintains the functioning of the system through supporting inexperienced members leading to better patient care (Vachon, 1998). This also suggests a socially structured defence mechanism to defend against anxiety for the group (Menzies-Lyth, 1990). The anxiety new nurses face is managed by more experienced nurses which also serves the function of reducing the experienced nurse's anxiety. This happens as they now have

the new nurse's anxiety to focus on and this is something they can maintain a large amount of control over through the duties they ask them to perform. Once again this shows how focusing on something that can be controlled during an unpredictable experience can reduce anxiety (Yalom, 1980).

Chapter Six: Conclusion

6.1 Summary of Findings:

The findings from this research support existing literature around the issues of the impact of working as an oncology nurse. This includes the elements that create a supportive environment for doing the work, the factors that can be of support to the nurse when they are having a difficult time, and the coping strategies used by the nurses. The findings suggest that oncology nursing is emotionally taxing work but is also experienced as being extremely rewarding. There are common factors the nurses identified as being important in providing an environment where they can feel contained and have the conditions to feel fulfilled in their work. These include having good peer support, a good manager, good nurse-patient ratios, a clear role, responsibility and the authority to carry it out. When this happened, the participants felt contained and supported in the work and found the work more fulfilling.

However, there is a tension between the demands of the hospital system, the emotional demands of the work, and the nurse's well-being. On occasions when staffing levels fall, a nurse goes through a particularly difficult experience, or there are issues with management the necessity of the system functioning means that the nurse has to manage increased stress and anxiety while also maintaining her productivity in terms of her tasks. At these times the participants felt uncontained and unsupported relying heavily on peer support. Despite this all participants said they would recommend working as an oncology nurse to a friend and talked about how rewarding they found the work and the relationships they experience with patients and their peers.

6.2 Strengths and Limitations:

The strengths of this study included that the participants of this study were very experienced in their field which adds to the richness of the material gathered. The semi-structured interviews allowed the interviews to be guided by existing research but left it open for other material to emerge. This also prevented the research from being limited by the researcher's assumptions. Thematic analysis allowed an in-depth exploration of the nurse's experience and what the underlying processes may have been.

The limitations of this research included the fact that the literature on oncology nurse experience is limited. The focus in this area is almost always on the patient. All the nurses interviewed for this study were female. Given the impact that gender roles can have on an individual and the reality that nursing and caring roles generally have been seen as a traditionally female occupation, it would be interesting to see if a male experience would be significantly different.

6.3 Recommendations:

The study supported previous research which suggested that nurse's self-care is of fundamental importance to their own health and to the optimal functioning of the hospital system. However, the individual does not hold all the responsibility for self-care. The environment and the system must facilitate this self-care and encourage it as much as possible through its policies and systems.

Training for nurses on attachment and how this can affect the relationship could be useful. An understanding of what may be driving others behaviour and how they may be viewing you could help in managing challenging work situations and possibly reduce anxiety by giving a better feeling of control in these situations.

There was a consensus that a more formal support structure would be welcome if some issues around previous attempts could be addressed. The issue of not wanting to show too much vulnerability when around more junior members of staff could possibly be addressed by having groups made up of nurses of similar level or experience. Another concern was that in the past these groups have been facilitated by staff members from the hospital making the nurses feel uncomfortable at the idea of opening up. Groups facilitated by an external person who's only relationship with the group was in this context may contain the group as separate to the hospital system. It may be interesting to explore this idea along with any others that may provide a needed and wanted solution to providing more support for nurses.

References

Abendroth, M. and Flannery, J. (2006). *Predicting the Risk of Compassion Fatigue*. Journal of Hospice and Palliative Nursing. 8(6). pp.346-355.

Cefrey, H. (2004). *Coping with Cancer*. New York. The Rosen Publishing Group, Inc.

Corner, J., & Bailey, C. D. (2009). *Cancer Nursing: Care in Context*. Oxford. John Wiley & Sons.

Dartington, A. (2011) *Where Angels Fear to Tread, Idealism, despondency and inhibition of thought in hospital nursing*. In Obholzer, A., & Roberts, V. Z. (Eds.). The unconscious at work: Individual and organizational stress in the human services. London: Routledge.

Dartington, T. (2010). *Managing Vulnerability: The Underlying Dynamics of Systems of Care* (Tavistock Clinic series). Karnac Books.

Figley, C. R. (2002). *Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care*. Journal of Clinical Psychology. 56(11). pp.1433-1441.

Florio, G. A., Donnelly, J. P., Zevon, M. A. (1998). *The structure of work-related stress and coping among oncology nurses in high-stress medical settings: a transactional analysis*, 3(3), pp. 227-242.

Harper, D. and Thompson, A. (2012). *Qualitative research methods in mental health and psychotherapy*. Chichester, West Sussex: John Wiley & Sons.

Irish Cancer Society (2017). Retrieved May 5th, 2018, from https://www.cancer.ie/about-us/media-centre/cancer-statistics#sthash.mThtbU5i.dpbs

Joffe, H. (2012*). Thematic analysis*. In Harper, D. and Thompson, A. (Eds.), Qualitative research methods in mental health and psychotherapy (pp. 209 – 223). Chichester, West Sussex: John Wiley & Sons.

Klein, M., & Mitchell, J. (1991). *The selected Melanie Klein*. London, United Kingdom: Penguin Books.

Medland, J. et al, (2004) *Fostering Psychological Wellness in Oncology Nurses: Addressing Burnout and Social Support in the Workplace*. Oncology Nursing Forum. 31(1). 47-54.

Meier, D. E. (2011). *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*. The Milbank Quarterly, 89 (3). pp. 343–380.

Menzies-Lyth, I. (1990). *Social systems as a defence against anxiety*. In Trist, E., Murray, H. and Trist, B. (Eds.), The Social Engagement of Social Science, Volume

1, A Tavistock Anthology: The Socio-Psychological Perspective (pp.439 – 462). Pennsylvania: University of Pennsylvania press.

McLeod, J. (2003). *Doing Counselling Research* (2nd ed.). London: SAGE Publications Ltd.

McLeod, J. (2008). *Introduction to Counselling* (1.1 edition). The Open University.

McLeod, J. (2010). *Doing counselling research*. Los Angeles, Calif. [u.a.]: Sage.

McLeod, J. (2012). *Qualitative research in Counselling and Psychotherapy*. London: SAGE Publications Ltd.

National Cancer Control Program (2017). Retrieved June 18th, 2018, from https://www.hse.ie/eng/services/list/5/cancer/about/background.html

National Cancer Strategy 2017-2026 (2017). Retrieved June 18th, 2018, from https://health.gov.ie/wp-content/uploads/2017/07/National-Cancer-Strategy-2017-2026.pdf

Post-White, J. (1998). *Wind behind the sails. Empowering our patients and ourselves*. Oncology Nursing Forum, 25, 1011-1017

Russell, k. (2016). *Perceptions of Burnout, Its Prevention, and Its Effect on Patient Care as Described by Oncology Nurses in the Hospital Setting*, 43(1), pp.103 – 109.

Stokes, J. (1994). *Problems in multidisciplinary teams: the unconscious at work.* Journal of social work practice. 8(2). pp.161-167.

The Expert Group on Mental Health [TEGOMH] (2006). *A Vision for Change*. Retrieved April 30, 2017 from http://www.hse.ie/eng/services/publications/Mentalhealth/Mental_Health_-_A_Vision_for_Change.pdf

Totton, N. (2006). *The Politics of Psychotherapy: New Perspectives*. London. McGraw-Hill Education.

Tuna, R., Baykal, Ü. (2014). *The relationship between job stress and burnout levels of oncology nurses*, 1(1), Pp 33-39.

Vachon, M. L. S. (1998). *Caring for the caregiver in oncology and palliative care.* Seminars in Oncology Nursing. 14(2), pp.152-157

Wakefield, A. (2000). "*Nurses' responses to death and dying: a need for relentless self-care*". International Journal of Palliative Nursing. 6(5). pp. 245-251.

Wallin, D. J. (2007). *Attachment in psychotherapy*. New York: Guilford Press.

Wenzel, J. et al, (2011). *Working Through Grief and Loss: Oncology Nurses' Perspectives on Professional Bereavement*. Oncology Nursing Forum. 38(4). pp.272-282

WHO | Cancer. (2018) Retrieved May 1, 2018, from
http://www.who.int/mediacentre/factsheets/fs297/en/

Woonhwa, K., Kiser-Larson, N. (2016). *Stress Levels of Nurses in Oncology Outpatient Units*, 20(2), pp.158 – 164.

Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Basic Books.

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Appendices

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Appendix 1.

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Participant Information Sheet

</div>

Introduction

My name is Greg Daly and I am a studying for an MA in Psychotherapy in Dublin Business School. I am researching the experience of working as a nurse on oncology wards.
I am inviting oncology nurses to participate in this study by agreeing to a 45-50-minute interview. If you would like to participate, please read the detailed information provided below.

Who is organizing this study?
This study is part of a Master's Degree in Psychotherapy being undertaken at Dublin Business School, Dublin, Ireland.

What is the purpose of the study?
The purpose of this study is to understand the impact of working as an oncology nurse.

What are the criteria for participation in the study?
Participants in this study must be experienced professionals working as an oncology nurse for over 2 years.

What is involved in participation?
If you choose to contribute to this study, you will be invited to take part in a face-to-face interview at a place of your convenience. The interview will take approximately 45-50 minutes and will seek to understand your experience of working as an oncology nurse. The interview will be taped and later transcribed by the researcher. No names or location will be used.

Are there any risks/benefits?
There are no known risks to you from taking part in this research.

Will my identity be protected?
Your identity will be protected and known only to the researcher. All identifying information will be removed during transcription to protect your anonymity. Notes about the research will be stored in a locked file. Each person who participates in the research will be given a code number so that the researcher will be the only person who can identify the participant. The key to the code numbers will be kept in a separate locked file. The audio recordings of the sessions will only be accessible to the

researcher and will be destroyed once transcripts have been made of the sessions.

Can I withdraw from the study?

If you initially decide to take part, you can subsequently change your mind. You can request to have your data removed from the study. Additionally, under the Freedom of
Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.

How can I get further information?

For additional information please contact

Researcher:
Greg Daly
gregdaly@yahoo.co.uk

Research Supervisor:
Dr. Grainne Donohue
grainne.donohue@dbs.ie

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DBS School of Arts,
13-14 Aungier Street,
Dublin 2

Appendix 2.

CONSENT FORM

Protocol Title:

A psychotherapeutic exploration of nurse experience in oncology wards.

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐

Yes

☐

No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

☐

Yes

☐

No

I understand that my identity will remain confidential at all times.

☐

Yes

☐

No

I am aware of the potential risks of this research study.

☐

Yes ☐No

I am aware that audio recordings will be made of sessions

☐

Yes ☐No

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐

Yes

No ☐

Participant _____

_____
             Signature and dated   Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved and have invited him/her to ask questions on any aspect of the study that concerned them.

_____   _____
        _____

Signature   **Name in Block Capitals**
      Date

Appendix 3.

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Interview Questions

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A psychotherapeutic exploration of nurse experience in oncology wards.

1. Can you tell me about what first brought you to this work?

2. Can you tell me what a normal working day is like for you?

3. It's my understanding that you work as part of a multidisciplinary team:

    - How do you see yourself fitting into this team?

    - What is your experience of how the team relates to each other?

4. How do you experience the organisation to work for?

    - Prompt if necessary: Is it easy to get the holidays you want, are you happy

        with your hours/work schedule, etc.

5. What aspect of the work do you find most rewarding?

6. What do you see as the biggest challenges in your work?

7. How would you describe your relationships with your patients?

    a. What is the most challenging aspect of this?

    b. What is the most rewarding?

8. I imagine you see patients in very vulnerable moments, how does this impact you?

9. Can you tell me your experience of working in an environment where death is a

    possibility?

10. Can you tell me about a time that you struggled in your work or felt overwhelmed?

11. What can you tell me about how you managed this experience?

12. What would you feel are the greatest supports to you in this work?

13. What would you tell somebody who was interested in getting into the field of

    oncology?

14. If you could make any changes to your role what would they be?

15. Is there anything you'd like to add about your working experience that you think

    might be useful in understanding your role?