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The Mother Teresa Effect: The Modulation of Spirituality in using The CISM Model with Mental Health Service Providers

Mark Newmeyer, Benjamin Keyes, Sonji Gregory, Kamala Palmer,
Daniel Buford, Priscilla Mondt and Benjamin Okai

Regent University

Abstract: *Mental health service providers are at risk of experiencing compassion fatigue, burnout, and vicarious traumatization as a result of working in difficult contexts or when working with individuals who have experienced trauma. Numerous studies have examined the mitigating factors in professional caregivers' stress and related prevention strategies thought to be associated with professional self-care. This retrospective study examined the impact of debriefing strategies referred to as Critical Incident Stress Management (CISM) and spirituality in 22 mental health service providers working in a stressful, cross-cultural context. Quantitative analysis of pre and post self-report instruments suggests that training and utilization of CISM techniques may be important in preventing future problems. To the surprise of the researchers, spirituality may not only serve as a protective factor in moderating compassion fatigue, but also increases compassion satisfaction among professional caregivers. Thus, the "Mother Teresa Effect".*

Key words: *Critical incident stress management, trauma, protective factors, ego-resiliency, compassion fatigue, spirituality, Mother Teresa effect*

INTRODUCTION

Counselors, social workers, psychologists, and other allied professionals engage in helping roles that commonly intersect with trauma, resulting in the minimization of their own emotional responses. Such exposure, as in lengthy therapeutic relationships or acute experiences as first responders can evoke stress for professionals (Regan, Burley, Hammer & Wright, 2006; Stanley, Feldman, Kaplan, 2010).

Scholarly literature devoted to understanding the aggravating and mitigating factors in professional caregiver stress is noteworthy. A Psych-Net database search examining professional journal articles from 1980-2013 yielded 134 articles in which "professional helper stress" and "professional mental health provider stress" functioned as key terms. Additionally, 252 articles were identified in which "professional social worker stress" was a key term; 374 articles were identified in which "professional counselor stress" was a key term; 468 articles in which "professional psychologist stress" was a key term; and 593 articles in which "professional nurse stress" was a key term.

Definitions of Stress, Related Prevention Strategies and Protective Factors

Burnout and occupational stress appears in a broad spectrum of vocations and can occur in practically any career. Best defined as job related stress, which presents with symptoms of exhaustion, cynicism, and ineffectiveness, burnout and occupational stress can occur in individuals not working with trauma related settings (Maslach & Leiter, 1997). For instance, a mental health professional may experience burnout while working with court-ordered clients in a similar manner that a computer programmer may experience burnout while attempting to balance the demands of numerous projects and deadlines.

Vicarious traumatization is a term used in early research published by McCann and Pearlman (1990) in which "Vicarious traumatization can be understood as related both to the graphic and painful material, trauma clients often present and to the therapist's unique cognitive schemas or beliefs, expectations, and assumptions about self and others". Vicarious traumatization has also been equated with secondary trauma, defined as encountering "distress while empathizing for another who has been affected by an event" (Figley, 1999, p. 54).

Research advanced by Galek, Flannelly, Greene, and Kudler (2011) found the following key predictors in the occurrence of secondary trauma syndrome (STS) and burnout:

(1) The number of years worked in the same employment position was positively associated with burnout but not STS; (2) STS, but not burnout, was positively associated with the number of hours spent per week counseling patients who had had a traumatic experience; and (3) social support was negatively related to burnout and STS. Only specific sources of social support (supervisory support and family support), however, were negatively associated with burnout.

Tabor (2011) departs from the equivalent use of vicarious trauma and secondary trauma indicating that they have been "incorrectly interchanged". She distinguishes vicarious trauma (defining it as a way in which helping professionals are traumatized by hearing the victim's account) from secondary trauma (defining it as witnesses being traumatized by seeing the victim's trauma or triggered by a memory of past trauma). According to Tabor (2011) vicarious trauma mimics the symptoms of the primary victim, includes personal intrusion from another's trauma (e.g., nightmares) and is produced only by working with victims of trauma. In vicarious trauma, unlike secondary trauma, the individual only hears about the events, but does not experience any part of the events. Secondary trauma can be initiated by multiple exposures to the effects of one trauma, as evidenced by a survivor from the 9/11 attacks becoming re-victimized when retelling her/his story during a memorial. Moreover, secondary trauma can be experienced by witnessing an impactful event (e.g., violent crime) (Figley, 1995; Halpern & Tramontin, 2007).

Compassion fatigue is differentiated from burnout, secondary traumatization, and vicarious traumatization. In a visual diagram

Correspondence regarding this article should be directed to: mnewmeyer@regent.edu

delineating these terms, Bush (2009) illustrates how they reinforce one another; burnout is "emotional exhaustion," compassion fatigue is "loss of self", vicarious trauma is a "change in cognitive schema," and secondary trauma has "symptoms similar to posttraumatic stress disorder". The symptoms of compassion fatigue on the mental health provider can be vast, indicated by Harr (2013), "decreased self-esteem, apathy, difficulty concentrating, preoccupation with trauma, perfectionism, rigidity, or, in extreme cases, thoughts of self-harm or harming others". Figley (1995) defined compassion fatigue as a "state of exhaustion and dysfunction (biologically, psychologically and socially) as a result of prolonged exposure to compassion stress". In other words, compassion fatigue decreases professional mental health workers' empathy and desire to care for clients. In addition, compassion fatigue often has a shorter recovery time than vicarious traumatization (Tabor, 2011).

Several factors that can prevent compassion fatigue have been identified. Psycho-education, partnership with mental health professionals, and overall emotional support appeared to act as a buffer to compassion fatigue for chaplains who worked directly with injured soldiers at Fort Bragg in North Carolina (Stewart, 2012). Prevention of compassion fatigue, however, is challenging to provide. Sullivan (2004) studied direct-care professionals working with HIV-positive clients in New York City. Using a 30-item self-report inventory (i.e., Figley's Compassion Fatigue/Satisfaction Scale [CF/S]) the practice of staff development increased compassion satisfaction and reduced burnout, but had no significant effect on compassion fatigue.

The lasting effects of compassion fatigue on caregivers emphasize the importance of prevention and promoting protective factors. Compassion satisfaction is defined by Stamm (2005) as enjoyment a caregiver receives when their work is contributing to the welfare of another person. Aukstinaityte and Zajanckauskaite-Staskeviciene (2010) asserted that compassion eventually develops into either fatigue or satisfaction, with the helping professionals' level of competence, support, and self-care affecting which result is obtained. This finding is significant because compassion fatigue was positively correlated with burnout while compassion satisfaction mitigates against burnout. Likewise, self-care appeared to reduce compassion fatigue and was defined as "listening to the signals of one's own body, preservation of good working and communication skills and healthy limits when struggling for oneself, short breaks at work, time spent with trusted people, self-belief and believing in one's own abilities, and satisfaction with important things in life" (Aukstinaityte and Zajanckauskaite-Staskeviciene, 2010, p.56).

Other protective factors identified in the literature include the ability to transcend the trauma in order to form a new, stronger identity. A qualitative study conducted by Sider (2006) revealed three themes of survival in those interviewed: tending the victim, transcending as survivor, and transforming as professional caregiver. Sider (2006) emphasizes the importance of looking beyond the traumatized individual to the survivor within.

Sider's (2006) approach is similar to what Hernandez, Gangsei, and Engstrom (2007) described as vicarious resilience - the valuable lessons a therapist can glean from watching clients successfully maneuver traumatic events. In a later study conducted by Hernandez, Engstrom, and Gangsei (2010), vicarious resilience is identified as a mitigating factor against compassion fatigue for caregivers working with traumatized victims. Hence, professional caregivers can reduce their own compassion fatigue if they learn the keys to overcoming horrific trauma by watching and learning from their clients. The paradigm shifts - caregivers do not merely regard the clients as victims that need help, but survivors from whom they can vicariously learn.

The body of research on career calling contributes to the discussion of preventative factors for compassion fatigue. Hirschi (2012) discovered that people reported more stress and reduced job satisfaction when they did not feel like they were fulfilling their purpose. Conversely, fulfilling one's career calling may serve as a moderator against stress. In fact, research demonstrates a correlation between spirituality and calling. Dik, Sargent, and Steger (2008) found a positive correlation between Spiritual Strivings scores, religious commitment, career calling and meaning in life.

McClelland (1989) was the first to introduce an effect, referred to as the Mother Teresa Effect, reproducing results across three studies. Participants in all three studies viewed a documentary film of Mother Teresa's work amongst suffering individuals in Calcutta, India. Some participants were inspired by the film despite the suffering displayed. McClelland found a positive physiological response in a subgroup of those who were inspired by the film — possessing the trait of affiliated trust which acted as a protective factor.

Recent research points to the positive effects of spirituality on resilience (Peres et al., 2006). Ai and Appel (2011) reported that survivors of hurricanes Katrina and Rita who either had high levels of altruism or spiritual support showed statistically significant adjustment compared to other survivors. Alawiyah, Bell, Pyles, and Runnels (2011) interviewed survivors following Hurricane Katrina and found that they also attributed their resilience to spirituality. Aukstinaityte and Zajanckauskaite-Staskeviciene (2010) identified the moderating characteristic of compassion-satisfaction as being associated more frequently with the participants who considered themselves as Christians. Recent studies (Van Hook, 2009; Harr, 2013; and Watkins, 2014) have shown a Christian/Spiritual attitude and focus can improve levels of compassion satisfaction due to a positive outlook on life in general. It might be interesting for further study to examine other qualities or traits that also cause a shift towards compassion satisfaction away from compassion fatigue.

Ego resiliency is another mitigating factor according to Masten and Coatsworth (1998) who referred to it as a set of constructive coping mechanisms that are used by an individual during and following a traumatic event. Ego resiliency refers to a system of behaviors, not one's personality; therefore, this concept can be taught and learned. Moreover, Smeekens, Riksen-Walraven, and Van Bakel (2007) confirmed ego resiliency as a moderating factor for children in stressful parent-child interactions.

For direct-care professionals, the debriefing process is typically thought to be an important preventative measure after exposure to traumatized victims. A systematic debriefing approach that is utilized with helping professionals is the Critical Incident Stress Management (CISM) (Boscarino, Adams and Figley, 2005; Vogt, Leonhard, Koper & Pennig, 2004; Everly & Langlieb, 2003). Key elements of CISM are: pre-incident preparation and training, demobilization, crisis management briefing, defusing, critical incident stress debriefing, family crisis intervention, individual crisis intervention, pastoral crisis intervention, organizational consultation and development, and follow-up and referral (Everly & Langlieb, 2003). These components serve the distressed subject by providing stabilization and movement to the next level of intervention. The stages of the CISM model also support the helper or responder during times of crisis or trauma by providing the structure for support and a way to process cognitive and affective reactions in a way that promotes psychological coping and resilience.

An intervention is successful if it stabilizes the person in crisis. This is true in "physical medicine as well as emergency mental health" (Everly & Langlieb, 2003, p. 114). In their economic evaluation of Critical Incident Stress Management (CISM), Vogt et al. (2004)

found that CISM produced an economic benefit by reducing the time individuals had to take off from work as a result of the critical incident. This finding has been seminal in establishing CISM as primary debriefing model for first responders and employees with agencies and corporations throughout the United States.

Boscarino, Adams & Figley (2005) assessed interventions like CISM, psychological debriefing, and other focused, short-term interventions administered to emergency responders at the World Trade Center disaster site. They found that the interventions evidenced valuable impact on the emotional well-being of employees when examining critical outcomes (i.e., alcohol use, PTSD symptoms, anxiety, depression, and somatization). They also found that crisis interventions provided at the worksite were clinically effective up to two years after treatment leading the authors to suggest that services should be offered for large scale disasters (Boscarino, Adams & Figley, 2005).

CISM has come under some criticism. Various studies have questioned outcome efficacy purported by CISM proponents (Bledsoe, 2003; Morrison, 2007; Wei, Szumilas & Kutcher, 2010). Bledsoe, a harsh critic of CISM has maintained that the approach might be harmful and that without more scientific studies the full impact of CISM is dubious (2003). Additionally, Morrison (2007) suggests that CISM had mixed effects. While professional staffs' perceptions indicate efficacy, target population outcomes (i.e. students) had no effect. Wei, Szumilas & Kutcher (2010) suggests that in school settings there is a need to better understand the impact of debriefing strategies on the psychological well-being of individuals. It should be noted here that the methodologies of the studies receiving criticism varied in their application of the CISM model and often veered from accepted protocols regarding CISM's efficacy.

GOAL OF THE STUDY

This retrospective study explores pre and post data collected on 22 helping professionals (i.e. participants) who engaged in a two-week cross-cultural professional helping experience. The participants traveled from the U.S. to Kenya and delivered trauma focused interventions to indigenous refugees experiencing a variety of complex trauma related conditions (e.g. PTSD). Among other powerful descriptors, the population being served is defined as being intensely impacted by a high prevalence of HIV and resulting death from AIDS and related opportunistic diseases. Cultural myths in this population also maintain that the spread of HIV and AIDS among adults may be averted by sexual intercourse with young children, thus giving rise to an alarming rate of sexual molestation.

In order to effectively intervene with the distressed population, the participants were trained in debriefing techniques associated with CISM. Serving as their own control group, it was hypothesized that across various self-report instrument there would be minimal differences in pre and post results, thus indicating that professional training, especially with CISM was beneficial in offsetting caregiver related stress among the participants. Secondly, it was hypothesized that results from the participants' self-report spirituality inventory would indicate that spirituality serves as a protective factor in reducing caregiver related stress.

METHOD

Participants

Participants (N = 22) volunteered to complete the instruments before and after the two-week experience. Each participant received an informed consent form that was approved by the human subjects review committee. All the forms were signed and accounted for. Additionally, confidentiality was ensured and surveys administered during the study were de-identified. Aggregate results were password protected in a relational database (i.e., IMB SPSS 20.0). All participants were graduate students, alumni, or faculty from a South-Atlantic university's graduate counseling program. Of the participants, seven identified as male (32%) and 15 female (68%). The age range breaks down as follows: nine participants were between 18-30 years old (41%), nine participants were within the 31-50 years old (41%), and four participants were between 51-70 years of age (18%). The participants' self-identified ethnicity was accounted for 5 Black/African (22%), 14 White (64%), one Hispanic (4%), and two Multi-cultural/other (9%). All 22 participants identified themselves as Christian for their religious background. The participants were trained in Critical Incident Stress Management.

Procedures

The participants in this study delivered trauma focused interventions to refugees and indigenous populations within the borders of the country of Kenya. The CISM model was used as a way of diffusing and debriefing participants who are actively involved in the delivery of trauma services to various subpopulations in Kenya. The ten core elements of the CISM model along with the basic tenants of psychological first aid were used as the structure for the work provided. As previously stated, the components are thought to help the distressed population being served as well as aid the professional caregivers (i.e. participants of this study) by providing the structure and support required for this level of care.

A battery to assess and establish the participants' current compassion fatigue, ego resiliency, stress management, and level of spiritual experience was administered. Pretests battery included a Demographic Questionnaire, Ego Resiliency Scale, Daily Spiritual Experience Scale, Stress Vulnerability Scale, and Professional Quality of Life Scale. Upon returning from Kenya, participants repeated the process, completing the same battery of instruments. In order to match participants' pre and post results while maintaining anonymity, participants used a unique code or word known only to them in place of their proper name.

Measures

The pre and post assessment battery was used to track changes in compassion fatigue, stress management, and their level of spiritual experience. Specifically, the instruments attend to the following areas: 1) Ego Resiliency Scale (Block & Kremen, 1996); 2) Compassion Satisfaction and Fatigue Subscales of the Professional Quality of Life Scale (Stamm, 2005); 3) Stress Vulnerability Scale (Miller & Smith, 2004); and 4) Daily Spiritual Experience Scale (Underwood & Teresi, 2002).

Ego resiliency scale: The ER scale was developed by Block & Kremen (1996) to identify self-reported resiliency traits in individuals. This instrument utilizes fourteen questions based on a four-point Likert scale and include questions such as "I like to take different paths to familiar places," and "I would be willing to describe myself as a pretty 'strong' personality" (Block & Kremen, 1996). Scores are interpreted by adding up the points from each answer to determine the total score. A score falling between 47-56 indicates a very high resiliency trait, 35-46 high resiliency trait, 23-34 undetermined trait, 11-22 low resiliency trait, and 0-10 very low resiliency trait (Block & Kremen, 1996).

Cohn, Fredrickson, Mikels, & Conway (2009) used the ER in order to link day-to-day and in-the-moment positive emotions to improvements in life outcomes. Findings suggest a mutually

enhancing relationship between positive emotions and ego resiliency (Cohn, Fredrickson, Mikels & Conway, 2009).

The ER scale was recently utilized in a study by Mak, Ng and Wong (2011), in which 1,419 Chinese students were recruited from seven universities and institutions in Hong Kong to test the mediating role of positive views toward self, world, and future (i.e., the positive cognitive triad) on the relationship of trait resilience with life satisfaction and depression. Results demonstrated that positive thoughts are important elements which contribute to the effect of trait resilience on an individual's well-being (Mak et al., 2011).

Compassion satisfaction and fatigue subscales of the professional quality of life scale (ProQOL): The ProQOL is a self-report measure that assesses compassion fatigue relative to job burnout. The instrument consists of thirty questions directed at identifying levels of happiness, relationship to vocation, and resiliency and are examined on a six-point Likert scale. Examples include, "I feel connected to others," "I like my work as a helper," and "I am an unduly sensitive person" (Stamm, 2005). The ProQOL includes directions for self-scoring that require different marks (an x, check, and circling); scoring those clustered items together result in High, Average, or Low scores. The combination of scores determines which category one falls into. For example, low burnout, low compassion fatigue, and high satisfaction indicate job satisfaction while high burnout, low compassion fatigue, and high satisfaction might mean one should change jobs. The scale is designed as a guide, not as conclusive and absolute data. Furthermore, the results section proffers an explanation for each category that was tested (compassion fatigue, burnout, and compassion satisfaction). An average score and basic self-care advice is given for each category (Stamm, 2005). Internal consistency reports indicate that the ProQOL demonstrates adequate alpha reliability (.84 to .90); furthermore, studies have shown evidence of test validity (Stamm, 2005).

In a study, Harrison and Westwood (2009) attempted to identify protective practices that reduce risks of vicarious traumatization among mental health therapists. Possible participants were asked to fill out the Professional Quality of Life: Compassion Fatigue and Satisfaction Subscales, R-III (Pro-QOL), which is a brief quantitative scale used for screening purposes only. The potential participants scoring below average on the Burnout and Compassion Fatigue subscales of the Pro-QOL were invited to take part in the study. Results showed that clinicians who engage with traumatized clients in an empathic manner are protected. When clinicians practice "exquisite empathy" (being highly present, having good boundaries, and being sensitive), they describe themselves as invigorated rather than depleted by their involvement with the traumatized client.

Stress Vulnerability Scale (SVS): The SVS arose in response to modern society's increase development of stress. Miller & Smith (2004) designed the questionnaire to assist people in identifying vulnerabilities to stress and trouble spots. Twenty questions based on a five-point Likert scale enable the individual to determine their "vulnerability quotient" in three main areas: habitual, lifestyle, and basic needs. To illustrate, "I take fewer than five alcoholic drinks a week," or "I do something for fun at least once a week," and finally "I have an income adequate to meet basic expenses" (Miller & Smith, 2004).

The Vulnerability scale is a self-report whereby the participants determine their score by adding up the figures then subtracting by 20. Interpretation of the score is offered with scores below 10 indicating excellent resistance to stress, over 30 indicating some vulnerability to stress, and a score over 50 indicative of serious vulnerability to stress. A brief self-care plan is addressed to provide relief from stress (Miller & Smith, 2004).

Daily Spiritual Experience Scale (DSES): The DSES scale was established by Underwood & Teresi (2002) in order to measure self-reported perceptions of God's activity, presence, and individual experiencing of the divine. In a spirituality and marital satisfaction study involving African American couples, Fincham, Ajayi and Beach (2011) used the DSES to assess spirituality. Along with other measures, the DSES aided the researchers in making the distinction between spirituality and religiousness and how it related to marital satisfaction.

The DSES is comprised of 16 questions based on a six-point Likert scale including never or almost never, once in a while, some days, most days, every day, and many times per day. Many times per day refers to the lowest numerical category (1) and never or almost never, the highest category (6). Only question 16 ('In general, how close do you feel to God?') deviates from this format and is scored by responding with not close at all, somewhat close, very close, and as close as possible. Responses are scored on a four-point Likert scale with (1) representing as close as possible, and (4) representing not close at all. Examples of the different items include, "During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns, "and "I feel God's love for me, through others" (Underwood & Teresi, 2002).

The DSES can be scored by adding up each question to determine the total score. This total will fall between 16 to 92 with lower scores representing more daily experiences, and a higher score representative of less experiences of the divine (Loustalot et al., 2006). The DSES utilizes a reverse scoring system, which requires attention to assessing the total mean scores (Koenig, George, & Titus, 2004). Furthermore, the DSES scale is not indicative of how spiritual a person is, rather, the scale is designed to highlight the way in which a person experiences the divine on a daily basis. Consequently, the instrument is an agent toward clarifying and accurately measuring concepts such as religion and spirituality.

The DSES has been examined for validity and reliability and found to be stable over time and is internally consistent (Underwood & Teresi, 2002). Similar findings demonstrated that the 16-item DSES is stable over time, internally consistent, and equivalent in an all-African American sample (Loustalot et al., 2006).

RESULTS

Preliminary Analysis

All twenty-two participants completed a battery of instruments at the beginning of the study (i.e. pretest) and completed the battery of instruments a second time at the conclusion of the study (i.e. posttest). Table 1 presents the means, standard deviations, and correlations among study variables. Study variables were also checked for normality. Shapiro-Wilk test for normality failed to reject the null hypothesis, thereby confirming normal distributions (Table 1). A visually examination using Q.Q. plots also confirmed the Shapiro-Wilk test results.

As might be anticipated, a correlation matrix among the variables (Table 1) shows significant correlations between pre and post SVS; pre and post ProQOL Compassion Satisfaction and Fatigue Subscale; pre and post ER Scale; and pre and post DSES and post DSES. Of particular interest though is the significant correlation between pre SVS and pre ER Scale, -0.430, $p < 0.05$, which was significant, but was no longer significant between post SVS and post ER Scale, -0.397. That is to say, before the two-week experience participants who reported lowered vulnerability to stress also endorsed the ER Scale in a manner consistent with high resiliency. This relationship,

Table 1
Correlations, Means and Standard Deviations among Variables

Item	1	2	3	4	5	6	7	8	*M*	*SD*	*Shapiro-Wilk*
1. SVS-Pre	__								19.14	7.76	0.45
2. SVS-Post	0.638**	__							16.90	9.42	0.75
3. ProQOL-Pre	-0.004	-0.151	__						11.31	5.82	0.16
4. ProQOL-Post	-0.154	-0.161	0.603**	__					10.45	6.05	0.07
5. ER Scale-Pre	-0.430*	-0.211	-0.281	0.002	__				45.04	4.98	0.23
6. ER Scale-Post	-0.143	-0.397	0.004	0.027	0.680**	__			46.77	5.55	0.10
7. DSES-Pre	0.226	0.052	-0.064	0.012	-0.188	-0.003	__		34.27	11.41	0.34
8. DSES-Post	0.024	0.115	0.055	0.213	-0.196	-0.333	0.643**	__	29.50	9.91	0.28

**Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

though mild in strength, was significant. However, the correlation was no longer significant after the two-week experience.

A repeated measure MANOVA was used to investigate if pre and posttest changes indicated significant effect(s). When examining pre and post-tests results, Wilks' Lambda = 0.799, F (5.284, 1) = 21, p = 0.032, was significant. However, there was not significance for an effect between the four tests and pre-post, Wilks' Lambda = 0.758, F (2.025, 3) = 19, p = 0.145.

Post-hoc analysis was deployed to better understand the pre and post-tests significant effect. Paired t-tests examined participants' vulnerability to stress, compassion fatigue, ego resiliency, and daily spirituality before leaving the United States and engaging in the two weeks of work in Kenya to immediately afterwards. There was not a significant difference in the scores for vulnerability to stress as measured by pre SVS and post SVS t (21) = 1.40, p = 0.176. There was not a significant difference in the scores for compassion fatigue, as measured by the pre ProQOL (compassion fatigue) and post ProQOL (compassion fatigue) t (21) =0.765, p = 0.453. There was not a significant difference in the scores for pre ProQOL (compassion satisfaction) and post ProQOL (compassion satisfaction) t (21) = 0.537, p = 0.198. There was not a significant difference in the scores for resiliency as measured by the pre ER Scale and post ER Scale t (21) = -1.90, p = 0.070. There was however a significant difference in the participants' sense of daily spirituality as measured by pre DSES and post DSES t (21) = 2.46, p = 0.023.

DISCUSSION

The twenty-two participants of this study traveled to a developing country and lived and worked for two weeks in challenging conditions. The participants also experienced unique professional challenges in working lengthy hours each day, providing mental health services to a population of individuals and families that have experienced significant personal and societal traumas. Given the abundance of professional literature addressing the importance of professional self-care and the increased risks associated with the trauma saturated settings and clients, the participants were all trained in CISM. The effectiveness of this set of debriefing strategies used to reduce and prevent caregiver stress was evaluated by administering a battery of instruments prior to the participants' experiences and then again the conclusion.

Results from the Stress Vulnerability Scale suggest that at the conclusion of the two weeks, participants endorsed items on the instrument in a manner that suggests a lower risk for becoming stressed. Though this trend was not statistically significant, it does indicate something unexpected. Likewise, a similar trend was evidenced in both the Compassion Satisfaction and Fatigue Subscale and Ego Resiliency Scale. Though group differences from pre to post were not statistically significant the slight trend toward compassion satisfaction and improved resilience and away from compassion fatigue represents an interesting phenomenon.

It is difficult to parcel out from other study variables the impact that CISM may have had on the participants. Given the difficult context that the participants of this study were working in, CISM likely contributed in facilitating their own lowered responses to stress. That is to say, posttest responses suggest that CISM was beneficial in offsetting caregiver related stress among the participants as noted by the unremarkable post SVS, ER Scale, and ProQOL scores.

This study also posited that spirituality would serve as a buffer in protecting participants from stress. As indicated in the RM MANOVA and post hoc analysis, the significance of spirituality as measured by the DSES appears to play a critical role in not only stress reduction, but in an overall positive trajectory in enhancing psychological sense of well-being. While McClelland (1989) identified the Mother Teresa Effect in several well-crafted laboratory experiments, we maintain that this study is landmark in that this effect is clinically measurable and accounts for the positive pre-post trends in all four instruments.

In this light, the Mother Teresa Effect surpasses being merely protective against unwanted stress, and is additive to the participants' sense of well-being. As helping professionals are working in difficult contexts, spirituality provides a basis for an enhanced quality of life as individuals embrace a set of transcendental ideals that give purpose and meaning to their career pursuits. This is not a new conceptual paradigm, however measuring, until now, has proved challenging.

We also contend that closely connected to these findings is the importance of understanding career aspirations and meaning of life topics to an individual's overall sense of wellness, even when functioning in the presence of extreme stress. The linkage between career, spirituality, and a variety of wellness factors is likely complex. This study is a call for follow-up research efforts that are prospective and seek to examine interrelated and perhaps causal relationships of stress, resiliency, career choice, spirituality and debriefing strategies for professional helpers working in high-stakes settings.

Limitations of the Study

In spite of the wealth of information gleaned from this research, various limitations weaken the findings. One such limitation concerning this retrospective analysis is that the design of the study did not include a control group. This of course brackets the inferences made in this study because the self-selecting participants served as their own control. Another limitation of the study is the relatively small sample size (N=22). Since the sample size was fixed and relatively small, there was considerable difficulty in providing a more robust statistical analysis and interpretation of the data that would follow. The results of this study must be viewed with

some caution as participants were from a homogenous grouping of providers.

Future Aims

This study reveals that there are several research opportunities for future considerations. One such consideration is to compare these findings with other diverse helping groups in order to establish validity with regard to factors that lessen compassion fatigue. Further study needs to be conducted to determine if there is a cut-off point at which spirituality diminishes as a protective factor against compassion fatigue.

Another area of interest is to determine whether the faith, cultural values, ethnicity, response factors, and the resiliency of the traumatized population mitigate against caregivers' compassion fatigue or increases their compassion satisfaction. Future studies should consider utilizing positive psychology (e.g. strengths-based and subjective well-being), in conjunction with intermittent surveys in both training and debriefing sessions to determine its impact on service providers' compassion fatigue or satisfaction.

Compassion fatigue has become "a thorn in the flesh" for many health care professionals who, out of sheer altruistic desires, go extra miles to care, heal, and restore hope to despaired populations emotionally devastated by traumatic events. The ongoing search for protective factors against Compassion Fatigue remains elusive although this study points to spirituality as one key factor. This research hypothesized that spirituality plays a significant protective factor in mitigating compassion fatigue. The evidence indicates that spirituality appears to have a relative moderating impact against compassion fatigue and is likely additive to the quality of life of helping professionals. Thus, the Mother Teresa Effect.

REFERENCES

Ai, A.L., & Appel, H.B. (2011). Pathways to post disaster resilience of black and white volunteers for hurricanes Katrina and Rita. *American Psychological Association 2011 Convention Presentation*.

Alawiya,T., Bell, H., Pyles, L., & Runnels, R.C. (2011). Spirituality and faith-based interventions: Pathways to disaster resilience for African American Hurricane Katrina survivors. *Journal of Religion & Spirituality in Social Work: Social Thought, 30*, 294-319.

Aukstinaityte, R. & Zajanckauskaite-Staskeviciene, L. (2010). Relationship between experienced compassion outcomes, burnout and health-related behaviour among psychologists. *Psichologija, 42*, 44-58. http://0psycnet.apa.org.library.regent.edu/index.cfm?fa=search.displayRecord&id=546305D3-0C59-8932-E81D-EFF755477599&resultID=1&page=1&dbTab=all

Bledsoe, B.D. (2003). Critical incident stress management (CISM): Benefit or risk for emergency services? *US National Library of Medicine, 7*, 272-279.

http://www.ncbi.nlm.nih.gov/pubmed?linkname=pubmed_pubmed&from_uid=12710792

Block, J., & Kremen, A.M. (1996). IQ personality and motivation structure and ego-resilience: Conceptual and empirical connections and separateness. *Journal of Personality and Social Psychology, 70*, 349-361.

Boscarino, J., Adams, R. & Figley, C. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health*, *7*, 9-22.

Cohn, M. A., Fredrickson, B. L., Brown, S. L., Mikels, J. A., & Conway, A. M. (2009). Happiness unpacked: Positive emotions increase life satisfaction by building resilience. *Emotion*, *9*, 361-368. doi: 10.1037/a0015952

Dik, B. J., Sargent, A. M., & Steger, M. F. (2008). Career development strivings: Assessing goals and motivation in career decision-making and planning. *Journal of Career Development, 35*, 23–41. doi:10.1177/0894845308317934

Everly, G. S. Jr., & Langlieb, A. (2003). The evolving nature of disaster mental health services. *International Journal of Emergency Mental Health*, *5*, 109-115.

Figley, C. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Figley, C.R. (1999). *Traumatology of Grieving.* Philadelphia: Taylor and Francis.

Fincham, F. D., Ajayi, C., & Beach, S. R. H. (2011). Spirituality and marital satisfaction in African American couples. *Psychology of Religion and Spirituality*, *3*, 259–268. doi: 10.1037/a0023909

Galek, K., Flannelly K.J., Greene P.B., & Kudler T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology, 60*, 633-649. doi:10.1007/s11089-011-0346-7.

Halpern, J., & Tramontin, M. (2007). *Disaster mental health: Theory and practice*. Belmont, CA: Brooks/Cole.

Harr, C. (2013). Promoting workplace health by diminishing the negative impact of compassion fatigue and increasing compassion satisfaction. *Social Work & Christianity, 40*, 71-88.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training, 46*, 203-219. doi:10.1037/a0016081

Hernandez, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies, 29*, 67-83. doi: 10.1521/jsyt.2010.29.1.67

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46*, 229-241 doi:10.1111/j.1545-5300.2007.00206.x

Hirschi, A. (2012). Callings and work engagement: Moderated mediation model of work meaningfulness, occupational identity, and occupational self-efficacy. *Journal of Counseling Psychology*, *59*, 479-485. doi: 10.1037/a0028949

Loustalot, F.V., Wyatt, S.B., Boss, B., May, W., & McDyess, T. (2006). Psychometric examination of the daily spiritual experiences scale. *Journal of Cultural Diversity, 13,* 162-167.

Keyes, B., Reese, M., Newmeyer, M., Cooper-Nurse, J., Wichterman, A., & Rubinow, R. (2009). *Effects of cross-cultural service learning project on graduate counseling students.* Manuscript submitted for publication.

Koenig, H.G., George, L.K., & Titus, P. (2004). Religion, spirituality, and health in medically ill hospitalized older patients. *Journal of American Geriatrics Society, 52*, 554-562. doi: 10.1111/j.1532-5415.2004.52161.

Maalouf, H. K., & Mason, K. I. (2008). *Ethnic disparities in the association between spirituality and resiliency in HIV-infected adults.* Paper presented at the *American Psychological Association 2008 Convention.*

Mak, W.W.S., Ng, I.S.W., & Wong, C.C.Y. (2011). Resilience: Enhancing well-being through the positive cognitive triad. *Journal of Counseling Psychology, 58*, 610–617. doi: 10.1037/a0025195

Maslach, C. & Leiter, M. (1997). *The truth about burnout.* San Francisco: Jossey-Bass.

Masten, A.S. & Coatsworth, J.D. (1998). The development of competence in favorable and unfavorable environments: Lessons from successful children. *American Psychologist, 53*, 205-220.

McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for

understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149. doi:10.1007/BF00975140

McClelland, D. (1989). Motivational factors in health and disease. *American Psychologist, 44*, 675-683.

Miller, L., & Smith, A.D. (2004). Reviewer's guide to the personal stress navigator. http://www.stressdirections.com/images/pdf/reviewer_guide-02.pdf

Morrison, J.Q. (2007). Perceptions of teachers and staff regarding the impact of the critical incident stress management (CISM) model for school-based crisis intervention. *Journal of School Violence, 6*, 101-120. doi:10.1300/J202v06n01_07

Peres, J., Moreira-Almeida, A., Nasello, A., & Koenig, H. (2007). Spirituality and resilience in trauma victims. *Journal of Religion and Health*, *6*, 343-350.

Regan, J., Burley, H., Hamer, G., & Wright, A. (2006). Secondary traumatic stress in mental health professionals. *Tennessee Medicine Journal of the Tennessee Medical Association, 99,* 39-40.

Sider, N.G. (2006). Peacebuilders healing trauma: The journey from victim to survivor to professional caregiver. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 67*, 1208.

Smeekens, S., Riksen-Walraven, J., & Van Bakel, H. A. (2007). Cortisol reactions in five-year-olds to parent–child interaction: The moderating role of ego-resiliency. *Journal of Child Psychology & Psychiatry*, *48*, 649-656.doi:10.1111/j.1469-7610.2007.01753.x

Smith**,** B.D. (2007). Sifting through trauma: Compassion fatigue and HIV/AIDS. *Clinical Social Work Journal, 35*, 193-198. doi:10.1007/s10615-007-0096-2

Stamm, B.H. (2005). *The ProQOL manual: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales.* Brooklandville, MD: Sidram Press.

Stamm, B. (2005). Professional quality of life scale: Compassion satisfaction, burnout, and fatigue/secondary trauma subscales – revision IV. http//www.isu/edu-bihstamm.

Stanley, R., Feldman, D., & Kaplan, Z. (2010). Intervention strategies in mental health professionals. *British Journal of Medical Psychology, 72*, 159-169. doi: 10.1348/000711299159916

Stewart, D.W. (2012). Compassion fatigue: What is the level among army chaplains? *Journal of Workplace Behavioral Health, 27*, 1-11. doi:10.1080/15555240.2012.640574

Sullivan, L.L. (2004). Staff development and secondary traumatic stress among aids staff. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65*, 2365.

Tabor, P.D. (2011). Vicarious traumatization: Concept analysis. *Journal of Forensic Nursing, 7*, 203-208. doi:10.1111/j.1939-3938.2011.01115.x

Underwood, L., & Teresi, J.A. (2002). The daily spiritual experience scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health-related data. *Annals of Behavioral Medicine, 24*, 22-33. doi: 10.1207/S15324796ABM2401_04

Van Hook, M.P., & Rothenberg, M. (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers: A study of the child welfare worker in community based care organizations in central Florida. *Social Work and Christianity, 36*, 36-54.

Vogt, J., Leonhardt, J., Köper, B., & Pennig, S. (2004). Economic evaluation of CISM—a pilot study. *International Journal of Emergency Mental Health, 6*, 185-196.

Watkins, T. (2014). *Compassion fatigue, secondary traumatic stress, and burnout* (Unpublished doctoral dissertation). Regent University, Virginia Beach, VA.

Wei, Y., Szumilas, M., & Kutcher, S. (2010). Effectiveness on Mental Health of Psychological Debriefing for Crisis Intervention in Schools. *Educational Psychological Review, 22*, 339-347. doi:10.1007/s10648-010-9139-2