Casualties of War: Compassion Fatigue and Health Care Providers

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“Ours nights are broken by sounds of nearby mortars, the drone of medevac (medical evacuation) helicopters, and endless nightmares. Each new day brings us more patients who wrench our hearts. Then we get up and do it all again. We’ve become intimately familiar with the brutalities of war” (Duncan et al., 2005, p. 62).

Medical personnel serving in Iraq and Afghanistan frequently think, and sometimes utter, these or similar words. This quote provides a glimpse of the battle against death, human destruction, and suffering that deployed health care providers fight every day.

Medical personnel are charged to render emergency care to anyone who arrives at the medical treatment facility regardless of its location. Without exception, they must provide that care consistently and conscientiously. Given the variety of patients and injuries, sometimes achieving this standard causes distress for health care providers. Incoming patients may include American military personnel, coalition troops, contractors, non-combatant Iraqis or Afghans, and insurgents. The patients run the gamut from infants to adults, males and females.

Having to turn away patients also creates stress for health care providers. The primary mission of medical units is the care of American Soldiers and, because resources are limited, other injured persons who are not at risk for loss of life, limb, or eyesight are sometimes turned away (Duncan et al., 2005). The stress that accompanies the provision of medical care for the casualties of war and the decision regarding who gets care, as well as personal circumstances of the care providers, produce their own casualties. As an occupational hazard, some doctors, nurses, medics, and other hospital personnel fall victim to compassion fatigue.

Compassion Fatigue Defined

“Compassion fatigue describes the emotional, physical, social, and spiritual exhaustion that overcomes a person and causes a pervasive decline in his or her desire, ability, and energy to feel and care for others” (McHolm, 2006, p. 12). No medal is given for these wounds and acknowledgment of the condition is often missed. The wounds nevertheless are present and the suffering, without intervention, can continue to affect an individual for a lifetime.

The phenomenon of compassion fatigue (also called secondary traumatic stress syndrome, secondary victimization, secondary survival, emotional contagion, counter-transference, or provider fatigue) is similar to post-traumatic stress disorder (PTSD) and burnout. In all these maladies, the victim is affected emotionally and psychologically by events associated with the workplace. However, while compassion fatigue, PTSD, and burnout all require attention and intervention, significant differences exist among these conditions (Linley & Joseph, 2007).
Post-Traumatic Stress Disorder

Described as a psychiatric disorder, PTSD (shell shock, combat neurosis, or war neurosis) occurs as a result of experiencing a traumatic event. Typical events that can result in PTSD include “combat, physical attack, sexual assault, torture, severe abuse, transportation accidents, and natural disasters” (Regan, Hagwood, Hamer, & Wright, 2006, p. 40). Essential to the diagnosis of PTSD is the individual's personal experience of the traumatic event. The re-experiencing of the traumatic event must include intense fear, horror, or helplessness, and is characterized by avoidance, emotional numbing, and increased arousal (Howard-Rubin, 2002).

PTSD is recognized widely as a psychological war wound, and its effects have been studied for decades. A 2009 study at Walter Reed Army Medical Center “found that 18% of Soldiers returning from Iraq and 11% of Soldiers returning from Afghanistan were at risk for PTSD” (Glasch, 2007, p. 28). Harben (2007, paragraph 6) suggested, however, that “15% to 30% of Soldiers returning from Iraq experience post-traumatic stress symptoms or other mental-health symptoms.” Regardless of these assertions and findings, “the Army’s statistics indicate that the active-duty diagnoses of PTSD have nearly doubled in the last 2 years” (Chedekel, 2007, p.1). The mental health community and others have estimated that this trend will continue as more Soldiers serve more than one tour in a combat area. In fact, one recent Army study found that “Soldiers who had deployed to Iraq more than once were more likely (24% as compared to 15%) to screen positive for PTSD symptoms” (Chedekel, 2007, p.1). Consequently, the increase in military front-line personnel deployed to Iraq and Afghanistan suggests there will be more health care providers deployed as well. Additionally, especially among low-density medical specialties within the Army Medical Command, the Department of Defense will deploy more health care providers more than once, which will increase their risk for developing stress reactions. The stress reaction most likely experienced by these personnel is compassion fatigue — “the emotional burden of being exposed to traumatic events of patients” (Finke, 2006, p. 2) — rather than firsthand experience of the event.

Burnout

Burnout is “a subtle process in which an individual is gradually caught in a state of mental fatigue and is completely empty and drained of all energy” (Espeland, 2009, p. 178). Maslach described burnout “as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (Espeland, 2006, p. 178). Anyone who experiences distress and aggravation in the workplace, regardless of profession or position, may experience burnout (Flemister, 2006). Symptoms of burnout include the individual becoming withdrawn and less empathic, and displaying negative behaviors toward co-workers and sometimes patients. It sometimes appears as if the care provider is angry with and blames the patients for becoming ill or requiring his or her services. Generally, burnout is cumulative and has a predictable course. As opposed to compassion fatigue, the remedy for burnout may be a vacation, time off, or a change in jobs or employment.

Compassion Fatigue Consequences

Compassion fatigue occurs when a caregiver closely identifies with the patient to the point of absorbing the patient's trauma or pain (McHolm, 2006). It results from giving high levels of emotional energy to patients without seeing the outcomes. The onset is insidious, and the disorder may take weeks or years to develop. Compassion fatigue affects only those in the care-rendering professions: it involves a state of tension and the caregiver's preoccupation with his or her patients' medical and emotional needs (Flemister, 2006).

Over time, the health care provider suffering the effects of compassion fatigue is at risk for depression, anxiety, sleep difficulties, relational conflicts, and ultimately, a decline in physical and emotional health. As a result, the affected individual impacts the operations of the organization and its functioning in a variety of ways. A decline in personal job performance and efficiency, a rise in errors and sick time, and a disruption in the morale of the unit may result (McHolm, 2006). Compassion fatigue can account for a caregiver leaving the organization as well as leaving the profession all together.

Military Health Care Professionals and Compassion Fatigue

"Nurses and other health care professionals caring for military personnel wounded [and dead] in Afghanistan and Iraq deal with horrific trauma almost every day" (Vaughn, 2005, p. 1). Their professions place these health care providers on the front line and increase their risk for developing compassion fatigue. At any given moment, they must care for war casualties with unimaginable wounds. They not only provide care for their own country's wounded, but they also provide care for anyone coming to their location for assistance. Medical personnel see and deal with the full range of trauma, including accidents, car bombs, mortar attacks, military operations, and mass casualties. In the end, they must deal with the finality of death and the sense of helplessness to prevent it. Regardless of the demographics, the political persuasion...
of the injured, or the personal feelings of the care providers, medical personnel must care for the injured and handle the deceased respectfully.

Many mitigating circumstances predispose deployed medical unit personnel to developing compassion fatigue. They generally work 12-hour shifts, 6 days a week, without scheduled days off for holidays. The events of each day seem the same. The movie “Ground Hog Day,” in which the main character experiences the same day repeatedly, is a good illustration of their routine. Personnel remain constantly alert for self-protection and for the call to render aid. Their sleep rarely is sound, and they may be roused at a moment’s notice to return to duty during a mass casualty event or in response to the sound of “bunkers” emanating from a loudspeaker.

According to Vaughn (2005, p. 1), “The youth of their patients and the horrendous nature of patient injuries can take an emotional toll on military caregivers.” Casualties arrive via fighting vehicles, private automobiles, ambulances (military and civilian), and on foot. At best, their wounds are covered with something; at worst, their wounds are exposed with internal organs visible. These types of wounds are rarely, if ever, seen in the emergency rooms of stateside hospitals but are common occurrences for deployed medical personnel. To compound the situation, most of the wounds are not single-site, single-injury cases (Vaughn, 2005). They involve multiple areas of the body with varying severity. Sometimes their care requires more than one team to provide attention to the casualty simultaneously. Sometimes, the patient does not survive.

Other factors that affect the emotional, psychological, and physical comfort level of deployed personnel include the separation from family, living conditions, chronic danger, the physical demands of the job, and limits to effectiveness. All these factors increase their stress level, and take a toll on their state of mind and ability to function at an optimal level (U.S. Department of Defense Military Health System, 2008).

The typical first-line health care provider in a deployed unit is generally ages 18-30. For younger individuals, their life experiences generally are minimal and their coping skills perhaps are not matured fully. These care providers see casualties in their own age group and younger on a routine basis. They see firsthand the awfulness of war and come face-to-face with their own mortality. For some, that is a defining moment. Because of these circumstances, the propensity to develop compassion fatigue is high (U.S. Department of Defense Military Health System, 2008; Vaughn, 2005).

Symptoms generally associated with compassion fatigue include withdrawal from others, avoidance of intimate relationships, decreased empathy and devaluing of others, outbursts with little provocation, heightened irritability, flashbacks of traumatic events, and hopelessness (Kraus, 2006). More specifically observable signs and symptoms associated with compassion fatigue include changes in appetite, sleep disturbances, mood, excessive working, difficulty making decisions, increase in gastrointestinal upsets, and headaches (Flemister, 2006; Vaughn, 2005).

Methods of Prevention

Prevention of compassion fatigue should be emphasized more than intervention. Methods to prevent the condition may take the form of increasing awareness through education, and alert intervention by supervisors and co-workers. Professionals in danger of developing compassion fatigue should be taught that it is a normal response to the situation, and they should pay attention to the signs and symptoms that may indicate its development. Strategies to minimize compassion fatigue can take two forms: individual and organizational (Huggard, 2003; Panos, 2007).

**Individual Self-Care Techniques**

Individuals should be encouraged to use self-care techniques to lessen the potentially harmful effects of their work. These techniques include spending time in self-reflection or meditation, perhaps reconnecting with a spiritual source to assist in achieving an inner balance. Journaling can assist personnel in making sense of the chaos and their feelings, controlling the impact of their thoughts about traumatic events. Deliberately determining not to dwell on negative thoughts, instead focusing on what was done right rather than what went wrong or who to blame, assists individuals to manage their stress. Other stress management techniques include taking care of physical needs, such as getting adequate rest, exercising, establishing routines, nurturing interests and friendships, and accepting professional and personal limitations. Finally, talking with a trusted person about the distressing clinical situation to get a different perspective, clarification of events, and maintenance of realistic boundaries also is beneficial. If all else fails in assisting affected individuals to manage this malady, professional help should be sought (Panos, 2007).

**Organizational Techniques**

The organization and its leaders play a role in mitigating the effects of compassion fatigue among personnel as well. Leaders should develop a supportive, caring workplace environment that is protective of the staff as well as the
Casualties of War: Compassion Fatigue and Health Care Providers

patients (Huggard, 2003). An educational program that alerts health care providers to the perils and propensity of medical personnel to develop compassion fatigue is helpful. Signs, symptoms, and treatment methods should be discussed. It is important to make individuals aware that compassion fatigue is not a personal failing. Managers should observe deployed staff members closely for signs and symptoms of compassion fatigue, and take quick action.

Leaders should minimize staff stress by keeping them as informed as possible about events that may affect their lives. Leaders should demonstrate their concern for staff members, promote team cohesion, and role model the sense of control. During a deployment, debriefing sessions for staff members should be provided as soon as possible following an especially stressful event (such as a death of a child, or mass casualty). Mental health care staff members trained to provide such assistance should be utilized. If a mental health care provider is not readily available, a chaplain’s service may be used. When possible, staff members should be given additional time off (even if only a few hours) to regenerate and perform self-care activities; if that is not possible, a change in work location or duties can be beneficial. Leadership is a key variable in decreasing the impact of stressful events on staff (Ehrenreich, 2004).

Conclusion

Unlike PTSD, compassion fatigue does not result from a personally experienced traumatic event. Unlike burnout, it is not the result of prolonged, accumulated job stress and exhaustion that can be relieved by a job change or a vacation. Compassion fatigue is “an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper” (Gould, 2005, paragraph 1). Persons in the helping professions are prone to develop this condition.

Both the individual and organizational leaders must take steps to prevent or treat this debilitating malady. Individuals should be aware of their vulnerability for compassion fatigue and participate in self-care activities (meditation, self-reflection, journaling, conversing with a trusted friend) to lessen the effects. Leaders must design environments of caring and institute programs (educational and therapeutic) to support and protect their staffs.

The military recently developed mechanisms for detecting mental health difficulties in its members and obtaining assistance for personnel during deployments as well as upon redeployment. While not a mental illness, compassion fatigue can lead to mental health difficulties. Avenues used to obtain assistance for those suffering with PTSD (leadership, primary health care provider, self-referral) also are available for those suffering with compassion fatigue. The effects of compassion fatigue can leave a mark on the individual and the organization, resulting in broken homes and broken people. The continued combat and casualties seen by the health care providers represent a fertile ground for developing compassion fatigue. Health care providers must help themselves in order to help their patients.

References

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