

# Workshop on the Stresses and Burnout of Working With Cancer Patients, Larnaca, Cyprus, June 22–24, 2007, A Collection of Abstracts

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**Palliative Care—A Second Regional Project of the Middle East  
Cancer Consortium**

Michael Silbermann. *Executive Director, MECC.*

The current workshop on palliative care to the cancer patient is MECC's third workshop in the past 3 years. Concomitantly NCI Bethesda, MD, sponsored the first survey on palliative care in MECC countries, which provides an updated status with regard to palliative services and hospice services in hospitals and in the community that are currently available. It has become apparent that there are very limited services in countries such as Turkey, Egypt, and the Palestinian Authority. As a consequence, many patients are treated only by home caregivers or at community health centers that provide a relatively limited palliative care. Further, most of the terminal patients are treated by their family physicians who, for the most part, lack the proper experience in treating pain and also lack the principles of the hospice approach ([www.ch.pca.net](http://www.ch.pca.net)).

As a result of the current state in many MECC countries, many of the patients die while suffering from severe pains and other depressing symptoms. Concomitantly, many of the deceased relatives report on an unbearable emotional burden that follows that experience.

Today most of the terminally ill patients die outside their home, especially in hospitals and in nursing homes. One of the major obstacles that prevents the provision of palliative services in MECC countries is the lack of evidenced-based standards. A recent consensus statement in the United States (National Consensus Project for Quality Palliative Care, 2004) can serve as a basis for treatment standards in those countries that still lack it. Moreover, this document can also be used as a guide for training and upgrading of existing services. MECC, as a regional organization, could initiate a study for the establishment of standards of the palliative care essentials to patients in the Middle East. Such standards might serve as the criteria for all those responsible for the provision of health services and their funding. More recently (October 2006) INTCR has published a booklet on the Clinical Guidelines for Palliative Care.

In August 2005, a project was conducted by the Center for Research on Aging: "Palliative and Hospice Services in Israel" by N. Bentur, S. Resnizky, and Y. Shnoor (Myers-JDC-Brookdale Institute). It became apparent that, by and large, the genuine parameters for quality of palliative care are still missing. The traditional parameters to evaluate health services such as morbidity and mortality rates, the

number of days of hospitalization, recurrent hospitalizations, and severity of pains—all of these are not necessarily representing the genuine state as far as palliative care is concerned. They usually provide only a partial answer as to how the patients and their relatives comprehend these services and the quality of the treatment that they are receiving.

The timing of referral and acceptance at the hospice and the longevity of the survival following the acceptance are recognized as a relevant parameter in the evaluation of the palliative care services. The duration of hospice-home services differ from country to country, and quite often the physician faces difficulties in assessing the duration of survival. There is, therefore, a need to develop tools in order to better assess the survival time and teach these tools to the treating physicians.

The purpose of palliative care services is to preserve the quality of life of the terminally sick patients, as well as that of their relatives. Quality of life by itself is a subjective, a multidisciplinary concept and contains components such as pain, the ability to function independently, satisfaction of the patient with the treatment, the feeling of support along with feelings of sorrow, grief, anger, hope, and anxiety. Therefore, in order to understand the overall quality of life of the very sick, one has to check physical parameters along with psychological and spiritual ones.

Ten years ago the McGill Quality of Life questionnaire was established which, among others, included 16 questions that could be grouped into 4 major parameters: physical, psychological, existential, and supportive. While evaluating many of these questionnaires, it became apparent that the feeling of existential welfare was the dominant factor in evaluating the quality of life of the terminal patient. Further, it became evident that the patient lends great importance to the spiritual aspects of the treatment. This part in the treatment planning should be further emphasized by all those who are involved in the palliative care of patients, be it in the hospital, hospice, or at home.

An additional interesting issue refers to the responses of the relatives treating the patients. A high degree of correlation was found between the patients' responses and those of their near relatives, especially when it referred to pains, nausea, and constipation, but less with respect to sorrow, depression, anxiety, and overall feeling of quality of life.

An additional important issue refers to the involvement of the relatives in decisions related to the kind of treatment given to the patient. It has become very clear that most of the patients are interested in open communication with the treating team and that they are interested in being part of the decision makers with regard to treatments that are intended to prolong their life (at a terminal stage). It is nowadays very common in the Western world to report to the patient very openly about the diagnosis even when it refers to a terminal disease. Moreover, it has become apparent that any information related to the treatment of pain, exhaustion, apnea is of great importance to all those involved in palliative care, and in most cases, the caregivers insist on having this kind of information. On the other hand, it is believed that transferring bad news is a very difficult task and might affect the sense of hope in the patient, as well as in his/her overall attitude to the treatment given. Hence, there is a need for research that will examine the ways to improve the communication between the treating team, the patient, and the relatives.

Many projects have indicated feelings of burnout among the supporting individuals. This feeling was felt more in younger people and increased with the decreased frequency of the nurses' visits at homes. This fact is of special importance to the hospice-home staff and especially to the social worker. It is very possible that the more frequent the visits are at home, the feeling of burden and burnout would decrease especially at the patient's terminal stage. The role of the social worker in home-care is becoming more and more essential and is as important to the treating relatives as to the patient himself. In addition, the responsible health care system needs to increase the psycho-social services, especially at the hospice and at the homecare services. Voluntarism is an additional issue that needs more attention within the public as a whole.

In countries in the Western world one notices huge differences in the services available to terminally sick patients. These differences are due to the different policies practiced in each of these countries. Further, the hospice-home care system does not fit to every patient and/or family, and therefore, a hospitalization-hospice system is needed for such patients, in order to provide an acceptable palliative care during the last days of life.

### Burnout Issue in Hospice Care

Mohamed Ezzat Amin. *Kaser El-Aini Faculty of Medicine, Cairo, Egypt.* Life is full of beginnings and endings, hellos and good-byes. It is easy to say hello, portending a pleasant beginning that is filled with hope for a special relationship. Conversely, saying good-bye is hard. It implies loss inevitably followed by grief. In hospice work, it is essential to say good-bye properly. According to the American Cancer Society, the word hospice is "rooted in the centuries-old idea of offering a place of shelter and rest, or 'hospitality' to weary and sick travelers on a long journey. Dame Cicely Saunders at St Christopher's Hospice in London first applied the term 'hospice to specialized care for dying patients in 1967.'" Hospice has been available in the United States since the mid-1970s. The National Hospice and Palliative Care Organization (NHPCO) estimates that there were 3300 operational US hospice programs as of 2003. Although death is a natural part of life, the thought of dying still terrifies many people. Hospice represents a compassionate approach to end-of-life care. Hospice is more a concept of care than a specific place. It is an option for people whose life expectancy is 6 months or less, and involves palliative care (pain and symptom relief) rather than ongoing curative measures. Hospice care focuses on all aspects of your life and well-being: physical, social, emotional, and spiritual. Hospice services are interdisciplinary, and will be structured according to patients' needs, which may change over time. The Hospice Association of America (HAA) suggests a hospice team may include any combination of the following services: Nursing Care: registered nurses monitor symptoms and medication, and help educate both patients and their families about what's happening. Social services: a social worker counsels and advises patients and family members, and acts as community advocate, making sure patients have access to the resources they need. Physician services: doctor approves the plan of care and works with the hospice team. Spiritual support and counseling: spiritual care is a personal process, and may include helping patients explore what death means to them, resolving "unfinished business," saying goodbye to loved ones, and performing a specific religious ceremony or ritual. Home health aides and homemaker services: home health aides provide personal care such as bathing, shaving, and nail care. Homemakers may be available for light housekeeping and meal preparation. Trained volunteer support: they're available to listen, offer patients and their families compassionate support, and assist with everyday tasks such as shopping, babysitting, and carpooling. Physical, occupational, and speech therapies: these hospice specialists can help patients develop new ways to perform tasks that may have become difficult due to illness, such as walking, dressing, or feeding yourself.

Respite care: respite care gives family a break from the intensity of caregiving. Brief inpatient stay in a hospice facility provides a "breather" for caregivers. Inpatient care: sometimes medical intervention will be recommended to ease the dying process (eg, an IV drip with pain medication), requiring round-the-clock nursing care. Bereavement support: support may include a trained volunteer or counselor visiting family at specific periods during the first year, as well as phone calls, letters, and support groups.

Because compassionate care giving is an essential component in hospice care, the hospice worker has a unique challenge of coping with loss on a regular basis. Health professionals caring for seriously ill/dying patients and their families are frequently exposed to distressing emotional situations and profound suffering. Burnout is a "Psychological syndrome in response to chronic interpersonal stressors on the job." (Maslach, 1982). Burnout passes through the following stages: stress arousal: anxiety, irritability, hypertension, bruxism, insomnia, palpitations, forgetfulness, and headaches. Energy conservation: work tardiness, procrastination, resentment, morning fatigue, social withdrawal, increased alcohol or caffeine consumption, and apathy. Exhaustion: chronic sadness, depression, chronic heartburn, diarrhea, constipation, chronic mental and physical fatigue, the desire to "drop out" of society. This might lead to: depletion of emotional and physical resources, negative self-image: feelings of incompetence and lack of achievement, self-neglect, questioning of previously held spiritual beliefs, neglect of family and social obligations, mental illness: anxiety, depression, substance abuse, and suicide.

To prevent burnout one or more of the following should be considered: staff journal, staff support, a day at the Zoo, elegant eating, breakfast of

champions, stress buster, Christmas party, meetings away from work, team support, memorial table, monthly team spirit days, and staff meeting.

### The First Pediatric Palliative Care Program in Jordan at King Hussein Cancer Center (KHCC): Current Status

Maha Arnaout, MD, Laila Alkhouli, RN and Dima Ezmegna, MD. *King Hussein Cancer Center, Amman, Jordan.*

**Background:** A pediatric palliative care program is necessary for comprehensive care of children with cancer. Care and support offered should aim to meet the social, cultural, spiritual, physical, and emotional needs of the child and his/her family. Symptom control should aim to promote comfort and enhance quality of life. After death bereavement support is an integral part of that care. Appropriate support should be available to the health care team.

**Case:** R.Q. was an 18-year-old female patient who was diagnosed in May 2005 with osteosarcoma of the right chest wall. She was pregnant in her third trimester. Chest wall biopsy was complicated with brachial plexus injury and neuropathic pain. She was managed for her pain by the pain/palliative service. After delivery, she received neo-adjuvant chemotherapy, followed by surgical resection of the tumor in February 2006. In May 2006, she had recurrence of her tumor at the original site, which was resected. She continued therapy with no response and developed metastasis to lungs and bone. At the time of referral, her major problems were pain, bony, and neuropathic. She had pleural effusion, depression, and major psychosocial issues. She was referred for palliative care in August 2006, and died in October 2006. She was 19 years old; her daughter was 1-year old. We followed her for 45 days.

**Discussion:** The Pediatric Palliative Care Program at KHCC was established in August 2005. It was integrated with the adult palliative care program. It provides care to children up to 18 years of age.

The palliative care team includes a Pediatric Oncologist, General Pediatrician, and Nurse Coordinator, with Access to a psychologist and a Social worker when possible, but not as fulltime members of the team. Services are provided through inpatient and outpatient settings, and through home care when possible. Patients are admitted for symptom management and stabilization, discharge planning, and for terminal care.

In the inpatient setting, 2 beds are assigned for pediatrics in the adult hospice; but only 15% of patients are admitted to the hospice due to the high adult load. The rest are admitted to the pediatric ward. The current hospice environment is not child/parent friendly.

In the outpatient setting, there are 3 clinics per week for regular patient follow-up to ensure adequate symptom management. As for home care, a pediatric team is not available. The adult home visit nurses currently cover this function. Area of coverage is limited; nurses are not experienced in the care of children. The Nurse coordinator calls the family daily for follow-up. Parents can call the nurse anytime.

Total patients referred to the pediatric palliative care program in 2006 was 61, of those 11 patients are alive.

Duration between referral and death ranged from 1 to 300 days (median 47 d).

The palliative team faces several problems when providing care, whether with medical staff, families, and hospice. Some families are referred with poor understanding of the reason for referral, palliation, or a DNR order. Families refuse admission to hospice; they are worried about the level of care for their dying child. It is considered as a place of death. Some families may neglect the dying child; concentrating on the children who will live. Psychosocial situation and level of education of the family affect understanding.

Patients are referred at the later stages of their disease; families feel alienated, new place, new nurses, and new doctors. Denial is common in both physicians and families.

Due to high occupancy rate, palliative care patients may be considered a strain on bed availability in the pediatric ward by medical staff. Terminal patients are also considered as demanding, needing extracare and are time consuming. Hospice nurses feel uncomfortable caring for a dying child. Home care equipment and medications may not be readily available for patient care at home.

Emotional and psychological strain is leading to staff stress and may lead to staff burnout.

Further education is important for physicians, nurses, and other health care staff working in palliative care.

The program is successful in improving the quality of life and reducing suffering of children. Problems will be solved in time. This program is fully supported by the administration of KHCC. Continuous progress is achieved. It is successful and essential.

### Insights From a Pediatric Physician Working With a Heterogeneous Population

M. Weyl Ben Arush, MD. *Pediatric Hematology Oncology Department, Meyer Children's Hospital, Rambam Health Care Campus, Technion Faculty of Medicine, Haifa, Israel.*

Burnout is particularly relevant in pediatric oncology where caregivers work closely with children who have life threatening illness. The impact of burnout can be severe: on the individual, on the team, and on the sick children and their families. It can impair the quality of care delivered to patients and have serious consequences for the personal life career. The sources of burnout may be organizational and causes low job satisfaction, and/or personal especially in physicians who have unrealistic high standards, possess strong dependency and achievement needs. In addition, breaking bad news, dealing with the angry parent, the depressed child/parents, feeling disappointment in the failure especially when a child died or failed to achieve remission, are majoring the causes of burnout. At Meyer Children's hospital, the population is heterogeneous including, young fellows, senior physicians from different cultures and personal situations (Israeli, Russian, Jewish, Arab, Christian, religious and laic, married or not, parents or not). In addition, we detected precipitating factors include broader pressure on the health care system, lack of time, over involvement of the physicians, poor relationship with other team members, heterogeneous population. Therefore, we had to develop strategies to avoid and decrease burnout among physicians, fellows, and seniors. The level of intervention was based on an organizational and individual level. Till now our methods are the following: creation of new positions (supported by the government or different associations), enhanced team work, reduced interdisciplinary conflict, increased staff autonomy and latitude, developing training course, encouraging active participation to international meeting, fellowship, improve training in communication skills, having staff rotating within the department and outside the department, encouraging the establishment of mentoring program to guide junior staff, improve clinical care facilities. Other interventions are now ongoing to protect the young fellows from burnout like developing research and academic program, define and redefine group goals so that each member of the staff feels engaged in the decision-making process. During the last 10 years, we created of a multidisciplinary team, which help set up a good atmosphere in the team, and a better repartition of the functions. Recently, we started a support staff with an outsider facilitator (counseling services): the aim was to create an atmosphere of openness: mutual support, caring for each other, learning from each other, ventilation of feelings, improving communication between staff members, maintaining a healthy balance between professional and private life.

These interventions need adjustment to the needs of the staff members which may change over time, related to personal considerations and the several events occurring in the department like the death of children.

### Preliminary Research Proposal: Recommendations for Improving the Quality of Palliative Care for Terminally Ill Patients

Netta Bentur\* and Randi Garber†. \*JDC-Myers-Brookdale Institute; and †JDC-Middle East Program, Jerusalem, Israel.

**Background:** The increase in the number of gravely ill patients with life-threatening illnesses is common to both developed and developing nations. It is widely believed that every patient is entitled to palliative care in the final stages of life, or when an illness is incurable. Nevertheless, research has shown that these patients do not necessarily receive the needed services to improve their quality of life. The SUPPORT study<sup>1</sup> conducted in the United States in the 1990s revealed many flaws in the quality of care of terminal patients. Other studies have also revealed a similar—and even graver—situation in many countries,

where palliative care and services designed to improve the quality of care of terminal patients are still in their infancy.

A comprehensive study of the palliative services in Israel revealed that there are only 3 in-patients hospices with a total of 78 beds, and that palliative services and home hospice units exist to a very limited extent.<sup>2,3</sup> The quality of care for terminal cancer patients cared for through these dedicated services was found to be higher than in the regular community services,<sup>4</sup> and the services more cost-effective.<sup>5</sup>

Even where hospice services do exist, they are not sufficient to treat all terminally ill patients,<sup>2</sup> and most individuals are cared for by regular community and in-patient services. These services not only do not incorporate the principles of hospice and palliative care, but often are not even aware of them. Thus, there appears to be a need to consider how to include dedicated palliative services in the uniform benefits package mandated by the National Health Insurance Law, so as to ensure that the health plans make them available to the extent and breadth that will enable anyone who is dying to receive them. This approach is relevant to other countries in the region with limited palliative care services.

**Study Goals:** The proposed study is designed to develop feasible means and processes to improve the quality of palliative care of terminal patients in the community and in-patients setting in the Middle East. This will be accomplished through documenting the ways and means that care is given today, identifying barriers to palliative care, and identifying practical ways and tools to improve the quality of care.

**Study Design:** A steering committee comprised of the principle investigators and key stakeholders in participating countries will guide the study. The steering committee will select the central motifs and relevant topics, confirm the definitions relevant to the participating countries, and identify the sources of information for each country. Based on these discussions, questionnaires will be developed, discussed, finalized, and translated to all relevant languages.

Health policymakers, stakeholders and health care planners, directors and head nurses of medical services, providers and insurers will be interviewed face-to-face using semiopen questionnaires; ward and clinics directors and head nurses will be interviewed using self-administered detailed questionnaires. Data will be analyzed by using qualitative and quantitative methods.

The principle investigators in the participating countries will maintain on-going communication to discuss conceptual and methodological issues as they arise through e-mail and videoconference and will hold twice-yearly meetings to discuss progress and analysis.

**Study Outputs and Expected Contribution:** In most of the countries in our region almost no dedicated palliative care services to terminal patients is provided, and even the awareness of their existence and advantages is limited.<sup>6-8</sup> The study will serve as the basis for understanding the options for developing palliative services, taking into account the existing organization of medical services reimbursement methods, financial limitations, and cultural values. The information will also make it possible to identify and examine possible and preferable alternative patterns for developing palliative services in the countries, establishing what constitutes a suitable patient and when the care should be provided, and to determine the staff required to provide efficient and economic services. The research will thus contribute to improved quality of care of terminal patients, making informed use of existing resources, which can then be gradually developed.

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### Integrative Oncology and Psychosocial Aspects of Care

Barrie R. Cassileth. *Memorial Sloan-Kettering Cancer Center, New York*. Over the past few decades, there has been enormous growth in the number of patients who remain alive after cancer diagnosis and treatment. Those numbers have risen gradually and importantly so that, today, 64% of cancer patients in the United States are alive and well more than 5 years after diagnosis. There are now more than 10 million survivors in the United States who daily go to their jobs, raise their families, and function in society free of active disease.

These good results are due principally to 3 factors: decreased tobacco use; early detection and screening resulting in earlier, more treatable disease; and improvements in cancer treatment. Survival rates vary by primary site, from less than 3% for cancer of the pancreas to more than 90% for thyroid cancer. They also vary by regions of the world, which indicates that environmental factors, socioeconomic status, and access to gold-standard care contribute to cancer survival.

Because of the growing number of cancer survivors, oncology care has moved beyond the important matter of extending patients' lives to an additional, newer focus on symptom control and quality of life. Over the 30 years since Priestly and Baum published the first Medline entry on cancer patients' quality of life, more than 22,000 "cancer quality of life" articles have entered Medline.

The concerns faced by cancer patients range from underlying fears of recurrence to tangible difficulties and dysfunctions, some resulting from the residual effects of a previous cancer, but most due to the very treatments that made survival possible. A number of disciplines, some quite new, have converged to address needs such as these, and they offer an array of approaches to symptom control and patient management. These include the fields of Integrative Medicine or Integrative Oncology, Supportive Care, Rehabilitation, Palliative Care, Psycho-Oncology, and Pain Management. Added to these is the National Cancer Institute's newly developed Survivorship initiative, which defines cancer "survivors" as all those from cancer diagnosis throughout life.

While some of these disciplines are more narrowly focused than others, all are concerned with the management of problems faced by cancer patients, not with management of the cancer itself. Pain Management programs use pharmacologic agents exclusively or predominantly; Psycho-Oncology addresses emotional problems but also moves to encompass broader issues such as smoking cessation and patient and family bereavement care; Palliative Care has been long-associated with hospice and terminal illness, but has expanded its purview to symptom control and seeks to aid patients from diagnosis onward; Rehabilitation focuses on the alleviation of physical dysfunction. All have evolved around the complex array of needs that exist during cancer treatment and beyond.

Survivorship as defined by the United States the National Cancer Institute, and Integrative Medicine, is more broadly based than others. Integrative Oncology adds nonpharmacologic means of symptom control to basic cancer care. Integrative Oncology is the synthesis of mainstream cancer treatment, which is aimed at tumor eradication or control, and complementary therapies, which are aimed at relief of physical and emotional symptoms. By incorporating treatment of the tumor and care for the rest of the patient as well, Integrative Oncology offers the all-encompassing approach that today's patients require. Integrative Oncology also includes attention to family members and professional caregivers, who suffer the stresses associated with cancer and cancer treatment along with patients.

The complementary therapies used by Integrative Oncology are noninvasive and nonpharmacologic. They include

- mind-body therapies using meditation, self-hypnosis, and other relaxation techniques,
- massage and other gentle touch therapies,
- acupuncture for relief of pain and many other symptoms,
- exercise regimens based on clinical status,

- music and art therapies,
- yoga, tai chi and related approaches,
- nutritional and dietary supplement guidance.

These therapies reduce or relieve pain and other physical symptoms, and control anxiety, depression, and stress. They are used during and after treatment to alleviate symptoms and increase feelings of well-being in patients, and they are also useful for family members and staff. Their effectiveness and safety are supported by research and, optimally, they are delivered by cancer-trained practitioners.

The Integrative Medicine department at Memorial Sloan Kettering Cancer Center offers a broad range of rational, evidence-based complementary therapies. We also try to assist the patient's desire, and the oncology professional's need, for solid information about herbs and other botanicals, vitamin products, and other dietary supplements via a Web site ([www.mskcc.org/aboutherbs](http://www.mskcc.org/aboutherbs)). Accurate, unbiased information is essential given today's multitude of "alternative" remedies promoted with untrue claims of cure. Finally, while cautioning patients about the dangers of using herbs and other botanicals during active treatment, we conduct research to determine whether such agents might have a future role in treatment or adjunctive care. The happy challenge of today's cancer care is the mandate to address the complexity of patient's needs that stem from successful cancer treatment regimens.

### Caring for Patients With Incurable Cancer: What Stresses Us

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Stress and burnout are common phenomenon among clinicians managing patients with incurable cancer. Among oncologists, various studies have demonstrated prevalence rates of 25% to 56%. Burnout results from overwhelming stress that creates an imbalance between the professional's needs and the rewards derived from the job itself. Opinions are divided regarding the major sources of stress for oncology clinicians: (1) Time pressure: the major reasons for stress and burnout are related to the issue of time pressures. This relates to more time to spend with patients, excessive paperwork, and inadequate time to spend away from work with family and friends. (2) Mortality stress: This school of thought holds that the primary source of stress in oncology derives mostly from the emotional strain of dealing with patients facing mortality issues and their soon-to-be-bereaved families. Oncologists must deal daily with stressed patients and families, disproportionate hopes and expectations, emotionally laden dialogues with patients and families, and the limitations of treatments that are unable to deliver cures. The ESMO survey of medical oncologists' attitudes to and involvement with the management of advanced and incurable cancer (1) shed some further light on the issue. In this survey of almost 900 oncologists, just over a third of respondents reported that they feel emotionally burned out by having to deal with too many deaths. This predilection to burnout was associated closely with negative attitudes to involvement in supportive and palliative care and low levels of actual involvement or referral to specialist colleagues. Burnout, therefore, was not so much associated to overexposure rather to poor attitudinal preparedness and aberrant role definition. On the other hand, physicians with positive attitude toward end-of life care and their role in it, expressed much lower tendency to burnout and much more personal satisfaction from end of life care despite the fact that they were much more personally involved with dying patients. These finding suggest that positive attitudes and involvement in palliative care are all resilience factors that helps prevent burnout caused by exposure to advanced cancer.

### Burnout in Homecare, Lessons Learned—A Personal Experience

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When I finally realized that I was experiencing "burnout" and not some rare tropical disease that I was convinced I had, it came as a great relief to me to finally understand what was wrong with me.

Whether one is found to have "chronic fatigue syndrome," "myalgic encephalitis" or pure total exhaustion, the endless list of physical,

psychological, and emotional symptoms one experiences mean we have to take a serious look at the way we are functioning in both our professional and private lives.

The closest people around me were able to see what was happening to me over a period of time, I had been running on empty batteries for months. My family, colleagues, and most sadly my patients were able to see that I wasn't the mum, friend, or nurse they all knew.

So eventually with the help of dear friend, colleague and doctor recognizing the problem, with a great deal of support from those around me; it was suggested to me that I should leave cancer nursing. Something that I would never have considered by myself, however, this person being an oncologist and working within our homecare team, understanding what my role had been taking out of me and how this was now affecting my physical health, made me realize after a long period of sick leave that "yes" it was time for a change. Time to move on. Only I could do it. I had a responsibility to myself and my family and was no longer functioning effectively as a professional in this particular role. I had become a very boring person, with no conversation outside homecare!

*Turning Point:* Having been forced to STOP as I could no longer continue to give all that I was giving at the pace I was running at and not putting anything back; with the exploration of complementary therapies slowly I began to restore my energy, strengthen my immune system, and find some kind of balance in my life again. I had to make a decision about where I would go from here—I could only look forward.

Once my decision to leave homecare was made, I immediately felt like a weight had been lifted from me, began to feel stronger, and more positive. With the prospect of a new position in a brand new hospital, the excitement of being instrumental in setting up the initial stages of a private hospital and working with a team of doctors I had always respected was just what I needed—a new challenge—Away from cancer. Homecare and the people I had cared for had taught me so much over the years, but at this point I had realized my "LIMITATIONS."

"Just think what happens to a plant if you don't look after it... it dies, the same happens if you don't nurture yourself, sooner or later you lose sight of your identity, which is disastrous for you and those who love you" (The Rules of Life by Richard Templar, 2006).

Therefore it was time for "time out."

*Change is as Good as a Rest:* Yes change "is" as good as a rest. However, I soon realized over the next few months how much I was missing homecare, I could care so well for the patients under my care in the hospital, but unfortunately I could see that not everyone shared my ideas of standards and values of care, which I was not prepared to compromise.

I couldn't see patients in their own environment, I couldn't interact with the whole family scene and the cancer patients I did meet in the hospital; many of them familiar to me I found difficult to leave, they were like a magnet to me.

Happy to be back!; I had to get back out there, after 6 months away from homecare I received what I believe to be a gift from heaven. A telephone call from our other cancer charity on the island offering me a position without me even knowing of the vacancy, they had come to me. I was "back in the saddle" so to speak, with a new team, another new beginning, but all the wiser this time around. I immediately felt a real sense of belonging, but also I knew I had to set myself a new set of ground rules. So...my limitations I knew, but how was I going to turn them into something positive for me rather than negative?

I new that I always became close to my patients and their families, this wasn't going to change, this is me, how I work and I believe how I get the most out of people.

Time to set some boundaries for myself. To care for my patients as I always had, but not single handedly; taking on all the responsibility and burden personally when I have a team of people around me to liaise and work with and of course teaching patients and their carers how to be more independent with sufficient support and education for them to feel safe and confident to stay at home.

As the central component or nucleus to the homecare setup, the nurse carries an enormous responsibility to ensure the patient receives the best standard of holistic care. However, she can only do this as part of a team. Now by letting others take the responsibility when I'm not on duty, by leaving the necessary plan of care or options available, I get a necessary break and my children get a mum with energy left for them.

This time I was determined not to neglect my family, I should be enjoying them in my time out of work and not letting thoughts of my patients consume me as they had in the past. Yes I'm dedicated, but I too have a life away from homecare and I can be even more effective in my work if I make time for me.

"Taking time everyday for ourselves may sound a little selfish, however, we all need time to regenerate, renew, and invigorate ourselves. Time to recharge and repair. If we don't we aren't taking on fresh fuel, our engines run down and so do we." (The Rules of Life by Richard Templar, 2006.)

"The more attention we give to ourselves the better equipped we are to give attention to others and feel more like it." (The Rules of Life by Richard Templar, 2006.)

So now I organize otherwise my workload to avoid too many out of hours homecare visits (with my children waiting for me in the car or playing in a patients back garden) then being too drained to do anything with them when I got home. Therefore, giving us quality time together without compromising my family's happiness and safety.

I could make clear to my colleagues what they CAN expect from me and what I'm not able to offer. Working for a charity we all have a responsibility to participate in fund raising and spread the word (which we do everyday in our work as homecare nurses, simply by doing what we do out in the community). However, patient funerals are a big issue for me, here in Cyprus when a family requests that donations are given at a funeral instead of flowers someone is expected to attend the funeral and give hand written receipts for every donation received, this definitely to me is not a nurses role. When after months sometimes years of caring for a patient, at the end of a busy and often stressful day being there to collect donations is totally inappropriate, this should be administration or volunteer's role. If I decide to attend a patient's funeral it would be for me and what I felt for that person.

As nurses we experience accumulative grief,<sup>1</sup> dealing with patients at all stages of their illness, so in a morning's work we can be seeing a patient for symptom control, end of life care, perform a lymphoedema treatment, attend an oncology outpatients clinic, go on a postbereavement visit, THEN pick ourselves up to see a new referral, being full of positive and useful advice for our new patient. My point is that a funeral at the end of one of these days can truly drain us of vital energy that we need to function affectively for the rest of the week!

We have to keep focused and be able to deal with many varying situations we find ourselves in everyday. WE HAVE to get it right, as a patient is only going to die once. So again stress the importance of making the most of our time out of work, to touch base, but to do that we have to know where our base is, "base is where we were before we got lost" (The Rules of Life by Richard Templar, 2006). Base is where we feel comfortable, secure, loved, restored, and trusted. It can be a place, like home, or makes us feel at home. A particular person who will accept us for who we are and let us be ourselves, a pet, a view, piece of music, or a state of mind we arrive at by doing something which takes us out of ourselves, such as a place of worship or meditation. My base is my family and surrounding myself with my closest friends, even though most of them are thousands of miles away most of the time, I know they are always there and my contact with them never fails to fill me with positive energy.

*The Value of Team Work:* I now work much closer with my colleagues, instead of trying to keep on top of my caseload single handedly. Making use of the whole MDT. We listen to each other and sincerely care and this gives us all strength and comfort as we know we all understand each other.

I may work as part of a small team and even though we are only 2 home care nurses in the area we still make time to work together regularly; seeing new referrals, difficult cases, and postbereavement visits together whenever possible. This way we both know our patients in great detail for when one of us is away and this way our patients have faith in both of us as they see us both often.

My colleague is much younger than I and fairly newly qualified, so I knew from the beginning that if I was to keep this young, inexperienced but extremely dedicated and caring nurse in Palliative care then I would need to invest a lot of time in supporting and teaching her. I'm happy to say that time has paid off. I had to ensure she felt supported at all times and never feels as though she is out there alone and isolated as I often did in the past.

We make our office a heaven to come back to and work from, with our crystals, wall hangings, family photos, and aromatherapy. To discuss our work, patients, debrief, reevaluate our ways of working and discuss our own professional development with our homecare co-ordinator and try to have plans and goals that we would like to achieve in the future. We never let feelings build up and know we can be honest with each other, as this is how fatigue can start and we lose our energy and motivation. Of course there's nothing like a nurses sense of humour to help us through the day!

**Burnout; A Life Lesson:** Now I know the signs very well, when they start to creep up on me...and they still do, I have to say "hold on" take a step back and look at what I'm doing again and how I'm working and dealing with my stress. Take some time off, which isn't always easy with only one other nurse left to cope alone. So! This is why I now speak up, put in writing to the appropriate person about things which I believe to be important and can improve our services and move forward; for example, a third nurse to the team would make all the difference and ensure that no-one should ever be left to cope alone. One day the people in power at the top may actually realize that they are more likely to lose their best staff due to "burnout" before it actually happens. I have learned that by speaking up might not always make a difference but at least I have of loaded and expressed my feelings to the right person in the appropriate manner (without taking it home), something I didn't do far early enough in the past.

Though burnout brought about major distress and upheaval in both my professional and personal life, I'm now grateful of the experience and the positive things, which have come from it, such as greater self awareness, personal growth, self confidence, and the ability to recognize my own limitations.

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### Caregivers' Burden and its Implication on Caregivers' and Patients' Health

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Cancer has a profound effect on all family members who often assume the role of primary caregivers. Caregivers face a wide range of stressors: a threat to the patient's life and well-being, stress of witnessing the pain and suffering of their beloved ones, the inability always to help them. Caregiving also implies assuming new responsibilities, roles, and duties, formerly accomplished by the patient, in addition to providing him or her with emotional support, attending to his or her care needs, and often becoming treatment managers. Caregivers frequently experience loss of the patient's companionship or support.

The enormous tasks, emotional strains and changes in caregivers' lives act altogether as severe stressors, especially in long periods of caregiving. Caregiving stress has been found to impact caregivers' psychological and physical health to the extent of their being regarded as "hidden patients." Various studies found high levels of depression, anxiety, and feeling of hopelessness in caregivers. Other studies have shown that family members reported levels of psychological distress very similar to those of the patients themselves or even higher.<sup>1</sup> They proved more prone to cardiovascular diseases, metabolic diseases, and upper respiratory infections, and they have an elevated mortality risk.

Immune functions are impaired in long-term stressful situations. Several studies have shown lower cytotoxic immune functions in elderly persons who care for spouses with Alzheimer disease: lower secretion of cytokines such as interleukin 2 (IL-2) and interferon-gamma (IFN- $\gamma$ ). These cytokines are essential for immune defense against infections and for surveillance against cancer.<sup>2</sup>

Women who are daughters of breast cancer patients are a unique group of caregivers exposed to multidimensional stressors. Daughters tend to assume the role of main caregivers, thus experiencing the burden of conflicts between their roles as mother and wife and as caregiver. They cope with the import of mother's illness and the threat to her life together with facing their own increased chances of breast cancer due to possible familial risk. In a study of 80 daughters of breast cancer patients, the relation of cognitive appraisals regarding breast cancer, psychological distress, stress hormone

(cortisol and catecholamines) secretion, and immune surveillance functions was examined.<sup>3</sup> The immune functions studied were natural killer cytotoxic activity (NKCA), secretion of IL-2, IL-12, and IFN- $\gamma$ , and IL-2 and IL-12-induced NKCA. Elevated levels of psychological distress, increased secretion of stress hormones and impaired immune surveillance functions were found in the daughters compared with matched controls. Differences between daughters and controls were especially profound in IL-2 and IL-12-induced NKCA, which has a major role in immune surveillance against cancer. More impaired immune functions were associated with higher psychological distress, higher levels of stress hormones, lower sense of control, and lower use of problem-focused coping. Persistent impaired immune surveillance functions presumably expose women to a higher risk of breast cancer development, and may even affect its course.

However, this study, like others, shows that increasing emotional support, and teaching effective coping strategies, may lighten the caregiving burden and may even serve as protection against its possible damage to health. For example, a controlled study with 104 caregivers of cancer patients assessed the effect of a cognitive-behavior group intervention on caregivers' distress, in comparison with a control group.<sup>4</sup> High and similar levels of psychological distress and sleep difficulties were reported in the intervention and control group in the preintervention phase. In the postintervention and follow-up measures, a significant decrease in the symptoms was found in the intervention group, while no significant change was observed in the controls. The decrease in symptoms in the intervention group was associated with increase in level of perceived emotional support. Accordingly, interventions for caregivers may be beneficial for caregivers' psychological and physical health. Moreover, healthy and not-distressed caregivers better fulfill their role of caring for the patient and attending to his or her psychological and physical needs.

Caregiving for cancer patients is a stressful experience that may have long-term effects on caregivers' psychological and physical health and impair their ability to care for the patient. Acknowledging the need to care for the caregivers and providing psychological interventions for them may help to preserve caregivers' and patients' psychological and physical health.

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### Art Therapy for Coping With Caregiver Burnout

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Medical Art Therapy helps patients bring their creative energy to the long, hard, isolating work of getting well. In 1991, I began the Art Therapy Program in Pediatric Hematology-Oncology at Georgetown University Hospital, and through many years there I have learned a great deal about how working creatively can ease the suffering of young patients, their families, and caregivers.

The profession of Art Therapy blends the disciplines of visual art and psychology, creating therapeutic approaches that operate on a largely nonverbal level. As such, primary process material—that which the individual has experienced but which may not have words attached to it—can be brought into the therapeutic work.

Recent advances in the scientific understanding of the brain have led to new insights into how people think and remember. Specialized bilateral processing in the human brain may explain why the creative process

helps us heal and integrate troubling experiences. Scholars assert that memory is a dynamic process, not a static filing cabinet of facts. Memories are called up and revised to incorporate new information when new understanding changes our perception of past events.

Memories, especially traumatic ones, are often accessible through the senses, but not necessarily through words. Rothschild<sup>1</sup> asserts that there are 2 main categories of memory—implicit and explicit. Implicit memory involves the storage and recall of learned behaviors such as walking and riding a bicycle. Language is not necessary to the retrieval of implicit memories. Explicit memory comprises facts and ideas, and the brain uses words to access them. The amygdala assigns emotional and affective significance to memories, and the hippocampus creates a cognitive map, putting memories into proper perspective.<sup>2</sup>

Individuals who experience a traumatic event may deal with it adaptively or maladaptively. In successful adaptation, the individual processes the stressful event and moves through the normal stages of grieving. In maladaptive processing, the individual walls the memory off from consciousness, in order to escape from the troubling emotions associated with the event.<sup>3</sup> Such “somatic memories” can trigger or sustain the autonomic nervous system’s arousal response.<sup>4</sup> It is the failure to transform and integrate traumatic sensory imprints that prevents the individual from feeling a sense of psychological well-being and physical safety.

Memories of traumatic events become troubling when they cannot be properly filed away as past events, not present occurrences. If they are stored as nonverbal, sensory experiences rather than, essentially, stories about past occurrences, the mind and body may reexperience the trauma when a trigger such as emotion, smell, or some detail of the environment recalls the event.

This interplay between verbal and nonverbal processing and consciousness may explain the effectiveness of traditional Art Therapy methods.<sup>5</sup> Contemporary art therapists are working to integrate new scientific findings into the practice of art therapy. McNamee<sup>6</sup> developed a bilateral art protocol, employing both dominant and nondominant hands (2003). Art Therapist Savneet Talwar has developed an art therapy trauma protocol (ATTP) to stimulate right-left brain interchange and promote cognitive mapping of traumatic memories.<sup>2</sup> Her method draws on EMDR and McNamee’s work, incorporating ideas from Michelle Cassou’s Point Zero method of painting.<sup>2</sup>

Participants in the first art session at this conference will learn a method of using drawing to start a conversation between the right and left hemispheres of the brain, helping to integrate the sensory and verbal dimensions of experience. The second art session will offer a technique for creating a work of art that can serve as a relaxation cue to the participant when placed in their work or home environment.

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**Preventive Approach to Burnout Among Healthcare Professionals**

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Burnout is a state of physical, emotional, and mental exhaustion with a reduced sense of personal accomplishment, this exhaustion caused by

long-term involvement in situations that are emotionally demanding excessive energy, and strength. Burnout is insidious, cumulative, and progressive resulting in stress. Stress is the condition of physical, physiological, emotional, and intellectual response that results when a threat to one’s wellbeing require a person to adjust to the environment. Distress is a negative stress and demands an exhausting type of energy. Eustress is positive and motivating shown in the ability to master a challenge:

**Stress Response:**

Physical Response	Emotional Response	Intellectual Response
Constant fatigue and sleep disturbance, change in appearance, change of appetite	Angry, irritability	Preoccupation, lack of concentration, diminished productivity, impaired problem solving, pessimism, uncooperativeness, absenteeism

The cost of failing to cope with stress effectively can be high and may include compromised client care, job burnout, and even physical and psychological deterioration. Symptoms of burnout are decreased efficiency and productivity, work pressure, dissatisfaction, absenteeism, and reduced sense of personal accomplishment. Health care professionals expect to gain sense of meaning from their profession, they are idealistic, highly motivated. When they feel that their work is insignificant or that they make no difference in their clinical settings, they burnout, and experience deterioration of professional performance.

**Risk Factors for Burnout of Health Care Professionals**

- High workload.
- Poor institutional support.
- Struggle to practice according to their personal philosophy of care.
- Sense of putting in more than they receive back.
- Role conflict.

**Stressors Affecting Oncology Nurses Involving**

1-Characteristic of the nurse:

- Overly dedicated and committed.
- High need to control.
- Perfectionism.
- Home and personal conflict.

2-Characteristic of cancer client population:

- Variability of prognosis.
- Confrontation with disfigurement, pain, disability, and death.
- Prolonged involvement.

3-Characteristics within the work setting:

- Inadequate nurse-patient ratio.
- Limited opportunity to participate in decision-making.
- Limited recognition and reward for work performance.
- Unclear role expectation, role conflict, role overboarded.
- Inadequate psychological and administrative support from peers.
- Competitive rather than collaborative relationship.
- Limited upward mobility.
- Limited open communication with peers, physicians, managers.
- Work overload.
- Overcrowded units, malfunctioning equipment.
- Pay inequities.

**Adapting to Stress**

The first step in coping is to assess if it really is what it seems to be, then options can be reviewed to resolve the problem either by trying to deal with the situation itself or control the emotional reaction felt in response to stressor.



Some effective techniques include:

- Reframing irrational thinking.
- Assertiveness training.
- Problem-solving skills.
- Communication skills.
- Relaxation techniques and Meditation.

Ways to care for oneself:

- Balance work, family, and personal needs.
- Be as healthy as you can be.
- Have realistic expectations for yourself.
- Be flexible.
- Focus on the accomplishment of your work.
- Be competent, be a lifelong learner, keep up with change.
- Cooperate with coworkers, understand yourself.
- Be proud of yourself and your work.
- Use healthy communication.
- Think positively.
- Plan fun into your schedule.

#### **Preventive Measures to Avoid Burnout**

The goal is to eliminate stressors that can be eliminated, master stressors that cannot be eliminated, and develop techniques for recognition and modification of stress response. It is important to recognize one's rights and establish a professional self-care plan accordingly.

#### **The Basic Rights for Professional Nurses:**

- To be treated with respect.
- To a reasonable workload.
- To an equitable wage.
- To determine their own priorities.
- To ask for what they want.
- To refuse without making excuse.
- To make mistakes and be responsible for them.
- To give and receive information as a professional.
- To act in the best interest of the client.

#### **To do's Daily List**

Eat well-balanced meals. Exercise every day. Get fresh air. Consecutive sleeping hours. Take time for yourself. Use relaxation methods. Read daily. Laugh, and share stories of happy times. Ask for help.

#### **Implication for Nurses**

Be commitment, compassion, competence, confidence, conscience.

### **Preventive Strategies for Coping With Working in the Home**

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The issue of work-related stress in the field of cancer care has been one of major concern to the directors of our Association. It was recognized right at the outset that caring for the cancer patients and their families, in providing physical or psychological support, if not done within a certain framework of planning, could easily prove to be an emotionally costly experience for the health carer. It was found in the early history of the Association that enthusiasm alone on the part of the carer could lead to physical and emotional exhaustion. It was this realization that led the directors to employ professionals in addition to the volunteers that it had started its services with.

Moreover, as the Association grew in size and services, it became obvious that even the professionals as well as the volunteers had to undergo some training in order to be able to cope much better with the task at hand. In spite of the fact that the value of preventive steps were recognized early on, it was through the process of trial and error that strategies were being formed and adopted gradually as the needs arose. The process involved identifying the special issues relating to cancer (cancer psychology) not only for the patient and family but also for the carer on the one hand and on the other hand trying to find the best possible methods of minimizing the risks of stress for those employees involved in cancer care.

Training programs had been adopted or devised which are constantly evaluated and updated as the needs change, since the Association runs a diverse number of services covering a wide range of patients' needs from individual psychological support, social support and nursing support to group for patients and home care. In addition to training, ongoing supervision, debriefing, and support for everyone involved is considered to be a must either on individual or group basis as well as workshops for the whole network of the Association's services.

The training programs, the supervision, and the workshops aim at the developing of self-awareness with regards to feelings around the issue of cancer, the development of communication skills, the setting of personal boundaries and the development of team spirit, areas which we have found to play a major role in stress management if properly attended to. Once the homecare team members have gone through the above-mentioned training, the task of care becomes less likely to be an unmanageable source of stress even though working in the home has its own special characteristics.

If one has gone through learning about his/her personal issues and feelings and learned how to best communicate effectively these feelings and in addition to having learned how to best function and serve the aim of the group that he/she is part of, then from my personal experience the risk of stress and burnout are minimized.

There are of course a number of other considerations to be taken into account when planning for job-related stress prevention one of which is job satisfaction. No amount of training, or support would make the job of caring for the cancer patient any easier if one is not fully committed to the idea of working in the field of oncology with all its possible ramifications.

It is important for the purpose of avoiding future damage that when recruiting staff the nature of the job and all the special issues involved in cancer care are fully explained and understood. Another consideration which can make a difference is the workload assigned to or undertaken. Knowing what the nature of the job is all about, we as an Association discourage staff to take on too much work for obvious reasons.

In conclusion, we believe that the main preventive strategy for coping is preparing in advance.

### **Scientific Basis for Complementary Approaching to Stress Management**

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Healthcare professionals working in the field of oncology and cancer care encounter many stressors in their professional lives. These stressors include large patient case load; lack of training in coping with difficult patient situations; consistent exposure to pain, loss, and human suffering; and the lack of psychological support before and after the death of a patient. Operating under consistent stress may cause healthcare professionals to experience professional burnout or to become physically or emotionally ill themselves.

Mind-body medicine techniques, such as meditation, autogenic training and biofeedback, and imagery may be helpful in reducing stress levels, and in preventing and treating physical and emotional illness in healthcare professionals. A principle of mind-body medicine is that the physical, emotional, mental, social, and spiritual aspects of one's life directly affect health and well-being. Furthermore, the mind-body connection can be accessed in a way that enhances each person's capacity for self-awareness and self-care.

The scientific basis for how these approaches reduce stress lies at the level of the hypothalamus. As noted in another presentation at this meeting, stressful stimuli cause the release of corticotropin releasing hormone (CRH) from hypothalamus. This master stress hormone initiates a cascade of actions that result in the well-described stress response, which includes cardiovascular, endocrine, immune, neural, and metabolic effects designed to enable the human being to meet a stressful challenge. Continuous challenges that do not subside cause chronic elevations of CRH, which lead to the deleterious effects of "chronic stress." Several mind-body medicine techniques invoke calming thoughts, access pleasant memories or states, which lead to an enhanced state of relaxation. The mechanism for these effects relates to an

attenuation of CRH release, which in turn decreases the activation of the sympathetic nervous system and circulating norepinephrine levels, and the relative activity of the parasympathetic nervous system increases. As a result, several physiologic changes occur including decreases in heart rate and respiratory rate, and increased blood flow to the periphery. With decreases in CRH and consequently the pituitary hormone, adrenocorticotropic hormone (ACTH), less cortisol is produced resulting in reduced metabolic activity and declines in oxygen consumption. The physiologic effects are coupled with psychological feeling of calm and relaxation leading to an enhanced state of well-being. There is also a heightened state of self-awareness.

In addition, there is evidence to suggest that mind-body medicine techniques stimulate the production of endogenous neurotransmitter systems that directly induce relaxation. Although less well characterized than CRH inhibition, some possible candidates include increased production of endocannabinoids, endogenous benzodiazepines, and serotonergic systems.

Training healthcare professionals to integrate a number of these mind-body medicine skills into their personal and professional lives may reduce their stress levels by calming the mind, healing the body, and renewing the spirit; thus reducing the probability of professional burnout or physical and emotional illness.

Conference attendees will participate in Mind-Body Medicine skills groups, where they will experience *Autogenic Training* and *Biofeedback* exercises, *Mindfulness Meditation*, and a number of *Imageries*, to help reduce stress and enhance health and well-being.

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### Palliative Care as Anti-burnout—The Family Medicine Resident Perspective

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Residency is a highly intense period involving substantial burnout. Residents usually work long hours, have stressful “life saving” responsibilities, and on the other hand have little control over the course and nature of their work. In a review about resident burnout published recently it was found that burnout is prevalent among residents and is associated with depression and difficulties in treating patients.<sup>1</sup> Family Medicine residency is no different than others in that respect.

In Israel, Family Medicine residency takes 4 years to complete: first, the resident rotates in a primary care clinic where for 9 months he takes part in taking care of the patients of his tutor. Then, the resident goes back to the hospital, where he spent the major part of his clinical studies, and rotates in Internal Medicine (12 mo), Pediatrics (6 mo), Psychiatry (3 mo), and in 4 elective departments (6 wk each). Completing this, the resident turns to the final stage in which he works for 12 months as an independent Family Physician in an outpatient clinic intended to continue being his working place after completing the residency. Like in any other residency, the Family Medicine resident has to pass 2 board exams. Although Family Medicine residents have to do much less night calls consisting a major part of the burden of the other “hospital residencies,” it was found that Family Medicine residency is associated with stress and burnout not less than others.<sup>1</sup> Moreover, the Family Medicine resident knows that soon he will leave the hospital never to come back (only to visit his future patients), so can get frustrated from the enormous effort he has to invest in integrating into and maintaining high performance in the busy hospital departments.

Many of the family medicine residents are drawn to this medical specialty because of its special characteristics: family medicine is a true

patient oriented approach using the biopsychosocial model as its main tool for understanding both health and disease. In practice, this approach and model translate into maintaining good patient-physician relationships, developing and using various communication skills, acknowledging the prime importance of the family, making home visits, and so on. Unfortunately, from various reasons, these ideals and practical measures are difficult to implement during the residency not only in the hospital setting but also in primary care clinics where the resident is expected to learn quickly to function efficiently as in the “real world:” treat many patients a day, each one in a short time (~10 min) and not to miss a medical diagnosis (the biological aspect of the biopsychosocial model). This gap between the Family Medicine ideals and the “real world” is quickly uncovered and may be a major source of frustration and burnout.

In Israel, Family Medicine residents are obliged to complete a 4-year academic course in Family Medicine. The Family Medicine academic course in Haifa includes a course in Palliative Medicine. It is natural for family physicians to be interested in Palliative Medicine because both share the same principles and ideas. Fortunately for me, the Home Hospice unit in our district accepts Family Medicine residents to take care of palliative patients admitted to the unit for home care. Working in the Home Hospice unit enables me to practice all the important aspects of patient care mentioned earlier. Although very demanding, often emotionally difficult and clinically challenging, I draw the major part of my professional satisfaction from the home hospice work which comprises only a small percentage of my working time, thus it serves for me as an antiburnout occupation. I feel that in practicing Palliative Medicine I have some success in making a difference and in alleviating patient suffering. This is highly rewarding and enables me to go through the difficult residency period with much less burnout.

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### Predictors of the Quality of Life and Burden of Family Caregivers Across Different Trajectories of Illness

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**Purpose:** The American Cancer Society’s Quality of Life Survey for Caregivers was designed to assess the impact of cancer on the quality of life of family members and close friends who are caring for cancer survivors. Family caregivers participated in this nationwide longitudinal study by being nominated by adult cancer survivors identified from state cancer registries. The purposes of this presentation are (a) to document the levels of quality of life and caregiving burden of caregivers and (b) to identify demographic factors that are associated with poor quality of life and caregiving burden, early and midterm in survivorship.

**Method:** Initial data were collected approximately 2 years after the care recipient’s cancer diagnosis, and the first follow-up data were collected approximately 5 years postdiagnosis. Initial data collection has been completed, with 1635 informal caregivers returning a completed caregiver survey. The first follow-up data collection is underway. Currently, 612 caregivers completed the first follow-up survey. Quality of life was measured as multidimensional in nature: psychological distress was measured using POMS-SF (McNair et al, 1992; Shacham, 1983); mental functioning and physical functioning were measured using MOS SF-36 or SF-12 (Ware et al, 1994; Ware et al, 1996); and spiritual adjustment was measured using FACIT-Sp (Peterman et al, 2002). Caregiving burden was measured using subscales of the Pearlin Stress Scale (Pearlin et al, 1990: stress overload subscale) and Caregiving Reaction Assessment (Given et al, 1992: impact on schedule and financial burden subscales).

**Results:** At approximately 2 years postdiagnosis, the levels of both mental ( $m = 49.73$ ) and physical ( $m = 49.93$ ) functioning of the caregivers were comparable to the mean of the US general population. Similarly, the overall levels of psychological distress of caregivers were lower than those found in patients who have undergone bone marrow transplantation (Baker et al, 2002) or in cancer patients with pain complaints (Shacham, 1983). The levels of psychological distress of our sample ( $m = 10.20$ ) more closely resembled those of a normative geriatric sample (McNair and Neuchert, 2005). The levels of spirituality

of the caregivers ( $m = 34.59$ ) were comparable to those found in patients with cancer and other chronic illnesses (Peterman et al, 2002). The levels of caregiving stress were relatively low to medium: Stress overload ( $m = 1.64$ ; scale ranged 1 to 4); impact on schedule ( $m = 2.35$ , scale ranged from 1 to 5); and financial burden ( $m = 2.11$ , scale ranged 1 to 5). Across various aspects of quality of life, age, and income were consistently significant predictors of the quality of life of caregivers at 2 years postdiagnosis. Older caregivers were better in mental, psychological, and spiritual health, but poorer in physical health. Household income was positively associated with mental and psychological as well as physical adjustment. With regard to predictors of caregiving burdens at 2 years postdiagnosis, younger caregivers reported greater levels of both stress and financial burden from caregiving. Spousal caregivers also reported greater levels of stress overload and conflict in schedule as the result of providing care to their partner with cancer. In addition, the financial burden of caregiving was inversely related to the caregivers' household income level.

At approximately 5 years postdiagnosis, the levels of both mental ( $m = 50.36$ ) and physical ( $m = 50.42$ ) functioning of the caregivers were comparable to the mean of the US general population (Ware et al, 1994; Ware et al, 1996). The levels of psychological distress of our sample ( $m = 10.31$ ) were comparable to those of a normative geriatric sample (McNair & Neuchert, 2005). The levels of spirituality of the caregivers ( $m = 32.78$ ) were comparable to those found in patients with cancer and other chronic illnesses (Peterman et al, 2002).

Approximately 12% of caregivers who completed the follow-up caregiver survey at 5 years postdiagnosis were actively providing care at the time of survey completion. Their levels of caregiving stress were similar to those at 2 years postdiagnosis: Stress overload ( $m = 1.51$ ; scale ranged 1 to 4); impact on schedule ( $m = 2.32$ , scale ranged 1 to 5); and financial burden ( $m = 2.61$ , scale ranged 1 to 5).

As at 2 years postdiagnosis, age was a significant predictor of various indicators of the quality of life of caregivers at 5 years postdiagnosis. Older caregivers had better mental, psychological, and spiritual health, but poorer physical health. Likewise, as at 2 years postdiagnosis, household income was positively associated with mental and physical health at 5 years postdiagnosis. With regard to predictors of caregiving burdens at 5 years postdiagnosis, caregivers' household income level was negatively related to financial burden of caregiving. Other aspects of caregiving burdens were not significantly predicted by caregivers' demographic characteristics.

**Conclusions:** Our study participants appear to have passed the initial period of crisis brought about by the diagnosis and treatment of their relative's cancer and now, at 2 and 5 years postdiagnosis, display normal levels of psychological well-being and health, but heightened levels of spiritual concerns, comparable to those of cancer patients. Family members reported relatively low to medium levels of caregiving burden at 2 and 5 years postdiagnosis. Whereas older age was a protective factor from poor quality of life, particularly in psychological and spiritual aspects, the physical burden of caregiving for older caregivers should not be overlooked. Clinicians and policy makers should also pay special attention to caregivers with limited socioeconomic resources throughout the trajectory of the illness.

### The Pathophysiology of Stress

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When an individual is exposed to stressful stimuli—some of which may be physical such as pain, trauma, infection, hypotension, exercise, hypoglycemia; or others that may be psychological in nature such as bereavement, fear, personal loss, or anger—the release of hypothalamic CRH (corticotropin releasing hormone), the master stress hormone, is stimulated. The CRH in turn is released into the portal blood flow to the corticotroph cells of the anterior pituitary gland. There the CRH binds to its receptor on the corticotrophs and stimulates the ultimate production and release of adrenocorticotrophic hormone (ACTH). The ACTH enters the systemic circulation and reaches the adrenal cortex of the adrenal gland where it stimulates the synthesis of the glucocorticoid hormone cortisol and also androgenic hormones such as androstenedione and dehydroepiandrosterone (DHEA), both of which may ultimately be converted into the more

potent testosterone or dihydrotestosterone (DHT) in peripheral tissues. The cortisol acts as an important stress hormone because it maintains blood glucose levels during a stressful “fight or flight” challenge. During stress, as more demands are placed on the body, more metabolic fuel is consumed but yet a critical amount continues to be needed to ensure normal brain function and to supply activated organs such as the heart, lungs, and skeletal muscle with a renewable supply of substrate. In addition, the cortisol also participates with aldosterone (the mineralocorticoid hormone) in driving sodium reabsorption by the kidney tubules. This serves the important function of conserving electrolytes and water within the vasculature to help maintain blood and perfusion pressures to critical organs and tissues that are participating in the fight or flight reactions. During the stress response, the blood concentrations of cortisol will rise until the cortisol starts to exert its negative feedback effect upon both the CRH neurons and the pituitary corticotrophs that manufacture ACTH in order to reduce their increased levels of secretion back to their normal baseline. This homeostatic mechanism, when working correctly, prevents overproduction or prolonged elevations in CRH, ACTH, and cortisol. Thus, metabolic substrate is only mobilized when there is a specific need during the stress response.

When an individual experiences chronic stress along with maladaptive responses or a lack of coping, cortisol levels may remain inappropriately elevated. This is due to a persistent stimulation of the CRH-ACTH-cortisol axis. Metabolically, this can take a toll on the organism. The ongoing high concentrations of cortisol may keep blood glucose levels high for prolonged periods; cause redistribution of fat from the thighs and buttocks to the abdominal and cervical regions (“buffalo hump”) due to mobilization of free fatty acids; cause insulin resistance to develop; produce fluid retention and hypertension; drive proteolysis in muscle, bone, and connective tissues; and inhibit peptide and protein hormone formation (especially by the pituitary gland). The persistent presence of increased cortisol will also have a profound effect to inhibit immune system capabilities. Elevated cortisol concentrations can decrease the number and functions of blood lymphocytes, eosinophils, basophils, monocytes/macrophages, and neutrophils. Further, cortisol can inhibit the production of immune cell signaling molecules such as the proinflammatory cytokines interleukin (IL)-1, IL-2, IL-2 receptor, IL-6, tumor necrosis factor (TNF), and gamma interferon. Chronically elevated glucocorticoids can also decrease antibody and immunoglobulin production. Consequently, chronic activation of the HPA axis is associated with the development and worsening of chronic infectious diseases.

### CRH and the Autonomic Nervous System

While CRH is best known for its neuroendocrine role in stimulating ACTH secretion from the anterior pituitary gland, CRH also acts as a neurotransmitter by stimulating sympathetic outflow from the brain and spinal cord and simultaneously inhibiting the outflow of parasympathetic activity to the periphery. Part of the sympathetic response is to stimulate the adrenal medullary release of the catecholamines epinephrine and norepinephrine into the circulation. Additionally, sympathetic nerves that innervate visceral organs and tissues such as the heart, coronary arteries, peripheral blood vessels, kidney, lungs, pancreas, gastrointestinal tract, and gonads, will release their contents of norepinephrine and neuropeptide Y at these sites. The overall result is to accelerate cardiopulmonary activity by increasing heart rate, strength of cardiac contraction, arterial vasoconstriction, and blood pressure, with shunting of blood from the splanchnic vasculature to skeletal muscles, heart, and brain, and increasing the rate and depth of respiration. Stimulated sympathetic catecholaminergic inputs to the liver and adipose tissue result in enhanced glycogenolysis and lipolysis, thereby supplementing the glucose and free fatty acid elevating action of cortisol. The integrated view is that CRH is acting in its neuroendocrine capacity to supply the main metabolic substrates (via its cortisol and catecholamine stimulating action) for the CRH-directed trigger of visceral organ stimulation upon sympathetic nervous system activation after physical or psychological challenge. Other CRH-directed sympathetic targets involve the stimulation of the renal renin-angiotensin-aldosterone system and the neurosecretion of anti-diuretic hormone (arginine vasopressin). These sympathetically driven hormones will act in concert with cortisol and the catecholamines to defend against volume depletion and hypotension during any homeostatically threatening situation.

Stress-related activation of CRH also alters the ratio of sympathetic to parasympathetic inputs to the gastrointestinal tract. The net outcome for

the stomach is an inhibition of gastric contractility and decreased emptying leading to sensations of fullness and bloating. In the case of the colon, accelerated motility with rapid transit times for chyme and poor absorption of nutrients and water is the result. Diarrhea and inflammation of the bowel can result if the stress is of sufficient intensity and length. It has been suggested that this mechanism of stress may contribute to the development of the irritable bowel syndrome and the exacerbation of Crohn's disease. Such inflammatory states of the bowel may lead to the "leaky gut" syndrome with maldigested food antigens provoking inappropriate immune responses in the form of food sensitivities.

#### CRH and Behavior

CRH is also well-positioned to participate in coupling physiological responses to corresponding stress-related behaviors. It has been observed in animal models that CRH injected into the brain produces behaviors that are typically seen when animals and humans experience stressful events and major clinical depression. Some of the notable conditions associated with high HPA activity are chronic stress, melancholic depression, anorexia nervosa, diabetes mellitus, syndrome X, and premenstrual syndrome. Dysregulated states associated with low cortisol production are adrenal insufficiency ("adrenal exhaustion or burnout"), chronic fatigue syndrome, fibromyalgia, postpartum depression, posttraumatic stress syndrome, and exacerbation of rheumatoid arthritis. Clearly, if the course of chronic stress and its associated disease states could be addressed through the use of mind-body medicine stress management techniques, a number of downstream pathologies might be favorably impacted.

#### Stress and Burnout: The Significant Difference

Ayala Malach-Pines. *Ben-Gurion University, Israel.*

Ever since the introduction of the concept of burnout into the scientific literature nurses' burnout has received extensive and continuous research attention. The reason seems obvious: nurses are considered to be particularly susceptible to the danger of burnout because of the very stressful nature of their work.

While there is no doubt that nursing is stressful, this is probably not the primary reason for nurses' burnout. Stress is rarely the primary reason for burnout. Instead, burnout is most often caused by a failure in the attempt to find meaning in work. An Israeli nurse who said she always knew she was going to be a nurse and saw nursing as a calling, explained why it is not hard work that causes her to burnout:

"The days I enjoy work most are the days in which I work the hardest ... I love it when I can identify the little things that disturb the patient, things even the patient is not aware of, and the fact that we can help him... When there is a patient who cannot be helped, these are the hard days. These are the days that I go home frustrated, feeling that there is nothing I can do well (Pines, 1990, p. 83). For this nurse, it is not strenuous physical work but the perceived inability to help patients in pain that is the cause of burnout.

Burnout is often conceptualized within the framework of stress. However, as noted by Toch (2002), stress tends to be "oversold" as a general term in which causes and consequences are often confused. Therefore, not much is gained by defining burnout within the stress framework.

Stress has been defined as "the nonspecific result of any demand upon the body, be the effect mental or somatic" (Selye 1956). As such, stress can be experienced by animals as well as people. Burnout, on the other hand, is the end result of a process in which highly motivated and committed individuals lose their spirit (eg, Freudenberg, 1980, p. 13; Maslach, 1982, p. 3; Pines and Aronson, 1988 p. 9). It can only be experienced by people who entered their careers with high hopes, ideals, and motivation. Different theories were offered in an attempt to explain the etiology of burnout, including, most recently-existential theory (Pines, 2000a).

According to the existential perspective, the root cause of burnout lies in people's need to believe that their lives are meaningful, that the things they do are useful and important (Pines, 1993). According to Victor Frankl (1976) "the striving to find meaning in one's life is the primary motivational force in man" (p. 154). Ernest Becker (1973) added, that people's need to believe that the things they do are meaningful is their way of facing their own mortality. In order to be able to deny death, people need to feel heroic, to know that their lives are meaningful. Today, in most Western countries, a frequently chosen answer for the existential quest is work. People who choose this option try to derive

from their work a sense of meaning for their entire life. This is why they enter it with such high hopes, idealistic and motivated, and relate to it as a calling. When they feel that they have failed, that their work is insignificant, that they make no difference—they start feeling helpless and hopeless and eventually burnout (Pines, 1993).

The existential perspective was supported in a study that included 8 samples: 100 Israeli hospital nurses (primarily women), 97 Israeli teachers (primarily women), 66 Israeli managers (primarily men), 267 American police officers (primarily men), 17 Israeli blue-collar workers (all men) a group of 50 Israeli retirees, a national sample of Israeli Jews (327), and another of 505 Israeli Arabs. In each sample respondents completed the Burnout Measure (Pines, 2004), a question about the work's significance and questions about different aspects of work related to stress and burnout. Results revealed, in all 8 samples, a significant correlation between burnout and lack of significance at work. In the professional samples, aspects of work were found that were stressful yet not correlated with burnout. For the nurses, there was no correlation between the number of hours per week and burnout ( $r = -0.08$ ) but there was a significant correlation between helplessness and burnout ( $r = 0.46$   $P = 0.000$ ) and negative correlations with accomplishments ( $r = -0.43$ ), productivity ( $r = -0.34$ ), challenge ( $r = -0.33$ ), and control ( $r = -0.24$ ) (all  $P$  levels  $< 0.02$ ).

During a burnout workshop (such as the one that will be conducted in the conference) the nurses participated in a multistep exercise that analyzed their goals and expectations when they entered nursing, and causes of burnout (Pines, 2001).

In response to the question about goals and expectations most of the nurses mentioned:

- Help people in pain.
- Professional fulfillment and self actualization.
- Make a significant contribution. Nursing is a calling.
- Help people who really need help.
- Be a skilled professional.
- Have control and influence.
- Have the support and recognition of physicians and administration.
- Have the resources and authority to do the work right.

The burnout causing stresses that were mentioned most often by the nurses were:

- Witnessing human suffering being unable to help.
- A big patient load that effects the quality of the work.
- The suffering of people there is no way to help.
- Daily confrontation with suffering, pain, old age, and death.
- Helplessness when confronting lost cases.
- Not enough control over patient care.
- Physicians who don't know their work and don't let you do yours.
- Lack of administrative support, lack of resources to do the work right.

Clearly, the causes of burnout are expressions of frustrated goals and expectations. The implication for preventing burnout among professionals working with cancer patients is clear: greater emphasis on the significance of work.

#### Quality of Life Among Terminally ill Cancer Patients in Jordan

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For terminally ill cancer patients, when cure is acknowledged to be impossible and alternative efforts to combat the progress of disease are exhausted, the main goal of end-of-life care is to achieve the best quality of life for patients and their families. Key positive outcomes for such patients include the prevention and alleviation of physical and psychological distress, maintenance of physical and mental functioning, and the presence of a supportive network of relationships. Concern for maintaining quality of life for patients has always been an important issue in oncology and its precise measurement is becoming more and more important. Quality of life is believed to be the most important outcome of care at the end of life in the terminal phase of illness;

however, the character of the brief time remaining to the patient is likely to be more important than its exact length. In such cases, the health care givers purpose is helping to make these last days as meaningful and comfortable as possible.

In Jordan, specialist palliative care services are offered by 2 organizations: the Al Malath Foundation for Humanistic Care and the King Hussein Cancer Centre. Additionally, supportive care is offered at the Al Basheer Hospital. This study aimed at assessing the quality of life among terminally ill Jordanian cancer patients, receiving care at the King Abdullah University Hospital and the Almalath foundation. Two instruments were used in this study: The Sociodemographic data checklist which includes (gender, age, religion, marital status, income, educational level, occupation, diagnosis, and treatment modalities, etc.); and The McGill Quality of Life Questionnaire which assess patient's physical symptoms; physical well-being; psychological well-being; existential well-being, and support.

A convenient sample of 84 patients were used for this study, 63 patients were recruited from King Abdullah University Hospital and 21 patients from Almalath Foundation. All patients were above 18 years of age with a mean of 48 years, 43% were males and 57% were females. The majority of patients were diagnosed with leukemia and breast cancer, unemployed, and exposed to chemotherapy treatment modality.

Results of the McGill quality of life questionnaire show that 21% of patients score around 5, indicating a moderate quality of life score. The most common physical problems reported by these patients were pain, nausea, and general weakness.

In terms of the psychosocial aspects no major differences were found between the 2 settings. However, patients at Almalath Foundation experienced better care and felt more supported as indicated by their responses on The McGill Quality of Life Questionnaire. Most of the patients expressed that social support had the greatest effect on making their quality of life better; while psychological problems in general had a negative impact on their quality of life. Meeting and assessing the physical and psychosocial aspects of terminally ill cancer patients by the health team professionals will have a great impact on promoting and improving the end of life care in order to achieve the best quality of life for patients and their families in Jordan.

These data are considered to be the first local assessment of the psychosocial aspects of Jordanian terminally ill cancer patients. Furthermore, our results indicate that specialized care center such as Almalath Foundation is better suited for patients' care and needs. We hope that this work will be a future guide for local health care professionals in assessing and promoting end of life care center and policies for Jordanian terminally ill cancer patients.

### The Problem of Burnout in the Hospice—A Cypriot Experience

Sophia Nestoros Pantekhi and Maria Christina Tchopourian. *Arodaphnousa Hospice, Cyprus.*

The Cyprus Anti-Cancer Society was established in 1971 as an NGO to support cancer patients in their "journey" through their illness.

The political-economical situation in Cyprus in 1976, the needs for caring for dying cancer patients, and the idealism of 2 men involved personally with cancer patients inspired them to build and run a "home" for dying cancer patients on a nursing charity base.

The Cyprus Anti-Cancer Society established in 1976 "Arodaphnousa" Hospice. It started to work with 23 beds, 15 nurses most of whom were practical nurses, without any experience in caring for ill dying human beings. Practical nurses did not have any education in nursing; they started to work here at the beginning for financial reasons, without being aware of the needs of the patients and their families. They cared very well for the somatic needs of the patients. Optimal treatment demands careful assessment of the multiple contributing factors to each symptom.<sup>1</sup>

The oncologists from the Nicosia General Hospital did rounds every Saturday for clinical assessment but there was no social worker and no psychologist. Then the role of the nurse was more important. Effective management depends on frequent adjustment to consistently sustain the minimal effective dose of medication and an emphasis on skilled nursing care as well as the use of the complementary skills of an interdisciplinary team experienced at end of life care.<sup>2</sup>

During the last 30 years a lot of studies have illustrated the need for palliative care and death education to be explicit in nursing programs.<sup>3</sup>

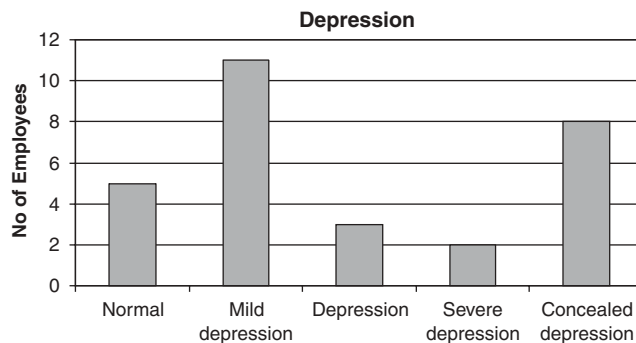


TABLE A. Depression — BDI

In 1992, the management council sent a registered nurse to visit the St Christopher Hospice, in UK for 12 weeks.

In 1996, the Cyprus Anti-Cancer Society employed a social worker, 2 years later a psychologist and then in 1999 a physician. Because the team is the vehicle of action<sup>4</sup> while the patients and family are central members of the palliative care team, the Hospice after 2000 has had its metamorphosis. It is working with a multiprofessional team—2 doctors trained in Palliative Medicine, nurses, 2 psychologists, a social worker, physiotherapist (trained in Lymphoedema), and an aromatherapist.

From one point of view we moved forward, to work as a team in the concept of palliative care as an approach that improves the quality of life of patients and their families,<sup>5</sup> but on the other hand what are the needs of the carers? Who cares?

Unfortunately, the management council cannot understand what these needs are. Why the professionals at the Hospice have needs?

The Psychologist, the Matron, and the Medical Director have met few times to discuss the problems of burnout of the staff working at the hospice. They wrote and suggested different options, like educational programs, support programs to improve the quality of service through the support of the staff.

A few months ago the psychologist of the hospice was asked to prepare a study<sup>6</sup> for the management council, to identify the needs of the staff of the hospice and screen for burnout problems.

Thirty-nine questionnaires were sent and 29 were answered.

In Table A depression (BDI) it is shown that 5 participants (17%) scored depression or severe depression. The factor "age" showed that the staff between the age 41 and 50 was affected more. Nurses who are working more than 20 years at the Hospice, seemed to be more affected and scored depressed or severe depressed and also the role of the professional seemed to be of importance—practical nurses working for more than 20 years showed to be emotionally exhausted, depersonalized, and with reduced personal accomplishment.

The results of the study have been given to all members of management council. Unfortunately, it seems that the problem of burnout in our Hospice is multifactorial.

From my personal experience working at the Hospice for the last 7 years I could place in order the most important sources of work-related stress of professionals working at the hospice and leading to burnout:

### Sources of Work-related Stress

1. Feeling overloaded and its effect on home life
2. Lack of training and education
3. The role of the professionals at the NGO
4. The role of the management council
5. Inadequate facilities (equipment, space) to do our job properly
6. Dealing with distressed patients and relatives
7. Encountering difficulties in relationships with colleagues

**Stressful Aspects of Work**

1. Encountering difficulties in relationship with administrative staff
2. Having an overall volume of work
3. Encountering difficulties in relationships with managers
4. Feeling they are poorly paid for the job they do
5. Inadequate staff
6. Having a conflict of responsibilities (clinical vs. managerial)
7. Uncertainty over the future funding of the association

Many studies showed that death and dying do not seem to be a major source of job stress (Vachon, 1978).<sup>7</sup>

Caregivers to the critically ill, dying, and bereaved must be aware that much of the stress they experience is the result of the interaction between who they are as people and the environment in which they work.<sup>5</sup>

Maintaining and improving professional carers' mental health is essential for their own well-being and for the quality of care that they provide to patients.<sup>8</sup>

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**Spirituality—Contribution to the Well-being of Healthcare Professionals**

Patricia A. Parachini, SNJM, DMin. *Georgetown University, Washington, DC*.

Although the concept of holistic medicine is not new, contemporary medicine has placed new emphasis on viewing the patient as one complex interconnected whole, in which body, mind, and spirit work together as one in the healing process. Healthcare professionals working directly with patients as well as those engaged in research are increasingly drawing from all available resources, including spiritual and religious resources, to achieve the best results in the care of their patients. Support for this changing approach to medical practice can be found in numerous books and articles that include results of studies that illustrate the positive effects of prayer, meditation, and other spiritual practices in addressing pain and lessening stress or anxiety (eg, Refs. 1, 9). Spirituality has come into its own as a valid means of contributing to the healing of those who are ill or experiencing distress.

It is significant that among healthcare professionals today, "spirituality...is recognized as a factor that contributes to health in many persons," and "...is found in all cultures and societies."<sup>6</sup> Spirituality is at the core of what it is to be human. Spirituality encompasses all aspects of a person—in-relationship: to oneself, others, and the cosmos—all in the context of one's relationship to the transcendent. Religion, an organized system of beliefs and related practices, is the primary spiritual path for many. But religion is not the only spiritual path for all. Those who consider themselves "spiritual," but do not espouse a specific religious belief, engage in certain spiritual practices that respect the mind, body, spirit connection, without affiliating with a specific religious tradition.

Spiritual practices are designed to guide individuals to greater peace and inner freedom and to help them address their spiritual needs, such as the

need for love and relationship. Among these spiritual practices are those adopted within the context of a religious tradition with a specific belief system. Some examples are praying and the reading of sacred texts; communal rituals, chanting, or the singing of hymns; centering prayer or mediation. Examples of spiritual practices not connected explicitly with religion, per se, are: the use of guided imagery; breathing and focusing exercises; and art and music therapy. Spiritual practices can assist individuals to become more in touch with the transcendent dimension of their lives as they develop a greater sense of their "Soul" or true self (see Ref. 4). From Palmer's perspective, this will enable them to live their lives with greater integrity so that their inner and outer worlds are more congruent.

Healthcare professionals, especially those caring for adult or pediatric oncology patients and their families, can benefit from attending to their own spiritual needs. Engaging in spiritual care with intentionality and consistency could enhance their overall well-being and help them prevent burnout, displayed in such behaviors as extreme fatigue, mistakes, poor relational skills, and lack of focus. It could contribute to a more effective and compassionate approach to their patients, as well.

In this age of "The New Medicine" (see Ref. 5), also referred to as integrative or holistic medicine, spirituality, and spiritual care are in the mainstream. As this PBS documentary illustrates, spiritual practices such as guided imagery or the use of breathing exercises are being used by medical practitioners throughout the United States as well as in other countries. In many instances these approaches are no longer considered "complementary" or "alternative" but rather are becoming an integral part of treatment plans. With the emphasis today on integrative medicine we are reminded of the practices of ancient cultures and religions that fostered this holistic approach and often identified one person in the community as the designated "healer." In many societies this designated healer drew from all available resources to address the ills of mind, body, and spirit, recognizing the interconnectedness of all that makes us human. As healthcare professionals look at the effects of their work on their personal lives, especially their spiritual well-being, they could benefit from reflecting on the following:

- What helps you cope with the stress related to your work with cancer patients?
- Do you regularly use any spiritual practices to maintain your well-being?
- Do you suggest to your patients the use of spiritual practices as part of their treatment plan?

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**The Relationship Between the Social Worker's Task and Burnout**

Gilly Pelleg, PhD. *"Clalit" Health Services; Haifa University, Israel*. The heart of palliative social work relates to the social and psychological health of the patient, family, and caregivers. A significant part of the social worker's intervention deals with emotional aspects. Burnout is often experienced by social workers in this field. Some causes were

identified and are discussed under 2 headings: emotional and organizational.

### 1. Emotional Causes of Burnout

- a. Identification. A situation where the social worker identifies with the patient or with part of the family. The ability to use denial mechanisms and to distinguish between oneself and the patient are reduced and so the personal threat increases.
- b. Meeting people in emotional pain. The social worker meets with people in emotional distress as a result of illness. Ongoing contact with a population in this emotional condition creates prolonged emotional overloading.
- c. Young population. Treating young terminal patients increases emotional strain, as dying young stands against our expectation of natural order.
- d. Low energy. There are cases where one goes into a house and senses that the energy there is low. It is hard to define what exactly creates this feeling, yet the feeling is real. A therapist leaves such a place feeling drained.
- e. There is a wide range of families; some are truly inspiring while others are very complicated to deal with. Demanding individuals, obstructed communication, lack or excess of caregivers all increase difficulty.
- f. The home setting. The therapeutic session, which takes place at the patient's home, is unique and contains vagueness on 2 accounts. First, the social worker is a guest. Control of setting does not exist and definition of the therapist's place is less clear. Additionally, in palliative home therapy, the social worker comes as part of a team. The patient usually does not initiate therapy sessions. Both factors increase vagueness and ambiguity as to the social worker's therapeutic place.

In situations of high burnout, the social worker may lower their attention to emotional aspects and focus more on technical issues. One can see a process of depersonalization or reduction in the number and length of sessions social workers hold with patients in cases of burnout.

### 2. Organizational Causes of Burnout

#### Organizational communication

- a. Different languages. The language of the social worker deals with emotions, psychological, social, and family processes. This is in contrast to the public health organization's use of economic and medical languages. There is a difficulty to speak of social work in measurable medical financial terms. As a result of differing languages, many social workers report feeling frustrated at not being appreciated for their hard work.
- b. Lack of emotional support for the team. There is a lack of organized, recognized emotional support. In addition to other tasks, the social worker is expected to support the care giving team. The question remains open—who cares for the care giver?
- c. Team work. Palliative care is characterized by multidisciplinary work, which creates contact and even slight overlap between various professionals. Conflict within the team can be threatening to the social worker.

#### Lack of resources

- a. One of the social worker's tasks is obtaining material resources. There is a significant problem here: today there are new and expensive drugs, which cannot be obtained by people of ordinary financial ability. This creates a sense of helplessness for the social workers whose role includes obtaining resources. A diminishing sense of personal accomplishment increases burnout.
- b. Low financial compensation. Salaries are relatively low in this profession, despite the great academic and emotional investments required. This creates a dissonance, which decreases work satisfaction and with time the worker's willingness to give and initiate.

**Summary:** Awareness of these emotional and organizational causes can help the professional to identify them when they appear. When social workers are aware, they can protect themselves from continuous and ongoing burnout, by making use of tools that prevent or slowdown the process. Moreover, while these causes can be a source of difficulty and frustration, they can also be a source of personal growth.

### Issues Causing Burnout Particular to Health Professionals Working in Home Care

Barbara Pittsillides, RGN, Msc Pall. *Specialist Palliative Care Nurse, The Cyprus Association for Cancer Patients and Friends, Home Care Service, Gregory Afxentiou Avenue, Larnaca, Cyprus.*

Working within the home setting offers both patient and families an improved quality of life. For the health professional the particular setting brings about specific difficulties, which may cause stress and even burnout. This is especially so when infrastructure is still developing as is within the countries of the Eastern Mediterranean.

**Family Dynamics:** Within the Eastern Mediterranean extended families in the home often like to become involved in care and decision-making. Unlike the hospital where only the closest members are involved and present, working in the home one deals with all the extended family members, often complicating the situation. For example, the health professional may be pulled into family conflicts, encounter difficult situations such as anger, jealousy, holding back information and decision making, or demands for increased emotional or physical support from the care team. Families can easily manipulate one staff member off on another.

In the ward situation one has a whole team around to support you there and then, debrief off at the time, alleviating your stress immediately. They may take over a difficult situation that you feel you are not managing or belongs to another discipline. In the hospital there are already limits set and boundaries developed that are expected of the patient and family.

In the home, health professionals often have a more intimate relationship with patient and family due to long-term care and boundaries and limits are much more difficult to set up.

Confrontation with death and suffering can take a toll on any health professional in any setting but due to familiar surroundings of the family in the home and the more intimate relationship the home care team develops with the patient and extended family this feeling of loss may be increased. There is also the issue of powerlessness. The feeling of helplessness often with the family wanting to stay at home but wanting to make sure they have done their all for their loved one, putting stress and pressure on nurses working in the community alone.

**Infrastructure:** If infrastructure is not adequately organized, nurses may feel unsupported and isolated. Lack of resources that is, time and workload, and the feeling you are unable to offer the care you believe most appropriate for the patient causes stress. Lack of equipment to support the patient at home may also be stressful. New members in a developing team are often untrained for this new role in the community, believing one can go from ward to home care with the same nursing knowledge. Unrealistic admission criteria may cause stress. Finally, when infrastructure is developing and patient care the priority the basics are left till last. Unclear role expectations may exist. Procedure manuals, policy, guidelines, and job descriptions, etc are most important to help the nurse become supported in the home.

**Team Conflict:** Team work can always cause conflict with each person having their own work practice, methods, and ethics. Virtual teams such as in home care where communication is even more difficult these problems are increased. There are different expectations by both members of the health care teams as well as the patients and their families. There may be difficulties causing role conflicts and roles may overlap invading persons' work territory. Being in a situation that you haven't been trained for and trying to fill all the gaps such as in services that are developing that haven't got a multidisciplinary team as yet can cause stress as one cannot meet needs adequately.

Finally, we have a particular situation in chronic illness and cancer care. The patient may be cared for by many health professionals in more than 1 team. A hospital team, hospice team, home care team, and the extended family team. Many interactions, misconceptions, miscommunications, and expectations exist, causing friction and stress for all involved.

The main priority to all teams should be **Goal of care.** If all those professionals and family members caring for the patient concentrate on focusing on the needs and goals of the patient then usually conflict reduces and the likelihood of stressful situations may be decreased.

### Oncology Social Work With an Ethnically Heterogeneous Population

Hanan Qasem. *Social Services Department Shaare Zedek Medical Center, Jerusalem, Israel.*

**From my Experience:** I am a Social worker at the Shaare Zedek medical center in Jerusalem, Israel. Shaare Zedek is a private hospital, which is run according to the Jewish religious Laws. While the majority of the patients in our hospital are Jewish, the entire spectrum of Israeli society is represented in the patient population. All receive the same medical, paramedical, and psycho-social care.

I am responsible for the Social work care of the Arabic-speaking patients of the oncology day care unit. At the same time I am the sole coordinator of our hospital's breast-cancer psychosocial treatment program. In this capacity I treat all breast cancer patients, regardless of their age, ethnic background, spoken language, or religion.

**Arab Social Worker Treating Arab Patients in a Jewish-Israeli Hospital:** Social work with oncology patients involves supporting and accompanying the patient and his family from the moment of the initial diagnosis, throughout the various stages of the disease and its treatment, until the final outcome. My role includes certain unique responsibilities inherent to the situation. Most prevalent is my role as a **communications facilitator**. This includes simple language translation, and no less importantly, it involves educating the staff as to cultural influences and nuances in the patient's narrative.

The "simple" language translation is far from simple. In crisis situation it is vital that the patient receive full, clear, and precise information about his or her disease. Translation by a professional social worker includes addressing therapeutic issues at the same time as dispensing important information. One clear result of this approach is that the patients learn to respect and to prefer the professionalism in my translation.

**Advocating** begins with the availability of an Arab social worker. This provides the patients with a sense of security, in that there is someone on staff who understands them and the culture they come from.

**Arab Social Worker Treating Jewish Patients in a Jewish-Israeli Hospital** From my experience, being an Arab treating Jewish patients is not a problem at all. People tend to accept me in my professional capacity, no questions asked.

I never ignore a conflict but never let it get in the way of professional intervention. I am emphasizing "joining" on the most basic level, and the purpose to help, focus on the human universal emotional distress.

Social work with ethnically diversified populations has been extensively addressed in the professional literature and in educating social work students. We are taught the importance of learning about the backgrounds of all of our clients as a prerequisite of true acceptance and respect, which are the foundations of social work practice.

The challenge of overcoming cultural differences is intensified when it is the social worker who belongs to the minority group. This difficulty is eased through the social worker's familiarity with the language, culture, and norms of the dominant group in whose he or she works.

### Burnout Among Nurses Who Treat Pediatric Cancer Patients

Mohammad A. Qubaja. *Head Nurse, Pediatric Oncology, Augusta Victoria Hospital, East Jerusalem.*

Burnout describes the end of result in professional life of nurses or caregivers and combines emotional exhaustion, depersonalization, and low personal accomplishment and in another general definition of burn out as a mental and physical exhaustion, indifference since of failure as professional and since of failure as a person, this problem is common among pediatric oncology nurses and may affect not only personal satisfaction, but also quality of care delivered in patients.

Burn out is particularly relevant in oncology where nurses work closely with patients who have life-threatening illnesses and therapy has limited impact.

The causes of burn out from the nature of the work it self, the work environment, and the characteristic it self of the individual.

Our professional demands that we still try to connect with children have cancer and to meet their needs on a personal level.

How can I do that without losing my ability for function as individual?

### My Experience as a Nurse in a Mixed Hospice in the City of Nazareth

Mali Szaifer, RN, MA. *Home Hospice in the Valleys, Israel.*

Our home hospice provides care for Arab and Jewish citizens of Nazareth aiming to provide high quality, culturally tailored palliative care. Hospice services for Nazareth are provided by a multicultural, multireligious, and multiprofessional team.

Cultural diversity can have both positive and negative impact on team. Diversity can vastly improve productivity via increased creativity, better understanding of the problem, better solutions, better decisions, and increased effectiveness.

In multicultural situations it is common for people to feel that their usual modes of coping are insufficient. They experience what is here called "diversity stress." Today diversity stress is widely experienced in part because key management assumptions involving moral judgments are changing.

Understanding diversity stress as a type of morality stress suggests particular patterns of causation, and of productive and counter-productive reactions on the part of individuals and organizations.

Stress and burnout are among the most common occupational diseases in health care professionals. Psychological morbidity affects both the quality of care delivered to patients and the professional and personal lives of the caregiver.

Looking after staff who care for dying patients and their families is a priority.

While it is common for health professionals to experience emotions such as anger and sadness in the course of clinical care, it is important that these do not result in behaviors, which could compromise the quality of that care.

Recognition of the emotion helps control it to some extent as does accepting the normality of experiencing emotion. Use and content of team debrief; availability of a bereavement counsellor for staff; availability of individual staff mentor, clinical supervisor; and availability of internal and external training for staff. It may also be helpful.

### Burnout in a Pediatric Hematology-Oncology Home Care—A Nurses Point of View

Ronit Wajntraub-Shtayer. *Pediatric Hematology-Oncology, Hadassah University Hospital, Jerusalem, Israel.*

As a nurse I feel myself lucky. I work in the Pediatric Hematology—Oncology department at the Hadassah hospital in Jerusalem and am the nurse in charge of the home care plan. I contribute in my work to patients, family members, and my colleagues: nurses, doctors, social workers, and all other taking part. My work gives me the opportunity to grow personally and professionally. We are a multiprofessional team-colorful in gender, religion, believes, education, and profession.

The home care is a service that is given to children and their families by the hospital. It is a 24-hour–7 days a week service and it is given to patients with no curative prognosis and their families.

It is an independent unit responsible on planning interventions and performing them for the benefit of the child and his family at their home. Coordination is needed between home, hospital, community health services, and others.

Usually home visits are done by the nurse alone and sometimes a social worker comes along. A doctor comes only if called by the family or by the nurse.

These are stressful situations full with emotional ups and downs. **Burnout** is to be expected and experienced on a regularly basis since there are many stress factors involved.

The factors I found most stressful for me are:

**Dealing With Children who are Sick, Suffering, and Dying** on an everyday basis. It is an everyday issue and it is there all the time, even if no patient died today. The meaning of it is "saying goodbye" almost all the time on a constant basis. If a person did not clear with himself subjects like suffering and death working in a pediatric hospice is not for him.

This work is done with **emotional involvement**. Is it demanded?

Is it requested? Is it needed as a skill? No, it is reality.

We get to know our patients, children, and families; their needs, the things they wish for, and the things they don't want to even hear about. We get to know their loves and hates. We get to know them in all their



days and night, in better and worse and we come with no judgmental sentences and with a lot of compassion and care. It uses a lot of our energy: physical and emotional.

It makes putting boundaries harder to families and to ourselves.

**Work and Home Conflicts** are awakened. Work comes home with us and does not go away!!! Our time with the patient and his families spills over. Nurses find themselves phoning and asking about a child from home and coming when the situation is worsening.

But the biggest stressor, from my personal looking is that mainly **I am alone**. As the person the families interact with I have to have updated knowledge in treatments, medications, services available and many other matters concerning that specific child and family. Communication is delicate. On one side hope should be obtained and on the other side things should be realistic with the preparation to the future to come. How do we get them ready and "survive?" Giving a service like a home care unit means I am always on duty, always have the right answer, always adapt myself to others, always kind and patient, mainly always what "they" want from me.

It is a big responsibility to be there and make the best offer for that particular child and family. It is a burden carried on a permanent basis. It is a very stressful feeling being there all alone and I need to bind all my strengths and use everything-everyone to change the feeling of being alone.

What can be done to reduce all these stressful issues?

Can we protect ourselves from burnout?

I find 2 attitudes that help me: the first is sharing with other members of the hospital team my thoughts and feelings, not always waiting for the next day. Second, I let myself be sad, cry, and feel bad after someone's death. Sometimes I even take a day off and do nothing or something just for myself.

### Staff Grief in the Context of Oncology Care

David K. Wellisch, PhD. *Department of Psychiatry, UCLA School of Medicine, Los Angeles, CA.*

This talk attempts to address the issue of staff grief in the context of oncology care in 3 sections. These include: (1) General issues, (2) The Psycho-Biology of Grief, and (3) Complicated Grief. Implications for oncology staff based on these 3 subareas are then addressed.

**General Issues:** Grief issues related to loss, and especially in the oncology work setting, is universal and unavoidable. The repression and suppression of grief makes it even more powerful and potentially damaging. Staff do not feel an equal amount of grief for every patient. Beloved patients are likely to generate more grief via the dynamics of identification and transference. Staff may feel more grief when caring for physicians and nurses, transference parental figures, idealized mates or children, or idealized reflections of themselves. MD's and RN's are likely to admit generally the same frequency of grief but RN's feel significantly more support than MD's for their grief and RN's appear to be less vulnerable to grief related burnout than MD's. Physicians reflect isolation and containment about grief and this becomes more pronounced as they are higher on the ladder of the medical hierarchy. Attending physicians are most likely to talk to no one about patient deaths and to find no one helpful to them in grief support. Physicians were much more likely to talk with each other about a patient death than a spouse or significant other.

**Psychobiology of Grief:** Grief is shown to have psychobiologic effects in several areas of the human physical experience. Cortisol is highly elevated in the context of the grief experience and remains elevated in relation to controls for at least 6 months duration after a loss. In women with chronically elevated cortisol (hypercortisolemia) who were judged to be depressed, they showed significant bone mineral density reductions compared to controls. Immune functions are reduced in bereaved persons over at least a 6-month period, with recovery occurring by the 6-month measurement. In animal research, cortisol elevation in the face of stress was significantly altered and controlled by the presence or absence of a social group. Monkeys who faced stress alone reflected significant cortisol elevations compared to being in groups. Bonding significantly reduced cortisol elevations regardless of sex (male or female). This may have important implications for highly stressed, isolated humans such as staff in oncology settings. Disclosure of stress, even through writing, has been shown to have significant regulatory

effects on immune functions. Doing some disclosure appears better than none, even if in a solitary fashion.

**Complicated Grief:** Complicated grief (CG) will be a likely DSM-IV diagnosis and is the subject of considerable research at present. It represents the clustering of traumatic and separation distress into a unitary factor. Several elements are reflective of CG including: feeling numb, feeling bitter over death, feeling one's future holds no meaning, feeling moving on (after a death) is difficult, and having trouble accepting a death. CG is diagnosed in a minority of those bereaved (10% to 20%) and rates in oncology staffs are unknown at present. CG is likely to have major effects on a small number of oncology staff. Staff with CG are likely to have developmental patterns reflecting: insecure attachments, excessive dependency, compulsive caregiving, and symbiotic marriages. Those with CG are likely to have more medical problems and much more severe psychological symptomatology and distress (including suicidal ideation). CG requires specialized treatment beyond supportive therapy. This can be very effective when targeted to CG.

**Summary:** >Grief is normal and expected in oncology staff. In a minority of staff, grief will become traumatic and complicated. It can have severe biologic and psychologic consequences in staff whom it is complicated and traumatic. Certain patients are likely to stimulate complicated grief in oncology staff. Staff need help in identifying who such patients are for them. Physicians may be more isolated interpersonally than nurses and thus more prone to complicated grief. Higher status physicians may be most isolated of all. Peer and group support appears vital in grief management. Doing something, even alone, is better than doing nothing about staff grief resolution.

### The Psychosocial Basis for Social Work in Oncology

David K. Wellisch, PhD. *Department of Psychiatry, UCLA School of Medicine, Los Angeles, CA.*

This talk attempts to address the psychosocial basis for Social Work in Oncology in 3 sections. These include: (1) services to patients, families, and caregivers; (2) services to institutions, agencies, and units, and (3) services to community. The psychosocial basis for the Social Worker's role in all 3 of these levels of services is addressed.

**General Issues:** Psychosocial issues play a key role in the ability of the patient, family, and caregiver to cope with and adapt to cancer and its treatments and outcomes. The Social Worker is the sole professional in the oncology unit dedicated full time to management of psychosocial issues. Given that Social Workers in oncology settings are consultants, providers of resources, and services deliverers, they face role fragmentation and multiple pulls on their time and energy. The oncology Social Worker stands at the interface between staff, patients, families, hospital administration, and community agencies. As such they must: work the "system," and attempt to "integrate" the system. This defines the term "casework" in social work in oncology.

**Services to Patients, Families, and Caregivers:** The goals of the Oncology Social Worker at this level include: fostering coping and adaptation to cancer and maintaining quality-of-life, assisting patients in navigating through the healthcare system(s), mobilizing new or existing resources for the patient and family, and advocating on behalf of patients and families for their share of resources and their rights. At this level the Social Worker may do general psychosocial assessments, highly specific psychosocial assessments, help develop multidisciplinary care plans, deliver psychosocial interventions, provide case management, provide discharge planning, provide direct material assistance, and advocate to ensure quality care and secure protection of existing laws.

**Services to Institutions, Agencies, and Units:** The fundamental basis of the Oncology Social Worker's role at this level is to contribute to a multidisciplinary effort to provide quality medical, psychosocial care in the context of cancer and its treatments. The Oncology Social Worker at this level attempts to help other disciplines manage stresses of clinical practice. The Oncology Social Worker tries to ensure that institutions and agencies are responsive to the needs of families, patients, and caregivers. This involves "orchestration" of people, resources, and systems. When programs do not exist within institutions for such multifaceted care, Oncology Social Workers may develop such programs, groups, or resources.

**Services to the Community:** Oncology Social Workers have a large and crucial role in elevating community awareness of cancer-related issues and

in developing specialized programs and in developing collaboration between community agencies to deal with cancer patients, families, and caregivers. This has often been focused on efforts to remove barriers to cancer prevention, screening, early detection, and access to care. Oncology Social Workers have a unique perspective in systems, which facilitate the success of such efforts. Oncology Social Workers often consult with community cancer agencies (such as the American Cancer Society) to provide community-based service, education, and program development.

**Summary:** The psychosocial basis for Social Work in Oncology is complex and multifaceted. Psychologically, Social Workers provide

crucial basic support services to individuals, groups, and families to aid in coping with cancer. Socially, Social Workers provide resources for patients, families, and caregivers to deal with cancer both in the hospital, out-patient, home, and hospice settings. Social Workers work at an institutional level and provide crucial consultative input to oncology staffs as well as psycho-social support and stress management to oncology staffs. At a community level, Social Workers in Oncology provide program development and interface between programs and agencies to facilitate patient education, coping, and reduction of barriers to care and support.

## ERRATA

Massimo B, Rosanna P, Roberto A, et al. Extracorporeal photopheresis for steroid resistant graft versus host disease in pediatric patients. *J Pediatr Hematol Oncol*. 2007;29:678–687.

The author names were incorrectly listed as Berger Massimo, MD, Pessolano Rosanna, Albiani Roberto, MD, Asaftei Sebastian, MD, Barat Veronica, MD, Carraro Francesca, MD, Biasin Eleonara, MD, Madon Enrico, MD, and Fagioli Franca, MD. They should have appeared as follows: Massimo Berger, MD, Rosanna Pessolano, MD, Roberto Albiani, MD, Sebastian Asaftei, MD, Veronica Barat, MD, Francesca Carraro, MD, Eleonara Biasin, MD, Enrico Madon, MD, and Franca Fagioli, MD.

Aliefendioglu D, Yilmaz S, Misirlioglu E, et al. Do cerebral blood flow velocities change in iron deficiency anemia? *J Pediatr Hematol Oncol*. 2007;29:747–751.

In this article, the names of two authors were misspelled. The names should have appeared as Sevda Yilmaz, MD, and Semra Saygi, MD.