

COMPASSION FATIGUE AMONG U.S. MILITARY RNs POST OVERSEAS
DEPLOYMENT

by

Dawn Marie Goldstein

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SIGNED: Dawn Marie Goldstein

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ABSTRACT

Purpose: Describe the meaning of compassion fatigue (CF) as experienced by the U.S. military registered nurse (RN) post-deployment from Iraq and Afghanistan.

Background: CF is characterized by deep emotional and physical exhaustion, and may resemble posttraumatic stress disorder (PTSD). Often this causes a shift in confidence and clouds RN perceptions. Symptoms include difficulty concentrating, intrusive imagery, hopelessness, exhaustion, and irritability leading to profound alterations in one's view of the world, patients, family, and friends. Outcomes include depersonalizing patients, poor coping mechanisms, lowered standards, clinical errors, and blurring boundaries, all can contribute to a toxic work environment and RNs leaving the profession.

Method: Hermeneutic phenomenological methodology facilitated a description of CF in words and meaning expressed by U.S. military RNs (i.e., Army, Navy). The sample was obtained through the snowball method and aided by key informants. Data were collected through interviews and observations with each active duty or reservist RN ($N = 8$) on three occasions. Participants described their military and nursing backgrounds and experiences of CF through hermeneutic interview. Analysis was ongoing during the interview process and included continual questioning, reflecting, and validating. This process allowed for understanding through engagement of text (e.g., dialogue, transcriptions). Journaling and self-reflection assisted with trustworthiness.

Findings: Participants shared many experiences. While some had unique experiences, their feelings and perceptions resonated with other participants and informed the emergence of four shared meanings and shared concerns: (a) *the term CF does not fit me*, manifested by expressions

of the meaning of CF; (b) *compassion fatigue as all encompassing*, manifested by physical, emotional, relational, and spiritual experiences; (c) *compassion fatigue will not interfere with my military duty*, manifested by the pervasive military lens that the meaning of the experiences are filtered, and (d) *compassion fatigue affects people long after deployment . . . gone, but not forgotten*, manifested by the lasting effects of CF.

Implications: While CF among military RNs has many similarities with the general nursing population, the practice environment appears to create additional triggers and manifestations. This study provides an understanding of the progression of CF in this population. Implementing interventions before and after trauma exposure can preserve the care in military caregivers.

CHAPTER I: INTRODUCTION

The United States responded to the September 11, 2001 attacks on U.S. soil by launching military offensives against Afghanistan in October 2001 and Iraq in March 2003. By the end of 2008, almost two million American military personnel had served in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq (Tuerk, Steenkamp, & Rauch, 2010). The complexity of war-induced trauma treatment following the onset of the military operations posed unique challenges for U.S. military Army, Navy, and Air Force registered nurses (RNs) who cared for people in these hostile war zones (Tyson, 2007). Challenges included the never-ending exposure to death, caring for trauma casualties, caring for polytrauma survivors, enduring long mission hours, and repeatedly experiencing ethical and moral dilemmas (Vaughn, 2005). Many of the nurses working in hostile war zones provided care for wounded combatants (e.g., American military troops, coalition troops, contractors, civilians, insurgents). Due to the extreme conditions these RNs experienced daily, they were at high risk of experiencing a significant stress response. In many cases, the stress response was a result of deploying to a combat environment, experiencing personal stress, and being indirect victims of trauma (Boivin, 2010; Stewart, 2009). Many even equated the stress reactions to secondary traumatic stress (STS), defined as exposure to another's trauma.

Among RNs working in hostile war zones and given the high risk of war-related primary stress as well as the STS, it is likely that these RNs may also be at risk for PTSD and compassion fatigue (CF). As it is currently conceptualized, CF consists of three concepts: increased burnout, increased STS, and low compassion satisfaction (Stamm, 2002; 2010). CF divides into two parts: burnout and STS. Burnout stems from the work environment and leads to feelings of exhaustion,

frustration, anger, and depression; it is defined as the feelings of hopelessness, cynicism, and inefficacy that emerge gradually in response to excessive job demands and prevents one from doing his or her job effectively (Maslach, 1982; Stamm, 2002). STS comes from one's internal responses to fear, grief, and work-related trauma (Stamm, 2007) and may result from exposure to individuals who have experienced extremely or traumatically stressful events. The negative effects of STS may include fear-of-sleep difficulties, intrusive images, or avoiding reminders of the person's traumatic experiences (Stamm, 2010). *Compassion satisfaction* is the contentment, sense of achievement, and pleasure one gets from helping others (Stamm, 2002; 2010) and is often viewed as a moderator of STS and burnout.

Symptoms of CF may infiltrate all aspects of an individual's life. As described by Figley (1995), these symptoms may alter a person's cognitive, behavioral, emotional, spiritual, physical, and inter-personal dimensions. Unfortunately, for some, these effects remain unnoticed simply because they were not directly involved in the primary event and therefore are overlooked as being potentially affected (Brady, Guy, Poelstra, & Brokaw, 1999). What is not known is how RNs working in a hostile war zone might experience CF. The purpose of this study was to explore the meaning of CF experienced post-deployment by U.S. military RNs (i.e., Army, Navy). This chapter establishes the case for significance of the problem, contextualizes the study, and introduces its basic components.

Background

The distressing number of young military service members who are injured may be the largest factor in the emotional toll on military RNs. The polytrauma injuries of those wounded due to war are rarely, if ever, seen in the emergency room of a stateside hospital but may be

common occurrences for deployed military RNs. The reported death toll of U.S. forces deployed to Iraq and Afghanistan during Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn reached 5,851 Americans for the period between October 2001 and March 2014. Estimates placed the number of physically injured U.S. personnel at over 51,000. The total number of amputations in Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn as of January 10, 2014, was 1,558; the total number of PTSD diagnoses surpassed 118,000 (Fischer, 2014). To further intensify the severity of traumatic effects, most of the combat wounds were not single location/single injury cases. The injuries involved multiple areas of the body with varying degrees of severity; polytrauma injuries accounted for almost 75% of all cases including acute blast injuries, gunshot wounds, traumatic amputations, and burns (Vaughn, 2005).

U.S. military RNs have often been placed in dangerous or stressful situations, whether in rescue efforts, post-disaster scenes, or dealing with the dramatic injuries following traumatic events of war. U.S. military RNs assigned to combat zones, hospitals, within units, and clinics provide for the needs of each person with absolute decision, empathy, and compassion. Military RNs have historically received little attention as to how their experiences impact their subsequent level of physical, functional, and mental well-being. To add to the complexity of today's military operations, military personnel are assigned to peacekeeping, humanitarian assistance, or to the battlefield, and sometimes all three missions are in the same location occurring at the same time (Foley, Minick, & Kee, 2000). The conditions, circumstances, and influences of the Middle East from 2003 to present have been described a *Three Block War*; in at

any one moment, three different situations can exist within a space of three city blocks, a metaphor to describe the demands of the modern battlefield.

“In one moment in time, our service members will be feeding and clothing displaced refugees – providing humanitarian assistance. In the next moment, they will be holding two warring tribes apart – conducting peacekeeping operations. Finally, they will be fighting a highly lethal mid-intensity battle. All on the same day, all within three city blocks. It will be what we call the three-block war.” (General Charles C. Krulak, 31st Commandant, U.S. Marine Corps, 1999, p. 3).

Military RNs in Iraq and Afghanistan may encounter unimaginable ethical challenges. In a multifaceted, complicated operational environment, improvised explosive devices, mortar, sniper, or rocket attacks can occur in any setting and by anyone (Lewy, 1978). Consequently, military RNs are often exposed to a broad patient population, all with severe injuries where deaths frequently occur or those with disabling injuries survive; concerns with an RN's quality of life and professional role assume a subordinate position to the ethics and practice necessitated by circumstances (Kraft, 2007). One RN may be assigned to an enemy combatant/detainee whom views the RN as an infidel, while another RN is caring for a child severely injured in the line of fire; many times these RNs must decide who can be saved and who is beyond saving. Military RNs encounter anger, frustration, feelings of futility, and ethical dilemmas on a daily basis while providing care in a hostile, combat environment.

Over the years, the concept of CF has received increased attention related to the realm of caregiver stress among the different members of the healthcare team. When hearing story after story of horrifying experiences, military RNs may start to feel emotionally exhausted, overwhelmed, stressed, and burned out. This stress is not without repercussions and can lead to a poor quality of a professional life (Figley, 2002). Negative emotions become contagious to others (Barsade, 2002), thus having destructive effects on teams and organizations such as the military.

Military-unit readiness can be negatively affected because these RNs are no longer able to think or function at peak performance (Lang, Pfister, & Siemens, 2010). Providing care to military personnel in war is a unique, distinctive experience; it can be assumed that RNs working in these environments will have a unique experience of CF. In order to best develop an understanding of that experience, this study explored the phenomenon from the perspective of the experts: U.S. military RNs who have provided patient care in a hostile war zone.

Statement of the Problem

There is a growing interest in understanding the clinical phenomenon of CF and its impact on healthcare providers. Although this phenomenon has received considerable attention within other healthcare populations, military RNs have not been well studied. Hagerty, Williams, Bingham, and Richard (2011) reported that 20% – 30% of military healthcare professionals deployed to combat environments experienced some type of psychological consequence. Physical costs of CF take their toll on individuals, including headaches, insomnia, and gastrointestinal distress (Boyle, 2011). Residual effects of CF within the military lead to overall low job performance, decreased quality of patient care and delivery, increased sick time, conflicts with other health care professions and peers, friction experienced with family and friends, and most importantly, nurses that leave the profession creating a deficit of caring and compassionate RNs who were initially drawn to their professions in which their compassion and empathy is critical (Smith, 2009).

The effects of traumatic stress on the body and mind can leave the military RN vulnerable to developing CF, thereby hindering the RNs' ability to provide safe, quality care for their patients in a variety of military settings overseas. Military RNs are at risk for a high level of

CF, often without knowledge and awareness of its devastating effects on their lives (Kenny & Hull, 2008; Smith, 2009). CF is chronic and can manifest suddenly without warning.

Furthermore, the symptoms may never resolve.

This research study addresses a major gap in the literature by describing CF symptoms as experienced by U.S. Army, Air Force, and Navy RNs post-deployment and in their own words. A hermeneutic interpretive phenomenological approach was used to increase understanding of the shared meanings for these military RNs. Distinct from quantitative studies that theorize, generalize, or predict causal relationships, researchers guided by hermeneutic phenomenology seek to understand meaning (Koch, 1995; Annells, 1996).

Research that provides a better understanding of the RN's perceptions, experiences, and symptoms of CF can help RNs to know themselves and their personal risks for CF. Tyson's (2007) study of CF in health care professionals working with combat veterans revealed that previous deterrents to CF, such as self-awareness, self-care, peer supervision, and individual therapy might not be enough to meet the needs of the health care professionals. The complex challenges facing military RNs treating combat trauma are an ethical imperative, not only on an individual and supervisory level, but on educational, organizational, and societal levels as well. Findings from this study identified the need for additional research and may help in the development of secondary prevention and intervention strategies for this population of active duty, activated reserve, or post-deployment RNs.

Purpose of the Study

The purpose of this study was to explore the phenomenon of CF as experienced by U.S. military RNs post-deployment to Iraq or Afghanistan during the war years from 2003 to 2014.

Specific aims included:

- Describe compassion fatigue experienced by U.S. military RNs.
- Describe common triggers of compassion fatigue.
- Describe the shared meaning of compassion fatigue.

In order to explore the experience of CF, the study addressed what constitutes the nature of this shared experience (van Manen, 1990). Through dialogue, this study explored common thoughts, feelings, concerns, and patterns through abstraction that led to the development, experiences, and outcomes of CF. The shared meaning of CF was grounded in the historical, political, social, and personal background within the experience of CF (Munhall, 2007).

Significance of the Study

For RNs working with traumatized populations, CF symptoms can negatively impact health care workers and the care they provide. Unresolved CF can lead to depression, anxiety, sleep difficulties, relational conflicts, and a decline in physical, emotional, and spiritual health (Stewart, 2009). RNs with CF are at higher risk for making poor judgments, treatment planning, and abuse of patients or other health care workers (Boyle, 2011). Possible negative consequences include low morale and motivation, errors in judgment, poor communication, staff conflicts, apathy, sick calls, substance abuse, relationship conflicts, and stigma. This is consistent with the finding of Kintzle, Yarvis, & Bride (2013) exploring the rates of STS or CF in military primary care providers and mental health care providers. U.S. military RNs might fail to recognize ominous events or subtle patient changes that could result in adverse patient outcomes, including death.

There are many commonalities in nursing, but patient care settings and the patient population differ; these differences may affect the nurse's perception of the work environment. For example, one factor that can negatively influence the U.S. military RN is the difficulty of providing patient care in an austere work environment, under enemy fire at an unsustainable pace, and witnessing horrific trauma daily; these factors impact the ability to provide safe, quality care (Foley, Kee, Minich, Harvey, & Jennings, 2002; Gaylord, 2006). These negative perceptions can even be the impetus for prematurely leaving the profession (Foley et al., 2002). Military RNs who are assigned to ground troops as medical support are closest at times to the enemy in battle, which increases the risk for developing STS or CF. These RNs in overseas conflicts are expected to provide care for American military troops, coalition troops, contractors, civilians, and injured opposition troops coming to their location for medical assistance (Boyle, 2011). Ultimately, they must contend with the finality of death and the sense of vulnerability and helplessness to prevent it. Regardless of demographics, political beliefs of the injured, or the personal feelings of the caregiver, the military RN must care for the injured as well as the deceased with respect and dignity (Stewart, 2009). This study contributes understanding to the science of CF among military RNs, which may help to reduce the risk of CF and even to increase quality of life among military service members and their families.

Underlying Philosophy

Hermeneutic Phenomenology

Qualitative research is based on the underlying philosophy of constructionism. Constructionists believe that reality is socially constructed. There are multiple realities constructed by human beings who experience a specific phenomenon, such as the meaning of

CF. This worldview emphasizes culture as a source of shaping an individual's thoughts and actions. Meaning is created through filters derived through one's culture. Qualitative research gives a *voice* (Munhall, 2007, p. 5) to each participant by considering one's own personal narrative and using one's distinct language. The knowledge from the *knower* and the participants who are the *knowers* (p. 21) provide the outcomes of qualitative research and inform the meaning of CF (Munhall, 2007).

Many qualitative research approaches are supported in philosophical perspectives that expand and enrich perceptions and understandings of a phenomenon. Phenomenology is a philosophy and research approach consistent with human science and the meaning of being human (Munhall, 1995). Hermeneutics refers to the theory of interpretation of the experience. It is through language that the researcher discloses or uncovers the concealed nature of being (Munhall, 2007; 2012).

This hermeneutic study examined the meaning rather than the lived experience (Munhall, 2012). During data analysis, my horizon of understanding intersected with that of the text, which refers to the written transcript, taped words, written comments about the interview situation, observations, and non-verbal expressions (Fleming, Gaidys, & Robb, 2003). This process involved continual questioning, reflection, and validation within the dialogue between the researcher and text, referred to as *the hermeneutic circle* (Annells, 1996, p. 707). The parts of the text are interpreted in relation to the whole and vice versa (Gadamer, 1998). In order to facilitate the process of understanding, the first series of interviews should be analyzed before proceeding to the next sequence. It is essential that, to be true to Gadamer's description of the hermeneutic circle, the process of repeatedly returning to a text through feedback and further discussion be

fully experienced. This process of movement back to the whole text from the parts expands new interpretations each time it is observed and results in a shared understanding of the phenomenon that can be reached between the researcher and participant (Fleming et al., 2003; Munhall, 2007). Renewed understanding emerges from this iterative process and any inadequate pre-understanding is discarded (Mak & Elwyn, 2003).

The Researcher's Historicity of Understanding

The hermeneutic circle of understanding is an expression of the researcher's fore-structures and pre-understandings. To come into the circle required me as the researcher to identify my fore-structures in terms of the phenomenon under investigation. I identified *fore-having* (personal lifeworld background, values, beliefs, culture), *foresight* (a point of view from which an interpretation is made), and *fore-conception* (expectations about what might be anticipated in an interpretation) of how I perceived the meaning of the experience of CF in military RNs (Geanellos, 1998; Mak & Elwyn, 2003). Rather than eliminate, bracket, or set aside my preconceptions of the phenomenon being studied, I identified those factors through continued reflection and journaling, as they influenced the process of analysis and interpretation (Koch, 1995). My pre-understandings are described in Chapter III and my self-reflections during the process of data collection and analysis are described in Chapter V.

Summary

Military RNs may risk their lives on a daily basis to provide needed care for U.S. military troops overseas. Their indirect exposure to the stress of traumatized patients puts them at risk for developing CF (Bride & Figley, 2009). Despite the significant stress experienced by military RNs during overseas deployment, there has been little focus on their risk of CF (Stewart, 2009).

This study provides understanding and meaning of the phenomenon of CF as experienced by the U.S. military RN. This chapter reviewed the problem statement and identified the purpose, research aims, and significance of the study. The underlying philosophy and conceptual perspectives that guided the study were described. Chapter II discusses the conceptual perspectives of STS, CF, burnout, military deployments, trauma history, compassion satisfaction, and illustrates the influence of each among U.S. military RNs.

CHAPTER II: LITERATURE REVIEW

Literature describing the experiences of U.S. military RNs caring for those wounded during the wars in the Middle East was minimal. Chapter II contains a review of the literature providing conceptual perspectives for this study. The following discussion illustrates the difficulty in describing the experiences of U.S. military RNs with CF. The concepts of CF, STS, and burnout are relevant to RNs, particularly those RNs who care for patients with combat-related injuries (Duncan et al., 2005). U.S. military RNs have been exposed to a wide range of role-related and secondary traumatic stressors from a lack of resources to constant interactions with traumatized victims (Stewart, 2009). In this chapter, the relevant literature related to STS, vicarious traumatization, burnout, and CF is reviewed. In addition, literature addressing the personal (trauma history) and environmental (hostile, combat environment) variables is explored in relation to the development of CF. The evolution of the theoretical model that best depicts CF for this population is presented.

Literature Search

For this literature search, I explored multiple topics including nursing, medicine, psychology, education, sociology, and military science. Sample articles were derived from the following online databases: CINAHL, PubMed, PsycINFO, ERIC, EBSCO, Web of Science, and Military publications. A literature search identifying studies using discrete measures of CF, STS, and burnout yielded 377 articles. Key terms included *compassion fatigue*, *combat experience*, *secondary traumatic stress*, *burnout*, *vicarious trauma*, *war*, *military nursing*, *compassion fatigue and nursing*, and *military healthcare providers and compassion fatigue*. The search initially included all articles published from January 2000 through June 2015. Using key

words *compassion fatigue* and *nursing* yielded 172 studies, included mental health workers, oncology staff, pediatric staff, social workers, child welfare workers, clergy, physicians, medical residents, and RNs working in various specialties. However, when the key term *military* was added, only two articles were located that addressed military nurses. The next section discusses components of CF, beginning with STS based on Stamm's Professional Quality of Life (ProQOL-5) model (2010; 2014).

Secondary Traumatic Stress (STS)

Hearing about or witnessing a traumatic event of another person has the potential to traumatize an individual. Figley (1995) first described STS as natural consequences of knowing about trauma experienced by another person that results in emotional and physical stress from taking on the affliction of helping someone else. STS exposure was operationally defined as an internal response and unpredictable based on learning about or witnessing a situation or event that resulted in a threat, injury, or near death in another person (American Psychiatric Association, 2000).

The individual with STS may develop symptoms by exposure to the traumatized individual and not from the exposure to the traumatic event. Empathy and exposure are two central concepts in STS. Figley (1995) summarized four major reasons why professionals caring for trauma victims were at risk for developing STS: (a) empathy, (b) history of personal trauma, (c) unresolved trauma of the worker would be activated by narratives of similar traumas in patients, and (d) children's trauma were difficult for professionals when dealing with the pain experienced by children.

There is an array of reactions that health care providers may experience in their work with trauma victims/survivors. Throughout the literature STS and *vicarious traumatization* often have been used interchangeably to describe the effects of work-related traumatic stress (Jenkins & Baird, 2002; Newell & MacNeil, 2010; Sprang, Clark, & Whitt-Woosley (2007). Vicarious traumatization refers to the cumulative effect of the patient's trauma, which alters the caregiver's professional worldview (Pearlman & Mac Ian, 1995). Symptoms of STS included an increase in negative arousal, intrusive thoughts/images of another's experiences, difficulty separating work from personal life, increased frustration diminished tolerance, anger, dread working with certain individuals or patients, depression, increased alcohol and substance use, hypervigilance, diminished sense of purpose, and feelings of hopelessness (Beck, 2011). Figley (1995) suggested that the terms CF and STS were synonymous. In the last decade, the understanding of trauma and its associated factor of secondary traumatization increased the public awareness of the potential harmful effects for those who interact in a professional capacity with survivors of trauma (Buchanan, Anderson, Uhlemann, & Horwitz, 2006).

The increase in understanding of the caregiver effects from a patient's trauma evolved into revised instruments and models of CF. Stamm (2009) emphasized that the harmful elements of CF might stem from work-related traumatic exposure. Looking at CF through the lens of military nurses, work-related traumatic exposure might cause fear and even have negative emotional consequences. Rivers, Wertenberger, and Lindgren (2006) examined Army RNs ($N = 131$) and found that RNs experienced higher emotional responses than physicians when caring for physically and psychologically traumatized soldiers. The researchers theorized that this high

emotional response was due to the increased time that RNs spent with patients as well as listening to the accounts of their traumatic events.

Burnout (BO)

Many circumstances might predispose an individual to feeling emotionally and physically stressed. The concept of burnout (BO) was incorporated into the theoretical base of CF (Stamm, 2005; 2009) to capture the energy depletion that stems from the external work environment (Figley & Klebert, 1995). Freudenberger (1974), a psychologist employed in an alternative free clinic institution, was the first to use the term *BO* to describe the pattern of mental exhaustion, loss of motivation, and reduced commitment that he observed between himself and the employees in his workplace. He hypothesized that excessive work demands had the potential to drain the energy, strength, and resources of staff members and proposed that over-commitment and over-dedication were the primary risk factors in job BO. Taking the concept further, Maslach and colleagues (Maslach, 1982, 2009; Maslach & Jackson, 1982) defined BO as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that developed in individuals. Stamm (2005; 2010) described BO as being associated with feelings of hopelessness and difficulties in dealing with work or in doing a job effectively.

Burnout often has a gradual onset resulting from the external work environment. Figley (1995) argued that CF was caused by a traumatic exposure and had a faster onset of and recovery from symptoms, whereas BO was possibly the catalyst for an individual to change jobs or careers. Factors that may contribute to BO included feeling that one's efforts did not make any difference, feeling that workload was excessive, or feeling lack of support. The consequences of BO often led to emotional exhaustion, depersonalization, and a decreased sense of personal

accomplishment. A wide range of negative personal, interpersonal, and professional outcomes was associated with BO (Cordes & Dougherty, 1993). The next section discusses CF, defined by Stamm (2010; 2014) as the negative aspects of helping individuals who experience traumatic pain and suffering.

Compassion Fatigue (CF)

Compassion is a response to human frailty that informs, motivates, and moves us to act on behalf of those who are suffering. This movement is used in context to ease suffering, offer care, patience, kindness, non-judgmental understanding, and includes an awareness of human imperfection, including oneself (Neff, 2003). Having empathy involves being sensitive to the feelings, concerns, and experiences of another person (Merriam-Webster, 2011), and is commonly viewed as an essential component of the helping relationship (Figley & Nelson, 1989; Herman, 1977). Empathic engagement allows an individual to share the emotional pain of others and motivated a desire to help (Figley, 1995); however, empathizing with traumatized patients also might compromise one's psychological development, identity, and worldview (Pearlman & Saakvitne, 1995).

Those in the field of psychology have explored much of the research on the phenomenon of CF. In psychology, CF has been defined as a consequence of working with a significant number of traumatized individuals while having a strong empathetic orientation (Figley 1995). In the health care provider, CF has been defined as reduced capacity in being empathetic for a suffering individual (Adams, Boscarino, & Figley, 2006). CF has been characterized by experiencing trauma or suffering in response to helping another person (Stamm, 2012).

However, Figley (1999) highlighted that CF developed as a common and treatable reaction to working with traumatized individuals.

An RN may have been the first person to coin the phrase *compassion fatigue*. Joinson (1992) fashioned the term compassion fatigue when she described the traumatic stress RNs developed when caring for patients. At the time, Joinson conducted a study with RNs in an emergency department setting and identified CF as losing the ability to care. She quoted RNs recounting stressful feelings that were overpowering, invasive, and interfered with their ability to function. The symptoms of CF might cause physical, emotional, or cognitive manifestations of mood alterations that interfered with everyday life over time.

Those in helper or caregiver roles may experience similar feelings of those in pain and even feel caught up in the empathetic emotion of the injured. Sprang et al., (2007) identified this intensity and duration of empathetic engagement or relationship between caregiver and patient as a strong predictor of CF symptoms. The symptoms of CF may parallel those of posttraumatic stress disorder (PTSD) except that the traumatic stressor was experienced indirectly through empathic engagement with individuals who had been traumatized (Figley, 1995, 2002; Gentry, Baranowsky, & Dunning, 2002). The *DSM-5* diagnostic criterion added the inclusion of negative symptoms with intrusion, avoidance, and arousal symptoms for at least one month after the traumatic experience (American Psychiatric Association, 2013). The stress leading to trauma could be described as traumatic stress that caused one's defenses to minimize the damage of the trauma by way of psychological responses (e.g., denial, numbing, repression, displacement). An individual suffering from CF may have intrusive recollections or dreams of the traumatized person or their traumatic event and might experience psychological distress when exposed to

internal or external cues that were reminders of the trauma. In an effort to manage these painful emotions and cognitions, the individual might consciously avoid thoughts, feelings, activities, places, or people associated with the traumatized individual or their traumatic event and might feel detached or estranged from others (Figley, 2002). They might engage and exhibit risk taking and more accident-prone behaviors, even leading to errors in nursing judgment.

Those with CF may notice physical manifestations. Some symptoms include difficulty falling or staying asleep, feeling angrier and more irritable than usual, and exhibiting an increased startle response (Figley, 2002; Gentry et al., 2002). In a study of physicians ($N = 253$), authors Nimmo & Huggard (2013) reported that 17% of participants experienced significant and enduring repercussions from CF; symptoms included increased rates of absenteeism, reduced safety and quality service, low levels of efficiency, and ultimately, a high rate of leaving the profession. Table 1 highlights two of the key concepts of CF, STS, and BO (Stamm, 2012)

TABLE 1. *Symptoms of Compassion Fatigue.*

Burnout (BO)	Secondary Traumatic Stress (STS)
<i>Symptoms</i>	
Negative feelings have a gradual onset	Psychological distress appears suddenly and subside quickly
Frustration	Exhaustion, fatigue, sadness, anger, anxiety, and grief
Fatigue: physical and emotional	Sleep disturbances
Illness	Nightmares
Cynicism	Intrusive imagery
Negativity	Avoidance
Loss of personal accomplishment	Somatic complaints
Relational disturbances	Increased psychological arousal
Withdrawal	Changes in beliefs, expectations, assumptions
Poor morale	Guilt
Compromised work quality	Detachment/disengagement from patients, relationships, etc.
	Relational disturbances
	High alcohol/substance abuse

TABLE 1. *Symptoms of Compassion Fatigue (continued).*

<i>Key Triggers</i>	
Personal characteristics: exhaustion, feelings of hopelessness and no control	Negative feeling driven by fear and work-related trauma
Work-related attributes: high workload demands, high patient acuity, short staffing	Associated with a particular event Previous exposure to trauma
Non-supportive work environment	Empathy and emotional energy Prolonged exposure to trauma material of patients Witnessing a patient's response to despair and trauma

Note. Adapted from Davey, Commings, Newburn-Cook, & Lo, 2009; Laschinger, Leiter, Day & Gilin, 2009; Maslach & Leiter, 2008; Sabo, 2011.

Conceptual Model of Compassion Fatigue

Compassion fatigue is best conceptualized as emotional and physical distress stemming from one's role as a professional caregiver. The most widely utilized conceptual model of compassion fatigue depicts negative factors of BO and STS weighed against a positive factor of compassion satisfaction (Stamm, 2010). Stamm (2002, 2005) defined STS as the negative emotions brought on by working with survivors of trauma (e.g., combat trauma) and BO as the feelings of frustration, anger, or exhaustion that negatively impacts job performance and satisfaction. *Compassion satisfaction* is the positive aspect or satisfaction one gains from his or her work. This study is informed by the Professional Quality of Life (ProQOL-5) model (Stamm, 2005; 2010; 2015). Figure 1 illustrates the basic concepts and structure of the ProQOL model.

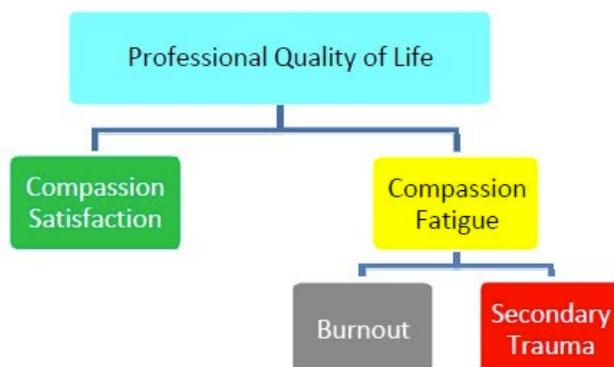


FIGURE 1. Professional Quality of Life (ProQOL) Model. From *Compassion satisfaction and compassion fatigue* by B. H. Stamm, 2009. Reprinted with permission.

In early research, several scales emerged, but they may not have been specific to secondary trauma exposure and burnout. Stamm's current conceptual model of compassion fatigue has an associated risk profile instrument, the Professional Quality of Life Scale (ProQOL) (2010). The current instrument takes many elements from previous scales that quantified stress and exposure such as the Impact of Event Scale (IES; Horowitz, Wilner, Kaltreider, & Alvarez, 1980) and the Traumatic Stress Institute Belief Scale, Revision L (Pearlman, 1996). Two measures emerged as specific indicators for secondary exposure: the Compassion Fatigue Self-Test in its various versions and the Secondary Traumatic Stress Scale (Figley, 1995; Figley & Stamm, 1996; Jenkins & Baird, 2002; Stamm, 2002). In 1993, Stamm added the concept of CS, which is reflected in the Compassion Satisfaction and Fatigue Test. The ProQOL-5 may be the most widely used instrument to explore compassion fatigue (Stamm, 2010); however, the ProQOL-5 does not provide a succinct measurement of CF, but assesses risk profiles by describing STS, BO, and CS (Stamm, 2010; 2012).

When both burnout and trauma are present in a person's life, it may be useful to narrow down the areas that have the greatest influence on a person. According to Stamm (2009), the

ProQOL model shows how three key environmental factors influence positive and negative aspects of helping and caring for others. These three factors are the individual's work environment (e.g., organization, individual's unit), personal factors, and exposure to the environment of the person or people receiving care or assistance (2009). All of these factors may contribute and influence how the practitioner perceives his or her ability to provide care. For example, a poor work environment due to understaffing, limited resources or toxic leadership may contribute to CF (2009). At the same time, a person may feel CS; he or she may feel pleasure and other positive aspects of helping others, despite having a poor work environment (2009). Figure 2 illustrates a comprehensive theoretical path analysis of contributing factors for CF and compassion satisfaction. The described pathway emphasizes components that may contribute to CF.

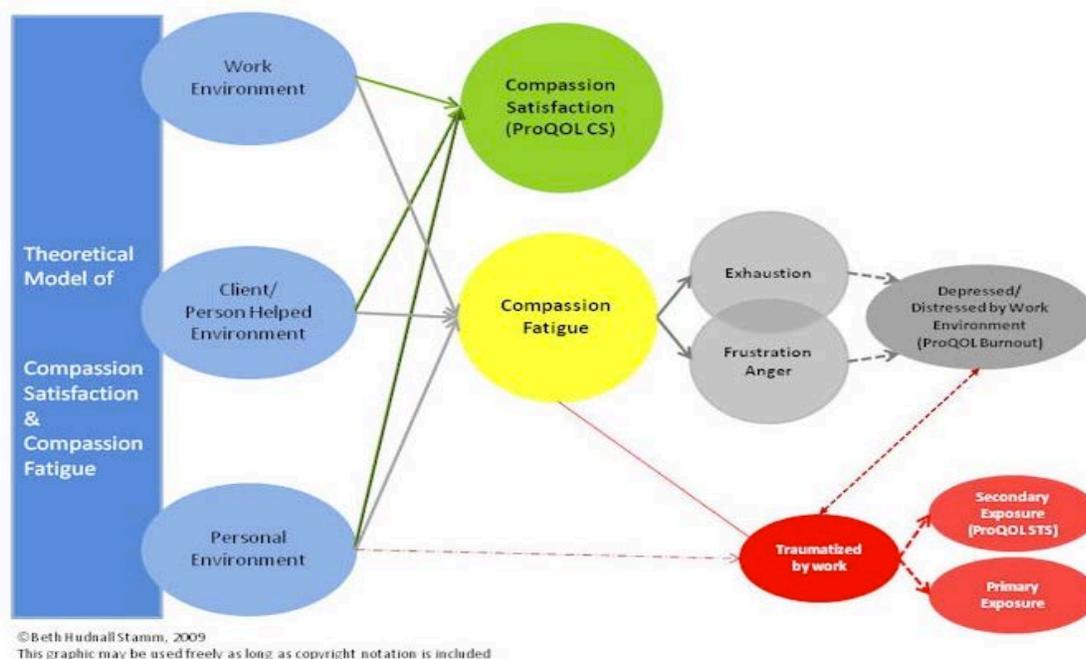


FIGURE 2. Theoretical Path Analysis. From *Compassion satisfaction and compassion fatigue* by B. H. Stamm, 2009. Reprinted with permission.

A strong theoretical link between trauma exposure and the pathways of the body's stress response system provided validation for hypothesizing physiological mechanisms and alterations or abnormalities in this disorder. Certain types of stresses put individuals at greater risk for chronic illness and poor health outcomes (Selye, 1976). From an evolutionary perspective, the classic stress response system involving neurobiological and psychological mechanisms enabled individuals to cope, adapt, and survive as a species (Friedman, 2001; Selye, 1976). However, intense stresses from a variety of traumatic situations (e.g., prisoner of war camps, natural disasters, combat) had a biological effect that was detrimental and posed a health risk for developing chronic medical illnesses similar to chronic stress (Valent, 1995). Trauma might manifest itself in varying degrees of severity. These symptoms combined to form a state of physical, emotional, cognitive, and spiritual instability in traumatized individuals, families, and groups (van der Kolk, 1996). Some RNs appeared to be more resilient than others to the transmission of traumatic stress; however, any RN who continually worked with traumatized individuals was at-risk for CF (Lester, Taylor, Hawkins, & Landry, 2015).

Prevalence of Compassion Fatigue in RNs

CF has been described in many helping professions; however, the reports of prevalence has been varied. The research team of Meadors, Lamson, Swanson, White, and Sira (2009) found that, among a sample of pediatric healthcare providers ($N = 167$), only 7.3% were at high risk for CF. The study explored the differences and correlations between PTSD, STS, CF, and BO. BO symptoms were not as strongly correlated to CF for the pediatric specialty or pediatric providers in that study as those found in previous studies with healthcare workers and mental health providers. The findings proposed that BO and STS each uniquely contributed to the development

of CF and that low CS may be a critical element in the development of CF. These findings resonated with Stamm's (2010) Professional Quality of Life Model.

RNs providing care in hospital emergency rooms frequently care for trauma victims, which may place them at risk for CF. In a study among emergency department RNs ($N = 67$) representing three community hospitals, 33% met the criteria for high CF risk. The most commonly reported symptom involved intrusive thoughts about patients, followed by avoidance and disrupted sleep patterns (Dominquez-Gomez & Rutledge, 2009). High rates of CF (28.4%) were also detected among emergency RNs and RNs from three other specialty units (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010) using the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL R-IV 2002). The findings of that study supported the hypothesis that emergency RNs were at a greater risk of CF and BO compared with RNs from three other specialty units.

Caring for children experiencing pain is often viewed as one of the most challenging of nursing assignments. Maytum, Bielski-Heiman, and Garwick (2004) conducted a descriptive, qualitative study of CF and BO among RNs ($N = 20$) working with chronically ill children. The sample consisted of RNs with baccalaureate degrees (65%); more than 70% of the sample had worked in the nursing field for more than 10 years. The most frequently reported work-related triggers of CF were watching painful procedures and observing children suffering from chronic illness. A common personal trigger was being too involved and crossing professional boundaries (Maytum et al., 2004).

The emotional challenge of caring for dying patients might be more common for those working in oncology. The emotional pain of caring for patients on oncology units was described

in the Quinal, Harford, and Rutledge (2009) study of STS among inpatient oncology RNs ($N = 43$). The researchers used the Secondary Traumatic Stress Scale to describe symptoms and the use and helpfulness of stress-reduction activities. In their sample, 37% of participants experienced symptoms of STS; the most commonly reported symptoms were difficulty sleeping, intrusive thoughts about patients, and irritability.

Another study involving hospice nurses offered similar findings. Behaviors that might lead to CF were described by Abendroth and Flannery (2006) in a study regarding CF among participants recruited from 22 hospice centers in Florida ($N = 216$); the researchers developed a demographic questionnaire focusing on demographic, work, and health-related information. They also utilized the Professional Quality of Life Compassion Satisfaction and Fatigue Subscales: Revision-III developed by Stamm (2002) to assess behaviors that could lead to CF risk. Data analysis revealed that 26% of the hospice RNs were at high risk and nearly 80% at moderate risk for CF. Triggers of CF included experiencing a traumatic patient death, anxiety, life demands, and excessive empathy leading to blurred professional boundaries. The participants who sacrificed their own personal and psychological needs for the needs of their patients reported increased smoking behavior, financial stress, headaches, and hypertension (Abendroth & Flannery, 2006).

CF has been documented in those who work with sexual assault survivors, possibly due to the high incidence of PTSD experienced by women and men who have been sexually assaulted. Townsend and Campbell (2009) examined the correlates of STS and BO among sexual assault RN examiners ($N = 110$). The researchers conducted telephone interviews guided by Figley's (1995) Compassion Fatigue Self-Test; data included organizational and demographic

variables, current levels of STS, and BO. Organizational variables played a significant role in predicting both outcomes. In this sample, more participants evidenced BO (41%) than STS (25%).

Several studies investigating CF described the prevalence within a specific population or type of nursing; however, some took a broader spectrum and included several inpatient and outpatients to determine the extent of who experienced CF. Yoder (2010) conducted a cross-sectional survey of RNs ($N = 106$) employed at a Midwest Magnet community-based hospital. Participants represented home care, emergency, intensive care, progressive care, oncology, and medical surgical units. CF and STS scores were significantly higher for RNs working 8-hour shifts than those working 12-hour shifts. Fifteen percent of the sample had scores indicating a high risk for CF. Events were categorized as possibly triggering CF or BO, including caring for patients, system issues, and personal issues. Frequently, events that precipitated CF were caring for young dying patients, caring for patients with extensive burns, or caring for patients victimized by a significant other. A common theme was the RNs' inability to save their patients.

There is no universal agreement thus far on the validity of an instrument to accurately capture CF among nurses. For example, Sabo (2006) posited the need for reliable, validated instruments to accurately measure CF as a concept and also suggested the need to shift from pathology to preventing CF. Sabo's discussion explored the potential benefits and limitations of attempting to quantify compassion and caring in relation to health outcomes.

Recent studies may have contributed to this body of understanding about CF. Current literature reported in nursing and other health care provider roles have examined selected concepts from the ProQOL model, including compassion satisfaction, BO, and STS (Stamm,

2010; 2014). Patient safety might be directly linked to nurse's job satisfaction (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). Sheppard (2015) explored compassion fatigue among graduate nursing students ($N = 54$) and identified that STS was a much stronger predictor of CF risk than BO. Working long hours and having negative work relationships were predictors of BO and CF risk among trauma nurses (Hinderer, VonRueden, Friedmann, NcQuillan, Gilmore, Kramer, & Murray, 2013). Yu, Jiang, and Shen (2016) investigated the prevalence and predictors of CF, BO, and CS in oncology nurses ($N = 669$). They noted a higher risk of CF among those with more years of nursing experience, correlating with persistent exposure to the patient's suffering and the use of passive coping skills. The strongest predictors of BO were personality traits such as being anxious, irrational, and neurotic, whereas those who were calm, agreeable, open, conscientious, and extroverted appeared to have less BO (Yu et al., 2016). Berg, Harshbarger, Ahlers-Schmidt, and Lippoldt (2016) identified shared perceptions among 12 trauma team members; findings suggested that fear of judgement by peers, poor ability to manage work stressors, or the failure to use coping resources might have contributed to high BO and CF results.

Compassion satisfaction may serve as a protective factor for reducing risk of CF. Interpersonal relationships and spirituality may be strongly correlated with reducing BO. Neville and Cole (2013) conducted a hospital-wide study among direct patient care RNs ($N = 164$) and found that significant relationships reduced BO and ultimately compassion fatigue. Increased levels of compassion satisfaction might result from a strong support system, use of adaptive coping skills such as exercise or meditation, and having positive work relationships ($N = 128$

trauma RNs; Hinderer et al., 2013). Table 2 identifies studies and articles that describe CF among RNs.

TABLE 2. *Compassion Fatigue among RNs.*

Author/Year	Purpose	Design	Sample	Findings
Abendroth & Flannery, 2006	Investigate the prevalence and the relationships between CF risk and RN characteristics.	Non-experimental descriptive design using cross-sectional data, descriptive, and inferential statistics.	<i>N</i> = 216 from 22 hospices across the state of Florida	78% of the sample was at moderate to high risk for CF with approximately 26% at high-risk.
Beck, 2011	Review literature on secondary traumatic stress (STS) in RNs	Systematic review	7 studies exam STS in RNs; 5 studies comprised all RNs.	Presence of STS in RNs reported in all of the studies. Three instruments identified Secondary Traumatic Stress Scale, Compassion Fatigue Self-Test for Helpers, and Compassion Fatigue Scale/Revised.
Dominguez-Gomez & Rutledge, 2009	Investigate the prevalence of STS in emergency RNs	Exploratory comparative design	<i>N</i> = 67 ED RNs from 3 general community hospitals in CA.	33% met the criterion for diagnosis of STS; 85% experienced at least one STS symptom in the past week.
Hagerty et al., 2011	Explore lived experience of combat-wounded patients and the military RNs who care for them.	Qualitative phenomenological design	<i>n</i> = 20 RNs <i>n</i> = 8 combat-wounded patients	Common themes RNs and patients: coping, shared experiences, finding meaning, psychosocial nursing care, families, and bureaucratic structure. Differences: patient's perspectives: "changed self." RNs described, "professional boundaries."
Hinderer et al., 2013	Examine relationship of BO, CS, CF, and STS to coping mechanisms and exposure to traumatic events	Cross-sectional descriptive design	<i>N</i> = 128 trauma RNs	35.9%, had ProQOL scores consistent with BO; 27.3% reported CF, and 9% had scores consistent with STS. More than 75% of trauma nurses in this study experienced CS related to caring for traumatically injured patients. CF was less prevalent than BO and was related to hours per shift, work relationships, and coping mechanisms.

Note. BO = burnout; CF = compassion fatigue; CS = compassion satisfaction; ER = emergency room; STS = secondary traumatic stress.

TABLE 2. *Compassion Fatigue among RNs (continued).*

Author/Year	Purpose	Design	Sample	Findings
Hooper et al., 2010	Explore prevalence of CF, BO, and CS among emergency RNs and RNs in other selected inpatient specialties	Cross-sectional survey	<i>N</i> = 109 RNs, <i>n</i> = 49 ER, <i>n</i> = 32 ICU, <i>n</i> = 16 Nephrology <i>n</i> = 12 Oncology	28.4% demonstrated a risk for CF
Ledoux, 2015	Discussion of how construct of CF is understood in nursing.	Discussion paper – Review of literature		CF is essential concept in nursing. Need to understand nurse compassion to understand CF. Recommends research, antecedents, effects, and prevalence.
Maytum et al., 2004	Identify triggers and coping strategies used to manage compassion fatigue (CF) and prevent BO in RNs working with children with chronic conditions	Descriptive qualitative pilot project	<i>N</i> = 20 pediatric RNs	RNs commonly experienced CF.
Meadors et al., 2009	Explore the overlap and differences between the concepts related to secondary traumatization: PTSD, STS, CF, and BO; examine influence of secondary traumatization.	Correlational design, hierarchical linear regression analysis.	<i>N</i> = 167 health care providers (<i>n</i> = 23 RNs) in PICU, NICU, & Pediatrics.	Personnel with higher levels of personal stress exhibited high levels of CF. Very few providers were at high-risk for CF (7.3%)
Meyer et al., 2015	Explore impacts of job stress exposure, CF, BO, and job satisfaction on nursing job outcomes.	Longitudinal study across 6 months of RN residency program	<i>N</i> = 216 novice pediatric RNs	Exposure to stressful events significantly related to BO. Trauma observed by new RNs had lasting emotional implications and lower job satisfaction. Stress predicts CF; no direct link of stress exposure and CS.
Neville & Cole, 2013	Examine relationships between health promotion behaviors, CF, BO, and CS	Non-experimental, correlational design	<i>N</i> = 214	Increase in CF may be due to increased complexity of patient care, increased changing technology, cost containment, and patient acuity. Subscale scores of health promotion, specifically spiritual growth and interpersonal relations, revealed the strongest correlations with CS and BO.

Note. BO = burnout; CF = compassion fatigue; CS = compassion satisfaction; ER = emergency room; STS = secondary traumatic stress.

TABLE 2. *Compassion Fatigue among RNs (continued).*

Author/Year	Purpose	Design	Sample	Findings
Quinal et al., 2009	Examine STS among oncology staff at a 500-bed Magnet-designated community hospital by determining the presence of individual symptoms and frequency with diagnostic criteria.	Correlational descriptive study	<i>N</i> = 43 hospital oncology RNs	37% of the RNs had moderate secondary traumatic stress
Rios-Risquez & Garcia-Izquierdo, 2016	Analyze associations between patient satisfaction with emergency services and perception of work stress and BO by nursing.	Descriptive, cross-sectional design. Data collected with questionnaires.	Two hospitals in Spain <i>n</i> = 148 ER RNs and <i>n</i> = 390 patients	No significant association between experiences of stress and BO among nurses and the satisfaction with care received.
Sacco et al., 2015	Establish prevalence of CS and CF in adult, pediatric, and neonatal critical care nurses. Describe demographic, unit, and organizational factors that may contribute to CS and CF.	Cross-sectional study; demographic questionnaire and ProQOL-5	<i>N</i> = 221 RNs from neonatal, pediatric, and adult ICUs in 739-bed tertiary care, New York academic medical center,	ICU RNs scored average in all 3 subscales of ProQOL indicating balance between CS, BO, and STS. No single unit had high degree of BO or STS. Work environment interventions correlate to increased levels of CS rather than preventing CF.
Sheppard, 2015	Describe CF in words and experiences of RNs to clarify construct of CF among RNs.	Concept development study: hybrid model incorporated theoretical, field, and analytical phase. Surveyed second-year DNP students; ProQOL survey and 10-week program	<i>n</i> = 16 RNs for field phase of concept development; <i>n</i> = 59 second-year DNP students	ProQOL most frequently used model to quantify and describe CF risk but may not adequately describe CF. Study did not support BO as a significant risk factor of CF; however, STS significant correlate of CF. CF seen as stigmatizing.

Note. BO = burnout; CF = compassion fatigue; CS = compassion satisfaction; ER = emergency room; STS = secondary traumatic stress.

TABLE 2. *Compassion Fatigue among RNs (continued).*

Author/Year	Purpose	Design	Sample	Findings
Shoorideh et al., 2014	Determine the correlation between moral distress with BO and turnover in Intensive Care Unit (ICU) RNs	Descriptive-correlational study	<i>N</i> = 159 ICU RNs	The findings showed ICU RNs' moral distress and anticipated turnover was high, but BO was moderate. A positive correlation between BO and anticipated turnover.
Townsend & Campbell, 2009	Explore the correlates of STS and BO among sexual assault nursing examiners	Cross-sectional interviews with RNs from a random sample of SANE programs	<i>N</i> = 110 sexual assault RN examiners	25% of the RNs reported that they experienced traumatic symptoms
Yoder, 2010	Describe the prevalence of CF among broad spectrum of RNs and investigate methods of coping.	Questionnaire with demographic information, ProQoL R-IV scale, and two narrative response questions.	<i>N</i> = 71 RNs from a Midwest Magnet 123-bed community hospital	15.8% high-risk category of CF, 7.6% BO, and 8.6% CS. Triggers and coping strategies identified.
Yu et al., 2016	Describe/explore prevalence of predictors of professional QOL (CF, BO, CS) using two theories: Multi-factor Model of CF and System-Based Model of Stress.	Cross-sectional survey of five secondary and 10 tertiary hospitals. Six instruments to collect data	<i>n</i> = 650 Chinese oncology RNs	Oncology RNs reported lower CS, higher BO and CF. Subjects vulnerable to moral distress. RNs with more years of clinical experience had higher levels of CF.

Note. BO = burnout; CF = compassion fatigue; CS = compassion satisfaction; ER = emergency room; STS = secondary traumatic stress.

Military RNs and Risk for Compassion Fatigue

All U.S. military RNs with issued orders to deploy may be placed in any location throughout the world. Some deployments pose higher threats of violence, chemical, and/or biological warfare (Elliott, 2015). These military RNs working in combat zones often endure complex challenges that may place them at significant risk for CF. When deployed to overseas combat zones, U.S. military RNs experience the stress of war, separation from loved ones, and situations that place them at personal risk for safety. Many of these nurses are placed in deployment situations that require nursing care while under these threats of violence and warfare (Elliott, 2015). The following discussion further outlines these risks.

Deployment to Hostile Environments

Military RNs often describe the dangers they faced when providing care in a war zone. In a case study, Tyson (2007), described the complexity of care for a critically injured and mechanically ventilated soldier in a helicopter, while also flying through hostile territory occupied by insurgents aiming rocket-propelled grenades (RPGs). The combat environment is unpredictable and inundated with uncontrollable factors. Using a composite case study methodology, Tyson described the potential for CF in clinicians treating troops serving in Iraq and Afghanistan. The author concluded that the complexities and environmental challenges encountered by clinicians working in the battle zones of Iraq and Afghanistan were more intense and significant than conditions in any previous war.

Changes in Workforce

The wars in Iraq and Afghanistan were the first sustained U.S. conflicts comprised of an all-volunteer male and female military force. Troops deploying to a combat zone ranged in age

from 18 – 60+ years. In Vietnam, the average age was 19 years old and in today's conflicts the average age is 29 years old. Ethnic minorities represent 24% – 40% of the force and women represent approximately 16% (Carson et al., 2000; Tyson, 2007). The deployment of females to combat zones has also been an unprecedented occurrence in American history; however, military nurses have been caring for those wounded in war since the Crimean War with Florence Nightingale (Goldstein, 2003).

Occupational Hazards

During a crisis military deployment, military RNs practice in unique settings such as mobile hospital or field hospital, where patient care is carried out under difficult environmental situations. Nurses may be working in an environment where the temperature exceeds 130 degrees, with high noise levels, in severe dust and sandstorms, surrounded by insect and rodent infestations, and facing exposure to sniper fire or minefield explosions. Extreme stress, chaotic workplace, and high intensity environments during wartime were considered occupational hazards for over 55% of the RNs at a military medical center ($N = 270$), who completed a questionnaire survey that compared stress levels and related behaviors in nurses (Kashani, Eliasson, Chrosniak & Vernalis 2010).

Environmental sensory overload. The impact of exposure to disturbing sights, sounds, or smells may leave lasting impressions on military RNs. Most smells, sounds, and tactile sensations were interpreted as negative, straining RNs mentally and physically (Agazio, 2010). In a phenomenological exploration (Scannell-Desch & Doherty, 2010) of Army, Navy, and Air Force nurses ($N = 37$) who provided care during the Iraq and Afghanistan wars, participants described distressing sights and sounds of whirling helicopters, thundering jets, patient screams,

sirens, explosions, the stench of vomit, and smells of open sewage, latrines, or burning feces. In many cases, participants reported the effects of the sensory overload, such as trouble sleeping, feeling anxious, hypervigilant, always ready to go at a moment's notice, never being able to fully rest, unable to get the smells out of their nostrils, or the particles of dead, burned flesh out from under their nails.

Dangerous and austere environment. Military RNs often described the dangers they may face on a daily basis when providing care in a war zone. In a personal autobiography, Kraft (2007), a clinical health worker stationed at Al Assad Combat Hospital in Iraq from 2003-2004, described how she had to adapt to the austere living conditions with challenges such as horrendous insects, threats of bombs and war, and witnessing the suffering of young severely wounded service members. In a descriptive qualitative study, Agazio (2010) described living and working conditions in austere and dangerous environments that added to the mental strain of military RNs ($N = 75$). One participant described wearing his 9mm Army issued handgun on him at all times, or hearing mortars and sniper fire shooting overhead (Agazio, 2010). The constant state of physical and emotional strain increases negative feelings driven by this work-related trauma, which that increases the probability of CF in these military RNs.

Extreme weather and lack of necessities. Military RNs may have provided care in extreme temperatures without proper heat, cooling, or resources to maintain sanitary, sterile, and safe patient care areas. In another study, participants ($N = 37$) described various challenges that affected the patients' medical conditions, such as high environmental temperatures. One military RN recalled working in Iraq in an ICU tent with high temperatures and lack of air conditioning, contributing to patient fevers; another RN in Afghanistan reported freezing temperatures and

only outside latrines for staff and patients (Scannell-Desch & Doherty, 2010). Resources were limited, which made providing safe, effective, and competent care a challenge. Equipment was frequently contaminated and some of the equipment had sustained heat damage, turning rubber and plastic medical supplies into brittle pieces and exam gloves disintegrating to powder. With limited supplies, RNs and other medical staff needed to improvise in order to compensate for equipment and supplies destroyed or not readily resupplied (Agazio, 2010); these situations often caused distress, frustration, anger, and disillusionment, which may raise the risk of CF.

Preparation and training. Military RNs who are deployed to war zones may need a wide array of preparation and training before getting to the battlefield. Once deployed, they care for patients who require a variety of nursing skills from basic, primary care, non-battle injuries to complex burns, polytrauma, multiple amputations, and extensive pain management, all across the lifespan (Scannell-Desch & Doherty, 2010). After conducting a phenomenological study of military RNs during the Vietnam War ($N = 24$), the authors recommended that military RNs obtain stronger medical-surgical and trauma nursing skills before being deployed in a war zone (Stanton, Dittmar, Jezewski, & Dickerson, 1996). The same recommendation was made by researchers Scannell-Desch and Doherty (2010), who stated that military RNs need much more training in critical care and with particular equipment prior to deployment. The lack of training and preparation for these military RNs increased their risk of emotional stress or even secondary traumatic stress.

Military nurses may be given positions in varied settings that place them in unfamiliar roles. According to Ross et al., (2008), 72 military nurses (Army, Navy, & Air Force) who participated in focus groups described personnel issues regarding training and assignment to jobs

when deployed overseas. Participants described that they had to train people at the deployment site, variable training levels existed for reservists; many were not trained in critical care and trauma; lacked training in assigned positions or lacked experience in area assigned; lacked an opportunity for training prior to deploying; young new nursing graduates were inexperienced and received their first officer assignment in a deployed environment. Interview data obtained from U.S. Army RNs ($N = 13$) reported that the patient care demands require high level assessment and clinical skills as well as, an advanced trauma and critical care skill set to provide care across age levels (Fry, Harvey, Hurley, & Foley, 2002). Without the necessary competencies and skillset for the high acuity patients seen in a deployed setting, military nurses may experience higher rates of burnout, which can lead to an increased risk of developing CF.

Fractured care delivery. Medical care that is not collaborative, cohesive, and driven by an interdisciplinary team, often produces broken or fractured care delivery that may compromise patient safety and quality care. Although team-delivered healthcare is found in Army military facilities, RNs ($N = 10$) reported that combat care differed in that the teams might not meet or work together until deployment into a combat zone (Elliot, 2015). Another area that might add to compromised care was working with unfamiliar colleagues, untested leadership, not being deployed with one's home unit and/or deploying alone and being assigned to an existing unit overseas (Ross et al., 2008). When patient safety and quality care are compromised, RNs may feel emotionally depleted, hopeless, and have the sense of reduced personal accomplishment; any of these feelings may raise the risk of CF.

Traumatic injuries. The trauma, as a result of rocket-propelled grenades may be a common scene for RNs working in war zones. In the study by Scannell-Desch and Doherty

(2010), participants revealed witnessing carnage such as multiple limb dismemberment caused by bombs and grenades. Participants recalled the physical scenes as horrific, but they were even more affected by the emotional cries for help. Some participants were shaken when victims were so maimed that identification became almost impossible. The authors identified a sub-theme related to RNs having to care for civilian children injured in the conflicts. Several examples were given, which depicted stories of caring for civilian children who had sustained injuries in violent or horrific ways. In some cases, the children sustained injuries through a family's efforts to cope with living in a war zone. On some occasions, the Afghan parents were unable to understand why modern medicine could not save their children; this pressure and cultural differences often posed personal and emotional struggles among the military RNs. The negative feelings of seeing and hearing horrific stories of children resulted in feeling heart broken, conflicted, depleted, and physical drained; all raise the risk of CF.

Moral and ethical conflicts. Military RNs may experience significant moral and ethical conflicts. The research team of Scannell-Desch and Doherty (2010) recounted military RNs reporting moral and ethical dilemmas, especially when they were assigned to a detainee. The RNs expressed fear when caring for insurgents or detainees in prison. The nurses of the 31st Combat Support Hospital, in Baghdad, Iraq, described the heart wrenching decisions they were faced with when it came to caring for ill or injured Iraqi civilians (Duncan et al., 2005). The memories of these tough decisions continued to impact their lives long after returning to the US. Ethical and moral conflicts can cause emotional frustrations, guilt, anxiety, anger, physical exhaustion that impact performance, and can lead to BO and CF (Shoorideh, Ashktorab, Yaghmaei, & Majd, 2014).

The moral conflicts weigh heavily and an increase in CF may increase the probability of nursing leaving the profession. Fry et al. (2002) concluded in their qualitative study involving Army nurses ($N = 13$), that moral distress occurred when people have a responsibility for moral action, yet they experienced barriers in carrying out the desired action. Kintzle et al. (2013) explored the rates of STS in military health care providers ($N = 70$). The most frequently reported symptoms were the avoidance symptom of feeling emotionally numb and the arousal symptom being difficulty sleeping; 34% of the participants reporting each, followed by intrusive symptoms of thoughts about the patient in 30% of the sample.

Trauma history. Unresolved personal traumas could amplify the response to caring for those with traumatic experiences. The literature on CF indicated that survivors of traumatic events were at an increased risk of developing CF as their unresolved conflicts may be triggered by the traumatic experiences of others (Figley, 1995; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995). Nelson-Gardell and Harris (2003) reported that child welfare workers and other professionals ($N = 166$) who endured a personal history of sexual abuse, emotional abuse, or neglect were at a greater risk of CF than their peers whom did not report a personal trauma history. In Adams, Figley, and Boscarino (2008) study of social workers ($N = 236$) living and working in New York City following the 9/11 attacks, those who reported past personal trauma were more likely to endorse symptoms of secondary trauma and overall psychological distress. The influence of personal trauma history on CF has not been examined in military RNs.

High patient volume and workload. Military RNs deployed overseas may work much longer hours than RNs working stateside, due to limited human resources and an unpredictable number of incoming wounded. Military RNs ($N = 123$) reported that they performed additional

duties that were not tied to their job descriptions, worked greater than 12-hour shifts, sometimes working seven-days per week, were involuntarily moved to multiple assignments throughout the world, were expected to work on scheduled off-duty days, attended mandatory training, and maintained rigorous physical fitness; none of these elements were required of their civilian RN counterparts ($N = 97$) within the same military treatment facility (Lang et al., 2010).

Stress factors, such as high patient volumes and heavy workloads may contribute not only to BO, but CF. Workload has been a broad concept that could be used to describe a wide range of job-related tasks, from the size and characteristics of one's caseload to the amount of job responsibilities; RNs must face their workday at a rapid pace daily (Fimian, Fastenau, & Thomas, 1988). The relationship between workload and CF has been explored in the literature; most studies focused on the percentage of trauma survivors in a health care provider's caseload along with the development of CF. Almost unanimously, the research indicated that heavy trauma caseloads and high percentages of trauma patient assignments were associated with an increased risk of CF (Creamer & Liddle, 2005; Fimian et al., 1988; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Sprang et al., 2007).

Stressors and coping. Two studies involving military nurses explored stressors and coping or the effectiveness of resiliency training. Kenny and Hull (2008) examined the stressors identified by critical care nurses caring for soldiers with severe life-threatening injuries at two military medical treatment facilities, one in the United States and the other in Europe. The response rate was 18% and the results were long answers to seven questions developed by the authors. In another study involving military nurses and medics, Weidlich and Ugarriza (2015) conducted a correlational, pilot study to examine the impact of Care Provider Support Program

(CPSP) training that looked at long-term effects of resiliency training provided to Army and civilian nurses, licensed practical nurses (LPNs), and medics ($N = 120$) from a military medical treatment facility at Fort Bragg, NC. The results of this study suggested that the resiliency training was effective at reducing the level of BO experienced by Army and civilian nurses, LPNs, and medics; however, coping skills and resiliency levels were not affected by this pre-deployment training. Table 3 identifies studies that describe CF among military RNs.

TABLE 3. *Experiences of the Military RN.*

Author/Year	Purpose	Design	Sample Size	Findings
Agazio, 2010	Identify challenges of nursing practice for Army RNs in military operations.	Qualitative descriptive design	<i>N</i> = 75 Army RN Corps officers w/deployment experience.	Prepare/train strong assessment skills, advanced trauma skills, personal mental preparedness for all age groups.
Elliott, B. 2015	Describe the military RN's post-deployment experiences and meaning	Qualitative, narrative inquiry	<i>N</i> = 10 military nurses	Common themes of experience: learning to manage change; facing reality of multiple losses; feeling like it is so trivial now; figuring where I fit in; and working through the guilt to move forward. Two themes for meaning: serving a greater purpose; looking at life through a new lens.
Foley et al., 2000	Explore experiences of military RNs as they engage in advocating practices.	Heideggerian hermeneutic phenomenology	<i>N</i> = 43 active duty U.S. Army RNs from peacekeeping settings.	Advocacy roles: predicated on some measure of human vulnerability, caring, adversary, safeguarding, preserving personhood
Foley et al., 2002	Describe characteristics of RNs and their work environments at two military hospitals.	Descriptive design (qualitative)	<i>N</i> = 103; 72 female, 31 male; 59 military RN, 41 civilian RNs	Scores above midpoint for RN-physician relationships, autonomy, control over practice, and clinical expertise.
Fry et al., 2002	Describe development of the model of moral distress in military nursing.	Qualitative content analysis to identify 10 moral distress stories.	<i>N</i> = 13 U.S. Army Nurse Corps officers, 6 female, 7 male	Identification of initial and reactive military nursing moral distress
Gaylord, 2006	Summarize findings related to the psychosocial effects of combat upon military service members to inform RNs caring for military members.			Deployment stress and exposure to combat associated with mental health problems. Military RNs caring for service members are at risk for developing CF.

TABLE 3. *Experiences of the Military RN (continued).*

Author/Year	Purpose	Design	Sample Size	Findings
Gibbons et al., 2011	Identify exposures, experiences, other factors influencing stress responses in military healthcare providers	Integrative review using Cooper's method	N= 38 articles	As with military combatants, military healthcare providers exposed to life-threatening situations increase probability of adverse psychological disorders following traumatic experiences.
Goodman, Edge, Agazio, & Prue-Owens, 2013	Understand military RNs' experiences of care for Iraqi patients.	Phenomenology	Three focus groups N = 15 RNs & LPNs	Three themes: expanding practice, ethical dilemmas, cultural divide.
Kashani et al., 2007	Investigate the state of the nursing staff during war time.	Descriptive, correlational study	N = 270 RNs at a military treatment center	Stress levels, primarily from work, were dramatically elevated in RNs; high morale and a strong degree of confidence in ability to cope. Mismatch showed the RNs inability to self-regulate as seen in unhealthy lifestyle choices within a chaotic work place.
Kashani et al., 2010	Investigate stress levels and related behaviors of RNs in a military medical center during wartime.	Descriptive quantitative. Self-report surveys: Moral scale, Perceived Stress Scale, Pittsburgh Sleep Quality Index, Epworth Sleepiness Scale. Wore actigraphy armbands.	N = 255; 69% female, 31% male; 49% married	RNs who felt more stressed were sleepier, more fatigued, tended to be overweight. Military RNs reported high moral & stress levels - mismatch
Kenny & Hull, 2008	Examine the stressors of RNs working in ICUs of two U.S. military medical treatment facilities pre/post beginning of <i>Operation Iraqi Freedom</i> & <i>Operation Enduring Freedom</i> .	Survey: long-answer questionnaire developed by authors to examine stressors and coping mechanisms	N= 18 out of 100 surveys sent (18% response rate).	

TABLE 3. *Experiences of the Military RN (continued).*

Author/Year	Purpose	Design	Sample Size	Findings
Kintzle et al., 2013	Explore rates of STS and how transfer of trauma occurs in contact with military personnel.	Descriptive statistics	<i>N</i> = 70 military primary & mental health care providers.	STSS mean score = 30.76. Most frequent symptoms - avoidance (emotionally numb) & arousal (sleep disturbances, intrusive thoughts of patients).
Kraft, 2007	Describe experience of clinical mental health provider in war zone.	Case Study	Personal Narrative	Autobiography describing 6-month deployment to Iraq 2003-2004 from personal perspective.
Lang et al., 2010	Examine difference in levels of BO between U.S. Army & civilian RNs assigned to large military treatment facility.	Cross-sectional design using Maslach Burnout Inventory	<i>N</i> = 364, convenience sample of RNs	Both groups reported BO but military RNs statistically higher levels of emotional exhaustion and depersonalization.
Lester, et al., 2015	Explore current research and programs designed to increase provider resilience within the military health system.	Review of current research	<i>N</i> = 10 studies	Resiliency training may increase provider resilience to address stress, prevent BO and CF. Only training is not an integrated solution; organizational and contextual factors play a role in provider resilience.
Scannell-Desch & Doherty, 2010	Describe the lived experience of U.S. military RNs who served in Iraq and Afghanistan (2003-2009)	Colaizzi's phenomenological method (both descriptive and interpretive phenomenology)	<i>N</i> = 37	7 themes and 7 subthemes. War broadened clinical skills but safety concern during deployment & ability to contact loved ones.
Stanton, Dittmar, Jezewski, & Dickerson, 1996	Determine shared perceptions, feelings, and experiences of U.S. military RN veterans.	Heideggerian hermeneutic phenomenology	<i>N</i> = 22 U.S. military RN veterans from WW II, Korea, Vietnam, & Operation Desert Storm	Five common themes/shared meanings: reacting personally to the war experience, living in the military, meaning of nursing in the military, social context of war, and images and sensations of war.

TABLE 3. *Experiences of the Military RN (continued).*

Author/Year	Purpose	Design	Sample Size	Findings
Stewart, 2009	Describe stress accompanying provision of medical care for casualties of war. Variables defined: PTSD, CF, BO, consequences, and military health care professional and CF.			Medical personnel in Iraq & Afghanistan battle death, human destruction, and suffering daily. Methods of prevention, organizational techniques, and self-care strategies.
Tyson, 2007	Existing data on the troops in Iraq and Afghanistan and case study of a clinician working with combat survivors to illustrate potential for CF in clinicians treating this cohort.	Composite case study	<i>N</i> = 1 clinician	Deterrants to CF – self-care, peer supervision, individual therapy – may not be enough for needs of clinicians working with combat survivors.
Weidlich, 2013	Examine the impact of a CPSP training on resiliency, coping, and CF over time; prior to, and 30 days post-training.	Prospective cohort pilot study	<i>N</i> = 120 military LPNs, RNs, and medics	CPSP training was effective in reducing BO, which leads to decreased CF in a group of Army RNs and civilian LPNs, and medics. Coping skills and resiliency levels not affected by CPSP training.

Summary

The literature review offered numerous accounts in which caregivers were at risk for developing CF, including the extreme state of tension and preoccupation with the suffering of those being helped to such a degree that it was traumatizing for the caregiver. The literature review illustrated the military RN and defined its members as being at risk for CF when providing medical care to service members and injured non-combatants, including civilians (Bride & Figley, 2009). The literature review also described existing perspectives of CF with emphasis on evolving theoretical models that pertained to the empathic understanding of a traumatized person's feelings that led to compassion stress and the positive and negative outcomes of helping those who experienced traumatic stress (Figley, 1995; Stamm, 2002, 2005, 2010).

Clearly absent in the literature were U.S. military RNs' voices about what the experience of CF means to them. Most phenomenological studies that have examined the meaning of military RN experiences with deployments, delivery of care, or caring for host-nation patients (Goodman, Edge, Agazio, & Prue-Owens, 2103). Research such as this is warranted and this gap provides the impetus for this study. Chapter II reviewed the literature describing CF. The concepts of STS, vicarious traumatization, BO, and compassion satisfaction were described and explored with regard to RNs, other health care professionals, and the U.S. military RN. The effects from an austere environment, war-induced traumas, preparation, and work environment were described in regards to U.S. military RNs and other health care professionals in the military. The effects of traumatic stress on the body and mind could leave the military RN

vulnerable to the development of CF, thereby hindering RNs' ability to provide safe, quality care for their patients in a variety of military settings.

In Chapter III, a discussion of the methodology involved in discovering and exploring the meaning of CF in U.S. military RNs post-deployment was developed. This discussion includes the design, sample, and procedures for the protection of human subjects, data collection, data analysis, and rigor in terms of trustworthiness.

CHAPTER III: METHOD

Chapter III describes the qualitative hermeneutic phenomenology utilized in this study of U.S. military RNs post-deployment through an exploration of their words, feelings, experiences, and shared perceptions of CF. This chapter includes a description of the study method, the role of the researcher, the sampling process and recruitment, the approach to gathering the participant's material, and the process of data analysis. In addition, the strategies for achieving trustworthiness of the findings are addressed.

Study Method

This study employed hermeneutic phenomenology to elicit the shared meaning of CF as experienced post-deployment by U.S. military RNs. Hermeneutics or interpretive methodology was utilized to study the person in the situation and uncover shared meaning rather than separating individual variables and situation variables, or predicting and explaining (Benner, 1994). Hermeneutics focuses on the ordinariness of everyday practical events that become part of one's life story (Kondora, 1993). The concepts of this process include historicity, pre-understandings or biases that are significant for self-understanding, the hermeneutic circle, the fusion of horizons, and the significance of the meaning of the experience (Annells, 1996; Crotty, 2003). To comprehend a certain culture, in this instance military culture, the researcher must seek common, everyday experiences and shared meanings (Benner & Wrubel, 1989). Meanings are derived from a person's background, including language, culture, and tradition (Benner 1985). The researcher enters the hermeneutic circle of understanding with each participant and through the narratives or text, specifically moves between the parts of the entire text and back to the whole in order to co-construct interpretations and develop understanding (Annells, 1996). As

the hermeneutic inquiry has no formal method, the research process adheres to the philosophical underpinnings of the Gadamerian hermeneutic phenomenology as its methodological framework (Fleming et al., 2003).

Purpose of the Study

The purpose of this study was to explore the phenomenon of CF as experienced by U.S. military RNs post-deployment to Iraq or Afghanistan during the war years 2003 through 2014.

Specific aims included:

- Describe compassion fatigue experienced by U.S. military RNs.
- Describe common triggers of compassion fatigue.
- Describe the shared meaning of compassion fatigue.

In order to explore the experience of CF, the study addressed what constituted the characteristics of the experiences that were shared among the participants. Through dialogue, I explored common thoughts, feelings, concerns, and patterns through abstraction that led to the development, experiences, and outcomes of CF. As described by Munhall (2007), the shared meaning that emerged from this study was grounded in the historical, political, social, and personal background within the experience of CF.

Hermeneutic Phenomenology

Guided by the philosophy and method of hermeneutic phenomenology, my role was both researcher and participant. When I met with each participant, two perspectives of a situation were recognized: the participant's and mine. The intersection of these two perspectives enhanced understanding and new perspectives.

The hermeneutic interview typically begins as conversation. The major aim of a conversation is to allow immersion into the subject matter, to hear the participants' stories and ask for clarification of their meaning (Fleming et al., 2003). It is through all forms of language that understanding becomes possible (Gadamer, 1990). The conversations consist of a process of co-constructing, which enhances the experiences through the *fusion of horizons* between the researcher and each participant (Fleming et al., 2003). Guided by the hermeneutic philosophy and method, the researcher relies on language and interpretation to elicit shared meaning through what is coined as the *hermeneutic circle* (Fleming et al., 2003). Journaling and self-reflection are used throughout the interview and analysis, which helps to cultivate truthfulness in the study (Crotty, 2003; Fleming et al., 2003; van Manen, 1997).

In this study, each interview began with a get-acquainted conversation. Each question was posed as open-ended and introduced broad concepts. I used active listening and observation in order to gain understanding through conversation. I described and interpreted expressions of meaning such as thoughts, emotions, feelings, motives, examples, behaviors, appearances, and both verbal and non-verbal communication. Ultimately, I elicited shared meaning by engaging in conversation with each participant. Throughout each interview, I took notes and journaled all personal reflections, which I incorporated into the ongoing analysis.

Protection of Human Subjects

This study involved human participants, thus it met the definition of clinical research. The University of Arizona's Human Subjects Protection Program (HSPP) approved the study prior to the recruitment of volunteer participants, and the collection of data. As soon as IRB approval was obtained, three potential key informants were contacted by e-mail. Two key

informants were retired Army nurse officers and the third key informant was a retired Air Force nurse officer. In my e-mail to the key informants, the purpose of the study was outlined and a recruitment flyer was included. The flyer described the study purpose, process, and telephone number in which interested military RNs could contact the researcher. The flyer contained examples of CF experiences, such as difficulty sleeping, nightmares, disturbing mental images, avoiding people or situations that reminded them of a distressing event, diminished interest in activities, irritability, inability to concentrate, low energy, or anxiety. Further recruitment occurred through referrals and snowball sampling.

Recruitment

The research sample was drawn from a population of U.S. military RNs who provided care during overseas deployment' the targeted sample size was 8-12 participants. Inclusion criteria consisted of participants who were 18 years of age or older, were able to converse in written and spoken English, from any branch of the military, and had been deployed in a military crisis situation as an RN to either Iraq, Afghanistan, or both theaters between the war years of 2003 and 2014. No participant was excluded from participating due to ethnicity or gender; according to the hermeneutic tradition, anyone who could speak to the phenomenon ought to be invited to participate. Interested participants were asked to contact me by telephone or e-mail.

Consent

As part of the consent process, I outlined the study purpose over the telephone with each interested participant. During these initial phone calls, potential participants were urged to ask questions or seek clarification about the study purpose or process. Once the participants agreed

to proceed, we discussed where and when to meet. In each case, we agreed on a location that provided privacy.

The consent process was formalized during the first physical meeting with each participant. I reiterated a review of the purpose and invited the participants to ask questions or seek clarification. After reviewing the written consent, the participants signed the consent and were given a copy of the consent document. The consent forms are presently stored in the Office of Nursing Research, College of Nursing, at University of Arizona where they will be kept for the next six years.

Potential for Risk

During the interviews, topics arose that could be sensitive or emotional in nature; there was a risk of psychological distress with each interview. The questions posed during all interviews were limited to the participant's experiences of CF. Participants were advised before each interview that they could elect not to answer a specific question and/or could withdraw from the study at any time without penalty. Although I have been trained as an Advance Practice RN (APRN) and am a U.S. Army Reserve (USAR) Officer, my role in this study was purely that of the principal researcher. I reiterated that my role was not to diagnose, offer any counseling or medical advice. Should any participant have become emotionally upset during an interview, the HSPP-approved process would have been offered; a referral to for counseling services through the Veterans Administration or Department of Defense military healthcare services.

Data Collection

Data from the interviews were obtained through close observations, conversation, and active listening. Fleming et al., (2003) defined the hermeneutic phenomenological data collection

process as gaining an understanding of a phenomenon, such as CF, through dialogue. Following this definition, I observed each facial expression, listened for a change in rate, tone, and volume, as well as made a mental note of all changes in affect. This information was captured in a notebook.

Journaling and reflection can enhance the process of data collection and analysis. A critical element of hermeneutic phenomenology included journaling and reflection in order to situate the researcher in the life-world of my study (Munhall, 2007). In my phenomenological journal, it was imperative that I went beyond description and interpret the meaning of what was truly being said by each participant. Phenomenological reflection allowed for a constant process of visiting and revisiting my pre-understandings throughout data collection and analysis to gain understanding and facilitate interpretation. I engaged in self-reflection before, during, and after each interview, and during the analysis.

Interviews and Observations

During the conversational interviews, participants were asked to describe their experiences of CF. According to Koch (1995), openness is critical as the exchange should be entirely unrestricted with few direct questions posed to each participant. In this study, I employed gentle probing as to the meaning, such as “go on,” or “tell me more,” as well as reflective inquiry offering comments such as, “What did that experience mean to you?” Throughout the interviews, I wrote brief notes about comments, body language, or other observations. This allowed me to follow up on any comment that seemed to elicit emotion or concern. I was also able to ask for clarification when a participant’s statement appeared to contradict a facial expression or body language.

In order to facilitate the immersion into the subject matter, each participant was interviewed three times; no participant was interviewed more than once in a seven-day period. The interviews or dialogues lasted an average of 80 minutes (range 27-139 minutes). The initial interview allowed for introductions that could easily transition into each participant's military and nursing history. Initial interviews were analyzed before proceeding to the second sequence of interviews. The second interview discussed key points from the previous interview while the third interview focused on the participants' reflections of my interpretations. All 24 narratives were collected from July 2015 through October 2015.

Each conversation was audio taped from beginning to end. The recordings allowed interviews to be transcribe verbatim by a professional transcriptionist. Each audio recording of the interview was uploaded into Microsoft® Word, including all field notes or notations made during and after the interviews.

Data Management

Participants are not personally identified in any reports or publications as a result from this study. Only my dissertation committee and I have access to the information provided by the participants. The notes taken during the interviews, the recordings, and the written narrative identified all participants by pseudonyms and the data sources are stored in a locked cabinet at my home office. Participants were assured that information would be kept secure and confidential. Interview data is secured using password protected files on a password-protected computer. Tape recordings will be destroyed upon completion of the study; narrative text is kept in a locked safe in the researcher's home office and will be destroyed in six years by shredding.

Data Analysis

Data for hermeneutic analysis may include written text and the researcher's journaling and self-reflections. Analysis incorporates self-reflection and journaling, movement from the whole to the parts and back, that evolves into new understandings to generate further meaning (Fleming et al., 2003; Geanellos, 1998). In this study, the analysis phase included both a description of each participant's experiences and a simultaneous interpretation of the meaning that was formed by both the participant and myself. The first encounters with the texts were influenced by my pre-understandings. The findings were reported as narrative texts that provided descriptions and interpretations of individuals living through events and experiences. Written transcripts summarized the initial analysis used to highlight key points from the previous interview. I returned to each participant with key points from the previous interview and asked, "In this narrative, am I interpreting the meaning of the experience for you?" and "Does this mirror our last conversation about CF?" This process allowed me to capture the meaning encapsulated in context. Through feedback and subsequent dialogue, a shared understanding in relation to the phenomenon of CF was reached.

In each long narrative, it was critical to choose the centrality of meaning, then to integrate the narrative with its meaning. Next, I self-reflecting on the question, "How could I discover the meaning of the experience as though there was only one meaning?" Although, there were common perceptions of experiences, they were essentially diverse from common or shared meanings. Each iteration with the text and perceptions of each participant facilitated a fusion of interpretations.

The last step when writing the phenomenological narrative involves creating phenomenological descriptions from shared concerns, feelings, and meanings. This is done in order to sensitize the reader to the deeper significance of the meaning of the experience being described (Munhall, 2007; Coles, 1991). Following these methodological and philosophical guidelines, the narrative was reflective of the complexity and interconnectedness of all expressions spoken and revealed. This provided me with understanding of a deeper contextualized meaning of the military RNs' experiences. I completed a critique of the meaning of the study. The critique was enriched when I asked each participant to offer suggestions for change that might mitigate CF in other military RNs who deploy overseas with the military. The final critique from each participant is described in Chapter V.

Strategies Used to Maintain Methodological Rigor

A key concept in qualitative research is establishing trustworthiness. Sandelowski (1986) described trustworthiness as remaining true to the scientific method as a means to achieve rigor and truth-value of the study findings. This qualitative study employed various means to evaluate that mutual understanding and trustworthiness occurred.

Trustworthiness

In hermeneutic interpretive phenomenology, the researcher seeks understanding and shared meaning, which necessitates trustworthiness between participants and their narratives. The researcher strives for integrity by examining how decisions were made in analysis, why decisions were made, if analysis clearly reflected the experience, and if participants could recognize the experience as restated by another. Four specific areas of trustworthiness are addressed, including auditability, credibility, confirmability, and objectivity.

Auditability. Auditability refers to the documentation of steps in the research process. The audit is a key trustworthiness process, but auditability refers to maintaining records that can be followed, understood, arranged to facilitate cross-referencing, and linked to assertions in the study with the data (Lincoln & Guba, 1985). I documented the various steps in my research process and the decisions made during different stages of the analysis. The steps in the research process, along with my self-reflection, continually answered whether the interpretations were influenced by my pre-understandings or biases. This process was further augmented by discussions and decisions from beginning to end with my research mentor.

Credibility. Credibility refers to the findings (narratives and interpretations) as being recognizable by the participants, and helps to verify that the researcher adequately captured the essence of the participants' stories and shared meaning. Each participant's story is personal and unique to each participant's experience, and although replication may be improbable, the narratives and shared meanings should be recognizable (Fleming et al., 2003). I established credibility by ensuring that the perspectives of the participants were represented as clearly and accurately as possible. Credibility referred to the findings themselves: observations, verbal accounts, interviews, reflection, and ongoing analysis. To use the voice of the participants, I used direct quotes from the text. During each participant's final interview, I shared my interpretation of his or her narratives, and inquired if my statements accurately reflected what was described during the previous interviews.

Confirmability. Confirmability refers to attaining mutual understanding and the fusion of horizons. The truth-value resides in the discovery of the human phenomena or experiences as perceived by each of the participants (Fleming et al., 2003). Through this discovery, the

participants and I shared language, history, and culture. To remain objective, I returned to each participant at all stages of the research process. Confirmability and understanding was further expanded through a collaborative review of the texts and continuous dialogues of the participant's shared experiences and meanings with my research mentor in order to complete the hermeneutic circle. This criterion allowed me to establish credibility, auditability, truth-value, and applicability.

Objectivity. Objectivity attempts to uncover truth by eliminating personal prejudice and bias. However, the hermeneutic philosophy purports that true objectivity is not attainable because any reader of this study would experience his or her own interpretation of language, culture, and time based upon his or her own worldview (Fleming et al., 2003). I strived to authentically and accurately depict the expressions of meaning through ongoing reflection during interviews, transcription, and subsequent interpretation. Reading and re-reading the narratives, while concurrently reflecting, allowed for a discovery of the expression of meaning, and how it contributed to human understanding, and shared interpretations.

Summary

Chapter III presented the methodology for this phenomenological study. The study method and ontological endeavor were described. The sampling procedure, process of data collection, concurrent data analysis, and approaches of ensuring rigor were defined. Chapter IV discusses my self-reflection and the study findings.

CHAPTER IV: FINDINGS

Chapter IV begins with a summary of my ongoing reflection. A description of my pre-understandings prior to interviewing participants provided the foundation of a pre-condition to the truth through a process of continual questioning, reflection, and validation. This chapter provides a description of the study settings, includes an introduction of each participant, and presents the findings and analysis.

Journals and Reflections

Self-reflection is an important part of the hermeneutic method. In order to identify fore-structures and pre-understanding of the phenomenon under investigation, the researcher engages in self-reflection and journaling before, during dialogue, and even during data analysis (Fleming et al., 2003; Geanellos, 1998). The beginning of this existential investigation utilized my fore-structures (fore-having, foresight, and fore-conception of beliefs about the nature of CF) and pre-understandings in order to reflect on my own beliefs or biases that might prevent me from hearing clearly the participant's experiences. My pre-understandings were reflected upon throughout data collection and analysis in order to facilitate my understanding of participants' stories and their meanings. During the research process, my pre-understandings evolved through the collection and interpretation of data that carried my experience of self into the study.

Self-reflection and journaling enabled me to develop deeper thoughts about the participants and their experiences, and included my feelings of frustration, surprise, or even questions as the study evolved. Self-reflection helped to identify any of my pre-understandings such as any assumptions that I held regarding CF in military nursing. By bringing pre-understandings to consciousness, I was able to consider their presence during textual

interpretation; that process prompted me to question their origin, adequacy, and legitimacy in order to look beyond them to other interpretations. The following components describe my fore-structures and pre-understandings.

Fore-having is defined as my personal lifeworld background, values, beliefs, and culture (Geanellos, 1998). My fore-having includes strong family influences. I was raised in a home with strict adherence to rules and regulations of the Lutheran faith and a strong German influence of stoicism, hard work, and discipline. I experienced my elders from my paternal side as strict, authoritarian, and domineering. Some important family members fought in both WWI and WWII, and their military history was a source of pride. My maternal grandmother was strong and influential. Within both maternal and paternal family patterns, the sharing of emotions and expressing psychological perceptions such as grief, anxiety, and depression, was not encouraged during my formative years. Being perceived as strong, self-sufficient, independent, and resilient were viewed as strengths.

Foresight is defined as a point of view from which my interpretation is made (Geanellos, 1998). My professional interest in the phenomenon of CF among military RNs developed through my professional roles and personal experiences. As an RN case manager, clinical educator, and experienced RN, I have had numerous encounters that influenced my understanding and interpretation. While serving in the U.S. Army Reserves within the Army Nurse Corps, I worked at two separate Military Treatment Facilities as well as within the VA Healthcare System. I have heard first and second-hand narratives from numerous patients with mental and physical injuries sustained during overseas deployments in hostile environments. My husband, who previously served in the U.S. Marine Corps, deployed six times to Iraq and two

times to Afghanistan as a Security Specialist Independent Contractor. His experiences certainly influenced my own foresights. As much as I have valued the personal freedoms that our military secured for our nation over the years, I have had reservations about our military involvement in other countries. I also have had my own trepidation of being called into a hostile or unstable environment if ordered to deploy in the future.

Fore-conceptions is defined as what I expected in the interpretations of the meaning of the experience (Mak & Elwyn, 2003). As I reflected on my own fore-conceptions, I anticipated that the participants would express pride in serving in military medical units overseas and caring for patients. My belief was that RNs embody the intrinsic empathy and caring for others and in doing good, while providing the best care for all patients. I believed that many military RNs experience guilt and grief when caring for military service members and civilians of all ages, wounded or killed, due to the intended and unintended consequences of war. I anticipated that RNs working in hostile environments would experience cultural challenges influenced by their own biases or prejudices about local nationals and combatants. I expected to hear participants described fear, including fear for their safety. I expected to hear them describe feelings of loneliness due to being away from family and friends, and uncertainty in so many facets of their lives. My belief has been that the risks of developing CF are extremely high among this population as these individuals cared for traumatized patients. My beliefs, roles, and personal and professional experiences caring for patients with polytrauma, whether from TBI, military sexual trauma, PTSD, and/or depression, have all been part of the fore-structures and pre-understandings that framed meaning from my culture. At the same time, I developed a

professional perspective of CF based on what I learned from the literature and even nonmedical literary sources, which complemented the everyday nature of CF among military RNs.

Through self-reflection, I was able to identify how my personal and professional knowledge and experience may have influenced the process of data collection through hermeneutic interviews, even to the data analysis. As I considered the meaning of CF in military RNs, I frequently wondered what it meant to be a human in that experience of CF and how having a better understanding of CF might affect each RN's self-care, behaviors, and outcomes. I wondered if I would be able to co-construct the meaning of CF with each participant. Finally, I wondered if the voices of military RNs might inform care providers, public policy makers, and the military system to improve the health of RNs working with traumatized populations. I was aware of my need to consider my own fore-structures prior to conducting the interviews in order to allow the participants' stories and experiences to emerge in their purest form.

Researcher's Worldview

My personal philosophical view blends behaviors, culture, politics, and spirituality, which all affect knowledge. Much of my thinking has been influenced by the writings of Parse (1990). My worldview is a compilation of beliefs, values, acquired knowledge, and clinical practices. My fundamental conviction supports the patient's belief of health, prevention, treatment, and restoration. Humans are part of the universe and the relationship is complementary and continuous. Health is ever changing and includes the overall physical, mental, social, and spiritual aspects of how humans live and what they experience. Nursing is a partnership with the patient to support one's definition of health and wellbeing. Each individual, family, or community define what the term, health, means to those living in the experience. The

next discussion introduces the participants, and how my observations and worldview helped to inform my perceptions of the participants.

Research Participants

Establishing the background of each participant provides a representation of each and leads the reader into the findings. Profiles were generated from comments made by the participants and from my perceptions formulated during interactions with each individual. Analysis was derived from commonalities among participants as they express feelings, concerns, and emotions while they described their experiences. Throughout the discussion of findings, quotations and anecdotes are included to support and illustrate the patterns of individual and shared concerns and shared meaning. Military personnel frequently use terms and abbreviations that may not have meaning to non-military personnel; to stay true to the participants' words and language; those terms are included in direct quotes. Brief definitions are offered within the narratives to lend understanding to the participants' narratives. Pseudonyms are used in all subsequent discussions and specific identifying information is omitted to protect participants' confidentiality. Profiles of the participants are provided first, followed by participant interview findings.

Two retired Army nurses served as key informants. A retired Air Force nurse was contacted to serve as key informant, but I did not receive a response to my communication attempts. Therefore, no Air Force personnel were included in this study.

The participants of this study ($N = 8$) consisted of U.S. military RNs; all were officers in the U.S. military during their overseas deployment. The sample included seven Army officers and one Navy officer.

Each participant held a four-year college degree. Additionally, six also had graduate degrees, and three were Advanced Practice Nurses. All were serving in the military at the time of the interviews and the total time in service ranged from eight to 23 years. One-half of the participants joined the Army as enlisted soldiers, served for at least four years, then completed a bachelor's degree in nursing and were commissioned as an officer. All participants deployed at least once for a minimum of six months; one soldier deployed three times to a war zone while another officer involuntarily extended, making her deployment 18 months in length. Table 4 depicted the study participant demographics.

TABLE 4. *Participant Demographics.*

ID	Pseudonym	Age	Gender	Race or Ethnicity	Military Service	Service Time (Yrs.)	Overseas Deployments
1	Alan	40	M	Caucasian	Army - AD	23	2
2	Betty	41	F	Filipino/mixed	Army - AD	23	1
3	Charlize	43	F	Filipino/mixed	Army - AD	17	1
4	Delphia	41	F	Asian Indian	Army - AD	17	5
5	Ed	39	M	Caucasian	Army - AD	13	2
6	Fran	46	F	Caucasian	Army - RC	8	1
7	Ginny	52	F	Caucasian	Navy - RC	12	2
8	Helen	36	F	Puerto Rican	Army - RC	19	3

Note. AD = Active Duty; RC = Reserve Component

Profiles of the Participants

A brief set of profiles is included below in order to provide context to the participants' stories. Each participant was assigned a pseudonym. Defining characteristics and locations were intentionally excluded from the narrative to protect the participants' identities. These profiles were based in part on the statements made by the participants during the interviews. All participants helped to create their profile by what they elected to share and what, if anything, they opted to withhold. My perceptions and impressions stemmed from repeated interactions with each participant and added to each individual profile.

Alan. All three interviews with Alan took place at the same restaurant. Alan was dressed casually during each interview; he always had a quiet, calm, but serious demeanor. He was soft-spoken, tired, and sarcastic. He frequently asked me to repeat questions, as he was hard of hearing due to an improvised explosive device (IED) blast during a deployment.

During the first interview, Alan described his Active Duty military career and nursing career. He outlined when his career began and described it as now winding down after 23 years of military service. Alan described his experiences during his two deployments and specified feeling frustrated with his first deployment. During his first deployment, he served as an emergency room nurse with a Forward Surgical Team (FST), a small, mobile surgical unit at the forward edge of the battle area. He expected to see more trauma cases, but rather than such excitement, his team managed the primary medical and mental health care for the Reserve units during the initial invasion into Iraq. Alan redeployed in 2012 as a Clinical Nurse Specialist in Trauma/Critical Care and as an Acute Care Nurse Practitioner. He functioned as the Director of Critical Care Nurses who supported the transportation of casualties with a medical evacuation team for U.S. military service members in Afghanistan.

Alan expressed feeling frustrated from the moment he arrived in the combat zone. In essence, he had to prove to his commander that integrating critical care nurses with medical evacuation teams improved patient outcomes. Each time Alan described his experience during his deployment to Afghanistan, I observed a heaviness in his demeanor. His expression was solemn and serious; his eyes were tired with dark circles under both eyes. When he described what he considered an error on his part, he teared up, avoided eye contact, and tapped his foot

with anxiety, especially when he described the story of an Afghan child that did not survive a bullet wound.

Betty. Betty's interviews were conducted in restaurants on Army installations. She was always talkative, smiling, appeared comfortable, and was personable. With each encounter, I felt that I had known Betty for years.

Betty began her military career as an enlisted soldier and clerk typist in the Army Reserves. Betty transitioned to active duty and started nursing school. After she graduated with her BSN, she was commissioned as an officer and deployed shortly thereafter to Iraq. Betty mentioned that when she started her Army career as a nurse, she loved nursing but did not love the Army. She stressed that often she did not feel prepared for her various roles in nursing.

Charlize. These interviews took place in a coffee shop or fast food restaurant. Charlize was animated, verbose, and very engaged. She described her nursing career and military career with energy and excitement. I often had difficulty staying on track with her descriptions of her experiences due to her rapid speech. By the third interview, she was contemplative and quiet. She remarked that it was easy for her to talk about her experiences from a clinical perspective, but it was far more difficult to talk about her feelings, thoughts, and concerns as it related to her experiences with CF.

Charlize began her military career as an enlisted soldier (mechanic) with a reserve unit shortly after high school. During her reserve unit years, she attended nursing school. Charlize obtained critical care experience by working in the ICU and on critical care transport. She then obtained an advanced practice degree while serving as an Active Duty officer. During that time, she functioned primarily in administrative and management positions. She expressed that she had

to learn quickly on the job how to manage operations at a family practice clinic. Shortly after that position, she deployed to an austere setting in Iraq as the sole nurse practitioner to several Army infantry units. She described living in meager conditions. Providing advanced practice was a challenge as there were no diagnostic resources such as a laboratory to rule out medical issues or radiology to order a CT scan or MRI to rule out traumatic injuries. She had to rely on her own clinical judgement, intuition, and clinical assessment skills.

Delphia. Delphia was an acute care nurse practitioner who worked mostly in acute care settings or in administrative positions for the Army. She expressed frustration with her role in the Army. To illustrate her frustration, she outlined that although she was certified as an Acute Care Nurse Practitioner, she was not able to function within her scope of practice as the Army only utilized Family Nurse Practitioners. She maintained her clinical skills by working in various military hospital settings. She described her nursing experience in trauma care, cardiology, and ICU within various military treatment facilities throughout the United States. She also had numerous deployments including to Iraq, Afghanistan, and other Middle Eastern and Asian military settings.

Each of Delphia's interviews were conducted in her office at a military hospital. She appeared hurried and was usually between meetings each time we spoke. Our interviews never exceeded 40 minutes and then she would state the need to rush to another commitment. She appeared very professional and soft spoken when describing her military and nursing career.

Ed. Ed's interviews were conducted in a coffee shop outside an Army post. Ed described his military and nursing experience in a very quiet, soft-spoken tone. Often it was difficult to

hear him speak as the volume of the coffee shop patrons or piped music drowned out his voice. He appeared nervous and uncomfortable sharing his experiences during the first interview.

Ed served in a reserve component for eight years as a field artilleryman. He then obtained his nursing degree and worked for more than a decade as an emergency room nurse in civilian hospitals. He deployed to Afghanistan with a Forward Surgical Team (FST) or a small, mobile surgical team in remote, austere areas providing medical support for a Special Operations Force. He outlined that he was often the only RN with the required training and experience in these remote areas, thus he frequently had to function in multiple high-stress roles such as an emergency RN, ICU RN, and flight nurse. He spoke of the intensity of the mission and described his nursing role as casualties arrived; he assisted in the OR with anesthesia, recovered the patients following surgery, and provided post-operative care before the patients were evacuated.

Fran. Fran's interviews were conducted in coffee shops; she always arrived dressed in workout clothes. She volunteered that some people thought she was "*obsessed with fitness*;" she called it just being healthy. Fran's demeanor was organized, serious, and tough, even when we developed a rapport throughout these conversations. She was very outspoken and presented a strong opinion on her challenges, but expressed pride with being selected for her special operation during her deployment to Afghanistan.

As a civilian, Fran had experience as a neonatal intensive care nurse and an emergency room nurse; in the Army, she was a case manager. The Army selected her for a special mission to Afghanistan with the Special Operations Forces. Fran described her pre-deployment preparation and extensive training in the Afghanistan culture and developing personal resiliency. While she assisted military service members, her primary role was to engage with members of

the Afghanistan public, especially local women. She explained that the military intent was to have nurses set up a medical clinic to treat the local population, but the military direction changed. She expressed frustration with her deployment, as she felt underutilized and distressed at having to turn away the local population.

Ginny. All of Ginny's interviews took place at her home in a rural city. She was always casually dressed having just returned from a morning run and sipping a cup of coffee. She was relaxed and very precise when describing her military and nursing experiences.

As a Naval Officer in the Navy Reserves, she served first in Europe and then in Afghanistan during her last deployment. Her extensive nursing career included intensive care, critical care post-anesthesia and emergency department. She also served as an educator, supervisor, manager, and director in various practice settings.

Ginny's maturity, confidence, and quiet demeanor were evident in each interview. She voiced that she experienced long-standing compassion fatigue and commented that she did not possess a lot of compassion. She expressed that the moral dilemmas she observed during overseas deployment had the greatest impact on her personal and professional attitude. From the statements she made during the interviews, Ginny seemed to have more of a deep understanding and acceptance of the Afghans' and their tribal culture than any other participants.

Helen. Helen's interviews took place in various restaurants. Helen was very confident, self-assured, and at times did not answer the question being asked. She would laugh and her affect was not congruent with the overall tone of the conversations.

Helen had been an Active Duty officer in the U.S. Army Reserves. She began her military career as an enlisted female combat medic and was one of the first females embedded in

a combat-ready, deployable force unit. Her primary responsibilities were running an aid station, providing sick call, and providing basic aid for combat and infantry units. She completed a degree in nursing while maintaining her enlisted soldier status. Her nursing career began in a progressive care unit followed by an intensive care unit, then emergency medicine, and finally as a flight nurse in a trauma center. Due to her specialized trauma skills, she deployed to Afghanistan. Her first deployment was working on an FST in northern Afghanistan; she was a member of a small female team that provided medical support to soldiers and cared for the local population. She was only one of three female nurses and voiced that, “*when you deploy, you have to do whatever you have to do.*” Sometimes that involved taking actions that felt uncomfortable, such as having to pat down Afghans prior to rendering care, to make sure the Afghani patients were actually women.

Summary of Participants

The profiles of the participants offered a brief glimpse into their lives and relationships with others before, during, and post-deployment, providing the background of their experiences with CF. Considering and reflecting on each participant’s experiences allowed me to distinguish between the similarities and differences among the participants. This process ultimately enabled me to identify similar patterns within the participants, including similar experiences, concerns and emotions. As these patterns slowly emerged from the dialogue, I included my own reflections obtained during interviews and engagement with the text. In this way, shared meanings were elucidated.

Shared Concerns, Shared Meaning and Patterns

The following accounts depict each participant's experiences and associated emotions. Direct quotes from the participants are used to illustrate shared concerns and patterns. My observations of participants' behaviors, demeanor, facial expressions, and body language are included within the narratives. In keeping with the hermeneutic tradition, I also include my self-reflections as they arose during data collection and analysis. Similarities and differences between individual experiences, feelings, and shared meanings are well defined. Concurrent analysis and reflexivity evolved into four abstractions of shared meaning that describe the participant's experiences of CF, which are outlined below.

Meaning #1: The Term CF Does Not Fit Me

This is defined as participants perceiving CF in others but avowing that it does not fit their own experiences. Shared concerns include (a) *seeing CF in military colleagues, but it doesn't fit me*, (b) *you lose compassion for people*, (c) *accepting less than my personal standard*, and (d) *no time for CF*.

Meaning #2: CF is All Encompassing

This is defined CF manifesting in emotions, feelings, and behaviors, with associated physical, relational, and/or spiritual distress. Shared concerns included (a) *not feeling prepared*, (b) *living with CF day and night*, (c) *disruption to relationships*, and (d) *emotionally depleted*.

Meaning #3: CF Will Not Interfere With My Military Duty

This is defined as the pervasive military lens through which participants' experiences were filtered. Shared concerns encompass (a) *keep your focus on the mission*, (b) *I would be*

viewed as weak and incompetent, (c) pushing it aside, dealing with it someday but not today, and (d) disclosure could destroy my career.

Meaning #4: CF Affects People Long After Deployment . . . Gone, But Not Forgotten

This is defined as the lasting effects of CF. Shared concerns include (a) *living with the guilt*, (b) *coping with CF*, (c) *more resilient than I thought*, and (d) *I am a different person; I am choosing a different path*.

The discussion of findings outlines the experiences that occurred, but more importantly, what the experiences meant to these military RNs. The following sections describe each of the shared meanings. Within each shared meaning comprises four concerns that were voiced by most or all of the participants.

Meaning #1: The term CF does not fit me. Each participant was asked what CF means. The majority of participants appeared reluctant to describe their own experiences of CF, but were able and willing to describe what they believed the term meant from their readings or how they saw CF manifested in others. By volunteering to engage in dialogue for this study, every participant self-identified as having most or all of the experiences of CF listed on the recruitment flyer. However, during the interviews, only one-half of the participants actually admitted to having CF. During many conversations, terms such as burnout, post-traumatic stress, and CF were used interchangeably. Betty and Delphia emphasized that they could not possibly have CF, because they cared so deeply for the military service members and civilians. Their feelings, thoughts, and concerns are depicted below.

Seeing CF in military colleagues, but it doesn't fit me. Many participants admitted having experiences or feelings that might fit the definition CF, but denied actually having CF.

Several mentioned recognized CF in military nursing colleagues, but as Betty described, most people minimized those experiences. Several participants voiced skepticism about the term. Delphia denied having CF but then offered that there was a period after deployment when “*you feel like no one really cares*” and she recalled this period feeling more like depression than CF. Several times Ginny expressed concern that she might be an outlier for this study because unlike many military nurses she believes she had CF long before her deployment to Afghanistan.

Helen described CF as “*an interesting theory.*” She read about it, but she was adamant that she could not possibly experience the symptom of being too tired to care. Charlize added that she compared “*CF to some sort of fibromyalgia.*” She saw the parallel with CF when relating her feelings and emotions as the caretaker of her adult son who sustained traumatic injuries from an accident. Ginny spoke of learning to compartmentalize emotions. She did not discount CF, but thought that everyone handled traumatic stress differently. Ginny reasoned that her issues post-deployment related to “*moral injuries, rather than traumatic stress.*” She offered an example of a moral injury: struggling with the ethical decisions to keep soldiers alive long enough for their families to see them before they died.

You lose compassion for people. Most of the participants expressed the loss of empathy and the loss of compassion, not only for patients but also for friends and family as well. Alan spoke quietly but harshly about how he hated the world when he returned from his last deployment to Afghanistan. For Alan, “*I hated the world when I came back . . . I just had no empathy.*” Fran expressed this same resonating theme, “*I just feel like my general compassion for the average person is gone; I know I shouldn’t feel this way, but I don’t necessarily want to go back to feeling that way again.*”

Most participants described an emotional change toward some patients post-deployment. Terms included feeling less tolerant, more judgmental, and even less caring toward patients who were not really “sick.” Some expressed disgust, annoyance, and even disdain for patients stateside who complained about small aches and pains. Some participants compared the tragedies of war such as wounds and burns caused by shrapnel, explosive devices, and bullets, to minor pains, aches, and infections seen in hospitals stateside. They expressed a lack of tolerance, patience, care, and empathy. Alan added,

“It drains extensively when I really don’t have the sympathy to express that I care. It takes longer for me to reset it. I am burned out; I run 100 miles an hour, I always have; I only have so much wax. When I came out of theater, I had no wax left; I had no empathy.”

For some participants, staying objective and depersonalizing individuals living in a third world country proved to be a coping mechanism that they adopted unintentionally. Several participants described needing to view their indigenous patients as the enemy during their deployment. For some, this mindset was a form of survival. Fran stated pragmatically,

“They are becoming just like a symptom, rather than a person. If you possibly think that you may be killed, you have to be ready . . . and the best way is to dehumanize them, they’re the enemy.”

During our dialogues, some participants did verbalize that their efforts to cope with the emotionally distressing memories had negatively influenced their current patient care. Alan, Fran, Ed, and Helen spoke of losing the ability to care for people in general. Several reported feeling less receptive toward others. Some participants expressed sentiments such as feeling numb, working to compartmentalize, avoiding emotions, and losing compassion for others.

Accepting less than my personal standards. Many participants outlined their expectations to deliver high-quality care to their military patients. Experiencing barriers to

quality care left participants feeling frustrated, feeling betrayed by their military supervisors, or feeling regret about decisions that resulted in poor outcomes. During her overseas deployment, Betty voiced concerns to management that medics were functioning outside of their scope of practice and worried that this might compromise patient safety. Others expressed similar concerns such as lack of command support, poor or absent leadership, limited personnel resources, or other concerns that may have compromised patient care. Several stated that when the workplace did not maintain standards, it infected the nurses as well. Some participants volunteered that some nurses cut corners, ignored misconduct, found humor in the morbid, and even acted disrespectful toward deceased patients and dismembered body parts. Alan described, “*When people are more stressed, you cut corners.*” He sternly added that standards of care declined and were further compromised by a toxic environment that was abusive. When Alan described the toxic work environment and his belief that the leadership tolerated the toxicity, the harshness in his voice and serious expression reflected anger and frustration.

He outlined,

“Belittling others, intentionally making each other look bad . . . an environment with leadership that was completely inappropriate and tolerated by command.”

No time for CF. Delphia explained that during her deployment to Iraq, the medical staff were constantly busy. She described how the constant work routine included caring for a steady stream of wounded and dead soldiers as well as civilians. Delphia resolutely remarked that she did not have time to think, process, and react emotionally to extreme injuries, screams of pain, the high intensity of trauma care, or the death of a child. She recalled that everything and everyone focused on each person coming through the doors, and how staying busy kept everyone

distracted and occupied. She repeated that the nurses did not have time for CF. Ginny described that she was able to set aside her feelings and emotions in order to continue caring for patients:

“I just compartmentalize it . . . take it out later and deal with it . . . I think it allows you to put your own personal feelings and emotions aside at least for a while, or maybe permanently.”

It was common to hear how they pushed deep their emotional responses as a form of survival for many. Some participants expressed that if they did not compartmentalize their feelings, it could give the appearance to their subordinates that they were incompetent or vulnerable to the enemy. The signs, feelings, and thoughts that the participants experienced or observed in peers, supervisors, or subordinates are discussed below.

Meaning #2: CF is all encompassing. The shared meaning of *compassion fatigue as all-encompassing* included collections of physical and emotional feelings, thoughts, and experiences. Many of these feelings occurred simultaneously. Their feelings, thoughts, and concerns are depicted below.

Not feeling prepared. All participants expressed that they did not feel fully prepared for the mission to which they were assigned before arriving in Iraq or Afghanistan. Several of the participants recounted feeling unprepared and stressed, and identified a lack of preparation in a combat arena. Even Ed and Fran, who described the extensive pre-deployment training they received prior to deployment, were not fully prepared for the austere, remote environment in Afghanistan.

Betty recalled feeling frustration that everyone on the team was a novice. She was a new RN of two-years, and was now deploying with eight, new RN graduates to Bagdad in a major head trauma unit. With frustration in her voice, she expressed concern that the staffing mix was

not sufficient. The new RNs were not trained to work in a high trauma unit. She added that the patient volume was high, and with limited licensed, nursing staff, her supervisors decided to use the combat medics as primary care givers. She added that the new graduates were not able to be precepted or mentored, due to their high volume and limited staff. Her frustration appeared to increase in her higher pitched tone and anxious body language. She described working six or seven, 12-hour shifts in a row, week after week. Her team asked if the new graduate nurses were receiving orientation and preceptorship. *“I’m like, ‘no, we’re all working 12-hour shifts, 7 days a week.’”*

With frustration in her voice, Helen discussed her concerns with nurses being unprepared. As she recounted her concerns, she sat upright and her voice and demeanor were notably serious. She described her extensive Emergency and flight nursing experience as being an absolute necessity to the skills she needed during deployment. However, despite those clinical experiences she lacked the knowledge of what her role would entail, the Afghan culture, or what to expect once she deployed:

“We’re expecting our nurses to engage, act, and treat, but we’re not convincing them to . . . seek out help if that’s what they need, or get prepared . . . Right from the get go, hey, you’re going into combat, these are the things you need to know . . . because most of the time we get sent into those areas with no preparatory anything.”

Several participants expressed frustration with being *“terribly misused.”* Many were assigned roles outside their scope of practice. Ed often functioned as a flight RN one day and a nurse anesthetist on other days. Other participants were given duties that did not require nursing experience or expertise. Fran described her feelings that her nursing skills were not utilized:

“It made me feel a little neutered . . . that’s one of the reasons I was chosen for this mission is my skill set to provide medical care, and so for them to come and say . . . that

providing medical support was a no-go, we can't do that anymore . . . like the kids and the women had zero access to health care . . . that was frustrating."

Living with CF day and night. Participants described physical sensations, and some terms to describe the physical sensations included, *depleted, wrung out, physically painful, and exhaustion*. All reported experiencing insomnia during their deployment and for months after they returned to the United States. Some of the participants self-medicated with alcohol, started smoking cigarettes, over-exercised, or took over-the-counter sleep aids. Only two of the participants received mental health therapy or treatment during the months following their deployment. Alan described some signs of CF in others, and suggested that his subordinates experienced "*insomnia, crying spells, inability to focus and concentrate.*" When Alan described his own physical and mental exhaustion, he appeared to avoid any eye contact. He did offer that his exhaustion caused "*diminished or a lack of coping skills.*" Helen described some physical manifestations of possible CF and prolonged stress: "*I'm always tired, but I can't sleep.*" Ginny concurred that her first noticeable sign of possible CF was the inability to sleep, stating, "*Besides isolating, I didn't sleep good.*" Betty remarked that it took her "*6 months to be able to sleep when I came home; I just couldn't sleep.*"

Several participants related weight loss to physical exhaustion and possible CF. Helen reported, "*I lost 20 pounds in Afghanistan.*" Ginny also described her isolation and change in appetite as an indication of her stress. Charlize described her loss of appetite, weight loss, exhaustion, and feeling completely "*wrung out.*"

Disruption to relationships. Most participants depicted consequences of time and distance away from family as emotionally difficult, and negative emotions were compounded by isolation and working with a new medical team. Some found that letters from family and

periodic phone calls helped them feel connected to their loved ones. Others found that distance and time away did not strengthen their family bonds, but rather weakened them. Alan solemnly expressed family issues as being a huge stressor during his deployment and indicated that his stress actually intensified upon returning home to his wife and children. He explained further,

“I hated the world when I came back . . . I just had no empathy, which really didn’t help . . . I still haven’t talked to my 21-year-old son since I came home.” “If a person is able to handle stressful situations, and they have a way to rebuild their wax, I think they can handle it better; whether it be spiritual, strong family ties, but then again, if they have weak family ties it can only take the wax away just as fast.”

Several participants described how the deployment caused such a disruption in their personal life that their relationships dissolved either while they deployed or as soon as they returned home. Charlize explained how the physical separation due to her deployment to Iraq and a pre-existing strained marital relationship negatively influenced her marriage. She spoke of being so angry with her husband that she did not want to call home or talk to her kids. Charlize divorced after her return from Iraq. She offered a brief illustration:

“People would say; you have to call home. You know, I didn’t . . . I came back . . . we barely talked, and I was mad at him . . . and . . . all those other things, sleep deprived, short tempered, less tolerant; I was cranky. . . I don’t remember initially seeing my family, but I remember being so stressed out about the details of my uniform . . . I reported to the hospital stateside the day after I got back.”

Emotionally depleted. Each participant experienced this depletion, but each used very distinct metaphors to describe his or her responses. Charlize and Betty described this mental depletion as not being able to shut down, anger, loss of joy/spiritual indifference, hypervigilance, and heartache. Alan also remarked about feeling completely burned out once he returned home.

Fran noted that others saw the changes in her when she returned from deployment. She sternly and factually described what others, especially her family, were telling her. She added that she too noticed her emotional changes. She further described her family's observations:

“They saw my temper, quick to anger, be absolutely horrible and labeling stuff that doesn't really matter.”

Most participants expressed anger at some point during the interviews, and shared having felt angry frequently during deployment. Ed remarked, *“values are so different . . . I was just really angry . . . there seemed to be a futility in what we were doing there.”* Fran spoke of a lot of frustration during her deployment, but her anger and irritability continued even after being stateside. Charlize came back and was *“short-tempered; I slept crappy, my language was foul.”*

Betty recalled an article in the American Journal of Nursing about her deployment in Iraq. As tears welled up, she sadly spoke about a young soldier pictured in the article. She described that this soldier was treated in the military hospital where she was working. She described her emotional heartache when caring for soldiers, like the soldier in the article, who did not survive their injuries:

“It took me a couple of days to realize what was wrong; I felt very sad . . . I realized my heart hurt . . . serious heartbreak . . . I was too tired to care anymore.”

Charlize became serious and somber during the last interview. She initially did not believe she had CF. She articulated that she had blocked out many of her experiences, but the interviews had brought back memories. She stated,

“... It is not just the traumatic events; it's the way you live . . . you had been immersed in this environment where normal there is not normal here.”

Charlize was able to link experiences and feelings. She was serious and surprised by what she remembered. As she reflected on her feelings, she elaborated on her behavior. She described herself as:

“Short tempered, irritable, judgmental, and bitchy . . . I had numerous - by name - complaints post-deployment . . . did it influence my caregiving, yes; probably, I gave sub-optimal care and did not show respect.”

Alan often brought up unpleasant feelings and uneasiness when discussing his experiences. He shared that he made his subordinates get counseling; he voiced his awareness that he also needed counseling but never felt he had the time. He often spoke of the stigma related to emotional changes that resemble PTSD; *“issues don’t go away; you just don’t talk about them.”*

Meaning #3: CF will not interfere with my military duty. The shared meaning of *compassion fatigue will not interfere with my military duty* included the pervasive military lens that filters all experiences. Each officer spoke indirectly of the military culture, as each one described how he or she perceived CF. The continuous data analysis resulted in the shared meaning of CF and the military experience. Their feelings, thoughts, and concerns are depicted below.

Keep your focus on the mission. Each participant described how the military is a micro-culture that emphasizes a commitment to the mission. The participants shared that the military principles of honor, service, and sacrifice were reinforced continuously. Each participant described the importance of being prepared, ready, and focused. The culture’s influence created a distinct identity for Fran, which she called being a *“military warrior.”*

All participants expressed that the mission or the assignment must be the priority in order to meet the defined operational goals. They conveyed the need to keep their focus, promptness, clarity, and urgency when it came to saving soldiers and anyone else who needed care. As Fran described, *“Over there you are so focused on the mission that you don't really think about it.”*

She described further:

“You are able to refocus and prioritize very quickly . . . you're not really multi-tasking, it's this quick judgment refocus and prioritizing your tasks at hand.”

I would be viewed as weak and incompetent. As described by many participants, the military culture emphasizes courage, never quitting or accepting defeat, maintaining discipline, and possessing physical and mental strength. Fran's expression turned serious and with a firm voice, she explained how the military rewards strength and perseverance and rejects weakness. All participants referenced that members of their unit might lose confidence in their abilities if they admitted to having CF. Fran described,

“I almost think CF in the military it's very much looked down upon as a weakness, 'cause the military is all about . . . go forward with the mission.”

Push it aside; deal with it another day. Many participants described ways they protected themselves from feeling overwhelmed by the austere, hostile environment, or extreme traumatic injuries that they treated daily. Fran, Ginny, Charlize, and Delphia spoke frequently about how they were able to focus on the present moment, keep busy, and compartmentalize emotions of alarm, anxiety, and trepidation when treating those with war-related polytrauma. Fran described the resiliency training she received pre-deployment:

“It was all about like focus and goal setting and avoiding thinking traps . . . I think it made me more resilient.”

Fran often described in a straightforward and unemotional tone, the importance of not dwelling on things, and making a quick assessment when determining if something was important in the moment. She learned to prioritize and any items that did not seem to have a negative consequence for her or her teammates, she would “*send it to voicemail.*” She voiced that she needed to get certain thoughts out of her head, in order to move forward with decisions that were important in the moment.

Disclosure could destroy my career. Several participants volunteered that sharing these experiences of CF with co-workers or supervisors could be damaging to their careers. Some participants voiced that supervisors completed yearly evaluations that could affect the individual’s ability to promote. Thus, the participants felt pressured to hide, minimize, and deny their feelings, concerns, and physical ailments from those who might use the information to block their career progression. Their expressed feelings were often observed in their body language and tone. Fran became serious and somewhat suspicious, and Delphia was quiet and hesitant in her descriptions of experiences that could be risky discussing as it related to her career. This produced an underlying foundation of mistrust when someone’s career was at stake. With a shaky, serious, sober tone, Alan described his concerns:

“A lot of people don't want help... I wasn't as far along in my depression and isolation . . . I'm glad I didn't go back to urgent care . . . it would have probably ended my career.”

Meaning #4: CF affects people long after deployment . . . gone, but not forgotten.

The shared meaning of *CF affects people long after deployment . . . gone but not forgotten* included shared meanings of the lasting effects of CF. Some participants did not fully realize their own CF experiences, until actually participating in the dialogues for this research study. Their feelings, thoughts, and concerns are depicted below.

Living with the guilt. Participants described feelings of failure, guilt, and regret.

Frequently during the interviews, many participants exhibited tense facial expressions, avoided eye contact, had slight vocal tics, wrung their hands, or had tears in their eyes while recalling a memory or experience. Their voices softened with sincerity when discussing their sudden awareness of heartache and sadness that were suppressed until our conversations deepened. Some were visibly uncomfortable, expressing that they felt vulnerable and exposed when recounting their experiences. I often saw tears or heard voices quivering when they described the loss of a comrade, child, or soldier. As an example, Charlize was always talkative, engaged, and animated. She described her first mass casualty of triaging the wounded during our first interview with vivid detail:

“Our first mass casualty was a cluster; and when I think about it now, I cringe . . . I didn’t sort them out well. I was like all these people are . . . they’re blown up . . . with open head injuries, gray matter under your fingernails, eviscerations too.”

Her demeanor changed by the third interview. Charlize looked heavy-hearted, and I never observed smiling, joking, or animation, as she displayed during the first interview. She was concerned and ashamed of forgotten experiences that displayed shame and guilt. She told me she felt “*uncomfortable*” after the first interview. She added:

“I was a little mortified because I had voiced some things that I do not typically; I tend to describe my experiences in a clinical fashion that is how I manage all my descriptors . . . keep it clinical . . . I wanted to clap my hand over my mouth as soon as I said it; I was ashamed.”

Ed described the friendship he established with another military branch member co-located at his remote site in Afghanistan. He sadly described how he would work out at the gym with several Marines stationed at their combat outpost and he made friends with many. He repeatedly shared one particular incident and each time, his gaze dropped to the floor, while

tears welled up in his eyes. He described the measures taken to save the young Marine, his gym companion, who did not survive:

“They brought him in . . . I was the first person that touched him when he came in . . . I was like, holy sh\$, I know who this guy is . . . I immediately ran over and intubated him, and we started CPR on him, and he was just bleeding everywhere.”*

During his last flight mission in Afghanistan, Alan recounted a “*missed injury*” on a 4-year old who was shot in the face. Alan was told that he was picking up a child who was shot in the head, and had been intubated. He was expecting the child to be deceased, but he expressed surprise that the child was awake, not bleeding and not intubated. Alan described patting her down and not being able to locate an exit wound. His tone and expression displayed frustration, anxiety, sadness, and guilt. He became teary:

“I missed an injury that I teach my medics and nurses not to ever do . . . Emotionally, it takes a little bit longer for me to get over it; I mean right now, I’m sitting here tapping my foot and trying not to make eye contact while I talk . . . Um, missed that completely . . . I screwed up . . . Still acutely aware of that this many years later . . . I get to live with that.” [He stopped].

We were both silent. I used this moment of silence to encourage Alan to share additional feelings. When Allen described his feelings of failing to save, his guilt and remorse were expressed in his words and his tone. His entire demeanor changed as he shared stories of unsuccessful field resuscitations; his shoulders slumped and he tried to hide his watering eyes.

Helen shared her experiences while deployed to Afghanistan, that she feels resulted in CF once she returned home. A month following her overseas deployment, she was stationed at a stateside Army base. A notorious, tragic, active shooter incident occurred at the Army station where Helen worked. With a furrowed brow, and saddened eyes, Helen elaborated on her struggles with guilt, regarding her clinical decisions while triaging and evacuating soldiers who

had been shot. She saw comrades die, while she made decisions of who to treat and who was beyond saving:

“I had a lot of guilt for a while . . . one of my mentors asked me, if you could go back and change your course of action would you, and I said, no, I wouldn't. It's like, you feel bad that you couldn't save people.”

Coping with CF. Several participants described using inappropriate humor as a method of coping. Alan described how *“people were joking around about pulling guns on each other.”* Betty described how colleagues would pick up amputated body parts and joke with each other. Charlize also mentioned that a deceased, badly burned Afghan body was propped up with a cigarette hanging out of his mouth. When Betty and Charlize described the inappropriate humor, they each appeared embarrassed and ashamed. As they started sharing their experiences, their voices changed to hesitation and nervousness. They each interrupted their stories to explain why the incident was humorous at the time, but they voiced feeling shame as they retold the full story.

Participants described how inappropriate humor was a coping mechanism for many of their colleagues. Several were surprised that they, too, took part in the humor. Others acknowledged that this was a coping mechanism to handle the stress. Fran added with a smirk on her face and in a jocular tone, *“I frickin' slipped on ice . . . slipped in a big puddle of Afghan blood, and we were just crackin' up.”*

Ginny, Betty, and Delphia expressed that often individuals were coping by *“compartmentalizing”* their feelings, and a few even became obsessed with diet and fitness as a way to compartmentalize or block feelings. Ginny recounted isolating and reading a lot. Some expressed avoidant behaviors or maladaptive behaviors such as smoking cigarettes, drinking

alcohol, or working out their anger and aggression in the gym. Fran described her obsessiveness with fitness that helped her cope:

“I work out a lot . . . my mantra is that strong people can control their emotions, especially the anger . . . It is my coping mechanism.”

More resilient than I thought. Several of the participants described how their own resilience was reinforced through Army resiliency training. Fran described the training taught her how to development of self-awareness and coping skills. Fran’s demeanor lit up when she described how she continues to apply the resiliency skills and behaviors in her life today. Helen emphasized that the resiliency program in the Army combined mental, emotional, and physical skills to teach soldiers to “overcome and bounce back” from adversity. Other participants expressed their resiliency was heightening by their own personal spirituality and family support. Delphia explained,

“It’s the resiliency that keeps you going... it plays a very important role and has huge impact on the mission . . . you have to prepare your mind to think that.”

Fran also spoke of the resiliency: *“Our resiliency training taught us . . . if you can't take it head-on, sometimes you gotta take a right or a left turn to get the mission done.”* Fran described the resiliency training that was conducted by a sports psychologists and the curriculum was tailored for the Special Operatives deploying overseas. Fran described that resiliency is mental flexibility and teaches new ways of adapting to various life situations. She spoke with pride and her tone exuded confidence that she utilizes these coping skills on a daily basis.

I am a different person; I am choosing a different path. Each of the participants expressed that mental stress was a contributing factor in either taking on new roles in nursing or leaving the profession completely. Charlize acknowledged that soldiers died while she was

providing medical care, and these tragic experiences changed her. Charlize noticed changes in her sister, when she too returned from her deployment to Iraq. Charlize portrayed her sister as *“kinder, harder, and sadder than she was before.”*

After these experiences, only one participant returned to direct patient care. Ed worked in the Emergency Room at a Military Treatment Facility and within a few months, he deployed again to another Middle East location for another nine months. Following their deployments, the three advanced practice nurses rarely provided direct patient care, nor participated in opportunities to maintain their advanced practice skills. In a firm and direct tone, Helen candidly described, *“My mom, was like . . . go back into the ER; I was like, no, and I'm never gonna be a floor nurse again . . . because I have no tolerance.”*

Alan described how he is now able to retire from the military, and how his perspective on wanting to provide patient care had changed. He expressed strong frustration in his voice, when he verbalized all the reasons why he wanted to leave patient care. He articulated disillusionment with Army leadership, lack of mentorship and development of new nurses and new officers. He explained with frustration and determination in his voice:

“I'm gonna teach at a college, and I'm never gonna walk through a damn hospital again. I'm gonna teach students to do great things and take care of patients . . . but I'm never gonna deal with taking care of patients.”

Fran described her current military assignment as a desk job, and she never provides direct patient care. She does not even function in the capacity of a nurse. When Fran described being banned from providing medical care to the civilians during overseas deployment, she often shared these experiences with foul language, and her tone was forceful and angry. As she described, she repeatedly saw women and children turned away from health care, when a very

easy treatment could have made a significant impact. She expressed angrily how the disappointment affected her future nursing career:

“I feel like I've completely wasted my education and all my skills . . . I can't go back because I just don't care anymore...I think compassion fatigue lead me to my career path that I have now . . . I just gave up on nursing, sit at a desk, and do something completely different.”

Although all participants continued to serve in a nursing role for a time after deployment, their roles were very different from the roles they experienced during their deployments. In addition to their evolving roles in nursing, each expressed subtle character changes. Some participants viewed these changes as positive, like developing more mental resilience and confidence, while others expressed more cynicism and negativity. Betty continued to report some sadness, however, she expressed with pride that she developed an inner strength that she did not have before her deployment.

Each participant described changes in their attitudes since being an RN stateside. Some outlined feeling impatience and low tolerance toward patients with minimal injuries or those who expressed entitlement – type behaviors. Frequently, three participants made comparisons between patients and situations they encountered stateside, and the injuries, traumas, and deaths experienced during their deployments. Ed described being yelled at by a parent whose child had to wait three hours in the Emergency Room. In amazement, Ed exclaimed *“I'm thinking you're you kidding me... your kid has a cold, and I was treating kids burned half to death.”*

Each participant often expressed feeling disengaged from personal relationships. Alan described avoidance behaviors and more isolation. Fran described a lack of desire in establishing new acquaintances or friendships. Fran and Charlize described the important bonds that were created with members of their deployment team. They spoke of staying in contact and always

being available to a few individuals that shared in their experiences overseas. These bonds and ties to those who served overseas remain strong today.

Summary

The participants revealed many experiences regarding their military deployments to Iraq and Afghanistan. My pre-understandings were that military culture could have a major influence on an individual's experience with CF. Manifestations of CF were present in each participant, some more apparent and pronounced than in others. Often CF infiltrated all aspects of each participant's life. Some participants reflected during the dialogues that they had worked to block out their emotions and memories, but recalling these memories during our dialogues was bringing up emotions that had been buried deeply. The study findings confirmed how each participant's cognitive, behavioral, emotional, spiritual, physical, and inter-personal dimensions may have been altered. My pre-conceptions and interpretations of meaning were described and my efforts to enhance rigor were included.

Chapter V will present my discussion and study limitations. A final appraisal from the participants is included as a call to action. Additionally, I will propose implications for health care practice and research.

CHAPTER V: DISCUSSION AND IMPLICATIONS

Chapter V begins with a review and discussion of the findings about military RNs' experiences and meanings of CF. Associations to the literature review are discussed in relation to the findings. The four abstractions of meaning are compared to the literature on compassion fatigue (CF) and also filtered through the lens of Stamm's (2009) CF model. Gaps in the literature regarding CF among military RNs are described. The chapter concludes with a discussion of limitations, the establishment of trustworthiness, and implications for nursing practice and research.

Discussion

This study informs understanding and meaning of the phenomenon of CF as experienced by the U.S. military RN. The research process assimilated the movement between text and perspective, self-reflection and journaling, and fore-conception and interpretation. Rich, detailed narratives developed continuously through this movement from the whole to the parts and back to the whole (Fleming et al., 2003; Geanellos, 1998). Although each participant's deployment and overall military experience was unlike any another U.S. military RN, they did share common meanings. The following shared meanings are briefly reviewed and findings further elaborated on or contrasted with extant literature.

Meaning #1: The Term CF Does Not Fit Me

Shared meaning #1 is defined as manifestations of CF. Although most participants described their own symptoms that might fit pieces of CF, they were quick to dismiss their symptoms as actually being CF. However, they did observe what they labeled as CF in their supervisors, colleagues, subordinates, and others. The shared feelings and thoughts included (a)

military RNs act like CF isn't real, (b) you lose compassion for people, (c) accepting less than my personal standard, and (d) no time for CF.

The most striking reflections shared by participants included: (a) the term CF did not fit their situation, (b) admitting CF meant weakness and even lack of confidence or skill, and (c) CF's lasting effects were powerful and persisted well beyond deployment. Before they each enrolled in this study, they acknowledged their feelings and experiences as probable CF. It was evident during the interviews that they struggled to accept the label for themselves. They expressed that other colleagues might have experienced CF, but very few felt that they too were experiencing CF. Their experiences led to shared descriptions including their loss of empathy, inability to care, tolerating lower standards, and a noticeable intolerance to working with patients.

The definition of CF was frequently discussed, and universally the participants expressed uncertainty with a definition. The terms BO, CF, and PTSD were used interchangeably with each participant. The terms: STS, vicarious traumatization, and compassion satisfaction appeared to be unfamiliar to each participant and were never used in any of the interviews.

Each participant addressed stigmatizing concerns. These concerns included fear of judgement, lack of confidence, and negative consequences related to expressing CF to subordinates, peers, or supervisors. This finding was consistent with Sheppard's (2015) qualitative study conducted among hospital-based RNs ($N = 16$) that identified the intense worry and fear nurses felt about having the label of CF. In the Sheppard study, the nurses self-identified as highly compassionate and avowed that, while they might have symptoms of CF, the label

unfairly portrayed them as uncaring. The overall worry was that the negative label might even compromise their employment (Sheppard, 2015).

In this study, several participants described a personal transformation post-deployment that also followed the definition of vicarious traumatization. The participants expressed how the daily, fast-paced and high volume of acute polytrauma victims offered very little respite or time to contemplate these experiences. Many participants were adamant in voicing that they did not have time to attribute what they were feeling and experiencing to manifestations of CF. They could describe how other colleagues, supervisors, or subordinates exhibited CF, but it was not apparent to them that the emotional and physical effects that they experienced were CF. The heavy polytrauma assignments were associated with an increased risk of CF for these study participants. This finding was similar to a study involving counselors ($N = 104$) by Jenkins and Baird (2002) who found that a personal transformation or life change occurred as a result of an exposure to heavy caseloads of patients experiencing trauma.

Meaning #2: CF is All Encompassing

U.S. military RNs gave exemplars of the physical and emotional effects they experienced from triaging and treating war-induced traumas in austere, isolated environments far from military support. The shared concerns included: (a) *not being prepared*, (b) *living with symptoms day and night*, (c) *disruption to relationships*, and (d) *emotionally depleted*. Their descriptions of emotions, feelings, behaviors, and relational and spiritual conflicts were responses they expressed freely and readily in our dialogues.

Looking at CF through the lens of military nurses, work-related traumatic exposure caused distress, even negative emotional consequences. Stamm (2009) emphasized that the

harmful elements of CF might stem from work-related traumatic exposure. In this study, the participants described feeling physically and emotionally depleted. They expressed problems with anxiety, insomnia, ruminating thoughts, irritability, and other parallel signs of PTSD.

As evidenced through conversations and interpretations, the constant exposure of polytrauma was not the primary source for CF. Precipitating issues increased risk factors for CF. One shared meaning that was repeated by the participants as a primary source for feeling physically and emotionally exhausted was the moral and ethical dilemmas they faced on a daily basis. Participants experienced the dilemmas of caring for detainees who were often involved in killing American servicemen and women. Many advanced, life-saving treatments prolonged service members' lives in order for them to die with family in the United States rather than overseas. Repeated exposure to moral and ethical dilemmas caused anxiety, stress, anger, and guilt. These findings parallel those in the Shoorideh et al. (2015) study, which identified a strong correlation between moral distress and burnout that led to staff nursing turnover among ICU nurses (N=159). For RNs in any setting faced with moral and ethical dilemmas, the impact could cause significant feelings of frustration, job dissatisfaction, fear, and depression, thereby increasing the risk for CF and ultimately leading to RNs leaving the profession.

The most traumatizing experiences with lasting effects were not the extreme patient cases of polytrauma; it was personal losses of friends and teammates. Several participants were dramatically affected by the loss of colleagues and two in particular provided the last life-saving techniques without success. Additional findings demonstrated changes in beliefs about themselves and others as well as questions about their spirituality that could lead to mistrust and insecurities regarding safety, values, and control. This work-related traumatic stress altered the

individual's professional worldview. Jenkins & Baird (2002) reported similar findings among therapists (N=99) who were exposed to shocking images and intrusive memories depicting how vicarious traumatization could alter an individual's personal identity.

Many participants expressed feelings of incompetence by working as a novice without clinical support or mentorship, lacking preparation and training for a deployment overseas, or seeing themselves completely unprepared for the upcoming mission. Very few military RNs in this study felt fully prepared for their assignment overseas. Fran and Ed received the most extensive pre-deployment training, yet Fran was not utilized as a trauma care nurse and Ed was put into roles outside his scope of practice. These findings were similar to a study by Ross et al (2008) conducted among military RNs (N=72) that reported the variability of competence levels in those deploying, including on the job training at the deployment site, a lack of trauma or critical care skills, or young, inexperienced nurses receiving their first officer assignment in a deployed environment.

Several participants in this study expressed strong emotions about feeling unsupported by leadership. They described the prevalence of toxic, abusive, or absent leadership in their deployments. These findings are similar to Steele's (2011) study encompassing 2-years of qualitative and quantitative data on Army leaders (N=1186) who held ranks ranging from Sergeant to Colonel. Steele (2011) described and defined destructive leadership involving dominance, coercion, manipulation, and demoralization.

Each participant described the importance of personal relationships and a strong, cohesive support system in the deployment environment and at home. Others described how personal relationships, such as marriages or parent-child relationships, crumbled and further

dissolved upon returning home from their deployment. The participants in this study elaborated on the distressing deployment environment, feelings of social isolation, and insecurities of being away from loved ones and friends. These personal relationships, along with a strong support system, slowed military RN's response to shut down and improved their ability to reset as well as to appraise, cope, and feel connected with others. These findings were similar to the study by Rika et al. (2013) where novice pediatric RNs ($N = 251$) identified that family support and satisfaction with peer relationships improved overall job satisfaction and decreased the risk for CF and BO.

Meaning #3: CF Will Not Interfere With My Military Duty

This is defined as the pervasive military cultural lens through which the participants' experiences are filtered. Each one described how the work was all consuming and shielded them from fully absorbing the stress around them. The shared concerns included: (a) *keep your focus on the mission*, (b) *I would be viewed as weak and incompetent*, (c) *push it aside, deal with it someday, but not today*, and (d) *disclosure could destroy my career*.

No current evidence in the literature correlated with this meaning as revealed through the dialogues and interpretations. The military RNs described a sense of pride in taking part in historical missions that deployed to a war zone. They each provided advanced trauma care to our military forces as nurses, but each one was also a soldier or sailor within a warrior culture. This finding of a warrior culture in my study was addressed by Lunasco, Goodwin, Ozanian, and Loflin (2010), who developed a pilot program for military service members ($N = 320$) to reduce mental health stigmatization and improve help-seeking behaviors among those service members with the warrior culture mindset.

The military emphasizes the importance of mission, commitment to one's unit, the unit's mission, and other service members. Other attributes of the military culture include secrecy, stoicism, and denial. Feelings and emotions need to be controlled and suppressed, such as distress, weakness, exposure, and fear (Hall, 2011). In this study, the participants described how the military organization or culture discouraged, even punished, expressions of depression, anxiety, fear, or grief. One participant remarked, "*There is no room for grieving.*" My interpretation of the shared meanings fit with the military environment and a culture permeating across age, gender, duty, and rank.

All participants in this study volunteered that the perception of weakness was not only detrimental to the team, but to them personally. Several shared that they could not confide in others, especially to their peers and supervisors, feelings or thoughts of anxiety, sleep disturbances, ruminating thoughts, sadness, or guilt. Each participant described how a supervisor and a higher-level rater evaluated him or her at least annually. Confiding to a supervisor and relaying experiences that could be considered a mental disorder could have negative repercussions. They feared that the stigma associated with mental illness, depression, PTSD, and CF could destroy their career and hinder their ability to promote to the next rank. The participants in this study expressed concern that they would be viewed as weak or incompetent, if they confessed experiencing CF to medical staff, mental health professionals, supervisors, or peers. This concern mirrors findings in the Sheppard (2015) study, which found among second-year doctor of nursing practice students ($N = 59$) that stigma associated with CF evoked shame and weakness.

Meaning #4: CF Affects People Long After Deployment . . . Gone, But Not Forgotten

Meaning #4 is defined as the lasting effects of CF. The shared concerns include: (a) *living with the guilt*, (b) *coping with CF*, (c) *more resilient than I thought*, and (d) *I am a different person; I am choosing a different path*. Each participant ended the third interview with a reflective, contemplative demeanor. They realized that they actually had these thoughts, feelings, and actions that resonated with knowing that these experiences might be pushed out of their minds at times, but they were really not forgotten.

The participants in this study shared experiences related to their inability to save patients, feeling like they failed, and remorse over clinical decisions that resulted in death; feelings closely associated with the concept of CF. Most of the participants expressed regret, shame, guilt, as well as questioning their decision-making ability. The inability to save patients was a common shared feeling among the participants in this study working in high acuity and trauma care settings. Yoder (2010) similarly reported the decision-making, remorse, and guilt. In a study of RNs ($N = 106$) caring for patients either dying or with extensive burns, Yoder described how these RNs were at high risk for developing CF.

Situations described by participants were similar to those reported in other research: lack of organizational support, feeling unprepared, not knowing what to expect upon arrival at their new duty station, and high volumes of patients with polytrauma. These triggers were comparable to the modified categories reported by Owen and Wanzer (2014). Additionally, Maytum et al. (2004) discussed similar identifying precipitating factors and coping strategies in nurses working with chronically ill children.

Stamm's Conceptual Framework

Overall, the study findings resonated with the basic theoretical approach of Stamm's (2005, 2010) overall concept of CF. In this study, the participants described negative and positive aspects of the experience that fit the conceptual model. They expressed that providing care in a combat environment and experiencing effects of war as soldiers themselves, contributed to the meaning of the CF experience.

In Stamm's (2005, 2009) conceptual model, the work environment, an individual's personal characteristics, and the exposure to secondary traumatic trauma in the work setting may contribute to the development of CF. Yet, Stamm (2009) reports that compassion satisfaction occurs when an individual experiences positive effects from helping others and feeling good about their colleagues despite a poor work environment. The shared experiences from the participants in this study and the interpretations are parallel to this definition of compassion satisfaction (Stamm, 2009, 2010). Several of the study participants expressed feeling a bond, respect, and personal satisfaction by helping fellow service members, despite all of the external factors affecting their work environment.

Stamm's (2005, 2009) conceptual model also depicts that BO and secondary traumatic stress contribute to the risk of CF. Similar to the conceptual model of CF (2009), the participants in this study expressed experiences of BO that appeared to be normalized as part of the military duty and nursing culture. The sense of BO as a normal part of nursing was also identified in Sheppard's (2015) qualitative study of hospital-based nurses (N=16), who accepted BO as an inherent aspect of nursing.

The greatest trigger for CF was the emotional distress that is often labeled as secondary traumatic stress. Stamm (2009) defines secondary traumatic stress as secondary exposure to individuals who have experienced traumatic, stressful events, resulting in symptoms from exposure to a traumatized individual. In this study, the intrusive memories, avoiding reminders of their colleague's or patient's traumatic experiences, and personal, unresolved grief were a result of the secondary traumatic stress that affected their personal and professional lives. The study participants described how the experiences of BO just went with the job, but the grief of watching soldiers and colleagues die, feeling powerless to save a life, and the moral and ethical dilemma is causing secondary traumatic stress contributed to CF, rather than BO.

Trustworthiness

In hermeneutic interpretive phenomenology, the researcher seeks understanding and shared meaning, necessitating trustworthiness between participants and their narratives. Four specific areas of trustworthiness are addressed: auditability, credibility, confirmability, and objectivity. Examples are provided to identify how I endeavored to achieve trustworthiness in this study.

Auditability refers to the documentation of steps in the research process. I wrote field records, notes, and kept records that could be followed and arranged to facilitate cross-referencing should another researcher choose to replicate this study. I documented the decisions and steps during various stages of the analysis. The steps in the research process, along with my self-reflection, continually answered if the interpretations could be influenced by my pre-understandings or biases. Credibility was first established by engaging in lengthy and concentrated interaction with each participant over the span of three face-to-face interviews. I

observed and noted the manner in which each participant described his or her experiences, body language, tone, affect, and behavior. Written transcriptions were reviewed with each corresponding audio file to adequately capture the essence of the participants' stories. I consulted with each participant to verify, collaborate, and analyze each interview so that meaning and interpretation was a collaborative process and each participant's experience would be recognizable. I established credibility by ensuring that the perspectives of the participants were represented as clearly and accurately as possible. To preserve the voice of the participants, I utilized direct quotes from the text. During each participant's final interview, I shared my interpretation of his or her narratives and inquired if my statements accurately reflected what was described during the previous interviews.

Confirmability was attained by developing a mutual understanding. Through this discovery, the participants and I shared language, history, and culture. To remain objective, I returned to all participants at all stages of the research process to inquire if the narrative, notes, and ongoing analysis revealed their experience and their voice. Several times, the statements they shared until I re-read their direct quotes surprised the participants. This process followed moving from the whole to the parts and back to the whole in hermeneutic phenomenology. Confirmability was further established by reviewing the participant narratives with my research mentor. During our reviews, we identified how my own pre-conceptions might be influencing my interpretations or even the interview questions asked. We also discussed the participants' shared experiences and through a team analysis, we identified shared meanings. In this way, the hermeneutic circle was completed.

Objectivity attempts to uncover truth by eliminating personal prejudice and bias. However, the hermeneutic philosophy purports that true objectivity is not attainable because any reader of this study would experience his or her own interpretation of truth based upon his or her own worldview. I strived to authentically and accurately depict the expressions of meaning through ongoing reflection during interviews, transcription, and subsequent interpretations. Reading and re-reading the narratives while concurrently reflecting allowed for a discovery of the expression of meaning, how it contributed to human understanding, and shared interpretations.

Fore-Structures

The hermeneutic circle of understanding is an expression of my fore-structures and pre-understandings. To come into the circle, it required that I worked out my fore-structures in terms of the phenomenon under investigation. As guided by the philosophy of hermeneutic phenomenology, I identified fore-having (e.g., personal lifeworld background, values, beliefs, culture), foresight (e.g., a point of view from which an interpretation is made), and fore-conception of what I perceived the meaning of the lived experience of CF was in military RNs (Geanellos, 1998; Mak & Elwyn, 2003). This final step of reflecting on my expectations about what I might have anticipated in the interpretations is described below in my fore-conceptions.

Fore-Conceptions

Based on my military background, I anticipated that each officer would be consistent with completing these interviews out of respect for me as fellow officer in the U.S. Nurse Corps. I knew that all participants would bring unique experiences from their career as RNs, but also varied experiences from being deployed overseas. I found it challenging to schedule numerous

interviews in different parts of the country and arranging to meet each participant in a location that was most comfortable for them, but it was not always the most conducive to an interview. I perfected my audio transcribing after the first interview required re-recording several times; a recording I obtained with my mobile phone. I anticipated each interview with some trepidation with all of the participants. I sensed that some participants felt they were not able to provide additional details after the second interview, but bringing the text to the third interview to analyze together truly illustrated the process of movement back to the whole text from the parts. This process did in fact expand new interpretations each time, particularly with three of the participants.

I wondered if there would be confusion between the concepts, specifically PTSD and CF; three of the participants defining CF with diagnostic terminology for PTSD confirmed this. I also inferred that each participant would have had more fear of the loss of his or her own lives. The three participants who were located in the most remote areas of northern Afghanistan expressed the most concern for their own well-being. Fran stated, *“It was kind of an easy life, because all you're worried about is really, am I gonna die today or are my friends?”*

Limitations

Several limitations are noted in this study. First, only Army and Navy RNs were successfully recruited. The findings are context- and time dependent for the eight participants and cannot be generalized to all U.S. military RNs.

I found it difficult to remain in the role of a nurse researcher, particularly as a nurse with 30 years of health care experience and a recent career change to Psychiatric Nurse Practitioner. It was exciting to see them realize that they, in fact, did have or had been suffering from CF. It was

also a sad revelation for me that some expressed shame, being vulnerable, and exposed when sharing their experiences without receiving any mental health advice, consultation, care, or treatment. The feeling that I had not offered any type of care to hurt and wounded individuals, my fellow nurses, was uncomfortable for me.

During the interviews, I felt resistance from three participants (i.e., Delphia, Ginny, Ed) as they were hesitant to share more physical, emotional, spiritual, or relationship experiences of CF. I found myself challenged and frustrated when I realized that I was offering more prompts that could be leading or validating; this was a new challenge for me. I did not realize how often I was not practicing active listening; I changed topics numerous times. The role of a nurse researcher/scientist is challenging and much more difficult than I anticipated. In the joint analysis with each participant, I was surprised how many of them had forgotten what they expressed in the prior interview. I almost felt like I was exposing a secret as I read and shared their previous texts or highlights from various passages. The movement from the whole to parts and back to the whole, the shared analysis, was personally gratifying and provided rich texts and interpretations. I worked together with each participant to bring life to the experiences being explored through the use of the hermeneutic circle with attention to language and writing to create a common understanding.

My role as an officer in the USAR was an advantage in that I understood military culture, hierarchy, rank structure, lines of communication, and concerns of retaliation. Nonetheless, limitations existed because, as Munhall (2007) described, I could not *un-know* myself. I was too close to their experiences at times because of my own personal knowledge and experience with the military.

My current role as a Psychiatric Nurse Practitioner was a limitation. I had a difficult time separating my current professional practice and that of a nurse researcher. I felt as if I was *taking from* participants and not offering something of myself to ease their angst, pain, sorrow, or grief.

As a naïve researcher, I might have unintentionally changed a topic during the interviews. I noticed often when reading the texts that I thought I was listening, but missed opportunities to elaborate a feeling with the participant. Within the interview, the use of semi-structured questions (e.g., *So, tell me about the conflict*) may have drawn out more of the experiences of CF than if participants had not received these prompts. However, the prompts were intentional and at times it might have been more leading to not ask the open-ended questions that I would have preferred.

Implications – Future Directions for Research

The findings from this study illustrate the need to test a CF assessment tool that is valid and reliable for the military health care population. In addition to assessing for CF with military nurses, further research is needed to identify protective factors moderating CF in order to prevent or mitigate risk. I also propose developing a new theoretical framework for CF that reflects military culture and how it filters illness perceptions and appraisal in military service members. This study also revealed an inconsistent knowledge base as to the definition of CF and how to distinguish it readily from BO, STS, or PTSD. Longitudinal studies should be conducted to explore the development of experiences in relation to such factors as chronic exposure to traumatized patients, lack of organizational support, care delivery in austere, hostile war environments, and preparation and training for overseas deployments in third world countries.

Further research is also needed to examine and compare CF between U.S. military RNs practicing in both military treatment facilities in the U.S. and within austere war environments. Another comparison study could examine military RNs and civilian RNs with CF to assist in defining concepts. Additionally, empirical studies are required to operationalize instruments that clearly reflect the concept of CF, strive to identify differential causal factors, and draw clearer distinctions between CF and BO. Interventional studies with comprehensive resiliency training pre-deployment, focus groups, mentorship, and leadership training could be trialed to mitigate CF experiences and provide education that could normalize and destigmatize this condition.

Implications – Future Directions for Practice

From these shared understandings, this study can give information that will assist others in generating further meaning, an intervention, or action that may be needed to minimize the severity of CF or improve the quality of life for military RNs. This understanding enables RNs to individualize approaches and enlarges our consciousness to a phenomenological way of being with others. There is no single approach to an experience and we as nurses are more cognizant of that meaning as we routinely individualize care (Munhall, 2007). Meaning should be at the core of nursing care, of what we do, and how nursing plans and cooperates with others through an integrated, collaborative approach to improve patient care.

CF focuses largely on negative symptomatology, exploring contributing factors leading to the onset and development of CF in the military population. Stamm (2005, 2010) and Figley (2002) suggested that empathy and emotional energy are moderators in the development of CF. However, being able to disengage, practicing compassion, feeling a sense of achievement, and experiencing satisfaction can reduce CF, promoting self-care in the U.S. military RN. Given the

lack of empirical evidence that empathy or caring-too-much is a single causal factor for CF, perhaps extending beyond the concept of a single and basic approach would have more relevance.

Prevention of CF should be emphasized as well as individualized interventional approaches. Preventative methods might take the form of increasing awareness through education as well as alerting nurse leaders and peers in the signs and experiences of CF. U.S. military RNs at-risk for developing BO, STS, and CF should be taught that these are normal responses to situations that involve caring for patients exposed to traumatic events and suffering traumatic injuries. Strategies to minimize CF could take two approaches: individual and organizational.

Before U.S. military RNs can implement self-care techniques, a clearly defined concept, awareness of risk factors, prevention, experiences, and interventions need to be established. An understanding and self-realization can facilitate a universal recognition and either normalcy or de-stigmatization. Based on the experiences described by the participants in this study, it is necessary to clearly articulate the role BO plays in the development of CF.

The organization and its leaders share a role in mitigating the effects of CF. Leaders should develop a supportive, safe environment free of stigmatization, improved patient care standards, and accountability. Nursing leaders can support the nursing discipline and RNs by acknowledging the risk of CF and exploring protective strategies that the nurse can adopt as he or she faces the suffering patient's experience. U.S. military RNs need encouragement to seek assistance from a chaplain or mental health services without repercussion or retaliation. Military leaders should demonstrate their concern and encourage unit cohesion. Several of the

participants expressed that the effects of poor leadership, lack of support, tolerating inappropriate behavior, and not maintaining standards were more unsettling and frightening than the fear of losing their own lives. Military leadership is key in decreasing the impact of stressful events and, ultimately, reducing or mitigating CF among their troops. I recommend that military hospital leaders take an interest in research related to CF and BO. Military leaders also need to monitor the nurse practice environment and demands placed on nurses so that policies and standards can be developed and adopted. In addition, a strategy must be developed to take into account the long-term consequences of these operational decisions to encourage nurses to remain in patient care and not leave the profession of nursing.

Collective Voices from Participants

Each participant expressed an urgency to critical appraise practice recommendations, and changes needed to prevent or mitigate CF in fellow military nurses. Both individual and military leaders must take steps to shift the emphasis from pathology to prevention for individuals who are engaged in caring work with those medically and emotionally traumatized by the effects of war. The study participants entrusted me with their voice, and they imparted the following:

Alan was very concerned about what is happening to the next generation of new Army nurses. He felt compelled to take care of staff. He often adamantly expressed wanting to protect them from toxic leadership. He spoke of preparing and developing RNs through mentorship.

Delphia sensed isolation from leadership when she was deployed to Afghanistan. She felt that command teams must set the tone, model leadership, and practice accountability. She recommended that nursing leaders teach these skills early in order to prepare new officers for the responsibility.

Fran described the extensive, pre-deployment resiliency training with the Special Forces as paramount in maintaining resiliency throughout her deployment. She commented how she continues to use the skills she learned prior to her deployment. She encouraged all nurses to develop mental and emotional flexibility and agility, taking advantage of learning the mental skills of resiliency.

Betty reflected that most of the RNs she knew who deployed overseas tended to minimize their experiences. She further pondered how this strategy might reduce or diminish the guilty feelings and sadness. She concluded that she never heard any of her military RN colleagues admit deployment was hard or difficult, not physically and especially not mentally.

Helen possessed a great deal of insight throughout the interviews, but she also admitted that she continues to struggle with vicarious traumatization. She explained that she changed and that she does not feel safe; however, she will continue to move forward and press onward. Helen's final recommendation was a call to action on behalf of the Army Nurse Corps. She stressed that Army nurses need to *"teach life skills, and basics of self-preservation."* She continued,

"The turmoil and turnover is insane, and that's why all you hear is nurses are leaving the profession, because they are so stressed out . . . We have to educate our Army nurses in: 1) what they can expect when they deploy to a combat environment, 2) CF as a result of secondary traumatic stress and burnout; feelings and experiences are normal, and 3) talk about how you are feeling, share with peers, seek professional help if needed."

Conclusions

From various disciplines, research has clearly established that those who work with patients experiencing traumatic injuries are suffering and, at some point their lives, detrimentally affect the psychosocial health and wellbeing of U.S. military nurses. The hermeneutic

phenomenological approach led to rich narratives from each participant. This study provides new knowledge and understanding of the experiences and meanings of being a U.S. military RN, providing care during overseas deployments; it outlines the frustration, distress, anxiety, and mistrust that undoubtedly raise the risk of CF in military RNs.

The present study addressed a major gap in the literature by describing the CF experiences of U.S. military RNs (i.e., Army, Navy). The hermeneutic interpretive phenomenological approach increased understanding of the shared meanings for these military RNs rather than to theorize, generalize, or predict causal relationships (Annells, 1996; Koch, 1995). The present study findings may be a catalyst in protecting the future of military nursing and reducing attrition, by maximizing military RN's mental and physical well-being. Future research providing a better understanding of the RN's perceptions, concerns, and experiences with CF could help military RNs know themselves better and their personal risk factors for CF.

APPENDIX A:
IRB APPROVAL LETTER



Human Subjects
Protection Program

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<http://ocr.arizona.edu/hssp>

Date:	April 13, 2015
Principal Investigator:	Dawn Marie Goldstein
Protocol Number:	1504782641
Protocol Title:	Compassion Fatigue Among U.S. Military RN's Post Deployment to Iraq and Afghanistan
Level of Review:	Expedited
Determination:	Approved
Expiration Date:	April 09, 2016
Documents Reviewed Concurrently:	Data Collection Tools: <i>Participant Questions_CF Study.docx</i> HSPF Forms/Correspondence: <i>F107 v2014. CITL verification.3.31.15.doc</i> HSPF Forms/Correspondence: <i>F200_CF_v2014-4.8.15.DMG.EDIT.doc</i> HSPF Forms/Correspondence: <i>Signature page.pdf</i> Informed Consent/PHI Forms: <i>T502a - ICF Consent Form v2014_2.9.15 EDIT.pdf</i> Recruitment Material: <i>CF Flier. updated. IRB.pdf</i> Recruitment Material: <i>Email to Key Informants.docx</i>

This submission meets the criteria for approval under 45 CFR 46.110, 45 CFR 46.111 and/or 21 CFR 50 and 21 CFR 56.

- ◆ The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).
- ◆ All research procedures should be conducted in full accordance with all applicable sections of the Investigator Manual.
- ◆ The current consent with the IRB approval stamp must be used to consent subjects.
- ◆ The Principal Investigator should notify the IRB immediately of any proposed changes that affect the protocol and report any unanticipated problems involving risks to participants or others.
- ◆ For projects that wish to continue after the expiration date listed above please submit an F212, Continuing Review Progress Report, forty-five (45) days before the expiration date to ensure timely review of the project.
- ◆ All documents referenced in this submission have been reviewed and approved. Documents are filed with the HSPF Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HSPF Office.

This project has been reviewed and approved by an IRB Chair or designee.
No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.

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