Editorial

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Market Analysis: The Modulation of Spirituality in using The CISM Model with Mental Health Service Providers

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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".

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.

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.

Results

Preliminary Analysis

All twenty-two participants completed a battery of instruments at the beginning of the study (i.e. pre-test) 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, 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.

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.