Chapter 23

PROVIDER FATIGUE AND PROVIDER RESILIENCY TRAINING

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INTRODUCTION

The effects of caring for traumatized individuals have been characterized in numerous ways and given different names over time during many traumatic events. Although each of these concepts was originally developed in a specific context with individual nuances, they have also been used interchangeably in connection with the phenomenon of secondary trauma—the reaction of caregivers to the traumatic events experienced by those they serve. Current military behavioral healthcare providers have built on the efforts of their predecessors, who have attempted to capture and understand the effects of trauma through the years. Providers are resilient by nature and military providers are especially so, as seen in their focusing, building, and reinforcing the resilience in achievable balanced health.

All members of the Department of Defense—soldiers, sailors, airmen, marines, and civilians—have been affected by the global war on terror. The US military has developed many programs and services to aid military personnel and their families, addressing psychological, spiritual, and physical recovery; however, only a few programs are directed toward caregivers. One such program is Provider Resiliency Training (PRT), created and implemented by the Soldier and Family Support Branch at the Army Medical Department (AMEDD) Center and School at Fort Sam Houston, Texas.

PRT has three phases. During the first phase of training, all care providers throughout the medical command (MEDCOM) watch a video on PRT and take the Professional Quality of Life (Pro-QOL) Scale (discussed in detail in this chapter). This phase takes approximately 30 minutes to complete. The second phase of PRT involves the development of initial self-care plans by all MEDCOM medical treatment facilities' staff, and takes about 2 hours to complete. The third phase—annual maintenance of the plan—is completed during the care provider's birth month and is used to readminister the Pro-QOL screening tool completed during the first phase. This allows trainers to review those results with individual participants. This third and final phase takes about 1 hour to complete.

PRT is a comprehensive course in definitions, concepts, models, and methods for dealing with provider fatigue. This training is designed for audiences at all levels of care provision. The first half of the introduction to PRT defines and clarifies the challenge of compassion fatigue/provider fatigue and the "cost of caring," as well as principles of practical holistic renewal. The second half is focused on strength and resiliency: How do individuals stay strong? Where does resiliency come from? How might resiliency be encouraged in self, colleagues, systems, and soldiers?

Like a mental gymnasium geared toward the overall fitness of caregivers and the development of their resiliency in the face of challenges, PRT aims to help providers find the inner strength to face fear and adversity with courage. Furthermore, PRT is focused on military providers who care for those who have experienced suffering and trauma. The stress of contemporary combat and operational environments is unlike that experienced by physicians, nurses, or chaplains in the civilian sector.

TERMS AND DEFINITIONS

A number of terms have been used to capture secondary reactions to trauma, including "burnout,"[1] "secondary victimization,"[2] "secondary traumatic stress disorder,"[3–7] "secondary survivor,"[8] "vicarious traumatization,"[9,10] "traumatic countertransference,"[11] and "compassion fatigue." A similar concept, "emotional contagion," is defined as an affective process in which "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions."[12(p338)] Furthermore, "rape-related family crisis"[13,14] and "proximity effects" on female partners of war veterans[15] are related concepts. The generational effects of trauma[16,17] and the need for family "detoxification" from war-related traumatic stress[18] have been noted. Finally, difficulties with client problems have been considered as simple countertransference and discussed within the context of posttraumatic stress disorder (PTSD) treatment.[2,11,19,20] However, the concept is difficult to measure or to separate from other factors of client-therapist transactions.

Historically, compassion fatigue, compassion stress, vicarious traumatization, secondary PTSD, and the current military concept of provider fatigue all involve the empathic connection with people experiencing the emotions of trauma, resulting in the provider experiencing the same emotions. Provider fatigue is related to the other concepts, primarily compassion fatigue, previously the latest in an evolving concept known in the field of traumatology as "secondary traumatic stress." Most often this phenomenon is associated with the "cost of caring"[3] for others in emotional pain.

The term "provider fatigue" was first used in 1992 by Joinson,[21] who described nurses worn down by

daily hospital emergencies. The same year, in his book *Compassionate Therapy*, Kottler[22] emphasized the importance of compassion in dealing with extremely difficult and resistant patients. However, neither publication adequately defined "compassion." Most past research emphasized only why practitioners lose compassion as a result of working with the suffering. On the other hand, some people, including military care providers, may feel that it is wrong for a practitioner to have deep feelings of sympathy and sorrow for a client's suffering. And practitioners certainly must understand their limitations in helping to alleviate the pain suffered by patients.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed)[23] notes that PTSD is possible when one is traumatized either directly (in harm's way) or indirectly, for example, as a parent witnessing a child's injury. Those involved in both types of incidents may experience trauma, although through different social pathways. The latter pathway is called "secondary traumatic stress." Few reports of the incidence and prevalence of this type of stress reaction exist; however, based on secondary data and theory analysis, it is possible that burnout, countertransference, worker dissatisfaction, and other related concepts may have masked this common problem.[2] Vicarious traumatization, for example, refers to a transformation in the therapist's inner experience resulting from empathic engagement with clients' trauma material. These effects are cumulative and permanent, and evident in both a therapist's professional and personal life.[10] Compassion or provider fatigue is a more user-friendly term for secondary traumatic stress disorder, which is nearly identical to PTSD except that it affects those emotionally affected by the trauma of another (usually a client or a family member). Terms as used in this chapter are defined as follows:

- **Primary traumatic stress** results from stressors inherent in an extreme event—what was immediately experienced or witnessed, especially things that contributed most to a traumatic response. For example, the military healthcare provider may be in danger of direct fire while assisting fellow soldiers.
- **Compassion stress** is the residue of emotional energy from the empathic response to the client, as well as the ongoing demand for action to relieve the client's suffering. It flows from having an empathic, caring response. Together with other factors it can contribute to provider fatigue unless the provider acts to manage the stress.
- **Compassion or provider fatigue** is the emotional residue or strain of exposure from working with those suffering the consequences of traumatic events. A form of secondary traumatic stress—compassion or provider fatigue—is the result of a healthcare provider engaging in the treatment of individuals exposed to various traumas. It is natural and normal for providers to experience compassion fatigue; if a provider is doing a job well, it is normal to feel fatigued, similar to an athlete feeling fatigued after a good workout. Provider fatigue should be expected, mitigated, and processed by every professional caregiver.
- **Burnout** is a cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress. Burnout is not necessarily trauma-related; it can occur in any job with an ongoing overwhelming workload. Burnout occurs when a person loses the ability to care.
- **Resiliency** is the ability to recover rapidly from illness, change, or misfortune. (In objects, it is the ability to regain the original shape after being bent, stretched, or compressed.) Resiliency occurs on a continuum (it is not an either/or proposition) and relates to a person's overall growth and development. Resiliency is about who the person is, while stress management is about what that person is doing; however, a provider's level of resiliency is evident in how he or she responds to stressors. Resiliency grows through healthy responses to stressors.

FIGLEY'S COMPASSION FATIGUE MODEL

In 1995, Charles Figley, a former Marine and leader in the field of traumatology, created a model of compassion fatigue delineating how exposure to suffering and an empathic response can lead to compassion stress and compassion fatigue.[24] The same experiences can be seen in the area of provider fatigue, and will be further discussed in the next section. Elements in the model include the following:

- **Emotional contagion** is experiencing the feelings of the sufferer as a function of exposure to the sufferer.
- **Empathic concern** is the motivation to respond to people in need.

- **Empathic ability** is the aptitude for noticing the pain of others.
- **Empathic response** is the extent to which the helper makes an effort to reduce the suffering of the sufferer.
- **Disengagement** is the extent to which helpers can distance themselves from the ongoing misery of the traumatized person.
- **Sense of achievement** is the extent to which helpers are satisfied with their efforts to help the client/sufferer.
- **Compassion stress** is the compulsive demand for action to relieve the suffering of others.
- **Prolonged exposure** is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time.
- **Traumatic recollections** are memories that trigger the symptoms of PTSD and associated reactions, such as depression and generalized anxiety.
- **Life disruption** is the unexpected change in schedule, routine, and managing life responsibilities caused by experiences that demand attention (eg, changes in health, lifestyle, social status, or professional or personal circumstances).
- **Compassion fatigue** is the state of tension and preoccupation with the traumatized by (*a*) reexperiencing the traumatic events; (*b*) avoidance/numbing of reminders, and (*c*) persistent arousal. It is a natural consequence of behaviors and emotions resulting from knowing about a traumatizing event experienced by another.
- **Compassion trap** is the inability to let go of the thoughts, feelings, and emotions useful in helping another, long after they are useful.[24]

It is thought that "other-centered" people, who are good at providing care, are vulnerable to compassion fatigue. Those without as much compassion suffer these effects less dramatically. The first author of this chapter conceptualizes this as follows: "the caregivers' gift is their burden." Being a compassionate person is helpful in the healing process, but that compassion may become a challenge if it is not balanced by resiliency.

Providers who are strongly empathetic may be most at risk of provider fatigue. No provider witnesses trauma in the abstract; for those who are strongly empathic it can be, and is, personal. The actual experience is felt vicariously as pain, with a consequential psychological impact. Often providers do not see self-care as a priority, which places them in jeopardy of burning out.

Another factor that puts the provider at risk for secondary traumatization is a personal history of trauma. When providers have experienced a significant loss in their own lives, the experiences and images of trauma may trigger those memories and stimulate fresh grief. Many providers are secondary witnesses to trauma on a regular basis. As witnesses and providers, they are vulnerable to the emotional pain of victims. Providers picture bits and pieces of the trauma in their minds and may experience intense feelings in their bodies.

Many military providers are both participants in the trauma (eg, being shot at) and caregivers of others affected. Figley summarized these experiences by noting that helping the traumatized can itself be quite traumatizing. An Army chaplain related the story of being part of a convoy in which a vehicle in front of him was blown up. He was in imminent danger himself. As he participated in helping his comrades through the trauma and debriefing that followed it, he found himself alone, wondering who would help him. He turned to his God and returned to camp. The next day was Sunday and his job took him to the pulpit, where he delivered an inspiring sermon to the soldiers he served.[25] The point made is that one may be in the face of danger, help those in danger, be alone in danger, and then rise the next day to serve those in danger. This situation occurs in the life of the military care provider on a regular basis.

FACTORS CONTRIBUTING TO COMPASSION STRESS

Empathic responses in the provider occur when the ability and desire to help others converges with exposure to suffering. Compassion stress flows from having an empathic, caring response to the work or to those who suffer. It is how providers feel (physically and/or emotionally) the trauma of the patients with whom they are working. For example, hearing of terrible abuse stirs within the provider a feeling of disgust and gastrointestinal upset. The level of stress is determined by how much the provider relates to or identifies with another's suffering and trauma. The following characteristics, based on Figley's model, often propel people to become healthcare providers, yet also predispose them to experience compassion stress: (*a*) the ability to be empathic, (*b*) the desire to help, and (*c*) the level of exposure to suffering. The chances of experiencing compassion fatigue are reduced to the degree that these features are lacking.[2,24]

- **Empathic ability** is the aptitude of the provider for noticing the pain of others. Figley's model suggests that without empathy, providers experience little if any compassion stress and no compassion fatigue. However, without empathy they feel little if any empathic response to suffering clients. Thus, the ability to empathize is key both to helping others and being vulnerable to the costs of caring.
- **Empathic concern** is the motivation to respond to people in need. The ability to be empathic is insufficient unless motivation exists to help others who require the services of a concerned psychotherapist. With sufficient concern, the empathic provider draws upon his or her talent, training, and knowledge to deliver the highest quality of services possible to those who seek it.
- **Exposure to the client** is experiencing the emotional energy of client's suffering through direct exposure. Mental health professionals directly employed in human services may decide to become supervisors, administrators, or teachers because of the costs of direct exposure to clients (of course, determining individual motivation is difficult, and some make the shift from direct practice because of additional pay, improved working conditions, and higher status).[24]
- **Empathic response** is the extent to which the provider makes an effort to reduce the suffering of the client through empathic understanding. This insight into feelings, thoughts, and behaviors of the client is achieved by projecting one's self into the perspective of the client. In doing so, the provider might experience the client's hurt, fear, anger, or other emotions. Therein lie both the benefits and the costs of such a powerful therapeutic response. The benefits are immediately obvious to every provider who practices his or her skills with another. The benefit for the provider is that a sense of bonding and understanding with the hurting person may emerge. This may be demonstrated by the latter feeling understood and having the pain/trauma be normalized by the provider's expression of empathy. The costs, rarely discussed, must be experienced for the provider to guard against or mitigate the effects.
- **Compassion stress,** the residue of emotional energy from the empathic response, is experienced as an ongoing demand for action to relieve the client's suffering. As with any stress, compassion stress with sufficient intensity can have a negative effect on the immune system and quality of life. Together with other factors, this stress can contribute to compassion fatigue unless the psychotherapist acts to control it. Two major types of coping actions appear to help control compassion stress:
  - A **sense of achievement,** the extent to which providers are satisfied with their efforts to help the client, can lower or prevent compassion stress. Having a sense of achievement involves a conscious, rational effort to recognize where the provider's responsibility ends and the client's begins.
  - **Detachment,** the extent to which providers can distance themselves from the ongoing misery of the client between treatment sessions, can lower or prevent compassion stress. The ability to disengage also requires a conscious, rational effort to recognize that to live their own lives providers must "let go" of the thoughts, feelings, and sensations associated with clients. Disengagement is the recognition of importance of self-care.[24]

Compassion stress can also be mitigated by both individual and unit management of stressors. If there is a sense of achievement, an ability to disengage, and the stress is well managed, the stress will be maintained at normal levels. If these are insufficient or not present, then the level of stress will rise. If compassion stress is permitted to build, despite the provider's effort at disengagement and a sense of work satisfaction, the provider is at a greater risk of compassion fatigue. Three other factors play a role in increasing compassion/provider fatigue:

1. **Prolonged exposure** is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time (eg, multiple sessions with one individual or multiple contacts from large-scale disasters such as the 2004 tsunami in Asia). To prevent prolonged exposure, providers should have regular breaks from client appointments, lasting from a day off to a week's vacation.
2. **Traumatic recollections** are memories that trigger symptoms of PTSD and associated reactions, such as depression and anxiety. These memories may be from the provider's experiences with either demanding or threat-

ening clients, clients who were especially sad or suffering, or clients with experiences that have a connection to traumatic events experienced by the provider.

3. **Life disruptions** are unexpected changes in schedule, routine, and managing life responsibilities that demand attention (eg, personal home-front concerns while at war; illness; or changes in lifestyle, social status, or professional or personal responsibilities). Normally such disruptions would cause a certain but tolerable level of distress. However, when combined with the other factors, these disruptions can increase the chances of the provider developing compassion fatigue.[24]

SYNERGISTIC EFFECTS OF PROVIDER FATIGUE

For the military healthcare provider, numerous sources of stress may come together to bring about provider fatigue. Although the primary ingredient of provider fatigue is unmanaged compassion stress, operational stress also contributes to the provider fatigue of military healthcare providers, as well as chaplains, support staff, and family members. Unresolved primary traumatic stress, secondary traumatic stress, and burnout, when added to unmanaged compassion stress, directly affect the overall level of provider fatigue. For example, providers may experience burnout from a continuously heavy workload (unrelated to trauma); secondary trauma from repeated exposure to the suffering of coworkers or family members; or primary trauma in the form of direct or indirect fire in a war zone, or the sights, smells, and sounds of providing direct humanitarian care. The interactive effect of different types of stressors can shape the overall development of provider fatigue. Military healthcare providers are at increased risk of provider fatigue because of both exposure to others' suffering and the risk of personal injury or death.

For many military providers, symptoms of secondary traumatization have a delayed onset. Many providers also have prior traumatic experiences that may cause no symptoms until associated with the stressors of working with traumatic material presented by patients. Some may develop clinical PTSD-like symptoms associated with their previously "benign" historical experiences. It is often necessary to resolve primary traumatic stress before addressing any issues of secondary stress or burnout.

Primary stress, secondary stress, operational stress, and burnout symptoms have a synergistic or interactive effect with compassion stress (Figure 23-1). Experiencing symptoms from any one of these sources appears to diminish resiliency and lower thresholds for the adverse impact of the stressors, which can in turn lead to a rapid onset of severe symptoms that can become debilitating to the provider within a very short period of time. The experiences of military providers differ from those of civilian providers because of danger while delivering service, multiple deployments, working with detainees, cultural differences, and lack of time for reprieve. Military-specific operational stress includes

- lack of reprieves, breaks, and exits during operations;
- experience of primary trauma while helping others;
- a cumulative effect of the provider's and clients' repeated deployments;
- isolation and relational issues;
- ethical issues, such as determining who the client is; and
- competing demands for treatment of the client versus the provider.

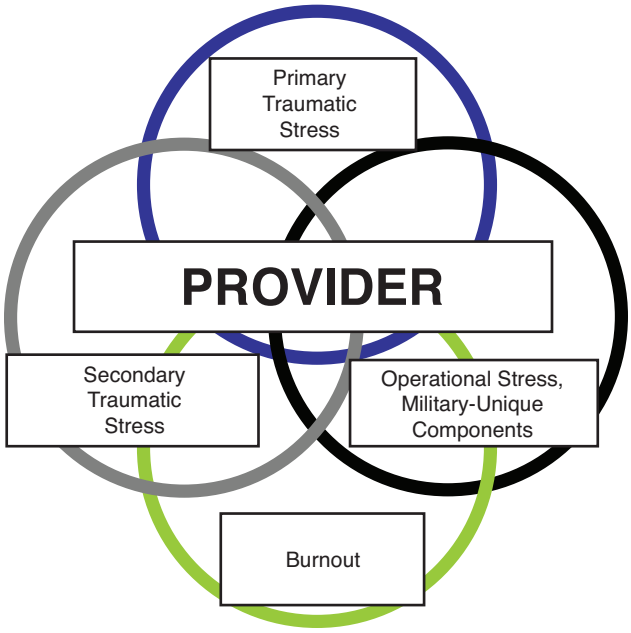

Figure 23-1. Synergistic effects of primary, secondary, and operational stress, combined with burnout symptoms, on providers.

WAYS TO IDENTIFY PROVIDER FATIGUE

Symptoms of provider fatigue may include withdrawal from family and friends; emotional numbing; loss of interest in things usually enjoyed; persistent thoughts and images related to the problems of others; physical symptoms such as headaches, gastrointestinal disturbances, and muscle tightness; sleep disturbance; and jumpiness.

Markers

Healthcare providers must monitor themselves and coworkers for the following markers. The more markers observed or felt, the greater the risk of provider fatigue. The markers fall into the categories of cognitive, emotional, behavioral, spiritual, somatic, and social.[2]

Cognitive Markers

- Intrusive thoughts and disturbing memories
- Preoccupation with trauma
- Lowered concentration
- Disorientation
- Thoughts of self-harm or harm to others
- Reduced sense of safety

Emotional Markers

- Powerlessness
- Anxiety or fear
- Anger
- Survivor's guilt
- Numbness or inability to feel emotions
- Sadness
- Emotional roller coaster
- Feelings of depletion, being run down, or out of steam
- Irritability
- Decreased self-esteem

Behavioral Markers

- Impatience
- Being snappy or short tempered with others
- Poor sleep
- Nightmares
- Appetite changes, eating more or less than normal
- Being jumpy or on edge; startling easily
- Being accident prone
- Losing things
- Being rigid or inflexible, wanting to do everything the same way
- Using ineffective or harmful self-care practices

Spiritual Markers

- Loss of hope
- Loss of purpose
- Anger at God
- Questioning prior religious beliefs
- Skepticism toward religion
- Reduced joy and sense of purpose with career
- Loss of compassion

Somatic Markers

- Shock
- Rapid heartbeat and sweating
- Breathing difficulties
- Aches and pains
- Dizziness
- Impaired immune system; being more prone to illness
- Exhaustion
- Gastrointestinal problems and headaches

Social Markers

- Decreased interest in emotional intimacy
- Mistrust and isolation
- Being overprotective as a parent or as a leader; not allowing others to have normal activities
- Loneliness
- Increased interpersonal conflicts
- Trouble separating work from personal life

Behavior Changes After Exposure to Trauma

Numerous problems including absenteeism have been documented after exposure to trauma. This is a real phenomenon that can affect military healthcare providers and their ability to do their jobs. In a mixed method study by Regehr, Goldberg, and Hughes,[26] emergency workers routinely exposed to pain and suffering were examined to better understand factors leading to higher levels of distress within the theoretical framework of emotional and cognitive empathy. Researchers found a significant increase in alcohol-related problems, an increase in mental health stress leave, and an increase in use of psychiatric medications after these providers were exposed to a traumatic event. The

study concluded that paramedics, who are exposed to many events outside the everyday experiences of the average person, have for the most part learned to deal with the events and take them in stride. A coping technique commonly used by paramedics is to deal with the events cognitively and technically while maintaining an emotional distance. At times, however, certain circumstances lead workers to develop an emotional connection with events based on their awareness of other aspects of the patient's experience. Aspects that can trigger this connection include the victim's alienation from others, profound loss, or the abuse of an innocent child. When this connection occurs, paramedics report increased symptoms of traumatic stress.[26]

Provider fatigue can be recognized on the job by its effects on work performance, morale, behavior, and relationships.[2]

Effects on Work Performance

- Decreased quality
- Decreased quantity
- Low motivation
- Avoidance of tasks
- Increased mistakes
- Setting perfectionist standards
- Obsession about details

Effects on Morale

- Decrease in confidence
- Loss of interest
- Dissatisfaction
- Negative attitude
- Apathy
- Demoralization
- Lack of appreciation
- Detachment
- Feelings of incompleteness

Effects on Behavior

- Absenteeism
- Exhaustion
- Faulty judgment
- Irritability
- Tardiness
- Irresponsibility
- Frequent job changes
- Overwork

Effects on Interpersonal Relationships

- Withdrawal from colleagues
- Impatience
- Decrease in quality of relationship
- Poor communication
- Subsuming own needs
- Staff conflicts

In addition to direct observation, compassion can be indirectly identified through self-administered survey instruments.

US Medical Command Use of the Professional Quality of Life Scale

The ProQOL[27] scale is the current version of the old Compassion Fatigue Self Test[2] and has been widely used in assessing compassion fatigue. The ProQOL is a 30-item survey instrument that consists of three subscales: (1) compassion fatigue, also known as secondary trauma scale; (2) burnout; and (3) compassion satisfaction. In keeping with the tone of this chapter, the discussion will focus specifically on issues related to compassion fatigue. The compassion fatigue variable is measured with 10 questions, and each response option ranges from 0 (never) through 5 (very often). Stamm[28] reported updated descriptive statistics for the ProQOL to include compassion fatigue. Based on a comprehensive reanalysis of existing published research, she found the compassion fatigue mean score to be 12, with a standard deviation of 6.9 and a Cronbach's alpha reliability score of .80. Throughout the remainder of this discussion, Stamm's new results and the research it was based on will be referred to as ProQOL data. Additionally, because the ProQOL attempts to identify persons who are "compassion fatigued," the instrument uses quartile scores as cutoff scores. In the ProQOL data the top quartile score is 17, meaning that respondents scoring 17 or above on the compassion fatigue scale are considered compassion fatigued.

Compassion fatigue is described as "your work-related, secondary exposure to extremely stressful events."[27] The list below contains the 10 items on the Trauma/Compassion Fatigue Scale taken directly from the ProQOL:

- I am preoccupied with more than one person I help.
- I jump or am startled by unexpected sounds.
- I find it difficult to separate my personal life from my life as a helper.
- I think that I might have been "infected" by the traumatic stress of those I help.
- Because of my helping, I have felt "on edge" about various things.

- I feel depressed as a result of my work as a helper.
- I feel as though I am experiencing the trauma of someone I have helped.
- I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
- As a result of my helping, I have intrusive, frightening thoughts.
- I can't recall important parts of my work with trauma victims.[27]

In 2008 the Surgeon General of the US Army, Lieutenant General Schoomaker, required all Army MEDCOM personnel to complete the ProQOL. This requirement met the intent to assess MEDCOM personnel on compassion fatigue, burnout, and compassion satisfaction. MEDCOM personnel accessed the ProQOL scale through a secure Army Web site. Respondents were assured that "[t]he information on the ProQOL is protected. Scores on the assessment are for use in helping individuals to develop a self-care plan. Employees are not required to share the information with their supervisors."[29]

The de-identified database was analyzed by personnel assigned to the Soldier Family Support Branch of the AMEDD Center and School, using SPSS (Version 16, SPSS Inc, Chicago, Illinois) statistical software. To meet the Surgeon General's intent of assessing the levels of compassion fatigue in MEDCOM personnel, the analysis started with descriptive statistics for MEDCOM population demographics and population scores. As the name implies, MEDCOM is a medical organization that has about 27,000 soldiers and 28,000 civilian employees[30] assigned across 35 medical treatment facilities. For parity's sake, demographic description is limited to respondent medical specialty. Figure 23-2 illustrates the percentage of MEDCOM personnel by medical specialty.

Using inferential statistics, the data were then analyzed to see whether MEDCOM scores differed from ProQOL data scores in a statistically significant way. A P value of < .001 was considered statistically significant. Analysis then focused on establishing descriptive statistics specific to MEDCOM compassion fatigue scores. With valid N = 50,478, the MEDCOM mean score for compassion fatigue was 9.8823 (minimum = 0.00, maximum = 50.00, ST = 6.71681, variance = 45.116).

A one-sample t test is an appropriate statistical test to compare a sample score to a known population score.[31] In this case, MEDCOM is considered a sample of the greater population represented by the ProQOL data scores. A one-sample t test was conducted to compare the MEDCOM compassion fatigue mean score of 9.88 to the ProQOL data compassion fatigue mean score of 12. The MEDCOM compassion fatigue mean score was lower than the ProQOL data score and the difference was statistically significant with a 2-tailed test (t_{12} = -70.835, P < .001, df = 50,477). The mean difference was -2.11768 (95% CI, -2.1763 to -2.0591).

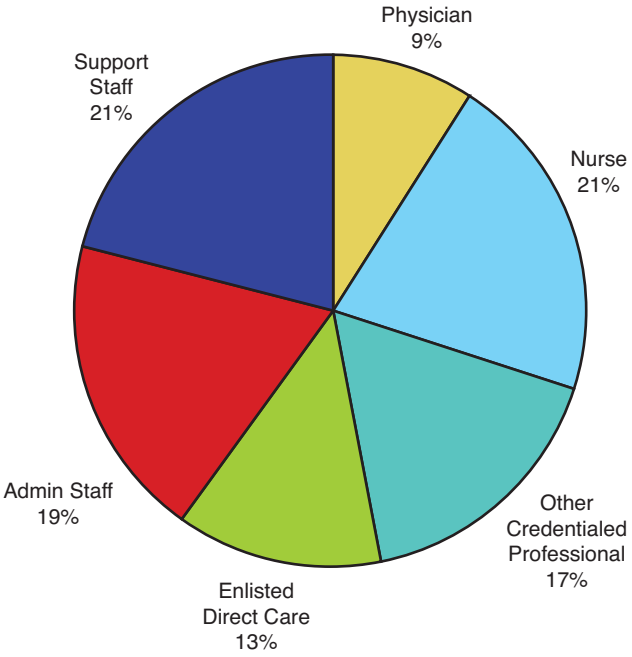

Figure 23-2. Percentage of US Army Medical Command personnel, by specialty, who completed the ProQOL survey in 2008. N=50,478.

TABLE 23-1

PERCENTAGE OF MEDICAL COMMAND PERSONNEL WHO MEET COMPASSION FATIGUE CUT SCORE

	Frequency	Percent	Valid Percent	Cumulative Percent
Not Compassion Fatigued	43,595	86.4	86.4	86.4
Compassion Fatigued	6,883	13.6	13.6	100.0
Total	50,478	100.0	100.0	

Another question of interest is how the percentage of MEDCOM personnel with compassion fatigue differs from the percentage of personnel with compassion fatigue in the ProQOL data. Stamm's establishment of a compassion fatigue cut score of 17, representing 25% of the ProQOL data population, allows this comparison. The percentage of MEDCOM personnel that scored at or above 17 on the compassion fatigue score was 13.6% (Table 23-1). This is further graphically represented in Figure 23-3.

To determine whether this difference is statistically significant, a goodness-of-fit test was conducted. A goodness-of-fit test is appropriate when the data score is nonparametric,[31] which is true in this case using quartile-based cut scores. The goodness-of-fit test compares the observed number of personnel (MEDCOM) that meet or exceed the cutoff score to the expected percentage (ProQOL data) of personnel that meet or exceed the cutoff score (Table 23-2). The difference was found to be statistically significant with a chi-square of 3,477.4 ($df = 1$, P value < .001).

This study focused on assessing the level of compassion fatigue among MEDCOM personnel and then comparing it to levels of compassion fatigue in the ProQOL data that represent the greater population. The findings establish that MEDCOM personnel report less compassion fatigue overall and MEDCOM has a lower percentage of personnel who meet criteria for compassion fatigue when compared to the cumulative samples in published research. Though important, speculations about the reasons for this difference are beyond the scope of this discussion; further research is warranted.

TABLE 23-2

MEDICAL COMMAND OBSERVED COMPASSION FATIGUE CUT SCORE FREQUENCIES COMPARED TO EXPECTED FREQUENCIES BASED ON PROQOL DATA*

	Observed N	Expected N	Residual
Not Compassion Fatigued	43,595	37,858.0	5,737.0
Compassion Fatigued	6,883	12,620.0	-5,737.0
Total	50,478		

*No cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 12,620.0.
ProQOL: Professional Quality of Life scale

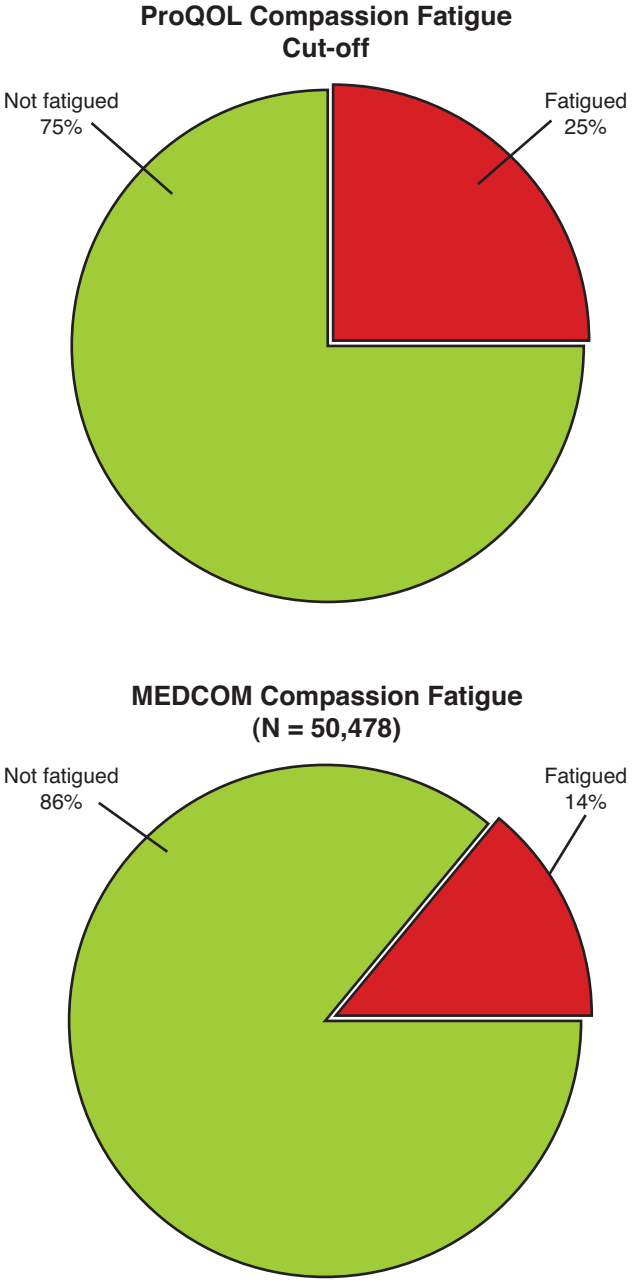

Figure 23-3. Percentage of ProQOL respondents with compassion fatigue compared to US Army Medical Command personnel with compassion fatigue.
MEDCOM: US Army Medical Command ProQOL: Professional Quality of Life scale

WAYS TO COMBAT PROVIDER FATIGUE

The EAT Model

The EAT model was created by Pechacek as a teaching tool for the AMEDD Center and School. The model offers a simple, easy-to-remember way for leaders, providers, wounded individuals, and anyone in the helping profession to articulate a way to manage provider fatigue and/or burnout. One way to combat provider fatigue is using the "EAT" action plan (Figure 23-4): **E**ducate yourself; **A**ssess your level of provider fatigue; and **T**ake action to build resiliency, create a self-care plan, and seek professional help if needed. Figure 23-5 is a visual reminder that focus on the provider is essential to combating provider fatigue. Providers are involved with many relationships, including those with a patient, soldier, and client, as well as those with a colleague who shares stories of trauma. The work environment may include many cases of trauma, and its resources may be stressed in the attempt to provide services to providers and others. Providers are also affected by war, disaster, or other traumatic event. The level of provider fatigue may be assessed with the markers and effects listed above through self and buddy observation and discussion, as well as through self-tests such as Figley's Secondary Trauma Scale[2] and the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales–III.[32]

Building Resiliency

Resiliency training focuses on strength rather than on pathology. For providers, it is important to have a resiliency model and to know where resilient strength comes from. Providers should identify a resilient role model: Who has the qualities that you as a provider would like to have? Have any of the people you work with inspired you? Resiliency, like the "Battlemind" concept (see Chapter 4, Combat and Operational Stress Control, in this volume), is a person's inner ability to face fear and adversity with courage, and the will to persevere and overcome adversity.

To build resiliency, providers must accomplish two difficult tasks simultaneously in a stressful situation: "self-soothing" and "self-confronting."[33] Self-soothing

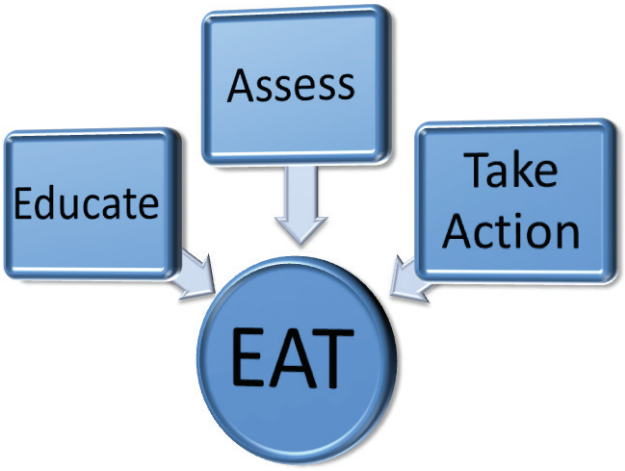

Figure 23-4. "EAT" to combat provider fatigue.
Educate yourself:
Who is affected?
What is provider fatigue?
What is resiliency?
Assess your level of provider fatigue:
What is the provider fatigue severity level?
What is the resiliency level?
How might resiliency be increased?
Take action:
Build up your resiliency
Create a self-care plan
Seek professional help if needed

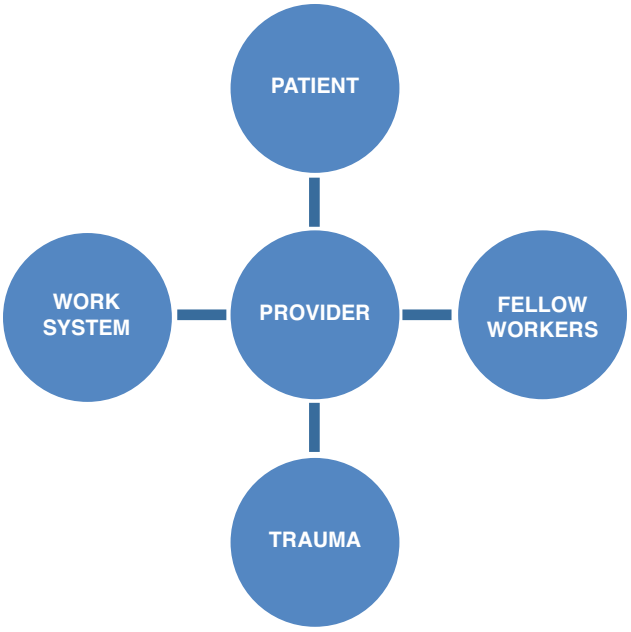

Figure 23-5. Focus on the provider is essential to combating provider fatigue. Providers are affected by their many relationships with patients and clients as well as colleagues, in a work environment with exposure to various types of trauma.

is the ability to deliberately relax while facing a stressful situation. Examples of self-soothing activities include working out, running, taking a bubble bath, hiking, diving, dancing, or just breathing deeply. The purpose of self-soothing is to enable the second step, self-confronting. Self-confronting is the process of assessing one's own anxiety and examining what might be learned from the situation. Providers should ask themselves questions such as:

- Why am I anxious?
- What am I trying to prove?
- Who am I trying to impress?
- What am I trying to fix?
- Am I depending on someone else to validate my sense of self-worth?
- What is the growth potential in this situation?

Self-soothing without self-confronting leads to avoidance, such as withdrawing, being demanding or driven by emotions, overeating, or substance abuse. Self-confronting without self-soothing leads to the risk of negativity without the willingness to step back and look for growth opportunities.

A Holistic Approach to Renewal

A provider can work to combat provider fatigue and build resiliency in five ways: (1) physically, (2) mentally, (3) emotionally, (4) spiritually, and (5) socially.

Physical Renewal

Nutrition is the first consideration in physical renewal. Under stress, some providers use food for comfort, and some refrain from eating. Maintaining good nutrition while avoiding fast food provides the best results. Furthermore, drinking the appropriate amount of water is important to fighting stress. Secondly, rest and relaxation are important for physical renewal, including sleep at night, breaks at work, and vacation time away from trauma.

Other means of physical renewal are exercise and laughter. Exertion through exercise releases pent-up frustrations and renews energy. Studies have shown that consistent exercise is associated with improved depression scores in patients with depression, cancer, and cardiac disease, and even in healthy subjects.[33] Other studies[34] have shown that laughter can reduce or prevent hypertension. Laughter may initially cause blood pressure to increase, but it then decreases and breathing becomes deeper, sending oxygen-enriched blood and nutrients throughout the body. This increase in blood flow and oxygenation of blood can actually assist in healing. Not conducive to physical renewal are forms of avoidance such as substance abuse, gambling, or other addictions.

Mental Renewal

Fear is normal for providers, who may worry about how well they are taking care of patients or accomplishing other duties. Fear can also lead to feelings of shame and guilt. Like physical renewal, mental renewal results from relaxation, through activities like reading books, listening to music, or learning relaxation techniques from tapes or seminars. When the sympathetic nervous system is calmed and quieted by relaxation, muscle tension decreases, the heart rate slows, and a feeling of well-being occurs.

Emotional Renewal

Emotional renewal means accepting and normalizing experience. Internalized anger, fear, depression, anxiety or other negative emotions can produce biochemical changes that have been shown to adversely affect the mind and body. The experiences of providing military medical care may cause troubling dreams or recurring thoughts. This is normal. Before providers can act to change their emotions, they must accept their situation. Emotional resiliency grows by thinking through daily events, sorting through emotions, talking with trusted friends, keeping a journal, and even laughing. Laughter can activate and strengthen the immune system by reducing four neuroendocrine hormones associated with the stress responses: epinephrine, cortisol, dopamine, and growth hormones.

Spiritual Renewal

Spiritual renewal is important to numerous military providers. Many have claimed that the sense of belonging to God or a higher power has assisted them in coping with anxiety and trauma. For many people, praise and worship with groups of people is uplifting and rejuvenating, listening to inspirational music or reading devotional books may be therapeutic, and taking time out to refocus attention on a greater "problem solver" reduces pressure when working in traumatic circumstances. Meditation can also be a source of provider resiliency; the ability to sit back, observe the mind, and direct attention to the present moment allows people to face challenges with renewed strength and flexibility. And for many, spiritual resiliency and renewal comes from forgiveness. Forgiveness is a way to avoid bitterness and recover from burnout; failing to forgive oneself and others often turns anger inward, resulting in bitterness, depression, and burnout.

For many military healthcare providers, spirituality is a deep sense of comfort, support, and daily inspiration. Studies have demonstrated that religion and spirituality are associated with reduced risk of medical morbidity and mortality and lower rates of divorce, criminal behavior, suicide, and drug abuse.[33] For some individuals, spirituality without a formal religion is their source of resiliency; however, according to a Gallup poll,[34] religion plays a huge role in the lives of others:

- for 70% of Americans, religion is a "very important" part of life;
- over 60% of Americans believe in angels; and
- 82% of Americans express interest in spiritual growth.

Social Renewal

Humans are social creatures. Military providers need to be with and relate to others for growth and development. Making time for others increases positive mental health and builds resilience. Having a social network increases coping strategies, a key ingredient for building resiliency both on the job and in all aspects of life. Providers have often asked, "How do I keep from getting depressed, listening to people's problems day after day?" The answer lies in the basic philosophy of looking for and emphasizing strengths rather than pathology in other people. Maddi[35] studied hardiness and wrote extensively about how people obtain hardiness and thrive under adverse conditions. He has found that people who thrive under stress maintain three key beliefs that help turn adversity into advantage: (1) commitment: striving to become involved in ongoing events rather than feeling isolated; (2) control: trying to influence outcomes rather than lapsing into passivity; and (3) challenge: viewing stressful situations as opportunities for new learning.[35]

Leadership

Like all complex systems, the military is greatly affected by its leadership. It is imperative that leaders at all levels be familiar with the concepts discussed in this chapter and encourage their soldiers to practice them. Colonel Joseph Pecko, former chief of the Soldier and Family Support Branch of the AMEDD Center and School, commented on the role of leadership and its place in striving for resiliency: "Leadership may have many meanings, but leadership practices in regard to provider fatigue are very important." Following the suggestions of PRT ensures strong leadership skills and the best results for all. Colonel Pecko encourages leaders to promote provider resiliency in the following ways:

- Place the care of the military care providers as the highest priority.
- Give credit and reward a job well done.
- Foster an environment of dignity and respect.
- Be available to talk with subordinates; spend time with them. Embrace an open door as well as anonymous "back door" policy. Allow providers to talk about their experiences and feelings. Let providers know that you are aware of their situation and offer help. Often, providers cannot take action on their own because they are too close to the situation, so the suggestions and attitude from leadership can be helpful.
- Keep your staff informed. Clearly express your policies and views on all matters. Allow subordinates to seek clarification on your policies without becoming defensive or seeing subordinates as disloyal. Try not to take subordinates' actions personally.
- Allow providers sufficient time to recover from duties, physically and mentally. Give them private time to do different work or catch up on tasks. Assist with the provider's everyday tasks when possible.
- Establish a climate where subordinate leaders can acknowledge stress and the desire to seek assistance. Teach leaders that seeking help takes courage. Encourage leaders to seek out and identify their most vulnerable and at-risk people.
- Take care of yourself as a leader and set a good example of self-care. Maintain a positive attitude during periods of adversity and challenge. The resiliency and mental toughness of the leader will shine through to others. Leaders setting an example in self-care and speaking the language of resiliency can bring about dramatic positive results in the work environment.

SUMMARY

In the 21st century, military care providers must understand provider fatigue and how it affects their care for those suffering from the effects of trauma. This chapter has defined types of fatigue related to the military healthcare provider and unit ministry teams, discussed Figley's model of compassion

fatigue, identified the symptoms and markers of provider fatigue, and listed methods of preventing provider fatigue as well as ways to promote renewal and resiliency for the provider, including the role of leaders. Promoting resiliency for the provider, like the broader mission of providing healthcare for all service members, depends on teamwork. At every level, leaders and providers must begin with self-care before promoting resiliency in their colleagues and subordinates.

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