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## Residence Directors as Residential Crisis Workers: Exploring the Role of Campus-Based Critical Incident Stress Management in the Mitigation of Compassion Fatigue

Noga Flory

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Residence Directors as Residential Crisis Workers: Exploring the Role of Campus-Based  
Critical Incident Stress Management in the Mitigation of Compassion Fatigue

A Dissertation Presented

by

NOGA GILLAT FLORY

Submitted to the Graduate School of the  
University of Massachusetts Amherst in partial fulfillment  
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2017

College of Education  
Educational Policy, Research and Administration

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Residence Directors as Residential Crisis Workers: Exploring the Role of Campus-Based  
Critical Incident Stress Management in the Mitigation of Compassion Fatigue

A Dissertation Presented

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NOGA GILLAT FLORY

Approved as to style and content by:

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Sharon Rallis, Chair

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College of Education

## DEDICATION

I dedicate this research to my family, without whose support, love, steadfast belief, and encouragement I would have made little progress over the years. Taking on doctoral-level research is not for the faint of heart, but living with someone who has taken on the feat, is a true indication of their strength of character and bottomless commitment. This was a long journey that was often fed by your sacrifices, and while I will always be grateful, I need you to know you inspired me to work hard and keep writing.

Ernie – you have been my best friend and my Love for over 20 years. Our marriage, the beautiful family we have made, and the life we have built are what sustain me every day, give me balance when everything else seems just off kilter, and enable me to serve others with care and compassion. I have been a student for much of our shared life, which often placed additional pressure and responsibilities on you (including transcription of all of my interview manuscripts – I'd have been lost without your help and expertise, and would likely still be working on coding my data!). Nonetheless, you always encouraged me, listened to my frustrations, made me laugh, helped me regain perspective, and put our family ahead of all else. I love you more than words can express, and am honored to have taken on this journey with you as you are truly my partner in every possible way.

Logan and Tyler - you brighten up my every day with your warmth, wisdom, laughter, and unconditional love. You humble me with your small and big acts of kindness, the clever questions you pose, and the trust and belief you place in me even when I second-guess myself and my judgement. I love you both infinitely, and hope you

will continue to strive for your dreams and aspirations, as I know without a doubt you have it in you to achieve anything you put your mind and heart to. You have my support as you have given me yours, and I am honored to be your mom.

Ima and Aba - you role model the importance of family, whether canceling your personal travel plans so you could be in town to pick up the boys after school, or dropping off meals and groceries to save us time when we are strapped. You have always placed a strong emphasis on education and learning without pressuring me to strive for perfect grades. I watched you both go through this process of research, writing, and publication while balancing family and work (in a foreign country, no less), so you instilled in me great resilience and an appreciation for being a life-long learner. I love you both and strive to make you proud.

Gerry and Toshi – Thank you for sharing your amazing family with me! You are missed every hour of every day, yet you left for us a legacy that is grounded in strong family bonds, multicultural traditions, and an endless love of learning. I love you and will forever be grateful to have known you.

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Julia - you've been my colleague longer than most, and the best supervisor I could ever hope for at this point in my career. Your friendship, encouragement, kindness and faith mean the world to me and enabled me to make this research a priority as you saw the relevance of the topic to the work we do, and advocated alongside me for better, more consistent standards of practice within our field.

To the brilliant Student Affairs professionals interviewed at my case study site - I thank you for your time, wisdom, enthusiasm, and interest in my research. Your willingness to share your expertise with me, balanced with your warmth and care, truly illuminated for me how lucky your institution is to have you guide the educational growth of your students and the professional development of your staff. I am inspired by you all, and am hopeful we can spread the value of CISM to others in our field in an effort to improve our practice and increase our collective resilience.

To all of the phenomenal Resident Assistants with whom I've worked over the past twenty years – you all have taught me the most about how to grow as a Student Affairs Professional. Thank you for trusting me with your confidences, for enabling me to share in your growth and preparation for life after college, and for pushing me to stay engaged in my role. To my outstanding professional colleagues - Grads, RDs and ADs - while we have experienced dramatic changes in our field, I have witnessed our collective efforts to adjust our vision, reframe our practice, and remain invested in our students' growth. It may be hard for us to explain what we do to those outside our field, but we all know the passion we possess, and the investment that oftentimes overwhelms us. Take care of yourselves, as you role model to others the value of balance in life and work.

Beth - had it not been for your casual mention of CISM on a long car ride to a women's ski clinic in Vermont, I might still be exploring which direction to take with my research. You enabled me to envision a solution to a problem that spans both our fields, and reinforced the need for more professionals to take on the important charge of crisis intervention for those who help the traumatized.



## **ABSTRACT**

**RESIDENCE DIRECTORS AS RESIDENTIAL CRISIS WORKERS: EXPLORING  
THE ROLE OF CAMPUS-BASED CRITICAL INCIDENT STRESS MANAGEMENT  
IN THE MITIGATION OF COMPASSION FATIGUE**

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Residence Directors, as a result of repeated exposure to their students' trauma, are prone to developing compassion fatigue. Research on the use of college-based Critical Incident Stress Management (CISM) has been shown to foster collaboration, consultation, and increased stress debriefing among staff who respond to critical incidents on campus. CISM can teach Residence Directors means of recognizing work-related triggers, contribute to the normalization of stress reactions, and improve healthy coping and self-care strategies. CISM can also potentially help reduce or diminish the incidence of compassion fatigue and burnout, thereby improving Residence Directors' overall professional and personal quality of life and their resilience within the field of student affairs. Nonetheless, CISM is not widely used among all college and university settings, although it is oftentimes used as a foundation for many campuses' crisis response protocols. My study describes the utility of CISM at an Upstate New York-based college which intentionally opts to include Residence Life Staff in its training and CISM-based

crisis intervention practices. I examine the scope of Residence Life Staff's involvement in Critical Incident Stress Debriefing and gauge the impact of CISM-based strategies on staff's reported levels of secondary stress, burnout, and/or compassion satisfaction.

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**CHAPTER 1**

**INTRODUCTION**

**Statement of Problem**

*Helping professionals who listen to the stories of fear, pain, and suffering of others may feel similar fear, pain, and suffering because they care. Helping professionals in all therapeutic settings are especially vulnerable to 'compassion fatigue' and include emergency workers, counselors, teachers, school administrators, mental health professionals, medical professionals, clergy, advocate volunteers, and human service workers. The concept of compassion fatigue emerged only in the last several years in the professional literature. It represents the cost of caring both about, and for traumatized people. (Thompson, Schools, & Chesapeake, 2003).*

Residence Directors are Student Affairs professionals who are faced with the formidable task of fostering the cognitive, emotional, and social development of students in preparation for their future roles as thoughtful, contributing, and fulfilled citizens in a global society. Though student affairs professionals have long dealt with the social-emotional and developmental needs of their students, the 2010 National Survey of College Counseling Center Directors confirms “an unsettling portrait on an increasingly seriously distressed college student population” (Gallagher, 2010, p. 5). As Residence Directors (RDs) aim to teach their students and Resident Assistants (RAs) self-management and coping techniques for improved emotional and psychological health and functioning, they are often faced with the “cost of caring” that results from helping someone through trauma and emotional pain. The satisfaction RDs derive from helping others, makes the work they do worthwhile. However, feelings of satisfaction are oftentimes accompanied by residual feelings of discomfort and distress over the stories



and experiences RDs absorb from those they help. It is crucial to recognize when this is happening because this “cost of caring,” also known as *Compassion Fatigue*, has a detrimental effect on RDs and the decisions they make as helpers (Figley, 1995).

**Compassion Fatigue** is a general term applied to anyone who suffers as a result of serving in a helping capacity (Rothschild, 2006; Scanlon, 2009 as appearing in Figley, 1995). Carla Johnson (1992) writes, “The symptoms of Compassion Fatigue follow classic stress patterns. You forget or lose things or have a shorter attention span. You’re exhausted and have frequent headaches or stomachaches. Your resistance is low and you get sick more often. You’re depressed. One particular sign to watch out for is anger, especially when it’s too frequent and too intense for the situation” (p. 119). When RDs’ basic needs are no longer met, their judgment and ability to cope are negatively affected, their effectiveness and capacity as helpers is diminished, and they are less likely to seek help or change self-destructive behaviors. Stress Management is a critical self-care strategy for Residence Directors, and ensures they continue to function effectively in their roles.

Ann Marie Klotz (2013), Director of Residence Life at Oregon State University recently wrote in her blog:

Our field is in trouble. In order for our field to continue to recruit and retain the healthiest, happiest, best role models for our students and staff we must make wellness a top priority. Student Affairs reflects the same struggles with obesity, stress and illness that is a problem across America. There are a lot of reasons why we don’t talk about personal wellness. We don’t want to hurt peoples’ feelings. We don’t want to make assumptions about their medical conditions, physical limitations or personal struggles. I empathize with those concerns. Life can be hard and we must be kind to each other. However, our field promotes a culture of gluttony, glorification of busyness, sleep deprivation and martyrdom. We are not brain surgeons, folks. We work in higher education. There has to be a way to get the work done in a reasonable number of hours AND make your own wellness a top priority. (Klotz, 2013).

A potential solution is Critical Incident Stress Management (CISM), a research-based, comprehensive, and flexible model of crisis intervention (Ginebaugh, Klingensmith, and Palombi, 2009). While it was originally developed for use among the first responder population to help mitigate exposure to stressful trauma situations, the model's systematic and multi-tactic approach for early intervention has expanded its utility to academic settings. "Critical Incident Stress Management has been used successfully in schools (Levenson, Memoli, & Flannery, 2000) and by colleges (Bennett, 2004) and universities (Paterson, 2006) who seek to coordinate and implement a response to crisis situations that succeeds in being both research-based and practically oriented (Everly, 2002)" (Ginebaugh, Klingensmith, and Palombi, 2009, p. 106). As such, including Residence Directors in college-based Critical Incident Stress Management (CISM) teams can be shown to foster consistent consultation, collaboration, and stress debriefing among staff who respond to critical incidents on campus. CISM can teach Residence Directors means of recognizing work-related triggers and serve to normalize coping and self-care strategies. It can potentially help reduce or diminish the incidence of compassion fatigue and burnout, thereby improving Residence Directors' overall professional and personal quality of life.

### **Conceptual Framework**

Literature has emerged on the concept of Compassion Fatigue as it applies to emergency workers, nurses, mental health counselors, drug and alcohol interventionists and other helping professions. Concurrently, national leaders in student affairs and higher education have brought increased attention to the field as their colleagues in the profession have suffered serious or terminal consequences resulting from work-related

stress. A review of Maslow's (1954) Hierarchy of Needs identifies the importance of satisfying lower-order needs (biological and safety) before higher-order needs (social and esteem) in order for people to achieve their full potential. As a theorist whose work stems from developmental psychology, Maslow frames the process people experience as they move through crisis toward a sense of balance so as to attain proficiency and solidify core values. Aligned with Maslow's Hierarchy of Needs, Yassen (1995) advises regulation of fundamental functions such as sleep, food, exercise, rest, and recreation; time spent outdoors interfacing with nature; maintaining structures of work; and limiting exposure to traumatic events. The advantages of proper training, including helpers' ability to read and care for their own stress responses are also emphasized in the literature (Figley, 2002). Bloom's (1999) Trauma Theory helps to conceptualize the role trauma plays in the disruption of people's ability to self-regulate low and high-ordered needs and persist in the face of chronic stress. Running parallel to the variety of helper symptoms, are a wide variety of treatments that have been advocated for helpers to provide resistance against helper stress and trauma (Figley, 2002, p. 18).

The growing literature on the organizational components of compassion fatigue and vicarious trauma stresses the need for changes in organizational practices, workload, group support, supervision, self-care, education, and functionality to help prevent manifestations of compassion fatigue in crisis workers (Bell, Kulkarni, & Dalton, 2003). Much of the literature on resilience and compassion satisfaction emphasizes the need and importance of peer, institutional, and personal help and support (Dutton & Rubenstein, 1995). Specifically, Munroe, Shay, Fisher, Makary, Rappaport and Zimmering (1995) suggest a special team that provides outside perspective and mediates helpers' roles in the

community. “Effective response to crisis on campus necessitates that counseling centers shift their focus from individual and small group therapy with struggling individuals to interventions that promote healing and resilience among groups of individuals who may not have normally sought out services. Trauma interventions for individuals, and small and large groups often occur outside the confines of the counseling center office through dissemination of information about stress management and self-care” (Ginebaugh, Klingensmith, & Palombi, 2009). Critical Incident Stress Management (CISM) is a model of crisis intervention which, by design, meets the core standards of major crisis response organizations (National Voluntary Organization Active in Disaster, 2005), and provides unique advantages for use in college and university settings.

### **Significance of the Study**

The purpose of my research is to raise awareness and sensitivity to the dynamic needs of Residence Directors as residential crisis workers, and to develop an understanding of the ways in which including Residence Directors in Critical Incident Stress Management training can serve to minimize manifestations of compassion fatigue in Residential staff. This study explores the ways in which CISM is implemented in college and university settings as means of establishing an inclusive and comprehensive approach to crisis intervention and response. The study also aims to uncover why CISM has been infused into the crisis intervention protocols of some colleges and universities, yet is not universally used despite the research that exists to tout the model’s far-reaching benefits. As Harper and Wilson (2010) state in their book *More Than Listening; A Casebook for Using Counseling Skills in Student Affairs Work*, “the opportunity to support – up close, everyday – human potential is, in large measure, what draws people to

the profession. Yet while it is true that the outcome of this growth and development are rewarding, the process itself can be distressing” (Harper and Wilson, 2010, p. 1). My research explores changes that can be made organizationally to foster a culture of work-life balance, provide Residence Directors with consistent supervisory support and critical incident debriefing, and reinforce their efforts at self-care through inclusion in Critical Incident Stress Management training. A qualitative phenomenological case study design including interviews, observations, and an analysis of public documents was used to explore the inclusion and utility of Residence Directors in CISM teams and CISM training.

### **Research Questions**

I interviewed and observed Residence Life staff and a CISM trainer at an upstate New York college. This school has prioritized CISM training for its Residence Life Staff, and has a full time staff member who serves as both the Director of the Counseling Center and the Director of Professional and Student Development within Residence Life and has been the core CISM trainer for the past 30 years. This school presented as an ideal case study setting, as CISM was embedded and infused into traditional Residence Life training practices. My overarching research question (**RQ1**) were: **How does a model of Critical Incident Stress Management (CISM) best serve Residence Directors at a college or university setting?** The following additional questions guided this study:

**RQ2:** How does a campus ensure best practices in the applications of CISM?

**RQ3:** What *value* do Residence Directors derive from their participation in CISM training?

**RQ4:** What *learnings* do Residence Directors take away from the CISM training that they perceive to manifest in their work?

**RQ5:** How do Residence Directors trained in CISM report that they *utilize* the model's basic principles and practices in their day-to-day work?

**RQ6:** How do Residence Directors perceive that their use of CISM techniques or strategies *affected* them and their abilities to *cope* with compassion fatigue and burnout?

**RQ7:** What resources, training, or supports do Residence Directors identify as missing, necessary, or most salient to them in their work and personal lives?

### **Overview of Methods**

The purpose of this research was to develop an understanding of the ways in which including Residence Directors (RDs) in college and university-based Critical Incident Stress Management training may serve to minimize manifestations of compassion fatigue in Residence Life Staff and improve campus-wide crisis intervention protocols and practices. A phenomenological descriptive case study included *interviews*, *observations*, and an *analysis of public documents*. One college in upstate New York was identified for its provision of CISM training, as well as its perceived inclusion and utility of Residence Directors on CISM teams. This study explored Residence Directors' actual function within their campuses' crisis intervention protocols and practices and sought to document the Residence Directors' perceptions of CISM and the model's influence on their quality of life and work. **Interviews** served to assess RDs' perceptions of the model's effectiveness in debriefing critical incidents; investigated whether the infusion of CISM into the campus' crisis intervention protocols has been shown to foster consistent collaboration and consultation; and explored whether the model served to teach RDs means of recognizing work-related triggers, and normalizing stress reactions. I conducted **observations** of critical incident stress debriefings, and examined their utility for

Residence Directors in the context of their on-call responsibilities. I also observed CISM refresher trainings so as to determine how a campus could ensure best practices in applications of CISM. Finally, an **analysis of documents** was to include a review of CISM training materials used; a targeted examination of campus-wide and Residence Life-specific crisis intervention materials/ manuals, specifically those which referred to the use of CISM or identified CISM as the foundation to their crisis intervention protocols; and a review of participants' Pro-QOL questionnaire findings. When appropriate, I also reviewed Residence Director on-call reports (with all identifying student information redacted), so as to examine their utility in triaging follow-up service delivery to students, as well as describe departmental structures and supports in the wake of residentially-based crises. The collection and analysis of data occurred over a 12-week time span, and upon transcription and analysis of the data, I revisited my research site to share my findings and/or gain clarity in areas still indistinct.

### **Overview of Chapters**

While exploring the manifestation of compassion fatigue (CF) within the field of Student Affairs, and examining the ways in which Critical Incident Stress Management can mitigate for CF and burnout, it is critical to understand the theoretical unpinning for trauma response, secondary traumatic stress, and the long term ramifications of neglected self-care. These areas as evidenced in the literature comprise **Chapter Two**. An appraisal of the evolution of CISM as a comprehensive model of crisis intervention, not only within the field of emergency medical response but as it exists and is utilized on college and university campuses, informed the rationale for creating sustainable personal and organizational change. A review of Bloom's Trauma Theory, Caplan's Crisis

[Intervention] Theory, Stamm's Compassion Satisfaction-Compassion Fatigue Model, and Maslow's Hierarchy of Needs, served as epistemological grounding for my conceptual framework. The research design and methods used in my study are elucidated in **Chapter Three** and include: rationale for a qualitative phenomenological case study design, research questions, participants and sampling procedures, instrumentation, data collection and analysis processes, limitation and delimitations of the study, verification of findings, and ethical considerations. **Chapter Four** combines a *review* and *discussion* of my findings and addresses each of the research questions as they manifest in the data collected and are reinforced by literature. In summary, **Chapter Five** strives to encapsulate my study and appraise key findings; discusses a rationale for doctoral studies and their contributions to scholarly research; reviews the study's implications for future practice; and draws final conclusions as to the significance of this topic to the field of student affairs. The **Appendices** provide documentation of the protocols, agreements, and guides utilized throughout the research process to maintain ethical compliance, from informed consent letters to transcription confidentiality contracts. They also include examples of CISM field resources and the Pro-QOL Questionnaire and Self-Score Guide as supplemental archival data. A comprehensive **Bibliography** alphabetically credits all in text references according to American Psychological Association (APA) guidelines.



## CHAPTER 2

### LITERATURE

#### Manifestations of Compassion Fatigue in Student Affairs Work

*It's the first week of classes, and people are falling apart at the seams. Roommate conflicts have manifested as complicated domestic disputes, students are feeling unsafe in their rooms, and the staff is already tapped out before classes are fully underway. One of my RAs was up for 36 hours running interference between residents who have severed their romantic relationship and are demanding answers where none are to be had. Another RA got an alarming text from a friend saying "it's not your fault! I'm sorry", and is grappling with the knowledge that her quick actions saved her friend's life, while struggling to maintain some space so thoughts of her friend's suicide attempt don't consume her every waking hour. A third RA emails me that due to some problems with his finances he's been withdrawn from the university and is "freaking out". A colleague stops by and shares that students have been throwing furniture off their balconies, and relieving themselves in public spaces. After meeting with the RAs, I meet with their students, I check in with the on-call staff who served as first responders, I write up my reports, make calls to campus partners, and ensure all t's are crossed and i's are dotted. My energy is depleted within three days of having students back on campus.*

In order to truly understand the scope of what we're dealing with when we say things like crisis intervention, critical incident, and traumatic stress, it is important to define the terms we use, and to frame them within a specific context. A **crisis** is "an acute emotional reaction to a powerful stimulus or demand" – an acute psychological RESPONSE to a **critical incident** such as an emergency, disaster, traumatic event,

catastrophe, or act of terrorism (Caplan, 1964). It is essentially a state of emotional turmoil that causes a disruption in psychological homeostasis (the balance between thoughts and emotions is interrupted causing increased stress); typical coping mechanisms fail as they are overwhelmed by distress; and there is clear indication of impairment or dysfunction in the individual or group involved in the crisis. Individuals may experience crises directly (**primary victims**), or as witnesses to painful acts that occur to others (**secondary victims**; Everly & Mitchell, 2007; Flannery, 1994). A **critical incident** is a powerful, overwhelming, or traumatic event that lies outside the range of usual human experience and triggers a **crisis response** or **acute stress response** (Antai-Otong, 2001, p. 127). Ordinarily, critical incidents are so emotionally draining that people have a difficult time functioning and often find themselves stuck in distorted thought cycles that manifest as fear, intense anxiety, and depression (Everly & Mitchell, 1999), or may present as self-blame, shame, or denial (Flannery, 2000). These are all **normal reactions** to **abnormal situations**. Consequently, **crisis intervention** is a short term helping process – an acute intervention designed to mitigate the crisis response – that is NOT psychotherapy, but “fosters natural resiliency through stabilization, symptom reduction, return to adaptive functioning, and facilitation of access to continued care” (Caplan, 1964). Crisis intervention targets one’s RESPONSE to a critical incident, not the event (or crisis) itself per se.

The terms “**Compassion Fatigue**” (Figley, 1995), “**Vicarious Traumatization**” (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and “**Secondary Traumatic Stress**” (Figley, 1987; Stamm, 1995) are oftentimes used interchangeably to describe the harmful effects that helpers suffer when working with trauma survivors. **Vicarious**

**Traumatization** refers to the transmission of traumatic stress through observation and/or hearing others' stories of traumatic events and the ensuing shift/distortions that occur in the caregiver's perceptual and meaning systems. **Secondary Traumatic Stress** occurs when one is exposed to extreme events directly experienced by another and becomes overwhelmed by this secondary exposure to trauma. **Post-Traumatic Stress** and **Secondary Traumatic Stress** have similar symptoms, including difficulty sleeping, irritability, avoidance, nightmares, and a feeling of being isolated from others. The only difference between the two is that post-traumatic stress is experienced directly, while secondary traumatic stress happens indirectly *when you, the helper, are helping someone else with their trauma* (Bride, Radey, and Figley, 2007).

I am a helper. I am not, however, a therapist. I have degrees in Psychology, Public Health, School Counseling, and Education, but I am not a certified mental health clinician. My academic training and professional experience certainly inform my practice and enable me to recognize my strengths and limitations as a helper and as a supervisor. I make referrals, sometimes on a daily basis, and encourage students and staff to seek out professional counseling, yet their stories still unfold in my office. Their narratives begin innocently enough as I ask them how they are doing. Are they sleeping? Have they eaten regularly? Are they attending class? Students appreciate having someone genuinely express interest in their wellbeing, instead of just carelessly throwing their way a "what's up?" as they pass another person in the hallway or on campus. They hold so much pressure inside, some self-induced and some external, so when I ask them how things are going, the floodgates open. I ask them these questions because I genuinely care, and remember what it was like to be an undergraduate student balancing a course overload,

multiple jobs, and a personal life - all on limited sleep and a marginal diet. I also know that if their basic needs are not met, they risk their overall ability to function in relationships, academics, and work, as well as their capacity to thrive, and grow into fulfilled adults. Unfortunately, as intentional as Residence Directors are in their work and mentoring of staff and students as they navigate the challenges of sustaining work-life balance, I believe they sometimes fail to take their own advice and recognize when they are operating at a diminished capacity, because they themselves are overloaded or tapped out and are failing to attend to their basic needs.

Residence Directors are full-time, professional, live-in staff with a Master's degree in a related field such as Student Development, Higher Education, Curriculum Development, or Counseling and must possess a minimum of one year post-baccalaureate lived-in experience which includes crisis intervention and programmatic work with diverse student populations. They oversee the comprehensive management of their residential areas which may include 1-3 residence halls and upwards of 1000 undergraduate students. They recruit, hire, train and supervise graduate and undergraduate staff, advise student leader groups, manage student conduct and crisis response, oversee facilities management and occupancy, and facilitate community and student development within their halls. In the field of Student Affairs, the Residence Director position is deemed to be entry-level and is generally retained for 2-3 years, at which time RDs re-enter the job search and seek to transition to mid-management positions such as Area Coordinators or Assistant Directors of Residential Life. As such, most Residence Directors are in their mid-to-late 20's and fresh out of graduate school.

In *Acts of Inquiry in Qualitative Research*, Brizuela, Stewart, Carrillo, and Berger (2000) identify the importance of the research process beginning with the researcher's reflection on her own role and identities and examining the effects of these on the research process (p. 17). They reflect on the issues of power and the researchers' relationships with those they study, and discuss the importance of resonating participants' voices and their multiple identities throughout the research process. The residential component of my work gives me an added lens through which to access my students and staff while it has also informed my research practices. I interface with students through housing processes (opening and closing, or occupancy management), conduct meetings, crisis response and on-call interventions, student council advising, residential programming, as well as any time I enter or exit the halls with my children and spouse. Through our daily interactions, students come to know *my* multiple identities and priorities (mom, Residence Director, graduate student, instructor), and view me more as an ally and less as an enforcer. Likewise, I am able to watch my students and staff advance through their college experiences and generally improve in their decision-making, progress in their goal-setting, and benefit from the social, emotional, and academic support they derive from the residential setting.

Concurrently, I have witnessed as our students' and staff's needs have diversified over the years, and it has been apparent to me that those needs are not always met by the services offered by the university. Many come with pre-established substance abuse patterns, diagnosed and undiagnosed learning disabilities, and treated or untreated mental health issues, not to mention the anticipated concerns of students' transition to college. Those who seek intervention, be it academic advising, drug and alcohol counseling, or

psychological support services, are often faced with mixed results. Their connection to, and retention of, services is often compounded by a waiting period, the severity of their symptoms, the extent of their self-advocacy or disclosure, as well as their level of compliance with any given treatment or intervention. This often means that as Residence Directors, we interface with and deescalate more challenging student behaviors and crises than simply loud music or roommate disagreements. Through our residential on-call system, we are further exposed to multifaceted student crises and emergencies. As a supervisor of 24 RAs, I witness the daily effects of the RAs' work responsibilities on their own well-being – their physical and emotional health, time management and balance, coping skills and self-care. Despite being a 40-hour per week position, working in a residential setting forces RDs to constantly be attentive to, and deal with, issues and problems as they arise. However, few RDs acknowledge the impact that serving students and RAs in crisis can have on their overall wellbeing, their sense of professional satisfaction, and the long term ramifications of serving in the roles of helping professionals and crisis workers.

Residence Directors' existing coping skills, social supports, and sense of self-efficacy can protect them from the deleterious influences of compassion fatigue. As helpers and supervisors, many Residence Directors engage in healthy coping behaviors and appear very self-aware and well connected to services and supports both on-campus and at home. They are generally apt to seek help or make a referral if a situation becomes overwhelming or overcomplicated, or if they perceive a threat to the health and wellbeing of themselves or others. Many can identify explicit time and stress-management systems they employ to stay on task, manage competing priorities, and

ensure their work, personal, and academic lives remain in healthy balance. RDs are generally able to keep in perspective any critical incidents that arise, although they are more heavily affected when a crisis involves their own residents, student staff or a fellow staff member.

Conversely, *repeated exposure* to students' stressors, acting out behaviors, and critical incidents can seriously diminish Residence Directors' ability to cope with their own needs, stressors, and responsibilities. A seemingly minor event could act as a serious trigger, and could generate a great setback in their coping, self-care, and self-management, subsequently interfering with their ability to work and thrive. The staff who struggle most in coping with work-related stress are generally also battling their own preexisting conditions (anxiety, depression, etc), low morale, or simply have not perfected their work-life balance due to inexperience. Bell, Kulkarni and Dalton (2003) write that age and experience are inversely correlated with the development of compassion fatigue. Their research posits that younger and less experienced counselors (or other helping professionals) exhibit higher levels of distress as they have less experience in integrating traumatic stories into their own belief systems, and have had less of an opportunity than more experienced helpers to develop effective coping strategies for dealing with the manifestations of secondary trauma (p.465).

### **A Call to Arms: The Changing Demographic of Today's Students**

As the demographics of the current generation of college students have changed considerably from the past, so have their needs, in particular their mental health needs. The call to provide counseling for such a broad range of students and issues is one of the major challenges facing college counseling centers and student affairs professionals, and

is a challenge that can oftentimes be overwhelming. Identity development, multicultural issues, marginality, career exploration, life transitions, relationships, addiction, stress, violence, and serious psychological problems challenge students to persist in the face of multiple barriers. There has been a marked increase in both the number of students with serious psychological problems on campus and the number of students seeking counseling services. An analysis of intake data gathered from students who sought counseling at a large university found that “the level of severity of these concerns is much greater than the traditional presenting problems of adjustment and individuation that were seen for college students in counseling center research from the 1950s and 1960s through the early 1980s” (Pledge, Lapan, Heppner, & Roehlke, 1998, p. 387). Students seen by the campus counseling center consistently presented with severe concerns including “suicidality, substance abuse, history of psychiatric treatment or hospitalization, depression and anxiety” (Pledge et al., 1998, p. 387). In the past, many of these students would not have considered postsecondary education an option. In present day, “as a result of early diagnosis, more effective treatment, and federal laws that prohibit discrimination against otherwise qualified people with disabilities—colleges and universities are seeing a greater variety of students who may need modifications or support in both academic and non-academic arenas (Dickerson, 2006). As a result, more schools [are] seeing the mental health of students as part of the education mission” (Eells, 2008, p. 47).

Recent surveys conducted by the American College Health Association (ACHA) and the National College Health Assessment (NCHA) confirm widespread self-reported symptoms of depression and emotional distress among college students, noting that 50%



of students said they felt “hopeless” at least once the previous year; one third felt “so depressed it was difficult to function”; 60% were “very sad” or “very lonely” in the past 12 months; and nearly 90% felt overwhelmed by all they had to do” (ACHA/ NCHA, 2009, p. 13). The 2003 National Survey of College Counseling Center Directors reported that “81.4% of such centers saw students with more serious psychological concerns than they had the previous five years” (Gallagher, Zhang, and Taylor, 2003).

Colleges and universities have, to some degree or another, always dealt with mental health needs of their students. As the statistics above indicate, however, their current prevalence, along with the reality of increased demand and limited resources, represent a critical challenge to student affairs administrators (Harper & Wilson, 2010). Over the past 25 years or so, the majority of student affairs professional preparation programs have shifted from being housed in counseling and educational psychology to residing instead in graduate programs of higher education administration or business administration. Additionally, the Council for the Advancement of Standards (CAS), known as “the preeminent force for promoting standards in students affairs” (Dean, 2006, CAS, n.d., para. 1) makes no reference to counseling skills or knowledge as competencies needed for entry-level professionals. Consequently, we’re left with a deficit in formal training of student affairs practitioners in such basic counseling skills as listening and reflection, which, in turn, means that much of the education about college student’ mental health issues occurs as part of on-the-job training to the detriment of both students and staff.

This is a predicament: At the same time we face heightened need to integrate student affairs practice and helping skills, training programs are bifurcating. . . Many staff members – such as those in academic advising, financial aid, student retention programs, residence halls, and intercollegiate athletics – find themselves

dealing quite regularly with students in crisis, as well as students in need of steady support and monitoring. But few of these professionals have educational or experiential backgrounds in counseling or mental health services. . . . Despite its roots in the vocational guidance movement, and a traditionally holistic concern for students, the profession of student affairs now leaves many practitioners somewhat unprepared to meet the needs of today's students. (Harper & Wilson, 2010, p. 7).

As means of closing this gap between student needs and professional staff competencies, more than 200 campuses have adopted the Question, Persuade, Refer (QPR) Program, which educates faculty and staff on becoming more effective “gatekeepers” by identifying and referring students with presenting mental health issues. Faculty and staff can satisfy an important role in the identification and referral of mental health-related cases, given the reported shortage of mental health professionals on college campuses and the rising needs of today's incoming students. Gatekeeper programs might be especially effective if they equip students with the skillset to help each other, as many young adults are inclined to disclose their depression, anxiety or general distress to their friends first (Hunt & Eisenberg, 2010, p. 7). Numerous Residential Life departments employ Gatekeeper Training as means of better training professional and paraprofessional staff to recognize signs of distress in students and make appropriate referrals. Besides Gatekeeper Training, incoming Residence Directors might attend a two hour Active Threat Training put on by the campus police department, a two-hour Title IX training presented by an attorney, and a two-hour Crisis Management and Response session facilitated by a Residence Director and an Assistant Director. These trainings modules provide an overview of legal or departmental protocols for critical incident reporting or response, yet are limited in the provision of detailed helping skills. They also rarely create a space for discussion on the influence of repeated exposure to

crisis. The reality is that Residence Directors often serve as first responders in campus-related critical incidents, and are subsequently prone to repeated exposure to students' traumatic events, past and present. While there is a need for Residence Directors to be trained in crisis intervention and "gate keeping", attending to critical incidents either on-call or in their halls is further compounded by non-traditional work hours, living where they work, balancing families and sometimes academics with work, and a culture of "students first" which manifests in blurred boundaries and diminished work-life balance. The lack of formalized training in counseling and helping skills therefore highlights a deficit in training on recognizing triggers, employing self-care strategies for coping, and utilizing supervision and peer support for proper critical incident debriefing.

The work of helping students in distress is gratifying. I discovered early in my career as Residence Director how essential it is to provide students in crisis with a caring professional who understands and respects their experiences, fosters a sense of hope and recovery, and de-escalates critical situations to ensure students' safety and connection to support services. I also recognized how crucial it is to debrief critical incidents with the Resident Assistants who serve as first responders, as they oftentimes carry the weight of an incident with them long after a resident first walks through their doors to disclose a private matter, or after an ambulance leaves the halls with a student requiring care. As many scholars note, though, being a helper also involves risk: "Caring people sometimes experience pain as a direct result of their exposure to others' traumatic material. . . This situation – call it Compassion Fatigue, Compassion Stress, or Secondary Traumatic Stress – is the natural, predictable, treatable, and preventable unwanted consequence of working with suffering people (Figley, 1995, p. 4).

## The Evolution of Compassion Fatigue

Professional work that is centered on the relief of emotional suffering or trauma in others, by design, involves absorbing information that is about suffering, and subsequently may entail internalization of that suffering by the helper. Charles Figley (1987) has spent over 30 years studying and defining the characteristics of Compassion Fatigue, although he initially referred to this phenomenon as a form of burnout, a kind of “secondary victimization” (Figley, 1987). Since the start of his research, Figley writes, “I have spoken with or received correspondence from hundreds of professionals, especially therapists, about their struggles with this kind of stressor. They talk about episodes of sadness and depression, sleeplessness, general anxiety, and other forms of suffering that they eventually link to trauma work” (Figley, 1995, p. 2). *Compassion stress* and *compassion fatigue* have been found to be the terms most favored by nurses, emergency workers, and other professionals who experience secondary traumatic stress (STS) in the line of duty, as these terms appear to be less stigmatized than the more clinical prognoses of STS and STSD (Secondary Traumatic Stress Disorder) (Figley, 1995, p. 15).

*Empathy* and *exposure* appear to be consistent variables in research on compassion fatigue. Helping professionals who work with traumatized people on a regular basis are especially vulnerable to manifestations of compassion fatigue as they are always surrounded by the extreme intensity of trauma-inducing factors. Figley (1995) notes, “Beyond this natural by-product of therapeutic engagement, there appear to be four additional reasons why trauma workers are especially vulnerable to compassion fatigue” (p. 15). 1) *Empathy* is implicit in the work of helpers who attend to the traumatized, since empathy is crucial in assessing the problem and formulating a treatment approach.

Concurrently, the process of empathizing with someone who has experienced trauma helps us understand that person's experience, but does not shield us from internalizing the traumatic material; 2) Most trauma workers have a history of having experienced some traumatic events in their own lives, and although their resilience generally draws them to the helping field so as to ease the suffering of those similar to them, there is a danger that helpers will over-generalize their experiences and methods of coping to those of their clients, subsequently yielding the helper ineffective; 3) "Unresolved trauma of the worker will be activated by reports of similar trauma in clients" (Figley, 1995, p. 16). Survivors of previous traumatic events may sustain unresolved issues that are more likely to be triggered by disclosures of similar trauma by clients; and 4) Trauma in children is generally most stress inducing in helpers. "Police officers, fire fighters, emergency medical technicians, and other emergency workers report that they are most vulnerable to compassion fatigue when dealing with the pain of children" (Figley, 1995, p. 17).

Beaton and Murphy (1995) have done extensive research on the secondary traumatic stress of crisis workers. They write that crisis worker exposure to trauma is "repetitive, potentially cumulative, and threatening to personal safety, health and well-being" (p. 51). They identified professional crisis workers to include fire fighters, paramedics, emergency medical technicians, ambulance drivers, law enforcement personnel, rescue workers, disaster response teams, and other front-line first responders for whom potential exposure to occupational trauma is a fact of daily life. Conversely, while McCann and Pearlman (1990) are clear about the potential risks to helpers of doing trauma work, they note that one of the most refreshing aspects of empathically engaging with trauma survivors is the transformation that can result for both the survivor and the

helper. “This transformation includes personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life. The darker side of the transformation includes changes in the self that parallel those experiences by survivors themselves” (McCann & Pearlman, 1990, p. 52). Pearlman’s research is grounded in the assertion that at the root of compassion fatigue (which she more often refers to as vicarious trauma), is a disrupted frame of reference. “One’s identity, world view, and spirituality together constitute frame of reference. As a result of doing trauma work, therapists are likely to experience disruptions in their sense of identity (sense of oneself as man/woman, as helper, as mother/father, or one’s customary feeling states), world view (moral principles, ideas about causality, life philosophy), and spirituality (meaning and hope, sense of connection with something beyond oneself, awareness of all aspects of life, and sense of the non-material)” (p. 54). To combat these disruptions helpers must balance work, play and rest to keep them grounded in their sense of self and within all realms of their complex identities. Socializing, exercising, meditation and yoga, spending time with family, engaging in professional development activities or debriefing work with colleagues are examples of coping strategies that consistently help ameliorate the demands of doing trauma work.

### **CISM: From First Response to Higher Education**

Critical Incident Stress Management (CISM) was originally designed for use among the first responder population as means of mitigating their exposure to residual stress resulting from service delivery at trauma-based calls. In its infancy, CISM relied heavily upon an intervention called Critical Incident Stress Debriefing, yet has since evolved to become a “comprehensive, systematic, and multi-tactic approach for early

intervention” (Mitchell, n.d., p. 3), and its uses have expanded beyond the first responder population. As institutions of higher learning continue to deal with the short and long term repercussions of students in crisis and large-scale traumatic events, there’s a call for campus counseling staff to advocate for additional mental health providers, and more advanced training in crisis response both for counseling staff and for their campus partners. Campus crisis responders, from police and counseling staff, to academic faculty, deans, and residence life staff may benefit from practice of emergency drills and table-top exercises which use CISM as a foundation to develop wide-ranging interventions and focus on community needs as extended recovery may be warranted. “A college community lends itself to a systematic multi-component model of crisis intervention primarily due to its self-contained and widespread interconnected social networks. The CISM model for a crisis response is an empirically supported program that would inform practice prior to, during, and following university-based crises” (Ingemann, Jackson, & Pittman, 2009, p. 97). The system of **Critical Incident Stress Management** encompasses seven fundamental integrated elements:

(1) **pre-crisis** preparation (both individual and organizational); (2) large scale **demobilization** procedures for use after mass disasters (currently known as **RITS** – Rest, Information, and Transition Services); (3) **individual acute crisis counseling**; (4) brief small group discussions, called **defusings**, designed to assist in acute symptom reduction; (5) longer small group discussions, called **critical incident stress debriefing** (CISD), designed to assist in achieving a sense of psychological closure **post-crisis** and/or facilitate the referral process; (6) **family crisis intervention** techniques; and (7) follow-up procedures, and/or **referral for psychological assessment** or treatment. (Everly, Flannery, & Mitchell, 2000, p. 24).

Ginebaugh, Klingensmith and Palombi (2009), state: “Critical Incident Stress Management has been used successfully in schools (Levenson, Memoli, & Flannery, 2000) and by colleges (Bennett, 2004) and universities (Paterson, 2006) who seek to

coordinate and implement a response to crisis situations that succeeds in being both research-based and practically oriented (Everly, 2002)” (Ginebaugh, Klingensmith and Palombi, 2009, p. 106).

Mitchell, and Everly (1986), who have been instrumental in expanding CISM research and practice over the past 30 years, explain that CISM was developed to help manage traumatic experiences within organizations and communities, and is a “package” of crisis intervention tactics that are strategically woven together to: 1) mitigate the impact of a traumatic event; 2) facilitate normal recovery processes in normal people, who are having normal reactions to traumatic events; 3) restore individuals, groups and organizations to adaptive function; and to 4) identify people within an organization or a community who would benefit from additional support services or a referral for further evaluation and, possibly, psychological treatment (Mitchell & Everly, 1986, p. 1).

The primary application of CISM is to *support staff members of organizations or members of communities* who experienced a traumatic event. CISM is **NOT** focused on primary victims, nor is it designed to replace, or function as, individual psychotherapy. In fact, the utility of only one aspect of CISM – Critical Incident Stress Debriefing (CISD) – “is a specific, 7-step group crisis intervention tool designed to assist a homogenous group of people after an exposure to the same traumatic event”. The 7-stage Mitchell model of ***Critical Incident Stress Debriefing*** (Mitchell, 1983; Mitchell & Everly, 1993) is designed to be used with first responders who have been affected by disaster or trauma, to help them cope with their thoughts and feelings in a controlled environment: (1) **introduction phase**—designed to establish guidelines for the group; (2) **fact phase**—seeks descriptions of the facts pertaining to the incident that occurred; (3) **thought**



**phase**—participants express their first thought or most prominent thought concerning the disaster; (4) **reaction phase**— aimed at eliciting what participants felt was the worst part of the incident – something they wish they could have changed (this is most reflective and emotionally intense of all the phases); (5) **symptom phase**— participants disclose how their affect, behavior or functioning has changed since the disaster (this phase focuses on moving individuals from emotional to cognitive material; (6) **teaching phase**—very cognitive, where symptoms are normalized and stress management skills are taught; and (7) **reentry phase**—often called psychological closure, includes provision of additional support resources, and a review of effective coping strategies (Jordan, 2002, p. 141). “In addition to verbal representations and cathartic ventilation, debriefings represent an early intervention forum wherein the patholytic factors of group support, normalization (demedicalization), health education, stress management and assessment for follow-up/ referral are harnessed within a 1–3-hour crisis intervention protocol” (Everly, Boyle, & Lating, 1999, p. 230).

Critical Incident Stress Debriefing is **NOT** a standalone process, however, and should never be provided outside of an integrated system of interventions within a CISM program (Mitchell, 2004, p. 4). Much of the literature that has been written in critique of CISM, describes settings, populations, and practitioners who have clearly misused the model, or attempted to assess the effectiveness of debriefings outside of their designated utility within CISM (Richards, 2001, p. 352). The outcome research which casts a negative light on the use of psychological “debriefings”, in truth describe divergent interventions that reflect primarily one-on-one counseling with medical patients. This is in direct contrast with CISD as a framework for standard group crisis intervention with

homogenous groups versus individual contacts. The table below summarizes some of the glaring differences among the negative outcome studies, and standard CISD practices:

**Table 1: Negative and Positive Outcome Studies on CISD**

<b>Negative Outcome Studies (17)</b> <small>* See appendix for full list of articles</small>	<b>Positive Outcome Studies/ Standard CISD (65)</b> <small>* See appendix for full list of articles</small>
<b>One-on-one</b> individual contacts	Homogenous <b>groups</b>
<b>Primary victims</b> such as dog bites, auto accident victims, rape victims, industrial accident victims	<b>Secondary homogenous groups</b> such as emergency personnel, hospital staff, first responders, and employees
5 minutes up to one hour ( <b>average 41 minutes</b> )	<b>One to three hours</b>
<b>Situation ongoing</b> or slowly resolving	<b>Situation complete</b> or resolved
<b>Different levels of exposure to various events</b>	<b>Roughly same level of exposure to same event</b>
Exposure is personal/direct	Exposure was secondary – another person’s trauma
Situations that <b>produce profound life alterations for the victims</b>	Someone else’s traumatic events that are <b>distressing to work with</b> but which usually have little life altering effects on the workers
<b>Poorly defined intervention</b>	<b>Clearly defined protocols and procedures</b>
<b>Inadequately trained single provider</b>	Well-trained team with a mental health professional
<b>No planned follow up</b>	Follow up required
<b>No integrated strategy</b>	Within a comprehensive, systematic and multi-component approach to managing traumatic stress within an organization ( <b>clear strategy</b> )
Goals appear to be the <b>complete elimination of PTSD symptoms</b> or to cure PTSD or to treat depression or to treat other disorders (all unrealistic)	Goals are to 1) <b>mitigate impact</b> ; 2) <b>enhance normal recovery</b> of normal people having normal reactions to abnormal events; 3) <b>assess</b> who may need additional assistance and <b>assure appropriate referrals</b>

Mitchell, J. T. (2003). Crisis intervention & CISM: A research summary. Retrieved April 13, 2015.

Several randomized controlled trials have demonstrated that when CISD was used with individual trauma survivors rather than in groups, it produced either no improvement compared with controls or had potential to cause harm to those debriefed. These studies led to claims that CISD is an ineffective crisis intervention technique and should be discontinued. In his field study of CISD versus CISM, David Richards (2001) criticizes these studies “on the grounds that they sacrifice internal validity for

experimental control, participants are self-selected, CISD timing is outside that recommended, and debriefers appear inadequately trained” (Richards, 2001, p. 352). In a similar paper which counterbalances misrepresentations of CISD and CISM, Robinson (2004) provides an analysis of Devilly and Cotton’s (2003) article on psychological debriefings and discusses the authors’ inappropriate generalization of “a few, very flawed studies of single session, once-off, individual debriefings to CISM, which operates in the workplace. Allegations are made of unethical and bad practices without substantiation” (Robinson, 2004, p. 29). Robinson highlights that Devilly and Cotton’s studies on psychological debriefing are not applicable or comparable to CISD or CISM, and in fact makes a case that randomized controlled trials, even if desirable, are unlikely to be achievable when multifaceted human interactions are involved (p. 33). “Consider for example, a disaster or major incident. For a successful randomized controlled trial, assessment would need to have been given to the people involved in the incident prior to the disaster (requiring a prediction of the disaster, knowledge of who would be involved and a willingness of people to be tested). Then post incident, half (at random) would be debriefed and half not. Then they would be reassessed. Clearly these conditions are unlikely to be achieved” (Robinson, 2004, p. 33).

In fact, no evidence has been found that any of the negative outcome researchers have been trained in the field of CISM or the CISD small group crisis intervention tool (Mitchell, 2004, p. 26). “In all the controversy, criticism and research debate... certain constants are emerging. The most effective methods of mitigating the effects of exposure to trauma... those which will help keep people healthy and in service, are those which use early intervention, are multi-modal and multi-component... and these components are

used at the appropriate time with the right target group” (Duggan, 2002 as cited in Mitchell, 2004, p. 43). At its core, Critical Incident Stress Management is a coordinated program of tactics that are linked and blended together to alleviate reactions to traumatic experiences.

A CISM program is *comprehensive* in that it: promotes pre-event stress and crisis management education; planning and policy development; as well as training and preparation for the management of traumatic stress. The program also contains a set of interventions which are helpful when a traumatic event is in progress. Finally, the CISM package has interventions that are useful in the aftermath of a traumatic event. It is *integrated* in that the components of a CISM program are linked and blended together into a cohesive approach for use in crisis intervention. When the word *systematic* is used, it means that the elements of a Critical Incident Stress Management program are applied in a logical, step-by-step manner. For example, after a traumatic event individual support processes may precede small group crisis interventions, and then the small group interventions may be followed up with additional individual sessions, referrals (if necessary) or post incident educational programs, etc. *Multi-component* means that a CISM program has many parts that are interlocked. It encourages a strategic, multi-faceted and interlinked approach to crisis management. (Mitchell & Everly, 1986, p. 2).

There is notable unanimity among researchers and authors in the field of debriefing and crisis intervention that three factors are to be considered primary agents of change in successful crisis debriefing interventions such as CISM. These factors are ventilation/ abreaction, social support, and adaptive coping (Everly, Flannery, & Mitchell, 2000, p. 28). *Abreaction* is defined by the Merriam-Webster Dictionary ([www.merriam-webster.com](http://www.merriam-webster.com)) as “the expression and emotional discharge of unconscious material (such as a repressed idea or emotion) by verbalization especially in the presence of a therapist”, and is viewed to be a cathartic and adaptive way to address and subsequently resolve the effects of residual trauma. Being able to discuss the distressing details of an event in a safe and controlled environment can help those with secondary exposure to trauma (i.e., educators, crisis workers, emergency personnel) achieve closure.

Similarly, the importance of having and relying on caring attachments to others is considered of equivalent utility for recovery. *Social support*, both during a critical incident as well immediately following, can provide emotional (reassurance) and structural (group cohesion) reinforcement, deliver necessary information, foster companionship and group decompression, as well as possess “important potential cardiovascular, immunology, and endogenous opioid benefits” (Everly, Flannery, & Mitchell, 2000, p. 28). Finally, many authors (Busutill, 1995; Everly & Mitchell, 1997; Flannery et al., 1995; Raphael, 1986; Shalev, 1994; Wollman, 1993) identify the importance of learning more *adaptive coping skills* in both cognitive and behavioral domains, with “an emphasis of information processing, cognitive appraisal, reasonable expectations of performance, and skills acquisition” as a basic necessity when addressing the aftermath of a critical incident (Everly, Flannery, & Mitchell, 2000, p. 28).

As previously mentioned, CISM is not a form of psychotherapy, nor is it a substitute for psychotherapy. It is, however, denoted as “psychological first aid” or “emotional first aid” and has its roots in crisis intervention theory, with four primary foundational structures: *a) crisis intervention, b) group psychotherapy, c) community psychology, and d) peer support* (Mitchell & Everly, 1986, p. 2). These same foundational structures that inform current day CISM practices are based largely on the notable research and practice of Eric Lindmann, Gerald Caplan, Howard Parad, and Irvin Yalom (Everly, Flannery, & Mitchell, 2000, p. 24). As currently evolved, CISM has emerged as an international standard of care, and has expanded in its utility beyond the original target population to include school systems, the business sector, church groups, and the industrial sector (Mitchell & Everly, 1986).

The self-contained nature of a university campus and its existing support structures serve as a protective element in mitigating the after effects of a traumatic incident, as there are inherent supports that are readily accessible. Additionally, the organization of a coordinated crisis intervention program and crisis response teams (CRT) that ensure the physical and emotional well-being of individuals involved in a traumatic event, and activate specific protocols depending on the stage of the crisis, “gives the impression that the university cares about its constituents and aims to facilitate healing within the community” (Ingemann, Jackson, and Pittman, 2009, p. 101). In fact, numerous studies have indicated that implementation of CISM has reduced the number of worker’s compensation claims for stress-related conditions, as well as minimized the number of lost work days, as CISM serves to lessen workers’ stress reactions and restore employees to normal life function, “A win/win situation for both the employee and the organization” (Lim, Childs, and Gonsalves, 2000, p. 487).

Statistics about the scope and severity of mental health needs of college students, as well as related manifestations of disruptive or threatening behaviors on our campuses are alarming, in that the field of Higher Education has not traditionally needed to serve as resources at the current need level for this particular population. Eighty percent of campus crimes are committed by students (Office of Postsecondary Education, n.d). “Across the United States, students at institutions of higher learning are increasingly coming to the attention of university officials due to pathological behaviors, including self-injury, suicidal gestures, violence, vandalism, emotional concerns, and disruptive behaviors in the classroom” (Schneider, 1998, in Ginebaugh, Klingensmith, & Palombi, 2009, p. 105). The rise in campus-related acts of violence over the last ten years - from

bomb threats, to active shooters, to fire emergencies, and suicidal students – has brought heightened attention to crisis management and the need for interdepartmental collaboration. “Colleges have historically been a place to foster academic excellence, personal growth, character, morale, ethical development, and good citizenship practices. However, colleges now have an obligation to try to help troubled students in need, by being alert to signs of distress and facilitating care when needed to ensure campus and student safety . . . The potential for human harm and even death on campus has compelled conscientious college leaders to plan and to execute a comprehensive program of policies and procedures to address a wide array of potential campus crises” (Ingemann, Jackson, and Pittman, 2009, p. 99).

The need for a consistent, well-coordinated, and effective response to campus crises compels counseling centers to shift their focus from individual and small group therapy with struggling students, to interventions that promote healing and resilience among groups of individuals who may not otherwise seek out support services (Ginebaugh, Klingensmith, & Palombi, 2009, p. 106). In college settings, campus threat assessment or crisis management plans likely occur in collaboration with multiple campus partners including academic affairs, student affairs, human resources, media relations, university police and security, residence life, health services, counseling and crisis prevention centers, religious affairs, and many others. These campus partners may undergo active threat (sharp-shooter response), and gatekeeper training (suicide prevention), promote use of crisis warning systems (text messages and email alerts), as well as participate in Threat Assessment Teams or Student of Concern committees which serve to conduct investigations and ensure a systemic approach to service delivery for

students in need of intervention. Nonetheless, few of these models of crisis response, in and of themselves, attend to the residual effects of exposure to trauma on the campus personnel who serve as primary or secondary responders when a critical incident occurs. Although campus police and the counseling staff may be trained in crisis intervention and critical incident stress debriefing, they may not be the ones most directly affected by a critical incident that occurs in the residence halls or in a college classroom. “The CISM model, as proposed by the International Critical Incident Stress Foundation, offers the most comprehensive form of strategic and tactical interventions that can be incorporated into any university disaster plan regardless of campus size and structure” (Ingemann, Jackson, & Pitman, 2009, p. 101). CISM training may be completed by both mental health clinicians and other university personnel. Benefits are reaped when all relevant campus constituents are trained in CISM, and subsequently understand the goals of mental health crisis intervention and access a common response language. This also raises the likelihood of a coordinated crisis response, ensures appropriate delegation of intervention tasks, and reduces duplication of efforts.

Instead of relying solely on mental health professionals and emergency personnel, CISM relies on a peer support model of crisis intervention that is more accessible and far-reaching and utilizes a crisis response team to help establish the physical and emotional wellbeing of individuals involved in a traumatic event or critical incident. The crisis response (CISM) team may be comprised of any aptly trained university personnel including administrators, counselors, nurses, faculty, support staff, campus security/police, physical plant staff, residence life staff, and students, and serves to quickly identify needs and resources, gather and disseminate accurate information, and provide



consultation and mutual aid while triaging psychological services and identifying those who were most significantly affected (Ingemann, Jackson, & Pittman, 2009, p. 102).

Trauma interventions for small and large groups often occur outside the boundaries of a counseling center through the dissemination of information about stress management and self-care and by means of normalizing stress reactions in those secondarily affected by trauma. Concurrently, a different skill set is needed for working through crisis situations which involve multiple individuals, particularly larger “mass” interventions, and as most graduate training programs in psychology do not focus on said skill sets, many mental health professionals called to provide emergency mental health services, do so without formal training. Generally speaking, the field of crisis response lacks basic standards, guidelines, or training competencies: “Counselors may be persuaded to undergo CISM training when they learn that training enables them to develop or augment the individual and group-crisis response skills needed when potentially large numbers of individuals are impacted by a traumatic event. CISM training helps counselors feel much more confident in their response abilities when trauma occurs” (Ginbaugh, Klingensmith, & Palombi, 2009, p. 107). Once mental health professionals are trained in CISM, there is an added benefit to pairing these with higher education-based, non-mental health CISM-trained constituents so there is a pool of potential in-house responders who can provide group interventions in response to an emergency. This cross-training gives counseling center staff an additional set of ‘feelers’ throughout the campus, “constituents sensitive to a developing emergency or crisis who may be able to mitigate traumatic stress by signaling the need for early intervention” (p. 107).

Grand Valley State University provides basic information about crisis response services, common signs of stress reactions, and examples of critical incidents on their university's counseling center webpage (<https://www.gvsu.edu/counsel/critical-incident-campus-crisis-response-services-66.htm>). They also identify who comprises their Critical Incident Response Teams, highlighting the basic or advanced group crisis intervention (CISM) training of their counseling center staff, public safety officers, students, and faculty, and provide prompts for students and staff on ways to reduce the impact of crisis-related stress in themselves or others.

Buffalo State College established its CISM team to provide and coordinate a variety of prevention and post-trauma-related services to the college community, supplementing existing campus resources such as the Counseling Center and Employee Assistance Program and offering assistance to those groups responding to the emotional impact of critical incidents. Members of the CISM team are Buffalo State Staff, faculty, and students who represent a cross section of the college's functional and structural make up. All members have had formal training in CISM, and the team builds on individuals' resilience to facilitate recovery from difficult situations.

Similarly, Temple University, Shepard's College, Washburn University, Iowa Western Community College and numerous other campuses incorporate CISM into their Emergency Response Plans or counseling support services webpages which are accessible online to the general public, and identify the training and availability of their Trauma Response Teams and critical incident follow up procedures. This transparency serves to both de-stigmatize utility of critical incident stress management interventions, as well as keep campus communities informed of preventative measures taken by each

school to create comprehensive crisis response networks that triage information, education, interventions, and referrals. Additionally, these campuses make a concerted effort to acknowledge that at work, in class, and in residential communities, people may turn personal problems or trauma into disruptive, violent actions, and that it is therefore crucial for staff, faculty, and students to play an active role in ensuring campus safety.

### **Relevant Theories**

*The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering, we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like the other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others. . . Specifically, compassion fatigue is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others (Figley, 2002, p. 14).*

The development of **Crisis Theory** or **Crisis Intervention Theory** owes much to Grinker and Spiegel (1945) who emphasized the military intervention principles of immediacy, proximity, and expectancy; Lindemann's (1944) studies of transitional crisis and grieving; Erikson's (1962) writing on normal development issues; and Caplan's (1964) formulation of emotionally hazardous situations – impediments to life goals that cannot be overcome through customary behaviors (Everly, Flannery & Mitchell, 2000, p. 24). The most important principles of crisis theory can be explicated in the following way:

All humans can be expected at various times in their lives to experience crises characterized by great emotional disorganization, upset, and a breakdown of previously adequate coping strategies. The crisis state is time limited, is usually touched-off by some precipitating event, can be expected to follow sequential patterns of development through various stages, and has the potential for resolution toward higher or lower levels of functioning. Ultimate crisis resolution depends upon a number of factors, including severity of the precipitating event,

the individual's personal resources (ego strength, experience with previous crises), and the individual's social resources (assistance available from "significant others"). (Slaikue, 1990, p. 14).

Erikson, Lindmann, and Caplan, all associated with Harvard University and Harvard Medical School, established the three primary foundations of **Crisis Intervention Theory**. Erikson contributed the concept of developmental crises – the idea that as people grow, they experience several developmental crises or “turning points” that they must overcome in order to become mature, integrated adults (Pasework & Albers, 1972, p. 70). Lindmann's redefinition of transient personality disorders made the assumption that removing stress will mitigate or eliminate observable behavioral symptoms, and suggested that reactions to crises follow a predictable pattern and have specific, identifiable stages (p. 71). Most notably, however, was Caplan's keen advocacy for the application of public health principles – specifically primary, secondary, and tertiary prevention – to community mental health problems. **Primary prevention** serves to reduce the incidence of a disorder by altering the environment, constraining the progress of disease, and reducing individual susceptibility. **Secondary prevention** aims to keep a mild disorder from becoming a chronic or more severe one, largely through case finding and treatment, while **tertiary prevention** works to keep a serious disorder from producing permanent disability. “The strategy in crisis intervention is to provide the individual with appropriate behavioral patterns that will enable him to deal effectively with the specific crisis. Crisis theorists have not delineated the mode of intervention; one assumes that the techniques used remain the prerogative of the intervener” (Pasework & Albers, 1972, p. 71). Nonetheless, there are a number of implicit assumptions that are intrinsic to **Crisis Theory**: crisis is not a pathological experience; crises are temporary

and therefor self-limiting; each type of crisis pursues a course made up of typical, identifiable stages; the individual in crisis is especially amenable to help; a small amount of assistance makes it possible for a person to surmount a crisis; and finally, weathering a current crisis permits the individual to cope more effectively with future crises (Pasework & Albers, 1972, p. 72).

According to Bloom's (1999), **Trauma Theory**, in order to understand what trauma does, we have to understand what it is. Lenore Terr, a child psychiatrist who did the first longitudinal study of traumatized children writes "psychic trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside. Traumatic events are external, but they quickly become incorporated into the mind" (p. 8). Van Der Kolk (1989) makes a similar point about the complicated nature of trauma when he says, "Traumatization occurs when both internal and external resources are inadequate to cope with external threat" (p. 393). Both clinicians make a point that it is not the trauma itself that does the damage. It is how the individual's mind and body reacts in its own unique way to the traumatic experience in combination with the unique response of the individual's social group. A traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience (Bloom, 1999, p. 1).

The *fight or flight* response is people's biological instinct to protect themselves from harm or danger as best as they possibly can. When they perceive a threat, their bodies react in a way that affects all of their organs, and "every episode of danger

connects to every other episode of danger in our minds, so that the more danger we are exposed to, the more sensitive we are to danger. With each experience of *fight or flight*, our mind forms a network of connections that get triggered with every new threatening experience” (Bloom, 1999, p. 3). When people are repeatedly exposed to danger, they become hypersensitive to even the most minor of threats to their safety, and react to these threats physically, emotionally, and cognitively. This is an instinctive response they cannot control, a protective measure that only goes off when they are exposed to too much danger and too little protection as children and as adults. “The real nature of the fight of flight response means that if we hope to help traumatized people, then we must create safe environments to help counteract the long term effects of chronic stress” (Bloom, 1999, p. 3).

Trauma Theory identifies that “our capacity to think clearly is severely impaired when we are under stress. When we perceive that we are in danger, we are physiologically geared to take action, not to ponder and deliberate. . . . When stressed, we cannot think clearly, we cannot consider the long-range consequences of our behavior, we cannot weigh all of the possible options before making a decision, we cannot take the time to obtain all the necessary information that goes into making good decisions” (p. 6). Subsequently, people’s decisions tend to be more impulsive and based on self-preservation, and as a consequence, are generally inflexible, overly simplistic, action-oriented, and often poorly constructed. When developing intervention strategies, this means that every effort should be made to reduce stress whenever good decisions are sought. It also means that those in helping professions need to “look at the growing sources of social stress that are inflicted on individuals and families at home, in the

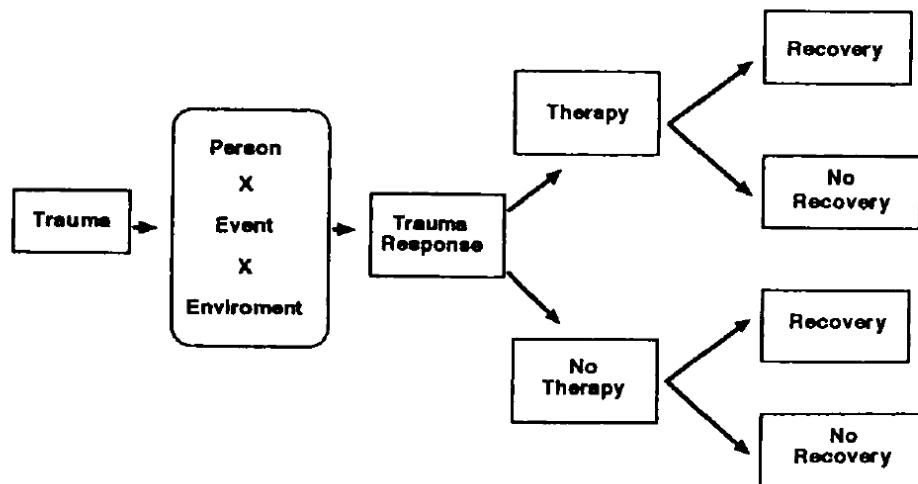
workplace, and in the community and evaluate what kind of buffers can be put in place that help attenuate the effects of these stressors” (Bloom, 1999, p. 6).

Bloom describes the process of **creating sanctuary** as the development of *safe environments* that promote healing and sustain growth, learning, and well-being. The ideology of creating sanctuary is grounded in the shifting of attitudes away from blame and toward compassion. Bloom (1999) says, “the presenting question with which we verbally or implicitly confront another human being whose behavior we do not understand [must shift] from ‘what’s wrong with you?’ to ‘what happened to you?’ . . . When people receive understanding from others, it enables them to begin their way down the long road of understanding – and changing – themselves (Bloom, 1999, p. 12).

Mary Harvey (1996) describes the **ecology of psychological trauma** and trauma recovery as a model with three basic assumptions: 1) individuals are not equally vulnerable nor similarly affected by potentially traumatic events; 2) in the aftermath of traumatic exposure, affected individuals may or may not access clinical care; and 3) clinical intervention in the aftermath of traumatic exposure does not guarantee recovery (Harvey, 1996, p. 6). The ecological analogy recognizes traumatic events as “ecological threats not only to the adaptive capacities of individuals but also to the ability of human communities to foster health and resiliency among affected community members” (p. 5). Existing literature on psychological trauma generally underemphasizes the role of the environment on individual variations in posttraumatic response and recovery, while the clinical literature tends to overlook the marvel of individual resilience, the possibility of recovery in the absence of clinical intervention, and the contributions of social, cultural, and environmental influences on the recovery process (p. 4). The ecological model

understands recovery from psychological trauma as a multidimensional phenomenon trademarked by seven outcome criteria: 1) authority over the remembering process; 2) integration of memory and affect; 3) affect tolerance; 4) symptom mastery; 5) self-esteem and self-cohesion; 6) safe attachment; and 7) meaning-making (Harvey, 1996, p. 13). “In acknowledging the multidimensional nature of trauma recovery and the possibility of recovery in the absence of clinical intervention, the ecological model highlights the construct of resiliency, the role of the larger environment, the contributions of natural supports, and the relevance of community interventions” (p. 21).

**Figure 1: An Ecological Model of Psychological Trauma**



*Organizational prevention of vicarious trauma* by Bell, Kulkarni, and Dalton (2003) identifies organizational correlates to burnout and vicarious trauma and offers prevention and intervention strategies framed as agency administrative responses. “The values and culture of an organization set the expectations about the work. . . An organization that ‘normalizes’ the effect of working with trauma survivors can provide a supportive environment for [helpers] to address those effects in their own work and lives.



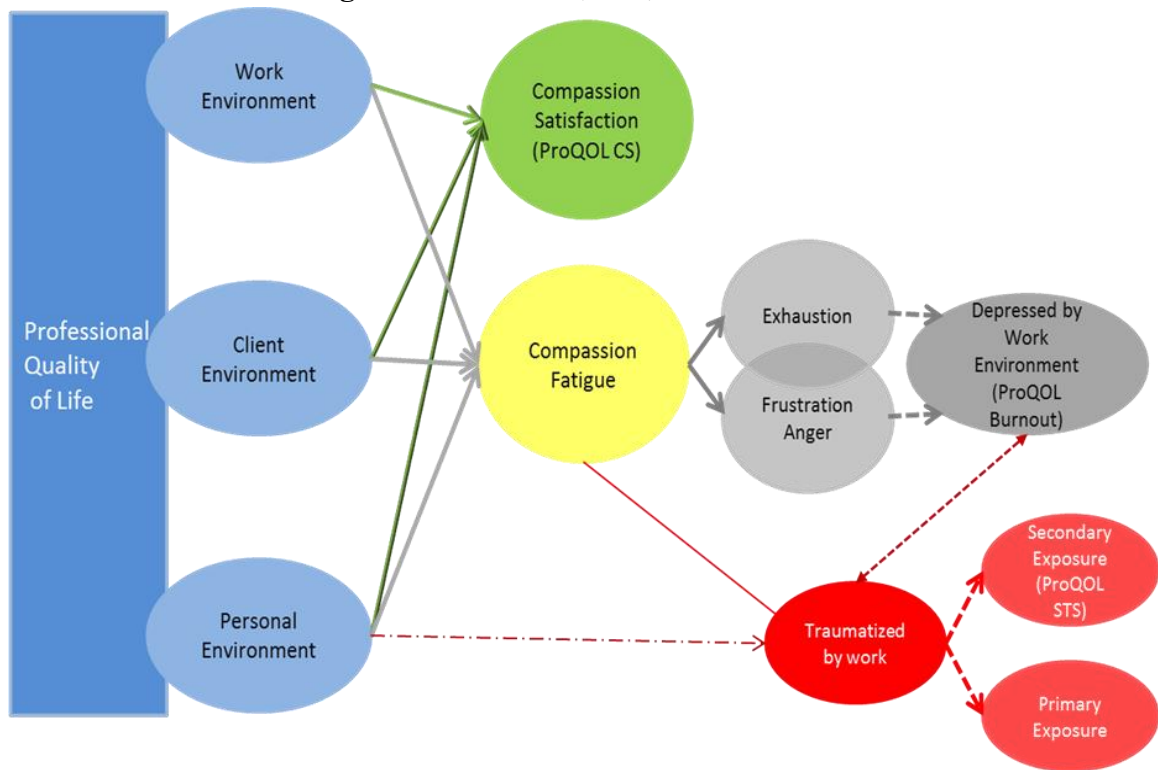
It also gives permission for [helpers] to take care of themselves” (p. 466). Yassen (1995) provides an example of a potentially harmful ‘norm’ that can stifle helpers’ attempts at self-care, stating that in some settings it is assumed that if staff do not work overtime, they are less committed to their work, and that caregivers who never take vacations are more committed to their work than others. He offers instead that an organization which values wellness in its employees, would not only allow for vacations, but also create opportunities for staff to vary their caseloads, take time off for illness, participate in professional development and continuing education opportunities, and make time for other self-care activities (Bell et al, 2003, p. 466). The article goes on to suggest that organizations can mitigate for incidences of vicarious trauma in their employees by considering and responding to workers’ needs around workload, work environment, education, group support, supervision, and resources for self-care.

In a recent focus group of new student affairs professionals at a large state university, a recurring sentiment centered on the dynamic forced upon new Residence Directors (RDs) within their first few weeks on campus by nature of filling five weeks of training with non-stop content, meetings, and skill building, while leaving them little time to process new information, and virtually no time in their offices to bring into practice what they learned. The unspoken expectation, then, is that after sitting through an 8-hour day of training and orientation, new RDs spend their off-hours in the office sifting through new information, and trying to prepare their halls for Resident Assistant training and the residence hall opening. How do colleges and universities expect new student affairs professionals to maintain good work-life balance when their organizational structures in fact overtax staff before students even set foot on campus?

Beth Hudnall Stamm (2002) developed a conceptual model (the CS-CF Model) for deconstructing compassion fatigue and compassion satisfaction in the context of one's Professional Quality of Life. She states that **Compassion fatigue** is the negative aspect of people's work as helpers and is comprised of two parts. The first part manifests in such symptoms as exhaustion, frustration, anger and depression typical of *burnout*. The second part known as *Secondary Traumatic Stress* manifests as negative feelings driven by fear and work-related trauma. Conversely, Stamm describes **Compassion satisfaction** as the pleasure people derive from being able to do their work. They may feel positively about their colleagues or their ability to contribute to the work setting or even the greater good of society through their work with people who need care.

In The **Concise ProQOL Manual**, Stamm (2010) outlines the full theoretical model of **Compassion Satisfaction and Compassion Fatigue** to show how three key components feed into the positive and negative aspects of helping others. These three are 1) the actual *work* situation itself; 2) the *environment* of the person or people to whom we are providing care or assistance; and 3) the *personal* agenda/baggage that we bring to the work we do.

**Figure 2: Stamm's (2010) CS-CF Model**

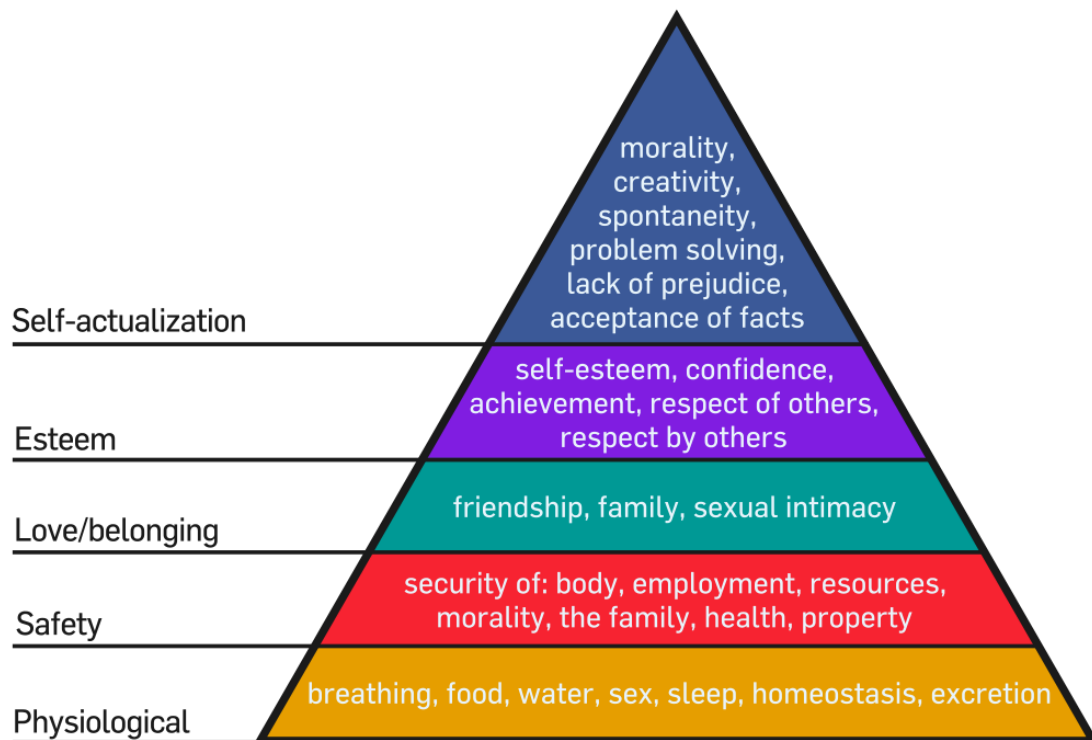


Through her research and practice in the field of traumatology, Stamm refined the **ProQOL** (originally called the Compassion Fatigue Self-Test and developed in the late 1980's by Charles Figley) – **The Professional Quality of Life Scale** – a 30 item self-reported measure of the positive and negative aspects of caring. She recommends use of this scale as means of identifying where helpers stand on the subscales of compassion satisfaction, burnout, and secondary traumatic stress, so they may seek support and intervention if they find their subscales to be off-balance. The ProQOL can be a guide in regard to an individual's or organization's balance of positive and negative experiences related to doing trauma work or serving in helping a role.

While reflecting on her 30 years of practice in organizational development and striving for a more holistic response to crisis work, Angela Courtney Obe (2009) says: "At the collective level, organizations are 'persons at law'. Like individuals they have a

unique identity and culture. We need, in our organizations, to hold to the intention to seek the highest common good and to include this among business ethics and objectives and to act to reward and encourage a culture of cooperation, [especially as we respond] to the occupational hazards of burnout, compassion fatigue and vicarious trauma to which those working in anti-violence organizations are exposed.” (p. 19). She draws on Maslow’s (1954) **Hierarchy of Needs**, among others, as means of developing a culture of reflective practice.

**Figure 3: Maslow’s Hierarchy of Needs**



From the developmental psychology literature, we learn that effective social-emotional function is viewed as movement towards satisfaction of higher-order needs (e.g., self-actualization). Self-actualization, according to prominent personality-

developmental psychologist Abraham Maslow (1954), is a state when humans achieve their full potential. Generally speaking, an individual is motivated to satisfy lower-order needs before higher-order ones, yet *growth* is viewed as movement from a lower-level toward a higher-level need. Maslow's hierarchy involves the following, ordered from lower-order to higher-order: *Biological needs* (e.g. food, water, oxygen, etc.); *safety needs* (e.g., physical and psychological security); *social needs* (e.g., need for affiliation, friendship, belongingness, etc.); *esteem needs* (e.g., need for achievement, success, recognition, etc.); and *self-actualization needs* (e.g., need for creativity, self-expression, integrity, self-fulfillment, etc.) (Sirgy, 1986, p. 331). "Developmental theories are used to explain the process people experience when moving through crisis to equilibrium, a process leading to increased levels of personal competence and confidence in achieving potentials and moral commitments. People mature through stages in life in which personal issues are confronted and resolved and tasks mastered before advancing" (Capile and Newton, 1991, p. 117).

**Physiological needs** are biological needs. They consist of needs for oxygen, food, water, and a relatively constant body temperature. They are the strongest needs because if a person were deprived of all needs, the physiological ones would come first in the person's search for satisfaction. Nonetheless, in times of stress, physiological needs are generally the first to be neglected - missed meals, lost sleep, dehydration, and inactivity. When all physiological needs are satisfied and are no longer controlling thoughts and behaviors, the needs for security can become active, thus calling on **safety needs**. Selye's (1976) research on stress and stress response connects physiological *processes* such as alarm, resistance, and exhaustion to safety needs and capacity for coping. Adults have

little awareness of their security needs except in times of emergency or periods of utter chaos, while kids more obviously demonstrate signs of insecurity and the need to feel protected (p. 718).

When the needs for safety and for physiological well-being are satisfied, the next class of **needs for love, affection and belongingness** can emerge. Maslow states that people seek to overcome feelings of loneliness and alienation. This involves both giving and receiving love, demonstrating affection, and striving for a sense of belonging. In the context of **compassion satisfaction**, this may consist of Residence Directors' alignment with an educational institution's mission and values, a need for collegiality and mentoring relationships, and affirmation that their work is worthwhile. When the first three classes of needs are satisfied, the **needs for esteem** can become dominant. These involve needs for both self-esteem and for the esteem a person gets from others. Humans have a need for a stable, firmly based, high level of self-respect, and respect from others. When these needs are satisfied, the person feels self-confident and valuable as a person in the world. When these needs are frustrated, the person feels inferior, weak, helpless and worthless.

When all of the preceding needs are satisfied, the **needs for self-actualization** are triggered. Maslow describes self-actualization as a person's need to be and do that which the person was "born to do." These needs often manifest themselves as restlessness. The person feels on edge, tense, lacking purpose. If a person is hungry, threatened, unloved or excluded, or lacks self-confidence, it is easier to identify what the person is restless about. It is not always clear what a person wants when there is a need for self-actualization. Maslow's Hierarchy of Needs explains how the attainment of a lower level

of need depletes the drive or motivation for that need. For example, once people feel secure in an environment, unthreatened by arbitrary or punitive measures, they may then be willing to risk more open relationships with others. In Charles Figley's anthology *Compassion Fatigue: Coping with Secondary Traumatic Stress in Those Who Treat the Traumatized*, Mahoney (1991) writes that helpers "may not know where to turn for help, and, as a group, are too often reluctant to acknowledge their need for help until their distress becomes so great that they leave the field" (Figley, 1995, p. 159). As such, increased importance is placed on resilience and transformation of negative to positive aspects as means of keeping compassion fatigue at bay and increasing compassion satisfaction (Pearlman & Carnigi, 2009; Stamm & Figley, 2009; Stamm, Figley & Figley, 2010).

**Resilience** is the ability to physiologically and psychologically adapt to environmental changes. "It is a survival skill required of every member of the animal kingdom. In humans, it is often manifested as the difference between individuals' conceptualizing themselves as survivors versus victims; that is, the difference between individuals who can take care of themselves and others versus those who become unable to care for themselves when subjected to significant stressors, whether those stressors are man-made and/or natural: war, pestilence, defective dams, earthquakes, floods, or a combination of a tsunami and damage to resultant nuclear power plants, or levee failures from hurricane surges and massive, significant flooding of a major metropolis" (Ginzburg, 2012). According to psychiatrist George Vaillant (1993), resilience is the objective adaptation to the external environment as opposed to the development of psychopathology. He explains that there are good and bad denial defense mechanisms,

and it is the good defense mechanisms that lead to resilience and the bad defense mechanisms that lead to dysfunctional psychopathology. Resilience comprises the “self-righting tendencies of the person, both the capacity to be bent without breaking and the capacity, once bent, to spring back” (Vaillant, 1993, p. 248). In order to remain effective in their practice of working with survivors of trauma, therapists, crisis workers, and helpers in all realms must overcome their denial of trauma’s impact on them as helpers, and develop effective interventions and care practices for themselves, as well as their clients.

### **Rationale for Creating Sustainable Personal and Organizational Change**

Student affairs administrators identify an overall lack of focus on wellness issues in student affairs literature, professional organizations, and graduate preparation programs (Marling, 2006). A recent review of literature on attrition in the field of Student Affairs suggests the following reasons for job dissatisfaction leading to attrition: a) burnout, b) unclear job expectations, c) conflicts between reasons for entering the field and realities of practice, and d) low pay (Rosser and Javinar, 2003, p. 815). When administered the Five Factor Wellness Inventory (F5-Wel), the “Coping Self” factor proved to be especially challenging for student affairs professionals: “This area includes third-order factors of Realistic Beliefs, Stress Management, and Leisure, and is composed of elements that regulate our responses to life events and provide a means for transcending their negative effects” (Myers & Sweeney, 2005, p. 10). Student affairs professionals named barriers to balance to include work stress, family obligations, and hectic, unpredictable schedules, all of which related to stress management (Marling, 2006). Research on Critical Incident Stress Management highlights organizations’



commitment to prevention, intervention, and follows up services as core principles of comprehensive, campus-wide crisis response models. Such research highlight benefits of engaging in behavior change as means of reducing such barriers to work-life balance, and subsequently may be used to draw conclusions as to how Residence Directors can more healthfully (and thus effectively) persist in the field of student affairs (Ingemann, Jackson, and Pittman, 2009, p. 100).

In *The Compassion Fatigue Workbook*, Francoise Mathieu (2012) identifies **Four Steps to Wellness** that can reduce and transform compassion fatigue and vicarious trauma. She advises that helpers, 1) Take stock of their stressors, 2) Look for ways to enhance their self-care and work-life balance, 3) Develop resiliency skills, and 4) Make a commitment to implement changes. Mathieu bases this model on Figley's Green Cross "Standards of Self-Care Guidelines", and offers a rationale and specific strategies for each step in Chapters 10-15 of her workbook. Mathieu distinguishes that step four should be occurring along with steps 1-3 so that as helpers assess their stressors, look for ways to improve balance in their lives, and work to strengthen their resilience as helpers, they subsequently commit to creating change in their habits and environments so as to inhibit the manifestations of greater vicarious trauma.

Symptoms of compassion fatigue appear to be very responsive to being treated and rapidly ameliorated (Gentry, 2000). While more research is needed, current principles and techniques offer a foundation for helping caregivers resolve their current symptoms and prevent future occurrences (p. 29). Gentry offers the following practices as means of attending to and/or treating symptoms associated with compassion fatigue while promoting resilience among those exposed to crises and high levels of stress in

their lines of work. His list is not exhaustive by any means, but I apply his recommendations to RDs, so as to better frame these as viable methods for addressing compassion fatigue in professional staff. Furthermore, as I worked to define how these practices align with the work of Residence Directors and can serve to ameliorate symptoms of Compassion Fatigue, I witnessed the emergence of ***Guiding Principles*** which neatly tied together evidence-based practice, my conceptual framework, and recommendations for change which can ensure the wellbeing and resilience of Residence Directors within the field of student affairs:

***Intentionality*** – Residence Directors who experience symptoms of compassion fatigue may attempt to ignore their distress until a threshold of discomfort is reached. For some, this may mean that due to the symptoms they experience they find themselves no longer able to perform their duties as they once had or as they would like. For others, this may entail progressive decline and pain associated with self-destructive behaviors. Whatever the cause, the literature indicates that successful reduction of compassion fatigue symptoms requires that RDs intentionally acknowledge and address, rather than avoid, noted symptoms and their causes (Gentry, 2000, p. 14). Intentionality is also based in an RD's assertion of limitations and boundaries, and frequent checks for contradictions between what they say and what they do. ***Guiding Principle 1: Residence Directors should cultivate a sense of introspection and self-reflection so as to normalize their stress reactions when they occur, as well as better recognize the impact that repeated exposure to stress and traumatic activity may have on their well-being.***

***Connection*** - One of the ways in which trauma seems to affect people is to leave them with a sense of isolation. The development and maintenance of healthy

relationships, which Residence Directors may use for both support and to diminish the effects of images and stories associated with secondary traumatic stress, can become a powerful contributing factor to the resolution and prevention of compassion fatigue symptoms. Tapping into social support networks – family, friends, supervisors, faculty, deans – planning activities, and taking time to regroup, are critical elements in overcoming stress and trauma. **Guiding Principle 2:** *Residence Life departments have a responsibility to create a community of practice that promotes social support, open dialogue, effective supervision, and structured debriefing of critical incidents.*

***Anxiety Management/ Self-Soothing*** – “The ability to self-regulate and soothe anxiety and stress is thought to be a hallmark of maturity. The mastery of these skills comes only with years of practice” (Gentry, 2000, p. 16). However, if we fail to develop the capacity for self-regulation, then we are susceptible to perceiving as threats those people, objects, and situations to which we respond with anxiety. Slowing down their daily routines long enough to be self-reflective can be challenging for Residence Directors who balance multiple competing priorities. RDs need to get away from the source of their stress and learn to build in time to decompress. Certainly, taking breaks, walking away from situations that do not necessarily warrant their immediate attention, or redirecting anxiety-inducing student matters to a colleague or supervisor can promote healthier problem solving and self-management. **Guiding Principle 3:** *Residence Directors must be taught means of recognizing personal triggers that manifest in their work and diminish their capacity to be compassionate helpers.*

***Self-Care*** - Self-management is closely associated with the concept of self-care. Self-care is the ability to rejuvenate oneself in healthy ways. It is quite common for

Residence Directors to find themselves feeling anxious during and after their work with severely challenging individuals or situations. Many RDs find themselves increasing their work efforts or falling victim to compulsive behaviors such as overeating, overspending, or alcohol/drug use in an effort to soothe the anxiety they feel from the demands of their work. Instead, RDs should work to master a system of healthy practices for resolving this anxiety, such as sustaining interests and relationships outside of work, sharing their experience with colleagues, exercise, meditation, and nutrition. **Guiding Principle 4:** *Residence Directors should practice self-care strategies that foster greater work-life balance and reinforce the practice of self-care within their day-to-day routine.*

***Narrative*** – “Many researchers and writers have identified the creation of a chronological verbal and/or graphic narrative as an important ingredient in the healing of traumatic stress, especially intrusive symptoms” (Gentry, 2000, p. 17). A Residence Director’s creation of a timeline or life-space map that identifies student narratives, symptoms, duration of incidents and follow up care which may contribute to the development of secondary stress may be invaluable in the dissolution of compassion fatigue symptoms. Concurrently, engaging in the formal documentation (on-call reports) of critical incidents, can serve as a narrative that helps RDs flush out the details of an incident, their intervention steps, campus partners utilized, and follow up necessary to bring closure to an incident. Because formal preparation programs for those entering the field of student affairs are limited in the scope of content they offer on mental health issues and relevant counseling skills, having current knowledge and understanding of the needs of today’s college students and examining the depth of interventions required of RDs in the context of their work, can inform future designs for comprehensive training

and professional development to ensure Residence Directors are better equipped to care for themselves and others. ***Guiding Principle 5:*** *Current practitioners in the field of student affairs must continually examine the ways in which the changing needs of college students are matched by the formal training that is offered during campus orientation and ongoing professional development opportunities for new professionals within the field.*

In thinking about my interest in educating Residence Directors about their vulnerability to compassion fatigue, my aim was to seek an application such as Critical Incident Stress Management that would be straightforward and educational while it engaged RD's to be self-reflective, reinforced healthy coping strategies they were already using, and encouraged those working in student affairs to examine existing structures that promote or inhibit work-life balance. I strove for my research to include narratives of RDs' experiences and their interpretations of how their work and exposure to stress within their roles affected their motivations, daily functioning, interpersonal growth, and life balance. Taking these narratives and existing literature into account, my research methods articulate the ways in which my research questions align with my chosen study design, while these still reflect the ***Guiding Principles*** that emerged in the course of my early research.

## CHAPTER 3

### RESEARCH DESIGN AND METHODS

This study was phenomenological in nature in that it explored the meaning of Residence Directors' lived experience. The research design employed a single-site descriptive case study strategy, as it looked explicitly at one institution in Upstate New York that prioritized provision of CISM training to its Residence Life Staff. In developing my case study, I wanted to portray different perspectives on a single phenomenon, and as such I utilized what Creswell (2012) refers to as "purposeful maximal sampling" (Creswell, 2012, p. 75), tapping Residence Life Staff in various roles within a single institution, and striving to understand their common or shared experience of CISM and its utility within the context of their work (p. 63). As the purposes of phenomenological inquiry are description, interpretation, and critical self-reflection, I as the researcher continuously examined my own role, biases, reflections, and experience with my topic and the process while delving into participants' *life history research* (Rossman and Rallis, 2012, p. 97). Through interviews, observations, and interpretation of related documents and protocols, this research provided insight into the ways in which a model of Critical Incident Stress Management could best serve Residence Life Staff in a college or university setting.

Since research has shown that colleges and universities routinely deal with short and long-term consequences of students in crisis and large-scale traumatic events, and since CISM is a crisis response model that is empirically supported, systematic, multi-component and yet self-contained (as are college campuses), it follows that the organization of coordinated crisis intervention protocols and crisis response teams

safeguards the physical and emotional well-being of its university community members and facilitates healing. CISM has been shown to lessen individuals' stress reactions and restore employees to normal life function by fostering cathartic ventilation, reliance on social supports, and adaptive coping skills (Everly, Flannery, & Mitchell, 2000, p. 28). As such, campuses that have either incorporated CISM into their existing crisis response protocols, or utilize CISM as a foundation for their crisis intervention practices, rely on a peer support model that is more accessible and far reaching than one that relies solely on mental health professionals and first responders, and maximize on support from trained university personnel to triage psychological services and identify those most significantly affected in times of crisis (Ingemann, Jackson & Pittman, 2009, p. 101). In residential college settings, first responders are oftentimes Residence Life staff, so equipping residence directors with information about stress management and self-care can mitigate traumatic stress by serving to normalize stress reactions, signaling the need for early intervention, and encouraging referrals to support services. Training residence life staff in individual, peer support, and group crisis intervention (CISM) and including them in Crisis Response Teams (CRTs or CISM teams) can not only better equip them to deal with most crises that occur within their halls and broader campuses by ensuring the physical and emotional safety of individuals involved, but can also improve staff's resilience within the field by mitigating for compassion fatigue or burnout that staff experience from their repeated exposure to stress and trauma. "A team can identify needs and resources, help provide accurate information and dispel misinformation, and provide consultation and mutual aid. The team itself may be comprised of members that include administrators, counselors, nurses, [faculty], support staff, security/ campus police,

physical plant staff, dining hall staff, residence life staff, and students” (Weisen & Lischer, 2006; Roth Donnelly & Reed, 2006).

This study acknowledged the global impact of critical incidents and defined CISM as a proactive strategy and “preventive health-promotion model that can be used to minimize adverse outcomes following a violent or traumatic event” (Anati-Otong, 2001, p.125). An effective and well thought out college crisis intervention program that relies on various campus supports and resources, promotes an ethic of care for its community members and works to expedite healing following a critical incident. As circulated at the 10<sup>th</sup> World Congress on Stress, Trauma, and Coping (the 13<sup>th</sup> World Congress was held in Maryland this May), “personnel who obtain crisis skills training are more likely to make better decisions, perform at a higher cognitive level, detect and deter stress reactions, and reduce errors and potential litigation” (Mitchell, 2009). Accordingly, results of this study could have far-reaching implications for many college and university settings, as this research examined campus communities that already employ CISM strategies and include residence life staff in their CISM training procedures and functional debriefing teams. Although mine was a single-site case study, as was noted in Chapter Two, there are multiple colleges and universities across the country which routinely train their residence life staff in CISM (as well as auxiliary staff, faculty, and students) and include them in campus-wide or regional CISM teams.

This chapter provides a comprehensive overview of the research methods and research design employed within this study. It begins with a rationale for selecting a phenomenological case study design, and proceeds with detailed sampling procedures, a reiteration of the research questions and their methods of investigation, discusses



instrumentation and data analysis, and considers limitations and ethical parameters in the verification of findings.

### **Rationale for Phenomenological Case Study: Employing Qualitative Research Practices**

*Choosing a study design requires understanding the philosophical foundations underlying the type of research, taking stock of whether there is a good match between the type of research and your personality, attributes, and skills, and becoming informed as to the design choices available to you within the paradigm. (Merriam, 1998, p. 1)*

**Qualitative inquiry** is both interpretive and naturalistic, and utilizes methods, instruments, and techniques for collecting and analyzing data that are sensitive to the underlying meaning implicit within the research. “Humans are best suited for this task, especially because interviewing, observing, and analyzing are activities central to qualitative research” (Merriam, 1998, p. 2). Inherent to qualitative research are *questions*, and a conceptual framework that has as its core the ultimate goal of expanding one’s knowledge and learning. The researcher collects data, the “basic unit or building blocks of information” comprised of images, sounds, words, and numbers (Rossman & Rallis, 2012, p. 4). When arranged into patterns, data become information, and when subsequently used or applied within a particular context, information becomes knowledge. Rossman and Rallis (2012) and Merriam (1998) explain that while all research should have the “goal of contributing to improving the human condition” (Rossman, and Rallis, 2012, p. 4), qualitative researchers in particular are interested in understanding the meaning people have constructed of their experiences of the world around them, and “implies direct concern with experience as it is ‘lived’ or ‘felt’ or ‘undergone’” (Merriam, 1998, p. 6). The synthesis of information into knowledge is an *active learning process* (Rossman and Rallis, 2012) whereby the researcher is the

*primary means* through which qualitative study is conducted, with the *purpose* to increase understanding about some aspect of our broader social world (p. 5).

One major advantage to qualitative methods in exploratory research lies in the use of open-ended questions and probes that give participants the opportunity to reply to in their own words, rather than being forced to select a prescribed answer from a fixed menu or scale. Open ended-questions can evoke answers that may be unanticipated by the researcher, are particularly salient to the participant while uncovering social norms or cultural influences, and are generally highly descriptive (Mack, Woodson, MacQueen, Guest, Namey, 2005, p. 4). A second advantage to qualitative research lies in the researcher's ability to review and analyze participants' initial responses and return with additional questions to gain clarity or supplementary detail. *How* and *why* probes encourage participants to elaborate on their original reactions and replies (p. 4). The qualitative researcher is subsequently attuned to personal narrative, employs complex reasoning to conduct systematic inquiry, and views the social world holistically while systematically reflecting on her own role within it to develop awareness of assumptions and preconceptions and how they affect research decisions (Rossman and Rallis, 2012, p. 10). This *reflexivity* "involves making the research process itself a focus of inquiry, laying open pre-conceptions and becoming aware of situational dynamics in which the interviewer and respondent are jointly involved in knowledge production" (Hsiung, 2010, webarchive).

While there are multiple genres of qualitative research, **Phenomenology** derives from German philosophy, and explores the meaning of an individual's lived experience. As Creswell (2012) breaks down **Five Qualitative Approaches to Inquiry**, he states that

“Phenomenologists focus on describing what all participants have in common as they experience a phenomenon. The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence – a grasp of the very nature of the thing” (Creswell, 2012, p. 58). Concurrently, **Case Studies** as a research strategy (though some do consider it a genre of its own) are also descriptive, exploratory, and explanatory, in that they illustrate events, processes, and perspectives as they unfold within their real-life contexts (Yin, 1994, p. 25). While case studies provide little basis for *statistical* generalization, they do serve to meet the researcher’s *analytic* goal of expanding and generalizing theoretical propositions (p. 21). “The essence of a case study, the central tendency among all types of case studies, is that it tries to illuminate a *decision* or set of decisions: why they were taken, how they were implemented, and with what result” (Schramm, 1971, as appearing in Yin, 1994, p. 23). As such, a phenomenological case study design lent itself as a prime mode of inquiry for this research, as I examined the lived experience of various residence life staff at one college setting, as they described their training in Critical Incident Stress Management and discussed their perceptions of the value and utility of the model’s crisis intervention strategies on the quality and *essence* of their life and work.

### **Research Questions**

Much of the literature on the use of Critical Incident Stress Management (CISM) in college and university settings posits that the self-contained nature of a college campus serves as a protective factor in mitigating for repeated exposure to stress and trauma, as there are inherent supports readily available in times of crisis. Weisen and Lischer (2006) identify that in addition to the utility of Crisis Response Teams (CRT or CISD) in

defusing, debriefing, and triaging of crisis response services, integrating peer support systems among faculty, staff, and students serves to promote ventilation of reactions and shared concerns, and fosters alliance-building (p. 184). In spite of this literature, although it is oftentimes used as a foundation for many campuses' crisis response protocols, with provision of training for counseling staff or law enforcement personnel, CISM is still not widely used among all college and university settings, nor are residence life staff routinely invited to participate in campus-based CISM trainings and practices. As such, this study holds value as it describes the utility of CISM at a college in Upstate New York that has prioritized CISM training for its Residence Life Staff, and has a full time staff member who serves as both the Director of the Counseling Center and the Director of Professional and Student Development within Residence Life and has been the core CISM trainer for the past 30 years. The study described Residence Life staff's values around inclusion in CISM work, RDs' perceived effectiveness of training, their awareness of peer support and outreach, and the function of structured debriefings in the context of their department's crisis intervention protocols. This school presented an ideal case study setting, as it was implied that CISM was embedded and infused into traditional Residence Life Training practices.

Given the lack of universal utility of CISM among colleges and universities, as well as the limited inclusion of residence life staff in CISM training, this study worked to answer the following overarching research question (**RQ1**): **How does a model of Critical Incident Stress Management (CISM) best serve Residence Directors at a college or university setting?** The following additional questions guided this study:

**RQ2:** How does a campus ensure best practices in the applications of CISM?

**RQ3:** What *value* do Residence Directors derive from their participation in CISM training?

**RQ4:** What *learnings* do Residence Directors take away from the CISM training that they perceive to manifest in their work?

**RQ5:** How do Residence Directors trained in CISM report that they *utilize* the model's basic principles and practices in their day-to-day work?

**RQ6:** How do Residence Directors perceive that their use of CISM techniques or strategies *affected* them and their abilities to *cope* with compassion fatigue and burnout?

**RQ7:** What resources, training, or supports do Residence Directors identify as missing, necessary, or most salient to them in their work and personal lives?

### **Site Selection and Sampling Strategies**

In qualitative research, as in other research methodologies, it is not necessary, nor feasible, to collect data from everyone in a given population in order to obtain valid findings. A sample or subset of a population is selected for any given study, and the research objectives and characteristics inform which and how many participants to select. In addition to determining the population to be studied, the researcher must select a setting for her research, and a phenomenon of interest. These choices are fundamental to the entire study, as is their description and justification (Rossman and Rallis, 2012, p. 137). Concurrently, as Rossman and Rallis (2012) advise in their text, the ideal research site is one where “entry is possible; there is a rich mix of the processes, people, programs, interactions, structures of interest, or all of the these; you can likely build strong relationships with the participants; and ethical and political considerations are not overwhelming” (Rossman and Rallis, 2012, p. 137).

For the purpose of this research, the population and phenomenon of interest were Residence Directors at college and university settings who had been trained in Critical

Incident Stress Management. The setting selected was a small private college in Upstate New York which had the desired population of interest and was within reasonable proximity to me as the researcher, thereby enabling greater access for data collection. This college is situated on 210 acres along the eastern and western shores of the Hudson River, and offers housing to over 3000 undergraduate students in 37 student housing facilities consisting of corridor, suite, apartment, and townhouse style residences. Its professional staff is comprised of eleven (11) Residence Directors, three (3) Assistant Directors, one (1) Associate Director of Housing and Residential Life, and one (1) Director of Housing and Residential Life. The paraprofessional staff is comprised of 76 Resident Assistants (RAs). There is a total of 6365 students, 4787 of whom are traditional undergraduates, 543 are adult continuing education, and approximately 800 are full or part time graduate students. A point of interest is that this college has a satellite campus in Florence, Italy, with nearly 1000 students. The college has been cited by the *Princeton Review*, *U.S. News & World Report*, *Kiplinger's Personal Finance*, *Barron's Best Buys in College Education*, and *Entrepreneur*, for its overall excellence, as well as leadership in the use of technology in and out of the classroom. The college is touted as a highly selective comprehensive liberal arts institution, and offers 44 Bachelor's programs, 12 Master's, and 21 Certificates.

This college was identified after I posted an email to a listserv of the North East Association of College and University Housing Officials (NEACUHO), soliciting information from other student affairs professionals regarding college and university campuses that trained their residence life staff on Critical Incident Stress Management, and incorporate Residence Directors in their CISM debriefing teams. What prompted the

email was an article by Weisen and Lischer (2006) of Saint Joseph's College of Maine which described their state-wide efforts to develop regional campus CISM teams as means of improving each member college or university's capacity to respond more comprehensively and efficiently to critical incidents that affected their communities. Weisen and Lischer provided a breakdown of the professional disciplines of those who attended their regional CISM training, and highlighted that 20 percent were Residence Life staff (p. 185). While no one from Maine responded to my email inquiry (perhaps too much time had passed since the study was implemented and those staff had moved onto positions outside of the Northeast United States), an Assistant Director of Residence Life at this small college in New York emailed back within ten minutes of my initial inquiry, and stated that not only were many of her RDs trained in CISM, but articulated that her campus also had its own CISM educator and that she could connect the two of us if I were interested. She clarified that while her RDs are not mandated to be trained in CISM, it is regularly offered as a professional development opportunity, and the campus has sent CISM teams to other campuses to conduct debriefings. Thus began a year-long correspondence including several phone conversations between myself and this CISM trainer, while the core of our dialogue centered on my research as well as my personal interest in becoming CISM certified. When it came time for me to begin to interface with Residence Directors who might serve as study participants, the CISM trainer provided me with a list of names and contacts for RDs she had trained in CISM at either her home institution as well as ones from neighboring campuses. I sent out an email explaining my research interests and the study parameters to this group of Residence Directors – the letter included content that was largely from my informed consent letter so as to clarify

the research procedures – and began to receive emails back expressing interest in participation. I also followed up with the Assistant Director who had contacted me initially, as well as the CISM educator, to request their involvement so as to gain a more collective perspective of the phenomenon under study within this bounded system. I employed *purposeful* sampling strategies, grouping participants according to preselected criteria relevant to my research questions (Rossman and Rallis, 2012, p. 139), and as mine was a phenomenological case study requiring several lengthy interviews with each participant, I chose to limit my sample size to no more than five participants: 2-3 Residence Directors, one Assistant Director, and one CISM educator.

Multiple means were used to ensure the fair and ethical treatment of my study participants, including my completion of an extensive internet-based human-research curriculum and exam (Collaborative Institutional Training Initiative – CITI); submission and approval of a University Human Subjects Review Form; development and utility of an informed consent letter, and acquisition of a transcription confidentiality agreement. In order to maintain the confidentiality and anonymity of the study participants, pseudonyms were assigned and utilized throughout the case study and in all research findings.

### **Instrumentation & Data Collection**

Phenomenological case studies are conducted over time and are a form of narrative inquiry or “life history research” that focuses on people’s storytelling through direct interviews; observations of participants as they go about their daily routines; and review, interpretation and analysis of personal correspondence and archival records (Rossman and Rallis, 2012, p. 104). While *instrumentation* refers to means of collecting



data, Merriam (1998) point out that the idea of “collecting data” is a bit misleading, as data does not simply exist as a physical entity like trash awaiting collection on a sidewalk (p. 69). Instead, Merriam states that data “have to be noticed by the researcher, and treated as data for the purpose of his or her research” (Merriam, 1998, p. 70). As such I utilized the traditional instruments of data collection in qualitative research for the purpose of making meaning of my research questions. I engaged in lengthy direct interviews with two Residence Directors and the CISM Educator and I had participants complete and submit the Professional Quality of Life Questionnaire to help determine their levels of compassion satisfaction and compassion fatigue/ burnout. The Assistant Director who initially connected me to this institution proved to be both unavailable and had not been personally trained in CISM, thereby proving to be a poor match for my participant group. While I sought to conduct observations of the participants in the context of CISM debriefings as they occurred, the limited timeline of my data collection, and the lack of critical incidents happening at the time prevented me from engaging in this practice on their campus. To account for this gap in relevant data, I included observations from the in-depth interviews conducted, sought access to relevant documents such as the college’s Residence Life crisis response and on-call protocols and reports, and conducted analysis and review of CISM curricula and debriefing materials, and participants’ Pro-QOL questionnaires and self-scoring guides.

Interviewing is the best technique to use when conducting rigorous case studies of a few selected individuals, and is essential when we are interested in past events that may not be replicated, or when we cannot observe behavior, feelings or how people interpret events that occur around them (Merriam, 1998, p. 72). Interviewing includes speaking

with participants both formally (when arranged beforehand) and informally (when the researcher is present on site for another purpose or event), and may occur directly and in person, or online via Skype, FaceTime, or a similar application (Rossman and Rallis, 2012, p. 168). For the purpose of this study, I conducted 2 *iterative, individual, semi-structured, open-ended* interviews with each participant, the first interview by phone, and the second, more lengthy interview was face-to-face. I completed necessary follow up via email and phone. Although phenomenological data gathering usually calls for 3 interviews, the first focusing on life history, the second on the details of the experience, and the third on reflection on meaning, I combined the second and third interviews out of respect for participants' time constraints and focused on this content during my campus visit and face-to-face interviews. While interview guides had been generated to help keep conversations flowing and focused, the interview questions were open-ended and related to one another in a way that allowed participants to free flow from one topic to the next while staying grounded in the research topic. Interviews were *recorded* via audiotape, and the content *transcribed* into text. This format allowed me to best respond and attune to the dynamics that emerged within each interview, particularly the participant's worldviews, while maintaining openness to new concepts that could arise (Merriam, 1998; Rossman and Rallis, 2012). Because this study looked to examine the feelings, beliefs, perceptions and interpretations of Residence Directors' exposure to CISM in the context of their work and the model's role in mitigating compassion fatigue, this flexible and more personal approach to inquiry was preferred.

Observation is fundamental to all qualitative investigations. Researcher observations are used during in-depth interviews to note body language and affect in

participants, while formal observation protocols take the researcher inside the study's setting to help ascertain social complexities, environmental conditions and context, as well as implicit and explicit theories of action. Rossman and Rallis (2012) highlight several reasons for including observations as part of a qualitative study: to understand the context; see tacit patterns; see patterns people may not see themselves; see patterns people may not want to talk about; provide direct personal experience and knowledge; and move beyond the selective perceptions of both the researcher and the participants (p. 193). "Observations signal participants' emotions, attention and interest, authenticity, and fatigue" (Rossman and Rallis, 2012, p. 169).

My original course of action was to utilize *direct, non-participatory observations* of Residence Life department meetings; CISM refresher trainings and or CISM team meetings; Residence Directors roles in Critical Incident Stress Debriefings (CISD); and Residence Directors in their crisis intervention capacities, paying close attention to utility of CISM-based strategies to both diffuse critical incidents, and provide structure, normalcy, and closure to RD's on call. In reality, this proved to be challenging on multiple levels, the most significant of which were access and time. Campus visits and availability of participants turned out to be the most difficult to coordinate, and prevalence of critical incidents added to privacy and confidentiality restrictions made *non-participatory observations* less viable. Concurrently, while I had a greater number of participants scheduled for interviews during my campus visits, several dropped out of the study as they absorbed additional responsibilities on campus because of existing staff vacancies, and they worried about becoming overextended. As the core of my study examines burnout in staff, while losing participants added to my stress and anxiety, I was

proud of these staff for asserting their boundaries and practicing the self-care I was endorsing myself. Finally, a major finding to be discussed in Chapter Four (4) will speak to my assumption of the CISM model's integration into the campus protocols and practices, and the reality I unveiled that, in fact, the model was not integrated at all.

In order to be better aware of what CISM-based strategies I should be attuned to in my observations, I attended a regional conference by the International Critical Incident Stress Foundation (ICISF) in March of 2015 and was triple certified in Individual, Peer Support, and Group Crisis Intervention – the 3 foundational components of Critical Incident Stress Management. I then attended a second conference in August of 2016 and gained my Advanced Individual and Group Crisis Intervention certifications with a goal of enrolling in ICISF's Approved Instructor Program and becoming a CISM educator myself. As I wanted to gain hands-on experience in CISM and put my training and certifications into practice, I volunteered my time with a regional emergency services medical corps as a team member/clinician and facilitated numerous CISM debriefings and one-on-one interventions for local fire fighters, EMS, and law enforcement personnel. Detailed *field notes* and archival data from these trainings were reflected upon and incorporated in the analysis of my participant interviews and are discussed in greater detail among my findings. "The *running record* is the data about the research, [while] the *observer comments* are the data about the process and yourself" (Rossman and Rallis, 2012, p. 194). I was sure to transcribe the raw field notes into computerized digital records in a timely manner so as to ensure some preliminary analysis and clarify vague statements. When appropriate, audio recording were used with permission of participants and administrators, and recordings were transcribed to supplement the field notes. At this

stage I generated *thick descriptions* which helped establish credibility and “present details, emotions, and textures of social relationships. . . [for] thick descriptions are necessary for thick interpretations. . . Credibility is established through the lens of readers who read a narrative account and are transported into a setting or situation” (Denzin, 1989, p. 83).

I engage in a review of relevant documents, or what Merriam (1998) refers to as “mining data from cultural artifacts” (p. 113), consisting primarily of public records, personal documents with confidential information redacted, and physical materials. Archival records included such things as organizational charts; Residence Life crisis response flowcharts and protocols; Residence Director on-call reports; CISM training materials and curricula; and participants self-scored ProQOL questionnaires. As stated earlier, availability and access to confidential archival data proved more challenging than originally anticipated, so document review was therefore limited to CISM training materials and curricula, and participants’ self-scored ProQOL questionnaires. Yin (1984) writes that documents are helpful in verifying accurate spelling of participants’ names and titles, as well as clarifying information about the organization that may have come up in interviews or observations. He adds that secondarily, documents can serve to corroborate information from other sources by providing additional detail, and that if the documents are in fact contradictory to information gathered, the researcher has grounds and details by which to inquire further into the topic. Finally, Yin states that inferences can be made from documents, yet that “these inferences should be treated only as clues worthy of further investigation rather than as definitive findings, because the inferences could later turn out to be false leads” (Yin, 1984, p. 81). The most important use of

*documents* was to substantiate and enhance evidence from other sources within the case study, and this proved to be the case here as well.

A major strength of case study data collection is the opportunity to use and rely on diverse sources of evidence. “The use of multiple sources of evidence in case studies allows an investigator to address a broader range of historical, attitudinal, and observational issues. However, the most important advantage presented by using multiple sources of evidence is the development of converging lines of inquiry, a process of triangulation... following a corroboratory mode” (Yin, 1984, p. 91). While triangulation is discussed in greater detail in the Verification of Findings portion of this chapter, the takeaway from my proposed instrumentation was the necessity and challenge of building a foundation of evidence about which findings or conclusions can be drawn (Rossman and Rallis, 2012, p. 174). As advised by a colleague, I relied heavily on the online qualitative research software tool, **Dedoose**, to confidentially manage and store data, as well as provide coding and analysis support. Data was also backed up in **Box** as an added precaution.

### **Analytic Framework and Data Analysis Procedures**

At its core, an analytical framework is grounded in knowledge of the data (*immersion*), its organization and reorganization into patterns and themes that align with the researcher’s conceptual framework (*analysis*), and meaning making (*interpretation*) of those patterns that relies on inductive and deductive reasoning to foster *emergent understanding* of what is under study (Rossman and Rallis, 2012, Pg. 263). Concurrently, there are two sets of overall analytic strategies – one focused on development, coding and sorting of groupings (categorizing strategies), while the other is based more on

description of connections among data resulting in a narrative portrayal of an individual or program within a specific context (holistic strategies). My aim was to develop an understanding of the ways in which a model of Critical Incident Stress Management (CISM) could best serve Residence Directors at a college or university setting, and to explore how utility of this model can help mitigate compassion fatigue in Residence Directors. As mine was a phenomenological descriptive case study, it lent itself more to holistic, contextualized analysis, which is “especially useful when you want to capture a person’s experience in a setting” (Rossman and Rallis, 2012, p. 268). The following two tables encapsulate how the proposed research methods, theoretical, and conceptual frameworks aligned with the research questions to craft a logical analytic framework.

**Table 2: Methods of Investigation for Research Questions**

(Highlighted columns were proposed but proved non-viable - \*CISM Debriefing (CISDs) data was available as a result of my volunteer work with a local emergency medical services corps as a CISM Team Member/ Clinician, but not specifically within the case study site)

Method →	1:1 Interviews w/ Residence Directors	1:1 Interviews w/ CISM Educator	1:1 Interviews w/ Asst. Director for Housing & Residential Life	Review of Pro-QOL questionnaire	Review of Residence Life On-Call Documents and Crisis Response Protocols	Review of CISM Training Materials	Obs. of CISM Training (and Rehearsal of Skills)	Obs. of CISM team meetings and debriefings (CISD)
How does a model of Critical Incident Stress Management (CISM) best serve Residence Directors at a college or university setting?	X	X	X	X	X	X	X	X
How does a campus ensure best practices in the applications of CISM?		X	X		X	X	X	X
What <i>value</i> do Residence Directors derive from their participation in CISM training?	X	X	X			X	X	X
What <i>learnings</i> do Residence Directors take away from the CISM training that they perceive to manifest in their work?	X	X	X			X	X	X
How do Residence Directors trained in CISM report that they <i>utilize</i> the model's basic principles and practices in their day-to-day work?	X	X	X		X	X	X	X
How do Residence Directors perceive that their use of CISM techniques or strategies <i>affected</i> them and their abilities to <i>cope</i> with compassion fatigue and burnout?	X	X	X		X		X	X
What resources, training, or supports do Residence Directors identify as missing, necessary, or most salient to them in their work and personal lives?	X	X	X		X			X

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**Table 3: Alignment of Conceptual Framework with Theory & Research Questions**

	Compassion Fatigue	Compassion Satisfaction
<b>Stamm’s (2009) Work Environment (Organizational Systems)</b>	<ul style="list-style-type: none"> <li>• A culture of isolation</li> <li>• Lack of trust</li> <li>• Lack of transparency</li> <li>• Lack of communication</li> <li>• Unclear boundaries</li> <li>• Long inconsistent hours</li> <li>• Ineffective supervision and debriefing</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy boundaries/transparency</li> <li>• Regular hours</li> <li>• Supportive supervision</li> <li>• Critical incident debriefing</li> <li>• Mentoring relationships and peer support</li> <li>• Collaboration with campus partners</li> <li>• Physical reminders of our life outside of work</li> <li>• Varied work-related tasks and projects</li> <li>• Innovative professional development opportunities that enhance our skills as helpers and crisis workers</li> </ul>
<b>Theories</b>	<p><b>Safety Needs:</b> Security of employment and resources; <b>Esteem Needs:</b> Respect of others, respect by others, achievement, confidence, self-esteem, competence (Maslow, 1954); “When people are repeatedly exposed to danger, they become hypersensitive to even the most minor of threats to their safety, and react to these threats physically, emotionally, and cognitively” (Bloom, 1999)</p>	<p><b>Safety Needs:</b> Security of employment and resources; <b>Esteem Needs:</b> Respect of others, respect by others, achievement, confidence, self-esteem, competence; <b>Self-Actualization:</b> Problem solving, lack of prejudice, acceptance of facts. (Maslow, 1954); “The real nature of the fight of flight response means that if we hope to help traumatized people, then we must create safe environments to help counteract the long term effects of chronic stress” (Bloom, 1999).</p>

**Guiding Principles**

- Current practitioners in the field of student affairs must continually examine the ways in which the changing needs of college students are matched by the formal training that is offered during campus orientation and ongoing professional development opportunities.
- Residence Life departments have a responsibility to create communities of practice that promote social support, open dialogue, effective supervision, and structured debriefing of critical incidents.

**Research Questions**

- **RQ1:** How does a model of Critical Incident Stress Management (CISM) best serve Residence Directors at a college or university setting
- **RQ2:** How does a campus ensure best practices in the applications of CISM?

<b>Stamm’s (2009) Client Environment (Our Students)</b>	<ul style="list-style-type: none"> <li>• Countertransference</li> <li>• Inappropriate disclosure</li> <li>• Traumatized by stories of those we help</li> <li>• Lack of empathy for those we espouse to help</li> <li>• Feelings that our work and efforts make no difference</li> <li>• Inability to focus or retain information</li> <li>• Intrusive thoughts about traumatic events we assisted with or that were disclosed to us</li> <li>• Burnout</li> <li>• Frustration &amp; anger</li> </ul>	<ul style="list-style-type: none"> <li>• Deriving pleasure from helping those who need care</li> <li>• Healthy boundaries</li> <li>• Appropriate disclosure</li> <li>• Person-centered helping (Rogers)</li> <li>• Solution-focused helping (DeShazer)</li> <li>• Awareness of our limitations as helpers</li> <li>• Referral to support services</li> <li>• Compliance with Student Code of Conduct to promote safety and security and consistently hold students accountable</li> </ul>
<b>Theories</b>	<p><b>Safety Needs:</b> Security of morality and property; <b>Esteem Needs:</b> Respect of others, respect by others, achievement, confidence, self-esteem, competence; “Traumatization occurs when both internal and external resources are inadequate to cope with external threat” (Van Der Kolk, 1989).</p>	<p><b>Safety Needs:</b> Security of morality and property; <b>Esteem Needs:</b> Respect of others, respect by others, achievement, confidence, self-esteem, competence; <b>Self-Actualization:</b> Problem solving, lack of prejudice, acceptance of facts (Maslow, 1954); Bloom (1999) describes the process of <b>creating sanctuary</b> as the creation of <i>safe environments</i> that promote healing and sustain growth, learning, and well-being. An essential tenet of creating sanctuary is based in the shifting of attitudes away from blame and criticism and toward compassion and understanding.</p>

**Guiding Principles**

- Residence Directors should cultivate a sense of introspection and self-reflection so as to better recognize the impact that repeated exposure to stress and traumatic activity may have on their well-being.
- Residence Directors must be taught means of recognizing personal triggers that manifest in their work and diminish their capacity to be compassionate helpers.

**Research Questions**

- **RQ3:** What *value* do Residence Directors derive from their participation in CISM training?
- **RQ4:** What *learnings* do Residence Directors take away from the CISM training that they perceive to manifest in their work?
- **RQ5:** How do Residence Directors trained in CISM report that they *utilize* the model’s basic principles and practices in their day-to-day work?

<b>Stamm's (2009) Personal Environment</b> (Ourselves and our families)	<ul style="list-style-type: none"> <li>• Withdrawal</li> <li>• Isolation</li> <li>• Depression and feelings of hopelessness</li> <li>• Inability to eat/ sleep</li> <li>• Lack of motivation</li> <li>• Increased use of substances (alcohol/ drugs) as means of coping</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy and fulfilling relationships</li> <li>• Self-care (sleep, eat, exercise, relax, laugh)</li> <li>• Hobbies and outings</li> <li>• Present and engaged with family members</li> <li>• Healthy coping skills</li> <li>• Self-referral to support services</li> </ul>
<b>Theories</b>	"A traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience" (Bloom, 1999).	<b>Physiological Needs:</b> Breathing, food, water, sex, sleep, homeostasis; <b>Love &amp; Belonging:</b> friendships, family, intimacy; <b>Safety Needs:</b> security of body, family, and health; <b>Self-Actualization:</b> Morality, creativity, spontaneity (Maslow, 1954).

### Guiding Principles

- Residence Directors should practice self-care strategies that foster greater work-life balance and reinforce the practice of self-care within the day-to-day routine.

### Research Questions

- **RQ6:** How do Residence Directors perceive that their use of CISM techniques or strategies *affected* them and their abilities to *cope* with compassion fatigue and burnout?
- **RQ7:** What resources, training, or supports do Residence Directors identify as missing, necessary, or most salient to them in their work and personal lives?

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Analysis of *Phenomenological studies* is primarily open-ended, extrapolating meaningful themes in participants' lived experience, and relying heavily on interview data. The researcher still seeks to define broad categories and subthemes, but is constantly attuned to how participants interpret their own experiences and how their feelings and perceptions affect the research landscape. Moustakas (1994) specifies the need to ask participants two general questions during the interview process (what have they experienced in terms of the phenomenon? what contexts or situations have typically influenced or affected their experiences of the phenomenon?), in order to yield data (significant statements, sentences, quotes, themes) that provide an understanding of how participants experienced the phenomenon (*imaginative variation*), and will enable *textural* and *structural descriptions* of those experiences (Creswell, 2012, p. 61). "From the structural and textural descriptions, the researcher then generates a composite description that presents the 'essence' of the phenomenon, called the *essential*, *invariant*

*structure (or essence)*” (p. 62). Some possible themes that I suspected would emerge in the course of my data collection and analysis and relate to my conceptual framework were based in Residence Directors’ ways of **coping**; whether stress debriefing allowed RDs to **compartmentalize** their trauma work in order to achieve **closure**; whether RDs trained in CISM felt they were more likely to engage in **self-care** practices that enabled them to sustain **perspective** and work-life balance; and whether RDs saw value in CISM training as a means of enhancing their **helping skills**.

Analysis of *case studies*, focuses holistically on the phenomenon under study, and relies on multiple points of data to “capture the complexity of a particular event, program, individual, or place” (Rossman and Rallis, 2012, p. 273). Through this multimodal data collection, an intricate description of the case emerges in which the researcher identifies such characteristics as the history of the case, the chronology of events, or a day-by-day interpretation of the activities of the case. After this description is generated, the researcher might focus on a few key issues (*analysis of themes*), not for the sake of generalizing findings beyond the case, but for the purpose of understanding the intricacies of the case. What follows next are assertions or interpretations of the meaning of the case – what Lincoln and Guba refer to as “lessons learned” from the case (Creswell, 2012. p. 75). The case study of a college which offers CISM training to Residence Life Staff may have specific elements of interest, such as **organizational support, value for professional development, structured crisis intervention protocols** and other such categories that would inform initial analytical thinking and provide aid in coding the data.

Speaking more generally, “data analysis is a process which brings order, structure, and meaning to the mass of collected data” and all analytic procedures usually include the following eight phases: organizing the data; familiarizing yourself with the data; identifying categories; coding the data; generating themes; interpreting; searching for alternate understandings; and writing the report (Rossman and Rallis, 2012, p. 273). As described in the instrumentation section of this chapter, audio-recording, transcription, field notes, and archiving were used as means of recording and storing data, while self-recorded voice notes, observer comments, *analytic memos*, highlighting, and post it flags were used to catalogue hunches, outline potential themes, develop operational questions, and note analytic insights and links between themes and my theoretical framework. These served to help me refine my thinking and reflections on the data, as well as keep my critical friends group and committee members aware of my progress. An *audit trail* was used as means of tracing the progress from raw data to final product (Lincoln and Guba, 1985).

### **Limitations and Delimitations**

This study had a sample size of 3 participants, and though the sample was appropriate for the research methods employed, results of the study could only be generalizable for the purpose of expanding theoretical notions, and served little basis for statistical generalization. Similarly, the site chosen for this case study was a small, private college with a Residence Life department that had the means and resources to train its staff in CISM and included it among its standard professional development practices. Recreating such efforts and crisis intervention models at a major, public state university with a larger Residence Life Department and more extensive campus constituents can

likely present great challenges, such as access to financial means and resources, administrator buy-in, state and federal constraints, and the social dynamic of micro-politics. Nonetheless, a significant milestone embedded within this research and one that I viewed as a personal and professional triumph, was my organization's willingness to listen to my research and advocacy for CISM and commit to getting all Residence Directors, Assistant Directors, and Graduate students in our department trained in Group CISM. In the span of two business days, we were able to certify 60 professional staff and interested campus partners from the Dean of Students Office, the counseling center, and our campus police force.

Having chosen a single-site case study design, versus a multi-site collective case study, I chose to demonstrate different perspectives on the issue by interviewing a variety of staff within the organization instead of conducting multiple cases. It would have been interesting to perhaps compare various institutions and their CISM practices, but access to other campuses was limited to folks who self-identified as willing to undertake participation in my study. I aim to focus future publications on a more detailed examination of other colleges and universities in the Northeast United States whose Residence Life staff are incorporated into CISM trainings, debriefing teams, and protocols.

The time frame projected for data collection was a limitation as travel to site visits could happen more easily over the summer, yet many residence life staff were either off contract at that time or neck deep in training and orientation preparations for the fall. Additionally, case study research is characterized as extensive and oftentimes longitudinal, yet my projected time frame for data collection spanned only 12 weeks for

the purpose of creating manageable boundaries for this research that allowed for adequate analysis and reflection.

Perhaps most importantly, the nature of Critical Incident Stress Management as a crisis intervention model is such that it exists for the purpose of addressing a broad spectrum of critical incidents to mitigate psychological trauma and post-traumatic stress. These conditions are difficult (and potentially harmful) to simulate for training and research purposes, and as such, my proposed observations of CISM debriefings were contingent upon the occurrence of college-based critical incidents throughout the time of my study (including interventions as part of RDs' on-call responsibilities), and were to be supplemented by observations of debriefings at settings other than the research site for the sake of generating supportive data. Concurrently, although the study participants had all been trained on CISM, their scope of experience with the model, and specifically with conducting debriefings, could have been limited. I had interest in gauging the model's utility for Residence Directors on a broader scale than just their participation in CISM teams and debriefings (i.e. enhanced competence in individual crisis intervention, awareness of stress reactions, development of peer support systems, and maintenance of self-care practices), so this was less of a limitation and more a delimitation.

### **Verification of Findings**

*Assuring validity becomes the process whereby ideals are sought through attention to specified criteria, claims to knowledge are made explicit, and techniques are employed to address the most pressing threats to validity for each type of inquiry. (Whittemore, Chase, and Mandle, 2001, p. 528).*

Qualitative researchers routinely engage in one of several procedures such as triangulation, member checks, thick description, peer debriefing, and external audits as

means of establishing validity (Creswell & Miller, 2000, p. 124). These strategies were used to enhance the credibility and rigor of this study and to ensure research findings and suppositions were verified for their accuracy and validity in the context of the phenomenon under study.

**Triangulation** is a procedure by which researchers look for convergence among multiple sources of data, through various points in time, and a variety of research methods for the purpose of gaining a complete picture of what is under investigation. The concept originates from military navigation whereby sailors triangulated among several distant points on the horizon to determine a ship's bearing (Creswell and Miller, 2000, p. 126). Denzin (1978) identifies four types of triangulation across *data sources*, *theories*, *methods*, and *among different investigators*, and posits that as a validity procedure, triangulation is a “systematic process of sorting through the data to find common themes or categories by eliminating overlapping areas” (p. 127). In the course of my research, triangulation occurred across participant interviews and their review of their transcripts (member checks); field notes from direct observations; and examination of archival data for the purpose of defining emerging themes.

Participant validation, also known as **member checking** takes the validity process and shifts it from the researcher to the participant, as the researcher seeks feedback, clarification, or elaboration by bringing emergent themes or findings back to the participants (Rossman and Rallis, 2012, p. 65). Member checking occurred at several points throughout the study – throughout the interview and transcription process, during review of field notes and observer comments with participants, through verification of

archival data, and at the conclusion of the study when findings were communicated to the participants for final review.

**Researcher reflexivity** was raised earlier in this chapter and is identified here as a validity procedure that serves to acknowledge and describe the researcher's assumptions, values, beliefs, and biases early in the research process so participants and readers understand the researcher's frame of reference, and are able to compartmentalize or suspend them while the study proceeds (Creswell and Miller, 2000, p. 127). More broadly, **Reflexivity** refers to an awareness of the researcher's role in the practice of research, and an understanding that the researcher and study participants affect each other mutually and continually throughout the research process (Alvesson and Skoldburg, 2000, p. 482). The interview guides intentionally created a space for participants to engage with me about my motivations for doing this research, and my aim for *prolonged engagement* within the research site served to establish rapport and foster ongoing exchanges.

Finally, and perhaps most importantly, I raise the necessity for **peer debriefing**, fondly referred among our cohort as reliance on and utility of *critical friends*. This served not only as a measure of validity, as this warranted review of the data by someone who was familiar with the research and the phenomenon being explored, but it also nurtured a feedback loop that subsisted on a consistent and critical level of peer accountability, collaboration, challenge, and support.

### **Ethical Considerations**

Ethical issues are present in any and all forms of research. As qualitative research begins with claims made by the researcher at the outset, and generates questions that



inform learning and discovery for the sake of improving a certain condition, ingrained in those questions is the researcher's moral compass. An ethical researcher draws on her moral principles to guide her decision making (Rossman and Rallis, 2012, p. 68) while being cognizant that the research process "creates tension between the aims of research to make generalizations for the good of others, and the rights of participants to maintain privacy" (Orb, Eisenhauer, and Wynaden, 2000, p. 93).

Qualitative research takes place in the real world, with people who live and work in a specific setting, and who entrust their lives and privacy to the researcher for a span of time. As such, the researcher has the responsibility to protect participants' identities, and to deliver full privacy and confidentiality if it is pledged. Rossman and Rallis (2012) state that "trustworthiness of a qualitative study is judged by 3 interrelated sets of standards: First, was the study conducted according to norms for acceptable and competent research practice? Second, was the study conducted in ways that honor participants—was it conducted ethically? Third, was the researcher sensitive to the politics of the topic and setting?" (p. 6). These are interrelated as compliance with all three is not inherent within the research process, and at any given time the researcher's integrity may be affected. As may be apparent in this case study, in the course of interviewing crisis workers or survivors of violence, the interview could trigger painful experiences and the participant may become distressed. The researcher is confronted with an ethical dilemma—to continue with the interview and gain more insight about the topic under study or to stop the interview, show empathy, and refer the participant to appropriate support services. "Deciding to continue [the interview] would indicate that the researcher considers that the value of the data obtained from the distressing experience outweighs the participant's

distress” (Orb, Eisenhauer, and Wynaden, 2000, p. 94), or perhaps the researcher believes in the therapeutic benefits of catharsis and ventilation, specifically as means of instilling in participants a sense of purpose, heightening self-awareness, and promoting healing (p. 94). This juncture denotes the importance of seeking ongoing consent.

As I formalized my research proposal and prepared for data collection, formal approval was sought and obtained from the University of Massachusetts Human Subjects Review Committee and Institutional Review Board. Attached in the appendices of this dissertation are copies of an Informed Consent Letter, the Collaborative Institutional Training Initiative Human Research Curriculum (CITI) completion report, as well as the Transcription Confidentiality Agreement. Upon endorsement of my research by the IRB, I initiated contact with the study participants and began to schedule site visitations, making sure participants were made aware of their rights, and understood means of letting me know if they elected to terminate participation in the study at a later point. I was sure not to exploit anyone affiliated with the study both formally and informally, nor discriminated against potential study members on the basis of their social identities including their age, socio-economic status, race, or gender.

## **CHAPTER 4**

### **FINDINGS AND DISCUSSION**

Chapter 3 presented a framework by which this study would be conducted, highlighting a rationale for the chosen research methods, proposed means of collecting data, and suggested analytical procedures. The purpose of this research was to develop an understanding of the lived experience of Residence Directors in the context of their training and utility of CISM protocols and practices, and to examine how this can serve to minimize manifestations of compassion fatigue for Residence Life Staff. A qualitative phenomenological single-site case study design included interviews, observations, and an analysis of public documents. Chapter 4 consists of a comprehensive account of this study's research findings and describes Residence Life staff's values around inclusion in CISM training, perceived effectiveness of CISM in the context of the model's utility in day-to-day work, awareness of organizational support and peer outreach, and reflections on comprehensive integration of CISM into campus crisis management as it is aligned with other Residence Life crisis intervention protocols. The findings are also discussed in the context of relevant literature as articulated in the conceptual framework for the study.

In summary, the setting selected for this case study was a small private college in Upstate New York which had the desired population of interest and was within reasonable proximity to me as the researcher, thereby enabling greater access for data collection. The college is located in the Hudson River Valley, and offers housing to over 3000 undergraduate students in student housing facilities consisting of corridor, suite, apartment, and townhouse style residences. Its professional staff is comprised of eleven (11) Residence Directors, three (3) Assistant Directors, one (1) Associate Director of

Housing and Residential Life, and one (1) Director of Housing and Residential Life. The paraprofessional staff is comprised of 76 Resident Assistants (RAs). There is a total of 6365 students, 4787 of whom are traditional undergraduates, 543 are adult continuing education, and approximately 800 are full or part time graduate students.

I conducted interviews with three professional staff at the college. The first, **Regina** \*(all names changed to ensure privacy), was the college's CISM Educator, although her full-time roles were Director of Professional and Student Development and Director of Counseling Services. She worked at the college for over 40 years and had served as one of the primary CISM trainers for the region for over 30 years, providing debriefing support to regional fire, EMS, and law enforcement agencies as needed, and facilitating basic Individual and Group CISM certification courses as requested for her college as well as other colleges, K-12 schools, juvenile justice programs, and other organizations in New York and western New England. The second participant was **Cheryl**, who worked as a Residence Director at the college and was in her third year in that role. Cheryl, alum of the college and a former Resident Assistant, Orientation Leader and Senior Orientation Coordinator, worked in residence life at a neighboring school upon completion of her Bachelor's degree, and then decided to return to her alma mater for her second professional role in student affairs, as she pursued her Master's degree in Higher Education Administration. In addition to serving as a Residence Director, Cheryl coordinated all housing assignments for the college. Last, but not least, **Marilyn** worked at the college as a Residence Director for 3 years, transitioned to an Assistant Director of Residence Life role briefly at another institution in another state, and then returned to New York to pursue a career in academic support services. Both Marilyn and Cheryl

were trained in CISM by Regina while they served as Residence Directors at the college, and the three have maintained a close professional relationship over the years despite changes in roles and professional affiliations. Both Marilyn and Cheryl underwent professional staff training upon hire at the college and ongoing professional development throughout each academic year. Both reflected that while crisis management protocols were discussed while preparing new professionals for on-call responsibilities, their Residence Life training included minimal helping or counseling skills, large-scale crisis intervention training, or stress management and self-care strategies.

This study strove to explore the overarching research question (**RQ1**) of **how a model of Critical Incident Stress Management (CISM) can best serve Residence Directors at a college or university setting**. The study then utilized the following additional questions to more deeply examine utility and applications of CISM training for Residence Life Staff as means of mitigating for compassion fatigue:

**RQ2:** How does a campus ensure best practices in the applications of CISM?

**RQ3:** What *value* do Residence Directors derive from their participation in CISM training?

**RQ4:** What *learnings* do Residence Directors take away from the CISM training that they perceive to manifest in their work?

**RQ5:** How do Residence Directors trained in CISM report that they *utilize* the model's basic principles and practices in their day-to-day work?

**RQ6:** How do Residence Directors perceive that their use of CISM techniques or strategies *affected* them and their abilities to *cope* with compassion fatigue and burnout?

**RQ7:** What resources, training, or supports do Residence Directors identify as missing, necessary, or most salient to them in their work and personal lives?

## **RQ1: How Can a Model of CISM Best Serve RDs at a College or University Setting?**

Attempting to answer this question was a lofty ideal, especially in light of this single-site case study design. Nonetheless, while the results of this study cannot be generalized to all settings and conditions, data collected were aligned with both the theoretical frameworks discussed in Chapter 2, as well as practical implications discussed in CISM literature. While I provide examples to illustrate the findings to this overarching question of CISM's utility for Residence Directors working in college and university settings, supplemental evidence is provided in later discussion of Research Questions 3 and 4. To start, I highlight the primary findings extrapolated for RQ1 which were that *while training RDs in Critical Incident Stress Management didn't ensure their participation or involvement in formal debriefing teams (CISD), it did provide them with a foundation upon which to rely when dealing with critical incidents of any magnitude, and it informed their practice day-to-day by building their capacity and promoting the development of structured systems of support.*

As articulated by Regina, the CISM Educator for the college,

I certainly would suspect that not only learning the protocols, going through training together brings them together, even as an informal team. [The RDs] are close friends, they went through the training, and it gives them structure. It gives them a language. It gives them a resource to each other. And, I think some of the exercises we do in the training also validate what they've been doing all along. (Regina, October 6, 2015).

These sentiments were echoed by Cheryl, a Residence Director who stated she likes having “a flowchart of things to go through” that she can access when an incident occurs in addition to her crisis protocols from the college. She and her colleagues often ask themselves how well equipped they would be if something were to happen on campus which affected numerous people. She reflects that what they gained from the CISM

training was a basic knowledge of “okay, I feel confident that if something big happened at least we have the right steps to go in. It may not be like scenarios [the role plays we did in training], but at least we have something to go off of now, a framework for managing incidents. I think if you have a game plan for something it makes it a lot easier to handle. When something happens we tend to say ‘I bet there's a ‘CISM about this.’ Everyone else calls it C-I-S-M. But we're like ‘there’s gotta be a ‘CISM about this’. We could probably handle this if we needed to” (Cheryl, October, 7, 2015).

Cheryl also described the benefits of having consistent opportunities to debrief with colleagues and relies on peer support to get through challenging situations when on call. She is clear that while peer support was implicit in the CISM curriculum, this culture of caring and connection is further fortified by their Director of Residential Life, also trained in CISM, who role models a high ethic of care and an open door policy. What is identified as a departmental norm at the college, is in fact reminiscent of Killian’s (2008) predictive factors of compassion satisfaction, specifically *higher reports of social support* and a *higher internal locus of control at the workplace* (p. 41). If an institution of higher learning makes it a priority to foster peer support networks and enables its employees to effect change within the work setting to improve work-life balance and promote self-care, employee satisfaction increases (compassion satisfaction) as does employee resilience.

As trainers, educators, and supervisors, we want to protect [helpers] from compassion fatigue, enhance their resilience, and help professionals deliver quality interventions, but to achieve these goals, we may need to shift paradigms, moving our focus away from individualistic efforts at education and training and toward a more systemic approach of advocacy for healthier working conditions. (Killian, 2008, p. 43)

Cheryl describes this shift from the individualistic to the collective:

I know there are certain times of the week when all of us call each other and check in. A lot of us check in with each other during lunch and are like, 'Hey, I heard this is going on' or 'I saw this in Advocate. You've dealt with this before. What did you do? Help me along here'. We often debrief during lunch, at staff meetings, or over the phone. (Cheryl, October 7, 2015).

When there are consistent and structural opportunities for feedback, consultation, and social support, and when these are role modeled to new professionals by more seasoned ones, Residence Life Staff are able to rebound more quickly following their involvement in critical incident management, and are better able to maintain healthy work-life balance (Fullerton, Ursano, Vance, & Wang, 2000; van der Kolk et al., 1996). Regina stated that what attracted her most to the CISM model was that it was peer-driven, non-clinical, made intuitive sense, and strung together logical interventions.

On a practical basis on any college campus the counseling center is never going to be big enough to address a major incident that impacts 4,000 students or 250 students. And, in fact, they [students] don't all need the clinical work. It's an opportunity to triage, teach to stress management, do some bringing the group together, and talking about resiliency. To pathologize everyone I think does harm. (Regina, October 6, 2015).

Instead of pathologizing, CISM serves to normalize stress reactions – as I sat through my own CISM training, the message was clear - physical, emotional, cognitive, and behavioral reactions to a critical incident are *normal reactions of a normal person to an abnormal situation or event* (Mitchell, 2006, p. 130). When helping professionals are able to contextualize their stress reactions following a critical incident, they are better able to engage in adaptive coping mechanisms and employ a cognitive anchor. "CISM and CISD reduce staff anxiety, facilitate coping skills, help employees to return to work, lead to cost-savings for the organization and many other benefits" (Robinson, 2004, p. 29). Regina reflected that years of working in student affairs paired with her extensive



exposure to CISM principles have helped her to hone self-care practices and develop a deeper understanding of her efficacy as an interventionist:

Not to be overly dramatic, but this model has become part of my life. The history of it! That one incident will stay with me forever. That moment that you feel - I, we, have to do something, and I don't have the skills to do it the way I want to do it. I will never be in that position again! So, I think it's very important - this mindset of service to others, self-care, and the balance in between – as a way of looking at the world. I would like to see more interest in this particular model and the training of more people. (Regina, October 6, 2015)

Routine, proactive and “*emotionally positive*” self-care strategies, such as reducing workload, accessing supportive supervision and socializing with peers have been directly linked with reduced incidence of reported work stress. Cheryl and Marilyn spoke of connecting with colleagues over lunch, checking in after long on-call shifts, and soliciting feedback from their supervisors as means of maintaining good work-life balance and keeping perspective when stress is high. “Helping professionals should maintain social support, and this might take the form of sustaining an active social network and perhaps processing or debriefing with especially tough cases... Talking with supervisors, consultants, and colleagues may represent a basic, effective practice that can ward off secondary traumatization” (Killian 2008, p. 42). In his book, *On Being a Therapist*, Jeffrey Kottler (1993) explains that serving in a helping role or profession can be quite stressful, even when workers are not first responders in acute disaster situations. While many studies have focused on compassion fatigue and burnout as consequences of professionals' service delivery in cataclysmic circumstances, there are also high incidence of burnout and subsequent turnover by helpers dealing with more typical scenarios and settings whereby crisis response can have a cumulative effect through repeated exposure. To mitigate for this and safeguard helping professionals from the

damaging effects of secondary traumatization, organizations can take on the task of establishing clearly defined teams, as well as proactively distributing workload so that traumatic exposure of any worker is limited. In the case of residence life and student affairs work, this manifests itself as rotating through shorter on-call shifts and building in structured opportunities for debriefing, thereby reducing psychological strain, and increasing compassion satisfaction and organizational commitment.

Organizations could institute policy changes to help make the workplace a space where [helpers] feel a sense of collegiality and support, and where they feel they have a sense of control (e.g., having some say about administrative policies, experiencing a degree of predictability in their workload, etc.)... As social support is an important ingredient in our fight against compassion fatigue, forging connections to broader community movements (e.g., participating in political advocacy for trauma survivors) might help us to resist the debilitating effects of alienation, isolation, helplessness, and cynicism. (Killian 2008, p. 42).

Nonetheless, working toward this level of organizational buy-in is easier said than done as is demonstrated by my findings for RQ2.

### **RQ2: How Does a Campus Ensure Best Practices in the Application of CISM?**

As is the case with most studies, I came into my research with some assumptions and pre-established beliefs. While some experts will tell researchers to identify and check their biases at the door so as to avoid any tendencies which prevent objective consideration of the research questions, Rossman and Rallis (2012) discuss assumptions as “fundamental propositions” that we take for granted. “Because you construct the study and because you ask the questions, becoming aware of your perspective, with its built in interests, biases, opinions, prejudices, and assumptions is an ongoing task” (p. 34). I was aware of some of my assumptions about the utility of CISM as well as the lived experience of Residence Directors before I collected my data, and then went about collecting evidence to either reinforce or debunk these. I had intentionally chosen this

particular campus for the case study, as I knew they had their own CISM educator, trained their residence directors in CISM, and I believed they had fully integrated the model into their campus culture and crisis management practices. In fact, I based my second research question (**RQ2**) on this assumption, seeking to know **how a campus ensured best practices in the application of CISM**. As inferred from both CISM literature and my analysis of the data, the secondary theme that emerged as a finding for RQ2 was that *a campus could ensure best practices in the applications of CISM if it fully integrated the model into its day-to-day functions, and if there is buy-in and role modeling from constituents at higher administrative roles within the university. CISM trainings have utility for all campus partners, yet the CISM model of crisis intervention lacks full fidelity and efficacy unless it is fully integrated. Conversely, applying even basic CISM practices and principles among campus constituents that serve students in crisis, can bring about protective and preventative measures to reduce compassion fatigue and increase compassion satisfaction in staff. Participants described utilizing group techniques in individual crisis intervention, as well as gained confidence that if a large-scale critical incident occurred, they would know how to mobilize departmental support, as well as could strengthen the intervention efforts of their campus partners.*

As it were, my interviews with Regina quickly demonstrated that her campus did not maximize on her credentials and that any CISM training that she was asked to facilitate was fragmented from any structured campus protocols. When asked how often she trained Residence Directors in CISM and what the campus did to incorporate CISM principles into its day-to-day practices, Regina reflected that trainings at the campus were in fact rare, and that most of the Residence Directors and residence life staff who have

been trained in CISM attended her trainings at other institutions and colleges that invited her to present and opened their doors to neighboring community members.

There hasn't been buy-in here. There hasn't been a complete rejection by any means, but it's not as active now as it was a few years ago. Maybe that will change and come back, but the greater enthusiasm right now in this valley is among K-12 school-based staff, as well as mental health providers and first responders. [On campus], unfortunately, all it takes is one more incident and then we revisit it. It's sort of like, 'Where did I leave my first aid kit? Now I need it!' (Regina, October 6, 2015)

Even on a small, private college campus with its very own CISM educator, without buy-in from Student Affairs leaders and other campus constituents, as well as role modeling top down of an organizational shift in attitude towards work-life balance, it's difficult to formalize a strategic plan for multi-component campus-wide implementation. Robyn Robinson (2004) describes the ways in which organizations can roll out utility of CISM to gain impetus toward full fidelity and more comprehensive implementation.

In work-based programs, it is possible to educate staff about stress, trauma and support facilities; to track staff following incidents; to ensure that an assessment procedure is operating so that appropriate interventions ensue; and to follow up with individuals and refer them to ongoing counseling where appropriate. It can be ascertained that the providers of CISM interventions . . . have some preparation, training and expectations regarding the more difficult aspects of their job. CISM caters for them in their professional roles. (Robinson, 2004, p. 30).

While the college did not fully integrate CISM into its campus crisis response protocols, all three participants were able to reflect on concrete ways in which being trained in CISM served to improve their efficacy as helpers in critical situations, taught them to rely on each other for support and feedback following their interventions with students, and motivated them to establish clearer boundaries so as to maintain better work-life balance. Marilyn spoke of reaching out to Assistant Directors on call for coaching, debriefing, or emotional support, as well as stated she would often connect with her direct supervisor

after coming off an on-call rotation which helped her feel better equipped to handle both small and large scale emergencies. “You end up developing a toolbox of sorts and knowing how to compartmentalize as well as who to tap into for support outside of work. I was on-call for a campus of three thousand students, at times as the sole professional, and would have to respond to any crisis with most situations resulting in trips to the hospital.” For Marilyn, CISM training provided a supplemental framework for not only handling crisis situations in progress, but also a means of regrouping following a particularly stressful week. Marilyn stated that outside of work she would usually go to the gym, or socialize with friends off campus, and made sure to stick to a 9am-5pm work schedule whenever possible, unless she was on-call or had an evening staff meeting. This helped her sustain a healthy work-life balance and she found that her recovery time following critical incidents diminished the more time she spent in her role and the more frequently she deployed her CISM skillset. Lorden (1998) writes “Several authors have suggested that burnout is a primary cause of attrition, given the long hours and stressful conditions commonly associated with student affairs work (p.209). Marilyn’s practice of asserting her boundaries within the blurred nature of her residential work, helped sustain her passion for the work.

Cheryl stated there were no department-wide expectations regarding all staff getting trained in CISM, although all RDs were required to be CPR and First Aid certified. She noted that there was greater attendance at CISM training offered on their campus versus at trainings offered at surrounding colleges, as the number of staff required to take extended time off was reduced and there was flexibility to head back to their offices and check in during breaks. Lorden (1998) alludes to this as well when she

references lack of professional development as a secondary leading factor affecting attrition in the field of Student Affairs: “research indicates that student affairs practitioners are often dissatisfied with professional development opportunities . . . ‘we always talk as if [professional development] is important, but it never happens’ (p. 209). Upon reflecting on her CISM training and the Psychological First Aid that is at the core of the model, Cheryl felt her CISM certification was a logical compliment to her First Aid and CPR certification as the two enabled her to care for her students’ and colleagues’ physical AND emotional needs. Cheryl spoke of initially feeling anxious while serving her on-call capacities, primarily as she feared the unknown, but felt the additional crisis response training helped her gain a good sense of “taking a step back, and thinking about everything that was going on around me. It helped me maintain perspective when a crisis arose, and helped me feel grounded and focused where I would otherwise have felt frozen and ineffectual.” Cheryl also reflected on what might be the benefits of the formation of a campus-based CISM team, and stated that while currently the campus mobilized other departments and campus partners to handle large scale disasters, she could absolutely envision a CISM-trained residence life team providing support in different contexts and felt service delivery to students and staff would perhaps be more streamlined and less fragmented were there a department or campus-wide commitment to a single, more comprehensive crisis intervention model.

Cheryl attributed her return to the college (her alma mater, and the school under study) to the organizational support and professional autonomy she experiences which foster good work-life balance. She disclosed her experience at other institutions where her balance was off-kilter and unhealthy because of unreasonable demands made on her

time and privacy. A disorganized on-call system was exacerbated by organizational expectations that she spend her evenings and weekends beyond her 40-hour week engaging with, programming for, and preparing meals with her residents. She was prohibited from having overnight guests without a guest pass and stated there were more restrictions placed on her as professional staff than on her residents. The live-in policy was changed without forewarning to exclude all non-staff, even legal partners and spouses of live-in staff. She posits these changes were likely made by the institution's higher echelon, not housing staff, but felt the administrators did not cultivate a good work or living environment and noted this other school subsequently suffered significant attrition and staff turnover. Conversely, upon returning to work as professional staff at her undergraduate institution, she felt like she had come HOME.

Here, I tend to do things on the weekends and evenings. I go out with friends. I tend to visit my parents more than I used to. I visit friends from other areas. I've been traveling with my boyfriend a little bit to visit his college friends, as well. And then sometimes, I just huddle down and I tell people, 'do not bother me. I'm here, but I'm not here, and I need this.' And they're like, 'We get it.' My boyfriend is a really good support, and keeps me grounded. He is the opposite of me, where I'm very outgoing and very loud, always doing a lot of things at once, he's like, 'Okay. Let's sit down. Let's order Chinese food and watch *How To Get Away With Murder* for three hours.' He helps me forget about everything else, and brings me down to a normal level of crazy. (Cheryl, October 7, 2015).

Taking this into consideration, we're forced to analyze the discrepancy between the level of satisfaction generally reported by student affairs professionals, and actual commitment to the profession, recognizing that attrition rates are as high as 61% (Lorden, 1998). Attrition impacts morale on campus and within the profession, as well cuts into organizational costs, as staff replacements are recruited, interviewed, hired, and trained. Student affairs and higher education research examines the influence of systemic factors on affective organizational commitment among student affairs professionals. More

explicitly, the research seeks to address the “predictive value of overall job satisfaction, organizational support, organizational politics, and work/ nonwork interaction on affective commitment” (Boehman, 2007, p. 308). There always seems to be a precarious balance between wanting to do good work, being invested in the lives and growth of students we’ve been enlisted to serve, and our need to assert boundaries within what is otherwise an unconstrained work and living style. It raises additional questions of how professional development such as CISM training, and organizational change toward better work-life balance may influence those attrition rates as well as improve our well-being.

#### **RQ3/RQ4: What Value and Learning Did RDs Derive From CISM Training?**

In my appraisal of how a college campus might ensure best practices in the applications of CISM regardless of the model’s full integration into campus life, I exposed the assets of college-based CISM through deeper exploration of research questions 3 and 4 (RQ3/ RQ4) which sought to identify **the value and learning that Residence Directors derived from their participation in CISM training**. The threads of self-confidence, hardiness, and organizational support persisted as undercurrents for the findings to RQ3 and RQ4, and demonstrated congruence between what staff prized as well as evoked from their training in CISM. The same threads demonstrated how staff aligned their CISM training with their existing coping mechanisms and the discovery that outreach to and reliance on others demonstrated strength and efficacy not weakness. Implicit within this was recognition that they needed to have compassion for themselves in order to treat others with kindness and compassion. Also inherent within this was an understanding that while resilient people engaged in protective factors to cope with stress



and trauma, some coping skills were healthier than others and there was no way to selectively numb negative emotions without numbing positive ones. Embracing vulnerability instilled in them a deep sense of worthiness and enabled them to seek connections as opposed to isolation (Brown, 2012, p. 3). *Staff engaged in perspective taking which enabled greater work-life balance; they actively sought peer support and check-ins as well as incident debriefing following on-call duties; they valued having a foundation/ framework/ structure for crisis response and acknowledged the importance of effective supervision and modeled ethic of care by supervisors; and they engaged self-care practices for healthy coping. In particular, staff emphasized learning about the protective value of working out, spending time with family and loved ones, getting off campus, talking through stressors, asserting boundaries, and engaging in hobbies such as crafts, cooking, and travel.*

Marilyn reflects on her CISM training and perceptions of her increased capacity in crisis response:

Residence Directors deal mostly with individual students and their crises, so going to group CISM training was beneficial since it enabled us to learn about the aftermath of a large scale incident for a group of first responders. For example, a lot of the scenarios in the group training were like ‘okay you have a car accident involving your students, a rollover where soccer team members were involved, or a house fire’. So, that was pretty helpful. I feel much more equipped now to handle larger tragedies and crises and to support my colleagues after the fact. (Marilyn, October 2, 2015).

Although Marilyn reflected on her individual work with students and her role in crisis response as exhausting and draining, she felt it was a good opportunity to learn how to navigate her own emotions and responses to stress while intervening with and supporting students in crisis. She felt that after her first year as Residence Director she was better able and more comfortable handling different types of situations and crises, and learned

through her CISM training how to effectively move on after an incident occurred. More specifically, she was able to apply the principles of her Group CISM training to individual crisis response by scaling down interventions and engaging her acquired supplemental helping skills. She recalled that from its inception, the field of CISM was based on a resiliency model which was (and still is) aimed at building *resistance* before exposure to traumatic events, as well as enabling individuals and groups to rebound from stress with the minimal disruption to general function (*resilience*). Where necessary, CISM is also designed to help identify those needing additional more individualized care, and drives appropriate referral for professional intervention (*recovery*) (Mitchell, 2006). Marilyn reflected that her confidence in effectively handling crisis situations derived from knowing and practicing the *mechanisms of action* that are implicit in CISM (including early intervention, catharsis/ventilation, group/ peer support, and opportunities for follow up), and indicated that establishing clear boundaries and making time for herself and her interests served to enhance her work-life balance. "I absolutely feel like I'm able to manage my stress. At the latest, I leave work at five o'clock unless I have meetings at night and plan ahead for those, so my work/life balance is actually really nice." (Marilyn, October 2, 2015)

Regina described talking through her day with her partner and highlights the value of relying on someone who is a skilled observer and a very good listener. Her partner is in law enforcement and his work as a first responder often results in stress that is reminiscent to the experiences of those Regina helps through her CISM work. She identified they have similar worldviews and often use humor to keep things balanced and lighthearted.

Staying in a healthy relationship really makes a difference - valuing the people around me, my friends, my partner - that's important! I think it has the effect of reminding me to breathe. You know? Breathe through it. Move on to the next step, the next thing that needs doing. Also very important to me is working out. Endorphins are good. I didn't start working out until the year I turned 50. That's almost 17 years ago. I've never slept better, felt better. (Regina, October 6, 2015)

Regina also reflected on the learning she has achieved through teaching about CISM to others, as well as expresses true gratitude for the people she has met through the International Critical Incident Stress Foundation (ICISF) regional conferences and the World Congress (a biennial national CISM conference held in Maryland).

When I teach these classes, I meet the most amazing people. And when there's a mix of people, when it's RDs, and faith-based people and medical people from the same community or different communities coming together, that energy is just wonderful. We make a difference in the world. (Regina, October 6, 2015).

Regina referenced the value of teaching about therapeutic factors in effective groups – principles such as imparting information, instilling hope, altruism, group cohesion, and catharsis (Yalom, 2012) – and reiterated that in the context of crisis intervention, consulting with peers may be more helpful than receiving guidance from a therapist since peers can identify with one another and may experience similar reactions following a critical incident.

Cheryl spoke of accessing peer and supervisory support as well as modeling the same high ethic of care to her student staff that she experienced through her work and interactions with her Director and Assistant Directors.

I tend to be pretty vocal about everything that's going on, so people tend to give good feedback. I think it creates a normalcy of, 'let's just check in with each other all the time.' I see everyone from my staff almost every day because we share an office. We've cultivated a really good team this year, so I check in with them and then I see them check in with each other. They go to each other's programs. They're like, 'Hey, I know you dealt with this last night. Do you need help with this tonight? Do you need help on duty? I'm not on duty, but I'm in the area.' They help each other assert boundaries, but also relax over dinner and just hang out. (Cheryl, October 7, 2015).

As I listened to Cheryl describe her relationships with her staff and supervisors, it became evident that there was a pay-it-forward dynamic which was activated by the Director of Residence Life, and trickled down through the Assistant Directors to the Residence Directors and Resident Assistants. Cheryl felt that, in their department, there was a clear demonstration of learning and skill acquisition that carried through to better and healthier professional and personal habits through top down role modeling and a value for work-life balance.

We always have the support and ear of our on-call Assistant Director. Beyond that, I have a really good connection with all of our Assistant Directors, even the ones who don't supervise me directly. I really value their opinions, and they always seem to know what incidents I'm involved with and give me feedback automatically. Likewise, our Director of Residence Life always checks in with me, and we're very open and communicative with one another. I think that's one of the main reasons I came back to this college - I felt like they care. They care about the people who work for them. They care about the students. They check in and demonstrate this care and talk about the importance of us looking out for each other. (Cheryl, October 7, 2015).

Sustaining peer contact and professional consultation provides an opportunity to share how one's work and personal life intersect and influence each other, to examine what areas of one's life have been disrupted by work, and to do a reality check by stepping back and assessing how much the work has increased one's skepticism or isolation. Killian (2008) contends that higher hours of clinical contact are associated with lower compassion satisfaction. It therefore behooves us to ask ourselves where our limitations lie, how many hours we've already clocked for the week, and how many students in crisis we supported and referred, and reduce workload when stress begins to interfere with our ability to concentrate, remember things, or when we become easily frustrated or irritable (Killian, 2008, p. 41). What may further exacerbate work-life imbalance are technological advances. While email, social media, data synchronization

programs, and electronic communication have improved the pace by which we are able to connect, communicate, and complete our work, they also promote irrational beliefs regarding people's availability. E-mails and cell phones need managing. "If people are not careful they end up with no 'downtime' to refresh mentally, emotionally, or physically" (Comstock, 2005).

Other themes that emerged from my conversations with the study participants regarding the value and learning that staff derived from their participation in CISM training, made it apparent that Residence Directors felt their self-efficacy as helpers improved as a result of their participation in CISM training, and as such were more intentional in their interventions, and more solicitous in their recovery from large and small scale crises, thereby enhancing their inherent resilience. Regina reflected on her increased self-awareness and the time it took for her to truly hone the balance between her work and home life. She broached the topic of vulnerability and deliberated the stigma associated with attending to our own mental health, acknowledging our limitations and failures, and seeking reassurance from others.

I am more self-aware now when things seem off-kilter. It's critical to have someone who can help keep you grounded, and then knowing for yourself too where your limitations lie. Knowing when to step away from a situation, recognize when you're just tapped out. Acknowledging you may not be able to do anything in the moment to change it or make anything go away. (Regina, October 6, 2015).

Killian's research (2008) confirmed that social support was the most significant factor associated with higher scores on compassion satisfaction (p. 40). He advises that staff should reflect on how much time they allocate for socializing, leisure, exercise, and hobbies as these enable them to recharge and rebound after working with students in crisis and traumatized individuals. "Being proactive in taking care of one's own mental

health seems to be key, [as does] reaching out to other professionals, sharing concerns, and providing one another encouragement, possibly in a regular, structured group format (Killian, 2008, p. 40). Keeping staff safe and assuring they can find satisfaction in their work as well as in their personal lives requires that they receive support in managing their own stress. Critical Incident Stress Management (CISM) plays an important role in providing that support to helpers following crisis response. As a subset of CISM, stress debriefing (CISD) in particular offers crisis responders immediate emotional support and enables them to “recognize, understand, resolve, and normalize their reactions. Sharing common experiences synthesizes this process and contributes to cognitive reintegration and reduction of chronic sequel disabling responses. It also may help identify those at risk for PTSD. The basis of the CISD model is prevention. Major components of this model include immediate emotional support, education about normal stress reactions, symptom reduction, and appropriate referrals” (Anati-Otong, 2001, p. 129).

While the staff interviewed do not currently serve on structured debriefing teams within the college, they demonstrated a willingness and confidence to step up and support both their own campus and neighboring communities in times of crisis. There was an expressed affinity between the CISM trained college staff interviewed and the more than 300 crisis response teams registered with the International Critical Incident Stress Foundation (ICISF) serving communities all over the world. Those trained on the standardized model of CISM are equipped to allow peers the opportunity to discuss the traumatic events with which they intervene, promote group cohesion, and educate each other on stress reactions and coping techniques (Roberts, 2002, p. 14).

**RQ5/RQ6: Utility of CISM in Day-to-Day Work, and Perceptions That Use of CISM Strategies Influenced Coping and Burnout.**

These findings segue into staff's reflections on **how they utilized the model's principles and practices in their day-to-day work (RQ5)**, as well as **how they perceived that their use of CISM techniques and strategies influenced their ability to cope with compassion fatigue and burnout (RD6)**. There was avid agreement among the participants of the study about the CISM model's versatility, which meant the training they underwent had relevance in a variety of contexts and strengthened their decision-making and critical thinking skills in all aspects of their life and work. Furthermore, they demonstrated awareness that specialized trauma training such as CISM has been shown to provide interventionists with some protection against compassion fatigue and thereby enhance their compassion satisfaction. *Staff reported they use the basic principles of CISM to generate educational programming and training content for their residential communities; they felt they were able to more effectively provide individual crisis counseling; identified being better prepared to facilitate recovery and make referrals for psychological assessment following critical incidents; conducted informal small group discussions among staff reminiscent of defusings to assist in acute symptom reduction following on-call duties; and when needed, they engaged the three primary factors in successful crisis debriefing interventions: ventilation, social support, and adaptive coping. Concurrently, Residence Directors who found ways to utilize CISM strategies in their life and work, developed strong social support networks (peers, supervisors, friends, family), consistently exercised positive self-care practices and demonstrated healthy coping skills, and as such, were more likely to have high compassion satisfaction and low compassion fatigue.*

“Organizations that work with traumatized [people] are well advised to incentivize such training and continuing education opportunities. Educating clinicians about risk and protective factors, as well as providing resources to enhance protection, helps reduce levels of CF and burnout” (Sprang, 2007, p. 276). Researchers such as Conrad & Kellar-Guenther (2006) engage in the study of factors that predict resilience and sustained health in helping professionals, and emphasize the protective function of social support particularly in the context of having opportunities to process traumatic aspects of the work (In Killian, 2008, p. 33).

Debriefing with supervisors, consultants, and colleagues was reported as a basic, crucial strategy that may ward off secondary traumatization. Programs in the helping professions could also consider adding a self-care component to their curricula and discuss techniques for maintaining health. These curricular considerations may serve to promote the long-term health of trainees and can help them maintain the quality of the care they provide their clientele long after they graduate. (Killian, 2008, p. 41).

Staff’s narratives about their work stress and coping reinforce the importance of recommended coping strategies including leisure activities, self-care activities, and supervision, maintaining peer support, participating in continuing education, and accessing new information and techniques.

Regina recalled there was a clinician at the college’s counseling center who wanted to do more prevention education. Unfortunately, like every campus, they were seeing such huge numbers of students coming in who really needed long-term clinical work that it was hard for counseling staff to get out of their offices and engage in community interventions. Regina therefore collaborated with the counseling staff to initiate the development of peer-education and peer-support training modules for their students and campus partners which aligned with Mentors in Violence Prevention (MVP) and Active Bystander Intervention models. These were not CISM-based per se, they



were “Escalation Workshops” but they engaged constituents from throughout the campus community and were based on peers recognizing red flags and intervening – stepping in – to disrupt risky behaviors before situations escalated into full blown crises. These Escalation Workshops focused on the pervasiveness of domestic violence, dating violence, and sexual misconduct, and the initial training consisted of a simple 39-minute video put out by the One Love Foundation. In 2010, Yeardeley Love, a lacrosse player at the University of Virginia was murdered by her boyfriend who was also a lacrosse player on the same campus. Her family established the One Love Foundation to honor her and raise awareness about the consequences of relationship violence. Regina says the training is really powerful, meaningful, and is not completely disconnected from CISM, as it addresses the need for community education and collaborative crisis response.

What we learn in CISM, whether the Group Training or Individual, applies here too. If you have a high-profile case of sexual assault, crisis intervention is exactly what you are doing. You’re teaching students and staff to recognize signs of distress, triaging care for the survivor, holding community meetings to disseminate information and provide community resources, teaching stress management techniques, and engaging coalition building. (Regina, October 6, 2015)

Regina also spoke in greater detail about the utility on college campuses of Crisis Management Briefings (CMBs) one of the large group crisis intervention techniques within CISM that she terms “the civilian counterpart of a demobilization”. Whereas a *demobilization* is usually a one time (end of shift; end of deployment), large-group information-sharing protocol for emergency services, military, or other operations personnel who have been exposed to a significant traumatic incident such as a disaster or terrorist event, *CMBs* are structured large group community/ organizational “town meetings” designed to provide information about the incident, control rumors, educate

about symptoms of distress, inform about basic stress management, and identify resources available for continued support (Mitchell, 2006, p. 80). CMBs may have small group applications and are especially useful in response to incidents of community violence, such as unattended student deaths, fires or floods, domestic violence and sexual assault, and active shooter threats. Regina provided the following example of how elements of CISM such as CMBs are infused into campus crisis response protocols:

CMBs have huge applications on a college campus because that's what we do. I don't remember what the incident was, but we were in the auditorium, there were lots and lots of students there, students were given information on what happened, what the college's response was, and then at one point the person leading it said, 'Does anyone else have something to add?' And, I stood up and, very briefly said, 'all of us in this room who have been through this together may see certain signs of distress in ourselves or each other and that's perfectly normal. Here are the resources available, it should dissipate.' It took three minutes to say that and identify what the resources are. That absolutely should be part of any of those large-scale meetings. (Regina, October 6, 2015)

A Crisis Management Briefing is not intended to be a lengthy intervention (it is generally 45-75 minutes in duration), and again, it is not a substitute for psychotherapy, but it may be one of the most effective tools available in early response to critical incidents. CMBs serve to provide community members with relevant information about the incident; they enhance the credibility of first responders, community leaders, and campus partners while reducing the sense of chaos among community members; they serve to minimize rumors and instead engender cohesion and group morale; and finally, they provide coping strategies while also creating an opportunity for psychological screening (Mitchell, 2006, p. 81). Regina reflected on her 30 years of CISM education intervention and spoke of the model's consistency, from George Everly's (2001) SAFER-R model of individual crisis intervention, to Jeffrey Mitchell's (1983) CISD protocol for group crisis response:

It's reassuring to me. You know, the foundation works and you don't fix something that isn't broken. And you know, I think the updates to the editions are good both in terms of coming up with more current examples and just knowing that we're doing evidence-based practice that's current. But knowing that the initial principles upon which CISM is based still work says a lot for the model, for its relevance, and for its resilience, too. (Regina, October 6, 2015)

Cheryl identified employing Group and Individual CISM techniques in her personal life and with her staff. Both CISD and the SAFER-R models follow similar patterns of introductions and expectation setting, acknowledgement of the event and people's reactions to it, normalization of stress reactions, teaching of effective coping mechanisms, and ultimately, referral and reintegration (Everly & Mitchell, 2012, p.130). The SAFER-R model refers to effective coping as *Mechanisms of Action*, and includes such strategies as meeting basic needs, advocacy, cathartic ventilation, social support, information, stress management, problem-solving, conflict resolution, cognitive reframing, and spiritual connection (Everly, 2001, p. 131). Cheryl provided an example of how these *mechanisms of action* play out day-to-day:

Again, I think having a framework of managing incidents is great. I tend to take what I know and have learned and use it on a smaller scale. My grandmother recently went into a long term care facility, and my mom was not handling it well. So, I reflected on the techniques I learned in the CISM training, specifically about active listening and normalizing common reactions to stress, and tried to be cognizant about what would work best to reassure my mom and provide relief and support. (Cheryl, October 7, 2015).

Cheryl soothed her mother, and they were able to brainstorm steps they were going to take to deal with this change. Her mom felt more grounded after she had a chance to name her fears and knew she wasn't alone in her worry. "I use stuff from 'incident management' every day, with my staff, residents, colleagues, and my family, so it's transferable to different types of situations, and the function of it spreads" (Cheryl, October 7, 2015).

Cheryl also reiterated her need for balance between her personal life and work, and shared the ways in which she decompresses in order to maintain both her professionalism, and her physical, emotional, and mental health. She said her means of relaxation largely depend on the time of year. She enjoys a lot of cooking to take the edge off a particularly busy day, and is refreshed by planning out vacations and outings with friends. In the winter, she tends to puzzle – she'll settle down with a warm drink because it's too cold to head out anywhere, and she'll work on a jigsaw puzzle for hours. She also maintains good communication with her supervisor, and if she's had a particularly challenging week, will plan for some structured time off. "I'll tend to be like, hey, I've had this crazy week. This is my plan. I'm going to leave early today and go home and cook something with my mom – you know, surprise her. I need to do something where I kind of get away and remove myself a little bit so I won't be bothered by new stress" (Cheryl, October 7, 2015). Cheryl and Marilyn were both able to easily identify symptoms of work stress such as sleep disturbances, loss of appetite, becoming easily distracted or having difficulty concentrating on a specific task, and experiencing changes in mood. They noted feeling edgy or becoming impatient with family, friends, or colleagues. Marilyn spoke of needing to assert her boundaries around extracurricular involvement in order to mitigate for increase in work-related stress. "I'm working in academic affairs and teaching ten credit hours on top of working forty hours a week, so at this point I wouldn't have time to get involved with too much else. I need to sustain balance - balance my time or give something up" (Marilyn, October 2, 2015).

As stated in Chapter 3, in addition to participant interviews and a review of relevant archival data, I elected to administer the Professional Quality of Life

Questionnaire (Stamm, 2012, Pro-QOL Version 5) to all three participants. The intent was to triangulate whether staff's utility of CISM principles and practices in their day-to-day work (RQ5), and their perceptions of their use of CISM techniques and strategies influenced their ability to cope with compassion fatigue and burnout (RD6) aligned with outputs from an assessment tool widely used to measure levels of compassion satisfaction and compassion fatigue or secondary/ vicarious trauma. To review, the ProQOL is comprised of three discrete scales or constructs (Compassion Satisfaction, Secondary Traumatic Stress, and Burnout) that do not yield a composite score. This is intentional as it allows for intersectionality or congruence among two of the constructs, which may indicate when a person is at risk for negative outcomes, or specify altruistic tendencies to help in distressing situations. "If one were to attribute affective domains to the three constructs, one could say that *compassion fatigue* dwells in the neighborhood of fear and anxiety, *compassion satisfaction* in pleasure or happiness, and *burnout* in emotional exhaustion and lack of self-efficacy" (Figley, 2002; Larsen, Stamm, & Davis, 2002, In Killian, 2008, p. 33). **Compassion satisfaction** is about the pleasure we derive from being able to do our work well. Higher scores on this scale represent a greater satisfaction related to our ability to be effective caregivers within our roles. **Burnout** is one of the elements of Compassion Fatigue (CF), and is associated with feelings of hopelessness and difficulties in dealing with work or doing our jobs effectively. Higher scores on this scale mean that we are at higher risk for burnout. **Secondary traumatic stress (STS)** is about work related, secondary exposure to extremely or traumatically stressful events. "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” (Stamm, 2012, p. 5). While higher scores do not necessarily indicate a problem, they are an indication that we may want to examine how we feel about our work and work environment, and may also benefit from discussing incidents or concerns with a supervisor, colleague, or health care professional.

All three study participants had an intuitive sense of what burnout was and were conscious of when they felt burnout manifest for them. They could name that having a non-supportive work environment, too high of a workload, or feeling ineffective in their work usually triggered onset of burnout. Concurrently, all three were able to define what motivated and grounded them within their work – what brought them gratification and a sense of self-worth - and had worked in Student Affairs long enough to have developed substantial strategies for success and resilience. When administered the Pro-QOL, all three scored high on **Compassion Satisfaction** (Regina-49, Cheryl-39, and Marilyn-47) and low on Compassion Fatigue (**Burnout**: Regina-13, Cheryl-24, and Marilyn-19; **Secondary Traumatic Stress (STS)**: Regina-17, Cheryl-23, and Marilyn-23). Regina, the most seasoned professional among the three, had the widest distinction among her scores, indicating greater resilience and a firm sense of self in both personal and professional domains. According to Stamm (2012) the average score on each of the three scales is 50 (SD 10; alpha scale reliability 0.75-0.88). About 25% of people score below 43 and about 25% of people score above 57. In the **compassion satisfaction** scale, if one’s score is in the higher range, they probably derive a good deal of professional satisfaction from their position. If one’s score is below 40, they may either find problems with their job, or might simply derive satisfaction from activities other than their job.

Conversely, in the **burnout** and **STS** scales, a score below 43 reflects positive feelings about one's ability to be effective in their work, while scores above 57 may be cause for concern if one's worries or fears within the work setting persist beyond the odd "bad day" or fleeting moodiness. The guidelines for self-scoring imply that while elevated scores in burnout and STS may not necessarily indicate a problem, they should be an indication that one may want to examine how they feel about their work and work environment (Stamm, 2012, ProQOL Version 5). Cheryl discloses that being on-call causes her the most stress out of anything else within her role. She says that particularly at the beginning of each year she struggles to straighten out her work/life balance.

My staff is totally new, and they're still reaching out. So, I always get a little bit of anxiety because it'll be like 11:30 at night and I'll get a text, 'Hey are you still up?' And I want to say, 'No'. But, that's so vague. What's really going on? And instead I say 'yes, what's up? What do you need?' Turns out they can't get in touch with the duty RD and they're in my office panicking. If it's not my own staff texting late at night, it's being startled out of sleep by the duty phone when it's my turn to be on. (Cheryl, October 7, 2015).

Cheryl shares an office with her RAs and the office abuts her apartment. Noise carries easily, and there's a connecting door from the office into Cheryl's living room. This minimizes her privacy and further exacerbates the smudged boundaries between life and work. Marilyn concurs with Cheryl's sentiments, and reflects on the structure of the college's on-call system and its potential to deplete RDs' reserves. She says there's generally one RD who is the lead professional on call during weekdays. On the weekends there would be a backup RD but the lead on call still has to respond to most crises. "RAs would call me for backup and I would have to go on scene to assist. Security might also call the RD on duty and we would go and respond in person. It might be a life threatening situation or intoxication or a simple hand injury. There is always a lot going on. It can

often be quite draining” (Marilyn, October 2, 2015). Marilyn clarified that she could call the assistant director on call for consultation in any given situation, but that as far as in-depth debriefing or emotional support, in her experience that usually wouldn’t happen until the following business day with her direct supervisor. Regina approaches the topic of on-call stress from a different perspective – that of an educator, and shares that she has facilitated numerous mini-CISM trainings for the RA staff at the college, a 45-60 minute intro to crisis intervention with case studies to follow so as to better prepare paraprofessional staff for their work as first responders in the halls. Over the years, her training has expanded to encompass more on victim advocacy and active bystandership, as well as Title IX matters such as sexual assault, domestic violence response protocols, and prevention education. The three women range in their professional experience from 4 years to 40 years in student affairs. As such, their ability to recognize their own weariness, to readily identify and tap into available sources of support, and their capacity to sustain balance when tested varies greatly. There’s potential and even a foundation for a community of practice with mentoring structures that would enable them all to thrive.

**RQ7: Resources, Training and Supports Identified as Missing, Necessary or Salient**

My final research question (RQ7) asked participants to **name the resources, training, or supports that they identified as missing, necessary, or most salient to them in their work and personal lives.** Their responses fell into two categories – the former focusing on what was missing, and the latter on what they found most salient to their lives and work. To some degree, evidence to this has been brought forth earlier in this chapter, but I summarize the findings here.



When discussing their deficits, staff identified that at times, and in some work settings, they were deeply affected by increased restrictions placed on their personal lives and time that made it difficult to assert personal boundaries and maintain good work-life balance (i.e. lack of contract and subsequent worker rights, increased on-call responsibilities, increased workday, decreased privacy, change in live-in specifications). Staff also reflected on the lack of buy-in by higher up administrators that there's value in pre-crisis intervention planning and preparation, and therefor felt they underutilized campus-based resources including their own CISM Educator.

Conversely, when discussing their assets or resources they felt were necessary for their continued success, Residence Directors recalled their appreciation for and reliance on effective developmental supervision, peer support and regular debriefing; they easily enabled social support networks, and they noted the institution's value for work-life balance. While there were not regularly structured opportunities for professional development within the campus, there was value for staff's professional growth and the institution often paid for staff to attend training at neighboring colleges. Finally, while the college did not have an integrated CISM model of crisis intervention, staff felt their CISM training reinforced the structured and detailed crisis response and on-call protocols provided by the college. This was made more evident through the college's utility of an information database called Advocate/ Symplicity for conduct and student life related matters. Advocate has two subsystems, CARE and VOICE which essentially enable inter-departmental communication around certain incidents that occur, whether they are facilities-related, critical incidents, or community standards violations that warrant follow up. The database is also utilized to varying degrees by the Dean of Students office, the

Counseling Center, and the Housing Assignments Office in addition to Residence Life staff, so triage of student care and referral is facilitated and tracked more efficiently. Resident Assistants input their incident reports into Advocate, and professional staff (Residence Directors and Assistant Directors) are then able to promote incidents to CARE or the on-call report for further dispensation. This database is comprehensive and multi-functional in a way that complements CISM and ensures assessment, referral, documentation, and continuity of care for students and interventionists alike.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS FOR PRACTICE

#### Summary of Study and Findings

Though student affairs professionals and Residence Directors in particular have long dealt with the social-emotional and developmental needs of their students, the 2010 National Survey of College Counseling Center Directors brought attention to the unprecedented increase of seriously distressed students on college and university campuses (Gallagher, 2010, p. 5). The work of Residence Directors (RDs) has shifted in recent years to include more intensive crisis management, stabilization of students in crisis, and oftentimes daily coaching for students and paraprofessional staff on self-management and coping techniques for improved emotional and psychological health and functioning. As such, RDs are often faced with the “cost of caring” that results from helping students through trauma and emotional pain. This “cost of caring,” also known as *Compassion Fatigue* (Figley, 1995), has a detrimental effect on RDs and the decisions they make as helpers. Compassion fatigue is a general term applied to anyone who suffers as a result of serving in a helping capacity and manifests in symptoms that follow classic stress patterns, such as forgetfulness, shorter attention span, exhaustion, and headaches or stomachaches. RDs’ resistance may be low so they get sick more often, may feel depressed, angry, or exhibit a sense of hopelessness. When RDs’ basic needs are no longer met, their judgment and ability to cope are negatively affected, their effectiveness and capacity as helpers is diminished, and they are less likely to seek help or change self-destructive behaviors. Stress Management is a critical self-care strategy for Residence Directors, and ensures they continue to function effectively in their roles.

Critical Incident Stress Management is based in crisis intervention. As such, it is neither therapy nor treatment. It is a multi-component approach to staff support, incorporating education, individual support, group meetings (including CISD), organizational consultation, family support, referral and follow-up. The providers of CISM services may be mental health professionals (such as psychologists and social workers) and peers (specially selected and specially trained members of the workplace) who work together in a partnership (Robinson, 2004, p. 29). Research on the use of college-based Critical Incident Stress Management (CISM) has been shown to foster collaboration, peer-support, and increased stress debriefing among staff who respond to critical incidents on campus. CISM teaches means of recognizing work-related triggers, contributes to the normalization of stress reactions, and improves healthy coping and self-care strategies. CISM can therefore help reduce or diminish incidence of compassion fatigue and burnout, thereby improving Residence Directors' overall professional and personal quality of life and their resilience within the field of student affairs.

This research study utilized a phenomenological, single-site case study design to explore the utility of Critical Incident Stress Management at an Upstate New York-based college which intentionally opts to include Residence Life Staff in its training and CISM-based crisis intervention practices. Seven research questions were used as a frame by which to examine the scope of Residence Life Staff's involvement in Critical Incident Stress Debriefing and gauged the impact of CISM-based strategies on staff's reported levels of secondary stress, burnout, and/or compassion satisfaction.

While the study design intentionally focused on a single college campus, my initial outreach extended to the entire Northeast region of the United States. This college

was identified after an extensive literary search and only after I posted an email to a listserv of the North East Association of College and University Housing Officials (NEACUHO), soliciting information from other student affairs professionals regarding college and university campuses that trained their residence life staff on Critical Incident Stress Management, and/ or utilized CISM within their college crisis response protocols. Weisen and Lischer (2006) of Saint Joseph's College of Maine described their state-wide efforts to develop regional college-based CISM teams as means of improving each campus' capacity to respond more comprehensively and efficiently to critical incidents that affected their communities. The authors provided a breakdown of the professional disciplines of those who attended their regional CISM training, and highlighted that only 20 percent were Residence Life staff. As this regional training occurred back in 2006, I had a difficult time accessing any of the residence life staff who may have been trained 10 years prior to my data collection (particularly in light of attrition within the profession). In fact, no one from any Maine schools ever responded to the email I had sent through the NEACUHO listserv. Concurrently, in my introduction, I highlighted the growth of CISM's utility in educational settings, as well as mentioned in my framing of my conceptual framework that numerous campuses have CISM resources posted on their college webpages, yet CISM has far from become a universal model of campus-based crisis intervention, and the response to my quest for case-study sites was decidedly underwhelming. Future research may expand beyond the Northeast, and would then perhaps serve as impetus for greater roll out of the model and a fortification of existing literature on college-based CISM.

Primary findings of this study determined that while training RDs in Critical Incident Stress Management did not ensure their participation or involvement in formal campus or community-based debriefing teams (CISD), it did provide them with a foundation upon which to rely when dealing with critical incidents of any magnitude, and it informed their practice day-to-day by building their capacity as helpers and promoting the development of structured systems of support (RQ1). The study also established that while a campus could ensure best practices in the applications of CISM by fully integrating the model into its day-to-day functions, CISM trainings have utility for all campus partners, and applying even basic CISM practices and principles among campus constituents that serve students in crisis can bring about protective and preventative measures to reduce compassion fatigue and increase compassion satisfaction in staff (RQ2). RDs trained in CISM were more apt to regularly engage in perspective taking which enabled more consistent application of self-care strategies for healthy coping. They actively sought peer support and feedback following on-call duties, and valued having a framework for crisis response that acknowledged the importance of effective supervision and effective work-life balance. In particular, staff emphasized learning about the protective value of working out, spending time with family and loved ones, getting off campus, talking through stressors, asserting boundaries, and engaging in hobbies outside of work (RQs 3 & 4).

Residence Directors who underwent CISM training also reported they were able to more effectively provide individual crisis counseling, were better equipped to handle large-scale critical incidents, and felt more prepared to triage care and make referrals for psychological assessment following crises that manifested in their halls. They were also

better able to facilitate their own recovery from work-based fatigue by conducting informal small group dialogues among staff reminiscent of defusings to assist in acute symptom reduction following on-call duties. This enabled them to engage the three primary factors in successful crisis debriefing interventions: ventilation, social support, and adaptive coping, which in turn contributed to reports of high compassion satisfaction and low compassion fatigue (RQs 5 & 6).

Finally, when asked to name the resources, training, or supports that they identified as missing, necessary, or most salient to them in their work and personal lives, Residence Directors acknowledged they were negatively affected by increased restrictions placed on their personal lives and time, which made it difficult to assert personal boundaries and maintain good work-life balance (deficits included lack of contract and subsequent worker rights, increased on-call responsibilities, extended workdays, decreased privacy, and changes in live-in specifications). They also reflected on the lack of buy-in by upper echelon university administrators that there was inherent value in pre-crisis intervention planning and preparation, and therefore felt they were underutilized as campus-based resources, as was their own CISM Educator. Conversely, when discussing their assets or resources they felt were necessary for their continued success, Residence Directors recalled their appreciation for and reliance on effective developmental supervision, peer support and regular debriefing. They easily enabled social support networks, and noted their department's value for work-life balance. While the college did not have an integrated CISM model of crisis intervention, staff did feel their CISM training reinforced and complemented the crisis response and on-call protocols provided by their department. This was exemplified through the college's

utility of an information database called Advocate/ Symplicity for conduct and student-life related matters. Advocate has two subsystems, CARE and VOICE which essentially enable inter-departmental communication around certain incidents that occur, whether they are facilities-related, critical incidents, or community standards violations that warrant follow up. The database is comprehensive and multi-functional in a way that complements CISM and is also utilized to varying degrees by the Dean of Students office, the Counseling Center, and the Housing Assignments Office in addition to Residence Life staff, so triage of student care (intervention, assessment, referral, documentation) is facilitated and tracked more efficiently (RQ7).

### **Contributions to Research**

Doctoral research, by definition, usually involves a contribution to knowledge. When a research student reviews the literature related to their particular topic of investigation, they are undertaking this part of the research process to not only establish what counts as knowledge in that area of discourse, but to establish what is currently known, so that they can then argue that their study constitutes a contribution to knowledge. (Hill, 2011).

As I expanded upon my comprehensive paper and refined my research topic for this dissertation, I found that while there was a saturation of written material on compassion fatigue and its manifestation in emergency and fire services, law enforcement, nursing, the practice of psychotherapy, and the military, there was little published on compassion fatigue in education, and even less written about compassion fatigue in residential life staff working at institutions of higher education. If I revised my search criteria to use the word “burnout”, the scope of publications widened significantly, but as was highlighted in my literature review, compassion fatigue represents more than burnout. While the scope of the work we do has blurred boundaries and living-in poses challenges of its own, these are compounded by the level of crisis work in which we



engage to support the needs of our students. Vicarious traumatization and secondary traumatic stress are more accurate parallels to the term compassion fatigue, and still, little research exists which examines residential life staff's exposure to trauma and the consequences that follow. There is equally little to be found on the curricular content of Higher Education Master's programs and their evolution over the years, although one can find loads of publications on today's millennial students and their growing needs. As such, there is a gap in knowledge surrounding how present day student affairs professionals are prepared for their work with a college student population arriving to our campuses with more evolved needs and more complex behaviors. There is also a significant gap in the literature on the realities of Residential Life work. I strove to fill that gap by pulling together a complex research topic that proposed a solution to burnout and secondary traumatic stress in residential life staff by means of engaging a crisis intervention model that validates ventilation, adaptive coping, and peer support.

My conceptual framework discusses the fundamentals of Maslow's Hierarchy of Needs as it promotes regulation of basic human functions such as sleep, food, exercise, rest, and recreation, and validates one's ability to read and care for their own stress reactions as means of engaging adaptive coping skills (Figley, 2002). Concurrently, Bloom's Trauma Theory helps to conceptualize the role trauma plays in the disruption of people's ability to self-regulate low and high-ordered needs and persist in the face of chronic stress. The growing literature on the organizational dynamics that influence and exacerbate burnout and secondary trauma, stresses the need for changes in organizational practices, workload, supervision, peer support, and self-care in order to circumvent manifestations of compassion fatigue in residence life staff as residential crisis workers.

Literature on resilience and compassion satisfaction emphasizes the need and importance of peer, institutional, and interpersonal help and support (Dutton & Rubenstein, 1995), and endorses the formation of peer support teams that may provide perspective and mediate helpers' roles in the community. As the model and practice of Critical Incident Stress Management gained its impetus from Crisis Intervention and Trauma Theory, and grew in utility among first responders and mental health clinicians, it was a fascinating and viable intervention for my case study. Having worked in residential life for over 20 years as live-in professional staff at a large university, I have accrued anecdotal evidence of what I perceive to be our roles as residential crisis workers. My review of the literature presented sufficient evidence to suggest these personal anecdotes were in fact documented as concerns voiced by national leaders in student affairs and higher education of mounting challenges within our field.

### **Implications for Practice**

For campuses that would aspire to integrate CISM more concretely into their day-to-day practice, I defer once again to my participation in CISM training and my reflections on the curriculum's content and utility. George Everly (2006), one of the co-founders of the International Critical Incident Stress Foundation (ICISF) highlights the core competencies that are implicit within the Critical Incident Stress Management model and describes the ways in which these competencies inform decision-making along the various phases and components of comprehensive crisis response. The model begins with pre-incident education and preparation that should be aimed at a wide range of campus constituents such as residential life staff, faculty, counseling center staff, police, facilities and operations, campus emergency medical personnel, and student life deans. As these

are campus partners who frequently align to support student needs, learning, success, and accountability, as well as are generally active in on-call reporting chains, it is logical to keep them all apprised of analogous crisis response expectations, protocols, and resources.

When a critical incident does occur, those coached in pre-incident preparation can better engage in assessment of symptoms (manifestations of acute stress) and triage follow up and referral for continued care. It's crucial for these same campus partners to employ strategic planning of integrated multi-component crisis intervention protocols within a broader incident command system. This might manifest itself as collaboration on significant incident staffing plans to minimize disruptive and destructive large student gatherings (mobs/riots) and reduce high-risk behaviors among residential students and their guests. This can also manifest itself as a structured plan for response during large scale incidents that may occur and result in human casualties (active shooter, floods, fires, unattended student deaths) and can inform the scope of response for both primary and secondary victims. The strategic planning and pre-incident education helps determine an appropriate level of response, be it one-one-one crisis intervention (including PFA - Psychological First Aid), family CISM, organizational/ community interventions and consultations, pastoral support, large-group crisis intervention-demobilizations, respite, or Crisis Management Briefings (CMB), or small-group crisis intervention- debriefing models (Critical Incident Stress Debriefing-CISD; Historical Event Reconstruction Debriefing-HERD; National Organization for Victim Assistance-NOVA model; Critical Event Debriefing-CED; and multi-stressor debriefing model) or defusings (Everly, 2006, p. 52). Those trained in CISM are prepared to support the campus community at any level, as well as are better attuned to their needs as

interventionists, thereby more consistently utilizing supervision for feedback and debriefing, fostering peer support networks and lateral mentoring relationships, and engaging healthy coping skills and self-care practices.

These CISM-based competencies which comprise data acquired through review of public documents (CISM training materials) also clearly align with Professional Competency Areas for Student Affairs Educators developed back in 2009 and revised in 2015 by student affairs administrators in higher education collaborating across multiple national organizations including ACPA (American College Personnel Association), College Student Educators International, and NASPA (National Association of Student Personnel Administrators). “The lists of foundational outcomes for each of the 10 competency areas represent reasonable expectations for professionals entering the field of student affairs and provide groundwork for future development to intermediate and advanced levels of proficiency” (ACPA/NASPA, 2015, p. 6).

Three competency areas in particular appeared to align most clearly with the principles and competencies of CISM as well as with the conceptual framework for my research. **Personal and Ethical Foundations (PEF)** involves

The knowledge, skills, and dispositions to develop and maintain integrity in one’s life and work; this includes thoughtful development, critique, and adherence to a holistic and comprehensive standard of ethics and commitment to one’s own wellness and growth... Professional development to advanced-level proficiency involves higher order critique and self-awareness, applications to healthy living and professional practice, and modeling, mentoring, and facilitating the same among others. (ACPA/NASPA, 2015, p. 12).

While professional development in this competency area explores foundational outcomes which emphasize awareness and understanding of personal values and beliefs centering on professional integrity and personal wellness, it acknowledges that personal and ethical foundations grow through a process of reflection and self-authorship, in

which individuals negotiate crossroads to achieve an internal foundation or *self-actualization*. Maslow's (1973) work was particularly relevant on this point. "The achievement of self-actualization occurred through the process of consistently making the growth choice – that is, a decision that allowed one to progress rather than regress" (In Neumeister, 2007. p. 48). This notion of an internal locus of control as a protective buffer during exposure to extreme stress is reinforced by a growing body of literature on resilience. George Bonanno (2008) looks at the human capacity to thrive in the face of trauma and discusses multiple pathways to resilience including self-enhancement, repressive coping, positive emotion and laughter, and hardiness. More specifically, Bonanno addresses hardiness in the context of internal locus of control and highlights its three dimensions: 1) being committed to finding meaningful purpose in life, 2) the belief that one can influence one's surroundings and the outcome of events, and 3) the belief that one can learn and grow from both positive and negative life experiences (Bonanno, 2008, p. 107). "Armed with this set of beliefs, hardy individuals have been found to appraise potentially stressful situations as less threatening, thus minimizing the experience of distress. Hardy individuals are also more confident and better able to use active coping and social support, thus helping them deal with the distress they do experience" (p. 108).

The second competency area, **Advising and Supporting (A/S)** reinforces the concept of self-actualization through attention to basic human needs. As we cultivate new approaches to advising and supporting the needs of others, we must take into account self-knowledge and role-model self-care. Only when we actively work to reinforce our own holistic wellness, can we aspire to fully nurture the growth of our

students and our colleagues. Progression from foundational to advanced level proficiency involves the “development of higher order capacities for listening, addressing group dynamics, managing conflict and crisis situations, and partnering with other professionals, departments, and agencies” (ACPA/ NASPA, 2015). To students entering graduate preparation programs in Higher Education, student affairs work is about making a difference in the lives of college students and working in the vibrant atmosphere of a college or university campus. Student affairs professionals may describe commitment in the context of a “calling” or a “sense of duty” to persist in the field, to promote student development and learning both within and outside of the traditional classroom. This comes at a price, however.

Student affairs practitioners and graduate faculty cultivate this ideal, but at the same time begin the socialization of the workaholic culture by creating expectations that long hours, low pay, and other sacrifices are the norm. This devaluation can in no way help in the formation of affective attachment, and it leads entry level professionals to question their commitment to a profession they see as a calling. (Boehman, 2007, p. 309).

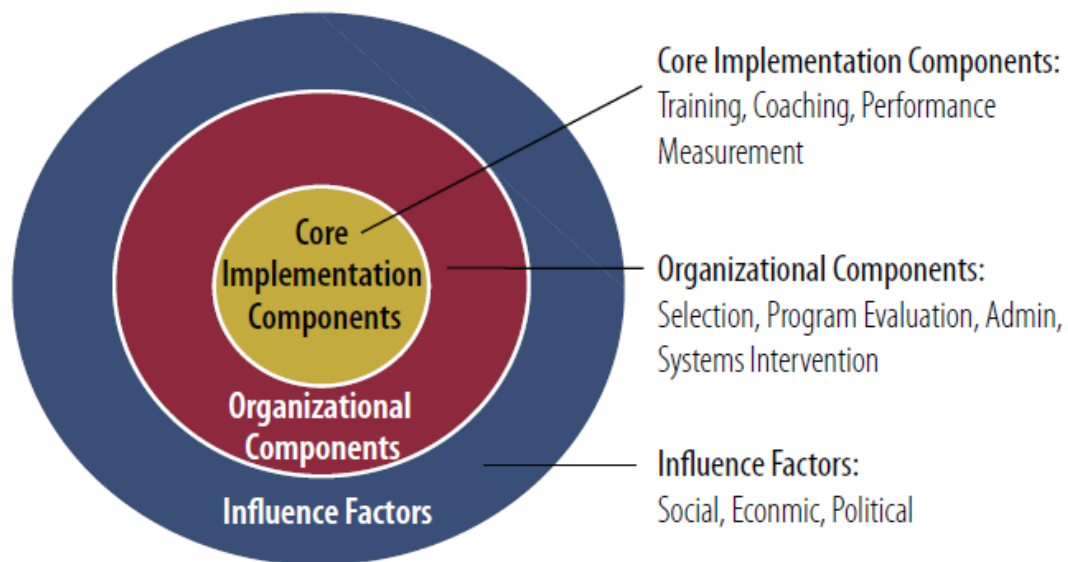
Regina speaks of this phenomenon as a norm that is fully ingrained within the field of Student Affairs - an expectation to be accessible at all times in order to be effective in our roles: “it leaves us wondering whether we're doing something wrong if we do feel tapped out. And, generally speaking, no one is telling us to take breaks, to cut ourselves some slack, to rely on one another, or to talk through rough weeks” (Regina, October 6, 2015). The responsibility to create a paradigm shift in this “all or nothing” mentality lies on those of us who have been in the field long enough to know we can be healthier and do better work if we take care of ourselves as we would others. There’s a reason why airlines advise you to put on your oxygen mask before you assist those near you.

The third competency area of **Organizational and Human Resources (OHR)** correlates to the ways in which infusing CISM into existing campus structures could serve to both improve staff's proficiency in crisis response as well as foster professional growth through a shift from knowledge to critical application thereby increasing staff resilience and strengthening the organization from within. "This competency area recognizes that student affairs professionals bring personal strengths and grow as managers through challenging themselves to build new skills in ... supervision, motivation, and formal evaluation of staff; resolution of conflict; management of the politics of organizational discourse; and the effective application of strategies and techniques associated with ... crisis management, risk management and sustainable resources" (ACPA/NASPA, 2015, p. 13). This competency area also highlights the complexities of organizational commitment – one's ability to internalize the objectives and values of the organization, their willingness to expend effort in the attainment of those objectives, and their desire to remain with the organization (Boehman, 2007, p. 309). Meyers and Allen (1991) further break down organizational commitment into three components: affective, continuance, and normative, whereby "*affective commitment* refers to the individual's emotional attachment to the organization; *continuance commitment* is a reflection of the costs associated with leaving the organization, such as a loss of prestige or social networks; and *normative commitment* reflects the moral commitment, or sense of loyalty to the organization" (Meyer & Allen, 1991, p. 67).

In their review of implementation research, Fixsen, Naoom, Blasé, Friedman, and Wallace (2005), discuss core implementation, organizational, and influence components that sway organizational and systems change. Their research aligned with the competency

area discussed above as it highlighted the need for building institutional commitment (**influence components**), strengthening the established infrastructure and providing support for staff (**organizational components**), and continuous supervision at all levels including provision of timely feedback (**core components**) (Fixen et al., 2005, p. 62). I found this especially relevant as I heard my study participant articulate how deeply affected they were by the lack of administrative buy-in into the CISM Model's utility as a comprehensive model of crisis response. While the college had access to a sustainable resource within the institution (their own CISM Educator), she was rarely utilized in this role, and those she trained were never organized into functional CISM debriefing teams, demonstrating how a lack in institutional commitment can deeply influence change.

**Figure 4: Multilevel Influences on Successful Implementation**



As this section is aimed at highlighting implications for future practice, institutions of higher education that aspire to more fully integrate CISM into their campus crisis protocols can benefit from Fixsen's et al. (2005) dimensions of high-performing programs and schools which emphasize five interdependent components of



implementation that should be taken into consideration by stakeholders and practitioners as they consider systems or organizational change: 1) structural and organizational characteristics of schools; 2) attitudes, norms and beliefs of staff; 3) climate/ empowerment/ experiential characteristics; 4) capacity/ skills; and 5) practice and procedural variables (p. 63)

Student affairs can roll out utility of CISM in small chunks. There is value in consulting with colleges and universities that have already trained their staff in CISM and have mechanisms in place for the model's deployment. A quick and brief assessment implemented among the staff and faculty on any given campus can seek to identify those campus partners who have already been trained in CISM and those who have utilized it in their work. A complementary survey can help identify those campus partners with whom Residential Life collaborates most frequently to triage student care, and include said partners in subsequent campus-based CISM training. As I prepared to implement my case study, I exercised both mechanisms – I surveyed who on my campus had already been trained in CISM, as well as consulted colleagues on who would benefit most from attending this training in the future, were the opportunity brought to our campus. I discovered our Deputy Chief of Police and numerous campus police officers had already been trained, as well as the Director of the counseling center and the Center's Outreach Coordinator. After conducting this doctoral research over the course of many years and acquiring my own Basic and Advanced Individual, Peer Support, and Group CISM Certifications, I advocated for my department to bring in a trainer to certify all of our professional and graduate staff in Group CISM, and provided a list of campus partners we should invite to attend. Included were members of our campus police department,

counseling center staff, our Student Life, Community Standards, and Title IX compliance Deans, and staff from our sexual violence prevention center. In August of 2016, our Department of Residence Life hosted a two-part CISM training, one for professional staff and campus partners and one for graduate staff, and on a campus serving 22,000 undergraduate students, we got 90 staff trained and certified in group CISM. I co-facilitated the training with an ICISF (International Critical Incident Stress Foundation) Approved Instructor, and reflected on my experience as a volunteer with our regional Emergency Medical Services non-profit organization as an active CISM Peer and Clinician. As I pursue my own Approved Instructor Certification, I aim to sustain the momentum we've gained in training our staff and campus partners in CISM, and hope to offer professional development trainings and crisis intervention consultation to colleges and universities in our area.

As both the literature and my research have shown, there's also great value in creating more systemic peer support networks within Residence Life departments. Whether these manifest as mentoring relationships between seasoned and new professionals, are more definitive debriefing circles that meet following Residence Directors' blocks of on-call responsibility, or deploy as CISM teams that mobilize to support staff following campus-based critical incidents, peer support serves to facilitate ventilation of work-related stress, normalize stress reactions, and activate adaptive coping strategies.

### **Conclusions**

This study makes a case for Residence Directors as residential crisis workers and serves to explore the utility of a crisis intervention model such as Critical Incident Stress

Management (CISM) in the mitigation of compassion fatigue in Residence Directors. The nature of this phenomenological single-site case study design was aimed at narrative inquiry or “life history research” and its analysis was primarily open-ended, whereby I extrapolated meaningful themes in participants’ lived experience, and relied heavily on interview data to make meaning of what was said and observed. The outcomes of the study did not yield results that are statistically generalizable, yet the findings could be effective in expanding theoretical notions, and pushing forth recommendations for better practice and further study of the subject matter. I selected the site for my case study based on what I already knew of the campus’ inclusion of CISM training as professional development for the residence life program, as well as relied on staff’s willingness and availability to sustain participation in my study.

I assumed there was greater integration of CISM into the campus’ day-to-day crisis response protocols, yet confirmed through my research that CISM training had significant utility for Residence Directors regardless of whether the model was fully integrated or only marginally so. My study participants clearly stated that being trained in CISM served to improve their efficacy as helpers in critical situations both large and small; taught them to rely on each other for support, emotional ventilation, and feedback following their management of critical incidents; and motivated them to practice self-care and establish clearer boundaries so as to maintain better work-life balance. As such, they all demonstrated high levels of compassion satisfaction and low levels of compassion fatigue (burnout and secondary traumatic stress) on the Professional Quality of Life Questionnaire (ProQOL, Stamm, 2012), and while their professional experience ranged in years from 4 to 40, they were incredibly self-aware, recognized when their reserves

and capacity to help others were low and needed recharging, and established a community of practice that values developmental supervision, peer support, healthy coping, and both professional and interpersonal growth. Since Critical Incident Stress Management is a crisis response model that is empirically supported, systematic, multi-component and self-contained, and since research has shown that colleges and universities routinely deal with short and long-term consequences of students in crisis and large-scale traumatic events, it follows that the organization of coordinated crisis intervention protocols and crisis response training safeguards the physical and emotional well-being of its university community members thereby expediting recovery for both students and staff.

**APPENDIX A**

**INFORMED CONSENT**

**STUDY OF THE UNIVERSITY OF MASSACHUSETTS AMHERST**

Residence Directors as Residential Crisis Workers: Exploring the Role of Campus-Based Critical Incident Stress Management in the Mitigation of Compassion Fatigue

**CONSENT FOR VOLUNTARY PARTICIPATION**

I volunteer to participate in this qualitative study and understand that:

1. I will be interviewed by use of a semi-structured guided interview format consisting of 25 questions. I may also have the option of completing the Professional Quality of Life (ProQOL) Questionnaire, which involves self-scoring participant rating scales on burnout, secondary traumatic stress, and compassion satisfaction.
2. The questions I will be answering address my views on issues related to Critical Incident Stress Management training for residential staff of my college or school. I understand that the primary purpose of this research is to identify strategies that will effectively increase residential staff's resistance to compassion fatigue and effectiveness when dealing with crisis.
3. The interview will be tape recorded to facilitate analysis of the data.
4. My name will not be used, nor will I be identified personally, in any way or at any time. I understand it will be necessary to identify participants in the study by position and college affiliation (e.g., a Residence Director said . . .).
5. I may withdraw from part or all of this study at any time.
6. I have the right to review material prior to the oral defense or other publication.
7. I understand that results from this study may be included in Noga Gillat Flory's doctoral dissertation and may also be included in manuscripts submitted to professional journals for publication.
8. I am free to participate or not to participate without prejudice.
9. Because of the small number of participants, approximately five, I understand that there is some risk that I may be identified as a participant of this study.

If you have questions or comments regarding this study, please feel free to contact Noga Gillat Flory at [ngillat@umass.edu](mailto:ngillat@umass.edu). You may also contact Noga's chairperson, Dr. Sharon Rallis, at 413-545-1056 or [sharonr@educ.umass.edu](mailto:sharonr@educ.umass.edu).

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**Researcher's Signature**

**Date**

---

**Participant's Signature**

**Date**

## **Informed Consent Letter**

Dear Residential Life Staff member:

My name is Noga Gillat Flory, and I am a doctoral student at the University of Massachusetts Amherst, School of Education. I am also a long-time Residence Director on the University of Massachusetts Amherst campus. For my dissertation research I am conducting a qualitative phenomenological case study on the utility of and access to Critical Incident Stress Management (CISM) among Residence Life Staff on campuses where this model of crisis intervention is used. I am seeking your participation in my study, and believe your insights will actively inform and truly enrich my research. I am interested in learning more about mid-level Residence Life Staff's repeated exposure to stress through crisis work in the residential setting, as well as exploring the utility of CISM in mitigating manifestations of compassion fatigue in Residence Life Staff.

Your participation will entail 1-2 interviews lasting about one hour, and may also include your voluntary submission of your Professional Quality Of Life (ProQOL) Questionnaire which utilizes self-scoring participant rating scales on burnout, secondary traumatic stress and compassion satisfaction. In Student Affairs, when you help students, you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in both positive and negative ways. The ProQOL asks some questions about your experiences, both positive and negative, as a helper in the context of your work. The topics I will want to explore in the interview include the ways in which the work responsibilities of an RD impact his/her own functioning and well-being, as well the role of repeated exposure to student and student staff crises on an RD's ability to cope with his/her own needs, stressors, and responsibilities. I'm also interested to determine what sources of support RDs rely on most frequently, or find to be the most helpful in debriefing critical incidents. I imagine you'll find the entire interview process interesting, and may derive satisfaction in knowing your participation helped shape best practice recommendations within the field of Student Affairs. Your campus serves as a good model for a case study, since CISM training is already in place as means of contributing to structured crisis intervention protocols and practices, and more intentional supports for staff who handle crises. With your permission, I would like to tape-record the interviews; the tape will be erased and the files deleted after transcription. Your name will be changed in any and all documentation within my research.

My Dissertation Committee comprised of Drs. Sharon Rallis, Sara Whitcomb, and Daniel Gerber will read and access various stages of my research and writing. I will protect both your identity and that of your campus/cluster/residence hall by assigning you pseudonyms, unless you choose to be identified. You should understand that I will quote

directly from our interviews but will not use your name in any part of the report. I'd be grateful for the opportunity to include your insight and experiences among my study and research findings.

I appreciate your willingness to give your time to my study and to helping me learn more about RDs methods of coping with secondary stress and their utility of CISM. If at any time during your participation in my study you wish to withdraw, you may do so with no negative consequences. If you have any questions, please feel free to ask me, or to call or email my Advisor and Dissertation Chair at [sharonr@educ.umass.edu](mailto:sharonr@educ.umass.edu) or 413-545-1056.

Thank you,

Noga Gillat Flory  
[ngillat@umass.edu](mailto:ngillat@umass.edu)

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The study has been explained to me, and I understand the conditions described above. I freely agree to participate.

(Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

## APPENDIX B

### DRAFT INTERVIEW GUIDES

#### Residence Directors – Personal Information:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Years in current profession: \_\_\_\_\_ Years at this college: \_\_\_\_\_  
Highest degree of education completed: \_\_\_\_\_  
Degrees earned and professional certifications: \_\_\_\_\_

#### Questions:

1. Tell me a little about yourself...
2. How long have you worked in Student Affairs?
3. What brought you to this college?
4. What do you like most about your work?
5. What do you find most challenging about your work?
6. What questions can I answer for you about my study? (i.e. how I came to do this work and to focus on this topic)?
7. How did you hear about the CISM training offered in your area/ campus?
8. What drew you to register to participate?
9. Which training did you undergo, individual or group crisis intervention? Did you intentionally pick one over the other or was the choice contingent on what was offered at the time?
10. What do you feel you gained from your participation in the CISM training?
11. What in the curriculum did you find most valuable?
12. What new content did you learn that you hadn't known before?
13. What from the content that you learned have you/will you apply within your work?
14. How has your use/knowledge of CISM techniques or strategies affected you personally?
15. How has your use/knowledge of CISM techniques or strategies effected how you do your work?
16. How has CISM training effected your relationships/ work with other colleagues?
17. What do your on-call responsibilities look like?
18. How has your training in CISM influenced your helping skills competencies?
19. What in your work causes you the most stress? What do you do to cope with stress?
20. What does it look like when you have good work-life balance?
21. What might it look like if you were overextended or burned out?
22. Who do you talk to when you're troubled by work-related issues?
23. What type of supervision or debriefing do you experience after dealing with particularly challenging crisis situations at work?
24. Has your department instituted any CISM-based supports (i.e. debriefing groups, peer support, professional development training on crisis response and self-care practices)?
25. Have you seen any changes in the campus' climate since CISM was introduced and trainings regularly offered?



**CISM Educator – Personal Information:**

Name:

Age:

Years in current profession:

Years at this college:

Highest degree of education completed:

Degrees earned and professional certifications:

**Questions:**

1. Tell me a little about yourself...
2. How long have you worked in Student Affairs?
3. How did you come to work in residence life?
4. What brought you to this college?
5. What do you like most about your work?
6. What do you find most challenging about your work?
7. What do you hope to learn from your participation in my study?
8. What questions can I answer for you about my study? (i.e. how I came to do this work and to focus on this topic)?
9. How did come about your first exposure to CISM?
10. What do you feel you gained from your participation in the CISM training?
11. What in the curriculum did you find most valuable?
12. What new content did you learn that you hadn't known before?
13. What motivated you to become a CISM educator?
14. In addition to serving as the Director of Professional and Student Development you also serve as the Director of Counseling Services for your college. How do you reconcile the work you do through CISM debriefings and your role as a clinician?
15. How has your use/knowledge of CISM techniques or strategies affected you personally?
16. How has your use/knowledge of CISM techniques or strategies effected how you do your work?
17. What do you do to cope with stress?
18. Who do you talk to when you're troubled by work-related issues?
19. Has your department instituted any CISM-based supports (i.e. debriefing groups, peer support groups, professional development training on crisis response and self-care practices)?
20. Have you seen any changes in the campus' climate since CISM was introduced and trainings regularly offered?
21. Who else do you train at your college besides Residence Life Staff?
22. What do you perceive RDs gain by being trained in CISM?
23. How can use/knowledge of CISM techniques affect how residence directors do their work?
24. How does CISM training affect RDs' relationships/ work with other colleagues?
25. How can it affect them personally?

**Assistant Director – Personal Information:**

Name:

Age:

Years in current profession:

Years at this college:

Highest degree of education completed:

Degrees earned and professional certifications:

**Questions:**

1. How long have you worked in Student Affairs?
2. How did you come to work in residence life?
3. What brought you to this college?
4. What do you like most about your work?
5. What do you find most challenging?
6. What do you hope to learn from your participation in my study?
7. What questions can I answer for you about my study? (i.e. how I came to do this work and to focus on this topic)?
8. How did you hear about the CISM training offered in your area/ campus (i.e. what was your first exposure to CISM)?
9. What drew you to register to participate?
10. In which training have you participated – individual and/or group crisis intervention?
11. Did you intentionally pick one over the other or was the choice contingent on what was offered at the time?
12. What do you feel you gained from your participation in the CISM training?
13. What in the curriculum did you find most valuable?
14. What new content did you learn that you hadn't known before?
15. What from the content that you learned have you been able to apply within your work?
16. What do you do to cope with stress?
17. Who do you talk to when you're troubled by work-related issues?
18. What type of supervision or debriefing do you experience after dealing with particularly challenging crisis situations at work? What's offered for RDs
19. Have you seen any changes in the campus' climate since CISM was introduced and trainings regularly offered?
20. What do you feel RDs gain by being trained in CISM?
21. How can use/knowledge of CISM techniques affect how residence directors do their work?
22. How does CISM training affect RDs' relationships/ work with other colleagues?
23. How can knowledge and use of CISM strategies affect them personally?
24. What does it look like when your RDs have good work-life balance?
25. What might it look like if they were overextended or burned out?
26. What types of structures has your department instituted (i.e. debriefing groups, peer support groups, wellness-based trainings) to support RDs in their work?

**APPENDIX C**

**DRAFT OBSERVATION PROTOCOL**

ID:

Date:

Time:

Location:

<b>Observation</b>	<b>Reflection</b>	<b>Interpretation</b>

## APPENDIX D

### HUMAN RESEARCH CURRICULUM COMPLETION REPORT

#### COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM) COURSEWORK REQUIREMENTS REPORT\*

\* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Noga Flory (ID: 1961951)
- **Email:** ngillat@educ.umass.edu
- **Institution Affiliation:** University of Massachusetts Amherst (ID: 500)
- **Institution Unit:** Housing and Residence Life
- **Phone:** 413-545-1625
  
- **Curriculum Group:** Human Research
- **Course Learner Group:** Group 2 Social and Behavioral Research Investigators and Key Personnel
- **Stage:** Stage 2 - Refresher Course
  
- **Report ID:** 16683606
- **Completion Date:** 12/09/2015
- **Expiration Date:** 12/07/2020
- **Minimum Passing:** 80
- **Reported Score\*:** 100

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
SBE Refresher 1 – History and Ethical Principles (ID: 936)	12/09/15
SBE Refresher 1 – Federal Regulations for Protecting Research Subjects (ID: 937)	12/09/15
SBE Refresher 1 – Informed Consent (ID: 938)	12/09/15
SBE Refresher 1 – Research with Prisoners (ID: 939)	12/09/15
SBE Refresher 1 – Research in Educational Settings (ID: 940)	12/09/15
SBE Refresher 1 – Instructions (ID: 943)	12/09/15
SBE Refresher 1 – Defining Research with Human Subjects (ID: 15029)	12/09/15
SBE Refresher 1 – Privacy and Confidentiality (ID: 15035)	12/09/15
SBE Refresher 1 – Assessing Risk (ID: 15034)	12/09/15
SBE Refresher 1 – Research with Children (ID: 15036)	12/09/15
SBE Refresher 1 – International Research (ID: 15028)	12/09/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program  
Email: [citisupport@miami.edu](mailto:citisupport@miami.edu)  
Phone: 305-243-7970  
Web: <https://www.citiprogram.org>

## APPENDIX E

### TRANSCRIPTION CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_ transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from Noga Gillat Flory related to her dissertation study on **Residence Directors as Residential Crisis Workers: Exploring the Role of Campus-Based Critical Incident Stress Management in the Mitigation of Compassion Fatigue**. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher, Noga Gillat Flory.
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.
4. To return all audiotapes and study-related materials to Noga Gillat Flory in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (Please print) \_\_\_\_\_

Transcriber's signature \_\_\_\_\_

Date \_\_\_\_\_

## APPENDIX F

### PRO-QOL QUESTIONNAIRE AND SELF-SCORING GUIDE

#### PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

#### COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 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 <i>[help]</i> .			
_____	3.	I get satisfaction from being able to <i>[help]</i> 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 <i>[help]</i> .			
_____	7.	I find it difficult to separate my personal life from my life as a <i>[helper]</i> .			
_____	8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I <i>[help]</i> .			
_____	9.	I think that I might have been affected by the traumatic stress of those I <i>[help]</i> .			
_____	10.	I feel trapped by my job as a <i>[helper]</i> .			
_____	11.	Because of my <i>[helping]</i> , I have felt "on edge" about various things.			
_____	12.	I like my work as a <i>[helper]</i> .			
_____	13.	I feel depressed because of the traumatic experiences of the people I <i>[help]</i> .			
_____	14.	I feel as though I am experiencing the trauma of someone I have <i>[helped]</i> .			
_____	15.	I have beliefs that sustain me.			
_____	16.	I am pleased with how I am able to keep up with <i>[helping]</i> 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 <i>[helper]</i> .			
_____	20.	I have happy thoughts and feelings about those I <i>[help]</i> and how I could help them.			
_____	21.	I feel overwhelmed because my case <i>[work]</i> 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 <i>[help]</i> .			
_____	24.	I am proud of what I can do to <i>[help]</i> .			
_____	25.	As a result of my <i>[helping]</i> , I have intrusive, frightening thoughts.			
_____	26.	I feel "bogged down" by the system.			
_____	27.	I have thoughts that I am a "success" as a <i>[helper]</i> .			
_____	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.			

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## 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.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, 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.

---

### 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.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 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.

---

### 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.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, 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.

## WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section**, total the questions listed on the left 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 them 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	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

### Burnout Scale

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

- \*1. \_\_\_\_\_ = \_\_\_\_\_  
\*4. \_\_\_\_\_ = \_\_\_\_\_  
8. \_\_\_\_\_  
10. \_\_\_\_\_  
\*15. \_\_\_\_\_ = \_\_\_\_\_  
\*17. \_\_\_\_\_ = \_\_\_\_\_  
19. \_\_\_\_\_  
21. \_\_\_\_\_  
26. \_\_\_\_\_  
\*29. \_\_\_\_\_ = \_\_\_\_\_

**Total:** \_\_\_\_\_

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

You Wrote	Change to	the effects of helping when you are not happy so you reverse the score
	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 them 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	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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## APPENDIX G

### CISM QUICK CARDS

<p style="text-align: center;"><b>SAFE-R MODEL</b> <b>For Individuals</b></p> <p><b>STABILIZE</b> <b>ACKNOWLEDGE</b> There is a crisis Help is available</p> <p><b>FACILITATE</b> Discussion Problem solving Plan</p> <p><b>ENCOURAGE</b> Acceptance &amp; utilization of resources Use of coping skills</p> <p><b>RECOVERY or REFERRAL</b></p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"><p><u>All crisis intervention should be</u></p><table><tr><td>Simple</td><td>Innovative</td></tr><tr><td>Brief</td><td>Practical</td></tr><tr><td>Immediate</td><td>Positive in Outlook</td></tr><tr><td colspan="2">Proximal to crisis, but in safe area</td></tr></table></div>	Simple	Innovative	Brief	Practical	Immediate	Positive in Outlook	Proximal to crisis, but in safe area		<p style="text-align: center;"><b>CRISIS MANAGEMENT BRIEFING</b></p> <ul style="list-style-type: none"><li>• <i>Large Group</i> intervention</li><li>• 30 to 45 minutes</li><li>• For non-operations people</li><li>• Requires thought and planning</li><li>• Used before, during or after crisis</li><li>• Repeated as situation changes</li><li>• Requires homogenous groups</li><li>• Groups with equal exposure to event</li><li>• No immediate present danger</li><li>• Gather specific groups together</li><li>• Credible representative presents facts</li><li>• Brief controlled discussion / Q &amp; A</li><li>• Info / stress survival skills / instructions</li><li>• Open the possibility of add'l meetings</li></ul>
Simple	Innovative								
Brief	Practical								
Immediate	Positive in Outlook								
Proximal to crisis, but in safe area									
<p style="text-align: center;"><b>CRITICAL INCIDENT STRESS DEBRIEFING</b></p> <p><b>INTRODUCTION</b> Offer brief introduction of team Explain what CISD is Explain why it is done Stress that it's not critique or investigation Stress confidentiality You don't have to speak Relate your own experiences Speak for yourself Don't give breaks Leave rank at the door Don't take notes or make recordings Team will remain after session</p> <p><b>FACTS— Ask....</b> Who are you? What was your role or exposure to event? What happened from your viewpoint?</p> <p><b>THOUGHTS – Ask...</b> What were your first or most prominent thoughts?</p>	<p style="text-align: center;"><b>DEFUSING</b></p> <ul style="list-style-type: none"><li>• Small group intervention</li><li>• Homogeneous group</li><li>• Situation ended</li><li>• Roughly equal exposure to trauma</li><li>• Lasts 20 to 45 minutes</li><li>• Designed to "take the edge off" event</li></ul> <p><b>INTRODUCTION</b> Intro team / present guidelines Stress confidentiality You do not have to speak Relate your own experiences Team will listen first - inform later Everyone's experience is important Purpose it not to find fault or place blame Purpose is not to critique or investigate No discussion of violations of procedure</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"><p style="text-align: center;"><b>Int'l Critical Incident Stress Foundation</b> <b>Emergency (24 hrs.) 410-313-2473</b></p></div>								

### CRISIS INTERVENTION

#### Emotional "first aid," not therapy

By professionals or non-professionals  
Limited by time, helper skills, resources

#### STABILIZE SITUATION

Assess rapidly  
Reduce stimuli/ protect from stress

#### MITIGATE IMPACT OF STRESS

Assure that help is available  
Stay calm and in control  
Provide clear instructions

#### MOBILIZE RESOURCES

Ask what the person needs  
Identify/call on available resources

#### PROBLEM SOLVING

Develop plan/pick best options  
Implement immediately

#### NORMALIZATION

Normal reactions of normal people  
Reactions: painful but typical

#### RESTORATION TO FUNCTION

Simple tasks / Aim for recovery

#### REFERRAL

After intervention: recovery or referral  
Refer psychosis or medical problems

### DEMOBILIZATION

- Large 30-minute group intervention
- For operations personnel / homogeneous groups
- For disasters / large scale accidents
- Provided only one time, after first exposure to incident
- Provided after mission is complete
- For groups with roughly equal exposure to trauma
- Start with brief introduction by CISM team member
- Provide information / stress survival instruction
- Ask for questions / comments
- Personnel rarely talk in demobilization
- Information section lasts 10 minutes max.
- Allow 20 minutes for rest and food
- Personnel can go home or move on to new duties
- Personnel should not return to disaster site for at least 6 hrs.

#### REACTIONS – Ask...

What was the worst part of the event from your perspective?

#### SYMPTOMS – Ask...

What were symptoms at scene?  
What were symptoms after event?  
Are there any left over symptoms?

#### TEACHING

Normal people, normal responses  
Need for exercise, food, rest, self care  
Talk to trusted people  
Re-establish routines  
What to expect  
Relate to what was discussed in CISM  
Address concerns

#### RE-ENTRY

Q & A  
Summarize / tie up loose ends  
Help establish plan of action  
Remind about confidentiality  
Final statements from team.

Emergency (24 hrs.) 410-313-2473

#### EXPLORATION – Ask...

What happened from your viewpoint?  
Who came first? What happened? Next?  
Was there direct contact with victims?  
Was anything significant to you?  
What sticks with you now?  
Anything else?

#### INFORMATION

Teach possible reactions  
Normalize their response  
Offer suggestions on stress survival / recovery  
Warn off alcohol, drugs, fatty foods, junk  
Food, caffeine and nicotine  
Encourage reasonable activities  
Summarize / conduct Q & A  
Provide handouts / contact numbers

Next step: CISM / one-on-ones / follow-up

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