



# Oncology Nurse as Wounded Healer: Developing a Compassion Identity

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Oncology nurses caring for patients with complex medical, psychosocial, and spiritual issues—including patients at end of life—rely on current medical interventions to offer comfort to their patients. Equally important, but less acknowledged, is nurses' reliance on the internal processes of reflection and self-care. That internal focus is vital to the longevity of the nurse in a rewarding, but often depleting, arena. Compassion fatigue and burnout among oncology nurses are great risks to professional development and personal growth. Repeated exposure to physical and psychosocial pain and suffering can cause symptoms that resemble those of post-traumatic stress disorder. Awareness of one's own fragility and the need to understand the connections between body, mind, and spirit can assist the clinician in developing a compassion identity that nurses and other clinicians can use to insulate themselves from the stressors of their difficult and rewarding environment.

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The oncology staff had administered breakthrough medication for the pain from Mr. C's growing tumors; however, the effects were short-lived and he was in a lot of pain. His family was dismayed and did not understand why he could not be made more comfortable. Rita, an experienced, middle-aged oncology nurse assigned to him, was upset and did not know what more she could do. She had many patients similar to Mr. C, suffering from intractable pain and anxiety. She considered herself to be compassionate to a fault and often spent hours beyond her shift assisting patients and families. A recent divorce had given Rita more time at work but also had caused her to experience an increase in fatigue. Signs of irritability and perfectionism were becoming apparent to her colleagues at the hospital. She refused offers to access support from

an employee assistance program, believing that she could manage her issues on her own. Frustrated with her inability to address the pain of Mr. C, she asked her supervisor, Edie, for help.

Edie, also an experienced oncology nurse, went into the room and calmly said, "We are going to try something different." She did not have a plan when she walked in or even when she said they were going to try a different approach; she just knew she had to give Mr. C some hope. First, she tried visualization—a soothing beach; it did not work. So, she started muscle relaxation and, sure enough, it worked—probably because the analgesic had kicked in by then, too. But the distraction of trying this alternative kept Mr. C's mind off his pain and let him and his family see that the staff was not going to give up on trying to control his pain.

Debriefing nurses who care for patients with difficult physical or psychosocial-spiritual symptoms is a facet of self-care that many experienced professionals welcome, as well as hold, as a source for growth and meaning. The situation with Rita and Edie may appear familiar; it has occurred in many different situations, and its familiarity may offer a blend of admiration and anxiety. What were the differences between Rita and Edie? What variable led one nurse to propose an alternative therapy to diminish the patient's pain and anxiety and the other nurse to relinquish care, leaving her feeling inadequate and frustrated?

As Potter et al. (2010) indicated, compassion fatigue is the tension arising from preoccupation with exposure to cumulative trauma, and it results from the expenditure of energy in caregiving over a long period of time to patients with serious or terminal diagnoses, with the clinician not seeing tangible results of the care. Burnout, however, flows from the cumulative stress from the demands of daily life, an exhaustion affecting all domains (physical, mental, emotional, spiritual). Burnout tends to be more environmentally based and compassion fatigue is more connected to the relational (Figley, 1995).

## Compassion Identity

To meet the challenge of caregiving, a nurse or other healthcare provider must find a way to maintain compassion identity while helping others live with hope when loss and death are inevitable. Compassion identity can be likened to one's internal global positioning system, that intuitive sense that constantly monitors clinicians' protracted work with the

chronically or terminally ill. Compassion identity allows the clinician to regularly and continually reevaluate and reexamine their internal resources in ways not required in other professions. Through this internal monitoring process, nurses may realize when it is time to temporarily excuse themselves from an intense case to replenish their compassion resources. Development and awareness of compassion identity leads to greater efficacy with patients.

Nurses often admit a strong connection between who they are and what they do. Many in the field, including social workers, physicians, and chaplains, enter their disciplines to deepen their inner lives, to seek answers to larger, existential questions, or simply to make a difference in a world where altruistic values are overlooked or seen as unimportant. However, those altruistic attributes can often lead the clinician to compassion fatigue unless deliberate and constant vigilance is exercised.

In the author's experience, nurses recognize that witnessing suffering is a part of their daily work, yet they seek to understand each person who is suffering as a unique individual. As witnesses to suffering, they serve as compassionate voices and recognize the human response to illness in the confusing, and often depersonalized, healthcare environment (Ferrell & Coyle, 2008).

The concept of being a witness to the suffering of others requires that the person witnessing the pain also must witness and attend to their own personal suffering and existential dialogue (Hanh, 1993). That self-awareness, often found in experienced hospice clinicians, can ground the practitioner in the moment. Compassionate presence provides the patient and family with a sense that their pain is acknowledged and validated, and that they are truly listened to, which affirms that their story is worthy of telling and being heard and has intrinsic dignity and value (Romanoff & Thompson, 2007). According to the author, many hospice professionals working in the field 10 years or more say that commitment to the development of a trusting and therapeutic rapport with patient and family is most important. Healthcare professionals are not free from the fear of mortality or being overwhelmed by the enormity of the suffering they encounter every

day; however, they need to have a desire and opportunity to openly discuss such universal sources of anxiety because, in the author's experience, those are the anxieties most present on the minds and hearts of patients. Together, members of a team are able to support the patient and family with each clinician bringing their own insight, brokenness, expertise, and personal experience to the service of the suffering patient. Stamm (2002) offered another dimension, compassion satisfaction, finding personal and professional value and satisfaction from the workplace.

## Competence Enhanced

Although Rita was trying to be effective, she found herself frustrated by personal stressors interfering with professional performance. In the midst of her own existential distress, Rita was unable to understand the deeper needs of her patient and offer viable alternatives to managing the pain of Mr. C. Perhaps her inability to find a viable intervention for Mr. C flowed from unfamiliarity with her own internal process. She believed herself to be self-sufficient and without need of therapeutic support. That often can lead clinicians to succumb to the compound effects of burnout and compassion fatigue. Edie, Rita's supervisor, entered the patient's room from a different stance. Instead of rushing to alter a medication dosage, she instead saw Mr. C as requiring interpersonal involvement greater than pharmaceutical intervention. Edie understood the connection between body, mind, and spirit. Such understanding can come from the practice of self-care, often allowing the nurse to find alternatives to problems outside the box. The clinician who practices meditation, has a spiritual practice, or is dedicated to spending time and energy on other self-care techniques often can help patients find meaning and comfort from nontraditional and perhaps nonpharmacologic sources.

## Wounded Healer Updated and Expanded

When writing on this topic, many authors reference the term "the wounded healer" (Nouwen, 1994, p. xvi). Rooted in Greek mythology (Chiron) and Greek legend (Asclepius), the notion of the

- ▶ Work with what you have, dispelling fears and finding strength to handle what is happening in the present moment.
- ▶ Remember that you have a right to your own life. Giving to others does not mean neglecting yourself.
- ▶ Pay attention to the people and activities that nurture your mind, body, and spirit. Commit to making time to increase those interactions or activities.
- ▶ Remember that service means enhancing another person's life, not giving yours away.
- ▶ Be aware of destructive ways of coping such as misusing medications, drinking too much, or overeating.

### FIGURE 1. Reminders to Prevent Compassion Fatigue in Healthcare Professionals

Note. Based on information from McLeod, 2001.

wounded healer came to modern culture through the work of Dunne (2012) and Nouwen (1994). The identity of a wounded healer flowed from the awareness of and attention to one's own pain and fear, which the wounded healer allows to be tended to by another. One's awareness of brokenness and mortality becomes a powerful tool when tending to the pain of another. Compassion identity is an update of this concept, particularly in reference to nursing and related professions that care for patients with life-limiting illness: "When two people have become present to each other, the waiting of one must be able to cross the narrow line between the living or dying of the other" (Nouwen, 1994, p. 69). Patients do not need a nurse who is just clinically competent at the bedside, but one who can be the hands, heart, and soul of compassion. The healing that flows from a clinician who is mindful of her or his own fragility and brokenness is, for many patients, the balm needed to ease suffering, diminish anxiety, and offer solace. The stance of the wounded healer is one that some may strive for, but not alone and not without risk. Connecting with a patient in body, mind, and spirit requires a willingness to go inward, experiencing one's own mortality and brokenness, which may be the only path to heal patient and self. McLeod (2001) offers reminders as healthcare professionals go about their daily work (see Figure 1).

## Conclusion

As oncology nurses interact with clinically challenging patients, their stance must be one of self-awareness. Their practice must flow from constant monitoring of their compassion identity. The author noticed that many effective nurses have a sense of their own brokenness and connectedness to others, allowing them to be both healers and companions to the sick and dying. Their success is built on outcomes from good supervision, professional education, and psychotherapy. A nurse's commitment to the practice of self-care can be an advantageous means of maintaining personal and professional boundaries. Such practices allow nurses to truly be present with their patients without being completely overwhelmed by the painful complexities before them. Internal resources cannot be taken for granted. With the assistance of compassion identity, clinical competence and

compassion can become renewable resources that, with constant nurturing, can support the nurse in the care of difficult patients. Compassion identity is not static, but a self-revelatory awareness that can deepen and become effective with additional practice and commitment.

## References

- Dunne, C. (2012). *Carl Jung: Wounded healer of the soul: An illustrated biography*. London, England: Watkins.
- Ferrell, B.R., & Coyle, N. (2008). The nature of suffering and the goals of nursing. *Oncology Nursing Forum*, *35*, 241–247. doi:10.1188/08.ONF.241-247
- Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner Mazel.
- Hanh, T.N. (1993). *For a future to be possible: Commentaries on the five wonderful precepts*. Berkeley, CA: Parrallax Press.
- McLeod, B. (2001). Self-care: The path to wholeness. In K. Doka & J. Davidson (Eds.), *Caregiving and loss: Family needs, professional responses* (pp. 205–207). Washington, DC: The Hospice Foundation.
- Nouwen, H.J.M. (1994). *The wounded healer: Ministry in contemporary society*. London, England: Darton, Longman, and Todd.
- Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L., & Olsen, S. (2010). Compassion fatigue and burnout: Prevalence among oncology nurses [Online exclusive]. *Clinical Journal of Oncology Nursing*, *14*, E56–E62.
- Romanoff, B.D., & Thompson, B.E. (2007). Narrative approaches in end-of-life care. *Bulletin of the American Academy of Hospice and Palliative Medicine*, *8*, 1–3.
- Stamm, B.H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion fatigue and satisfaction test. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 107–119). New York, NY: Routledge.