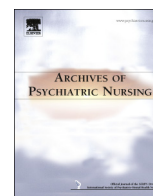




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journal homepage: www.elsevier.com/locate/apnu

Compassion Fatigue in Military Healthcare Teams

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A B S T R A C T

Since the onset of the Iraq war and Afghanistan conflicts, military healthcare teams have had increasing exposure to the traumatic effects of caring for wounded warriors, leading to a phenomenon termed compassion fatigue. The purpose of this integrative review was to develop a proposed definition for compassion fatigue in support of these teams. There is no current standardized formal definition, and this lack of clarity can inhibit intervention. Seven main themes evolved from the literature review and were integrated with the core elements of the Bandura Social Cognitive Theory Model as the first step in developing a uniformed definition.

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Despite the fact that compassion fatigue has been observed in military healthcare teams and discussed in the literature; a specific definition has not been uniformly recognized. Figley (1995) described the term compassion fatigue as natural consequential behaviors and emotions which result from having knowledge about a traumatic event experienced by another person. In an article written by Najjar, Davis, Beck-Coon, and Doebbeling, (2009), they suggested that compassion fatigue usually developed when caring professionals absorbed the traumatic stress of those they help. They also further described that these caring professionals are usually involved in direct care activities supporting traumatically injured individuals at the point of injury. Supporting the occurrence of this phenomenon within military healthcare teams, Voss Horrell, Holohan, Didion and Vance, (2011) observed the existence of a relationship between military healthcare teams who have worked with trauma casualties and an increased prevalence of compassion fatigue.

Since the onset of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Afghanistan conflicts, military healthcare teams have had increased exposure to death, trauma casualties, trauma survivors, and therefore increasing the likelihood of developing compassion fatigue (Stewart, 2009). However the literature is unclear whether there is a related effect to the amount of exposure to trauma casualties and the development of compassion fatigue (Hooper et al., 2010). Nevertheless, the literature is consistent in supporting that over time, the military healthcare member suffering with compassion fatigue is at risk for depression, anxiety, sleep

difficulties, relationship issues and a decline in physical and psychological wellbeing (Linnerooth, Mrdjenovich and Moore, 2011; Stewart, 2009; Voss Horrell et al. 2011). Hagerty et al. (2011) reported data that indicated 20–30% of military personnel deployed to combat environments experienced some type of psychological ramification, including compassion fatigue, which led to a decrease in overall job performance, a decrease in quality of patient care and delivery, an increase in sick time, and decisions to leave the profession.

Defining the phenomena of compassion fatigue in military healthcare teams is imperative. These teams include active duty, reserve, or National Guard licensed nurses, physicians, medics, psychologists, social workers, and chaplains serving in the Air Force, Army, Navy, or public health and who have been involved in the delivery of care supporting casualties of OIF/OEF. This proposed definition is the foundational step needed to explore and develop potential interventions that could be utilized to improve the physical and psychological wellbeing of those that have been identified with compassion fatigue. The purpose of this study is to formulate a clear and uniformed definition of compassion fatigue in military healthcare teams which could be used to further advance future diagnosis and development of effective interventions for this vulnerable population.

BACKGROUND

History of Compassion Fatigue

The term compassion fatigue was first acknowledged in a study related to the concept of burnout in nurses nearly two decades ago. This study also noted that compassion fatigue is most likely linked to all healthcare personnel involved in providing care for patients, and is defined as “a unique form of burnout” (Joinson, 1992, p. 116). At that time, Joinson (1992) conducted a study with nurses in an emergency department setting and identified compassion fatigue as a way to describe the “loss of the ability to nurture” (p. 118).

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Figley (1995) identified secondary traumatic stress as “the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress results from helping or wanting to help a traumatized or suffering person” (p. 15). He also identified compassion fatigue as a more friendly term that is associated with secondary traumatic stress disorder (STSD), which some authors also identified as an outcome of counter-transference resulting from empathic healthcare providers indirectly experiencing the trauma experienced by their patients (Quinal, Harford, & Rutledge, 2009). This concept went on to further be associated with the emotionally related stress that is experienced from the trauma reported by the patient, which Figley described as emotional residual experienced by healthcare providers who work with patients that have experienced suffering or trauma. Dominguez-Gomez and Rutledge (2009) further defined their concept as the provision of caring work performed by the healthcare team that could contribute to the development of compassion fatigue or secondary traumatic stress in this population.

There is no question that working with the victims of trauma forever changes the way healthcare personnel may view the world (Voss Horrell, Holohan, Didion and Vance, 2011). Historically, compassion fatigue has been analyzed by professions other than nursing (Yoder, 2010). Over the years, the concepts of compassion fatigue have received increased attention related to the realm of caregiver stress within different members of the healthcare team. Sabo (2006) posits that compassion fatigue has an acute onset and will result from caring for people who are suffering through a trauma rather than a caregiver working in a toxic work environment, which is often associated with burnout.

The phenomenon of compassion fatigue has evolved over time. During its evolution, it has been identified as a concept that is multi-dimensional, supported by multifaceted definitions with an underlying theme linked to the care of the traumatized individual. Over time, as more has become known about this phenomenon, reports now link compassion fatigue to those in the care-rendering professions, involving the state of tension and the caregiver's desire to relate with his or her patients' mental and emotional needs (Flemister, 2006).

Increased Exposure to Trauma due to Increased Military Operations

Since September 11, 2001, it has been reported that approximately 1.64 million U.S. troops and more than 410,000 citizen soldiers, to include the National Guard, have been deployed for Operations Enduring Freedom/Iraqi Freedom (OEF/OIF) in Afghanistan and Iraq (Stewart, 2009). Most of the troops who continue to serve in the military have completed or are scheduled to complete multiple deployments (Bride & Figley, 2009). In 2009, the reported death toll of U.S. forces deployed to Iraq and Afghanistan surpassed 5,000 Americans killed. Estimates place the number of physically injured U.S. personnel at over 35,000, and no estimate of those psychologically injured is available (U.S. reaches milestone of 5,000 deaths in Iraq and Afghanistan wars, 2009).

To further intensify the impact of the severity of traumatic effects on the healthcare team, most of the combat wounds are not single-site, single injury cases (Vaughn, 2005). These injuries often involve multiple areas of the body with varying degrees of severity. In a study conducted by Bridges and Evers (2009), they described injury characteristics of 3,492 patients transported by air evacuation in the Iraqi and Afghanistan operational areas, as well as patients returning to the United States. Their findings revealed that 69% of the patients had suffered polytrauma injuries.

Increased Involvement of Military Healthcare Teams

From the beginning of war, personnel in the healthcare profession have placed themselves in harm's way, calming the dying, soothing

pain, and providing a sense of calmness to those in distress (Cuellar, 2009). In 2003 the United States began assigning military nurses and other military healthcare personnel to hospitals in Bahgram and Kandahar, Afghanistan, with the mission to support more than 7,000 U.S. and 9,000 coalition forces deployed to Afghanistan (Korzeniewski and Bochniak, 2011). When the U.S. invasion began in late March 2003, military healthcare teams assigned to surgical teams and temporary hospitals moved into Iraq, and immediately started to build a site to receive casualties. Within hours of set-up, the injured and dead began to arrive in triage areas and the morgue (Ruff & Roper, 2005).

In an article by Stewart (2009), he noted that military healthcare teams caring for military personnel wounded and dead in Afghanistan and Iraq were faced with horrific trauma almost every day. Stewart stated that no matter where in the war zone, military members view healthcare teams as highly valued, noting that the presence and comfort provided created a sense of safety in the experience for the wounded. Without question, engagement in a combat zone and purposefully placing oneself in harms' way can be very stressful. By virtue of their professions, the military healthcare teams are placed on the front line to care for the injured and dying. The exposure to traumatic injury and death could lead to an increased risk for developing compassion fatigue. Stewart (2009) further identified various traumatic scenarios that military healthcare teams faced when in a combat environment. These included military operations, accidents, car bombs, mass casualties, and mortar attacks. Stewart stated that given this unique environment, if the military healthcare team continues to perform direct care activities without adequate intervention to support their own personal wellbeing, this exposure to death and injury, in time, may result in feelings of helplessness.

In a research study conducted by Hagerty et al. (2011), they stated that similar to the military members that were injured, military healthcare personnel caring for the injured also dealt with various stressors. In this study, Hagerty and colleagues identified several situations encountered by military healthcare personnel that generated stress. These included deployment, fatigue, increased workload, and distress involved in caring for those patients with severe physical and emotional trauma. Involvement with a patients' family, patient anger, and dying military personnel were also identified as factors contributing to stress. Many different circumstances predispose deployed military healthcare teams to the development of compassion fatigue. Stewart (2009) reported that they generally work 12-hour shifts, 6 days a week, without scheduled days off for holidays; and constantly remain alert for personal safety protection and for the responsibility to render care to the injured. It was also noted that their sleep pattern was rarely normal, and that they may be roused at any time to return to duty for a mass casualty occurrence or as a response to alarms sounding off and instructions broadcast from speakers in the compound, alerting them to find shelter for protection against incoming fire or mortars.

In a 2008 study by the U.S. Department of Defense Military Health System, factors that may cause a negative effect on the emotional, psychological, and physical level of deployed military healthcare teams were identified to include separation from their family, difficult living conditions, chronic and increased feelings of danger, physical requirements related to their job, and overall limits to ones sense of effectiveness. All of these risk factors increased stress levels and negatively impacted the state of mind and ability to function at optimal levels. In this study, the authors also noted that military healthcare teams worked long hours in the combat zone, far too often threatened by possible injury or death, in an attempt to provide the highest quality care to casualties that were severely wounded. It was described in this study that military healthcare teams were there to care for the welfare of the military member, and each year, there are hundreds of military healthcare teams that volunteer or are sent to combat zones.

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