

# Perceived Benefits and Challenges of an Oncology Nurse Support Group

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This study explores the perceived benefits and barriers of participating in a monthly oncology nurse support group. Ten oncology nurses participated in an average of seven support group meetings over a one-year period. Interviews were conducted, transcribed, analyzed, and thematized using qualitative descriptive methods. Clear benefits for oncology nurses are indicated; participants described a reduction in end-of-life care stress, an increase in self-care, and improved patient and team care. Barriers include scheduling and compensation, as well as group leadership labors. This study provides further confirmation that oncology nurses receive multiple benefits from the support group structure. Peer support groups for oncology nurses seem a promising and economical communication intervention for mitigating burnout, professional dissatisfaction, patient care distress, and interprofessional communication deficits.

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Key words: oncology; nurse; support group; self-care; workplace stress

Digital Object Identifier: 10.1188/14.CJON.E71-E76

The global nursing shortage is made worse by estimates that cancer rates are expected to increase 50% by 2020 (Toh, Ang, & Devi, 2012). Suboptimal staff support and difficulty retaining experienced RNs (Buerhaus, 2009) leave oncology nurses working more overtime hours and double shifts (Toh et al., 2012). As organizations are restructured to meet care demands, the results include increased stress, job insecurity, lowered job satisfaction, and higher attrition (Brown, Zijlstra, & Lyons, 2006). Future healthcare reform projects that an increasing amount of oncology care will be provided by nurses in the home, which presents implications for a growing need for peer support (Smith et al., 2012). Among RNs new to the field, many report a desire to leave their job after one year (Kovner, Brewer, Greene, & Fairchild, 2009). As oncology nurses continue to absorb high workplace demands and patient care needs, interventions that improve self-care and retention rates should be established (Medland, Howard-Ruben, & Whitaker, 2004). As presented in the nursing literature over time, ongo-

ing peer support structures for nurses increase retention and work satisfaction across nursing contexts (Guillory & Riggan, 1991; Gunusen & Ustun, 2010; Messmer, Brage, & Williams, 2011). This study examines the benefits and barriers of a monthly oncology nurse support group.

## Background

Stress, anxiety, and coping are among the most prevalent workplace issues for oncology nurses (Cohen, Ferrell, Vrabell, Visovsky, & Schaefer, 2010). Occupational factors (i.e., job strain and limited control), high work demands, inadequate staffing, and a lack of resources are primary burnout factors (McSteen, 2010; Sherman, Edwards, Simonton, & Mehta, 2006).

Causes of compassion fatigue include the lack of support, time, and resources to provide high-quality care to patients (Perry, Toffner, Merrick, & Dalton, 2011). Much of the suffering nurses endure is caused by witnessing the pain of others, but also by witnessing or delivering medically futile care (Ferrell &

**TABLE 1. Support Group Theme Descriptions and Examples**

Theme	Description	Example Quotes
<b>Benefits</b>		
Encouragement to engage feelings and enact self-care	Nurses described their ability to recognize personal limits and be more happy at home and with family.	"I think that we nurses are givers and it's hard to take support . . . to say 'No. I'm going to take care of myself.'" "I think it helps to be able to separate work from home a little bit better. If you can talk to the people here in the support group about things that are going on."
Improved patient care	Nurses identified their ability to connect more closely and carefully with patients.	"You get kind of hardened after a while. And it's just a defense mechanism. If you don't talk about it and [don't] support each other then you get hardened. And the care you give your patients suffers."
Improved team functioning and collegiality	Nurses related their experiences of improved collaboration and problem-solving with team members.	"We have taken that opportunity to say: 'Why don't you just let somebody else take that patient for the next three or four times. Take a break. See if you can't help yourself and help them.'" "It was just a really trying day [with a patient]. I think being part of the support group—all the other nurses jumped in. Because of that connection that we all had . . . as a team, we could support this individual and in turn support each other."
Opportunity to process end-of-life care stress	Nurses shared their struggles with end-of-life care and the dying and death of their patients.	"Just the emotional part and how difficult it is to take care of these patients day in and day out. . . . You can't help but to get attached to them."
<b>Barriers</b>		
Group leadership	Nurses acknowledged the significant effort involved in serving as the leader of the support group.	"The stress of trying to do something different requires time, energy, and coordination to make group time meaningful."
Regular participation	Nurses desired increased attendance and participation from their colleagues.	"There is just not enough time in the day." "A lot of people unfortunately aren't willing to slow down long enough to attend."
Scheduling	Nurses described the limitations the group faced as they navigated complex work schedule.	"For some, meetings would take away time from patients and others were having to cover, and it wasn't fair."

Coyle, 2008). Nurses throughout care settings have identified "aggressive care" and "aggressive care denying palliative care" as the most common sources of their distress in caring for critically ill and dying patients and their families (Ferrell, 2006). Participating in care that is ethically divergent from a nurse's own beliefs and values, and the cyclical experience of patient death, exacerbate workplace stress (Cohen et al., 2010). As a result, nurses experience detachment from the job (depersonalization) and a lack of personal accomplishment (Maslach & Leiter, 2008; Maslach, Schaufeli, & Leiter, 2001).

Oncology nurses are left with little to no resources for self-care (Vachon & Huggard, 2010). Given the occupational hazards of burnout and compassion fatigue, self-care is an important aspect of oncology nursing, particularly because nurses are at great risk for suppressing feelings (Borneman & Brown-Saltzman, 2010); most nurses receive little mentoring, debriefing, or counseling after their first death experience (Keene, Hulton, Hall, & Rushton, 2010). Commonly, nurse job stress emerges at home—impacting relationships and causing irritability, sleeplessness, and fatigue (McCloskey & Taggart, 2010). Some nurses opt to call in sick, feeling guilty that they want to avoid work and temporarily escape the daily pressures (McCloskey & Taggart, 2010), or even more dramatically, leave

the field of nursing (MacKusick & Minick, 2010). Oncology nurses need to self-reflect, engage in peer support, and permit themselves to grieve (Stairs, 2000).

Despite the well-documented need for nurses to manage stress, few workplace resources promote self-care skills and coping (Aycock & Boyle, 2009). Social support from coworkers has been found to reduce nurses' perceived job stress, yet few oncology nurse support groups are available (AbuAlRub, 2004). The goal of the current study was to examine the experiences of oncology nurses participating in a nurse support group to better understand benefits and barriers. Specifically, the authors aimed to learn the extent to which a support group facilitates nurse self-care and the features needed to facilitate an effective group process.

## Methods

A self-organized group of nurses working in a chemotherapy unit within a large, university-supported cancer center started a monthly support group in 2009. To date, the group meets regularly despite turnovers in leadership. The group provides a venue for nurses to discuss challenges faced as part of working with patients with cancer and their families and aids in coping

with the death and dying of patients. Although meeting schedules have varied, the group currently meets once a month on Friday mornings. Despite overlapping with the regular work-day schedule, the outpatient care setting allows nurses to gather during a time when no patients are scheduled. Meetings are held in the unit break room.

## Procedures

Nurses who attended at least one support group meeting during the previous year were eligible to participate in the study. The institutional review board of the sponsoring institution granted approval for this study. Inclusion criteria included being an oncology nurse in the study site's outpatient chemotherapeutic infusion unit. Oncology nurses were recruited by personal invitation from the research team, establishing a purposive sample. Every nurse approached consented to participate. One-time interviews were conducted in a private room in their work setting. A research team member interviewed nurses individually using an interview guide. Participants were prompted to share their own reasons for participating, the impact on their life and work, feelings of satisfaction, perceived barriers to speaking in and attending meetings, and recommendations for developing a support group at other institutions. Demographic information also was collected. The research team had no participation in support group meetings.

## Data Analysis

Interviews were recorded, transcribed, and analyzed using an iterative process of theme analysis composed of four distinct grounded theory phases (Creswell, 1998; Strauss, 1987). Qualitative data software was not employed. Stage one included open coding in which researchers identified unrestricted text suggesting a theme. Two team members independently conducted this phase. Phase two involved integration, in which the two researchers met to connect, collapse, or associate themes identified during open coding. Discussion about themes, reconciling differences in coding, and initiating categorization of the data were undertaken. In phase three, researchers clarified the categorization of information units (talk), enabling phase four, in which interpretive claims about the categories identified were proffered (Lindlof & Taylor, 2002; Strauss, 1987). The third author examined the categorization of data and evaluated the meaningfulness of the process. Finally, all three researchers determined interpretive claims.

## Results

Ten oncology nurses participated in interviews; all served as staff nurses in a chemotherapy unit. The majority of participants were female ( $n = 8$ ) and all were Caucasian. Nurses ranged in age from 27–58 years ( $\bar{X} = 46$ ,  $SD = 11$ ) and had been oncology practitioners from 4.5–34 years ( $\bar{X} = 21$ ,  $SD = 11.65$ ). Half of the nurses gained bachelor's degrees in science and the other half had associate degrees in nursing. Nurses participated in an average of seven support group meetings over one year (range = 2–13). Interviews averaged 23 minutes in length. Because of recording error, two interviews were not transcribed.

- Rotate responsibility of leading the support group.
- Create and distribute flyers explaining the goal of the group and scheduling details.
- Work with nurse management to determine best scheduling options.
- Encourage others to come and listen with no pressure to talk or share.
- Rotate the time the group meets.
- Explore the possibility of holding meetings out of the building or on different floors.
- Schedule meetings during working hours.
- Bring food and drink to facilitate community building.
- Invite other nurses from other units.
- Suggest activities, such as clay, bubbles, crayons and coloring books, stress beads, paraffin wax, book club, reading lists, yoga, and relaxation techniques.

FIGURE 1. Oncology Nurse Support Group Features

All participants agreed that oncology nurses should have access to and participate in a workplace support group. Benefits included an opportunity to process end-of-life care stress, a safe place to validate feelings, improved patient care, and better team functioning. Scheduling, regular participation, and group leadership were considered barriers. Those themes are summarized in Table 1.

Support group meetings were not used to discuss management complaints, personal staff conflicts, or workload challenges. Instead, nurses focused on communication strategies beneficial to patients, families, and team members while practicing relaxation techniques for stress management. “We established our ground rules . . . that we weren't going to complain, we were going to talk about what helps us,” summarized one nurse. Meetings had no specific agenda but, rather, provided time for nurses to relax. Challenging care interactions, sharing resources, and saying publicly to a colleague that they did a good job were emphasized. Stress-reducing activities in the support group were hands-on, and included coloring, clay, and yoga (see Figure 1). One nurse described that hands-on activities enabled her “mind to float away” and “be set free.” Meetings often included food, and were considered more enjoyable if held on a different floor from the workplace. “We encourage people to talk . . . and then when they do, be supportive,” explained one nurse. The emphasis on support and self-care strongly differentiate this communication intervention from a case conference or team meeting structure.

## Benefits

The support group prompted explicit coping practices to mitigate the emotional labor of nursing. The stress of working in a cancer center was tied to regular feelings of loss. Nurses reported that the support group emphasized the “need for an outlet” to deal with the death and dying aspects of their job. Support group meetings were seen as a time “to put things in perspective” in processing patient deaths. The support group facilitated an “emotional recharge” that enabled nurses to express themselves and hear from others that it was okay to have feelings of patient attachment, grief, and loss.

All participants shared the attachment to and loss of patients as they described the emotional toll of caring for a high census

► **Advance Healthcare Network for Nurses**

<http://nursing.advanceweb.com/Continuing-Education/CE-Articles/Making-a-Self-Care-Plan.aspx>

This article encourages nurses to self-assess their own self-care needs and identify goals to enact self-care. This reading is available for one contact hour and expires November 8, 2014.

► **Communication in Palliative Nursing**

This volume provides communication tools to nurses to ease challenging communication with families and teams. A dedicated chapter for self-care is included.

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[www.nursetogether.com/holistic-self-care-for-nurses](http://www.nursetogether.com/holistic-self-care-for-nurses)

This web resources offers encouragement for nurses, empowers nurses in their professional development, and provides opportunities for career exploration.

**FIGURE 2. Self-Care Resources for Nurses**

of patients and family, and attending to their personal, financial, and emotional needs. “You can’t give that much,” said one nurse, “We’re not that super-human.”

Meetings were a reminder to engage in self-care, as well as a place to share resources to aid in self-care (see Figure 2). Nurses “notoriously take care of everyone else,” and the group “gave permission” for nurses to take care of themselves. Nurses also described improving their work-life balance. One nurse described the support group as a “debriefing” that allowed her to talk “without having to explain.” The support group meeting provided a venue for talking about routine workplace issues that had gone unaddressed and were often “carried home.”

Feelings of frustration emerged from the inability “to give the care we’re capable of giving.” Nurses felt they could not have these discussions at the nurses’ station. Speaking freely allowed nurses to recognize that others had similar feelings. Nurses reported relief that they were not the only ones who became close with their patients. “They’ve been there,” one nurse explained, “It was really beneficial to me to hear them talk . . . to know that you’re not in it by yourself.” Colleagues were considered more understanding than family; similar experience with and knowledge of patients made nurses feel “normal” and “better [knowing] that other people think the same way.”

The support group also encouraged “a sense of camaraderie” and team self-care. Although nurses usually work independently of each other (“We get separated from each other.”), support group participation helped them reconnect. Learning about each other’s communication styles, varying ways that stress was created and felt, and different styles of coping were considered beneficial to team health.

The support group not only promoted self-care among nurses individually, but also prompted teamwork aimed at promoting self-care in the workplace. Consequently, nurses reported “dealing better with patients” and being “able to give more throughout the day.” Emotional improvements were cited as a result of better stress management. “I’m not as tired and I’m mentally prepared to do more . . . I feel like I’m quicker to respond to people’s needs.” Overall, the support group was seen as “good for the unit and morale.”

## Barriers

Nurses described scheduling as the principal barrier to support group involvement. Disagreement arose over the best time to gather and whether or not meetings should be compensated work time. Several nurses reported they would not come in on their day off or stay early or late for a support group. Without management support, group meetings were held once a month during an early morning shift prior to patient arrivals. Still, nurses indicated this monthly gathering was not enough.

Given that scheduling was the biggest barrier, most nurses shared that regular participation in the support group was difficult. Nurses recognized colleagues who would benefit and desired to participate, but “just didn’t come in early for it.” Principally, all of the nurses interviewed shared a desire for increased participation and attendance among colleagues.

Finally, nurses acknowledged that the support group required a designated leader to generate planning and ideas. Although one nurse volunteered for this role, she shared that little assistance was offered and that labor was required. In addition, an active leader must cultivate attendance among oncology nurse staff.

## Limitations

The homogeneity of participants limits the diversity of gender and ethnicity. However, the demographic profiles of nurses are consistent with the oncology nurse population in this region of the country. The sample size was small for this study, which is appropriate to the qualitative nature of this investigation. Face-to-face interview descriptions present a subjective set of findings as opposed to an anonymous survey with quantifiable evaluation tools. Analyzing specific benefits in relation to varying levels of work time experience would provide further depth in understanding oncology nurse needs over time.

## Discussion

In the current study, involvement in an oncology nurse support group provided opportunities to process stress, validate emotions, and improve team, as well as patient and family, care. The experience clarified to participants that self-care is not integrated into everyday practice, despite consensus that self-care is crucial for career longevity (Altounji, Morgan, Grover, Daldumyan, & Secola, 2013; Grafton & Coyne, 2012; Luquette, 2007), happiness at home, increased quality of care of patients and their families (Peters, Cant, Sellick, Lee, & Burney, 2012), and interprofessional team collaboration (Fetter, 2012).

## Implications for Practice

- Practice self-care to improve longevity in the field, patient and family care, and collaboration with other teams.
- Use peer support structures to increase retention and work satisfaction across nursing contexts.
- Contribute to coping skills and improve work experiences by joining support groups for team-building interactions.



The current research substantiates that oncology nurses struggle to process the loss of life they regularly witness, as well as to negotiate the dissonance experienced when futile treatments are administered (Cohen & Erickson, 2006). Nurses described increased enjoyment during their time at home away from work. The bureaucratic dynamics of the workplace were specifically removed from these meetings so that nurses could securely expose feelings, while leaving behind conflicts with other nurses, management concerns, and workload issues.

In a work context with minimal time and resource to deal with communication difficulties, sharing helped nurses reach a higher level of meaning, coping, managing, and caring. With the exception of a very few international studies (Peterson, Bergstrom, Samuelsson, Asberg, & Nygren, 2008), a void in research exists concerning nurse support groups. This absence showcases the need for further research to learn about ways to structure and execute oncology nurse support groups, and how decreased work stress, greater longevity, minimized absenteeism, and improved patient and team care are linked to the unique social support offered in the context of a peer support group.

Nurses described the challenge to protect and ensure involvement in the support group because of time. Pressures of pay, life outside of work, and scheduling compromised regular attendance and the addition of new attendees. A leadership burden also was described by some nurses, recognizing that the enterprise required planning labors.

Findings from the current inquiry extend the authors' understanding of nursing stress management and the necessity to intervene at the system level (Kravits, McAllister-Black, Grant, & Kirk, 2008). Current results validate benefits for oncology nurses participating in a support group. Additional qualitative research is needed to determine support group best practices, strategies to cultivate institutional support, solutions to scheduling challenges, and the further integration of support group benefits into workplace practice.

## Conclusion

The quality of a nurse's work environment impacts emotional exhaustion, job satisfaction, and the quality of nursing care (Friese, Lake, Aiken, Silber, & Sochalski, 2008). Working conditions, inadequate preparation, lack of time to relax or grieve, and staff relationships contribute to workplace stress and necessitate communication and self-disclosure about the emotional labor of nursing work (McCloskey & Taggart, 2010).

This work fortifies the recommendation to hospital administration and staff to support nurse oncology support groups. Administrative buy-in can play a vital role in alleviating scheduling challenges, offering self-care support during paid work hours, and cultivating consistency in access for all nursing staff.

As efforts are made to accommodate compounding care demands, nurses face greater burnout because of an increasingly complex healthcare system, sicker patients and caregivers, and increasing home care. Social support has been identified as a key factor that increases nurse retention and quality of life (Aycock & Boyle, 2009). Support groups for oncology nurses seem a promising communication intervention for mitigating the deleterious effects of burnout, professional abandonment, patient

care distress, and interprofessional communication deficits. This study confirms that oncology nurses receive multidimensional benefits from the support group structure. With the critical shortage of nurses accelerating, more healthcare system intervention is needed to initiate peer support group program development.

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