Who Cares for the Carers? Literature Review of Compassion Fatigue and Burnout in Military Health Professionals

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Abstract

The Dunt Review[1] into mental health services in the Australian Defence Force (ADF) enabled significant investment in programs and initiatives across the defence environment in Australia. The subsequent attention to long standing mental health issues for our veteran community is both timely and admirable, and has indeed begun to address mental health stigma, education and community support around this country. Arguably, the overwhelming focus of these programs has been on Post-Traumatic Stress Disorder as it relates to the physical and mental trauma of operational deployment. However, this paper will attempt to redirect at least some of this focus onto potential issues of compassion fatigue in uniformed health professionals arising from their care of traumatised (physical and/or psychological) clients. The paper will also highlight burnout as a similar possible consequence of stressful defence health work/life experience.

This literature review based paper identified myriad peer reviewed references relating to research and programs for international healthcare systems and overseas forces on these conditions. However, at least within the published domain, very little can be identified for the Australian military context or in the ADF's current mental health strategies to specifically address these mental health issues for our uniformed health professionals.

This paper introduces these relevant concerns for the broader military/veteran's health peer group, leadership and academic audience to consider as worthy of greater attention in Defence and Veteran's Affairs research and policy agendas.

The paper will encompass:

1. An introduction, background and definitions of 'Compassion Fatigue', being vicarious traumatisation of clinicians as a consequence of caring for traumatised people.

2. A similar discussion of Burnout' as a wider but still significant workforce issue that reduces the quality of care provided to patients, and the morale, quality of life and physical and mental health of sufferers.

3. A brief outline of a 'Four Stages of Burnout' model, being (1) Physical, Mental and Emotional Exhaustion, (2) Shame and Doubt, (3) Cynicism and Callousness and finally (4) Failure, Helplessness and Crisis.

4. Identified issues for military health services from compassion fatigue and burnout as identified in the literature.

5. Recommendations that individual practitioners and the defence health organisation should consider to address issues identified.

Background

PTSD can occur after someone experiences or The Dunt Review[1] into mental health services in the Australian Defence Force (ADF) and related investments in programs and initiatives have begun to address mental health awareness stigma, education and support in Australia. Arguably, the explicit focus has been on Post-Traumatic Stress Disorder (PTSD) as it relates to operational deployment by members of the ADF. However, at least within the public and published domain, very little was identified for this paper in the Australian military context regarding other potential mental health risks for uniformed caregivers that can arise from military workplace, organisational and/or systemic stressors.

Compassion fatigue is a particular type of vicarious mental health traumatisation in health professionals dealing with difficult and challenging issues in clinical practice. Factors common to most healthcare settings have been identified elsewhere as influencing risk of serious occupational stress, especially in high demand clinical workgroups[2].

Similarly, research on burnout has extended beyond healthcare environments to other sectors where people-work is fundamental to the job[3].

This paper will argue that these issues deserve considered attention within the ADF and Veteran's mental health policy, research and intervention agenda.

Methodology

The predominant method of identifying suitable papers for reference was an online search of the ProQuest database. Initial search terms included 'military', 'uniformed', 'compassion fatigue' and 'burnout'. All relevant abstracts were downloaded for closer examination. An extended search for other relevant material was undertaken through following citations and references identified in earlier articles or alternative search terms when identified.

A hardcopy review of ADF health references available to the author was also undertaken as identified in the reference list.

Searches and subsequent selection of material was not deliberately limited to any one health professional group. The majority related to the nursing profession, with the extended search also finding relevant material relating to other caring professions such as social work and teaching. An initial 5 year timeframe was preferred but extended to older articles based on relevance and consistency with current discourse.

Introduction

In 2012, the author worked with an ACT community mental health team at a time when the issue of compassion fatigue and burnout in mental health professionals was being researched in that jurisdiction[4]. Calear and O'Donnell's recommendations regarding further education and support measures for at-risk health professionals gained significant attention and generated system-wide education for mental health staff across ACT Health.

Professor Nel Glass of the Australian Catholic University presented a conference paper[5] in 2013 on development and implementation of a wellbeing and lifestyle program for Victorian health care organisations. After reporting systemic issues that limited program success, her concluding remarks cautioned that:

> "given the context of health care professionals work it is imperative that health organisations recognise the need to lead and take responsibility

to develop wellness programs based on emotional and physical health that support practitioners' continuous lifestyle management intervention... as an actively shared responsibility between individuals and their work organisations".

Definitions

Compassion Fatigue

'Compassion Fatigue' is described as emotional, physical, social and spiritual exhaustion that overtakes a person, causing a pervasive decline in his or her desire, ability, and energy to feel and care for others[6]. Compassion fatigue can arise as vicarious traumatisation or 'shared trauma' in clinicians as a consequence of caring for traumatised people. This is most commonly framed in military health settings as relating to exposure to physical combat related trauma but can equally occur when caregivers closely identify and therefore absorb patient's emotional or psychological trauma or distress, such as those working in mental health provision back home in garrison[6,7].

Flemister[8] suggests that compassion fatigue mainly affects those in the care-rendering professions given dynamic tension between the professional care-provider role and personal empathetic responses absorbed from the medical and emotional needs of patients/clients. Identified consequences for care givers include an increased risk for depression, anxiety, sleep difficulties, relational conflicts and decline in physical and mental health. Tyson related how clinicians can experience a syndrome of symptoms paralleling their client's diagnosis of post-traumatic stress disorder (PTSD), and transcend to alterations in self-identity, cognitive schemas, interpersonal relationships, physical health, job morale, world view and spirituality[7].

For military health organisations, a decline in job performance and efficiency, a rise in errors and sick time, and a disruption in morale in military units may also result[6]. These have obvious implications for health capability effectiveness and efficiency as well as the health and wellbeing of individuals. Therefore there is an urgent requirement for all military caregivers to understand the issues involved and receive appropriate education and intervention[9].

Burnout

'Burnout' as constructed by Maslach and Jackson in the 1970s[10] is now well accepted as a multidimensional syndrome consisting of emotional

exhaustion, depersonalisation, and reduced personal accomplishment[2].

Burnout is a common result of occupational stress prevalent among many service-oriented professions, such as law-enforcement, management, teaching and healthcare[11]. Burnout differs from stress in that stress involves too much, whereas burnout is about not enough as suggested by the following table[12].

Stress versus Burnout

Stress	Burnout
Characterised by overengagement	Characterised by disengagement
Emotions are overreactive	Emotions are blunted
Produces urgency and hyperactivity	Produces helplessness and hopelessness
Loss of energy	Loss of motivation, ideals and hope
Leads to anxiety disorders	Leads to detachment and depression
Primary damage is physical	Primary damage is emotional
May kill you prematurely	May make life seem not worth living

Source: Smith, Segal and Segal, 2012[12] citing Stress and Burnout in Ministry

Burnout speaks to issues in individual and collective resilience for healthcare systems across nations[13]. Flemister[8] suggests that anyone who experiences distress and aggravation in the workplace regardless of profession or position, even where there is no care-giver/recipient relationship, may experience burnout. Freudenberg[14] defined burnout as "to fail, wear out or become exhausted by making excessive demand on energy or resources". Stewart[15] described how individuals suffering from burnout become withdrawn and less empathic, and display negative behaviours toward co-workers and sometimes patients. This can result in breakdown of work team communication and degrade the quality of healthcare delivery[16].

Burnout is usually a cumulative process over time with a predictable course, although research by Dunford et al[17] suggests that there may be more dynamic implications for staff undergoing career related transitions[15,17-18]. The above has potential implications for health organisations undergoing restructuring, which will be explored later, or for ADF members moving between postings and/or deployments where the nature of work responsibilities, peer relationships and support significantly changes.

Whilst the literature clearly suggests that the risk of employee burnout is not limited to healthcare populations, issues impacting on self-determination and professional efficacy for health care professionals, such as health system reorganisation and conditions of practice uncertainty can escalate stressors leading to burnout[19]. Burnout thereafter becomes particularly significant for health care settings as it reduces the quality of care delivered to patients as well as the morale, absenteeism, quality of life and physical/mental health of caregivers[13,20]. Work-related stress affects both physical and mental wellbeing and long term health, and may result in stress-related disease or end-organ dysfunction[21]. It can therefore be a pre-condition for other types of serious occupational stress, such as compassion fatigue and vicarious traumatisation[2].

When considering employee health and well-being, it is inappropriate to frame burnout as a personal or private issue when organisational contributors such as long hours, little down time, and continual peer, customer, and superior pressures, demands and expectations are ignored[22-23]. Burnout goes beyond the usual scope of occupational health by making clear how workplace stressors impact as environmental pressures that degrade lived experience of health and wellbeing[24].

Four Stages of a Burnout Model

As identified above, the evolution of burnout is an insidious and cumulative process. The condition develops over time, often without the sufferer being aware until all physical, mental, emotional resources are exhausted and a crisis occurs. Gorkin[25] describes burnout as a progressive erosive spiral within a "Four Stages of Burnout" model:

1. **Physical, Mental and Emotional Exhaustion.** This initial phase may present as outward coping with the stressful work situation despite an increasing negative impact on internal feelings of wellbeing, energy and satisfaction with life. Caring about work or home life seems like a waste of energy. Eventually, the sufferer's reserves of energy and coping become depleted and serious doubts about self and the situation around them begin to mentally creep in.

2. **Shame and Doubt.** At this stage, negative self-talk and suspicions about one's suitability for their responsibilities or demands at hand begin to arise. Every day becomes a bad day. Previously successful people begin to doubt that they are the right person for their job. As self-confidence begins to plummet, feelings of being a fraud and an imposter begin to rise, and doubts about past success increase in line with feelings of anxiety, panic and depression.

3. **Cynicism and Callousness.** Serious feelings of vulnerability and insecurity now impact on

the sufferer's attitude to self and others. The majority of the day feels either mind-numbingly dull or overwhelming. Sufferers feel that nothing they do makes a difference or is appreciated, even in the presence of evidence to the contrary. People experiencing this level of burnout have developed a psychological shell in an attempt to protect themselves from further damage. At this stage, external behaviour such as short-temperedness and alienation from colleagues and family become evident. Interpersonal contact and social activity becomes difficult to maintain. Professional engagement becomes difficult and may be exhibited as decreasing work team involvement and absenteeism. Decisions may appear odd or hasty, being made in an attempt to just move the issue along. All of these are late warning signs for others to acknowledge and potentially raise with the sufferer given the need for this serious level of mental distress and coping exhaustion to be addressed.

4. **Failure, Helplessness and Crisis.** All previous and latter maladaptive coping strategies have now failed. The hard outer shell has cracked and even slight emotional challenges or stressors elicit incongruous and emotional reactions. Situations and issues previously easily managed are now major problems. And all interpersonal relationships become strained and difficult to maintain.

Health care professionals suffering from any of the above levels of burnout require workplace support and access to professional assistance in order to re-establish and develop new coping strategies leading to longer term resilience and recovery.

International Context

In considering such issues in military health care systems, the literature reveals research and programs relating to overseas forces; as diverse as the United States, Canada, Slovenia and Peru[7,15,26-30]. A Canadian review of their operational stress support system formally raised concerns for the mental health of their military health carers, and other professional carers such as military chaplains and social workers, as long as a decade ago[31]. Unfortunately, a follow up review in Canada in 2008 found that ongoing shortages in health workforce numbers and increasing demands on their services had led to even greater instances of stress and burnout in that caregiver community[32]. This finding prompted a recommendation that:

"The Canadian Forces develop and implement a national program or initiative aimed specifically at assisting and preventing stress and burnout among the mental health care community".

The outcome of a further follow-on Canadian review commissioned in 2010 is not known, but the mental health of care providers in the Canadian military clearly remains firmly on their agenda[33].

Australian context

Unfortunately, no readily or publically available references expressing similar concerns for the wellbeing of Australian Defence Force Health Services were identified for this paper. No peer reviewed papers were identified in online catalogue searches. The widely circulated "Capability through mental fitness" document publicising the ADF mental health and wellbeing strategy in 2011 does not appear to directly address health workforce mental health issues other than as generic members of the ADF[34]. A word search of the Dunt Review Report[1] identified only one instance of "carers", being in the context of family and partners. There were no instances or even implied mention of compassion fatigue or burnout as issues for ADF personnel, let alone health care providers. Twenty instances of "health professionals" were identified, all in the context of staffing and training, consolidation into psychology support teams, as resources to enable follow up of Post Operations Psychological Screens (POPS), and as providers on the psychiatric health help line.

Unlike the Canadian Marin Review, it seems that little attention has been paid toward the mental wellbeing of military health carers as a specific at-risk group. The ADF Mental Health & Wellbeing Plan 2012-1535 only identifies a clinical supervision model as a priority deliverable for mental health practitioners. That is the only initiative in current plans and programs that approaches issues of service related mental health wellbeing for ADF healthcare providers.

As discussed later, assessments of overseas programs, and health workforce related data within mental health research is available but has not yet been analysed to any level of focussed detail. This paper is therefore intended to raise awareness for defence health policy, research and wellbeing promotion regarding potential impacts of service in the ADF on Australian military health professionals as a specific at-risk group.

Issues for Military Health Organisations

Capability and Retention. Stewart[15] suggests that compassion fatigue can account for caregivers not only leaving the organisation but leaving the profession altogether. This is clearly an issue for military organisations where the retention of highly trained and experienced personnel is critical to the maintenance of capability. Ciftcioglu[36] investigated occupational commitment and turnover intention relating to burnout syndrome. The article suggested potential substantial costs for organisations and individuals alike given a positive association between burnout and turnover, absenteeism, reduced productivity and other human performance factors. Ballenger-Browning et al[27] cited similar studies correlating staff absenteeism, poor staff retention, ill-health and reduced job performance with burnout.

Aguis et al[37] reported high rates of suicide, early retirement, increased substance use, and marital problems in medical practitioners experiencing serious work related stress. Glass[5] raised similar issues with the support of emergency service workers in Victoria, with implications for individual health status, self-reported wellbeing, absenteeism and future work intentions.

Restructuring and change fatigue. The ADF health environment has changed significantly since the Alexander Review of 2008[38] and companion Army operational health restructuring. Changes in the career expectations and working conditions of uniformed health professionals have occurred across strategic, garrison and operational domains. The organisation as a whole must always be cognisant of potential impacts that such restructuring and related change fatigue may have on Defence health personnel.

Greenglass and Burke[19] examined similar issues in the Canadian public health care system. Their paper relates health service mergers or closures, service reductions and extensive job losses. In their study looking at predictors of burnout in nursing staff in particular from these changes, they identified:

• issues of cynicism towards the organisation arising from perceptions of psychological contract violation,

• negative reactions in organisational commitment if employees felt they had been treated unfairly or poorly informed during restructuring, and

• reductions of commitment in previously highly motivated individuals in times of staff downsizing.

The same paper also identified positive staff attributes, such as control coping that generally underpins organisational commitment, high job performance and job change intentions. Both individual and group resilience, and therefore tolerance to ongoing or significant change, is a finite resource that erodes over time.

Greenglass and Burke concluded that health care organisations undergoing change need to consider the inherent stressors that are likely to impact on the delivery of services by employees. This includes possible psychological impacts that perceived job insecurity, workload and task distribution may have on individuals and workgroups. Such issues can impact on wider efficacy and resilience inherent in the social structures and culture of affected workplaces. Finally, they suggest that individual resource variables, such as self-efficacy, individual coping and prior organisational commitment also need to be assessed to avoid burnout in vulnerable individuals.

Locus of Control. Leading on from the above, Maslach et al[39] sought to identify which types of people might be at greater risk of experiencing burnout. As Leiter[40] advised, burnout is inconsistent with a sense of self-determination and diminishes the potential for subsequent effectiveness. Understanding such issues is of significance to military health organisations where hierarchical systems of top-down command and control are strictly maintained and higher authority cannot readily be challenged. Maslach et al[39] determined that the exhaustion dimension of burnout is higher for those who have an external locus of control (attributing events and achievements to powerful others) rather in those with a strong sense of their own efficacy, efforts or ability to influence circumstances (internal locus of control).

Toppinen-Tanner et al[41] defined burnout as a chronic stress syndrome caused by work-related overload and lack of resources. For lower level health managers and clinical leaders, a sense of higher support and adequate resourcing for self-determination to appropriately address and satisfy local demands and concerns within their direct responsibility and wider influence is critical. The demands for health unit performance and efficiency, and the associated resources, support and policies directing such services are often externally determined, directed and controlled. It is therefore likely that lower level workgroups and individuals may experience increased levels of unhealthy stress and reduced ability to adjust accordingly.

ADF Mental Health Research

Without doubt the most significant recent research work undertaken by the ADF into the mental health

of its members has been the 2010 ADF Mental Health Prevalence and Wellbeing Study[42]. Whilst the study reported that the 12-month rate of mental disorders in the ADF was very similar to that of a matched sample from the Australian community, it also noted that the ADF has a different profile reflective of the unique demands of service.

Additional relevant data has been collected for the Middle East Area of Operations (MEAO) series of health studies:

1. The **MEAO Preliminary Study** conducted in 2009 gained stakeholder support and informed development of subsequent research programs.

2. The **MEAO Census Study**[43] is a retrospective, self-report survey of around 27,000 ADF members deployed to the MEAO between 2001 and 2009.

3. The **MEAO Prospective Study**[44] was a follow-up study that collected pre- and post- deployment data on about 3000 members who deployed in 2010/11. That study obtained self-reported surveys, with selected members also participating in physical and neuro-cognitive testing.

4. The **MEAO Mortality and Cancer Incidence Study** was based on linkages to national databases to compare MEAO personnel rates of morbidity and cancer incidence to general Australian population statistics.

The key findings of both the MEAO Census and Prospective Health Studies were released in Canberra on 8 August 2013. Clinically significant findings from the study across psychological, physical and social wellbeing domains were reported. Both datasets enable further analysis regarding military health care professionals as an at-risk cohort, but detailed work to that level has not yet been resourced.

Mental Health Prevention and Promotion

Stewart[15] emphasised how prevention of compassion fatigue is more important than intervention. Just as in measures undertaken by military health organisations to prepare military forces for combat related impacts on mental well-being, health professionals who are at danger of developing compassion fatigue and burnout must also be prepared and supported through positive individual and organisational strategies to additionally deal with potential erosion of their professional and personal self-concept leading to mental health problems[15,45].

The Department of Defence in the post-Dunt reform period has invested significantly in education programs and initiatives to build mental health awareness, access, support and resilience in ADF members. Through a Military Occupational Mental Health and Wellbeing Model, the Department has adopted a holistic view of the multifactorial environment that supports and impacts on members[34]. At both organisational and individual levels, the model recognises the environment, culture, social support networks and impact on families as factors requiring attention. In addressing these domains, five key strategic foci are identified, being:

1. Foundation strengths

2. Risk reduction

3. Early intervention

4. Treatment and Recovery

5. Transition.

This comprehensive strategy is critical to supporting the mental health of ADF members across their service life. But despite such strategic level support, individuals and the defence health system alike will always need to maintain close attention to human issues such as anxiety, depression, compassion fatigue and burnout.

Self-Care

Within the above framework, the ADF provides a number of mental health awareness events at strategic way-points in military careers. Individual ADF members, including military health care providers, are increasingly aware of mental health issues and initiatives in the military community. Gradually, this will displace cultural stigma and misperceptions about the impact of mental health issues on deployability and career longevity.

At the individual level, members have been provided with tools and initiatives that promote early identification of problems in themselves and their mates. Ready access to mental health services through a number of entry points also supports the command chain, family/social networks and support to full recovery. The most significant elements of individual support are promotion of self-awareness and encouragement to seek support early.

Rhodes[46] highlights the need for U.S military health providers to apply the basic elements of self-care to their own mental health whilst also recommending changes to U.S. Department of Defence policy to better balance workload and deployments with rest and recovery for military care providers.

Given the ubiquitous nature of smartphones and other online technologies, the launch in February

2013 of the PTSD Coach Australia smartphone application provides a ready source of information, self-assessment, support access and promotion of early intervention and recovery for serving members and veterans[47].

Australian health care providers working in the military and/or with veterans can find more relevant practical support through a smartphone application developed by the U.S National Center for Telehealth & Technology. Their Provider Resilience application gives health care providers tools to guard against burnout and compassion fatigue as they help service members, veterans, and their families. Incorporating the ProQoL assessment model, the app provides ratings for compassion satisfaction, resilience and burnout. It also provides practical support through resilience building advice, timers to indicate when the last rest and recreation leave was taken, and daily shots of humour through Dilbert cartoons[48].

As noted above, the Provider Resilience application incorporates the ProQoL self-assessment tool. This professional quality of life self-test is freely available for online at www.proqol.org. The ProQoL tool is an attractive self-assessment measure for health professionals given its specific focus on the negative and positive effects of helping others who experience suffering and trauma[49]. Sub-scales for compassion satisfaction, burnout and compassion fatigue directly assess these issues for health care providers. As for the Provider Resilience app, the tool can be repeated at regular intervals, such as every few months, to assist individuals to monitor their own levels of distress and resilience over time.

In all such education and access initiatives aimed at individual self-care are three R's – Recognise, Reverse and Resilience[12]. The first challenge for health professionals experiencing mental distress from their work is to watch for early warning signs of burnout and recognise that they may benefit from the help of others. This can be difficult. Whilst most individuals can recognise they are under a lot of stress, burnout is more gradual and may not be noticed as a serious issue until a tipping point in coping is triggered.

The next challenge is to reverse as much as possible damage done by actively addressing factors that contributed to the breakdown in mental health and related wellbeing. As recommended by a Slovenian study of coping behaviours and personality traits relating to burnout in their military:

> "All individuals who cope ineffectively should be trained to identify the most intense job stressors, observe the ineffective coping strategies they may

use in response, and substitute them with more active coping strategies"[29].

Coping strategies may need to address work, lifestyle and personality traits that act together to degrade performance, motivation and self-concept. Considering and implementing changes in daily routines to maximise rest, time for recreation and exercise are fundamental to good health and wellbeing in all its forms. Changes in diet and a review of the use of alcohol or drugs as coping mechanisms should be undertaken. On the work front, the setting of boundaries and a review of tasking in frank consultation with supervisors are important to identify and agree on healthier work demands and peer support. On the spiritual level, stress management tips and strategies can be readily found online, through contact with medical services or accessing veteran support organisations.

The final concern is for individuals to regain a sense of control and rebuild resilience against future stressors and challenges. This goal is most likely to only be successful with the input of professional counselling. In regaining positive ways of thinking and coping, particularly for highly skilled and valuable health professionals, it may be necessary to acknowledge losses, re-evaluate goals and priorities, and re-establish a sense of purpose and self-efficacy[12]. This will require both time and significant family, peer and organisational support for optimal recovery to be realised.

Workforce Research and Monitoring

Action Orientated Strategies. As previously outlined, the Department of Defence has established a comprehensive strategy to address capability through mental fitness[34]. Seven priority actions were identified within the mental health strategy, being:

1. Addressing stigma and barriers to care

2. Enhancing (mental health) service delivery

3. Developing e-mental health approaches

4. Upskilling health providers

5. Improving pathways to care

6. Strengthening the mental health screening continuum

7. Developing a comprehensive peer support network.

A readily available resource for Commanding Officers/Officers Commanding of ADF health units to consider is the ADF's Profile of Unit Leadership, Satisfaction and Effectiveness (PULSE) survey. Performance of the PULSE survey within a health

unit permits assessment of the collective workgroup in their service context. Undertaking this practical level of directly relevant action orientated research at the unit level allows for assessment of:

- reported levels of job stress, job satisfaction and work motivation
- perceived support, fairness and autonomy in the workplace,
- communication, commitment and turnover intention
- teamwork, confidence and leadership.

Given the significant recent reforms and organisation-wide stressors from Defence efficiency requirements and similar, it might be useful for the Defence senior leadership to encourage workplace based research such as the PULSE survey to identify whether burnout in particular is an issue requiring attention[50-51]. The attempt alone to quantify such issues at the local level would be seen by staff as a positive initiative[52].

The Canadian Experience. Dedicated research funding for resilience based strategies for health care providers should be considered in line with initiatives overseas. For example, Canada faces similar issues as Australia given a similar experience of decade long operations in the Middle East. In the earlier cited Marin Review, the Canadian Ombudsman sought to investigate the prevalence and risks of compassion fatigue and burnout in Canadian military health carers. The review sought to make tacit identified issues in defence mental health policies, health promotions and education systems[31]. The report identified that:

"Other issues included staff burnout, staff and funding shortages, problems with civilian staffing, and a lack of time, money and direction to implement recommendations from focus groups".

This finding no doubt contributed to Recommendation[27] suggesting that:

"The Canadian Forces take steps to deal with the issues of stress and burnout created by lack of resources and high caseloads among Canadian Forces caregivers"[31].

Despite the above identified shortfalls, Zimmermann[26] describes a more positive Canadian military program called "Care for the Caregivers". Zimmermann's paper describes the structure and objectives of 4-day small group workshops offered to military chaplains as well as health care professionals in the Canadian forces. The program addresses topics such as post-traumatic stress disorder, vicarious traumatisation, coping techniques, spirituality, self-care, and family

issues. The paper reported positive feedback from participants and that the program had become a standard post-deployment activity for the Canadian military. The program has been conducted twice in Australia on an evaluation basis and is currently being considered within a wider spirituality and wellbeing strategy under development.

Health Workforce Characteristics, Stigma and Gender. Broader issues of workforce culture, particularly service life characteristics that reward constant high performance in challenging roles and environments, impact on potential compassion fatigue and burnout. Further research needs to consider the unique lifestyle demands and limitations of uniformed service life given their potential to increase burnout risk compared to civilian working environments. Data on potential predictors for burnout such as provider demographics, social support, institutional factors and beliefs about mental health service utilisation, treatment modalities and possible medication needs to be gathered[27]. As recommended by a Peruvian study of burnout in military nursing personnel, specific demographic groups that may require particular attention include younger/less experienced staff, those who are single, have children or work in the most critical or high intensity areas[30].

Broader structural issues such as recruiting, career models and retention also require attention. Research and monitoring relating to career choices and underlying psychological contracts, as well as potential gender based differences in military health care service experience need to be considered[53]. Research into the Australian military context of potential gender differences in experiencing burnout, coping and recovery, as well as issues of mental health service utilisation, barriers and stigma amongst all levels and categories of military health care providers in general are recommended[52-54]. Comparison of staff burnout prevalence between garrison and deployed practice environments may also reveal relevant context based factors either supporting or degrading resilience and coping respectively[28]. Finally, issues of self-stigmatisation, confidence in health service and command chain confidentiality and other potential barriers to service utilisation by military health professionals should also be closely examined[55].

In developing subsequent recommendations and initiatives to address issues identified by research into the above issues, measurement and ongoing monitoring standards sensitive to compassion fatigue and burnout within the unique nature of ADF health care employment will need to be considered[46].

Conclusion

Significant investment in mental health services for members of the ADF have come about following release of the Dunt Review findings and recommendations. Whilst increasing attention has been paid to long standing mental health issues in our veteran community, this paper argued that potential issues of compassion fatigue and burnout in our uniformed health professionals potentially require a similar investment in research, education and intervention. Burnout was identified as a possible cumulative consequence of stressful defence health work/life experience, with compassion fatigue being a particular risk for health care providers who deal, or have in the past dealt with, the physical and/or mental pain of others.

It is sincerely hoped that this paper sufficiently raises relevant concerns about these issues for them to occupy an appropriate place within the broader Defence and Veteran's Affairs research and policy agenda.

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