LIBERTY UNIVERSITY

JOHN W. RAWLINGS SCHOOL OF DIVINITY

Compassion Fatigue: The Effects of Secondary Traumatic Stress and Vicarious Traumatization Among Baltimore Police Department Community Chaplains

Submitted to the Faculty of the Rawlings Divinity School of Liberty University

In fulfillment of the requirements for the completion of

the Doctor of Ministry Degree

Department of Christian Leadership and Church Ministries

by

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Thesis Project Approval Sheet

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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Baltimore is plagued with a history of high crime, violence, and murder resulting in trauma. The purpose of the Doctor of Ministry action research project was to educate Baltimore Police Department (BPD) Community Chaplains concerning compassion fatigue while maintaining effective quality care. A two-day workshop was developed as an intervention to address the problem. Pretest and posttest surveys were administered using the Professional Quality of Life Scale, Version 5, and the Skovholt Professional Practitioner Resiliency and Self-Care Inventory. Data in the form of surveys, group notes, field notes, recorded testimonials, and stories were collected and analyzed. Results of the data yielded minimal significant increase in the knowledge of compassion fatigue thereby increasing the effectiveness and quality of the BPD Community Chaplains. The results demonstrated a divergence from the expectation of the researcher. Instead of demonstrating compassion fatigue, the results demonstrated moderate to high levels of compassion satisfaction for the majority of the BPD Community Chaplains.

There is a cost associated with caring for the traumatized. Those who serve the traumatized should be trauma-informed, and practice adequate self-care. Those individuals who are trauma-

informed and practice self-care may experience compassion satisfaction.

For future study, the researcher offers the recommendations of repeating the study in a post Covid Pandemic, face-to-face format, with revisions to the design of the intervention such as increased time of engagement with the content material, while inviting all BPD Community Chaplains from each of the nine districts throughout the city to participate in the research project.

Keywords: Compassion Fatigue, Secondary Traumatic Stress, Self-Care, Trauma Informed-Care, Law Enforcement Chaplain, Community Chaplain, Compassion Satisfaction

Dedication

This labor of love is dedicated to my Lord and Savior, Jesus the Christ; my Abba! You loved me and found me worthy. You gave Your life for mine, and I am eternally grateful. Your sacrifice is the reason why I live, love, and serve. To You, my Lord, be all the Glory!

It truly takes a village. I did not get here on my own. I am standing on the shoulders of strong women who have come before me. To my mother, the Late Jeanette D. Jones. Mommy, I did it! I remember the story you shared with me. You said you asked me one day what I wanted to be when I grew up and you said I told you I wanted to be a professional student. How I have lived into that prophetic voice. Thank you for your sacrifices, your love, your hugs, your kisses, your tears. You did have a purpose; you were my mother. I could not have done this without you. Thank you for the encouragement and support to chase my dreams. Ubuntu, I am because we are.

To my maternal grandmother and great-grandmother, the Late Leola C. Rutledge and the Late Rev. Elder Clara Williams, thank you for such a rich heritage, great values, strong work ethic, and rich love for the Lord. To my Ranny, thanks for taking care of me for the first two years of my life. You gave me an awesome foundation. It was an honor to care for you for the last two years of your life. To my Momma, my great-grandmother, thank you for the days spent at the church as a child. I know I terrorized you all, well, until the choir started to sing. I did not appreciate it then, but I relish the memories now. Thank you for sharing the Bible stories in the aluminum wash basins during bath time. Thank you for sharing with me the love of the Lord that sustains me today. I am honored and humbled to walk in your footsteps. Thank you for the shoulders and paving the way for me!

To my baby sister, Sonia A. Jones. You stoked the ember in my heart, and your love for the Lord and breath of the Spirit turned it into a raging fire. I finally learned to read the book, LOL. No other sister in the world can do what you do. Thank you for being mine. I love you!

To my baby brother, the Late Barry C. Jones. I love you, dude! I have a cold one and a bag of Doritos waiting for us.

To my spouse, the love of my life, C. F. Jones-Ramirez. You said it and it happened. Thank you for the love and support. You are my biggest fan, and I love you! Now please, no more prophetic words about another degree. LOL!

To my fur baby, my Bichon, Tucker. Thank you for the wet nose, the ball playing, and the walks. You were always on time for breaks with a walk or playing fetch. Thank you for being my comfort and support buddy with hugs, kisses, and unconditional love.

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To a mighty man of God who loves to serve the Lord with all of his heart. Pastor Matt Stevens, the Baltimore Police Department Coordinator of Faith Based and Community Programs. It has been an honor to learn from you, work with you, and serve with you. Thank you for allowing me the greatest opportunity to serve our BPD Officers and the people of Baltimore.

There are two very important and special women who have journeyed with me in this season of my life, through the tears, moments of joy, pain, anger, frustration, victories, failures, fears, illnesses, and surgeries; Carrie Miller, LCSW-C, LCADC, and Cecilia Amaral, MS, CPC. Carrie, thank you for helping me through the darkest seasons of my life. With your help, support, and prayers, I found my way to the other side of trauma. Cecilia, I am both humbled and honored to have you as my Spiritual Director and *Companion Over the Threshold*. Your light, love, prayers, and spiritual guidance sustained me during this journey. Your prayers kept me lifted and covered me during my heart surgery, recovery, and my battle with COVID-19 as I walked this doctoral journey. Thank you for the Momma Bear moments, stretching me, and encouraging me to dig deeper and spend more time in the presence of my Abba. I am especially grateful for the discovery of our little taste of heaven here on earth in Aston. You are a wonderful gift from God, thank you!

Finally, much gratitude to the Baltimore Police Department and to all the BPD Community Chaplains who participated in this important work. Thank you, humbled to serve!

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CHAPTER 1: INTRODUCTION

Introduction

Chaplaincy is a ministry of presence where ordained clergy serve outside of the church, proper, and serve in the marketplace of society.[1] Chaplains have been known to serve in venues such as the military, healthcare, education, governmental agencies, industrial, and private businesses.[2] Bennett comments, chaplaincy has recently experienced a surge in first responder venues, such as emergency medicine, mental healthcare, firefighter services, and law enforcement.[3]

There can be a high cost to pay when serving as a law enforcement chaplain. By serving and caring for traumatized people, people in crises, and distressed individuals, law enforcement chaplains can potentially be exposed to Compassion Fatigue (CF), also known as Secondary Traumatic Stress (STS), and Vicarious Traumatization (VT).[4] In this chapter, the ministry context of law enforcement chaplaincy in Baltimore, Maryland will be presented. The problem, purpose, and thesis statements of the action research project will be discussed, along with the basic assumptions, definitions, limitations, and delimitations of this action research project.

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[1] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 2.

[2] Ibid., 3.

[3] Larry Bennett, *First Responder Chaplain: Spiritual Caregiver* (North Charleston, SC: CreateSpace Independent Publishing Platform, 2016), vii.

[4] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publishing Inc., 2012), 587-588.

Ministry Context

Baltimore is the largest city in Maryland and is recognized nationally as a thriving and productive seaport.[5] Baltimore is affectionately known by her nickname, the Charm City. The city enjoys its jewels such as the Inner Harbor, the Baltimore Museum of Art, Walters Art Gallery, Fort McHenry, the birth place of the National Anthem, the Maryland Zoo in Baltimore, the Baltimore National Aquarium, the home and grave site of Edgar Allan Poe. Baltimore is home to the world-famous Lexington Market, founded in 1782. She is home to several academic institutions of higher education including, the Johns Hopkins University and Hospital, Morgan State University, Loyal University of Maryland, the Peabody Institute of Conservatory Music, St. Mary's Seminary, Coppin State University, the University of Baltimore, Notre Dame of Maryland University, and Baltimore City Community College.[6]

Although Charm City offers tourists a myriad of attractions, historical, literary, and cultural sites and events, the city currently possesses a darkness. Baltimore is also known for its recent rise in crime rates, murder rates, and civil unrest since 2015, following the death of Freddie Gray.[7] Since 2015, the city's population has declined steadily due to civil unrest and violent crimes.[8] The population of Baltimore City in July 2019 was 593,490.[9] In 2020, Baltimore's population continued to decline. According to the most recent United States census

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[5] "Baltimore," Britannica.com, accessed January 18, 2021, https://www.britannica.com/place/Baltimore

[6] Ibid.

[7] Alison Knezevich, "Baltimore Population Drops Below 600,000, the Lowest Total in a Century, Census Estimates Show," The *Baltimore Sun*, March 26, 2020, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-population-estimates-20200326-nebck2k2anbwrcfsbknphsfgwi-story.html?

[8] Ibid.

[9] Ibid.

data for 2020, Baltimore had a negative growth rate of 1.51%, resulting in an estimated population of 584,537.[10]

Baltimore Crime and Disparities

Baltimore has one of the highest crime rates in America when compared to all communities regardless of their populations. The city has a crime rate of 63 per one thousand residents, which means there is potentially a one in 16 chance of becoming a victim of either violent crime or property crime.[11] Baltimore's high crime rate may be due to the excessive poverty levels experienced within the city. Malter has reported, "Nearly 24% of Baltimore's population is living below the poverty line, which is $20,090.00 a year for a family of three."[12] The poverty level increases dramatically when one considers children alone. Thirty-five percent of the children living in Baltimore City are "…living below the poverty line and 61% living in low-income households that have incomes that are less than two times the poverty level."[13]

Sixty-three percent of the population in Baltimore City is African American.[14] Asante-Muhammed, Director of the Racial Wealth Divide Initiative and co-author of *The Racial Wealth Divide in Baltimore*, concurs stating, "Black residents make up 63% of Baltimore's population and do worse than the African American national average on nearly every outcome measure.

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[10] "Baltimore City, Maryland Population 2020," World Population Review, accessed January 18, 2021, https://worldpopulationreview.com/us-counties/md/baltimore-city-population.

[11] "Baltimore, Maryland Crime Analytics," Neighborhood Scout, accessed January 18, 2021, https://www.neighborhoodscout.com/md/baltimore/crime#description.

[12] Jordan Malter, "Baltimore's Economy in Black and White," CNN Business, last modified April 29, 2015, https://money.cnn.com/2015/04/29/news/economy/baltimore-economy/.

[13] Ibid.

[14] Ibid.

Whites, on the other hand, constitute 28% of the population and fare better than national averages on most outcomes."[15]

> Daraius Irani, vice president of Innovation and Applied Research at Towson University, called the report's [*The Racial Wealth Divide in Baltimore*] findings "shameful" and "tragic." He said it was similar to national research he's done that showed, for instance, that black households in the United States have 1/10th of the wealth of white households. "By every metric African-American households are worse off than white households, and that holds true in the city [Baltimore]" …. It's a national tragedy...[16]

There are several documented disparities in the African American demographic that may contribute to the high crime rate in Baltimore. Income is one such disparity. Maryland is the richest state in the country.[17] The median income for a family living in Maryland is $73,538; for whites, $60,550; and for blacks, $33,610.[18] Wells, a reporter for the *Baltimore Sun* Newspaper concurs, citing, "Median household income for African-Americans in Baltimore is nearly half that of whites, $33,801 compared to $62,751…. More than two-thirds of black residents of Baltimore don't have enough liquid savings to survive for three months in case of job loss, compared to less than a third of whites."[19] Another disparity experienced by African Americans is employment. Due to insufficient industrial jobs, manufacturing positions, and declining population, there appears to be an economic crisis in the city.[20] Asante-Muhammed points out

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[15] Dedrick Asante-Muhammed, *The Racial Wealth Divide in Baltimore*, Prosperitynow.org, last modified January 2017, 3, https://prosperitynow.org/files/resources/Racial_Wealth_Divide_in_Baltimore_RWDI.pdf.

[16] Carrie Wells, "Report Highlights Economic Disparities Between Races in Baltimore," *The Baltimore Sun,* January 30, 2017, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-racial-wealth-divide-20170130-story.html.

[17] Jordan Malter, "Baltimore's Economy in Black and White," CNN Business, last modified April 29, 2015, https://money.cnn.com/2015/04/29/news/economy/baltimore-economy/.

[18] Ibid.

[19] Wells, "Report Highlights Economic Disparities Between Races in Baltimore."

[20] Ibid.

the unemployment rate in the city is three times greater among people of color than for whites.[21] Wells agrees stating the unemployment rate in Baltimore City is "…three times greater in African American households than that of Caucasian households."[22] A third disparity is education. Asante-Muhammed further explains in the same report that one out of five African Americans lack a high school diploma, a little more than 21.8%, while one out of 10 Caucasians lack a high school diploma, 12.8%.[23] "This disparity widens in higher degree attainment, with only 13% of African Americans in Baltimore having a B.A. or higher, compared to 51% of Whites."[24] A fourth disparity is healthcare.

> Life expectancy rates in the neighborhoods of Upton and Druid Heights [two of the poorest neighborhoods in the city] -- where median income is well below the poverty line at $13,388 a year -- is [sic] only 63 years old. That's 20 years lower than the 83-year life expectancy for Roland Park [one of the wealthiest neighborhoods in the city], less than five miles away. In that neighborhood, the median income is $90,492.[25]

Malter explains in his article, "Baltimore's Economy in Black and White," those individuals who reside in the poorest of neighbors in Baltimore City are three times more likely to die due to heart disease; eight times more likely to possess diabetes; 15 times more likely to be affected by or experience homicides; and 20 times more likely to be victims of HIV/AIDS than those who live in more affluent neighborhoods in Baltimore City.[26]

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[21] Dedrick Asante-Muhammed, *The Racial Wealth Divide in Baltimore*, Prosperitynow.org, last modified January 2017,4, https://prosperitynow.org/files/resources/Racial_Wealth_Divide_in_Baltimore_RWDI.pdf.

[22] Wells, "Report Highlights Economic Disparities between Races in Baltimore."

[23] Dedrick Asante-Muhammed, *The Racial Wealth Divide in Baltimore*, Prosperitynow.org, last modified January 2017, 10, https://prosperitynow.org/files/resources/Racial_Wealth_Divide_in_Baltimore_RWDI.pdf.

[24] Ibid.

[25] Jordan Malter, "Baltimore's Economy in Black and White," CNN Business, last modified April 29, 2015, https://money.cnn.com/2015/04/29/news/economy/baltimore-economy/.

[26] Ibid.

Following the death of Freddie Gray in April 2015, Baltimore City has experienced some of the highest violent crime rates and murder rates in the country. These violent crimes included murder and non-negligent manslaughter, armed robbery, rape, and aggravated assault, including assault with a deadly weapon.[27] According to NeighborhoodScout's [sic] analysis, the Federal Bureau of Investigations reported crime statistics which indicated chances of becoming a victim of one of the aforementioned crimes in Baltimore City are one in 53.[28] Murder has also been on the rise in Baltimore City since 2015. The year 2015 was one of the deadliest ever in the city per-capita. There were 344 homicides in 2015, second only to the 353 murders in 1993, when Baltimore had about 100,000 more residents.[29] There were 318 reported killings in Baltimore in 2016.[30] In 2017, Baltimore set another dismal record of 343 killings, "…bringing the annual homicide rate to its highest ever - roughly 56 killings per 100,000 people. Baltimore, which has shrunk over decades, currently has about 615,000 inhabitants [in 2017]."[31] According to the *Baltimore Sun*, there were 309 confirmed murders in Baltimore in 2018.[32] There were 348 murders reported in Baltimore in 2019 "…with a grim record of 57 killings per 100,000 people,

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[27] Jordan Malter, "Baltimore's Economy in Black and White," CNN Business, last modified April 29, 2015, https://money.cnn.com/2015/04/29/news/economy/baltimore-economy/.

[28] "Baltimore, Maryland Crime Analytics," NeighborhoodScout, [sic] accessed January 18, 2021, https://www.neighborhoodscout.com/md/baltimore/crime#description.

[29] Kevin Rector, "Deadliest Year in Baltimore's History Ends with 344 Deaths," *The Baltimore Sun,* January 1, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-deadliest-year-20160101-story.html.

[30] Kevin Rector, "In 2016, Baltimore's Second-Deadliest Year on Record, Bullets Claimed Targets and Bystanders Alike," *The Baltimore Sun*, January 2, 2017, https://www.baltimoresun.com/news/crime/bs-md-ci-homicides-2016-20170102-story.html.

[31] "2017 Sees Highest Murder Rate Ever in Shrinking Baltimore," CBS News, last modified January 2, 2018, https://www.cbsnews.com/news/baltimore-homicide-murder-rate-highest-2017-crime-increase-freddie-gray-killing/.

[32] "Baltimore Homicides," *The Baltimore Sun*, last modified January 18, 2021, https://homicides.news.baltimoresun.com/.

the city's worst homicide rate on record."[33] In 2020, Baltimore recorded 335 murders.[34] As of January 18, 2021, Baltimore had experienced 10 murders.[35] At that time, the most recent murder was Dante Barksdale, the Director of Baltimore's Safe Streets, a violence prevention program.[36] It is ironic that Barksdale, the director of an organization that attempted to clear the streets of gun violence while restoring safe streets in Baltimore City, was murdered on the very streets he and several citizens patrolled.[37] Barksdale was the tenth reported homicide as of January 18, 2021.

Baltimore's Civil Unrest and Injustice

In addition to the years of violent crime rates and dismal murder rates, Baltimore City has faced severe civil unrest and civil injustice. Freddie Gray, a 25 year-old African American man, suffered life threatening injuries while in police custody, resulting in his death on April 19, 2015. In 2015, Baltimore City's Gun Trace Task Force (GTTF) was exposed for its own violent crimes and corruption. The purpose of the city's GTTF was to clean up the city while removing weapons and violent criminals from the streets of Baltimore. However, the task force was investigated and found to have committed serious crimes over several years. During its establishment, nine officers plundered the city and its residents for hundreds of thousands of

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[33] Tim Prudente, "2019 Closes with 348 Homicides in Baltimore, Second Deadliest Year on Record," *The Baltimore Sun*, last modified January 1, 2020, https://www.baltimoresun.com/news/crime/bs-md-ci-cr-2019-homicide-final-count-20200101-jnauuumukbdh3edsyypspsm3he-story.html.

[34] "Baltimore Homicides," *The Baltimore Sun*, last modified January 18, 2021, https://homicides.news.baltimoresun.com/.

[35] Ibid.

[36] Justin Fenton and Hallie Miller, "Dante Barksdale, 'Heart and Soul' of Safe Streets, is Shot to Death Sunday in Baltimore, Officials Say," *The Baltimore Sun*, January 17, 2021, https://www.baltimoresun.com/news/crime/bs-md-ci-cr-man-shot-head-20210117-vfz43kphhjgnnjfdddef4lvmbq-story.html.

[37] Harmeet Kaur, "Dante Barksdale, Who Worked for More Than a Decade to Keep Baltimore's Street Safe from Gun Violence, is Shot and Killed," CNN News, January 18, 2021, https://www.cnn.com/2021/01/18/us/dante-barksdale-baltimore-safer-streets-trnd/index.html.

dollars in cash, drugs, and jewelry.[38] A full investigation into Baltimore's defunct GTTF revealed about $300,000.00 dollars of stolen money, three kilograms of cocaine, 800 grams of heroin, and hundreds of thousands of dollars in stolen jewelry was pilfered from the citizens of Baltimore.[39] The unfortunate death of Freddie Gray and the corruption of the Baltimore City Police Department may be two of the causes for the divide and severe lack of trust between the citizens in the neighborhoods of Baltimore City and the Baltimore Police Department (BPD).[40]

Prior to the Freddie Gray tragedy and the discovery of criminal activity, gross misconduct, and corruption of the GTTF within the BPD, Lt. Colonel Melvin Russell of the Community Collaboration Division, a small contingent of police officers tasked with rebuilding community and officer relations,[41] sought to repair the relationship with the citizens of Baltimore and the BPD. In 2014, Russell began to revamp the BPD Chaplains' Academy in hopes to address the issues of discord and mistrust between the citizens of Baltimore and the police department.[42] The Baltimore City Police Chaplaincy Academy was re-established in 2014. Russell recalls the BPD possessed chaplains in the 1970s.[43] He stated the purpose of the chaplains was more ceremonial, assisting in academy graduations and awards ceremonies.[44]

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[38] German Lopez, "8 Cops Allegedly Used an Elite Baltimore Police Team to Plunder the City and Its Residents," Vox, February 13, 2018, https://www.vox.com/policy-and-politics/2018/2/2/16961146/baltimore-gun-trace-task-force-trial.

[39] Ibid.

[40] Ibid.

[41] "Investigation of the Baltimore City Police Department," U.S. Department of Justice Civil Rights Division, last modified August 10, 2016, https://www.justice.gov/crt/file/883296/download.

[42] Jesse Coburn, "Baltimore Police Build Chaplain Corps to Help Heal Relations with Community," The Baltimore Sun, last modified July 3, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-police-chaplains-20160703-story.html.

[43] Ibid.

[44] Ibid.

Russell further comments the chaplain program was grossly underutilized during those times.[45] He sought to create a newer, more relevant, and active chaplains' academy, which would train local clergy in the matters of police policies, procedures, and protocols, while also supporting the needs of the BPD officers and community. Russell developed a concept he called 'Relational Equity,' where chaplains are active, acknowledged, and vested in the communities where they live, work, worship, and serve. The vision of Russell's faith-based chaplains' academy of the BPD is to:

> Appoint at least six chaplains for each of the 36 sectors that make up the BPD districts across the city. The chaplain's role is to GET IN the car for Ride a Longs with officers, GET OUT of the car to engage and serve the community, and to connect the police and citizens together bridging the gap of mistrust.[46]

The first class of the revamped BPD Chaplaincy Academy graduated in March 2015. One month later, the city experienced riots, violence, fires, and destruction of community property due to the death of Freddie Gray while in police custody. The first graduating class of the BPD Community Chaplains put their skills to the test as they rode with officers and responded to community calls during civil unrest and violence.

Baltimore Police Department Community Chaplains respond and serve with their officers in the face of violent crimes, traumatic events, and crises including murder scenes, and civil unrest. They attempt to restore order and trust, while providing assistance in communication, and providing comfort and support to BPD officers, their families, and the citizens of Baltimore during traumatic crises and stressful events. Baltimore Police Department Community Chaplains

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[45] Jesse Coburn, "Baltimore Police Build Chaplain Corps to Help Heal Relations with Community," The Baltimore Sun, last modified July 3, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-police-chaplains-20160703-story.html.

[46] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 4.

responded to the call one month after graduation from the chaplaincy academy during the city-wide Freddie Gray riots, where police officers became the targets of angry protestors and demonstrators who threw rocks, bottles, and other foreign objects, injuring 20 officers.[47] Some BPD officers, as well as community chaplains, suffered from post-traumatic stress disorder following that traumatic event.[48]

Problem Presented

Baltimore City is infamous for its high levels of crime and violence. The city is ranked the fourth most dangerous city in America.[49] Violence and crime in the city have escalated sharply after incidents such as the death of Freddie Gray on April 19, 2015, and the exposure of corrupt police officers in the city's Gun Trace Task Force Unit. Police and community relations have deteriorated since those events and others. Citizens of Baltimore do not trust the officers of the Baltimore Police Department, citing corruption, police brutality, and racism.[50]

Baltimore Police Department Community Chaplains are specially trained ordained clergy who are tasked to support the BPD officers, bridge the gap of communication and trust between the police officers and the community, while also meeting the spiritual needs of officers and members of the community during traumatic events and crises.[51]

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[47] German Lopez, "8 Cops Allegedly Used an Elite Baltimore Police Team to Plunder the City and Its Residents," Vox, February 13, 2018, https://www.vox.com/policy-and-politics/2018/2/2/16961146/baltimore-gun-trace-task-force-trial.

[48] Josh Sanburn, "Inside the Fight to Change Baltimore's Police One Year After Freddie Gray's Death," Time.com, April 29, 2016, https://time.com/4304225/baltimore-crime-police-freddie-gray/.

[49] "Baltimore Ranks 4th Most Dangerous City in America," CBS Baltimore, accessed December 9, 2020, https://baltimore.cbslocal.com/2019/10/25/baltimore-ranks-top-4-for-most-dangerous-cities-in-america/.

[50] German Lopez, "8 Cops Allegedly Used an Elite Baltimore Police Team to Plunder the City and Its Residents," Vox, February 13, 2018, https://www.vox.com/policy-and-politics/2018/2/2/16961146/baltimore-gun-trace-task-force-trial; "Investigation of the Baltimore City Police Department," U.S. Department of Justice Civil Rights Division, last modified August 10, 2016, https://www.justice.gov/crt/file/883296/download.

[51] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 4.

Due to the high levels of violent crime, shootings, and deaths on the streets of Baltimore, the Baltimore Police Department Chaplaincy Academy was revamped in March 2014. Chaplains participate in ride-a-longs with police officers to provide moral support. They ride along to serve as liaisons between a community that has lost trust in the BPD.[52] Chaplains also serve the community, providing compassion, comfort, and care during incidents of trauma, crises, grief, and loss.

The Baltimore City Police Department Chaplaincy Academy was revamped and graduated its first class of BPD Community Chaplains in March 2015. On April 12, 2015, Freddie Gray, a 25 year-old African American man, was arrested for carrying what was believed to be a switchblade. Gray was placed under arrest with his hands and feet shackled together and he was placed, unsecured, in a police transport vehicle where he sustained a life-threatening neck injury in an alleged "rough ride."[53] Gray, who was targeted and had not provoked the police, was arrested for carrying what was believed to be a switchblade. The Maryland State's Attorney later determined Gray possessed a legal pocket knife.[54]

While in police custody, during a "rough ride,"[55] Gray requested medical assistance several times. Later reports shared by the Baltimore Police Department showed that several requests for medical treatment were ignored until Gray was found unresponsive in the rear of the

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[52] "Investigation of the Baltimore City Police Department," U.S. Department of Justice Civil Rights Division, last modified August 10, 2016, https://www.justice.gov/crt/file/883296/download.

[53] German Lopez, "8 Cops Allegedly Used an Elite Baltimore Police Team to Plunder the City and Its Residents," Vox, February 13, 2018, https://www.vox.com/policy-and-politics/2018/2/2/16961146/baltimore-gun-trace-task-force-trial.

[54] Ibid.

[55] German Lopez, "8 Cops Allegedly Used an Elite Baltimore Police Team to Plunder the City and Its Residents."

police transport vehicle.[56] Gray was taken to Baltimore Shock Trauma, where he was found to have sustained a life-threatening emergency. Several days after his arrest, Gray died from his injuries, which he sustained while in police custody. The city became besieged with anger, violence, and crime. Riots broke out in the city after reports were released that Mr. Gray tragically sustained life-threatening injuries while in police custody due to being arrested for carrying a legal pocket knife; not a switchblade.[57] After the death of Mr. Gray, police officers and community chaplains patrolled the city amid violence, rioting, looting, fires, destruction of property and vehicles while attempting to restore order to the city.

The problem is that some Baltimore Police Community Chaplains may be responding to crises while failing to protect themselves against Compassion Fatigue.

Purpose Statement

The purpose of the Doctor of Ministry action research project is to educate Baltimore Police Community Chaplains regarding compassion fatigue while maintaining effective quality care. The Baltimore Police Department Community Chaplains have served in the agency since the 1970s, according to Melvin Russell, who served and retired as Lieutenant Colonel of the Baltimore Police Community Collaboration Division.[58] Russell explained BPD Community Chaplains served and participated in more ceremonial services, such as officer graduations, banquets, and award ceremonies.[59] Due to the current climate, lack of trust, and broken

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[56] "Freddie Gray's Death in Police Custody – What We Know," BBC News, May 23, 2016, https://www.bbc.com/news/world-us-canada-32400497.

[57] Ibid.

[58] Jesse Coburn, "Baltimore Police Build Chaplain Corps to Help Heal Relations with Community," *The Baltimore Sun*, July 3, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-police-chaplains-20160703-story.html.

[59] Ibid.

relationship with BPD officers and the citizens of Baltimore, Russell surmised that BPD Community Chaplains needed to take a more active role in the department. Relations and communication between the BPD and the citizens of Baltimore had deteriorated after traumatic events, such as the death of Freddie Gray and the exposed corruption of the now defunct Baltimore City Police Gun Trace Task Force Unit.[60, 61]

The first class of BPD Community Chaplaincy Academy graduated a month prior to the Freddie Gray tragedy that left the city in turmoil. In April 2015, after the death of Freddie Gray, the new graduates of the Baltimore Police Chaplains' Academy were tested.[62] These newly graduated BPD Community Chaplains served with and supported police officers while providing a ministry of presence, peace, and calm in Baltimore City communities during fighting, violent crimes, shootings, fires, destruction of property, and rioting.[63]

Baltimore Police Community Chaplains historically served the agency in ceremonial matters. As the relationship between BPD officers and the communities of Baltimore City deteriorated, BPD Community Chaplains underwent additional training and took on new roles and responsibilities. The first graduation class of 2015 received training in crisis intervention, post shooting trauma, family and grief trauma support, clergy and police confidentiality, ride-a-long protocol, critical incidents, mental health, and community policing.[64] It appears the

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[60] U.S. Department of Justice Civil Rights Division, "Investigation of the Baltimore City Police Department." Last modified August 10, 2016. https://www.justice.gov/crt/file/883296/download.

[61] Del Quentine Wilber and Kevin Rector, "Justice Department Report: Baltimore Police Routinely Violated Rights," The Baltimore Sun, last modified August 9, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-doj-report-20160809-story.html.

[62] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 4.

[63] Ibid., 8

[64] Ibid., 4.

community chaplains received specialized training on how to serve in traumatic events as they served officers and the community.

The research questions for this action research project are: 1). Did the BPD Community Chaplains receive adequate training and preparation to protect themselves against compassion fatigue and vicarious traumatization, while serving those who directly experience traumatic events and crises? 2). How can Baltimore Police Community Chaplains combat Compassion Fatigue while providing effective quality care, if detected? 3). Will a two-session workshop focusing on Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization have a significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains?

Basic Assumptions

The following assumptions are presented in this action research project. First, it is assumed some of the community chaplains of the Northeast and Northwest districts of the Baltimore Police Department are trauma-informed and can identify compassion fatigue, secondary traumatic stress, and vicarious traumatization. Second, it is assumed the community chaplains of the Northeast and Northwest districts of the Baltimore Police Department will respond and voluntarily participate in the project, providing full disclosure regarding their level of trauma training, understanding of trauma, and their level of preparedness regarding responding to traumatic events and crises. A third assumption is that the community chaplains of the Northeast and Northwest districts of the Baltimore Police Department will be transparent and honestly answer the items on the research instruments. It is further assumed that some community chaplains of the Northeast and Northwest districts of the Baltimore Police Department are not adequately trained or trauma-informed concerning compassion fatigue,

secondary traumatic stress, and vicarious traumatization, being unable to recognize and protect themselves against compassion fatigue and secondary traumatic stress.

Definitions

The following terms will be used throughout this action research project to expound on the problem, purpose, and thesis of the action research project.

Figley defines *Burnout* as a dynamic process which is gradual in nature. He explains burnout may affect trauma workers or helpers emotionally, psychologically, physically, and mentally due to the exhaustion they may experience when assisting traumatized individuals.[65] He further explains the exhaustion trauma workers experience is due to their long term involvement with the traumatized individuals they serve.[66] Valent, as cited in Figley's *Treating Compassion Fatigue,* states burnout is due to one's agitation, frustration, and inability to perform well due to the deleterious nature of one's work with traumatized individuals over a period of time.[67]

The Latin word for compassion is misericordia*. Compassion* as defined in the precedent review of literature is caring for people or having a heart for people who suffer. Nance defines compassion as possessing an emotional reaction or response towards those who are suffering while also possessing a strong desire to alleviate the suffering of the individual.[68] Nance continues and indicates caregivers who show compassion toward those who suffer often possess character traits like sensitivity, empathy, and tolerance, while also being non-judgmental.[69]

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[65] Charles R. Figley*, Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), 11.

[66] Ibid., 11.

[67] Paul Valent, "Diagnosis and Treatment of Helper Stresses, Traumas, and Illnesses," in *Treating Compassion Fatigue*, ed. Charles R. Figley (New York, NY: Routledge, 2002), 19.

[68] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 17.

[69] Ibid.

Hunter et al. define compassion as bearing the suffering of others. They offer having compassion suggests having sympathy or pity for someone who may be suffering; having an emotional reaction or response to an individual's distress or tragic situation.[70] Hunter et al. continue and establish the claim that compassion is a cardinal virtue for the pastoral tradition.[71] They state possessing compassion is at the heart of charity, healing, and caring. The person possessing compassion transcends class and culture, caring for all in need.[72] McKim defines compassion as being able to sympathize with others who are suffering, and having a desire to help those in need.[73]

Compassion Fatigue (CF), as defined by Charles Figley, a world renowned pioneer who has produced seminal research in the field of compassion fatigue and secondary traumatic stress, describes compassion fatigue as a by-product of working with people who experience trauma.[74] He considers compassion fatigue, secondary traumatic stress, and vicarious traumatization to be synonymous; the condition being an occupational hazard for those who possess careers in service and caring for people suffering from traumatic events or crises.[75] Nance concurs with Figley, stating compassion fatigue is a serious and natural occurrence for those who care for traumatized individuals who experience pain, suffering, or grief.[76] Nance states service workers and those

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[70] "Compassion," in *Dictionary of Pastoral Care and Counseling*, ed. Rodney J. Hunter (Nashville, TN: Abingdon Press, 1990), 206-207.

[71] Ibid., 207.

[72] Ibid.

[73] Donald K. McKim, *The Westminster Dictionary of Theological Terms* (Louisville, KY: Westminster John Knox Press, 2014), 61.

[74] Charles R. Figley, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), xiv.

[75] Ibid., 17.

[76] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 1.

who experience prolonged exposure to those who have suffered from trauma or pain will likely develop compassion fatigue at some point during their careers.[77] Gilbert-Eliot makes the point caregivers and those who serve the traumatized for prolonged periods will likely exhaust their ability to be compassionate and empathize resulting in compassion fatigue.[78] Paget and McCormack state compassion fatigue is a condition experienced by most caregivers, including chaplains.[79] The authors explain chaplains and caregivers who attend to traumatized individuals develop the risk of becoming vicariously traumatized due to providing spiritual care to the victims as well as being exposed to the sharing and reliving of the victims' traumatic stories, experiences, or crises.[80] Hunsinger notes, "Compassion fatigue, a term coined by psychologist Charles Figley, refers to the exhaustion and dysfunction that come with ongoing exposure to one who is suffering."[81]

Compassion Satisfaction (CS) is the opposite of compassion fatigue. Gilbert-Eliot states compassion satisfaction is the joy and reward one experiences due to working with and aiding traumatized victims.[82] She further states, compassion satisfaction focuses on the positive aspects of caring for traumatized people as they grow, heal, and get stronger, consequently aiding in the caregiver's growth, healing, increased and improved ability to journey with the traumatized

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[77] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 1.

[78] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue* (Emeryville, CA: Rockridge Press, 2020), 35.

[79] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 114.

[80] Ibid.

[81] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 29.

[82] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue,* 38.

individual.[83] Molnar et al. define compassion satisfaction as a positive phenomenon where the caregiver or person in a helping profession receives or experiences a sense of reward, efficacy, and competence due to caring for the traumatized.[84]

Emotional Contagion. An emotional contagion is defined as the affective process whereby the caregiver or helper may begin to assume, experience, or feel the emotional responses of the traumatized person whom he or she is caring for or providing treatment.[85]

Empathy is being able to understand the feelings and emotions of others.[86] Halpern and Tramontin define empathy as one's ability to listen to those who have experienced distress, trauma, or some form of suffering.[87] Reed states empathy is the ability to possess an understanding or awareness, as well as being sensitive to "vicariously experiencing" the thoughts and feelings of another person suffering from trauma.[88]

Relational Equity, as defined by Lt. Colonel Russell of the Baltimore City Police Community Collaboration Division, a small contingent of police officers tasked with rebuilding community and officer relations, is being known and recognized by the community in which one

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[83]Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue,* 38.

[84] Beth E. Molnar and Kyle D. Killian, Vanessa Emery, Ginny Sprang, Ruth Gottfried, and Brian E. Bride, "Advancing Science and Practice for Vicarious Traumatization/Secondary Traumatic Stress: A Research Agenda," *Traumatology* 23, no. 2 (2017): 130, https://doi.apa.org/doi/10.1037/trm0000122.

[85] Charles R. Figley, "Introduction," in *Treating Compassion Fatigue*, ed. Charles L. Figley (New York, NY: Routledge, 2002), 2.

[86] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 3.

[87] James Halpern and Mary Tramontin, *Disaster Mental Health: Theory and Practice* (Belmont, CA: Brooks/Cole Cengage Learning, 2007), 206.

[88] Theresa Reed, *It's Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress* (Pasadena, CA: Turlesea Group LLC, 2020), 7.

lives, works, or worships. Relational Equity is having a vested interest in the community where one lives, works, or worships.[89]

Secondary Traumatic Stress (STS). Gilbert-Eliot states secondary trauma can affect anyone. She defines secondary traumatic stress as a condition that occurs when someone else, other than the traumatized individual, is physically or emotionally harmed due to being repeatedly exposed to the traumatic story or experience.[90] Gilbert-Eliot further explains the trauma is considered secondary because the trauma did not directly happen to the caregiver. The trauma happened to the victim to whom the caregiver provides care. The caregiver experiences the trauma second hand due to hearing and experiencing the traumatic event, while providing care for the traumatized individual.[91] Sawicki defines STS as the behaviors and emotions a caregiver may experience while closely working with or immediately following the service to a traumatized individual.[92] Hunsinger explains secondary traumatic stress as a form of empathic stress, where the caregiver becomes exposed to someone else's traumatic events, resulting in feelings of helplessness, hopelessness, or fear.[93] Gentry et al. define secondary traumatic stress as the extreme exposure of the caregiver to someone else's direct contact or exposure to trauma, which severely affects the caregiver's ability, over time, to provide care due to their secondary

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[89] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 4.

[90] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue*, 3.

[91] Ibid.

[92] Soraya M. Sawicki, "Mental Health Workers' Vicarious Trauma, and Self-Care: A Phenomenological Approach" (DSW diss., Capella University, Minneapolis, 2019), 41, ProQuest Dissertation & Theses Global.

[93] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 29.

exposure to the trauma.[94] Reed describes secondary traumatic stress as the event that occurs to a caregiver when the caregiver indirectly experiences the traumatic events of others due to hearing or listening to the person's traumatic experience.[95]

Trauma-Informed Care. "Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing."[96] Yoder adds trauma-informed care is possessing the knowledge and awareness of trauma, what it is, and how it holistically affects an individual mentally, spiritually, physically, emotionally, psychologically, and behaviorally.[97]

Vicarious Trauma/ Vicarious Traumatization (VT). Reed defines vicarious trauma or vicarious traumatization as a result of intense empathizing of a caregiver due to his or her exposure to the traumatized person's story or event being told and retold.[98] Reed further explains the power of the trauma shared can inadvertently affect the life of the caregiver.[99] Sim acknowledges that vicarious trauma can occur when the service provider or caregiver becomes overwhelmed with the traumatic experience of the person to whom they are providing care,

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[94] J. Eric Gentry, Anna B. Baranowsky, and Kathleen Dunning, "ARP: The Accelerated Recovery Program (ARP) for Compassion Fatigue," in *Treating Compassion Fatigue*, ed. Charles Figley (New York, NY: Routledge, 2002), 124.

[95] Theresa Reed, *It's Not Drama, It's Vicarious Trauma*: *Recognizing and Reducing Secondary Traumatic Stress* (Pasadena, CA: Turtlesea Group, LLC, 2020), 8.

[96] Monique Tello, "Trauma Informed Care: What is It and Why It's Important," Harvard Health Publishing, Harvard Medical School, accessed March 2, 2021, https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562.

[97] Carolyn E. Yoder, *Trauma Healing: When Violence Strikes and Community Security is Threatened* (New York, NY: Good Books, 2020), 2.

[98] Theresa Reed, *It's Not Drama, It's Vicarious Trauma*: *Recognizing and Reducing Secondary Traumatic Stress*, 8.

[99]Ibid.

resulting in internalized psychological, physiological, or spiritual responses imposed on the caregiver as if the caregiver directly suffered the traumatic event.[100]

Limitations

The following limitations have been identified in this Doctor of Ministry action research project. First, not all Baltimore Police Department (BPD) Community Chaplains in the Northeast and Northwest districts will participate in the study. Second, due to the 2020-2021 COVID-19 pandemic, volunteer opportunities within the police department have been reduced for the community chaplains. For example, ride-a-longs, which are one of the main duties and responsibilities of the BPD Community Chaplains, have been temporarily suspended due to the COVID-19 pandemic and safety constraints. Physical presence of the community chaplains (face-to-face presence) within the police precincts has been reduced and limited. These actions may affect the responses given in the Professional Quality of Life Scale –Version 5 (PROQOL), because the instructions in the instrument ask the participant to answer the questions in the survey with the last 30 days in mind.[101] Finally, some BPD Community Chaplains who begin the study may not complete the study.

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[100] Christy Gunter Sim, *Survivor Care: What Religious Professionals Need to Know About Healing Trauma* (Nashville, TN: Higher Education & Ministry the United Methodist Church, 2019), 121.

[101] Martha Teater and John Ludgate, *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (Eau Claire, WI: PESI Publishing & Media, 2014), 44.

Delimitations

There are some delimitations associated with this action research project. The researcher serves as a BPD Community Chaplain in the Northeast and the Northwest districts of Baltimore City. Consequently, she has access to the community chaplains who serve in those two districts, thereby narrowing or restricting the sample or population being studied in this research project. In addition, only those BPD Community Chaplains who have graduated from the Baltimore Police Department Chaplaincy Academy from 2015 and beyond, since the revamping of the chaplaincy program, will be invited to participate in the study. The ages of the participants in the study ranged from 55 to 65 years and above. Due to the limited technological experience and access of the participants, the researcher opted to disseminate the Demographic Questionnaires, the Pretests/Posttest Professional Quality of Life Scale – Version 5, and the Pretests/Posttests Skovholt Practitioner Professional Resiliency and Self-Care Inventory instruments via the United States Postal Service.

Thesis Statement

The rate of violent crime in Baltimore City escalated severely after the death of Freddie Gray in 2015.[102] CBS Baltimore, a local news station, published, "Baltimore's violent crime rate is reported nearly five times higher than the national violent crime rate of 369 per 100,000 people."[103] The news station also reported "The city's robbery rate of 837 incidents per 100,000 people is the highest in the country and the murder rate of 51 per 100,000 is second highest,

[102] "Baltimore Homicides," *The Baltimore Sun*, accessed December 11, 2020, https://homicides.news.baltimoresun.com/.

[103] "Baltimore Ranks 4th Most Dangerous City in America," CBS Baltimore," accessed December 11, 2020, https://baltimore.cbslocal.com/2019/10/25/baltimore-ranks-top-4-for-most-dangerous-cities-in-america/.

trailing only St. Louis..."[104] In 2019, there were 348 reported homicides.[105] As of November 20, 2020, there were 314 reported homicides in Baltimore City.[106]

MacGillis, a reporter with the *New York Times*, states the city is plagued with trauma due to violent crimes, homicides, corruption, poverty, and racism.[107] As an agent of the BPD, the community chaplain is tasked to ride along with his/her assigned officer and provide moral and spiritual support, while also providing the presence of God when serving on his/her tour of duty. While serving on his/her tour, it is not uncommon for the BPD Community Chaplain to be confronted with trauma, grief, loss, pain, or suffering. On December 7, 2020, BPD Community Chaplain Pastor Hadley and two Northeast District Neighborhood Community Officers (NCOs) responded to a call to consult with a mother who lost her sixteen-year-old daughter due to health issues. The parent had difficulty coping with the loss of her daughter, and she reached out to the BPD NCOs, who in turn consulted one of the BPD Community Chaplains. She did so because she needed someone willing to listen, assist, and journey with her through her bereavement. Chaplain Hadley, along with Officer Cooper and Officer Banks, responded to the call, as each experienced the loss of a child, and shared their stories of how they have had to cope with their respective losses.[108]

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[104] CBS Baltimore, "Baltimore Ranks 4th Most Dangerous City in America."

[105] "Baltimore Homicides," *The Baltimore Sun*, accessed December 11, 2020, https://homicides.news.baltimoresun.com/.

[106] Ibid.

[107] Alec MacGillis, "The Tragedy of Baltimore," *The New York Times Magazine*, March 12, 2019, https://www.nytimes.com/2019/03/12/magazine/baltimore-tragedy-crime.html.

[108] Baltimore Police Department – Northeastern District, "Baltimore Police Department – Northeastern District," Facebook, December 7, 2020, https://www.facebook.com/BPDnortheast/.

Serving as a BDP officer or community chaplain in Baltimore City can expose both first responders to high levels of stress, traumatic events, and crises. Serving or ministering in such a high crime environment may render the BPD Community Chaplain susceptible to compassion fatigue and secondary traumatic stress, as he/she serves the BPD officers and responds to the community during traumas and crises. The thesis statement for this action research project is: If Baltimore Police Community Chaplains identify and manage compassion fatigue, then they will be better equipped to provide effective quality care.

Chaplains by nature are altruistic, compassionate, caring, and empathetic people who serve as God's conduits to facilitate healing, peace, and comfort to those who may be traumatized psychologically or emotionally hurting, ill, injured, angry, grieving, or suffering.[109] Figley, Anderson, and others in the review of literature agree, the cost of caring for others who suffer trauma may inadvertently expose caregivers and first responders, such as the BPD Community Chaplain, to compassion fatigue, secondary traumatic stress, or vicarious traumatization.[110, 111] Yoder and Anderson both agree that it is critical for caregivers and first responders, such as the BPD Community Chaplain, to be trauma-informed to lessen the risk of compassion fatigue, secondary traumatic stress, and vicarious traumatization.[112, 113]

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[109] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publishing Inc., 2012), 588.

[110] Charles R. Figley, "Compassion Fatigue as Secondary Stress Disorder: An Overview in Compassion Fatigue," in *Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), 15.

[111] Michael W. Anderson, "Secondary Trauma Among Chaplains," 587.

[112] Carolyn E. Yoder, *The Little Book of Trauma Healing: When Violence Strikes and Community Security is Threatened* (New York, NY: Good Books, 2002), 2-3.

[113] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, 587.

CHAPTER 2: CONCEPTUAL FRAMEWORK

Literature Review

The law enforcement chaplain serves in a spiritual capacity while providing the presence of God.[114] The person holding this position is an ordained clergy person with additional specialized training as a first responder, which equips him/her to serve the law enforcement agency and community. Working in partnership, the police officer and the law enforcement chaplain are daily exposed to traumatic events and crises like violence, crime, shootings, and death.[115]

There is a cost for those who serve, care, and minister to people suffering from traumatic events. Willis states long-term exposure to violent crimes, tragedies, traumas, and disasters can adversely affect the professional and personal life of the law enforcement chaplain.[116]

Compassion Fatigue, also known as secondary traumatic stress and vicarious traumatization, is a serious condition that occurs when the law enforcement chaplain begins to suffer secondary trauma due to serving and caring for those who directly experience traumatic events or crises.[117] This review of the literature consists of the history of chaplaincy, the chaplain, compassion fatigue, self-care, and compassion satisfaction.

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[114] Terry Morgan, *The Chaplain's Role: How Clergy Can Work with Law Enforcement* (Scotts Valley, CA: CreateSpace Publishing, 2012), 103.

[115] David W. DeRevere, Wilbert A. Cunningham, Tommy W. Mobley, and John A. Price, *Chaplaincy in Law Enforcement: What It Is and How to Do It*. 2nd ed. (Springfield, IL: Charles C. Thomas Publisher, LTD., 2005), 20.

[116] Dan Willis*, Bulletproof Spirit*: *The First Responder's Essential Resource for Protecting and Healing Mind and Heart* (Novato, CA: New World Library, 2014), xix.

[117] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 1.

History of Chaplaincy

The origin of the office of chaplain and the ministry of chaplaincy can be traced back millennia to ancient times. A review of the literature traces the ministry of chaplaincy to the Judeo-Christian time period. History demonstrates the role of clerics, as they provided encouragement and compassionate care to people in crisis during war.[118] Although there is no mention of the word chaplain or the office of chaplaincy in the Bible, men and women have been found to have compassion for their neighbors while providing assistance in times of need. Woodward agrees, nowhere throughout scripture does the Bible explicitly refer to the term chaplain or the office of chaplaincy. Implicitly, there are several examples of people who possess and fulfill the role of chaplain in the Bible, as the term is understood today.[119] Geyer and Geyer argue that Jesus was the epitome of a model chaplain:

> *Jesus was the model of compassion.* He showed His concern for individuals as well as large groups. He put His compassion into action by feeding people who were hungry, teaching people who were like sheep without a shepherd, and helping a widow whose only son died…. He cared enough about another person – the woman with the hemorrhage – to find her in the crowd and to speak to her individually.[120]

Since the time of Christ, men and women have served as chaplains in many settings, like healthcare, education, private businesses and industry, fire departments, and law enforcement. Chaplains have also served governmental agencies such as the Senate and the House of Representatives, embassies, armed forces, cemeteries, law enforcement, and correctional agencies.[121] The office of chaplaincy and the role of chaplain are best known and documented in

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[118] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 2.

[119] Whit Woodward, *Ministry of Presence* (North Fort Myers, FL: Faithful Life Publishers, 2011), 52.

[120] Richard E. Geyer and Patricia M. Geyer, *Chaplains of the Bible: Inspiration for Those Who Help Others in Crisis* (Greenville, SC: Ambassador International, 2012), 147.

[121] Paget and McCormack, *The Work of the Chaplain*, 2.

military history.[122] Sullivan states, chaplains have served and provided a ministry of presence in the military for centuries.[123] An oil painting captures one such historical account rendered by the hand of German born artist Jan Boeckhorst. The painting entitled, "Saint Martin Dividing His Cloak," c. 1640-1645, is currently on display in the National Gallery of Art. The painting depicts the compassionate care of Martin, a holy man who attends to the needs of a beggar.

> According to legend, Martin of Tour was a soldier in the army of Constantine the Great serving in Gaul, near the French city of Amiens, in the fourth century. On a winter's day Martin encountered a poor beggar at the city gates and cut his military cloak in half to help shield the shivering man from the cold. The night after his act of charity, Martin had a vision that Christ came to him wearing the part of the cloak he had given to the beggar, saying: "What thou hast done for that poor man, thou hast done for me." Martin, who had converted to Christianity as a child but who had entered military service at his father's behest, then left the military to devote his life to the Christian faith.[124]

Hunter et al. editors of the *Dictionary of Pastoral Care and Counseling,* define chaplaincy as the ministry of specialized clergy, which may include crisis care and management, counseling, administration of sacraments, education, assistance in ethical decision-making matters, and supporting staff, personnel, and the community.[125]

It has been difficult to determine the exact origin of the ministry of chaplaincy in the United States. However, Gouse makes the claim the first documented records of formal

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[122] Paget and McCormack, *The Work of the Chaplain*, 18-19.

[123] Elena E. Sullivan, "Chaplains," in *Encyclopedia of Law Enforcement*, ed. by Larry E. Sullivan, Marie Simonetti Rosen, Dorothy Moses Schulz & M.R. Haberfeld (Thousand Oaks, CA: SAGE Publications, Inc., 2004), 47.

[124] "Saint Martin Dividing His Cloak, c. 1640/1645," National Gallery of Art, accessed November 27, 2020, https://www.nga.gov/collection/art-object-page.52251.html.

[13] "Chaplaincy," in *Dictionary of Pastoral Care and Counseling*, eds. Rodney J. Hunter, H. Newton Malony, Liston O. Mills, and John Patton (Nashville, TN: Abingdon Press, 1990), 136.

chaplaincy in the United States can be attributed to President George Washington.[126] In July 1775, President George Washington established the Army Chaplain Corps. The Army Chaplain Corp was considered one of the first known chaplain ministries in the U.S.[127]

Today, chaplains serve in a myriad of governmental, public and private agencies, and organizations. Chaplains serve areas where compassionate care is required.[128] Bennett comments most recently chaplaincy has experienced a surge in first responder venues such as emergency medicine, mental healthcare, firefighter services, and law enforcement.

Law Enforcement Chaplaincy

DeRevere et al. define law enforcement chaplaincy as a ministry of presence where pastoral care in action is demonstrated.[129] Woodward also defines law enforcement chaplaincy as a ministry of presence where the chaplain provides godly influence and reminds those who are being served of the "providence and provision of God."[130] Holm provides yet another definition of the ministry of presence where there is trust and significant involvement and connections occurring between the chaplain and those receiving care.[131] Hunter et al. define the ministry of presence as servanthood. The chaplain is seen serving and ministering to those in pain, with those who experience hurt and harm during traumatic events and crises.[132]

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[126] Valerie Gouse, "An Investigation of an Expanded Police Chaplaincy Model: Police Chaplains' Communications with Local Citizens in Crisis," *Journal of Pastoral Care & Counseling* 70, no. 3 (2016):195-196, https://doi.org/10.1177/1542305016666554.

[127] Ibid., 195-196.

[128] Paget and McCormack, *The Work of the Chaplain*, 2.

[129] DeRevere, et al., *Chaplaincy in Law Enforcement: What It Is and How to Do It*, 25.

[130] Whit Woodward, *Ministry of Presence* (North Fort Myers, FL: Faithful Life Publishers, 2011), 17.

[131] Neil Holm, "Practising [sic] the Ministry of Presence in Chaplaincy," *Journal of Christian Education* 52, no. 3 (2009): 29.

[132] "Ministry of Presence," in *Dictionary of Pastoral Care and Counseling*, eds. Rodney J. Hunter, H. Newton Malony, Liston O. Mills, and John Patton (Nashville, TN: Abingdon Press, 1990), 950.

The Ministry of Law Enforcement Chaplaincy was born out of a need to serve multiple death notifications. Gouse[133] and the International Conference of Police Chaplains[134] convey the events of February 1973, where three Internal Revenue Agents lost their lives in a tragic automobile accident. The aftermath of the accident was challenging because the attending chaplain experienced difficulty making timely death notifications to the families of the deceased who lived outside the Washington DC area where the tragedy occurred.[135]

The International Conference of Police Chaplains further explained the frustration of Chaplain Joseph Dooley and his inability to secure assistance from neighboring law enforcement chaplains due to a lack of interdepartmental or interagency cooperation and communication.[136] After attending to the immediate crisis, Chaplain Dooley sought a way to secure interdepartmental and interagency assistance and cooperation for law enforcement chaplains to prevent future episodes of working in isolation.[137] The subsequent actions of Dooley prompted the establishment of the International Conference of Police Chaplains (ICFC) in October 1973.[138]

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[133] Gouse, "An Investigation of an Expanded Police Chaplaincy Model: Police Chaplains' Communications with Local Citizens in Crisis," 196.

[134] About Us: The Beginning," International Conference of Police Chaplains, accessed November 28, 2020, http://www.icpc4cops.org/about-us/our-beginning.html.

[135] Ibid.

[136] Ibid.

[137] About Us: The Beginning," International Conference of Police Chaplains, accessed November 28, 2020, http://www.icpc4cops.org/about-us/our-beginning.html.

[138] Ibid.

The Chaplain

The origin of the term chaplain is derived from the Old French word, *capella*, which refers to the chapel. The term originally described one who had charge of a chapel.[139] Further etymology concerning the term chaplain follows:

> Chaplain, originally a priest or minister who had charge of a chapel, now an ordained member of the clergy who is assigned to a special ministry. The title dates to the early centuries of the Christian church. In the 4th century, chaplains (Latin cappellani) were so called because they kept St. Martin's famous half cape (cappella, diminutive of cappa). This sacred relic gave its name to the tent and later to the simple oratory or chapel where it was preserved. To it were added other relics that were guarded by chaplains appointed by the king during the Merovingian and Carolingian periods, and particularly during the reign of Charlemagne, who appointed clerical ministers (capellani) who lived within the royal palace.[140, 141]

Over centuries, the office and ministry of chaplaincy have evolved. Chaplains can be found serving in various settings either, private or public. Chaplains can be found serving in both local and federal governments.

> In modern usage the term chaplain is not confined to any particular church or denomination. Clergy and ministers appointed to a variety of institutions and corporate bodies—such as cemeteries, prisons, hospitals, schools, colleges, universities, embassies, legations, and armed forces—usually are called chaplains.[142]

According to Evans, a chaplain is a person who serves as a pastoral and spiritual counselor, acts as an advocate, and guides those in crisis or who experience trauma.[143] Woodward comments today's chaplain is a minister who provides care in crisis response. He or

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[139] "Chaplain," Britannica.com, accessed November 28, 2020, https://www.britannica.com/topic/chaplain.

[140] Ibid.

[141] Whit Woodward, *Ministry of Presence* (North Fort Myers, FL: Faithful Life Publishers, 2011), 17.

[142] Ibid.

[143] Keith Evans, *Essential Chaplain Skill Sets: Discovering Effective Ways to Provide Excellent Spiritual Care* (Bloomington, IN: WestBow Press, 2017), 7.

she also provides encouragement, counsel, and pastoral services in the public or private sectors to all in need of compassionate care.[144]

Chaplains are ordained clergy who provide a ministry of presence outside the traditional church. Geyer and Geyer state a chaplain is a minister who serves those who find themselves distressed and need spiritual care in the workplace.[145] Woodward further defines a chaplain as clergy who represents the presence of God in the community during traumatic events or crises.[146]

The review of the literature demonstrates there is an increasing need for first responder chaplains to serve in specialized areas of community care.[147] These first responder chaplains receive additional specialized training and are qualified individuals who serve communities in times of crises, disasters, or traumatic events. These first responder chaplains serve in emergency medicine, firefighting services, disaster and crisis response, and law enforcement.[148]

Law Enforcement Chaplain

Sullivan states chaplains who serve in law enforcement are ordained clergy with extensive experience and training who are endorsed by an accredited denomination.[149] Law enforcement chaplains provide spiritual support to the officers and the police department, while also providing the presence of God in matters of faith for the community for whom they serve.[150]

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[144] Woodward, *Ministry of Presence*, 22.

[145] Richard E. Geyer and Patricia M. Geyer, *Chaplains of the Bible: Inspiration for Those Who Help Others in Crisis* (Greenville, SC: Ambassador International, 2012), 15.

[146] Woodward, *Ministry of Presence*, 22.

[147] Bennett, *First Responder Chaplain: Spiritual Caregivers*, vii.

[148] Ibid., 4.

[149] "Law Enforcement Chaplains Qualifications and Qualities," International Conference of Police Chaplains, accessed November 28, 2020, http://www.icpc4cops.org/chaplaincy-intro/chaplain-qualifications.html.

[150] Elena E. Sullivan, "Chaplains." in *Encyclopedia of Law Enforcement,* ed. Larry E. Sullivan et al., (Thousand Oaks, CA: SAGE Publications, Inc., 2004), 47 accessed November 28, 2020. http://dx.doi.org/10.4135/9781412952415.n21.

According to the International Conference of Police Chaplains, law enforcement chaplains provide several services and assistance to members of law enforcement agencies. Chaplains are tasked with helping law enforcement personnel with the pressures and responsibilities of their job, and home life, while also responding to and caring for victims of crime and trauma.[151] Paget and McCormack state to handle the stress, rigors, and demands of law enforcement, the chaplain must be physically fit and in good physical condition.[152] The chaplain should be trauma-informed regarding burnout and have knowledge of self-care strategies. The chaplain should be trained in first aid, cardiopulmonary resuscitation, and critical incident stress management.[153] In addition to physical fitness and survival training, the law enforcement chaplain should receive law enforcement procedural training and be familiar with how to use a police radio and know the proper codes and channels of operation.[154] Other areas of specialized training for the law enforcement chaplain include community policing, crisis intervention, safely navigating crime scenes, family and grief support.[155]

The law enforcement chaplain has many duties and responsibilities. However, the primary responsibility of a law enforcement chaplain is to assist the law enforcement officer to whom he or she may be assigned to work and support.[156] Law enforcement chaplains also assist the local community by extending God's presence, showing care, concern, and compassion to

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[151] "What Law Enforcement Chaplains Do," International Conference of Police Chaplains, accessed November 28, 2020, http://www.icpc4cops.org/chaplaincy-intro/chaplains-work.html.

[152] Naomi K. Paget, and Janet R. McCormack, The Work of the Chaplain. (Valley Forge, PA: Judson Press, 2006), 74.

[153] Ibid.

[154] Ibid.

[155] Ibid., 74.

[156] Elena E. Sullivan, "Chaplains," in *Encyclopedia of Law Enforcement*, edited by Larry E. Sullivan, Marie Simonetti Rosen, Dorothy Moses Schulz & M.R. Haberfeld (Thousand Oaks, CA: SAGE Publications, Inc., 2004), 48.

those in need. Sullivan points out the law enforcement chaplain brings a sense of peace and spirituality to the agency and its community.[157] The law enforcement chaplain bridges the gap between police officers, the community, and other spiritual leaders within the community.[158] Paget and McCormack concur:

> Law enforcement chaplains also have many duties that relate to a victim or the community at large. In this arena, they may counsel victims of crime, disasters, or other major critical events; provide direct spiritual-care assistance to victims; make death and injury notifications; participate in suicide and hostage intervention; serve as part of the community disaster response team; and provide spiritual care for the homeless.[159]

Chaplains also aid and assist law enforcement officers when and where needed, and instructed to do so. A law enforcement chaplain's duties and responsibilities may include providing support for law enforcement personnel, their families, and the community.[160] According to the International Conference of Chaplains, chaplains may assist in death notifications and assist victims of domestic violence.[161] Chaplains may provide spiritual guidance to the community, the law enforcement officers, and the families they serve.[162]

Moosbrugger expresses in his doctoral dissertation, the law enforcement chaplain complements law enforcement agencies by undertaking tasks that officers may not be trained to perform or have the time to complete, such as visiting the ill or injured officers or their families,

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[157] Elena E. Sullivan, "Chaplains," in *Encyclopedia of Law Enforcement*, edited by Larry E. Sullivan, Marie Simonetti Rosen, Dorothy Moses Schulz & M.R. Haberfeld (Thousand Oaks, CA: SAGE Publications, Inc., 2004), 48.

[158] Ibid., 47.

[159] Paget and McCormack, *The Work of the Chaplain*, 72.

[160] "What Law Enforcement Chaplains Do," International Conference of Police Chaplains, accessed November 29, 2020, http://www.icpc4cops.org/chaplaincy-intro/chaplains-work.html.

[161] Ibid.

[162] Ibid.

providing crisis intervention, or serving death notification.[163] All of these responsibilities of the law enforcement chaplain are significant. Assistance, guidance, direction, and counseling while responding to crises and traumatic events are some of the most critical stressful responsibilities of law enforcement chaplains.

Responding to ongoing stressful and traumatic events could be detrimental to the health of the chaplain. Hunsinger points out being exposed to prolonged pain and trauma of the ones chaplains serve can have a cumulative effect thereby rendering the chaplain susceptible to compassion fatigue or secondary traumatic stress.[164] Compassion fatigue (also known as Secondary Traumatic Stress) is a relatively new concept developed by Charles Figley, who claims that secondary traumatic stress of the caregiver is due to the cost of caring for others who suffer from trauma.[165]

Trauma and Traumatology

Traumatology is the study of trauma and traumatic stress. Charles Figley researched and developed this concept. Kyer, Halpern, and Tramontin state Charles Figley is a world-renowned authority of compassion fatigue.[166] "Traumatology, or the field of traumatic stress studies, has become a dominant focus of interest in the mental health fields only in the past decade…the origin of the study of human reactions to traumatic events can be traced to the earliest medical

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[163] Daniel P. Moosburger, "The Leadership of Law Enforcement Chaplain – Influence, Effectiveness, and Benefit to the Agency and Community: A Case Study of the Arlington Police Department, Arlington, Texas." (PhD diss., Regent University, 2006), 18, ProQuest Dissertations & Theses Global.

[164] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 71.

[165] Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue; Coping with Secondary Traumatic Stress Disorder*, ed. Charles R. Figley (New York NY: Routledge, 2002), 1.

[166] Beverly D. Kyer*, Surviving Compassion Fatigue: Help for Those Who Help Others* (Cheyenne, Wyoming: URLink Print and Media, 2020), 17; James Halpern and Mary Tramontin, *Disaster Mental Health: Theory and Practice* (Belmont, CA: Brooks/Cole Cengage Learning, 2020), 73.

writings in Kunus Pyprus, published in 1900 B.C. in Egypt."[167] Consequently, human trauma is not new to the field of research. However, there appears to be a gap in the literature concerning compassion fatigue, secondary traumatic stress, or vicarious trauma concerning the law enforcement chaplain. Research concerning compassion fatigue, secondary traumatic stress, vicarious trauma, and the law enforcement chaplain is lacking. Review of the literature is replete concerning Post-Traumatic Stress Disorder (PTSD), and those who suffer from traumatic events. Throughout his research and studies in the field of trauma, Figley noted most studies focused on those who suffered and were diagnosed with post-traumatic stress disorder. He found very little in the literature concerning caregivers or first responders who develop symptoms of trauma due to serving people who experience trauma directly.[168]

Bessel van der Kolk, a trauma expert, as cited in Yoder, argues trauma is the greatest threat to the health and well-being of people in the United States.[169] He believes that if left ignored or left untreated, trauma can be debilitating. The word 'trauma' is derived from the Greek word *traumat,* which means wound. Yoder comments trauma is how one responds holistically to stress above and beyond the normal stressors of life.[170] Diane Langberg, also a world-renowned trauma expert, asserts:

> Trauma means living with recurrent, tormenting memories of atrocities witnessed or borne. Memories that infect victim's sleep with horrific nightmares, destroys their relationships or their capacity to work or study, torment their emotions, shatter their faith, and mutilate hope. Trauma is extraordinary…not because it rarely happens but because it swallows up and destroys normal human ways of living.[171]

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[167] Figley, *Compassion Fatigue; Coping with Secondary Traumatic Stress Disorder*, xiii.

[168] Ibid., xiv.

[169] Bessel Van Der Kolk, *The Body Keeps the Score* (New York, NY: Penguin Book, 2014), 350.

[170] Ibid., 6.

[171] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 5- 6.

Not often explicitly listed in the review of literature, law enforcement chaplains are considered first responders as members of the law enforcement agency. Donnelly comments the most commonly recognized first responders are police officers, fire fighters, and emergency medical technicians (EMT) or paramedics. These individuals are commonly called to respond to traumatic events such as car accidents, violent crimes, injuries and illnesses, homicides and other crises.[172] As first responders who partner and serve with law enforcement officers, law enforcement chaplains are exposed to compassion fatigue, secondary traumatic stress, and vicarious trauma because they are also exposed to victims of violent crimes, injuries, illnesses, homicides, and car accidents.

Chaplains provide a special type of care when ministering to those who experience trauma. Anderson offers unlike other first responders and mental health professionals who serve traumatized people, chaplains journey with people in their pain and trauma while listening and providing spiritual care.[173] He continues and states by the nature of their calling and ministry, chaplains are subjected to the events of trauma and crises, as they join with those who have experienced trauma and tragedy, exposing themselves to compassion fatigue and secondary traumatic stress.[174]

Compassion Fatigue

A review of the precedent literature demonstrates, compassion fatigue (CF), secondary traumatic stress (STS), secondary victimization (SV), secondary stress (SS), vicarious traumatic

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[172] Elizabeth Anne Donnelly, "Secondary Trauma among First Responders," in *Encyclopedia of Trauma: An Interdisciplinary Guide* ed. by Charles Figley (Thousand Oakes, CA: Sage Publications, Inc., 2012), 590.

[173] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide* ed. by Charles Figley (Thousand Oakes, CA: Sage Publications, Inc., 2012), 587.

[174] Ibid.

stress (VTS), and vicarious traumatization (VT) are all synonymous terminology.[175] Some in the field of traumatology prefer the term compassion fatigue, because it sounds more benign and palatable. However, Kyer reports others in the field believe the terms secondary traumatic stress or vicarious traumatization are more clinical in nature and are used to describe compassion fatigue.[176] Reed suggests compassion fatigue presents itself when the helper or caregiver endures an oversaturation of trauma as presented in stories or experiences shared with them by their clients, which result in emotional and physical exhaustion.[177]

Carla Joinson first used the term Compassion Fatigue in 1992, while observing certain behaviors in nurses like fatigue, irritability, fear and having dread of reporting to work.[178] Figley, a pioneer trauma expert, further developed compassion fatigue while working closely with trauma workers and mental health professionals.[179] Figley has produced significant seminal work in the field of compassion fatigue and secondary traumatic stress. In this work, Figley researched the effects of trauma on helpers, caregivers, and first responders who cared for those who suffered from traumatic events or crises. This research was performed because there appeared to be a gap in the literature concerning traumatic stress and those who serve people who directly experience traumatic stress. Figley recognized there was minimal literature in the field of

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[175] Beverly D. Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others*, (Cheyenne, WY: Urlink Print & Media, 2020), 18; Charles R. Figley, *Treating Compassion Fatigue*, ed. Charles R. Figley (New York NY: Routledge, 2002), 2.

[176] Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others*, 18.

[177] Theresa Reed, *It's Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress* (Pasadena, CA: Turtlesea Group LLC, 2020), 7.

[178] Kathleen Gamblin and Sharon Francz, "Compassion Fatigue: When Caring Takes Its Toll," *Oncology Nursing News* 5, no. 5 (September 2011): n.p., accessed June 12, 2021, https://www.oncnursingnews.com/view/compassion-fatigue-when-caring-takes-its-toll.

[179] James Halpern and Mary Tramontin, *Disaster Mental Health: Theory and Practice* (Belmont, CA: Brooks/Cole Cengage Learning, 200), 73.

compassion fatigue, secondary traumatic stress, and vicarious traumatic stress when compared to PTSD.[180]

Figley became interested in the effects of trauma on those who care for and minister to those who suffer directly from traumatic events or crises. Those who suffer directly from crises or traumatic stress may develop post-traumatic stress disorder. Those who care for the traumatized may develop compassion fatigue, secondary traumatic stress, or vicarious traumatization due to the care they provide to the traumatized. Anderson asserts by nature of who chaplains are and what they do, such as being caring, compassionate, and empathetic spiritual people, they may appear more susceptible to STS and CF.[181]

Repetitive exposure to trauma and traumatic effects, over time, will have an adverse reaction in the lives of first responders, such as law enforcement chaplains. Anderson, the author of the article, "Secondary Trauma Among Chaplains," believes compassion fatigue is an occupational hazard for those chaplains who serve and minister to traumatized people.[182] Gilbert-Eliot explains, the human brain is hardwired to experience empathy and compassion.[183] She asserts because of the wiring of the human brain, people can empathize in matters of the heart and life. She also suggests that individuals can become overwhelmed with the trauma of others if they are not careful, thereby reducing their capacity over time, leaving them physically and psychologically exhausted and unable to cope.[184]

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[180] Charles R. Figley, "Introduction," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* ed. Charles R. Figley (New York, NY: Routledge, 1995), xiii.

[181] Anderson, "Secondary Trauma Among Chaplains," 588.

[182] Ibid.

[183] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue* (Emeryville, CA: Rockridge Press, 2020), 35.

[184] Ibid.

One of the most prevalent risk factors for compassion fatigue among law enforcement chaplains is secondary exposure to trauma and traumatic events. The repeated and prolonged exposure to stress and trauma puts the law enforcement chaplain at an increased risk of compassion fatigue. As previously mentioned in the study, trauma is defined as any situation that stresses one beyond normal coping ability or capacity, resulting in harm to the mind or body.[185] In the face of crises or traumatic events, our bodies naturally and instinctively enter into what is called the General Adaptation Syndrome. The General Adaptation Syndrome, also known as "fight, flight, or freeze," was developed by Hans Selye in 1936, and it is the body's way of coping with prolonged exposure to stress.[186]

Another prevalent risk factor, ironically, is one of the vitally important qualities necessary for the effective law enforcement chaplain, empathy. Having the ability to feel and understand the feelings and experiences of others is defined as empathy. Nance offers, most individuals choosing careers in caregiving or providing assistance to others typically possess the quality of empathy.[187] Reed explains the dilemma those in helping professions may find themselves dealing with concerns empathy. She states being empathetic "can be a blessing and a curse."[188] Caregivers need to be empathetic, however an over indulgence in empathy can place the caregiver's health in jeopardy. Kyer concurs, believing most caregivers are caring, compassionate, and empathetic individuals. She too finds it ironic, knowing and understanding

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[185] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue* (Emeryville, CA: Rockridge Press, 2020), 3.

[186] Rebecca Donatelle, "Thriving Type A: Hardiness, Psychological Resilience, and Grit," in *Health: The Basics*, 13th ed. (New York, NY: Pearson, 2019), 75.

[187] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts.* (Atlanta, GA: Expected End Entertainment, 2018), 3.

[188] Theresa Reed, It's *Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress* (Pasadena, CA: Turtlesea Group LLC, 2020), 25-26.

the necessary qualities that help caregivers accomplish their jobs may also expose them to pain, anger, and the trauma of compassion fatigue.[189] Figley believes empathy is vital for those who serve as caregivers. He also contends that it is a key element in the development of secondary traumatic stress.[190] Figley explains, empathizing with the traumatized enables the caregivers to comprehend the experiences of the traumatized, and increases the risk of secondary exposure to the caregivers potentially, placing them at risk as well.[191] Reed comments there are other factors that may increase the risk of compassion fatigue or secondary traumatic stress among law enforcement chaplains, such as possessing a personal history of trauma, being able to identify with the victim or sharing commonalities with the victim, and bearing the burden of confidentiality as a pastor or priest.[192]

Beaton and Murphy state there is an identifiable cost for caring for others as caregivers, first responders, or crisis workers.[193] Law enforcement chaplains who may experience compassion fatigue, secondary traumatic stress, or vicarious traumatization may present with physical, emotional, spiritual, behavioral, and relational signs and symptoms. Gilbert-Eliot reports physical signs and symptoms of compassion fatigue may present as digestion issues, body aches, respiratory issues, cardiac issues, hypertension, poor immune function resulting in

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[189] Beverly D. Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others* (Cheyenne, WY: URLink Print and Media, 2020), 31.

[190] Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* ed. Charles R. Figley (New York, NY: Routledge, 1995), 15.

[191] Ibid.

[192] Theresa Reed, It's *Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress*, 25-26.

[193] Randle D. Beaton and Shirley A. Murphy, "Working with People in Crisis: Research Implications," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* ed. Charles R. Figley (New York, NY: Routledge, 1995), 52.

frequent colds or flus, and diabetes.[194] Nance describes emotional signs and symptoms of compassion fatigue as bouts of anxiety and depression. The caregiver may experience a sense of hopelessness or helplessness. He or she may experience anger or fear. They may shutdown or isolate from friends and loved ones while feeling numbness, or hypersensitivity.[195] Nance also describes spiritual signs and symptoms one may experience, such as being disillusioned with God, possessing a loss of direction or purpose, feeling separated or abandoned by God, being apathetic, possessing a lack of self-satisfaction, and questioning one's call or the meaning of life.[196] Nance further discusses behavioral signs and symptoms that may be observed in someone suffering from compassion fatigue; these being mood swings, lacking patience, appearing withdrawn, appearing irritable, confused or angry, and experiencing changes in eating and sleeping patterns .[197] Nance comments it is not unusual to experience relational signs and symptoms such as decreased libido, lack of pleasure or joy, mistrust, social isolation, possessing difficulty with maintaining clear healthy boundaries between one's personal life and professional life.[198]

Experiencing any of the aforementioned signs or symptoms for a short or prolonged period of time may confirm the diagnosis of compassion fatigue or secondary traumatic stress. Review of the literature suggests self-care, education, and being trauma-informed are three of the best practices for management and prevention of compassion fatigue and secondary traumatic

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[194] Gilbert-Eliot*, Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue*, 13.

[195] Nance, *Overcoming Compassion Fatigue: When Helping Hurts*, 29.

[196] Ibid.

[197] Ibid.

[198] Ibid.

stress. Mathieu joins Kyer and Figley, believing and affirming compassion fatigue is a normal response or reaction caregivers will eventually suffer due to caring. Mathieu offers learning the warning signs and paying attention to self-care are two of the best strategies to address compassion fatigue.[199] Reed concurs, stating that one needs to practice mindfulness, which intentionally checks one's physical, emotional, and mental states of being. Being mindful of one's psychological and physical condition is vital to recovering from compassion fatigue, secondary traumatic stress, or vicarious traumatization. Reed also emphasizes the importance of having and practicing coping strategies to provide balance, healthy habits, and healthy boundaries.[200] Figley believes that appropriate education prior to being placed in the fields of service is critical. He argues all health care, mental health, medical, first responder, and spiritual care curricula should include the topics of compassion fatigue and secondary traumatic stress in trauma worker education.[201] He believes educators and employers must do a better job caring for and preparing those who give care to the traumatized. He comments, "It is important to know how these supporters become upset or traumatized as a result of their exposure to victims. By understanding this process, we not only can prevent additional, subsequent traumatic stress among supporters, but we can also increase the quality of care for victims by helping their supporters."[202] Yoder concurs and adds, all who care for the traumatized should be trauma-informed and have knowledge of what trauma is and how it will affect them holistically.[203]

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[199] Françoise Mathieu, "Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-care Tips for Helpers" accessed November 11, 2020. https://www.compassionfatigue.org/pages/Top12SelfCareTips.pdf.

[200] Theresa Reed, *It's Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress*, 52.

[201] Charles Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," 16-17.

[202] Ibid.

[203] Carolyn E. Yoder, *The Little Book of Trauma Healing: When Violence Strikes and Community Security is Threatened* (New York, NY: Good Books, 2020), 2-3.

Carrie Miller, LCSW – C is a retired Program Manager for the Baltimore County Health Department. She has worked professionally and in private practice for more than 40 years in the mental health field. In a personal interview, Miller, as the Program Manager of Baltimore County Health Department, shared she has supervised several social workers and has had the opportunity to counsel and educate some of her younger social workers who suffered from compassion fatigue or secondary traumatic stress, and burnout over the course of her 40 years of experience. She explains:

> Good supervisors are needed in the field to help prevent compassion fatigue and burnout. Most of the cases of compassion fatigue and burnout I have witnessed as a program manager for the county were seen in my younger social workers who served in the areas of child protective services, those working as Home Family Therapists (Functional Family Therapy, which is an evidenced-based practice), and those working with individuals in the recovery population.[204]

She further comments, "Supervisors have to assist their social workers with achieving better balance and boundaries yielding to better self-care."[205]

Compassion Satisfaction

The review of the literature demonstrates there can be a cost for caring for the traumatized if self-care and proper precautions are not recognized by the law enforcement chaplain. However, there are law enforcement chaplains and other first responders who work closely with the traumatized daily, and they do not experience compassion fatigue. These individuals experience the opposite of compassion fatigue. These individuals experience

[204] Carrie Miller, LCSW – C, Personal Interview, December 16, 2020.

[205] Ibid.

compassion satisfaction. Stamm defines compassion as a sense of deep empathy while also being sensitive to the needs of others who suffer from trauma.[206]

Molar et al. discuss the concept of compassion satisfaction, which is the sense of pleasure, enjoyment, and accomplishment a caregiver experiences as he or she serves in helping professions.[207] Kyer defines compassion satisfaction as a sense of competence and accomplishment one experiences because one has provided assistance to a person or persons in need, thereby making a positive difference in their lives.[208]

Why does it appear some law enforcement chaplains fall victim to compassion fatigue while serving and ministering to the traumatized, and other law enforcement chaplains do not seem to succumb to compassion fatigue, yet seem to thrive in compassion satisfaction? Stamm comments:

> Everyone is at risk, but the risks are compounded for those who work around trauma; there is the risk for direct personal exposure and then there is the risk of work-related secondary exposure. In the face of this compound risk, how do people stay sufficiently healthy to do their work? It would seem that human spirit, although clearly breakable, is remarkably resilient.[209]

Donatelle defines psychological resilience as a dynamic process where people adapt positively to sustained adversity or trauma.[210] She describes individuals with a high degree of

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[206] B. Hudnall Stamm, "Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Satisfaction and Fatigue Test," in *Treating Compassion Fatigue*, ed. Charles R. Figley (New York, NY: Routledge, 2002), 107.

[207] Beth E. Molnar et al., "Advancing Science and Practice for Vicarious Traumatization/Secondary Traumatic Stress: A Research Agenda." *Traumatology* 23, no. 2 (2017): 129-142. https://doi.apa.org/doi/10.1037/trm0000122.

[208] Beverly D. Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others* (Cheyenne, WY: URLink Print and Media, 2020), 192.

[209] B. Hudnall Stamm, "Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Satisfaction and Fatigue Test," 108.

[210] Rebecca Donatelle, "Thriving Type A: Hardiness, Psychological Resilience, and Grit," in *Health: The Basics,* 13th ed. (New York, NY: Pearson, 2019), 84.

resilience as those who possess: 1) a positive and proactive personality; 2) experience and have knowledge of self-efficacy; 3) possess a sense of control, flexibility, and are able to adapt; 4) possess balance and perspective; and 5) possess a perceived safety net of social support.[211]

Those first responders who enjoy compassion satisfaction while serving and ministering to the traumatized also seem to possess psychological hardiness. Donatelle defines psychological hardiness as one who possesses control, commitment, and willingness to embrace challenges.[212]

Individuals who experience compassion satisfaction while working with the traumatized remain trauma-informed and practice self-care. Kyer comments one of the greatest detriments to compassion satisfaction is a gross lack of self-care.[213] Self-care is the intentional practice of caring for oneself and being mindful of how one feels in mind, body, and spirit. Caring for self enables the caregiver to continue providing care for others. Self-care is analogous to the instructions given during pre-flight take-off: "Should there be turbulence anytime during the flight, oxygen masks will fall from the ceiling. Place your mask securely over your nose and mouth first, before assisting small children or others in need in the vicinity."

Self-Care

With compassion satisfaction, one cares for self in order to care for others, whereas compassion fatigue typically results from attempting to pour from an empty cup. Nance points out many people have the misconception that self-care is selfish behavior. She explains self-care is a necessity, and should be a priority for all caregivers working with traumatized individuals or

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[211] Rebecca Donatelle, "Thriving Type A: Hardiness, Psychological Resilience, and Grit," in *Health: The Basics,* 13th ed. (New York, NY: Pearson, 2019), 84.

[212] Ibid.

[213] Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Other*, 192.

individuals who suffer from emotional issues.[214] Self-care requires getting adequate rest, eating well, exercising, and making time for self and loved ones. Paget and McCormack agree, chaplains must incorporate, practice, and maintain good life long self-care habits, which include eating a healthy and balanced diet, exercise, restorative sleep, and engagement in spiritual practices. [215] Langberg adds to the conversation the importance of self-care, stating one should eat well, get regular exercise, get adequate sleep, make and keep regularly scheduled medical check-ups, and make time for recreation and relaxation. She further emphasizes the caregiver cannot care more about their clients than themselves; doing so may lead to compassion fatigue.[216] Miller concurs, "You have to make it about you and not about your client; taking time for self is not selfish, it is a necessity for those who care for traumatized people."[217]

There is a cost to caring. Law enforcement chaplains are exposed daily to traumatic events and crises, whether serving the law enforcement officers they work with or whether serving those traumatized in the community. Over time, repeated exposure to secondary trauma could have an adverse reaction on the law enforcement chaplain. Educational institutions, law enforcement agencies, and law enforcement chaplains need to be trauma-informed, so as not to

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[214] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts*. (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[215] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain.* (Valley Forge, PA: Judson Press, 2006), 113.

[216] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 324.

[217] Carrie Miller, LCSW – C, Personal Interview, December 16, 2020.

risk re-traumatizing a victim.[218, 219] To be trauma-informed and practice self-care may also reduce the risk of compassion fatigue and secondary traumatic stress in caregivers.[220, 221] When law enforcement chaplains are trauma-informed and care for themselves, they may continue to provide effective quality care for the officers and people in the community whom they serve.[222]

Being compassionate and caring for those in need due to trauma, pain, and suffering has been evident for millennia. There is significant evidence throughout the Bible of compassion for one's neighbor. Jesus was the model chaplain and demonstrated how and why one should care for one's neighbor. One of the greatest acts of care, concern, and compassion can be seen in the parable of the Good Samaritan and other stories in the Bible.

Theological Foundations

Compassion and Compassionate Care

The Bible is replete with the theme and stories about the compassionate nature of God, and Christ. The biblical themes of compassion and compassionate care are foundational to the

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[218] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 181-182, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf

[219] Susan J. Ko, Nancy Kassam-Adams, Charles Wilson, Julie D. Ford, Steven J. Berkowitz, and Marleen Wong, "Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice*," Professional Psychology: Research and Practice* 39, no. 4 (2008): 399, DOI:10.1037/0735-7028.39.4.396.

[220] Council on Social Work Education, *Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice* (Alexandria, VA: Council on Social Work Education, 2018), 164.

[221] Charles R. Figley, "Introduction," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, ed. Charles R. Figley (New York, NY: Routledge, 1995), 16-17.

[222] Travis Hales, Nancy Kusmaul, and Thomas Nochajski, "Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice," *Human Services organizations: Management, Leadership, & Governance* 41, no. 3(2017): 317, http://dx.doi.org/10.1080/23303131.2016.1268988.

researcher's thesis concerning compassion fatigue and the ability to provide effective quality care while maintaining self-care.

Compassion, as defined by the *Oxford English Dictionary,* is the feeling or emotion of pity, or being moved by the suffering or distress of another person, while wanting to alleviate their suffering.[223] In the article, "Toward a Transformation and Sustainable Practice of Compassion in Workplaces," Lee suggests the word compassion, as it appears in the gospels, is more than a feeling or emotion.[224] He suggests compassion moves one to action to address the issues of grief, sorrow, or pain.[225] The Bible teaches that God is loving and demonstrates compassion for His creation. Some of these teachings are evident in the Book of Exodus, the Psalms, and in the Book of Isaiah. This list is by no means exhaustive of the occurrences in the Hebrew scriptures of God's compassion for His people or creation. One of the most evident expressions of compassion God displayed in the Old Testament was the exodus of the Israelites from Egypt. God heard the cry of the Israelites as the Egyptians oppressed them. "I have indeed seen the misery of my people in Egypt. I have heard them crying out because of their slave drivers, and I am concerned about their suffering."[226] The Book of Exodus demonstrates the compassion God possessed for the Israelites. God was so moved by their suffering, misery, and oppression that He took action and sent Moses to lead the Israelites out of Egypt. Ryken, in *Preaching the Word: Exodus: Saved for God's Glory*, suggests Exodus 34:6 is one of the most

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[223] "Compassion," Oxford English Dictionary, accessed April 21, 2021, https://www.oed.com/viewdictionaryentry/Entry/37475.

[224] Min-Dong Paul Lee, "Toward A Transformative and Sustainable Practice of Compassion in Workplaces," *Journal of Biblical Integration in Business* 21, no. 1 (Fall 2018): 24.

[225] Ibid.

[226] Exodus 3:7, New International Version (NIV). Unless otherwise noted, all scripture references in this thesis project will be from the New International Version of the Bible (Grand Rapids, MI: Zondervan, 2011).

important scriptures in the Torah, so much so it is repeated several times throughout the Hebrew Scriptures.[227] In this verse, God described to Moses who He was, His character, and His nature. Ryken expresses the fact that the Lord repeats His name twice in the scripture suggesting God shared with Moses His character and nature:

> …he was revealing himself as the God of creation and redemption — the God who made and saves his people. And in order to give Moses a fuller revelation of his goodness, he went on to explain the meaning of his sacred name: "The LORD, the LORD, the compassionate and gracious God, slow to anger, abounding in love and faithfulness, maintaining love to thousands, and forgiving wickedness, rebellion and sin" (Exod. 34:6).[228]

Another grand act of compassion, evident in the New Testament, was the birth of Jesus Christ. God possessed such love and compassion for humanity that God sent His Son to redeem humanity. Lee comments the Bible teaches the compassion of God is clearly evident in the Incarnation of Jesus.[229] He further explains God is the source of the biblical understanding of compassion.[230] The Incarnation of Jesus, the life, crucifixion, death, and resurrection of Jesus as an atonement for the sins of humanity was an act of compassion granted by humanity's compassionate and loving God.[231]

The name of God, the character and nature of God conveys the deep compassion God possesses for humanity. As created beings, in the image of God, humanity is expected to reflect the nature and character of God thereby, being caring and compassionate beings, showing care

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[227] Philip Graham Ryken, "When God Passes By." In *Preaching the Word: Exodus: Saved for God's Glory* (Wheaton, IL: Crossway, 2012), n.p., accessed April 27, 2021, http://ezproxy.liberty.edu/login?url=https://search.credoreference.com/content/entry/crossesgg/when_god_passes_by/0?institutionId=5072.

[228] Ibid.

[229] Min-Dong Paul Lee, "Toward A Transformative and Sustainable Practice of Compassion in Workplaces," 25.

[230] Ibid.

[231] Ibid.

and compassion for others while serving and meeting the needs of one another, but especially meeting the needs of those on the margins, or those afflicted by trauma, pain, grief, suffering, or loss.

Theologian Karl Barth explained, "Compassion is the behavior in which someone steps in for another person who is in need, someone who is there for and acts for that person. Jesus is the one who in this sense had compassion."[232] Throughout the gospels, one can read the many stories of Jesus being "moved by compassion" when healing and addressing the needs of others. Jesus empathized with the ill, the oppressed, the least, the last, and the lost. Compassion moved Jesus because He cared about and loved those who were being oppressed and marginalized.

Having compassion compels caregivers to act. As Jesus journeyed and taught, He encountered people who suffered and needed spiritual and physical healing. Jesus was moved to compassion, and He provided healing for those in need. Matthew 9:36 explains the heart of Jesus and His compassion for those in need and marginalized. The pericope explains, "When he saw the crowds, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd."[233] Reeves et al., authors of the *Story of God Bible Commentary: Matthew,* point out that Jesus had compassion for the large crowd. He had compassion on them because they appeared "…harassed and helpless like sheep without a shepherd."[234] The authors further explain, Jesus had compassion, but He also required help to meet the needs of the people.[235] It

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[232] Karl Barth, *Insights: Karl Barth's Reflection on Life of Faith* (Louisville, KY: Westminster John Knox Press, 2009), Kindle, loc. 220.

[233] Matthew 9:36.

[234] Rodney Reeves, Tremper Longman III, and Scott McKnight, *The Story of God Bible Commentary: Matthew* (Grand Rapids, MI: HarperCollins Christian Publishing, 2017), 210, accessed April 26, 2021, ProQuest Ebook Central.

[235] Ibid.

was at that point when Jesus solicited the assistance of His disciples to help with the needs of the crowd. He explained to the disciples in Matthew 9:37, "The harvest is plentiful but the workers are few."[236] Jesus and His disciples offered aid to the crowd because the marginalized people were not being cared for; their needs were not being met.

It is the duty of chaplains to offer assistance to those suffering and in need. Chaplains by nature of their call are unique and special caregivers for those suffering from trauma, grief, or loss within the community and outside the church building.[237] Matthew 25:35 describes, "For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me."[238] Osbourne and Clinton, authors of the *Zondervan Exegetical Commentary of the New Testament*, state the above scripture is one of the best proof scriptures for compassionate ministry in the New Testament. They further explain providing hospitality to the suffering, those who were hungry and thirsty were evident of some of the greatest needs in the world.[239] Having those basic survival needs met were among the most compassionate signs of ministry in the early church requiring devoted leadership.[240]

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[236] Matthew 9:37.

[237] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 587.

[238] Matthew 25:35-36.

[239] Grant R. Osbourne, Clinton E. Arnold, and Arnold Clinton, *Zondervan Exegetical Commentary of the New Testament* (Grand Rapids, MI: HarperCollins Christian Publishing, 2017), 1007, accessed April 26, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5397370&ppg=1283.

[240] Ibid.

Jesus, the First Chaplain

During His ministry on earth, Jesus cared for the grieved, the oppressed, and those who suffered. Jesus was the epitome of a chaplain possessing a heart of compassion. Geyer and Geyer state, Jesus' ministry was one of chaplaincy where He cared for and provided for the physical and spiritual needs of those suffering, the ill, and the oppressed outside the synagogue.[241] The gospel of Matthew 15:32 explicitly demonstrates the compassionate nature of Jesus, as "Jesus called his disciples to him and said, 'I have compassion for these people; they have already been with me three days and have nothing to eat. I do not want to send them away hungry, or they may collapse on the way."[242] Each time Jesus healed someone or had an encounter with an ill person, or one who was suffering or grieved, He did so with a heart of compassion. Jesus had unconditional compassion for the least, the last, the lost, the outcast, the poor, and the oppressed. In His humanness, the compassion of Jesus reflected the compassion, care, and generosity God had and continues to have for humanity. Jesus taught His disciples to do the same; have and offer compassion to those they encountered. *The Life Application New Testament Commentary* suggests believers should have the heart, character, and nature of God who is compassionate, kind, loving, and caring.[243] Barton et al., further comment demonstrating compassion is to show genuine care and concern for the needs of others while addressing those needs, which is displaying the compassionate nature of God.[244]

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[241] Richard E. Geyer and Patricia M. Geyer, *Chaplains of the Bible: Inspiration for Those Who Help Others in Crisis*, (Greenville, SC: Ambassador International, 2012), 105.

[242] Matthew 15:32.

[243] Bruce Barton et al., *Life Application New Testament Commentary* (Carol Stream, IL: Tyndale House Publishers, Inc., 2001), 824.

[244] Ibid.

The Chaplain

Created in the image of God, Imago Dei, chaplains are caring, compassionate, altruistic servants and conduits of God who empathize with those who suffer, grieve, or experience pain, agony, or trauma. DeRevere et al., describe the ministry of the law enforcement chaplain as that of being a shepherd. "The function of the shepherd as found in biblical history serves as an excellent role model for the chaplain in law enforcement."[245] Jesus, the Good Shepherd, is the role model for chaplains; a person full of love and compassion for all. The authors also make the comment that chaplains who care for and serve their officers and citizens of the communities should possess a shepherd's heart.

Historically, chaplains have been priests or clergy who have ventured into times of war and uncertainty, providing care and the presence of God to those in need.[246] Chaplains are ordained clergy persons who serve as conduits for God in the presence of traumatic events or crises. Woodward, the author of *Ministry of Presence: Biblical Insight on Christian Chaplaincy* states no matter the venue of Christian chaplains, all chaplains, including law enforcement chaplains, function as evangelists and act as extensions of the church while providing the providence of God and serving as conduits of God.[247] The ministry of presence, as defined in the *Dictionary of Pastoral Care and Counseling* is a form of servanthood. It has been defined as a ministry where those who serve do so alongside people who maybe hurt, suffering, or oppressed. The chaplain serves to provide the presence of God in crises and traumatic events.

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[245] David W. DeRevere, Wilbert A. Cunningham, Tommy W. Mobley, and John A. Price, *Chaplaincy in Law Enforcement: What It Is and How to Do It* (Springfield, IL: Charles C Thomas Publishers, 2005), 22.

[246] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press Publishers, 2006), 2-3.

[247] Whit Woodward, *Ministry of Presence: Biblical Insight on Christian Chaplaincy* (North Fort Meyers, FL: Faithful Life Publishers, 2011), 16.

The Ministry of Chaplaincy

The ministry of chaplaincy can be reckoned to a ministry of presence or keeping watch. Matthew 26:36-45 illustrates Jesus being in the Garden of Gethsemane and praying to God during the darkest moments of His ministry. During that time, Jesus asked three of His closest friends to keep watch as He went into the Garden to pray. Jesus needed and wanted His disciples' support, care, and compassion for Himself on the eve of His arrest. Osbourne et al. in *Matthew: Zondervan Exegetical Commentary on the New Testament Series,* offer that Jesus wanted and needed His three closest friends to keep watch, as in a spiritual vigil.[248]Jesus requested prayer from His disciples. He asked for support and compassion from Peter and the Sons of Zebedee, James, and John. Osbourne et al. state Jesus was not looking for the three to protect Him from the imminent arrest, He was requesting they "…bear with him in prayer as he pours out his anguish to the Father."[249] Chaplains who are good at their ministry are present and available emotionally, physically, spiritually, and psychologically. The chaplain, who serves as a conduit, ambassador, or representative of God, has the responsibility and privilege to keep watch and "…stay with someone who is experiencing emotional, physical, or spiritual pain, without trying to fix the person's problems, offer unsolicited advice, or recite religious platitudes."[250] As a chaplain, effective ministry of presence is integral to the care and support of the suffering and the traumatized.

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[248] Grant R. Osbourne, Clinton E. Arnold, and Arnold Clinton, *Zondervan Exegetical Commentary of the New Testament* (Grand Rapids, MI: HarperCollins Christian Publishing, 2017), 1054, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5397370&ppg=1283.

[249] Ibid.

[250] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press Publishers, 2006), 9-10.

DeRevere et al. state that the presence of the law enforcement chaplain reminds his/her officers of the compassionate nature and presence of God while they are on duty. They continue, stating the law enforcement chaplain's ministry of presence is one of love in action shown in pastoral care.[251] The authors maintain the chaplain who serves alongside the police officer is the presence of God in the field or workplace, providing a ministry of presence to all they serve.[252]

Jesus declared to His disciples that He would make them fishers of men.[253] He explained to His disciples how important it was to care for those they would encounter, stating, "'For there will never cease to be poor in the land. Therefore, I command you, 'you shall open wide your hand to your brother, to the needy and to the poor, in your land.'"[254] Jesus taught His disciples how to be compassionate caregivers to those in need. John 13:12-14 states:

> When he had washed their feet and put on his outer garments and resumed his place, he said to them, 'Do you understand what I have done to you? You call me Teacher and Lord, and you are right, for so I am. If I then, your Lord and Teacher, have washed your feet, you also ought to wash one another's feet.

Kenagaraj, the author of *John: A New Covenant Commentary* offers two interpretations for the above scripture. The second interpretation Kenagaraj offers supports the claim of the researcher as alluded to above, Jesus as teacher performed an exemplary act of service and compassion for His disciples to emulate.[255] Jesus, the Good Shepherd, is the model of love,

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[251] David W. DeRevere, Wilbert A. Cunningham, Tommy W. Mobley, and John A. Price, *Chaplaincy in Law Enforcement: What It Is and How to Do It* (Springfield, IL: Charles C Thomas Publishers, 2005), 24-25.

[252] Ibid., 25.

[253] Matt. 4:19.

[254] Deut. 15:11, (ESV).

[255] Jey Kenagaraj, *John: A New Covenant Commentary* (Havertown, PA: The Lutterworth Press, 2013), 165, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=3328598.

compassion, and care. As conduits of God, chaplains are to emulate the character and nature of Jesus, to and for the people they serve.

The synoptic gospels of Matthew, Mark, and Luke share the story of the paralytic man who was lowered through the roof of a home in Capernaum while Jesus sat teaching the crowd. The paralyzed man was carried on a mat by four compassionate friends who were determined to seek healing and restoration for their disabled friend. These four men possessed the heart and nature of chaplains. They journeyed with their paralyzed friend. They possessed compassion for their friend, and they sought healing for their friend. Compassion compels actions. Theologian Dietrich Bonhoeffer stated the following from his book, *Letters and Papers from Prison*:

> There remains an experience of incomparable value. We have for once learned to see the great events of world history from below, from the perspective of the outcasts, the suspects, the maltreated — in short, from the perspective of those who suffer. Mere waiting and looking on is not Christian behavior. Christians are called to compassion and to action.[256]

Possessing compassion demonstrates the care and concern for the needs of those suffering. Jesus models compassion for His disciples in the gospel of Matthew 15, which describes the story of Jesus feeding the four thousand. The pericope explains the pursuit of Jesus by large crowds of people. As He sat on a mountainside and had compassion for them, Jesus healed the lame, the sick, and the blind. Scripture further explains Jesus called to His disciples, saying, "I have compassion for these people; they have been with me three days and have nothing to eat. I do not want to send them away hungry, or they may collapse on the way."[257] Jesus, full of compassion for distressed people, saw a need and felt compelled and moved by God to care for those in need, demonstrating the heart of the Good Shepherd and a true chaplain.

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[256] Dietrich Bonhoeffer, *Letters and Papers from Prison* (Minneapolis, MN: Fortress Press, 2015), 16.

[257] Matthew 15:32.

In Luke 8:43-48, a story is conveyed concerning a woman who had a hemorrhage for 12 years. This woman had spent all the money she possessed seeking a cure for her affliction. She was considered unclean and had to live outside the community in a state of isolation due to her affliction. She heard about Jesus and decided to make her way to Him in search of healing. She finally encountered Jesus, she reached out and touched the hem of His garment and immediately was made well. A transference of healing power occurred between the Healer and the one being healed.[258] "I know that power has gone out from me."[259] The woman came forward, explaining her affliction and what she had done. Having compassion for her, Jesus called her daughter, re-establishing her position in the community, and He tells her, "…your faith has made you well."[260] Chen, the author of *Luke: A New Covenant Commentary,* describes the unnamed woman as being in a state of "self-imposed obscurity."[261] The woman was desperate. Isolated and living on her own for twelve years due to her state of uncleanliness. She was destitute and decided she had nothing left to lose, and pursued an encounter with Jesus. While on His was to heal the daughter of Jairus, the unnamed woman risked being seen in the crowd and reached out to touch the garment of Jesus. As she did so, healing power left Jesus. At that moment, Jesus asked who it was that touched Him, as He felt the healing power leave His body. He asked twice who had touched Him. The woman fell to her feet and confessed touching Him. He did not chastise the woman. Having compassion, He spoke to the woman. Chen explains, Jesus

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[258] Diane G. Chen, *Luke: A New Covenant Commentary* (Eugene, OR: Wipf and Stock Publishers, 2017), 119, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5050868.

[259] Luke 8:46b.

[260] Luke 8:48.

[261] Diane G. Chen, *Luke: A New Covenant Commentary* (Eugene, OR: Wipf and Stock Publishers, 2017), 118, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5050868.

addressed the woman as daughter in front of the entire community restoring her, demonstrating compassion.[262] She further explains Jesus restored the unnamed woman from a physical aliment. He also restored her religious and social standing in the community by addressing her as daughter.[263]

There is a cost to those who care for the traumatized and suffering. Austrian born neurologist, psychiatrist, philosopher, author, and Holocaust survivor, Viktor Frankl, made the statement, "That which is to give light must endure burning." Helping people sometimes hurts the helper or the caregiver. The key to being an effective caregiver is possessing empathy for the ones being treated. However, over saturation of empathy, the quality or character trait needed to be an effective caregiver can be the key that leads to the detriment of the one who provides the care.[264] Kyer explains most caregivers are caring, compassionate, and empathetic individuals. She finds it ironic to know and understand the necessary qualities that help caregivers accomplish their jobs, may also expose them to pain, anger, and the trauma of compassion fatigue.[265]According to Figley, caregivers such as law enforcement chaplains, may be exposed due to a cost for caring for those who suffer from traumatic events or crises.[266] Law enforcement

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[262] Diane G. Chen, *Luke: A New Covenant Commentary* (Eugene, OR: Wipf and Stock Publishers, 2017), 119, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5050868.

[263] Ibid., 118.

[264] Beverly D. Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others* (Cheyenne, WY: URLink Print and Media, 2020), 31.

[265] Ibid.

[266] Charles R. Figley, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), 52.

chaplains who are repeatedly subjected to traumatic events and crises without proper care and support can become injured both psychologically and physically.[267]

Theologian Henri Nouwen also knew the cost of compassion and caring for others. He wrote:

> Compassion is hard because it requires the inner disposition to go with others to the place where they are weak, vulnerable, lonely, and broken. But this is not our spontaneous response to suffering. What we desire most is to do away with suffering by fleeing from it or finding a quick cure for it. Yet perhaps our greatest gift is our ability to enter solidarity with those who suffer…When I reflect on my own life, I realize the moments of greatest comfort and consolation were moments when someone said, 'I cannot take your pain away, I cannot offer you a solution to you [sic] problem, but I can promise you that I won't leave you alone and I will hold onto you as long and as well as I can.' There is much grief and pain in our lives, but what a blessing it is when we do not have to live our grief and pain alone. This is the gift of compassion.[268]

The story of the Good Samaritan found in the gospel of Luke 10:25-37 demonstrates the above thoughts of Nouwen. The Good Samaritan, while on his journey, came upon an unfortunate soul who had been beaten and robbed. The Good Samaritan, having shown mercy to the injured one in distress, placed him on his donkey and sought shelter for him. He had the mercy and compassion of God[269] for the injured person, and he chose to help him, caring for him and pouring oil and wine on his wounds. The Good Samaritan showed mercy and compassion for his neighbor, as many first responder chaplains do in their daily ministries in the marketplaces of our communities. In the article, "Toward a Transformative and Sustainable Practice of

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[267] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 587.

[268] Henri Nouwen, *The Way of the Heart: The Spirituality of the Desert Fathers and Mothers* (New York, NY: HarperCollins Publishing, 1981), 34.

[269] Diane G. Chen, *Luke: A New Covenant Commentary* (Eugene, OR: Wipf and Stock Publishers, 2017), 155, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=5050868.

Compassion in Workplaces," Lee contends, compassion can be costly when a caregiver encounters and engages the suffering of the traumatized. He explains the Samaritan made an adjustment in his schedule during his journey to care for the beaten and injured person he found lying helpless on the ground. It cost the Samaritan time and resources to care for the wounds of the injured soul as he cleaned the wounds with wine and oil. It cost the Samaritan financially as he paid, at his own expense, for the injured soul to stay at an inn as his wounds healed, with the promise to pay more, if required.[270] Compassion is costly emotionally, physically, psychologically, spiritually, and financially.

Jesus experienced the cost one assumes when caring for those in distress. Jesus experienced the pain and grief of Mary and Martha as they grieved the death of their brother Lazarus. "When Jesus saw her weeping, and the Jews who had come along with her also weeping, he was deeply moved in spirit and troubled…. Jesus wept."[271] Jesus experienced compassion for all who suffered. In his commentary, *John: A New Covenant Commentary*, Kenagaraj expresses the deep sorrow and compassion Jesus had for those grieved and bereaved.[272] His ministry was a ministry of compassion. Kenagaraj remarks the emotions and compassion Jesus had for the bereaved caused Him to weep, "…bursting into tears."[273] He further points out, "Jesus' emotions of compassion and deep distress as a human and his self-

[270] Min-Dong Paul Lee, "Toward A Transformative and Sustainable Practice of Compassion in Workplaces," 26.

[271] John 11:33-35.

[272] Jey Kenagaraj, *John: A New Covenant Commentary* (Havertown, PA: The Lutterworth Press, 2013), 146, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=3328598.

[273] Ibid., 147.

identification with grieving humanity are intermingled in the shortest verse, 'Jesus wept,' (11:35)."[274]

Figley points out that anyone who has repeated exposure to traumatized people can become impacted by compassion fatigue, which he states is a natural consequence and disruptive by-product of working with traumatized clients and people who suffer. Even Jesus became emotionally affected when caring for those in need.[275] Theologian Henry Nouwen offered this statement concerning the cost of caring for the caregiver, when helping hurts:

> Compassion asks us to go where it hurts, to enter the places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion in the condition of being human.[276]

Self-care is paramount for those who serve as caregivers.[277] Compassionate care requires the caregiver to actively engaged and be present with the suffering and those who experience trauma.[278] Lee concurs, stating, "Genuine compassion involves the compassion-giver imaginatively entering into the compassion-recipient's condition and feeling similar fear, stress, and pain. These feelings can…profoundly affect the compassion-giver."[279]

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[274] Jey Kenagaraj, *John: A New Covenant Commentary* (Havertown, PA: The Lutterworth Press, 2013), 146, accessed April 28, 2021, ProQuest Ebook Central, https://ebookcentral-proquest-com.ezproxy.liberty.edu/lib/liberty/reader.action?docID=3328598.

[275] Figley, Charles R., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), xiv.

[276] "Henri J.M. Nouwen Quotes," Goodreads.com, accessed April 22, 2021, https://www.goodreads.com/author/quotes/4837.Henri_J_M_Nouwen.

[277] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 324.

[278] Naomi, K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 114.

[279] Min-Dong Paul Lee, "Toward A Transformative and Sustainable Practice of Compassion in Workplaces," 29.

Jesus taught and demonstrated the importance of self-care for the caregiver. When Jesus became overwhelmed at hearing the news of the death of John the Baptist, He went away to seek solitude, as described in Matthew 14:13. In Mark 6:30-32, Jesus recognized His disciples needed a break. He recognized while caring for the crowds, His disciples had not taken the time to eat. He recognized the disciples needed to take some time to care for themselves. Jesus said to His disciples, "Come with me by yourselves to a quiet place and get some rest. So they went away by themselves in a boat to a solitary place."[280] Self-care is important for the caregiver. The caregiver must recognize self-care is not selfish, but a necessity for their survival as caregivers. Nance recognizes self-care is not selfish behavior. She asserts self-care is necessary for the caregiver.[281] She further explains if caregivers fail to take the time to care for themselves, they risk exposing themselves to compassion fatigue and secondary traumatic stress.[282] Consequently, it is imperative the law enforcement chaplain be trauma-informed and know the signs and symptoms of compassion fatigue and secondary traumatic stress for self-care purposes. It is important for the law enforcement chaplain to take time away for themselves to be replenished by the Holy Spirit. The law enforcement chaplain is only as capable of caring for others as he or she is able to care for himself /herself.

[280] Mark 6:30-32.

[281] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts* (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[282] Ibid.

Theoretical Foundations

Trauma and Traumatology

A review of the precedent literature has shown that there have been years of research in the field of Trauma, known as Traumatology.[283] As Traumatology has evolved, several theories and models of trauma and trauma-informed care have been developed. Judith Herman developed the Theory of Trauma. Herman developed her seminal work, *Trauma and Recovery*, in 1992. Although her work was published over two decades ago, her work continues to be relevant in the field of Traumatology.[284] Zaleski et al. have described Judith Herman as a "…pioneering clinician in the field and a major player in the theoretical debate [concerning Trauma and Traumatology]."[285] The premise behind Herman's Theory of Trauma was based on years of research working with victims of trauma from various events, such as natural disasters, wars, interfamily dynamics, sexual assaults, abuse in its various forms, physical, emotional, psychological, and domestic violence.[286] Her seminal work focused on new methods or approaches of understanding, defining, and treating people suffering from Post-Traumatic Stress Disorder.[287] Her theory centered around three concepts of trauma: hyperarousal following a traumatic event, intrusions of terrifying thoughts or feelings subsequent to traumatic events

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[283] Charles R. Figley, "Compassion Fatigue: Toward a New Understanding of the Costs of Caring," in *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*, ed. B. Hudnall Stamm (Baltimore, MD: Sidran Press, 1999), 4-5.

[284] Kristen L. Zaleski, Daniel K. Johnson, and Jessica T. Klein, "Grounding Judith Herman's Trauma Theory within Interpersonal Neuroscience and Evidence-Based Practice Modalities for Trauma Treatment," *Smith College Studies in Social Work* 86, no. 4 (2016): 378, http://dx.doi.org/10.1080/00377317.2016.1222110.

[285] Ibid.

[286] Ibid.

[287] Ibid.

experienced, and constriction which is the avoidance or isolation experienced, subsequent to traumatic or terrifying events.[288]

Trauma appears to be an inevitable event. The Centers for Disease Control and Prevention report most people in the United States will experience some form of traumatic event at least once in their lifetime.[289]

> Statistics from research published in 1995 help demonstrate the need for trauma-informed care. In the National Comorbidity Survey, a research study of 9,282 Americans aged 18 to 54, 60% of men and 51% of women in the United States had experienced at least one traumatic event in their lives, while 17% of men and 13% of women had experienced three or more such events.[290]

Trauma Informed-Care

Due to the increased prevalence of trauma and its adverse effects on the population, several health and human services organizations have adopted approaches to Trauma-Informed Care (TIC).[291] Trauma-Informed Care considers the physical, emotional, spiritual, and psychological influences trauma may have on individuals who have experienced traumatic events or crises.[292] Hales et al. note, "Trauma-Informed Care (TIC), is an organizational model

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[288] Kristen L. Zaleski, Daniel K. Johnson, and Jessica T. Klein, "Grounding Judith Herman's Trauma Theory within Interpersonal Neuroscience and Evidence-Based Practice Modalities for Trauma Treatment," *Smith College Studies in Social Work* 86, no. 4 (2016): 378, http://dx.doi.org/10.1080/00377317.2016.1222110.

[289] Centers for Disease Control and Prevention, "Adverse Childhood Experiences Reported by Adults-Five States, 2009," *Morbidity and Mortality Weekly Report* 59, no. 49 (December 2010): 1609, https://www-proquest-com.ezproxy.liberty.edu/docview/820625265?pq-origsite=summon.

[290] Scott A. Richardson, "Awareness of Trauma-Informed Care," Social Work Today, accessed July 14, 2021, https://www.socialworktoday.com/archive/exc_012014.shtml.

[291] Travis Hales, Nancy Kusmaul, and Thomas Nochajski, "Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice*," Human Service Organizations: Management, Leadership, & Governance* 41, no. 3 (2017): 317, http://dx.doi.org/10.1080/23303131.2016.1268988.

[292] "Using a Trauma Informed Approach," Office of Victims of Crime: Training and Technical Assistance Center, accessed July 14, 2021, https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/41-using-a-trauma-informed-approach/.

that presumes that everyone (from staff to clients) have experienced trauma."[293] Trauma-Informed Care, as explained by Butler et al. is having the knowledge and understanding of how violence, abuse, pain, suffering, loss, grief, tragedy, or trauma can affect the lives of those who have experienced the aforementioned events.[294] The authors further explain being trauma-informed is to possess a basic understanding of trauma and violence. To be trauma-informed is to understand and appreciate how trauma and violence can adversely affect one's life.[295] Possessing an understanding and appreciation of trauma-informed care gives the helper or caregiver a better appreciation of the possible needs of the individual being cared for or treated. This means providing the services necessary to serve and treat the traumatized individuals while empowering and encouraging the traumatized individuals to take an active role in their treatment/recovery efforts.[296]

In TIC, there is a shift in the paradigm of thought on the part of the caregiver or helper. With the model of TIC, the helper asks the question, "What happened to you?" versus the more judgmental question of "What is wrong with you?"[297, 298] Understanding and having an

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[293] Travis Hales, Nancy Kusmaul, and Thomas Nochajski, "Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice*," Human Service Organizations: Management, Leadership, & Governance* 41, no. 3 (2017): 317, http://dx.doi.org/10.1080/23303131.2016.1268988.

[294] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

[295] Ibid.

[296] Ibid.

[297] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

[298] Scott A. Richardson, "Awareness of Trauma-Informed Care," Social Work Today, accessed July 14, 2021, https://www.socialworktoday.com/archive/exc_012014.shtml.

appreciation of the prevalence of trauma, the Trauma-Informed Care Model takes the position that individuals may have had previous traumatic events within their lives. Having an understanding and appreciation of those potential facts positions the caregiver or helper to be more sensitive, compassionate, caring, and empathetic in the services they provide to the traumatized individuals.[299]

Trauma Theories and Models

The Trauma Transmission Theory is a phenomenon of Compassion Fatigue developed by Charles Figley, which expresses and explains the "cost of caring," when sharing or participating in the emotional, physical, or psychological pain or trauma of others.[300] The Trauma Transmission Theory suggests caregivers, in an effort to understand their traumatized clients, may become triggered by their clients' trauma and/or become triggered by their own past trauma histories or events.[301] The theory further suggests caregivers or helpers of the traumatized may experience burnout or secondary traumatic stress due to their empathy, care and compassion due to the exposure and connection with their traumatized clients.[302] The quality of empathy that makes a helper or caregiver excel at what they do is the risk factor that predisposes them to compassion fatigue, also known as secondary traumatic stress, or vicarious traumatization.

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[299] Scott A. Richardson, "Awareness of Trauma-Informed Care," Social Work Today, accessed July 14, 2021, https://www.socialworktoday.com/archive/exc_012014.shtml.

[300] Charles R. Figley, "Introduction," in *Treating Compassion Fatigue*, ed. Charles L. Figley (New York, NY: Routledge, 2002), 2.

[301] Charles R. Figley, "Epilogue: The Transmission of Trauma," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* ed. Charles R. Figley (New York, NY: Routledge, 1995), 249.

[302] Ibid., 252.

One's level of compassion fatigue is proportionate to the level of one's empathic ability.[303] The empathetic ability of a caregiver or helper can be conjoined to one's susceptibility to an emotional contagion.[304] An emotional contagion is defined as the affective process whereby the caregiver or helper may begin to assume, experience, or feel the emotional responses of the traumatized person whom he or she is caring for or providing treatment.[305]

Figley, a pioneer in Compassion Fatigue, discovered there was minimal research in the field of Traumatology concerning secondary traumatic stress and vicarious traumatization.[306] Many in the field of Mental Health believed a milestone in trauma was achieved in 1980 with the publication of the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).[307]

Due to his seminal work in the field of Compassion Fatigue (CF), Secondary Traumatic Stress (STS), and Vicarious Traumatization (VT), the study of CF was formally introduced to the Mental Health field. Figley researched the human reactions to traumatic stress and identified it could be traced back to the early medical writings of Kunus Pyprus, which published in 1900 B.C. in Egypt.[308] In his seminal work, Figley was disturbed to find inconsistencies in the research concerning those who experienced post-traumatic stress and those who suffered from compassion fatigue or secondary traumatic stress. In his review of the traumatological literature

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[303] Charles R. Figley, "Epilogue: The Transmission of Trauma," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* ed. Charles R. Figley (New York, NY: Routledge, 1995), 252.

[304] Ibid.

[305] Charles R. Figley, "Introduction," 2.

[306] Charles R. Figley, "Compassion Fatigue: Toward a New Understanding of the Costs of Caring," in *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*, ed. B. Hudnall Stamm (Baltimore, MD: Sidran Press, 1999), 4-5.

[307] Charles R. Figley, "Introduction," xiii.

[308] Ibid.

and research studies, Figley discovered nearly all the research presented focused on individuals who were directly affected by trauma. He noted minimal research was found or conducted focusing solely on those who were exposed, secondarily, to traumatic events due to caring for the traumatized. "Nearly all of the hundreds of reports focusing on traumatized people excluded those who were traumatized indirectly or secondarily and focus on those who were directly traumatized…" [309, 310]

In addition to the precedent literature demonstrating a wealth of research concerning post-traumatic stress disorder (PTSD) within the field of Traumatology, the literature also demonstrated a healthy concentration of studies involving mental health care workers, such as social workers, therapists, counselors, psychologists, child protection, and welfare workers.[311] During his research, in the 1980s through the 1990s, there appeared to be minimal research in Traumatology concerning Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization.[312] There appeared to be even less research in Traumatology concerning first responders like firefighters, law enforcement officers, emergency medical technicians, paramedics, law enforcement chaplains, or emergency service chaplains who serve as caregivers and may be repeatedly exposed, secondarily, to traumatic events due to their positions as first responders and law enforcement chaplains. Mathieu explains in his article entitled "Compassion Fatigue," the concept of CF is a recent concept. He further explains it was not until the 1990s that CF started to receive recognition among helping professionals experiencing emotional and

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[309] Charles R. Figley, "Introduction," in *Treating Compassion Fatigue*, ed. Charles L. Figley (New York, NY: Routledge, 2002), xiii.

[310] Charles R. Figley, "Compassion Fatigue," 5.

[311] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Erdmans Publishing Company, 2015), 29.

[312] Charles R. Figley, "Compassion Fatigue," 10.

physical exhaustion, which negatively affected the quality of work and care for their patients and clients.[313]

The Chaplain and Self-Care

The researcher of this doctoral action research project believes law enforcement chaplains, by nature of their character and servanthood, are unlikely to complain or share their feelings regarding traumatic experiences due to their commitment to confidentiality.[314] The precedent review of the literature demonstrates law enforcement chaplains are highly caring and compassionate servants who place the needs of others far above the needs of themselves.[315] While this practice may be commendable for the care of his or her police officers and the community, law enforcement chaplains may experience adverse reactions due to secondary exposure to trauma and traumatic stress because of the traumatized people they care for and serve.[316] Anderson explains in his article, "Secondary Trauma Among Chaplains," chaplains sometimes fail to "…practice what they preach."[317] Seldom do chaplains care for themselves as well as they care for their clients. Anderson continues, adding, "Chaplains' hyper-altruistic tendencies and propensity to not acknowledge the same stress-induced symptoms they recognize

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[313] Françoise Mathieu, "Compassion Fatigue," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 137.

[314] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 588.

[315] Ibid.

[316] Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* ed. Charles R. Figley (New York, NY: Routledge, 1995), 17.

[317] Ibid.

in others leave them particularly susceptible to physical, emotional, behavioral, professional, and interpersonal burnout symptoms."[318]

In the Gospel of Matthew 14:13, Jesus learned of the beheading of John the Baptist. The scripture explains Jesus went away privately by boat to spend some time in solitude.[319] Boring, the author of the "The Gospel of Matthew: Introduction, Commentary, and Reflections" in the *New Interpreter's Bible Commentary*, suggests Jesus went to a solidarity place to withdraw from the authority of Herod Antipas after the beheading of John the Baptist by crossing the Sea of Galilee.[320] Boring contends Herod Antipas had no authority on the other side of the Galilee.[321] Consequently, crossing the Sea of Galilee would likely ensure the safety of Jesus.[322] The researcher questions whether Jesus might have also sought time away in solitude, due to the grief of the tragic loss of His cousin and forerunner? Is it possible that Jesus sought solitude because He may have been grieving the loss of a loved one? Is it possible Jesus sought time for self-care to be able to continue care for the crowd that pursued Him from the shoreline of the Galilee? We also learn in the pericope that people from the town followed Jesus by foot as Jesus traveled along the shore by boat. The pericope further explained that upon landing, Jesus "…had compassion on them [the crowd] and healed their sick."[323] The researcher questions whether Jesus had adequate time to grieve the loss of His cousin before turning His attention to the

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[318] Michael W. Anderson, "Secondary Trauma Among Chaplains," 588.

[319] Matthew 14:13.

[320] M. Eugene Boring, vol. 8, "The Gospel of Matthew: Introduction, Commentary, and Reflections," in *The New Interpreter's Bible: A Commentary in Twelve Volumes* (Nashville, TN: Abingdon Press, 1994), 323.

[321] Ibid.

[322] Ibid.

[323] Matthew 14:13.

people He had compassion for and for those He healed. No one knows for sure. It appears Jesus may have had minimal time to grieve before returning to the service of healing the sick.

Some chaplains may be following in the footsteps of Jesus, as the story illustrates in Matthew 14:13. With good intentions, some chaplains may attempt to take time for compassionate self-care. However, as Anderson reflects in his article, "Secondary Trauma Among Chaplains," chaplains rarely take their own advice. Anderson points out, "Chaplains often fail to 'practice what they preach' – giving themselves even a modicum of self-care."[324] Anderson also emphasizes that rarely do chaplains reserve time for themselves because they appear to be "always on,"[325] and ready to serve. However, what happens when chaplains fail to seek or practice compassionate self-care after serving and caring for the traumatized?

Hunsinger points that out prolonged exposure to pain, suffering, and trauma can lead to compassion fatigue or secondary traumatic stress.[326] Figley claims it will only take a matter of time before one recognizes compassion fatigue as an occupational hazard for those who are good at serving in their roles as caregivers and first responders.[327]

Chaplains who fail to properly care for themselves may succumb to compassion fatigue or secondary traumatic stress. These individuals may begin to experience signs and symptoms such as nightmares, avoidance and isolation issues, feeling numb emotionally and psychologically, experiencing sleeplessness, possessing a lack of appetite, and experiencing a

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[324] Michael W. Anderson, "Secondary Trauma Among Chaplains," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 588.

[325] Ibid.

[326] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 71.

[327] Charles R. Figley, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), 17.

loss of empathy.[328] Chaplains who experience compassion fatigue may resort to substance abuse to help them cope or self-medicate against the sign and symptoms they experience. [329, 330] Some helping professionals and chaplains may even leave the helping career or profession.[331]

The researcher questions, at this time in the history of Baltimore City, are the BPD Community Chaplains at risk of compassion fatigue or secondary trauma in response to the reported high murder rate, high volume of crime, and violence in the city? The researcher seeks to investigate, identify, and document the level of compassion fatigue, secondary traumatic stress, and compassion satisfaction, if any, in the Baltimore Police Department Community Chaplains, when responding to traumatic events and crises in Baltimore.

The research in the field of compassion fatigue has been well documented and studied in mental health care venues.[332, 333] The research has also recently extended to nurses and doctors

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[328] "Chaplain Burnout," Religion & Ethics News Weekly, Public Broadcasting Services (PBS), last modified November 11, 2011, https://www.pbs.org/wnet/religionandethics/2011/11/11/november-11-2011-chaplain-burnout/9903/.

[329] Karen Besterman-Dahan et al., "Bearing the Burden: Deployment Stress in Among Army National Guard Chaplains," *Journal of Health Care Chaplaincy* 18, n.n. (2012): 153, https://doi:10.1080/08854726.2012.723538.

[330] Joseph Hunter, "Handling Stress and Burnout As a First Responder," PTSD & Trauma Informed Prevention, Training and Education, Armor Up, last modified June 7, 2018, https://armorupnow.org/2018/06/07/handling-stress-and-burnout-as-a-first-responder/.

[331] Megan Best, Geila Rajee, and Anne Vandenhoeck, "A Long Way to Go Understanding the Role of Chaplaincy? A Critical Reflection on the Findings of Survey Examining Chaplaincy Responses to Covid-19, *Journal of Pastoral Counseling* 75, no.15 (2021): 47, https://journals.sagepub.com/doi/pdf/10.1177/1542305021992002.

[332] David Turgoose and Lucy Maddox, "Predictors of compassion Fatigue in Mental Health Professionals: A Narrative Review," Traumatology 23, no. 2 (2017): 172, http://dx.doi.org/10.1037/trm0000116.

[333] Alberto Rossi, et al., "Burnout, Compassion Fatigue, and Compassion Satisfaction Among Staff in Community-Based Mental Health Services," *Psychiatry Research*, 200 (2012): 934, https://doi-org.ezproxy.liberty.edu/10.1016/j.psychres.2012.07.029.

who work in hospitals, emergency rooms, and hospice care facilities.[334, 335] A significant number of the research models in the precedent review of the literature concerning compassion fatigue and secondary traumatic stress in helping professionals utilized the self–assessment measuring instrument developed initially by Charles Figley and later further developed and enhanced by Elizabeth Stamm. These studies utilized the Professional Quality of Life Scale, Version 5 (PROQOL).[336]

The PROQOL, Version 5 assessment tool is the most reliable and valid evidence-based assessment tool used to determine one's level, if any, of compassion fatigue, compassion satisfaction, and burnout rates.[337] The PROQOL assessment is the tool the researcher will implement in her action research project along with the Skovholt Practitioner Professional Resiliency and Self-Care Inventory. The researcher plans to invite the BPD Community Chaplains to participate in her action research project to determine the levels, if any, of compassion fatigue, secondary traumatic stress, burnout, vicarious traumatization, and compassion satisfaction.

The review of the precedent literature yielded minimal research concerning the care, prevention, and treatment of compassion fatigue and secondary trauma stress in first responders, such as chaplains of law enforcement.[338] McCormick et al. state in the article, "Spirituality

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[334] Xiaoyi Cao, et al., "Prevalence and Predictors for Compassion Fatigue and Compassion Satisfaction in Nursing Students During Clinical Placement," *Nurse Education in Practice* 51, n.n. (February 2021): 2, https://doi:10.1016/j.nepr.2021.102999.

[335] Emily Peters, "Compassion Fatigue in Nursing: A Concept Analysis," *Nursing Forum An Independent Voice for Nursing* 53, no. 4 (October/December 2018): 467, https://doi-org.ezproxy.liberty.edu/10.1111/nuf.12274.

[336] Alberto Rossi, et al., "Burnout, Compassion Fatigue, and Compassion Satisfaction," 934.

[337] Martha Teater and John Ludgate, *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (Eau Claire, WI: PEPSI Publishing & Media, 2014), 44.

[338] Wesley H. McCormick et al., "Professional Quality of Life and Changes in Spirituality Among VHA Chaplains: A Mixed Methods Investigation," *Journal of Health Care Chaplaincy* 23, n.n. (2017): 115.

Among VHA Chaplains: A Mixed Methods Investigation," there is very little research in the literature concerning the quality of life of the first responder chaplain, whether positive or negative.[339] There are several training courses and workshops for those in the profession of chaplaincy. Some of these courses are developmental courses and courses for continuing education purposes. These courses seem to lack specific information regarding the detection, prevention, management, and care of the first responder or law enforcement chaplain suffering from compassion fatigue or secondary traumatic stress. There are however curricula and programs, such as Clinical Pastoral Education Programs (CPE), which prepare individuals to care for people in crisis.

> Clinical Pastoral Education is interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounters with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop new awareness of themselves as persons and of the needs of those to whom they minister.[340]

There are very few models in Chaplaincy that specifically incorporate self-care, or compassionate self-care concepts into education. Parker, the author of the article "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," states the care of chaplains would be maximized if curricula and programs such as CPE intentionally incorporate self-care and compassionate self-care into their programs for students of chaplaincy.[341] There are several programs to train chaplains to care for others, being

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[339] Wesley H. McCormick et al., "Professional Quality of Life and Changes in Spirituality Among VHA Chaplains: A Mixed Methods Investigation," *Journal of Health Care Chaplaincy* 23, n.n. (2017): 115.

[340] "CPE Students," ACPE, accessed May 13, 2021, https://acpe.edu/education/cpe-students.

[341] C. James Parker, "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," *Journal of Health Care Chaplaincy* no vol., n.n. (February 2020): 12, https://doi.org/10.1080/08854726.2020.1723187.

sensitive to the physical, emotional, psychological, and spiritual needs of all traumatized people regardless of race, creed, gender, sexual orientation, or faith. However, there are very few programs or models in the review of literature to demonstrate the intentional inclusion of self-care and compassionate self-care concepts in the education of student chaplains.[342] Figley, Nance, Paget and McCormack, Langberg, and Miller, agree, professional helping curricula in colleges and universities, religious and spiritual educational curricula, CPE programs, and supervisors of new therapists, and other helping professionals should ensure self-care components in the curricula and educational programming.[343, 344, 345, 346]

The researcher of this study agrees with the assertions of Figley, Nance, Paget and McCormack, and Miller. If people in helping professions are empowered with the knowledge of Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization, they may be better prepared to serve and care for traumatized folks. Being trauma-informed, knowing the warning signs of Compassion Fatigue, and learning how to practice self-care may help the law enforcement chaplain combat the effects of Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization.[347, 348]

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[342] C. James Parker, "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," *Journal of Health Care Chaplaincy* no vol., n.n. (February 2020): 12, https://doi.org/10.1080/08854726.2020.1723187.

[343] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts*. (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[344] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain.* (Valley Forge, PA: Judson Press, 2006), 113.

[345] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 324.

[346] Carrie Miller, LCSW – C, Personal Interview, December 16, 2020.

[347] Reed, *It's Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress*, 52.

[348] Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Other*, 192.

CHAPTER 3: METHODOLOGY

Review of precedent literature demonstrates that caregivers who serve, support, and care for traumatized individuals may often experience levels of stress which can affect them emotionally, spiritually, psychologically, and physically, rendering them ineffective in their care of traumatized people whom they serve.[349] Figley states individuals who work with traumatized people on a regular basis are at high risk of suffering from compassion fatigue, which he claims is a natural byproduct of working closely with traumatized individuals.[350] He insists compassion fatigue is an occupational hazard for those who care for and support traumatized people.[351]

This chapter will address the researcher's problem statement and research questions. The researcher believes if Baltimore Police Community Chaplains are educated to identify and manage compassion fatigue, they will be better equipped to combat compassion fatigue while providing effective quality care to the Baltimore Police Department, its officers, and the communities of Baltimore City.

Intervention Design

The BPD Community Chaplains were and continue to be exposed to a great deal of trauma during their tours of duty. They are involved in community response following traumatic events, such as armed robberies, rapes, accidents, shootings, and death notifications.

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[349] Della W. Stewart, "Compassion Fatigue: What is the Level Among Army Chaplains?" *Journal of Workplace Behavioral Health* 27, n.n. (2012): 1-2, https://doi.org/10.1080/15555240.2012.640574.

[350] Charles R. Figley, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York, NY: Routledge, 1995), xiv.

[351] Ibid., 17.

The researcher is concerned whether the BPD Community Chaplains have received adequate trauma-informed care and training regarding compassion fatigue such as how to identify compassion fatigue and how to combat compassion fatigue while serving and caring for traumatized people.

The intervention designed by the researcher was a two-day workshop developed to identify and address the subject matter of compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction among Baltimore Police Department Community Chaplains. The researcher invited the BPD Community Chaplains in the Northeast and Northwest Districts, where she serves, to participate in her action research project to determine the levels of compassion fatigue that the BPD Community Chaplains may experience due to the exposure of high levels of trauma, high occurrence of murder, and high violent crimes they respond to regularly.

The researcher secured written approval for her Doctor of Ministry research action project from the Institutional Review Board of Liberty University. The letter of approval is located in the appendices of the thesis. The researcher secured consent to conduct the study with the BPD Community Chaplain Coordinator after she introduced her research proposal explaining the problem, purpose, and thesis statements. A letter of approval is located in the appendices of the thesis. Upon approval from the BPD Community Chaplain Coordinator, the researcher presented her action research project to her community chaplain colleagues. The proposal for the study was presented during a monthly scheduled BPD Community Chaplains' meeting held via the Zoom video platform, to garner interest in the project. Consent forms for participation were mailed via the United States Postal Service to all BPD Community Chaplains in the Northeast and Northwest districts who expressed interest in the action research project. Self-addressed, pre-

postage paid envelopes were sent along with the consent forms for the ease and convenience of responding to the action research project. The researcher developed an anonymous demographic questionnaire to document gender, age, years serving as a BPD Community Chaplain, and other vital information for her purposive sample. A copy of the anonymous demographic questionnaire is located in the appendices of the thesis. The researcher disseminated the demographic questionnaire, and the following pretest surveys: the Professional Quality of Life Scale Compassion Satisfaction and Compassion Fatigue, Version 5, (PROQOL), and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory, to the participants via the United States Postal Service.

The PROQOL-5 is a self-administered instrument used by caregivers and helpers to determine the positive and negative effects they may experience while serving or working with traumatized individuals. The instrument is a 30-item Likert survey. It is the most commonly used instrument to assess the following subscales of Compassion Fatigue: compassion satisfaction, burnout, and secondary traumatic stress.[352, 353, 354] Charles Figley originally developed the scale in 1995. It has been revised, with the current iteration being the fifth version, further developed by Beth Hudnall Stamm.[355]

The Skovholt Practitioner Professional Resiliency and Self-Care Inventory is an instrument used to assess one's professional resiliency and self-care. The inventory was

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[352] "The PROQOL Measure in English and Non-English Translations," PROQOL: Professional Quality of Life, last modified March 21, 2021, https://proqol.org/proqol-measure.

[353] "The Professional Quality of Life Scale-5," The National Children Traumatic Stress Network, accessed July 14, 2021, https://www.nctsn.org/measures/professional-quality-life-scale-5.

[354] "PTSD: National Center for PTSD," U.S. Department of Veterans Affairs, accessed July 14, 2021, https://www.ptsd.va.gov/professional/treat/care/toolkits/provider/selfAssessmentProQOL.asp.

[355] "Professional Quality of Life," ProQol, accessed July 14, 2021, https://proqol.org/about.

developed as a self-administered, reflective, Likert survey to be used by health professionals, such as social workers, psychologists, therapists, counselors, clergy, medical professionals, and educators, as well as others who serve in people helping professions. The inventory focuses on four subscales: professional vitality, personal vitality, professional stress, and personal stress.

These two Likert surveys were used as pretests and posttests to determine whether the project's intervention, a two-day workshop, imposed any significant difference in the levels of acquired knowledge of compassion fatigue, secondary traumatic stress, and compassion satisfaction. The surveys were anonymously administered to the BPD Community Chaplains. An intervention, a two-day workshop, entitled "Compassion Fatigue, Secondary Traumatic Stress, and Compassion Satisfaction: What BPD Community Chaplains Need to Know," was administered, focusing on compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction. Following the intervention, post-tests of the aforementioned surveys were administered. Data from the demographic questionnaire, two surveys, group notes, stories, interviews, testimonials, and the researcher's field notes were collected. The data was collected and analyzed following each of the two workshop sessions to determine whether the intervention concerning compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction made significant differences in the recognition of compassion fatigue and the level of compassion fatigue experienced by the BPD Community Chaplains.

Purpose, Objectives, and Learning Outcomes

The purpose of the intervention was to educate and address the following with the Baltimore Police Community Chaplains regarding the subject of compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction: history and etiology, identification and definitions, signs and symptoms, risk factors, management, treatment, and self–care. The objectives of the intervention were as follows: 1). The project participants will be asked to participate in pre-test surveys to determine their level of compassion fatigue, secondary traumatic stress, and compassion satisfaction. 2). The project participants will be able to identify the etiology and demonstrate a cursory understanding of the history of compassion fatigue, secondary traumatic stress, and compassion satisfaction. 3). The study participants will be able to identify, differentiate, and discuss the definitions concerning compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction. 4). The project participants will be able to identify the physical, emotional, psychological, spiritual, behavioral, and physical categories of signs and symptoms of compassion fatigue, secondary traumatic stress, and compassion satisfaction. 5). The project participants will be able to identify and discuss the risk factors associated with compassion fatigue, secondary traumatic stress, and vicarious traumatization. 6). The project participants will be able to identify and discuss appropriate treatment and management techniques used to cope with compassion fatigue, secondary traumatic stress, and vicarious traumatization. 7). The project participants will be able to identify, discuss, and develop relevant self-care techniques and strategies to combat and cope with compassion fatigue, secondary traumatic stress, and vicarious traumatization. 8). The project participants will be able to identify, define, and discuss the concept of compassion satisfaction, and how it differs from compassion fatigue, secondary traumatic stress, and vicarious

traumatization. 9). After the completion of the intervention, the study participants will take the post-test surveys to determine whether the intervention had a significant impact on the recognition of compassion fatigue and how to combat against the condition.

The learning outcomes for the intervention were: 1). The BPD Community Chaplains are able to identify and articulate the concepts of compassion fatigue, secondary traumatic stress, and compassion satisfaction. 2). The BPD Community Chaplains are able to recognize and identify the signs and symptoms of compassion fatigue, secondary traumatic stress, and vicarious traumatization. 3). The BPD Community Chaplains are able to design and implement the treatment and management skills, techniques, and strategies learned to combat compassion fatigue, secondary traumatic stress, and vicarious traumatization. 4). The BPD Community Chaplains can identify risk factors that may predispose them to compassion fatigue, secondary traumatic stress, and vicarious traumatization. 5). The BPD Community Chaplains are equipped to develop their own unique self-care plans and SMART Goals. 6). The BPD Community Chaplains are able to practice the self-care techniques identified in the intervention to help them cope and maintain a healthy lifestyle, while providing effective quality care to those whom they serve.

Tasks and Steps to be Completed

The intervention had several tasks that addressed the learning objectives of the training intervention. Task # 1: The researcher provided the study participants with an orientation for the Doctor of Ministry action research project. The concept, context, and purpose of the study were described in full. Written consent was secured from all participants who volunteered for the study. The researcher shared, explained, and reviewed the consent forms with the participants via a PowerPoint presentation in a Zoom video platform during a regularly scheduled monthly

meeting for the BPD Community Chaplains. Those participants who consented to participate in the project had the opportunity to ask and have answered questions they had concerning the project during the Zoom meeting. Following the Zoom orientation for the study, the participants choosing to participate in the study submitted their consent forms as hard copies, mailing them in the self-addressed stamped, pre-paid postage envelopes provided by the researcher. Task # 2 entailed the mailing and subsequent receipt of the anonymous demographic questionnaires and the two Likert surveys, the Professional Quality of Life Scale (PROQOL) Compassion Satisfaction and Compassion Fatigue Survey, Version 5 (2009), which is the most widely used evidence-based assessment tool used to determine compassion fatigue, compassion satisfaction, and secondary traumatic stress,[356] and the Skovholt Practitioner Professional Resiliency and Self – Care Inventory. Permission was granted by the owners of each research instrument to be utilized for the purpose of this action research project. The letters of permission are located in the appendices of the thesis. The PROQOL and the Skovholt surveys were made available as hard copy documents to ensure as much accessibility to encourage full participation for those participating in the study. During the orientation of the study, the participants expressed their consensus to have all documents disseminated as hard copies. Task # 3: The first day of the intervention was held via the Zoom video platform which was made available by the researcher's Zoom account. The history, etiology, signs, symptoms, and risk factors of compassion fatigue, secondary traumatic stress, and vicarious traumatization were presented and discussed. Data were gathered during the sessions from group discussions, shared testimonials, stories, and the researcher's field notes. The data from the pretest surveys were also analyzed for common

[356] Martha Teater and John Ludgate, *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (Eau Claire, WI: PEPSI Publishing & Media, 2014), 43.

themes, slippages, and silences, as suggested by Sensing.[357] Task # 4: The second day of the intervention was held during the third month of the study. At that time, the topics of treatment and management of compassion fatigue, secondary traumatic stress, and vicarious traumatization were presented and discussed. The concept of compassion satisfaction was introduced and discussed. Self-care and the design of self-care programs were presented and discussed. Task # 5: The anonymous dissemination and subsequent collection of the posttest surveys occurred. Task # 6: All other data, such as field notes, group discussion notes, and testimonials notes, were collected and analyzed. Task # 7: The volunteers were thanked for their participation in the project, and they were advised as to how they could receive the results of the project.

Research Sample

The researcher used a purposive sample for this Doctor of Ministry action research project. The researcher invited the BPD Community Chaplains from the Northeast district and the Northwest district of the Baltimore City Police Department to participate in the doctoral action research project. The researcher serves as a BPD Community Chaplain in each of those districts, due to her relational equity within both communities. Relational Equity, as defined by Lt. Colonel Russell, is being known and recognized by the community in which one lives, works, or worships.[358] One with relational equity has active engagement in the community and possesses a certain degree of respect and influence among the residents and citizens who live within the community. The researcher lives in the Northeast district, where she is active in the community. The researcher is employed by the State of Maryland and teaches at the local

[357] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses* (Eugene, OR: Wipf & Stock Publishers, 2011), 72.

[358] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 4.

community college in the Northwest district of the city. The researcher's purposive sample were volunteer BPD Community Chaplains who graduated from the 2015 class and beyond, of the BPD Chaplaincy Academy. Revamping of the BPD Police Chaplaincy Academy took place in 2014 to retrain and re-equip the BPD Community Chaplains to move them from more sedate ceremonial activities to assume more active and community-based activities.

The sample contained both male and female chaplains. All BPD Community Chaplains were required to have at least three years of ministry and be able to pass a criminal background check before being selected as candidates for the BPD Police Chaplaincy Academy. The entire squad of BPD Police Community Chaplains comes from a myriad of faith traditions. The faith traditions of the BPD Community Chaplains who participated in this doctoral ministry action project were reported and recorded in the demographic questionnaire. Other pertinent data, such as ages, gender, marital status, years of service as a BPD Community Chaplain, and levels of education, were reported, analyzed, and will be shared in chapter four of the thesis. Of the 38 potential and active BPD Community Chaplains in the combined Northeast and Northwest districts of the city of Baltimore, 18 BPD Community Chaplains attended the orientation for the study. Of the 18 BPD Community Chaplains, 15 agreed to participate in the study and signed the study consent forms. One individual left the study during the final month, opting not to complete the posttest surveys. The study was completed with 14 participants.

Location of the Intervention

The initial location of the intervention was to be the respective roll call rooms of the Northeast Police District Facility and the Northwest Police District Facility. The researcher learned in a Zoom video platform meeting with the Northeast District BPD Community Chaplains held on February 22, 2021, civilians were no longer allowed in the district precincts

due to the COVID-19 pandemic and the recent rise in COVID-19 cases reported within those respective facilities. Consequently, all face-to-face monthly scheduled community chaplains' meetings were held via the Zoom video platform. The researcher had planned her project as a face-to-face intervention, however it was not possible to facilitate the intervention in a face-to-face format due to the COVID-19 pandemic status at the time of the commencement of the action research project. The researcher resorted to her plan B, which was approved by the Liberty University Institutional Review Board. The study and intervention were administered via the researcher's Zoom video platform account, while mailing hard copies of the demographic questionnaire, pretests, and posttest surveys via the United States Postal Service.

Time Line and Duration of the Intervention

The time line and duration of activities were as follows: The researcher received approval for her Doctor of Ministry action research study on April 29, 2021. The researcher secured permission from the BPD Community Chaplain Coordinator to facilitate the project and administer the intervention via the Zoom video platform shortly thereafter, in the beginning of May 2021. There were four meeting dates for the action research project. The initial meeting with the BPD Community Chaplains was an interest meeting to introduce and discuss the action research project. The interest meeting held on May 6, 2021, via the Zoom video platform with the BPD Community Chaplains. The meeting lasted approximately 45 minutes. A second meeting, the project's orientation meeting was held on May 24, 2021. During the orientation meeting, the research problem, purpose, and thesis statements were shared with the participants in greater detail. The project orientation meeting lasted one hour to allow for questions and answers following the presentation of the content matter of the project. The first meeting of the intervention was held on Monday, June 28, 2021 at 7:00 pm via the Zoom video platform. The

meeting was scheduled to last an hour. However, due to the enthusiasm of the participants and at the request of the participants, the meeting was extended by 30 minutes. The second session of the project occurred on July 26, 2021, beginning at 7:00 pm and concluding at 8:30 pm, via the Zoom video platform.

Those BPD Community Chaplains who chose to volunteer and participate in the study were sent a Demographic Participant Questionnaire to complete. Those BPD Community Chaplains who chose to participate were given two Likert pretest surveys to complete prior to the intervention. These surveys were the Professional Quality of Life Scale Compassion Satisfaction and Compassion Fatigue (PROQOL) Version 5, the latest version, and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory. These surveys were disseminated as pretests to assess the knowledge of and possible levels of compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction, if present, among the BPD Community Chaplains. All surveys were anonymous. The Demographic Participant Questionnaire, the PROQOL, and the Skovholt surveys were returned in pre-postage paid, self-addressed stamped envelopes to ensure total anonymity. Upon the completion and receipt of the questionnaires and surveys, the researcher provided the study participants with the Zoom video platform link for the study's intervention, which was a two-day workshop entitled, "Compassion Fatigue, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Satisfaction: What BPD Community Chaplains Need to Know." The study participants were also given a participant workbook, which complimented the intervention's PowerPoint presentation.

The third gathering was the first evening of the two-day intervention entitled, "Compassion Fatigue, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Satisfaction: What BPD Community Chaplains Need to Know." The following learning

objectives for the first evening of the intervention were addressed: 1). The study participants will be able to identify the etiology and demonstrate a cursory understanding of the history of compassion fatigue, secondary traumatic stress, and compassion satisfaction. 2). The study participants will be able to identify, differentiate, and discuss the definitions concerning compassion fatigue, secondary traumatic stress, and compassion satisfaction. 3). The study participants will be able to identify, differentiate, and discuss the signs and symptoms concerning compassion fatigue, secondary traumatic stress, and compassion satisfaction. The first evening of the workshop/intervention lasted 90 minutes. The subsequent session of the workshop/intervention lasted 90 minutes.

At the conclusion of the evening, the researcher collected group notes, shared interviews, and testimonials. The researcher informed the participants of what they could expect in the fourth monthly meeting, which was the presentation and discussion of compassion satisfaction and self-care.

The learning objectives for the fourth monthly meeting were as follows: 5). The study participants will be able to identify and discuss appropriate treatment and management techniques used to cope with compassion fatigue, secondary traumatic stress, and vicarious traumatization. 6). The study participants will be able to identify and discuss relevant self-care techniques and strategies to combat and cope with compassion fatigue, secondary traumatic stress, vicarious traumatization. 7). The study participants will be able to identify, define, and discuss the concept of compassion satisfaction, and how it differs from compassion fatigue, secondary traumatic stress, and vicarious traumatization. Upon the conclusion of the evening, the researcher had the participants remove the posttest surveys from their workbooks. The researcher asked the participants to complete the surveys before the conclusion of the Zoom video platform

meeting. The researcher then asked the participants to place the completed posttest surveys in the provided pre-postage paid, self-addressed stamped envelopes. The researcher asked the participants to place their envelopes in the mail on the following day. The researcher also collected recorded discussion notes, group notes, and shared interviews, stories, and testimonials for analysis.

Once all surveys were completed and received, the researcher followed up with an email thanking the project volunteers for their participation. The researcher also informed the participants as to how they could receive the results of the study upon completion of analysis.

Ethical Issues

As with any research, there were ethical issues and concerns addressed in this action research project. During the initial orientation meeting, the researcher introduced and discussed the action research plan with potential BPD Community Chaplain Participants. The researcher fully disclosed and was transparent, explaining the purpose and intent of the research project. The researcher discussed why she believed the research study was important and gave the rationale for the project. The methodology was discussed and shared with the participants. The potential participants were given the opportunity to ask questions concerning the research project. Upon agreement to voluntarily participate in the research project, the participants were mailed a statement of informed consent, confidentiality, and anonymity which they were asked to read, sign, and date. The project was virtually held due to COVID-19 pandemic restrictions. The informed consent document, along with the Demographics Participant Questionnaire, pretest and posttest surveys, were mailed using the United Postal Service. Each of the study participants were mailed individual self-addressed, pre-paid stamped envelopes for the demographic questionnaire, the PROQOL, and the Skovholt surveys. A copy of the statement of consent and

confidentiality was placed in the appendix of the thesis. The researcher also discussed the importance of anonymity within the research study. The researcher shared with the participants any foreseeable risks, as minimal as they may have been, and shared any benefits to participating in the project.[359]

Resources Required for the Intervention

The following materials, equipment, and supplies were required for the action research study: the researcher provided hard copies of the PowerPoint presentation in the form of a participant workbook/manual for the convenience of note taking. All demographic questionnaires, pretest and posttest surveys were collected via United States Postal Service. Each participant was given self-addressed, pre-postage paid envelopes for the return of their completed consent forms, demographic questionnaire, and surveys. With full disclosure and permission from the participants, the workshops were recorded via the Zoom video platform to ensure an accurate record of the progress of the intervention.

Due to the current COVID-19 pandemic restrictions, the intervention was virtually held via the researcher's Zoom Video platform account. A Zoom video platform link invitation with meeting identification number and password was provided to all study participants via email and the established GroupMe, a free group messaging application.

Data Collection

The data collected during the action research project were the Participant Demographic Questionnaires, the pretests and posttests of the Professional Quality of Life Scale Compassion Satisfaction and Compassion Fatigue (PROQOL) Version 5, and the Skovholt Practitioner

[359] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses* (Eugene, OR: Wipf & Stock, 2011), 35.

Professional Resiliency and Self-Care Inventory. The pretests and posttest data were collected and analyzed with the researcher's outside observer to determine if the intervention, the two-day workshop on compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction, made a significant difference in the knowledge of compassion fatigue and the level of compassion fatigue experienced by the BPD Community Chaplains.

The intervention was administered virtually via the Zoom video platform. The participants were advised at each session when the recording commenced and when the recording concluded. All group notes, stories, testimonials, and the researcher's field notes were collected and securely retained for data analysis purposes.

Pretests and posttest surveys were given to the single group being studied. There was no control group for this action research project. The dependent variable for the study was the two-day workshop intervention entitled, "Compassion Fatigue, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Satisfaction: What BPD Community Chaplains Need to Know." The pretests and posttests surveys were disseminated accordingly. The data were collected and analyzed. Coding of data occurred via pretest and posttest surveys, discussion group notes, the researcher's field notes, stories, testimonials, and interviews.

Implementation of the Intervention Design

This section of the Methodology Chapter provides a narrative concerning the implementation and collection of data. Data collection and observation were completed using Sensing's concept of triangulation. For qualitative Doctor of Ministries action research projects, Sensing advises the use of triangulation. Triangulation is a process of gathering data from multiple aspects, thereby providing the researcher with a richer view of the data collected from

the intervention.[360] Denzin, as cited in Sensing's *Qualitative Research* identifies four different types of triangulations: Data triangulation, Investigator triangulation, Theory Triangulation, and Methodological Triangulation.[361] The researcher chose to utilize Data Triangulation. The researcher collected data in the form of her field notes, group notes, and observations of the interactions of the participants. She also collected data from the participants in surveys, shared stories, and recorded testimonials. During the project, the researcher had the privilege to compare data and collaborate with an outside observer, a professor from Pepperdine University.

Prior to the implementation of the intervention, the researcher disseminated a demographic questionnaire, gathering the specifics of her purposive sample. Pretest surveys, the PROQOL-5, and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory, along with shared stories, recorded testimonials, group discussions notes, and observations, were recorded and collected for analysis.

Upon the conclusion of the intervention, the researcher began processing and analyzing the recordings of shared stories, testimonials, group discussions, and field notes. Fourteen of the 15 participants returned their posttest surveys by the August 6, 2021 due date. The data of the posttest surveys were compared to the data of the pretest surveys, and the results will be shared in chapter four.

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[360] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses*, 72.

[361] Ibid., 73.

Data Analysis

Themes, according to Sensing, are areas of overlap and agreement found in the data during analysis.[362] The data collected and analyzed following the intervention were the pretest, posttest surveys, group notes, field notes, recorded personal stories and testimonials. A system of triangulation was used to analyze the collected data from the participants as inside observers. The researcher collaborated with her outside observer and his analysis of the data. The researcher analyzed her data collected during the intervention, and the following themes appeared during the analysis of all collected data. 1). Participants were found to possess moderate to high levels of satisfaction and professional vitality while working and serving as BPD Community Chaplains. The researcher recalls the following recorded statement of one of the study participants, "I get pleasure knowing I am making a difference on the streets of Baltimore." 2). The participants found their service satisfying and rewarding. One insider stated, "I find it rewarding to serve as a BPD Community Chaplain. I enjoy giving back to the community." 3). Participants understood their role and purpose as BPD Community Chaplains. 4). Data in the recorded testimonials, shared stories, and participants' experiences indicated participants expressed their stress levels increase when responding to calls such as shootings, loss of life calls, or responding to calls involving children. 5). Although basically equipped to serve, participants recognized more continuing education is necessary. The analysis of the data demonstrated that participants wanted more training to remain current in trends concerning trauma-informed care and grief response. One participant shared in her recorded testimony, "Before I knew any better, I used to ask the question, 'What's wrong with you?' Now due to

[362] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses,* 197.

training I sought on my own, outside of the Chaplain Academy, I have learned to ask the question, 'What happened to you?' I have learned asking 'What happened to you?' instead of asking, 'What is wrong with you?' is less judgmental."

The analyzed data presented divergence in the project. Sensing states areas of disagreement in the data are referred to as slippage.[363] Instead of displaying levels of compassion fatigue as assumed by the researcher, the data demonstrated participants of this doctoral action research project actually presented with compassion satisfaction. Compassion satisfaction is the opposite of compassion fatigue. Molnar et al. define compassion satisfaction as a positive phenomenon where the caregiver or person in a helping profession receives or experiences a sense of reward, efficacy, and competence due to caring for the traumatized.[364] The researcher observed the interactions of the BPD Community Chaplains, as they expressed their feelings concerning serving as BPD Community Chaplains during a small group break out session in the Zoom video platform. The researcher observed the sense of joy, reward, satisfaction, and for some, the exhilaration of being able to journey with those involved in traumatic events. One participant shared, "It is a privilege and humbling to be able to journey with someone during one of the worst or most terrifying moments in their lives. These people do not know me personally, but they do know that I care and that I am here to help. To be able to help in those situations are blessings for me."

The researcher assumed the BPD Community Chaplains may be at an increased risk for compassion fatigue due to responding to the high levels of trauma, crime, and murder in the city

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[363] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses*, 197.

[364] Beth E. Molnar and Kyle D. Killian, Vanessa Emery, Ginny Sprang, Ruth Gottfried, and Brian E. Bride, "Advancing Science and Practice for Vicarious Traumatization/Secondary Traumatic Stress: A Research Agenda," *Traumatology* 23, no. 2 (2017): 130, https://doi.apa.org/doi/10.1037/trm0000122.

of Baltimore. The analyzed data collected in this doctoral action research project demonstrated this is not the case. The analyzed data suggests the BPD Community Chaplains are trauma-informed and practice adequate self-care measures and techniques to combat compassion fatigue.

The researcher and the outside observer noticed silences in the collected data. Sensing defines a silence in the data as realities not presented by the participants.[365] The data demonstrated that participants were aware of and practiced satisfactory self-care regimens. The outside observer and the researcher analyzed and compared their data from surveys, group notes, field notes, recorded testimonials and stories. The data demonstrated most BPD Community Chaplains practiced adequate self-care. The collected data demonstrated self-care was practiced in the following manner: making time for self, taking time away from serving as a BPD Community Chaplain, exercising, attempting to eat well, getting adequate rest and sleep. The silences noted by the researcher and outside observer were the topics of boundaries, being able to say 'No,' spending quality time with loved ones, and seeking support from a professional.

The data demonstrates the BPD Community Chaplains possessed moderate to high levels of compassion satisfaction, and professional vitality. The precedent review of literature suggests a caregiver may experience compassion satisfaction when he or she practices self-care. Adequate self-care, as presented in the precedent review of the literature, suggests eating a healthy diet, getting plenty of rest and restorative sleep, and engaging in exercise.[366, 367] The precedent review of literature also demonstrates other significant components of quality self-care for caregivers

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[365] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses*, 197.

[366] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro: New Growth Press, 2015), 324.

[367] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 13-14.

include scheduling and attending regular medical check-ups, spending time with family, friends, and loved ones, balancing work and personal life, maintaining a time of devotion and prayer, and seeking support through peer groups, spiritual direction, or professional therapy.[368, 369, 370] Although the data suggests study participants possessed moderate to high levels of compassion satisfaction and professional vitality, the aforementioned silences appeared in the data for the researcher and the outside observer. The data suggests the participants possessed the following components in their self-care regimens: attempting to eat well, getting exercise, getting adequate rest and sleep. The data was silent concerning other significant components of self-care such as scheduling and attending medical appointments for physical check-ups, achieving and maintaining balance between work and personal life, setting aside time for personal devotion and prayer, participating in peer support groups, or seeking professional therapy and spiritual direction. The researcher and outside observer wondered how the project participants could achieve moderate to high levels of compassion satisfaction when it appeared significant aspects of the self-care regimen were absent from the data.

The data demonstrate the participants appear to have low to moderate levels of secondary traumatic stress. Possessing self-care regimens that lack provisions for medical, emotional, psychological, spiritual care, along with work-personal life balance, may be the cause for moderate cases of secondary traumatic stress. Another intriguing concern in the silence of the data concerned healthy boundaries, and having the ability to say 'No.' The data demonstrate the

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[368] Françoise Mathieu, "Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-care Tips for Helpers," accessed November 11, 2020. https://www.compassionfatigue.org/pages/Top12SelfCareTips.pdf.

[369] James Halpern and Mary Tramontin, Disaster Mental Health: Theory and Practice (Belmont, CA: Brooks/Cole Cengage Learning, 2007), 194-195.

[370] Soraya M. Sawicki, "Mental Health Workers' Vicarious Trauma, and Self-Care: A Phenomenological Approach." (DSW diss., Capella University, Minneapolis, 2019), 78-79, ProQuest Dissertation & Theses Global.

project participants possess compassion satisfaction. Having healthy boundaries and being able to say 'No,' possessing a devotional/prayer life, and peer support through small group sharing, spiritual direction, or professional therapy/counseling are typically practiced with caregivers who possess compassion satisfaction. These concepts were missing in the collected data. This may be the reason for the low to moderate cases of secondary traumatic stress found in the study. The raw data results of the study are presented in the following chapter.

CHAPTER 4: RESULTS

The purpose of the Doctor of Ministry action research project was to educate Baltimore Police Community Chaplains concerning compassion fatigue while maintaining effective quality care. The researcher hypothesized if the BPD Community Chaplains were trauma-informed and educated concerning the nuances of compassion fatigue, secondary traumatic stress, and vicarious stress, they would be able to serve the BPD police officers and the citizens of Baltimore while practicing self-care and maintaining effective quality care. Fourteen BPD Community Chaplains participated in this study.

Three research questions guided this study: (1) Did the BPD Community Chaplains receive adequate training and preparation to protect themselves against compassion fatigue, secondary traumatic stress, and vicarious traumatization while serving those who directly experience traumatic events and crises? (2) How can Baltimore Police Community Chaplains combat compassion fatigue while providing effective quality care? (3) Will a two-day workshop focusing on the topics of compassion fatigue, secondary traumatic stress, and vicarious traumatization have a significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains?

Table 1 displays the frequency counts for the demographic variables found in the Demographic Participant Questionnaire. Table 2 displays the frequency counts for the levels of compassion fatigue categories (burnout and secondary traumatic stress). Tables 3 through Table 9 display the pretest ratings of the Professional Quality of Life Scale – Version 5 and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory. No significant differences were found in comparison to the pretest and posttest surveys (the PROQOL and the Skovholt Inventory). To answer the research questions, Table 10 displays the Wilcoxon matched pairs tests for the seven subscale scores.

Descriptive Analysis

Table 1 displays the frequency counts for selected variables in the Demographic Participant Questionnaire. All BPD Community Chaplains were at least 55 years old, with 42.9% above 65 years of age. The majority of the BPD Community Chaplains (71.4%) were female, and 78.6% were African-American. Twenty-one percent (21%) of the sample were married. As for current employment status, half were retired and 42.9% worked full-time. All but one participant (92.9%) reported a Christian religious affiliation. Years of service as a Baltimore Police Community Chaplain ranged from 2 to 6 years, with the median of Mdn = 4.5 years. Years of service ranged from 2 to 6 years, because only those BPD Community Chaplains who graduated after the revamping of the Baltimore City Police Chaplaincy Academy in 2014 were included in this study. All but three BPD Community Chaplains (78.6%) had at least a four-year college degree, and 57.2% also had a graduate degree (see Table 1).

Table 1

Frequency Counts for Demographics Variables

Variable	Category	*n*	%
Age range			
	55-64 years	8	57.1
	Above 65	6	42.9
Gender			
	Male	4	28.6
	Female	10	71.4
Race/Ethnicity			
	Caucasian	2	14.3
	African American	11	78.6
	Multicultural	1	7.1
Marital Status			
	Married	3	21.4
	Divorced	7	50.0
	Other	4	28.6
Current employment status			
	Full-time	6	42.9
	Self-employed	1	7.1
	Retired	7	50.0
Religious affiliation			
	Christian	13	92.9
	Prefer not to say	1	7.1
Years as BPD Community Chaplain			
	2 or 3 years	6	42.9
	4 or 5 years	4	28.6
	6 years	4	28.6
Education			
	Junior college	3	21.4
	4-year degree (BS, BA)	3	21.4
	Graduate school (MS, MA)	5	35.8
	Post graduate (PhD, DMin, EdD)	3	21.4

Note. $N = 14$.

Table 2 displays the frequency counts for the level of compassion fatigue categories (burnout and secondary traumatic stress). All BPD Community Chaplains (100.0%) had moderate or high compassion satisfaction with both pretest and posttest analysis. For the level of burnout, all BPD Community Chaplains possessed low to moderate burnout, as reflected in the pretest and posttest surveys. In a similar manner, all BPD Community Chaplains possessed low to moderate secondary traumatic stress, as reflected in the pretest and posttest surveys (see Table 2).

Table 2

Frequency Counts for Level of Burnout Categories

Scale	Category	*n*	%
Pretest Compassion Satisfaction			
	Low (22 or less)	0	0.0
	Moderate (23 to 41)	4	28.6
	High (42 or more)	10	71.4
Pretest Burnout			
	Low (22 or less)	10	71.4
	Moderate (23 to 41)	4	28.6
	High (42 or more)	0	0.0
Pretest Secondary Traumatic Stress			
	Low (22 or low)	7	50.0
	Moderate (23 to 41)	7	50.0
	High (42 or more)	0	0.0
Posttest Compassion Satisfaction			
	Low (22 or less)	0	0.0
	Moderate (23 to 41)	7	50.0
	High (42 or more)	7	50.0
Posttest Burnout			
	Low (22 or less)	10	71.4
	Moderate (23 to 41)	4	28.6
	High (42 or more)	0	0.0
Posttest Secondary Traumatic Stress			
	Low (22 or less)	6	42.9

Moderate (23 to 41)	8	57.1
High (42 or more)	0	0.0

Note. $N = 14$.

The Professional Quality of Life Scale – Version 5 (PROQOL)

The PROQOL-5 is a self- administered instrument used by caregivers and helpers to determine the positive and negative effects they may experience while serving or working with traumatized individuals. The instrument is a 30-item Likert survey. It is the most commonly used instrument to assess the following subscales of Compassion Fatigue: compassion satisfaction, burnout, and secondary traumatic stress. [371, 372]

The PROQOL Pretest Rating Comparisons

Table 3 displays the ratings for the ten pretest compassion satisfaction items, sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = never to 5 = very often. The highest levels of agreement were for Item 3, "I get satisfaction from being able to [care/help] people" and Item 24, "I am proud of what I can do to [care/help]" (M = 4.79). The lowest level of agreement was for Item 16, "I am pleased with how I am able to keep up with [caring/helping] techniques and protocols" (M = 3.86) (see Table 3).

[371] "The PROQOL Measure in English and Non-English Translations," PROQOL: Professional Quality of Life, last modified March 21, 2021, https://proqol.org/proqol-measure.

[372] "The Professional Quality of Life Scale-5," The National Children Traumatic Stress Network, accessed July 14, 2021, https://www.nctsn.org/measures/professional-quality-life-scale-5.

Table 3

Ratings of Pretest Compassion Satisfaction Items Sorted by Highest Mean

Item	*M*	*SD*
3. I get satisfaction from being able to [care/help] people.	4.79	0.43
24. I am proud of what I can do to [care/help].	4.79	0.43
12. I like my work as a [caregiver/helper].	4.57	0.65
30. I am happy that I chose to do this work.	4.57	0.76
20. I have happy thoughts and feelings about those I [care/help] and how I could help them.	4.29	0.83
22. I believe I can make a difference through my work.	4.29	0.91
6. I feel invigorated after working with those I [care/help].	4.21	0.89
18. My work makes me feel satisfied.	3.93	0.83
27. I have thoughts that I am a "success" as a [caregiver/helper].	3.93	0.83
16. I am pleased with how I am able to keep up with [caring/helping] techniques and protocols.	3.86	1.23

Note. N = 14. Ratings based on a five-point metric: 1 = *never* to 5 = *very often*.

Table 4 displays the ratings for the ten pretest burnout items sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = never to 5 = very often. The highest level of agreement was for Item 21, “I feel overwhelmed because my case [work] load seems endless” (*M* = 2.57). The lowest level of agreement was for Item 15, “Reversal of score-I have beliefs that sustain me” (*M* = 1.29) (see Table 4).

Table 4

Ratings of Pretest Burnout Items Sorted by Highest Mean

Item	*M*	*SD*
21. I feel overwhelmed because my case [work] load seems endless.	2.57	1.16
19. I feel worn out because of my work as a [caregiver/helper].	2.43	1.02
17. Reversal of score-I am the person I always wanted to be.	2.29	0.83
26. I feel "bogged down" by the system.	2.07	1.38
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [care/help]	1.93	0.62
10. I feel trapped by my job as a [caregiver/helper].	1.86	1.29
1. Reversal of score-I am happy.	1.79	0.80
4. Reversal of score-I feel connected to others.	1.57	0.76
29. Reversal of score-I am a very caring person.	1.43	0.76
15. Reversal of score-I have beliefs that sustain me	1.29	0.61

Note. $N = 14$. Ratings based on a five-point metric: 1 = *never* to 5 = *very often*.

Table 5 displays the ratings for the ten-pretest secondary traumatic stress items sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = never to 5 = very often. The highest level of agreement was for Item 2, “I am preoccupied with more than one person I [care/help]” ($M = 4.00$). The lowest level of agreement was for Item 25, “As a result of my [caring/helping], I have intrusive, frightening thoughts” ($M = 1.50$) (see Table 5).

Table 5

Ratings of Pretest Secondary Traumatic Stress Items Sorted by Highest Mean

Item	*M*	*SD*
2. I am preoccupied with more than one person I [care for/help].	4.00	1.04
5. I jump or am startled by unexpected sounds.	2.64	0.74
7. I find it difficult to separate my personal life from my life as a [caregiver/helper].	2.57	0.94
9. I think that I might have been affected by the traumatic stress of those I [care for/help].	2.50	0.94
11. Because of my [helping], I have felt "on edge" about various things.	2.29	0.91
13. I feel depressed because of the traumatic experiences of the people I [care for/help].	2.07	0.83
28. I can't recall important parts of my work with trauma victims.	2.07	1.00
14. I feel as though I am experiencing the trauma of someone I have [cared for/helped].	1.93	0.83
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [cared for/help].	1.79	1.19
25. As a result of my [caring/helping], I have intrusive, frightening thoughts.	1.50	0.76

Note. $N = 14$. Ratings based on a five-point metric: 1 = *never* to 5 = *very often*.

The Skovholt Practitioner Professional Resiliency and Self-Care Inventory

The Skovholt Practitioner Professional Resiliency and Self-Care Inventory is an instrument used to assess one's professional resiliency and self-care. Thomas Skovholt developed the inventory as a self-administered, reflective, Likert survey to be used by health professionals, such as social workers, psychologists, therapists, counselors, clergy, medical professionals, and educators, as well as others who serve in people helping professions. The inventory focuses on four subscales: professional vitality, personal vitality, professional stress, and personal stress.

The Skovholt Practitioner Professional Resiliency and Self Care Inventory
Pretest Rating Comparisons

Table 6 displays the ratings for the eight pretest professional vitality items, sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = strongly disagree to 5 = strongly agree. The highest level of agreement was for Item 1, "I find my work as a practitioner or as a student to be meaningful" (M = 4.79). The lowest level of agreement was for Item 8, "My work environment is like a greenhouse--where everything grows--because the conditions are such that I feel supported in my professional work" (M = 3.29) (see Table 6).

Table 6

Ratings of Pretest Professional Vitality Items Sorted by Highest Mean

Item	*M*	*SD*
1. I find my work as a practitioner or as a student to be meaningful	4.79	0.43
3. I am interested in making positive attachments with my clients /students/patients	4.64	0.50
2. I view self-care as an ongoing part of my professional work/student life.	4.50	0.52
5. The director/chair at my site/school is dedicated to practitioner welfare	4.29	0.83
4. I have the energy to make these positive attachments with my clients /students/patients	4.14	0.66
6. On the dimension of control of my work/schooling, I am closer to high control than low control	3.93	1.14
7. On the dimension of demands at my work/schooling, I have reasonable demands rather than excessive demands from others	3.79	1.19
8. My work environment is like a greenhouse--where everything grows--because the conditions are such that I feel supported in my professional work	3.29	0.99

Note. N = 14. Ratings based on a five-point metric: 1 = *strongly disagree* to 5 = *strongly agree*.

Table 7 displays the ratings for the eleven pretest personal vitality items, sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = strongly disagree to 5 = strongly agree. The highest level of agreement was for Item 10, "I have a strong

code of values/ethics that gives me a sense of direction and integrity" (*M* = 4.71). The lowest level of agreement was for Item 19, "My sleep pattern is restorative" (*M* = 3.43) (see Table 7).

Table 7

Ratings of Pretest Personal Vitality Items Sorted by Highest Mean

Item	*M*	*SD*
10. I have a strong code of values/ethics that gives me a sense of direction and integrity	4.71	0.61
12. I have positive/close friendships	4.36	0.74
11. I feel loved by intimate others	4.29	0.83
16. I have one or more abundant sources of high energy for my life (e.g. friends and family, pleasurable hobby, enjoyable pet, the natural world, a favorite activity)	4.07	0.92
9. I have plenty of humor and laughter in my life	3.93	1.14
15. I have a lot of fun in my life	3.79	1.12
13. I am physically active and receive the benefits of exercise	3.64	1.28
17. To balance the ambiguity of work in the caring professions, I have some concrete activities that I enjoy where results are clear cut (e.g. a collection such as coins/rocks/dolls, gardening, a fantasy sports team, weaving, remodeling and painting)	3.64	1.22
14. My financial life (expenses, savings and spending) is in balance	3.57	1.45
18. My eating habits are good for my body	3.57	1.02
19. My sleep pattern is restorative	3.43	0.94

Note. N = 14. Ratings based on a five-point metric: 1 = *strongly disagree* to 5 = *strongly agree.*

Table 8 displays the ratings for the nine pretest professional stress items, sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = strongly disagree to 5 = strongly agree. The highest level of agreement was for Item 27, "I am excited to learn new ideas-methods-theories-techniques in my field" (*M* = 4.71). The lowest level of agreement was for Item 28, "The level of conflict between staff/faculty at my organization is low" (*M* = 3.57) (see Table 8).

Table 8

Ratings of Pretest Professional Stress Items Sorted by Highest Mean

Item	*M*	*SD*
27. I am excited to learn new ideas-methods-theories-techniques in my field.	4.71	0.47
26. I have at least one very positive relationship with a clinical supervisor/ mentor/teacher.	4.29	0.91
24. My work is intrinsically pleasurable most of the time.	4.29	0.83
23. I have found a way to have high standards for my work yet avoid unreachable perfectionism.	4.07	0.62
21. Overall, I have been able to find a satisfactory level of "boundaried [sic] generosity" (defined as having both limits and giving of oneself) in my work with clients/students/patients	4.00	0.55
22. Witnessing human suffering is central in the caring professions (e.g., client grief, student failure, patient physical pain). I am able to be very present to this suffering, but not be overwhelmed by it or experience too much of what is called sadness	3.93	0.92
25. Although judging success in the caring professions is often confusing, I have been able to find useful ways to judge my own professional success.	3.79	0.89
20. There are many contradictory messages about both practicing self-care and meeting expectations of being a highly competent practitioner/student. I am working to find a way through these contradictory messages	3.71	0.73
28. The level of conflict between staff/faculty at my organization is low.	3.57	1.09

Note. N = 14. Ratings based on a five-point metric: 1 = *strongly disagree* to 5 = *strongly agree.*

Table 9 displays the ratings for the ten pretest personal stress items, sorted by the highest mean ratings. These ratings were given using a 5-point metric ranging from 1 = strongly disagree to 5 = strongly agree. The highest level of agreement was for Item 33, "I derive strength from my personal values and or spiritual, religious practices and beliefs" (*M* = 4.79). The lowest level of agreement was for Item 31, "My level of physical pain/disability is tolerable (*M* = 3.36) (see Table 9).

Table 9

Ratings of Pretest Personal Stress Items Sorted by Highest Mean

Item	*M*	*SD*
33. I derive strength from my personal values and or spiritual, religious practices and beliefs	4.79	0.43
29. There are different ways that I can get away from stress and relax (e.g., TV and videos, meditating, reading, social media, watching sports)	4.57	0.51
35. I have one or more supportive communities where I feel connected	4.21	0.97
37. I have time for reflective activities (alone: e.g., journaling-expressive writing- solitude or with others: talking through one's concerns with others)	4.14	0.77
38. When I feel the need, I am able to get help for myself	4.14	0.66
34. I am not facing major betrayal in my personal life	4.07	1.27
32. My family relations are satisfying	4.07	1.21
36. I am able to cope with significant losses in my life	4.00	0.96
30. My personal life does not have an excessive number of one-way caring relationships where I am the caring one	3.93	1.14
31. My level of physical pain/disability is tolerable	3.36	1.28

Note. N = 14. Ratings based on a five-point metric: 1 = *strongly disagree* to 5 = *strongly agree.*

Answering the Research Questions

Three research questions guided this study: (1) Did the BPD Community Chaplains receive adequate training and preparation to protect themselves against compassion fatigue, secondary traumatic stress, and vicarious traumatization while serving those who directly experience traumatic events and crises? (2) How can Baltimore Police Community Chaplains combat compassion fatigue while providing effective quality care? (3) Will a two-day workshop focusing on compassion fatigue, secondary traumatic stress, and vicarious traumatization have a significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains? To answer these questions, Table 10 displays the Wilcoxon matched pairs of tests comparing pretest and posttest scores for the three PROQOL scores and the four Skovholt

Inventory scores. Inspection of the table found no significant differences or changes from pretest to posttest for any of the seven measures (see Table 10).

Table 10

Wilcoxon Matched Pairs Tests for Scale Scores

Scale	Time	*M*	*SD*	*z*	*p*
Compassion Satisfaction				0.06	.95
	Pretest	43.21	5.01		
	Posttest	42.71	5.53		
Burnout				0.11	.92
	Pretest	19.21	6.24		
	Posttest	19.21	5.85		
Secondary Traumatic Stress				0.09	.93
	Pretest	23.36	4.99		
	Posttest	22.57	4.55		
Professional Vitality				0.28	.78
	Pretest	4.17	0.52		
	Posttest	4.16	0.53		
Personal Vitality				0.46	.65
	Pretest	3.91	0.67		
	Posttest	3.79	0.67		
Professional Stress				0.67	.51
	Pretest	4.04	0.40		
	Posttest	3.96	0.38		
Personal Stress				0.39	.70
	Pretest	4.13	0.43		
	Posttest	4.05	0.56		
Total Score				0.60	.55
	Pretest	4.05	0.43		
	Posttest	3.98	0.44		

Note. $N = 14$.

Summary

In summary, this Doctor of Ministry action research project investigated the knowledge and level of training of the BPD Community Chaplains concerning the concept of Compassion Fatigue. The researcher believed the BPD Community Chaplains may be at risk for moderate to high levels of Compassion Fatigue due to the extremely high crime and high violence reported in the city of Baltimore as they serve with the BPD Officers. The researcher believed that if the BPD Community Chaplains were continually trained concerning compassion fatigue, secondary traumatic stress, and self-care, they would be better positioned to not only care for themselves, they would be better equipped to provide effective quality care to their BPD Officers and the citizens of Baltimore.

The intervention developed by the researcher to test her theory was a two-day workshop entitled, "Compassion Fatigue, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Satisfaction: What BPD Community Chaplains Need to Know." Pretest surveys were anonymously administered to the study participants. The intervention was then applied. Posttest surveys were then anonymously administered following the intervention. The researcher gathered and analyzed data from recorded group notes, testimonials, shared stories, and pretests-posttests survey data for 14 BPD Community Chaplains. The results of the project demonstrated no significant difference gained due to the applied intervention. None of the seven measures related to compassion fatigue showed significant pretest to posttest differences (see Table 10).

The researcher believed the intervention, a two-day workshop focusing on compassion fatigue, secondary traumatic stress, and vicarious traumatization, would make a significant difference in the level of knowledge concerning compassion fatigue, secondary traumatic stress, trauma informed-care, and self-care. It was believed the intervention would further educate the

BPD Community Chaplains as first responders who provide effective quality care to the traumatized, they serve.

The project did not yield the results the researcher anticipated. The data collected from the project demonstrated the majority of the BPD Community Chaplains possess moderate to high levels of Compassion Satisfaction with a few BPD Community Chaplains demonstrating low to moderate levels of burnout and secondary traumatic stress. The divergence of the results may be due in part to the poor design of the intervention and implementation. The intervention, a two-day workshop, was not a workshop that took place over a full two days, 16 hours. The workshop was held on two days. Each day consisting of an hour and half of instruction, yielding three hours of engagement with the material. The minimal time allotted for the engagement of the material may be the reason why the research failed to yield the results the researcher anticipated. Another potential reason for the divergence of the anticipated results may be due to the project being held virtually, utilizing the Zoom Video platform due to the COVID-19 pandemic. The project was initially designed to be a face-to-face research project where physical interaction and in-person engagement with the material would be possible.

In the final chapter, these findings will be compared to the precedent review of the literature. Conclusions and implications will be drawn, and a series of recommendations will be suggested.

CHAPTER 5: CONCLUSION

Brief Overview and Purpose of the Study

In this concluding chapter, the researcher will offer a brief review of the purpose of the Doctor of Ministry action research project. The results of the action research project will be compared with the precedent review of the literature. Conclusions and implications will be shared, while also offering a series of recommendations for further consideration and study.

The Baltimore Police Department (BPD) Community Chaplains have served in the agency since the 1970s, according to Melvin Russell who served and retired as Lieutenant Colonel of the Baltimore Police Community Collaboration Division.[373] Russell explained that BPD Community Chaplains served and participated in more ceremonial capacities in the 1970s, such as police officer graduations, banquet dinners, award ceremonies, and funerals.[374] Presently, there is a need for the BPD Community Chaplains to take a more active role in the police department. Relations and communication between the BPD and the citizens of Baltimore have deteriorated after traumatic events, such as the death of Freddie Gray and the exposed corruption of the defunct Baltimore City Police Gun Trace Task Force Unit.[375]

The BPD Community Chaplains who actively volunteer are now more involved in the BPD operations, such as ride-a-longs, post shootings presence for victims, vehicular accidents, responding to domestic violence calls, death notifications, and other traumatic events or crises

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[373] Jesse Coburn, "Baltimore Police Build Chaplain Corps to Help Heal Relations with Community," *The Baltimore Sun*, July 3, 2016, https://www.baltimoresun.com/maryland/baltimore-city/bs-md-ci-police-chaplains-20160703-story.html.

[374] Ibid.

[375] U.S. Department of Justice Civil Rights Division, "Investigation of the Baltimore City Police Department."

which affect the BPD officers and community. The BPD Community Chaplains perform under the instruction and guidance of the supervising BPD Officer, with whom the community chaplain serves during his or her tour of duty. The BPD Community Chaplains also provide care and welfare for the BPD officers and their families. While serving with their BPD officers, the BPD Community Chaplains are also exposed to trauma, albeit secondarily, due to the stories and reports they hear as they serve, care, and provide for their officers and the community.

Purpose of the Study

The purpose of the Doctor of Ministry action research project was to educate Baltimore Police Community Chaplains concerning compassion fatigue while maintaining effective quality care. As the relationship between BPD officers and the communities of Baltimore City deteriorated, BPD Community Chaplains underwent additional training and took on new roles and responsibilities. The first class of the revamped Baltimore Police Chaplaincy Academy graduated in 2015. These BPD Community Chaplains received specialized training in crisis intervention, post shooting trauma, family and grief trauma support, clergy and police confidentiality, ride-a-long protocols, critical incident management, mental health care issues, and community policing.[376] The researcher was concerned and questioned whether the BPD Community Chaplains possessed sufficient knowledge about compassion fatigue and self-care to attend to their duties and responsibilities as BPD Community Chaplains while caring for themselves, and maintaining effective quality care as they serve.

[376] *The Baltimore City Chaplain Program* (Baltimore, MD: Baltimore City Police Department, 2015), 8.

Correlation of Results to the Precedent Review of Literature

The following research questions were addressed in this Doctor of Ministry research project: 1). Did the BPD Community Chaplains receive adequate training and preparation to protect themselves against compassion fatigue, secondary traumatic stress, and vicarious traumatization, while serving those who directly experience traumatic events and crises? 2). How can Baltimore Police Community Chaplains combat compassion fatigue while providing effective quality care? 3). Will a two-day workshop focusing on the topics of compassion fatigue, secondary traumatic stress, and vicarious traumatization have a significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains?

Research Question # 1

Concerning the first research question: Did the BPD Community Chaplains receive adequate training and preparation to protect themselves against compassion fatigue, secondary traumatic stress, and vicarious traumatization while serving those who directly experience traumatic events and crises? The pretest/posttest results of the study demonstrate the BPD Community Chaplains received adequate training and preparation to protect themselves against compassion fatigue, secondary traumatic stress, and vicarious traumatization while serving those who directly experience traumatic events and crises. The results of the project suggest the BPD Community Chaplains have benefitted from the trauma-informed care training and preparation they received while candidates in the BPD Chaplaincy Academy. The BPD Chaplaincy Academy curriculum provided instruction regarding trauma-informed care, however several of the participants, 11 out of 14 (78%), agreed the curriculum could have provided in-depth instruction regarding trauma-informed care and self-care. Participants also agreed continuing

education regarding trauma-informed care and self-care may be helpful in keeping up-to-date with current trends.

These findings are consistent with the research in the precedent review of literature. Figley made the assertion there is little in the way of research regarding the implications for a trauma worker's education in research.[377] He argues, "We must do all that we can to insure [sic] that trauma workers are prepared."[378] Figley believes that appropriate education prior to being placed in the fields of service is critical. He argues that all health care, mental health, medical, first responder, and spiritual care curricula should include the topics of trauma-informed care, compassion fatigue, secondary traumatic stress, and vicarious traumatization in trauma worker education.[379] He believes educators and employers must do a better job caring for and preparing those who care for the traumatized. He comments, "It is important to know how these supporters become upset or traumatized as a result of their exposure to victims. By understanding this process, we not only can prevent additional, subsequent traumatic stress among supporters, but we can also increase the quality of care for victims by helping their supporters."[380] Yoder concurs, adding, all who care for the traumatized should be trauma-informed and should have knowledge of what trauma is and how it will affect them holistically.[381]

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[377] Charles R. Figley, "Introduction," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, ed. Charles R. Figley (New York, NY: Routledge, 1995), 16.

[378] Ibid., 17.

[379] Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* 16-17.

[380] Ibid., 7.

[381] Carolyn E. Yoder, *The Little Book of Trauma Healing: When Violence Strikes and Community Security is Threatened* (New York, NY: Good Books, 2020), 2-3.

Research Question # 2

Concerning the second research question: How can Baltimore Police Community Chaplains combat compassion fatigue while providing effective quality care? The data indicate and align with the precedent review of literature, which demonstrates providing information concerning compassionate self-care increases the benefit of providing effective quality care.

Self-care is the intentional practice of caring for oneself and being mindful of how one feels in mind, body, and spirit. Caring for self enables the caregiver to continue providing care for others. Self-care is analogous to the instructions given during pre-flight take-off, "Should there be turbulence anytime during the flight, oxygen masks will fall from the ceiling. Place your mask securely over your nose and mouth first before assisting small children or others in need in the vicinity." Nance points out many people have the misconception that self-care is selfish behavior. She explains self-care is a necessity, and should be a priority for all caregivers working with traumatized individuals or individuals who suffer from emotional issues.[382] Self-care requires getting adequate rest, eating well, exercising, and making time for self and loved ones. Paget and McCormack agree, chaplains must incorporate, practice, and maintain good lifelong self-care habits, including eating a healthy and balanced diet, exercise, restorative sleep, and engagement in spiritual practices.[383] Langberg adds to the conversation the importance of self-care, stating that one should eat well, get regular exercise, get adequate sleep, make and keep regularly scheduled medical check-ups, and make time for recreation and relaxation. She further emphasizes the caregiver cannot care more about their clients than themselves; doing so may

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[382] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts*. (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[383] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain.* (Valley Forge, PA: Judson Press, 2006), 113.

lead to compassion fatigue.[384] Miller concurs, "You have to make it about you and not about your clients; taking time for self is not selfish, it is a necessity for those who care for traumatized people."[385]

The data also indicate and align with the precedent review of literature, which shows that providing information concerning trauma-informed care increases the benefit of effective quality care of community chaplains. Trauma-informed care, as explained by Butler et al. is having the knowledge and understanding of how violence, abuse, pain, suffering, loss, grief, tragedy, or trauma can affect the lives of those who have experienced the aforementioned events.[386] The authors further explain to be trauma-informed is to possess a basic understanding of trauma and violence. To be trauma-informed is to understand and appreciate how trauma and violence can adversely affect one's life.[387] Possessing an understanding and appreciation of trauma-informed care gives the helper or caregiver a better appreciation of the possible needs of the individual being cared for or treated. This means providing the services necessary to serve and treat the traumatized individuals while empowering and encouraging the traumatized individuals to take an active role in their treatment or recovery efforts.[388] The data from this action research project demonstrate and support the position of the precedent review of literature. Educational

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[384] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 324.

[385] Carrie Miller, LCSW – C, Personal Interview, December 16, 2020.

[386] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

[387] Ibid.

[388] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

institutions, law enforcement agencies, and law enforcement chaplains should be trauma-informed and practice self-care to reduce the risk of compassion fatigue, secondary traumatic stress, and vicarious traumatization. When law enforcement chaplains care for themselves, they are better equipped to continue to provide effective quality care for the officers and people in the community to whom they serve.

Research Question # 3

The third research question is similar to the two previous research questions: Will a two-day workshop focusing on the topics of compassion fatigue, secondary traumatic stress, and vicarious traumatization have a significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains? The results from the pretest and posttest scores demonstrated a two-day workshop focusing on the topics of compassion fatigue, secondary traumatic stress, and vicarious traumatization had minimal significant impact on the effectiveness and quality of care provided by the BPD Community Chaplains. In an interview, one of the participants made the following recorded statement:

> There was not a great deal of new information I learned due to your compassion fatigue study. After the [Chaplaincy] academy, I attended workshops and seminars about secondary traumatic stress for my own benefit after taking part in the trauma-informed care class at the academy. But what I did learn was the importance of self-care, which I took for granted. The workshops I have attended in the past talk about caring for the traumatized. Not many talk about self-care of the first responder chaplain or caregiver. I struggle a lot with saying 'No.' I have a hard time saying 'No' when people ask me for help. But I now know the importance of self-care, setting and keeping boundaries and saying 'No.' I used to put myself and my needs on the back burner. I used to have the mind that I would get to my needs later…well, later would never come. I felt tired, and lacked energy, and somehow, I kept going. I would do what it took to get the job done. Now I wonder, how would I have been if I had taken the time to contend with my needs first? I probably would have given more, because I would have had more to give.[389]

[389] Recording and group notes of study participant, BPD Community Chaplain, July 26, 2021.

The researcher hypothesized the BPD Community Chaplains would experience some form of compassion fatigue, secondary traumatic stress, or vicarious traumatization due to the high crime rates, high murder rates, and high rate of violence experienced by the BPD officers and citizens of the communities in Baltimore City. The Trauma Transmission Theory, as described in the precedent review of literature, is a phenomenon of the transmission of trauma from the victim to the first responder or caregiver due to the degree of empathy the first responder or caregiver possesses. The Trauma Transmission Theory was developed by Charles Figley, which expresses and explains the cost of caring when sharing or participating in the emotional, physical, or psychological pain or trauma of others.[390] The Trauma Transmission Theory suggests caregivers, in an effort to understand their traumatized clients, may become triggered by their clients' trauma and/or become triggered by their own past trauma histories or events.[391] The theory further suggests caregivers or helpers of the traumatized may experience burnout or secondary traumatic stress due to their empathy, care, and compassion due to the exposure and connection with their traumatized clients.[392] The quality of empathy that makes a helper or care giver excel at what they do, is the risk factor that predisposes them to compassion fatigue, also known as secondary traumatic stress, or vicarious traumatization. One's level of compassion fatigue is proportionate to the level of one's empathic ability.[393] The empathetic ability of a caregiver or helper can be conjoined to one's susceptibility to an emotional

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[390] Charles R. Figley, "Introduction," in *Treating Compassion Fatigue*, ed. Charles L. Figley (New York, NY: Routledge, 2002), 2.

[391] Charles R. Figley, "Epilogue: The Transmission of Trauma," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* ed. Charles R. Figley (New York, NY: Routledge, 1995), 249.

[392] Ibid., 252.

[393]Charles R. Figley, "Epilogue: The Transmission of Trauma," 249.

contagion.[394] An emotional contagion is defined as the affective process whereby the caregiver or helper may begin to assume, experience, or feel the emotional responses of the traumatized person whom he or she is caring for or providing treatment.[395]

This project found that a two-day intervention in the form of a workshop entitled, "Compassion Fatigue, Secondary Traumatic Stress, Vicarious Traumatization, and Compassion Satisfaction: What BPD Community Chaplains Need to Know," did not demonstrate a significant increase in knowledge concerning compassion fatigue, secondary traumatic stress, or vicarious traumatization, thereby increasing the effectiveness and quality of care being provided to the BPD Officers and community. The results of the project demonstrated no significant increases between the pretest and posttest scores in the seven subscales of the two instruments used in the research, the Professional Quality of Life Scale – Version 5 (PROQOL) and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory (see Table 10).

There were evidentiary findings in the precedent review of literature that demonstrated not all law enforcement chaplains suffer from compassion fatigue, secondary traumatic stress, or vicarious victimization, as they serve and care for traumatized individuals. The review of literature demonstrates there are law enforcement chaplains who enjoy their service, resulting in compassion satisfaction. Compassion Satisfaction (CS) is the opposite of compassion fatigue. Gilbert-Eliot states compassion satisfaction is the joy and reward one experiences due to working with and aiding traumatized victims.[396] She further states, compassion satisfaction focuses on the

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[394] Charles R. Figley, "Epilogue: The Transmission of Trauma," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* ed. Charles R. Figley (New York, NY: Routledge, 1995), 249.

[395] Charles R. Figley, "Introduction," 2.

[396] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue,* 38.

positive aspects of caring for traumatized people as they grow, heal, and get stronger, consequently aiding in the caregiver's growth, healing, increased and improved ability to journey with the traumatized individual.[397]

Results and Theological Foundations

The results of the Doctor of Ministry action research project demonstrated the BPD Community Chaplains actually possess moderate to high levels of compassion satisfaction (see Table 10). These findings did not support the hypothesis of the researcher. The researcher believed the BPD Community Chaplains would possess moderate to high levels of compassion fatigue due to the extreme levels of high crime, violence, murders, trauma calls, and crises they respond to with their BPD Officers.

Compassion satisfaction is defined as possessing the joy and reward one experiences due to working with and aiding traumatized victims.[398] The BPD Community Chaplains were found to have low to moderate levels of secondary traumatic stress and burnout (see Table 2). None of the seven subscales related to compassion fatigue (from the PROQOL and the Skovholt Instruments) demonstrated significant pretest to posttest differences (see Table 10).

There are few models in Chaplaincy that specifically incorporate self-care concepts into educational programs and curricula. However, the results of the study were consistent with the findings of the precedent review of the literature. Parker reports in "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," the care of chaplains would be maximized if programs and curricula such as Clinical Pastoral Education

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[397] Trudy Gilbert-Eliot, *Healing Secondary Trauma: Proven Strategies for Caregivers and Professionals to Manage Stress, Anxiety, and Compassion Fatigue,* 38.

[398] Ibid.

(CPE), would intentionally incorporate overall self-care and compassionate self-care into their programs for students of Chaplaincy.[399] Nance, Paget and McCormack, Langberg, and Miller agree, asserting that professional helping curricula in colleges and universities, religious and spiritual educational curricula, CPE programs, and supervisors of new therapists, and other helping professionals should ensure self-care components in the curricula and educational planning and programming.[400, 401, 402, 403]

Jesus was the epitome of a chaplain. He had compassion and empathy for those who He cared for outside the synagogue.[404] Jesus was also aware of when He and His disciples required rest after caring for the needy, the grief stricken, and the oppressed. In the Gospel of Matthew 14:13, Jesus learned of the beheading of John the Baptist. The scripture explains Jesus went away privately by boat to spend time in solitude.[405] After learning of the death of His cousin, Jesus sought time alone to grieve. Jesus sought solitude to care for Himself.

In Mark 6:30-32, Jesus recognized His disciples needed a break. He recognized while caring for the crowds, His disciples had not taken the time to eat. He recognized the disciples needed to take some time to care for themselves. Jesus said to His disciples, "Come with me by

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[399] C. James Parker, "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," *Journal of Health Care Chaplaincy* no vol., n.n. (February 2020): 12, https://doi.org/10.1080/08854726.2020.1723187.

[400] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts*. (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[401] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain.* (Valley Forge, PA: Judson Press, 2006), 113.

[402] Diane Langberg, *Suffering and the Heart of God: How Trauma Destroys and Christ Restores* (Greensboro, NC: New Growth Press, 2015), 324.

[403] Carrie Miller, LCSW – C, Personal Interview, December 16, 2020.

[404] Richard E. Geyer and Patricia M. Geyer, *Chaplains of the Bible: Inspiration for Those Who Help Others in Crisis*, (Greenville, SC: Ambassador International, 2012), 105.

[405] Matthew 14:13.

yourselves to a quiet place and get some rest. So they went away by themselves in a boat to a solitary place."[406] Self-care is important for the caregiver. The caregiver must recognize that self-care is not selfish but a necessity for their survival as caregivers.

Results and Theoretical Foundations

In the article, "Toward a Transformative and Sustainable Practice of Compassion in Workplaces," Lee contends compassion can be costly when a caregiver encounters and engages the suffering of the traumatized.[407] Caring for others during trauma, grief, crises, or tragedy can be damaging to the caregiver over time. Hunsinger points out prolonged exposure to one's pain, suffering, and trauma can predispose the chaplain to compassion fatigue or secondary traumatic stress.[408] However, the precedent review of literature demonstrates there are chaplains who serve as first responders, and they do not suffer from compassion fatigue. These individuals serve with joy and enthusiasm, while empathic, and they experience compassion satisfaction. The precedent review of the literature demonstrates those who experience compassion satisfaction are trauma informed, they practice some form of self-care, and they are empathetic.

Trauma-Informed Care considers the physical, emotional, spiritual, and psychological influences trauma may have on individuals who have experienced traumatic events or crises.[409] Hales et al. note "Trauma-Informed Care (TIC), is an organizational model that presumes that

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[406] Mark 6:30-32.

[407] Min-Dong Paul Lee, "Toward A Transformative and Sustainable Practice of Compassion in Workplaces," 26.

[408] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 71.

[409] "Using a Trauma Informed Approach," Office of Victims of Crime: Training and Technical Assistance Center, accessed July 14, 2021, https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/41-using-a-trauma-informed-approach/.

everyone (from staff to clients) have experienced trauma."[410] Trauma-Informed Care, as explained by Butler et al. is having the knowledge and understanding of how violence, abuse, pain, suffering, loss, grief, tragedy, or trauma can affect the lives of those who have experienced the aforementioned events.[411] The authors further explain to be trauma-informed is to possess a basic understanding of trauma and violence. Being trauma-informed is having an understanding and appreciation of how trauma and violence can adversely affect one's life.[412] Possessing an understanding and appreciation of trauma-informed care gives the helper or caregiver a better appreciation of the possible needs of the individual being cared for or treated. This means providing the services necessary to serve and treat the traumatized individuals, while empowering and encouraging the traumatized individuals to take an active role in their treatment or recovery efforts.[413]

The 2014 revamped program of the BPD Chaplaincy Academy did provide some degree of education and training concerning trauma-informed care. The researcher found the following theme during the analysis of the collected data: Although basically equipped to serve, participants recognized that more continuing education is necessary. The analysis of the data

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[410] Travis Hales, Nancy Kusmaul, and Thomas Nochajski, "Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice*," Human Service Organizations: Management, Leadership, & Governance* 41, no. 3 (2017): 317, http://dx.doi.org/10.1080/23303131.2016.1268988.

[411] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

[412] Ibid.

[413] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 178, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf.

demonstrated that participants wanted more training to remain current in trends concerning trauma-informed care and grief response of victims of trauma.

Self-care is important for caregivers. The results of the project showed that most of the BPD Community Chaplains were aware and practiced some degree of self-care. The research project showed that BPD Community Chaplains had high to moderate levels of compassion satisfaction, not compassion fatigue (see Table 10). The data demonstrated that BPD Community Chaplains received adequate training regarding compassion fatigue, secondary traumatic stress, and vicarious traumatization. The researcher and outside observer analyzed and compared the data from surveys, group notes, field notes, recorded testimonials and shared stories. The data demonstrated most BPD Community Chaplains practiced adequate self-care. The collected data demonstrated self-care was practiced in the following manner: making time for self, taking time away from serving as a BPD Community Chaplain, exercising, attempting to eat well, getting adequate rest and sleep. There were silences noted by the researcher and outside observer concerning self-care. The data reflected silences concerning some components of self-care. Topics such as setting and adhering to boundaries, being able to say no, and seeking support from a professional, such as a therapist or spiritual director, were all lacking in the observations and collected data.

There are several programs to train chaplains to care for others, being sensitive to the physical, emotional, psychological, and spiritual needs of all traumatized people regardless of race, creed, gender, sexual orientation, or faith. However, there are very few programs or models in the review of literature to demonstrate the intentional inclusion of self-care and compassionate

self-care concepts in the education of student chaplains.[414] Parker, the author of the article "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," states the care of chaplains would be maximized if curricula and programs such as CPE would intentionally incorporate self-care and compassionate self-care into their programs for students of chaplaincy.[415]

Figley and others argue caregivers who perform well in their vocations usually possess a high degree of empathy.[416, 417, 418, 419] However, it was found in the precedent review of literature the possession of empathy could also prove to be the risk factor, which may predispose well intentioned caregivers to high levels of compassion fatigue, secondary traumatic stress, and burnout.[420, 421]

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[414] C. James Parker, "Self-Compassion and Healthcare Chaplaincy: A Need for Integration into Clinical Pastoral Education," *Journal of Health Care Chaplaincy* no vol., n.n. (February 2020): 12, https://doi.org/10.1080/08854726.2020.1723187.

[415] Ibid.

[416] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts.* (Atlanta, GA: Expected End Entertainment, 2018), 3.

[417] Theresa Reed, *It's Not Drama, It's Vicarious Trauma: Recognizing and Reducing Secondary Traumatic Stress* (Pasadena, CA: Turtlesea Group LLC, 2020), 25-26.

[418] Beverly D. Kyer, *Surviving Compassion Fatigue: Help for Those Who Help Others* (Cheyenne, WY: URLink Print and Media, 2020), 31

[419] Charles R. Figley, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* ed. Charles R. Figley (New York, NY: Routledge, 1995), 15.

[420] Charles R. Figley, "Epilogue: The Transmission of Trauma," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized,* ed. Charles R. Figley (New York, NY: Routledge, 1995), 249.

[421] Charles R. Figley, "Introduction," in *Treating Compassion Fatigue*, ed. Charles L. Figley (New York, NY: Routledge, 2002), 2.

Implications

What the Researcher Learned

Due to this Doctor of Ministry action research project, the researcher learned that most of the BPD Community Chaplains do not suffer from compassion fatigue. According to the data, the researcher learned the current curriculum in the BPD Chaplaincy Academy appears to provide satisfactory knowledge regarding compassion fatigue, secondary traumatic stress, and vicarious traumatization. The researcher also gleaned from the collected data that participants in the project were trauma-informed and educated outside of the Baltimore Police Chaplaincy Academy at their own expense for their own edification and interests.

The researcher further learned although the intervention of the two-day workshop provided some new content and information to the participants, the data showed that the two-day workshop did not make a significant difference in the acquisition of new knowledge of compassion fatigue, secondary traumatic stress, or vicarious traumatization, as indicated by the pretest and posttest scores on the survey instruments (see Table 10).

The researcher learned that most of the BPD Community Chaplains understood compassion fatigue, self-care, and their importance to the work of an effective chaplain. The researcher also learned a few of the BPD Community Chaplains were lacking in areas of self-care, particularly in the areas of eating well, exercising, and getting adequate sleep (see Table 7). She also learned some of the BPD Community Chaplains tend to worry and be concerned about areas in their personal lives such finances and relationships (see Table 7). Despite these concerns, the researcher learned from the collected data that participants try not to bring their

personal concerns to the workplace, but sometimes struggle to leave the events of their tours of duty at the precinct.

How Results Might Apply in Other Settings

The focus of this Doctor of Ministry action research project was conducted with the Baltimore Police Community Chaplains as first responders who serve with the Baltimore Police Department. The BPD Community Chaplains appeared to be at risk of compassion fatigue due to the nature of their service and interaction with the traumatized police officers and citizens of Baltimore. The researcher believed the BPD Community Chaplains would benefit from this Doctor of Ministry action research project. There are several other first responders in Baltimore who care for the traumatized. They may benefit from this project regarding compassion fatigue, secondary traumatic stress, and vicarious traumatization.

Baltimore is a city plagued with high crime, violence, and murder. The city has a crime rate of 63 per one thousand residents, which means there is potentially a one in 16 chance of becoming a victim of either violent crime or property crime.[422] Other than the BPD Community Chaplains, the Baltimore City Police Department would benefit from this project. This project may enlighten the Baltimore City Police Department regarding the potential risk of compassion fatigue, secondary traumatic stress, and vicarious stress for the officers of the police department due to their response to calls of high violence, crime, trauma, and tragedy they witness on a daily basis. A project such as this may shed light on why some law enforcement agencies have such high suicide rates and issues with alcohol, drugs, and family issues.[423]

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[422] "Baltimore, Maryland Crime Analytics," NeighborhoodScout [sic], accessed January 18, 2021, https://www.neighborhoodscout.com/md/baltimore/crime#description.

[423] Jane Shakespeare-Finch, "First Responders and Trauma," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles R. Figley (Thousand Oaks, CA: SAGE Publications, Inc., 2012), 273.

Several agencies, such as emergency departments of hospitals, fire departments, paramedics and emergency medical technicians, trauma response teams, community disaster response teams, child welfare agencies, and crisis management teams, could benefit from studies regarding compassion fatigue. Figley and others in Traumatology believe it is imperative for first responders and caregivers to be trauma-informed and educated regarding compassion fatigue and secondary traumatic stress. [424, 425] Over time, repeated exposure to secondary trauma could have an adverse reaction on the law enforcement chaplain and other first responders.[426] Educational institutions, law enforcement agencies, and law enforcement chaplains need to be trauma-informed so as not to risk re-traumatizing a victim.[427] It is imperative all first responders and caregivers are aware of, have knowledge of, and are trained in trauma-informed care. Having the knowledge and skill to serve the traumatized enables first responders and caregivers to meet the needs of those who are traumatized while also reducing their risk of compassion fatigue, secondary traumatic stress and vicarious traumatization. The review of literature demonstrates individuals with adequate and proper training reduce their risk of compassion fatigue, particularly if they are individuals who serve the needs of the traumatized over a prolonged period of time.

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[424] Charles R. Figley, "Introduction," in *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, ed. Charles R. Figley (New York, NY: Routledge, 1995), 16-17.

[425] Sharise M. Nance, *Overcoming Compassion Fatigue: When Helping Hurts*. (Atlanta, GA: Expected End Entertainment, 2018), 6-7.

[426] Deborah van Deusen Hunsinger, *Bearing the Unbearable: Trauma, Gospel, and Pastoral Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 71.

[427] Lisa D. Butler, Filomena M. Critelli, and Elaine S. Rinfrette, "Trauma Informed Care and Mental Health," *Directions in Psychiatry* 31, no. 13 (2011): 181-182, https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf

Recommendations and Future Research

The following limitations have been identified in this Doctor of Ministry action research project. First, the action research project was implemented during the Corona Virus Pandemic. The researcher initially planned this research project to be conducted in a face-to-face format. However, due to the COVID-19 pandemic, the Baltimore Police Department implemented restrictions and limited access to civilian volunteers within the district precinct facilities. Consequently, the project was implemented via the Zoom Video platform. For future study, the researcher would recommend the project be held in a face-to-face format to encourage more engagement and participation of the participants. At times, it was difficult to have all participants comply with unmuting their cameras or videos on their devices, thereby showing their faces during the workshop sessions, promoting full engagement and participation.

Not all Baltimore Police Department (BPD) Community Chaplains participated in the research project. Community chaplains from two of the nine Baltimore City Police districts, the Northeast and Northwest districts, participated in the study. Recommendations for future research would seek to include representation from all nine police districts in the city. The researcher recognizes the generalizability of this project was decreased by the limited number of participants in her study (N=14).

Due to the 2020-2021 COVID-19 Pandemic, volunteer opportunities within the police department were reduced for community chaplains. For example, ride-a-longs, which are one of the main duties and responsibilities of the BPD Community Chaplains, were temporarily suspended due to the COVID-19 pandemic and safety constraints. Physical presence of the community chaplains (face-to-face presence) within the police precincts had been reduced and

limited. The limitations of interactions may have had an adverse effect on the responses given on the Professional Quality of Life Scale –Version 5 (PROQOL). The instructions on the instrument ask the participant to answer the questions on the survey with the last 30 days of interaction in mind. The quality and quantity of participant engagement with BPD officers and citizens of the communities of Baltimore may have affected the responses offered by the participants on the PROQOL – 5 instruments. For future research, the researcher recommends the project be repeated during post COVID-19 pandemic restrictions when, BPD Community Chaplains are free to fully resume their duties without restriction.

The intervention designed by the researcher was a two-day workshop developed to identify and address the concept and subject matter of compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction among Baltimore Police Department Community Chaplains. The project did not yield the results the researcher anticipated. The data collected from the project showed that most of the BPD Community Chaplains possess moderate to high levels of Compassion Satisfaction, with a few BPD Community Chaplains demonstrating low to moderate levels of burnout and compassion fatigue (See Table 10). The divergence of the results may be due in part to the poor design of the intervention and implementation. The intervention, a two-day workshop, was not a workshop that took place over a full two days, 16 hours. The workshop was held on two days, each day consisting of an hour and half of instruction, yielding three hours of engagement with the topics. The minimal time allotted for the engagement of the material may be the reason why the research failed to yield the results the researcher anticipated. The limited engagement and activity of the participants with the BPD Officers and communities may also be a reason why the research did not yield the results the researcher anticipated. There was very little reported exposure to violent

crime or trauma due to the limited and restricted activity of the BPD Community Chaplains during the COVID-19 pandemic. This is important because the PROQOL-5 instrument asks the participants to answer the survey with the last 30 days in mind. Future recommendations for research would be to actually have a full two days of engagement with the content material, thereby allowing more interaction and engagement with the content material. Another future recommendation would be to duplicate or replicate the study in post-COVID-19 pandemic era where activities of the BPD Community Chaplains occur with little to no restrictions during one's tour of duty.

Future recommendations for research would be to offer more in-depth training regarding compassion fatigue, trauma-informed care, and self-care to the local chaplains of the Maryland State Troopers, the Baltimore City Fire Department Chaplains, and other first responder chaplains across the state of Maryland. Future recommendations for research would be to offer said training to all law enforcement chaplains nationwide.

Other considerations of future research would be to include the following inquiries in the Participant Demographic Questionnaire: 1). How active are the BPD Community Chaplains within their districts? 2). How often are they responding to traumatic calls or events during the day, week, month? 3). What type of traumas have the community chaplain been exposed to secondarily? 4). Does the BPD Community Chaplain have a history of personal traumatic events?

Conclusion

Baltimore City has a history of high crime, violence, and murder. The city continues to be plagued with high levels of crime, violence, and murders, resulting in trauma. The problem addressed in this Doctor of Ministry action research project was that some Baltimore Police Community Chaplains may be responding to crises while failing to protect themselves against Compassion Fatigue. The purpose of the Doctor of Ministry action research project was to educate Baltimore Police Community Chaplains concerning compassion fatigue while maintaining effective quality care. A two-day workshop was developed as an intervention to address the problem. Pretest and posttest surveys were administered using the Professional Quality of Life Scale, Version 5, and the Skovholt Professional Practitioner Resiliency and Self-Care Inventory. Data in the form of surveys, questionnaires, group notes, field notes, recorded testimonials, and participants' stories were collected and analyzed. Results of the data determined the intervention, a two-day workshop, yielded minimal significant increase in the knowledge of compassion fatigue, thereby increasing the effectiveness and quality provided by the BPD Community Chaplains. The results of the research project demonstrated a divergence from the expectation of the researcher. Instead of demonstrating moderate levels of compassion fatigue, the results of the research demonstrated moderate to high levels of compassion satisfaction for most of the BPD Community Chaplains who participated in the study (see Table 10). For future study, the researcher offers the recommendation of repeating the study in a post COVID-19 pandemic, face-to-face format, with revisions to the design of the intervention such, as increased engagement with the content material, while inviting all BPD Community Chaplains from each of the nine districts throughout the city to participate in the research project.

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APPENDIX A

April 29, 2021

Angela Jones-Ramirez
Charity Williams

Re: IRB Application - IRB-FY20-21-807 Compassion Fatigue: The Effects of Secondary Traumatic Stress and Vicarious Traumatization Among Baltimore Police Department Community Chaplains

Dear Angela Jones-Ramirez and Charity Williams,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study is not considered human subjects research for the following reason: Your project will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at .

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

APPENDIX B

Consent

Title of the Project: Compassion Fatigue: The Effects of Secondary Traumatic Stress and Vicarious Traumatization Among Baltimore Police Department Community Chaplains
Principal Investigator: Angela T. Jones-Ramirez, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 18 years of age, and be an active Baltimore Police Department Community Chaplain who has graduated from the Baltimore City Police Academy from the year of 2015 or later. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to determine the levels, if any, of compassion fatigue, secondary traumatic stress, or vicarious traumatization among Baltimore Police Department Community Chaplains who serve, care, and support traumatized individuals.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Take two (2) anonymous pre-test surveys to access the level of knowledge concerning compassion fatigue, secondary traumatic stress, vicarious stress, burnout, and compassion satisfaction while also assessing the level of compassion fatigue, secondary traumatic stress, and compassion satisfaction, if any are present. This study will not have control groups or experimental groups. There will be four monthly gatherings during the regularly scheduled monthly meeting for the chaplains. Each gathering will be approximately 60 minutes. These sessions will be conducted via the Zoom Video Platform and will be recorded. Pre-tests and post tests will be anonymous. The intervention, a two-day workshop will be facilitated via the Zoom Video Platform and will be recorded solely for data collection purposes and analysis by the researcher.
2. During the second monthly gathering, the volunteers will participate in the first evening of the workshop intervention entitled, “Compassion Fatigue, Secondary Traumatic Stress, and Compassion Satisfaction: What BPD Community Chaplains Need to Know.” The participants will learn about compassion fatigue, secondary traumatic stress, and vicarious stress. This class will be a 60-minute class held via the Zoom video platform.

The class will be recorded solely for data collection purposes and analysis by the researcher.

3. During the third monthly gathering, the volunteers will participate in the second evening of the workshop intervention entitled, "Compassion Fatigue, Secondary Traumatic Stress, and Compassion Satisfaction: What BPD Community Chaplains Need to Know." The participants will learn about burnout, compassion satisfaction, and the importance of self-care techniques and strategies to combat compassion fatigue and secondary traumatic stress. This class will be a 60-minute class held via the Zoom video platform. The class will be recorded solely for data collection purposes and analysis by the researcher.
4. During the fourth monthly gathering, the volunteers will participate in two anonymous post-test surveys. The post-test surveys will be used to determine the level of knowledge concerning compassion fatigue, secondary traumatic stress, burnout, vicarious stress, and compassion satisfaction while also assessing the level of compassion fatigue, secondary traumatic stress, and compassion satisfaction, if any are present. The post-test surveys will also address the knowledge of resiliency and self-care of the Baltimore Police Department Community Chaplains. This class will be a 60-minute class held via the Zoom Video platform. The class will be recorded solely for data collection purposes and analysis by the researcher.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are of an academic nature. The participants may learn what it is to become trauma informed concerning compassion fatigue. The participants may learn how to better care for themselves learning management/prevention techniques and coping skills to combat against compassion fatigue.

Benefits to society include improved quality of care given by trauma informed Baltimore Police Department Community Chaplains when serving, caring for, or supporting traumatized individuals or victims.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

1. The researcher cannot guarantee that participants of the study will not discuss, share, or disclose any information shared during the intervention and focus group discussions.
2. As ordained clergy, the researcher is a mandated reporter. The researcher is required report to the appropriate authorities immediately any knowledge of intent to harm self or others while participating in this study.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- All pretest surveys and posttest surveys will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Focus groups will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings and notes.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

What are the costs to you to be part of the study?

There is no financial cost to participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or the Baltimore Police Department Community Chaplains. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please inform the researcher that you wish to discontinue your participation, and do not submit your study materials. Your responses will not be recorded or included in the study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Angela T. Jones-Ramirez. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at

or by email at . You may also contact the researcher's faculty sponsor, Dr. Charity Williams, at .

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, .

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record and/or video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX C

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you care for people you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a chaplain. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experience these things in the last thirty (30) days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I care for.
_____ 3. I get satisfaction from being able to care for people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I care for.
_____ 7. I find it difficult to separate my personal life from my life as a chaplain.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I care for.
_____ 9. I think that I might have been affected by the traumatic stress of those I care for.
_____ 10. I feel trapped by my job as a chaplain.
_____ 11. Because of my caregiving, I have felt "on edge" about various things.
_____ 12. I like my work as a chaplain.
_____ 13. I feel depressed because of the traumatic experiences of the people I care for.
_____ 14. I feel as though I am experiencing the trauma of someone I have helped.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with caregiving techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a chaplain.
_____ 20. I have happy thoughts and feelings about those I care for and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____ 24. I am proud of what I can do to help.
25. As a result of my caregiving, I have intrusive, frightening thoughts.

_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a chaplain.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason — for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress _____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

WHAT IS MY SCORE AND WHAT DOES IT MEAN

In this section, you will score your test and then you can compare your score to the interpretation below.

To find your score on **each section**, total the questions listed on the left in each section and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale: _____

*1. _____ = _____

*4. _____= _____

8._____

10._____

*15. _____ = _____

*17_____ = _____

19. _____

21._____

26._____

*29. _____ = _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question
1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

APPENDIX D

Skovholt Practitioner Professional Resiliency and Self-Care Inventory

The purpose of the inventory is to provide self-reflection for practitioners and students in the helping, health, and caring professions; broadly defined as relationship-intense professions. In all of these fields, the welfare of the other (client, patient, student, advisee, mentee, member of religious community etc.) is primary. Practitioner here refers to individuals in these professions. All of these professions are distinct with specialized areas of knowledge and techniques. However, they are united by the enormous amount of emotional investment necessary for the professional relationship with the other who is often experiencing a kind of suffering or human need of one kind or another.

Questions are addressed to both active practitioners and also students in training programs across the broad range of the caring / relationship-intense professions. Some of the questions are more relevant to some professionals or students in some training programs than others.

Inventory is also available in in Skovholt, T. M. and Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout and compassion fatigue prevention and self-care strategies for the helping professions. (3rd* ed.) New York: Routledge.

The checklist consists of four sub-scales: Professional Vitality, Personal Vitality, Professional Stress and Personal Stress.

1=Strongly Disagree, **2**=Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree

Professional Vitality Circle your Response

1. I find my work as a practitioner or as a student to be meaningful..... 1 2 3 4 5

2. I view self-care as an ongoing part of my professional work / student life..... 1 2 3 4 5

3. I am interested in making positive attachments with my clients /students/patients…… 1 2 3 4 5

4. I have the energy to make these positive attachments with my clients /students/patients…… 1 2 3 4 5

5. The director / chair at my site / school is dedicated to practitioner welfare……. 1 2 3 4 5

6. On the dimension of control of my work / schooling, I am closer to high control than low control……1 2 3 4 5

7. On the dimension of demands at my work/ schooling, I have
reasonable demands rather than excessive demands from others … …… 1 2 3 4 5

8. My work environment is like a greenhouse--where everything grows--because
the conditions are such that I feel supported in my professional work…… 1 2 3 4 5

Subscale Score for Professional Vitality (Possible score is 8-40) _____

Personal Vitality

9. I have plenty of humor and laughter in my life……1 2 3 4 5

10. I have a strong code of values / ethics that gives me a sense of
direction and integrity……. 1 2 3 4 5

11. I feel loved by intimate others……1 2 3 4 5

12. I have positive /close friendships…….....1 2 3 4 5

13. I am physically active and receive the benefits of exercise ……1 2 3 4 5

14. My financial life (expenses, savings and spending) is in balance……1 2 3 4 5

15. I have a lot of fun in my life……1 2 3 4 5

16. I have one or more abundant sources of high energy for my life.
(e.g., friends and family, pleasurable hobby, enjoyable pet, the natural
world, a favorite activity) ……. 1 2 3 4 5

17. To balance the ambiguity of work in the caring professions, I have some concrete
activities that I enjoy where results are clear cut (e.g. a collection such as
coins / rocks / dolls, gardening, a fantasy sports team, weaving, remodeling
and painting, fixing up a car) ……..... 1 2 3 4 5

18. My eating habits are good for my body...……1 2 3 4 5

19. My sleep pattern is restorative……1 2 3 4 5

Subscale Score for Personal Vitality (Possible score is 11-55) _____

Professional Stress

20. There are many contradictory messages about both practicing self-care and meeting expectations of being a highly competent practitioner / student. I am working to find a way through these contradictory messages. ..……. 1 2 3 4 5

21. Overall, I have been able to find a satisfactory level of "boundaried [sic] generosity" (defined as having both limits and giving of oneself) in my work with clients / students / patients …… 1 2 3 4 5

22. Witnessing human suffering is central in the caring professions (e.g., client grief, student failure, patient physical pain.). I am able to be very present to this suffering, but not be overwhelmed by it or experience too much of what is called 'sadness of the soul.' …… .. ……1 2 3 4 5

23. I have found a way to have high standards for my work yet avoid unreachable perfectionism. …… .. 1 2 3 4 5

24. My work is intrinsically pleasurable most of the time…… 1 2 3 4 5

25. Although judging success in the caring professions is often confusing, I have been able to find useful ways to judge my own professional success…… 1 2 3 4 5

26. I have at least one very positive relationship with a clinical supervisor / mentor / teacher. ……... 1 2 3 4 5

27. I am excited to learn new ideas—methods—theories—techniques in my field…… ……1 2 3 4 5

28. The level of conflict between staff / faculty at my organization is low……..…. 1 2 3 4 5

Subscale Score for Professional Stress (Possible score is 9-45) _____

Personal Stress

29. There are different ways that I can get away from stress and relax (e.g., TV and videos, meditating, reading, social media, watching sports) …….1 2 3 4 5

30. My personal life does not have an excessive number of one-way caring relationships where I am the caring one…… 1 2 3 4 5

31. My level of physical pain / disability is tolerable……1 2 3 4 5

32. My family relations are satisfying……1 2 3 4 5

33. I derive strength from my personal values and or spiritual, religious practices and beliefs ……. 1 2 3 4 5

34. I am not facing major betrayal in my personal life……...1 2 3 4 5

35. I have one or more supportive communities where I feel connected……... 1 2 3 4 5

36. I am able to cope with significant losses in my life…….1 2 3 4 5

37. I have time for reflective activities (alone: e.g., journaling-expressive writing-solitude or with others: talking through one's concerns with others) …… 1 2 3 4 5

38. When I feel the need, I am able to get help for myself ……1 2 3 4 5

Subscale Score for Personal Stress (Possible score is 10-50) _____

Total Score for the Four Subscales (Possible score is 38-190) _____

There are a total of 38 questions in the Skovholt Professional Resiliency and Self-Care Inventory. All are scored in a positive direction with 0 low and 5 high. As stated earlier, the scoring system is a method for self-reflection by practitioners and students in the caring professions. There is no total number that is considered best.

HIGH ANSWERS

As a way to consider professional resiliency and self-care in your career work, consider these questions. First, scan the questions and focus on your high answers, those with 4 and 5 responses. What do you conclude? Write here.

_____

_____

_____

_____

LOW ANSWERS

Then focus on your low answers, those with 1 and 2 responses. What do you conclude? Write here.

_____

_____

_____

_____

IN BALANCE? IF NOT, WHAT REMEDIES COULD YOU CONSIDER?
Look across the four categories of Professional Vitality, Personal Vitality, Professional Stress and Personal Stress. Are they in balance? If not in balance, what remedies could you consider? Write here.

_____

_____

_____

_____

Finally, consider the different topics covered in the inventory, your answers and the comments you made for future self-reflection, clinical supervision and discussion with others. Best wishes!

Thomas Skovholt, PhD, LP, ABPP
Professor Emeritus
University of Minnesota
Licensed Psychologist
in Independent Practice
USA

APPENDIX E

Participant Demographic Questionnaire

This is an anonymous participant demographic questionnaire is to be used for the sole purpose of describing the research study participants. The researcher thanks you for your voluntary participation in this Doctor of Ministry Research Action Plan Study.

Please answer the following questions as best you are able.

1. What is your age range?
   a. 18 – 24
   b. 25 – 34
   c. 35 – 44
   d. 45 – 54
   e. 55 – 64
   f. Above 65
2. What gender do you identify as?
   Male
   Female
   Other (Please Specify) _____
3. What is your ethnicity?
   a. Caucasian
   b. African American
   c. Latino or Hispanic
   d. Asian/Pacific Islander
   e. Middle Eastern/Arabic
   f. Native American/ American Indian
   g. African
   h. Two or More Ethnicities
   i. Prefer not to say
   j. Other _____
4. What is your marital status?
   a. Single, never married
   b. Married
   c. Divorced
   d. Separated
   e. Cohabitating/Domestic Partnership
   f. Widow or Widower
   g. Other _____
5. In addition to being a Volunteer BPD Police Chaplain, which of the following best describes your current employment status?
   a. Fulltime

   b. Part – time
   c. Self – employed
   d. Unemployed (looking for work)
   e. Unemployed (not looking for work)
   f. Retired
   g. Student
   h. Disabled
6. What is your religious affiliation?
   a. Christian
   b. Catholic
   c. Islam
   d. Judaism
   e. Buddhism
   f. Hinduism
   g. Prefer not to say
   h. Other _____
7. How many years have you served as a BPD Chaplain? _____
8. What is the highest level of education you possess?
   a. High School
   b. Trade School
   c. Junior College
   d. 4-year college (BS, BA)
   e. Graduate School (MS, MA)
   f. Post Graduate School (PhD, DMIN, EdD)
   g. Prefer not to say
   h. Other _____

APPENDIX F

BALTIMORE POLICE DEPARTMENT

BRANDON M. SCOTT
Mayor

MICHAEL S. HARRISON
Police Commissioner

Angela T. Jones-Ramirez, MS, M-Div.
Doctoral Candidate, Liberty University

Dear Angela,
After careful review of your research proposal entitled Compassion Fatigue: The Effects of Secondary Traumatic Stress and Vicarious Traumatization Among B.P.D. Community Chaplains, I/we have decided to grant you permission to conduct your study with the B.P.D. Community Chaplains.

Check the following boxes, as applicable:
X The requested data WILL BE STRIPPED of all identifying information before it is provided to the researcher.
X I/We are requesting a copy of the results upon study completion and/or publication.

Sincerely,

Neal (Matt) Stevens,
B.P.D. Coordinator of Faith Based and Community
Programs Community and Youth Services Section

APPENDIX G

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Counseling and Student Personnel Psychology Program

Department of Educational Psychology
College of Education and Human Development

[redacted]

To Whom It May Concern
IRB
Liberty University

April 7, 2021

Angela Jones-Ramirez has my approval to use my instrument the *Skovholt Practitioner Professional Resiliency and Self-Care Inventory* in her doctoral action research study.

Sincerely,

[redacted]

Thomas Skovholt, PhD, LP
Professor Emeritus
University of Minnesota
and Licensed Psychology
in Independent Practice

[redacted]

Permission to Use the ProQOL

Thank you for your interest in using the Professional Quality of Life Measure (ProQOL). Please share the following information with us to obtain permission to use the measure:

Please provide your contact information:

Email Address

Name

Angela T. Jones-Ramirez

Organization Name, if applicable

Liberty University

Country

United States

Please tell us briefly about your project:

I am a doctoral candidate at the Liberty University in Lynchburg, VA. I have conducted my doctoral thesis regarding compassion fatigue and Baltimore Police Community Chaplains. I used the PROQOL 5 as one of my research instruments. At the bottom of the page of the instrument, it states the following: "© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test." I have used the ProQOL under the three conditions provided on this form. I am now requesting permission to have the ProQOL 5 published as part of my doctoral action research project upon submission to the Scholar Crossing Digital Commons of Liberty University. Thank you the consideration. Please advise pending your decision of permission to publish the instrument in my doctoral action research project.
Angela T. Jones-Ramirez
Doctoral Candidate
Liberty University

What is the population you will be using the ProQOL with?

The population that will use the ProQOL is male and female Baltimore Police Community Chaplains, all over the age of 50.

In what language/s do you plan to use the ProQOL?

Listed here are the languages in which the ProQOL is currently available (see). If you wish to use a language not listed here, please select "Other" and specify which language/s.

English

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

- **You credit The Center for Victims of Torture and provide a link to**
- **It is not sold; and**
- **No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."**

Note that the following situations are acceptable:

You can reformat the ProQOL, including putting it in a virtual format
You can use the ProQOL as part of work you are paid to do, such as at a training: you just cannot sell the measure itself

Does your use of the ProQOL abide by the three criteria listed above? (If yes, you are free to use the ProQOL immediately upon submitting this form. If not, the ProQOL office will be in contact in order to establish your permission to use the measure.)

Yes

Thank you for your interest in the ProQOL! We hope that you find it useful. You will receive an email from the ProQOL office that records your answers to these questions and provides your permission to use the ProQOL.

We invite any comments from you about the ProQOL and the experience of using it at [ ] Please also contact us if you have any questions about using the ProQOL, even if you noted them on this form. Note that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we greatly appreciate your engagement.