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**The Cases They Carry: A Narrative Analysis of Crisis Counselors Working in Behavioral  
Health Emergency Settings**

A DISSERTATION

Submitted to the Faculty of  
Montclair State University in partial fulfillment  
of the requirements  
for the degree of Doctor of Philosophy

by

Rachel E. Sugerman

Montclair State University

Upper Montclair, NJ

May 2021

Dissertation Chair: Dr. Dana Heller Levitt

MONTCLAIR STATE UNIVERISTY  
THE GRADUATE SCHOOL  
DISSERTATION APPROVAL

We hereby approve the Dissertation

**The Cases They Carry: A Narrative Analysis of Crisis Counselors Working in Behavioral  
Health Emergency Settings**

of

Rachel E. Sugerman

Candidate for the Degree:

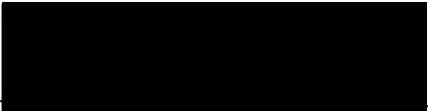
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Dissertation Committee:

Certified by:

  
Dr. Dana Heller Levitt  
Dissertation Chair

  
Dr. Scott Hernes  
Vice Provost for Research and  
Dean of the Graduate School

  
Dr. Kathryn Herr

Date

*May 6, 2021*

  
Dr. Leslie Kooyman

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### **Abstract**

Utilizing a qualitative approach informed by narrative inquiry, this study considered the ways in which eight crisis counselors working in behavioral health emergency settings make meaning of their experiences. Participant narratives focused on the intense, multidimensional, and often emotionally demanding nature of crisis work, something they understood to be inherent to working within these settings. The findings revealed that these crisis counselors often felt isolated, unsupported, and unprepared for their positions, leaving them to negotiate the demands of the work and to make meaning of their experiences on their own. Participants developed various methods of coping, yet these techniques were not always enough to protect them from the negative effects of crisis work. In these situations, participants experienced many of the same issues documented in other helping professions, including feelings of countertransference and vicarious trauma. Participant narratives also uncovered the experience of moral injury, an emerging area of study among healthcare workers but one that has remained largely neglected in the counseling literature. The findings suggest that crisis counselors are well aware of the risks of working with clients experiencing behavioral health emergencies but continue in these roles out of a sense of purpose and appreciation for the newfound perspective the work affords them. The study provides important insights into the understudied world of crisis work, and provides implications that help to inform best practice for counselors, clinical supervisors, and counselor educators.

*Keywords:* crisis counseling, behavioral health emergencies, vicarious trauma, moral injury, vicarious posttraumatic growth

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**Dedication**

To the eight incredible participants and the countless other crisis counselors who work tirelessly to better the lives of others. Your strength, resilience, and passion are nothing short of inspiring.



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## The Cases They Carry: A Narrative Analysis of Crisis Counselors Working in Behavioral Health

## Emergency Settings

## Chapter One

**Introduction**

My interest in crisis work, and, specifically behavioral health emergencies, began in 2012 when I was offered a position in an emergency psychiatric screening program. Still early in my career, I had spent the year prior employed at a day treatment program that focused on vocational rehabilitation. My experiences at this program were nothing short of amazing given its emphasis on wellness and recovery, a philosophy I unequivocally share. I immediately felt at home working there and was fortunate to have an excellent supervisor that both challenged and supported me. I vividly remember her reaction when I told her I was offered the job as a crisis counselor, what I now realize was equal parts congratulatory and cautionary. Leaning back in her chair, she looked at me thoughtfully and said: “Don’t let your experience there harden you”—a thought I did not fully grasp until years later. Looking back on this exchange, I now realize what she meant, that being exposed to behavioral health emergencies on a regular basis does change people, but in ways that are difficult to articulate or fully understand.

It was not until recently, after seven years of experience in this setting, that I moved on from crisis work. While working in this capacity, I experienced some of the highest and lowest moments of my career. There were times I experienced grief, sadness, hopelessness, horror, anger, and emptiness. Often, I felt bitter and resentful, wondering how to interpret the suffering I so frequently bore witness to firsthand. Working in this setting, I also experienced uplifting and awe-inspiring moments, both in my interactions with clients and in the courage with which I saw my colleagues face such difficult situations. In some cases, I had the chance to see what it felt

like to save someone's life, to bring a person back from the depths of despair. There were many times I was amazed and inspired at the strength of the human spirit.

My own experiences as a crisis clinician were equal parts draining, intense, and rewarding. They taught me a great deal about the shared experiences of humankind, exposing me, at different times, to both the heart wrenching and the uplifting. Working in a behavioral health emergency setting, my days were filled with great uncertainty, as I experienced frequent ups and downs, often during the same shift. What I came to realize was that this kind of work changed me, but in ways that are even now difficult to describe. I also know that I was not the only one who was changed by these experiences. Looking at the coworkers beside me, I saw these same changes in them. Something was different about all of us as a result of this kind of work, but what? Something kept us coming back to this job day in and day out. How were we able to reconcile these highs and lows? What was the meaning we took from these experiences?

### **Background of the Problem**

Often referred to as an "occupational hazard" in the research literature, responding to client crises is common for counselors, regardless of their area of specialization (McAdams & Keener, 2008). The terms crisis and behavioral health emergency are often used interchangeably; however, important distinctions exist between the two. A crisis refers to an individual's inability to adapt to a situation using their customary coping mechanisms (Jackson-Cherry et al., 2018). Crises involve the subjective experience of distress, can occur in response to a variety of situations, and may be precipitated by either singular or ongoing events. Behavioral health emergencies, on the other hand, refer to situations in which an individual's behavior or symptoms have escalated to the extent that, without intervention, imminent harm to that



individual or others is likely to occur (Callahan, 2009; Klepsies, 2014). These situations, including client suicide, homicide, and violence, require immediate emergency intervention. The possible negative effects for counselors working with clients experiencing behavioral health emergencies have been well-documented, including clinician burnout, secondary traumatic stress, and vicarious traumatization (James & Gilliland, 2013; Klepsies, 2014; Klepsies & Ponce, 2009). Clinicians who have experienced client suicide frequently report feelings of anger, shock, guilt, grief, self-doubt, shame, and betrayal (Hendin et al., 2000; McAdams & Foster, 2000). Such experiences may additionally cause clinicians to doubt their level of competency (Lafayette & Stern, 2004), as well as cause them to make more conservative judgments when referring at-risk clients for hospitalization (McAdams & Foster, 2000). Similarly, clinicians who have experienced acts of physical violence directed towards them by clients have reported feelings of vulnerability, decreased emotional wellbeing, and a greater sense of fear (Guy et al., 1991; Klepsies & Ponce, 2009).

Positive effects, or vicarious posttraumatic growth, have also been observed in clinicians exposed to vicarious trauma (Arnold et al., 2005; Bell, 2003; Brockhouse et al., 2011; Cohen & Collens, 2013; Hernandez-Wolfe et al., 2015; Hyatt-Burkhart, 2014). Research in the area of vicarious posttraumatic growth has shown positive changes in the cognitive schema of mental health professionals working with survivors of trauma related to self-perception, interpersonal relationships, spirituality, and philosophy of life. Although not well understood, some research has suggested that the clinician's engagement in an existential meaning-making process may be influential to the experience of vicarious posttraumatic growth (Cohen & Collens, 2013). In other words, clinicians who are able to find personal significance, or purpose, in their work may experience positive changes to their cognitive schema as a result of their work with trauma

survivors. Because crisis work also exposes clinicians to distressing and potentially traumatic situations, an ability to find meaning in the work may prevent burnout, secondary traumatic stress, and vicarious traumatization. In fact, finding satisfaction and meaning in one's work can predict overall perceived quality of life (Burke & McKeen, 1995).

### **Statement of the Problem**

The majority of research on the experiences of clinicians who have encountered behavioral health emergencies has considered them primarily through a deficit lens; that is, most studies have emphasized what leads to the development of vicarious trauma. Despite research demonstrating the experience of vicarious posttraumatic growth in clinicians, currently very little is understood about how or why the phenomenon occurs (Cohen & Collens, 2013). However, prior research has pointed to the possibility of meaning-making as significant to the development of vicarious posttraumatic growth (Cohen & Collens, 2013). What has not been researched is how clinicians construct and integrate these meanings into their personal and professional lives. Given that the field of counseling's fundamental focus is on wellness and prevention, a greater understanding of how and why vicarious posttraumatic growth occurs is needed. However, a deeper understanding of the range of crisis counselors' experiences will provide insight into the ways in which meaning making may contribute to their wellbeing and ability to cope with the intense nature of their work. The current study therefore aims to explore the spectrum of meanings crisis counselors construct and assign to their work with clients in the midst of behavioral health emergencies in an effort to more fully understand this range of experiences.

Research shows that counselors are likely to come in contact with clients experiencing behavioral health emergencies at some point during their careers, regardless of their area of specialization (Kleepsies & Hill, 2011; Kleepsies et al., 1993). Standards set forth by the Council

for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) state that counselors should be knowledgeable about the effects of crisis, disasters, and trauma on diverse individuals across the lifespan. However, researchers have addressed that these areas have been insufficiently covered in counselor education programs (Allen et al., 2002; Barrio Minton & Pease-Carter, 2011; Morris & Barrio Minton, 2012). The standards demonstrate the significance of such work yet the lack of training and research in crisis and behavioral health emergencies is troubling. Existing research on clinicians who work with clients experiencing behavioral health emergencies has focused on the effects of these situations as they occur as isolated incidents. However, little to no research has been conducted on the experiences of crisis clinicians, whose jobs require them to interface with clients experiencing behavioral health emergencies on a regular basis (Carabello, 2013).

### **Research Question**

Given what we know about the effects of behavioral health emergencies on clinicians when these events occur in isolation, I am interested in exploring what this means for clinicians who are exposed to them with great regularity. Because behavioral health emergencies within the context of crisis work are unavoidable, this study endeavored to answer the question: How do crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies? My research set out to uncover the ways in which crisis counselors make meaning of these experiences, and how these constructed meanings are integrated into their personal and professional lives and identities. By utilizing a qualitative research design informed by narrative inquiry, this study sought to develop a deeper understanding of the complexities of the lived experiences of crisis counselors.

### Significance of the Study

There is much that can be learned from the experiences of crisis counselors given their regular exposure to behavioral health emergencies. CACREP (2016) standards assert that counselors should be knowledgeable about the effects of crisis, disasters, and trauma on individuals across the lifespan. Additionally, counselors should be familiar with risk assessment procedures, including assessing risk of suicide, self-inflicted harm, and aggression or danger to others (CACREP, 2016). However, these areas have been insufficiently covered in counselor education programs (Allen et al., 2002; Barrio Minton & Pease-Carter, 2011; Morris & Barrio Minton, 2012). In fact, Guo et al.'s (2016) study found that only 29.4% of 654 CACREP-accredited counselor preparation programs required students to take a standalone course in crisis counseling. To add to this confusion, counselors receive conflicting messages about how they should proceed in the face of behavioral health emergencies. Standard C.2.a of the American Counseling Association's (ACA, 2014) *Code of Ethics* states that counselors "should not practice in areas beyond their level of education or training" (p. 8). The aim of the present study is to shed light on the complexities of the lived experiences of crisis counselors, uncovering the ways in which they construct and assign meaning to their work with clients experiencing behavioral health emergencies. Increased understanding in this area may prove beneficial to the creation and implementation of preparation and supervision interventions designed to promote vicarious posttraumatic growth while minimizing burnout, secondary traumatic stress, and vicarious traumatization.

This study, which aimed to gain a greater understanding of the process by which crisis counselors make meaning of their work with clients experiencing behavioral health emergencies, adds to the body of literature that pertains to best practices involved in the education, training,

and supervision of counselors in the area of behavioral health emergencies. Because crisis counselors regularly face situations that most counselors will likely only have to address a handful of times in their careers, a deeper understanding of how they integrate such experiences into their personal and professional identities can help promote greater intentionality in future curriculum and training design. However, as mentioned earlier in this chapter, counselors are likely to encounter clients experiencing behavioral health emergencies at some point during their careers, regardless of area of specialization (Kleepsies & Hill, 2011; Kleepsies et al., 1993). Insight into the experiences of crisis counselors therefore contributes to the training and supervision of all counselors. Research into the meaning-making processes of counselors who experience vicarious posttraumatic growth also proves beneficial to creating and implementing preparation and supervision interventions designed to promote it. Furthermore, greater insight into how clinicians make meaning of their experiences upholds the values of the field of counseling by de-pathologizing the experience of vicarious trauma in favor of understanding how prevention and early intervention can help to support the healthy development of counselors, and, by extension, their clients. Insight gained from this study therefore adds to the body of literature pertaining to best practices in counselor preparation, training, and supervision.

### **Theoretical Framework**

Both as a clinician and as a researcher, I have always rejected the notion of one single objective “truth” or reality. Instead, I ascribe to a social constructivist perspective, believing that individuals create their own realities based on their interactions with the world and the meaning they give to these experiences (Edwards, 2013). Accordingly, my point of view values multiple, coexisting truths with an understanding that knowledge does not inherently exist but rather is co-constructed: “Knowledge is not only *shared* in interaction, it is *created* in interaction” (Whiting,

2007, p. 141; italics in original). In order to make sense of our experiences, we must interpret, construct, and assign meaning to them, a process that is collaborative in nature and inextricably linked to the ways we view ourselves in connection to others. Such a perspective suggests that counselors who work with clients experiencing behavioral health emergencies not only construct meaning from their interactions with clients but also interpret and assign meaning to these experiences based on their interactions with colleagues, family members, collateral sources, and other emergency personnel. Beyond the immediate work environment, the ways in which these counselors develop an understanding of and assign meaning to their work with clients is born from an amalgamation of both personal and professional experience.

This study utilized an interpretive/constructivist qualitative approach informed by narrative inquiry with the aim of illuminating how crisis clinicians make meaning of their experiences working with clients in the midst of behavioral health crises. Accordingly, the subjective experiences of participants were analyzed through the stories they told and the ways in which they chose to tell these stories. Data was collected through semi-structured interviews designed to encourage participants to reflect upon their unique experiences. Participants consisted of a sample of master's level counselors with a minimum of one year of post-master's experience whose primary job responsibilities require regular interface with clients experiencing behavioral health emergencies. In chapter three, I delineate the criteria and the methodology used for the study.

### **Positionality**

The process of reflecting on the origins of my research question forced me to consider how my own values and worldview led me to this study. While positivist perspectives view research as an "objective" process whereby some "truth" is uncovered, qualitative researchers

believe in the existence of multiple realities that are dependent on individual perception (Heppner et al., 2018). As a qualitative researcher, my own theoretical lens, worldview, personal experiences, and interests not only color the research process itself, but are also reflected in the very area I chose to study. In the quest for a deeper understanding of how people interpret and attribute meaning to their experiences, I had to consider how my own positionality affected the research process.

I view the world in terms of a social constructivist lens, believing that we create our own realities based on how we interpret our subjective experiences of ourselves and the world around us. Per Ponterotto (2005), “reality, according to the constructivist position, is subjective and influenced by the context of the situation, namely the individual’s experience and perceptions, the social environment, and the interaction between the individual and the researcher” (p. 130). Consequently, I am interested in how people make meaning of their experiences, and, as such, am interested in questions that are often existential in nature. From an existential perspective, the quest to find meaning represents a given of existence, something with which we must all contend (Yalom, 1980; Yalom & Josselson, 2013). This viewpoint asserts that meaning does not inherently exist; rather, individuals must *create* meaning in their own lives, a belief that highlights the importance of freedom and choice in the quest to find meaning.

My own experiences working as a crisis counselor also led me to this study’s research question. As such, an introspective attitude was essential to the process of gathering and analyzing my data. I had to remain constantly aware of how my own worldview and experiences may have unduly influenced my evaluation of participant stories. Because this study was inspired by my own experiences as a crisis counselor, I had “insider status” with the participants (Merriam & Tisdell, 2016), a perspective that functioned in both positive and negative ways. On

the one hand, I had entry into the conversation, a fact that perhaps helped participants feel more relaxed or forthright during our interviews. On the other hand, I entered the conversation with my own set of experiences and assumptions. Again, I had to be extremely careful to interrogate my assumptions, taking care not to highlight only what I hoped or expected to find in the data or that which coincided with my own experiences as a crisis counselor.

### **Chapter Summary**

In this chapter, I provided the reader with insight into what drew me to my research question based on my personal experiences as a crisis counselor and the lack of existing research in this area. I provided a brief overview of behavioral health emergencies and the effects, both positive and negative, that they can have on crisis counselors. In considering the likelihood that counselors will encounter clients experiencing behavioral health emergencies regardless of area of specialization, I pointed to the need for a deeper understanding of the lived experiences of crisis clinicians as a means to inform future curriculum training and design, as well as best practice in the provision of clinical supervision. Finally, I discussed the value of a qualitative study informed by narrative inquiry, including an explanation as to why a social constructivist approach was appropriate to my research question given that meaning making does not occur as a solitary process but rather in collaboration with others (Neimeyer et al., 2014).

### **Organization of the Dissertation**

This dissertation is organized in a five-chapter format. The first chapter was devoted to introducing the study and describing the background and statement of the problem, stating my research question, explaining the significance of the study, and providing the reader with an overview of the theoretical framework for the study and my own positionality. In the second chapter, I review the relevant literature pertaining to crisis counselors, including their



background and training, as well as outline what is known about the effects of working with clients experiencing behavioral health emergencies. The third chapter provides the reader with an in-depth description of the study's methodology, including data collection and analysis using Gilligan's Listening Guide and a coding process designed to identify themes across participants' stories. The fourth chapter provides the reader with insight into the collective narrative of participants, illuminating the themes that arose across participant narratives when discussing their experiences working with clients experiencing behavioral health emergencies. Finally, chapter five discusses the study's implications and provides recommendations for future research.

### **Definition of Terms**

Some of the terms used throughout this document have different meanings in varying contexts.

The purpose of the following list is to provide the reader with a description of the terms as they will be referred to in this study.

*Behavioral Health Emergency* - A term used to refer to a situation in which an individual's behavior or symptoms have escalated to the extent that, without intervention, they are likely to harm themselves or others within the foreseeable future.

*Burnout* - Occupational strain characterized by emotional exhaustion, cynicism, and reduced personal accomplishment and self-efficacy (Maslach et al., 2001).

*Clinical Supervision* - "Clinical supervision includes the supportive and educative activities of the supervisor designed to improve the application of counseling theory and technique directly with clients" (Association for Counselor Education and Supervision Taskforce on Best Practices in Clinical Supervision, 2011).

*Counseling* - "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (American Counseling Association, 2014, p. 366).

*Counselor Impairment* - The experience of physical, mental, or emotional difficulties that affect the counselor's ability to provide professional services to clients.

*Countertransference* - A counselor's reactions to a particular client that stem from the counselor's own unresolved personal issues. Such feelings can include emotional, behavioral, and cognitive experiences, both conscious and unconscious, and can manifest in both positive and negative forms (Gelso & Hayes, 2001; Hayes, 2004).

*Crisis* - A situation in which an individual is unable to adapt to a situation using their customary coping mechanisms (Jackson-Cherry et al., 2018). Crises involve the subjective experience of distress, can occur in response to a variety of situations, and may be precipitated by either singular or ongoing events.

*Crisis Clinician* - Generally master's level practitioners whose primary responsibility is to provide emergency mental health evaluations in order to determine the least restrictive, most appropriate level of care for clients.

*Critical Incident* - An event that is stressful enough to disrupt an individual's ability to utilize his or her normal coping techniques (Mitchell & Bray, 1990).

*Emotional Labor* - A process in which individuals must regulate their own emotions and emotional expression as a requirement of their job (Hochschild, 1983).

*Licensed Professional Counselor (LPC)* - "Master degreed mental health service providers, trained to work with individuals, families and groups in treating mental, behavioral and emotional problems and disorders" (American Counseling Association, 2010, p.1).

*Secondary Traumatic Stress* - A pattern of symptoms closely mimicking those observed in Posttraumatic Stress Disorder (PTSD) that arise as a result of hearing about a client's traumatic experiences (Bober & Regehr, 2006). Symptoms of Secondary Traumatic Stress can include hyperarousal, avoidant behaviors, difficulties in interpersonal functioning, and a decreased ability to enjoy life (Halevi & Idisis, 2017).

*Vicarious Trauma/Compassion Fatigue* - Refers to a disruption in a clinician's cognitive schema as a result of hearing about their clients' experiences of trauma (McCann & Pearlman, 1990).

Vicarious trauma involves alterations in the clinician's belief systems, expectations, and assumptions about the self and the world (Pearlman & Saakvitne, 1995).

*Vicarious Posttraumatic Growth* - Positive changes in cognitive schema as related to self-perception, interpersonal relationships, spirituality, and philosophy of life as a result of exposure to vicarious trauma (Cohen & Collens, 2013).

## Chapter Two

### **Literature Review**

In considering the meaning making practices of crisis counselors, it is important to consider how their training and supervision experiences may impact the ways in which they perceive and interpret interactions with clients. Accordingly, this chapter focuses on providing the reader with an understanding of what differentiates counselors from other mental health practitioners in terms of professional philosophical perspective, training, and supervision. Specific attention is paid to the underlying philosophies of the field of counseling, as well as the values and ethics with which professional counselors abide. This chapter also sheds light on the preparation, supervised clinical practice, and licensing standards of professional counselors as a means to contextualize counselor development and the significance of professional identity to this study.

In order for the reader to understand the study's population of interest, this chapter also provides a review of the literature on crisis counselors. In addition to discussing the background and training of these counselors, this chapter provides a review of the literature on the effects, both positive and negative, crisis counseling may have on clinicians. Possible coping strategies, including clinical supervision are also discussed. Finally, the chapter concludes with a discussion of existing theories of meaning making as a means to conceptualize the phenomenon of interest in this study.

### **The Counseling Profession**

Before turning to a discussion more specific to crisis counselors, consideration of the origins and underlying philosophical assumptions of the counseling profession is necessary in order to more fully understand and contextualize the experiences of crisis counselors. The field

of counseling was born out of the vocational guidance movement of the late 1800s as a result of the Industrial Revolution and associated social reform movements (Glosoff et al., 2017). Over time, the focus of counseling evolved from one based purely on vocational guidance to additional approaches to counseling aimed at promoting the overall health and wellness of individuals, couples, families, and groups. According to the American Counseling Association (2014), “counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 366). Similar to other helping professions, including social work and psychology, the field of counseling assists clients with managing and resolving psychological, emotional, behavioral, vocational, and relational challenges (Bedi & Domene, 2008). Counselors utilize theoretical and evidence-based practice as a means to promote the wellbeing of clients and to help them achieve their goals. Although still a relatively new profession when compared with other mental health disciplines, the field of counseling differentiates itself through a number of underlying philosophies (Remley & Herlihy, 2014). In the sections that follow, I present a discussion of these differences, as they provide insight into how such nuances may impact the provision of crisis counseling and the ways in which crisis counselors interpret, understand, and make meaning of their experiences.

### **Underlying Philosophies**

The majority of mental health disciplines, including psychiatry, social work, and clinical psychology, operate from a medical or illness model, one that focuses on the diagnosis and treatment of psychopathology (Remley & Herlihy, 2014). Practitioners who operate from this perspective are trained to identify what is “wrong” with a patient or client with the goal of helping the individual return to a previous level of functioning prior to the onset of an illness or symptoms. In contrast, the field of counseling assumes a wellness approach, one that is

strengths-based and aimed at maximizing an individual's mental and emotional wellbeing and potential (Mellin et al., 2011). Counselors, therefore, are not solely concerned with treating what is "wrong" with their clients; rather, counselors operate from a holistic approach aimed at building on what is "right," helping their clients to optimize their emotional, psychological, and social wellbeing (Myers & Sweeney, 2008). Although counselors are trained to view clients through a wellness lens, they are often forced to conform to the medical model of diagnosing mental disorders in order to receive reimbursement for their services (Remley & Herlihy, 2014). Crisis counselors, in particular, must contend with this break from their training due to the nature of their work and the systems with which they are a part.

The field of counseling is also distinct from other mental health professions with regard to its guiding perspective on wellness and psychopathology. Rather than viewing psychological illness or distress as pathological, counselors view such constructs as arising within the course of normal human development (Gerig, 2014). Accordingly, counselors conceptualize client problems or issues as occurring within a developmental context, viewing them as normal reactions to demands encountered at various life stages (Mellin et al., 2011). This is another perspective of counseling that may be difficult for crisis counselors to reconcile, given that they primarily work with individuals with severe and persistent mental illness rather than clients facing crises that are more developmental in nature. Additionally, crisis counselors are frequently asked to focus specifically on psychopathology and to make recommendations based on a client's level of risk to self or others.

Another underlying philosophical assumption of the counseling profession is that a proactive, or preventive, approach can be more beneficial than a reactive, or remediation, approach (Conyne, 2004). Consequently, counselors highlight the usefulness of

psychoeducation, often functioning as teachers and role models when working with clients (Remley & Herlihy, 2014). When prevention is not possible, professional counselors stress the importance of early intervention in treating mental and emotional problems. Because crisis counselors intervene at a time in which a client's presenting issue has already escalated to the point of being potentially life-threatening, they must frequently take a reactive and often restrictive approach, one that diverges from their foundational training focused on prevention and early intervention. Again, crisis counselors are asked to break from their training and fundamental beliefs about treatment, forcing them to take on a reactive stance due to the nature of their work.

A final distinguishing characteristic of the field of counseling is its focus on client empowerment. Rather than viewing clients as passive recipients of care, counselors instead view them as active participants in their own treatment. This distinction can be noted in the field's preference for referring to mental health consumers as *clients* rather than *patients*. Counselors promote a collaborative process aimed at helping clients to build problem-solving skills that will enable them to independently handle problems in the future, effectively preventing overreliance on the counselor (Remley & Herlihy, 2014). This perspective again deviates from what crisis counselors are often tasked with doing: recommending that a client lose their sense of autonomy by being committed to an inpatient psychiatric unit on an involuntary basis, essentially stripping them of their ability to make their own decisions about what is best for them. The nature of crisis work frequently requires counselors to act in ways that, at least at a surface level, seem to break with their education and training. This deviation from the fundamental assumptions of counseling can sometimes be significant to the meaning making practices of crisis counselors as they work to reconcile these discrepancies.



### **Values and Ethics**

The field of counseling is further unified by adherence to its own set of ethical codes, among them the American Counseling Association (ACA; 2014) *Code of Ethics*, the American Mental Health Counselors Association (AMHCA; 2020) *Code of Ethics*, and the National Board for Certified Counselors (NBCC; 2016) *Code of Ethics*. In the midst of responding to client crises, counselors often encounter complex ethical dilemmas that require careful consideration of professional, legal, and personal values and standards. Such issues are rarely black-and-white, and counselors must reflect on how their own personal values, professional responsibility, and the potential for legal ramifications can influence the ethical decision-making process (Levitt & Moorhead, 2013). Counselors must consider ethical guidelines while simultaneously engaging in a process of self-reflection to prevent personal biases from affecting their ability to make sound ethical decisions.

### **Counselor Preparation**

In addition to its underlying philosophical assumptions and unified perspective on ethics, the field of counseling is also distinct from other mental health disciplines in terms of its education and training standards. As the sole accrediting body for the counseling profession, the Council for Accreditation of Counseling and Related Programs (CACREP) sets standards that have been adopted by several credentialing bodies as minimal education requirements for certification or licensure. Master's level counselor preparation programs that are accredited by CACREP address eight core areas: professional counseling and ethical practice, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group counseling and group work, assessment and testing, and research and program evaluation (CACREP, 2016). Specific counseling specializations, including Addiction

Counseling, Career Counseling, Clinical Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, School Counseling, Rehabilitation Counseling, and Marriage, Couple, and Family Counseling also include concentration specific curricular standards (CACREP, 2016).

Standards set forth by CACREP (2016) state that counselors should be knowledgeable about the effects of crisis, disasters, and trauma on diverse individuals across the lifespan. The standards also assert that counselors should be familiar with risk assessment procedures, including those involved in determining risk of suicide, self-inflicted harm, and aggression or danger to others (CACREP, 2016). However, research has found that these areas have been insufficiently covered in counselor education programs (Allen et al., 2002; Barrio Minton & Pease-Carter, 2011; Morris & Barrio Minton, 2012). According to Guo et al.'s (2016) study, only 29.4% of 654 CACREP-accredited counselor preparation programs required students to take a stand-alone course in crisis counseling.

CACREP accredited counselor preparation programs require that students complete supervised clinical experience consisting of a minimum of 100 practicum and 600 internship hours (CACREP, 2016). To complete these requirements, students must complete a minimum of 40 direct service hours (e.g., counseling with clients or students) during their practicum and 240 direct service hours during their internship placements. These direct service hours make up only a small portion of the total supervised clinical experience a counselor will need in order to be eligible for state licensure and independent practice. In addition to content-based and experiential courses, master's level counseling programs typically require students to pass an exit or comprehensive examination before graduation. CACREP-accredited counselor preparation programs commonly use the Counselor Preparation Comprehensive Examination (CPCE), a

knowledge-based exam covering the eight core counseling content areas as an exit examination (Baggerly & Osborn, 2013).

Upon graduation, master's level counselors must also pass a licensing examination before they can begin working with clients. Licensure requirements and licensing examinations vary by state; however, all 50 states, the District of Columbia, and Puerto Rico require successful completion of either the National Counselor Examination (NCE) or the National Clinical Mental Health Counselor Examination (NCMHCE; ACA, 2010). Upon receipt of their initial license, counselors are granted provisional licensure; that is, they are still required to practice under direct supervision. Once provisionally licensed, most states require that counselors complete between 2,000 and 3,000 hours of supervised experience prior to obtaining licensure to practice independently (ACA, 2020). Once fully licensed, counselors are expected to remain abreast of current developments in the field and complete continuing education requirements. Because many mental health professionals do not receive adequate training during the course of their graduate coursework relative to crisis intervention and suicide risk assessment (Dexter-Mazza & Freeman, 2016; Kleepsies et al., 1993; Morris & Barrio Minton, 2012; Ruth et al., 2013; Schmitz et al. 2012; Wozny, 2005), continuing education in these areas becomes even more vital. Although beginning counselors frequently report feeling underprepared to intervene in crisis situations (Allen et al., 2002; Morris & Barrio Minton, 2012), even a one-day continuing education training on suicide risk assessment and intervention can lead to increased participant knowledge and confidence in these areas (Mirick et al., 2016). In the section that follows, I discuss more in depth how counselor development and level of self-efficacy may influence the provision of counseling services.

### **Counselor Development**

When studying the meaning making processes of crisis counselors, it is important to consider the participants' developmental level and number of years of experience. Counselor development refers to the ongoing process of growth and change that occurs over the course of a counselor's career. Despite counselor development being an ongoing process, novice counselors and more seasoned counselors encounter distinct challenges at various stages of development (Moss et al., 2014; Skovholt & Rønnestad, 2003). Beginning counselors tend to be more focused on the self than the other, presenting with a heightened level of anxiety and poor self-efficacy (Stoltenberg, 2005). They tend to be preoccupied with their own thoughts, emotions, and behaviors and are often dualistic in their thinking (Bernard & Goodyear, 2019). Beginning counselors may be especially prone to burnout as they struggle with appropriate boundary setting and walking the fine line between under- and over-involvement with their clients (Skovholt & Rønnestad, 2003). Neophyte counselors may also undergo a great deal of personal and professional growth as their work frequently forces them to confront their personal values, beliefs, biases, and assumptions. In their pioneering work on counselor development, Rønnestad and Skovholt (2003) noted that newer counselors may also experience feelings of disillusionment after realizing that their graduate training did not fully prepare them for the heterogeneity of clients they will encounter in their practice. One participant in their cross-sectional and longitudinal qualitative study of the development of 100 counselors and therapists reflected on this experience, noting "Sometimes you feel like you were trying to fight a forest fire with a glass of water" (Rønnestad & Skovholt, 2003, p. 18).

As counselors gain more experience in the field with a variety of clients, they may begin to incorporate more of themselves into their clinical work (Whiting et al., 2001). They develop a

stronger awareness of their individual strengths and areas for growth, become less mechanical in the ways in which they deliver interventions, and are more confident in their clinical judgment and skills. During more advanced stages of development, counselors are better able to negotiate an appropriate level of involvement with their clients and improve in their ability to self-regulate (Rønnestad & Skovholt, 2003). Skovholt et al. (2004) termed this skill “boundaried generosity,” noting the importance it has for counselors due to their long-term intimate involvement with human suffering. Due to the complex situations in which they find themselves, the ways in which crisis counselors experience, interpret, and make meaning of their experiences may vary according to their stage of counselor development.

One area that has been identified in the literature as being significant to counselor development is what is known as a *defining moment experience*. A defining moment experience refers to “a pinnacle moment or critical incident that occurs within a therapeutic context and contributes to professional development and the personal growth of professional counselors” (Coll et al., 2019, p. 142). Although the term typically refers to pivotal moments in the early stages of counselor development, defining moment experiences have also been studied in more advanced counselors and appear to be significant to the ongoing development of professional counselors. Defining moment experiences can refer to either positive or negative moments that cause counselors to engage in a process of self-reflection that may lead to personal and professional transformation. This is especially relevant to this study’s population of interest in that crisis counselors may often face situations that may foster new learning and growth. How crisis counselors make meaning of these critical moments is what this study sought to illuminate.

### **Professional Identity Development**

The importance of a unified professional identity has long been a topic of discussion within the field of counseling (Gale & Austin, 2003; Hanna & Bemak, 1997; Mellin et al., 2011). Professional identity is defined as “the attitudes, values, knowledge, beliefs and skills shared with others within a professional group” (Adams et al., 2006). Despite the existence of debate around whether counselor identity should be viewed according to area of specialization, counselors, in fact, largely advocate for a unified professional identity based on a shared philosophy (a developmental, prevention, and wellness orientation), training in a CACREP-accredited program, and adherence to the *ACA Code of Ethics* (Mellin et al., 2011). According to Calley and Hawley (2008), professional identity in counseling is related to the following factors: (1) values of the profession, (2) scope of professional activities, (3) emphasis of scholarship, (4) theoretical orientation, (5) historic knowledge of the counseling profession, and (6) counselor credentialing and training. Counselor professional identity is created through an ongoing process during which certain critical developmental milestones are met (Cureton et al., 2019) and occurs through reciprocal conceptual and experiential learning as a counselor’s personal and professional selves become fused into one (Auxier et al., 2003).

Similar to the ways in which a counselor’s developmental level may influence how they understand and make meaning of behavioral health emergencies, a counselor’s professional identity is also likely to be influential. The nature of crisis work may ask counselors to diverge from the philosophical assumptions of the field, including its focus on wellness and prevention, client autonomy, and a developmental rather than a pathological view of human distress. In the sections that follow, I explore this divergence more in depth, beginning with a discussion of the specialized settings and circumstances under which crisis counselors work. First, I provide the

reader with an understanding of client crises, and, more specifically, behavioral health emergencies, before turning to a discussion of the background, training, and job responsibilities of crisis counselors.

### **Crises and Behavioral Health Emergencies**

#### **Crises**

A crisis refers to a disruption in an individual's psychological homeostasis such that they are unable to adapt to a situation using their customary coping mechanisms (Jackson-Cherry et al., 2018; Roberts & Yeager, 2009). The term crisis can refer to a variety of situations, whether singular or ongoing events, that result in the subjective experience of distress. Crises can be developmental, existential, or psychiatric in nature, or they can be experienced in response to a traumatic event (Cavaiola & Colford, 2011).

The term crisis itself is rich in meaning. Numerous authors have noted the significance of the Chinese symbol for *crisis*, a combination of the characters "danger" and "opportunity" (Cavaiola & Colford, 2011; Echterling et al., 2005; Everstine & Everstine, 2006). Although the terms danger and opportunity may at first appear incompatible, both are integral to an understanding of crisis intervention as Cavaiola and Colford (2011) noted:

*Danger* is inherent in any precipitating crisis event; it is those physical, emotional, and psychological challenges that strain the resources of individuals in coping with crisis successfully, something that propels them into a state of disequilibrium and disorder...*Opportunity*, on the other hand, refers to the crisis outcome that provides victims with the chance to emerge from the event successfully, perhaps even stronger than before. (p. 2)

Understandably, it is this juxtaposition of risk and possibility that can lead to distinct outcomes following a crisis situation, either successful resolution and possible growth or irreparable damage and, possibly, even death. In fact, the uncertainty associated with the word crisis can be noted in the Greek word from which it is derived, *krinein*, meaning *to decide*. Such an understanding of the word crisis suggests that how the individual chooses to respond to it is what ultimately determines whether the crisis will be dealt with in a productive manner (Cavaiola & Colford, 2011). For the crisis counselor, the meanings attributed to their work with clients facing behavioral health emergencies may also lead to both positive and negative outcomes. It is this process of making sense of and ascribing meaning to these situations that is at the heart of this study.

### **Behavioral Health Emergencies**

As mentioned in the first chapter, it is important to note that distinctions exist between the terms crisis and behavioral health emergency despite the frequency with which the two are used interchangeably. Although they may fall somewhere in the spectrum of client crises, behavioral health emergencies refer to situations in which an individual's behavior or symptoms have escalated to the extent that, without intervention, imminent harm to that individual or others is likely to occur (Callahan, 2009; Kleepsies, 2014). These situations, including client suicide, homicide, and violence, require immediate emergency intervention.

Research points to the likelihood that counselors will encounter behavioral health emergencies at some point in their clinical practice. In fact, the majority of mental health professionals will work with at least one suicidal client during the course of their careers (Kleepsies & Hill, 2011; Kleepsies et al., 1993). Mirick et al. (2016) found that 86.4% of a sample of 543 mental health practitioners working in community agencies had encountered at



least one suicidal client within the past three months. Another study found that as many as 23% of counselors will experience a client's completed suicide, with almost a quarter of this population having had the experience while working as a student intern (McAdams & Foster, 2000). Fewer studies have focused on the likelihood that counselors will encounter clients at risk of harming others. One study in the field of psychology found that 40% of 750 participants reported having been physically attacked by a client on one or more occasion (Guy et al., 1991). Research in the field of social work has suggested that incidents of physical violence in clinical practice frequently go unreported (Macdonald & Sirotich, 2001). However, risk assessment makes up an "inescapable part of clinical practice" regardless of area of specialization (Haggård-Grann, 2007).

Research has repeatedly demonstrated that working with clients experiencing behavioral health emergencies results in strong cognitive, affective, and psychological responses for clinicians (Guy et al., 1991; Hendin et al., 2000; Kleepsies & Ponce, 2009; McAdams & Foster, 2000; McAdams & Keener, 2008). However, this research focuses on the experiences of clinicians in response to behavioral health emergencies as they occur as isolated incidents. To date, little to no research has been conducted on the experiences of crisis counselors, whose jobs require interface with clients experiencing behavioral health emergencies on a regular basis (Carabello, 2013).

### **Crisis Counselors**

Crisis counselors are a subgroup of mental health professionals whose primary responsibility is to provide emergency mental health evaluations. Usually master's level practitioners, crisis counselors provide services to clients experiencing behavioral health emergencies, situations in which individuals are likely to harm themselves or others without

intervention (Kleepsies, 2000). Crisis counselors must therefore be skilled at accurately assessing clients for suicidal and homicidal ideation, managing potentially aggressive and assaultive behavior, and making decisions about whether individuals are able to adequately care for themselves given their current symptomatology. Crisis counselors are often tasked with identifying the appropriate level of care for clients experiencing behavioral health emergencies and must make a recommendation ranging from discharge to the community with referrals to appropriate resources anywhere up to, and including, involuntary hospitalization. According to Dupre (2012):

The demands placed on the counselor evaluating the need for involuntary commitment are enormous. Successful crisis intervention in these situations requires strong assessment and intervention skills, the ability to remain calm and focused under duress, encyclopedic knowledge of the DSM...familiarity with the intricacies of state laws governing civil commitment, and detailed awareness of community resources. (p. 30)

Crisis counselors are required to quickly assess and manage potential risk, defuse crisis situations, ensure the safety of both clients and the public, and provide emotional first aid to involved individuals (Yeager & Roberts, 2015).

The nature of crisis work means that crisis counselors are regularly exposed to acutely stressful situations that require engagement with clients experiencing high levels of emotional distress. Additionally, they must calmly and professionally interact with clients, client families, other service systems, law enforcement, and emergency services personnel to coordinate care and ensure the safety of clients and the community (Stroul, 1993). The experiences of crisis counselors differ from those of other mental health professionals due to the frequency with

which they are exposed to behavioral health emergencies. Such events represent the norm rather than the exception for crisis counselors.

Because of the 24/7 nature of crisis work, crisis counselors are often required to work non-traditional schedules consisting of long hours, overnight shifts, weekends, and holidays. As essential personnel, they are required to work during government declared states of emergency, including those caused by inclement weather, natural disasters, or public health crises. Recently, during the COVID-19 pandemic, crisis counselors have continued to report to their positions alongside other frontline workers, emergency services personnel, and medical workers. Even under normal circumstances, crisis counselors must often enter uncontrolled and potentially dangerous settings in which they may be exposed to aggressive or assaultive clients, unsanitary conditions, or infectious disease agents.

States vary in terms of the position, scope, education, and training requirements of crisis counselors. In the state of New Jersey, for example, crisis counselors may work in either designated psychiatric emergency screening centers or affiliated emergency service programs. Crisis counselors who are involved in the civil commitment process hold the title *mental health screeners*. They are required to meet the following educational credentials:

A master's degree in a mental health-related field from an accredited institution, plus one year of postmaster's, full-time equivalent, professional experience in a psychiatric setting; a bachelor's degree in a mental-health-related field from an accredited institution, plus three years post-bachelor's, full-time equivalent, professional experience in the mental health field, one of which is in a crisis setting; a bachelor's degree in a mental health-related field from an accredited institution, plus two years post-bachelor's, full-time equivalent, professional experience in the mental health field, one of which is in a crisis

setting and currently enrolled in a master's program; or a licensed registered nurse with three years full-time equivalent, post-RN, professional experience in the mental health field, one of which is in a crisis setting. (N.J.A.C. 10:31)

Additionally, crisis counselors who work as mental health screeners must complete a training program sponsored by the New Jersey Division of Mental Health and Addiction Services (DMHAS) that includes courses specific to the New Jersey Screening Law and process, clinical assessment and documentation, assessment of drugs and alcohol abuse, assessment of children, suicide assessment, providing a safe and secure environment, assessment of special populations (including deaf/hard of hearing individuals and older adults), and mobile outreach and working with the police (Rutgers University Behavioral Healthcare Technical Assistance Center, 2019). Certified Mental Health Screeners are then required to complete 15 credits of continuing education every two years in order to maintain their certification (Rutgers University Behavioral Healthcare Technical Assistance Center, 2019). Because many mental health professionals do not receive adequate training during graduate school in the areas of crisis intervention and suicide risk assessment (Dexter-Mazza & Freeman, 2016; Klepsies et al., 1993; Morris & Barrio Minton, 2012; Ruth et al., 2013; Schmitz et al. 2012; Wozny, 2005), specialized training for mental health screeners is paramount. Likewise, specialized continuing education is necessary in order to ensure that mental health screeners are competent in the areas relevant to behavioral health emergencies. In addition to requiring specialized knowledge and skills, crisis counselors are subject to a variety of cognitive, psychological, emotional, and even physical challenges in their work with clients experiencing behavioral health emergencies. In the section that follows, I discuss the challenges crisis counselors may face as a result of caring for these clients.

### **The Cost of Caring**

The cost of caring has been well documented in the social services literature. The stress of working in crisis situations can lead to burnout, secondary traumatic stress, and vicarious traumatization (James & Gilliland, 2013). Although few authors have focused specifically on the experiences of crisis counselors, much can be gleaned about the effects of crisis work based on research from other disciplines and areas of specialization. Crisis work requires counselors to work in high-stress environments, assess clients for potential dangerousness, and provide recommendations for clients to appropriate levels of care. Crisis counselors are regularly exposed to clients who are suicidal, traumatized, psychotic, and in the midst of experiencing extreme emotional distress. Exposure to such situations results in strong emotional, psychological, cognitive, and even physical responses in counselors. In the sections that follow, I provide a review of the literature on the effects of crisis work, including emotional labor, countertransference, burnout, secondary traumatic stress, and vicarious traumatization. The section concludes with a discussion of coping strategies used by crisis counselors, including self-care and clinical supervision.

#### **Emotional Labor**

Originally coined by Hochschild (1983), emotional labor refers to the process by which individuals must regulate their emotions and emotional expression as a requirement of their job. During a behavioral health emergency, crisis counselors must manage an array of potentially extreme and distressing emotions in order to successfully perform their job duties. Reactions to client behavioral health emergencies may include grief, sadness, anger, uncertainty, fear, disgust, or disbelief. Given the fast-paced nature and setting of crisis work, crisis counselors must also quickly establish rapport with clients, an undertaking that requires a high degree of empathic

response, another emotionally demanding function. Despite how they might be feeling, crisis counselors must interact with clients, client families, other service systems, law enforcement, and emergency services personnel in a calm and professional manner. As a result, crisis counselors must engage in what is known as *surface acting*, a task that results in emotional dissonance between their inner emotional experience and the emotions that they display during a given interaction (Miller & Sprang, 2017; Zapf, 2002). Engaging in surface acting can be both emotionally and physically taxing for crisis counselors who struggle to remain calm and professional even when their internal state might differ significantly. Emotional dissonance experienced as a result of emotional labor may lead to alienation from one's own emotions, poor self-esteem, and depression (Zapf, 2002). Crisis counselors may, therefore, become disconnected from how they truly feel, compartmentalizing their own emotions and reactions in order to successfully perform the functions of their jobs. The importance of processing these emotions at a later time is likely significant to the meaning making practices of crisis counselors, a task that might possibly be completed during the course of clinical supervision, a topic that will be discussed later in this chapter.

### **Countertransference**

As mentioned previously, crisis counselors must manage their own feelings toward a client or situation in order to provide professional and ethical services. Crisis counselors specifically must be aware of possible countertransference, or reactions to a particular client that stem from their own unresolved personal issues. Such feelings can include emotional, behavioral, and cognitive experiences, both conscious and unconscious, and can manifest in both positive and negative forms (Gelso & Hayes, 2001; Hayes, 2004). Because crisis counselors are also required to collaborate with family members, emergency personnel, and other treatment

providers, they must also manage potential countertransference reactions to others involved at the scene. If left unexamined, countertransference has the potential to result in a counselor losing objectivity, whereby they make decisions based on their own emotional needs rather than those of the client. Unchecked countertransference can, therefore, lead to unethical practice, poor decision-making, boundary violations, and, specifically in the case of crisis work, dangerous and potentially lethal outcomes. Self-reflection and self-awareness are thus essential for crisis counselors, as either over- or under-involvement with a client can lead to potentially extreme consequences. The importance of self-awareness compounded by the need to compartmentalize their emotions represents an interesting conundrum for crisis counselors, as they must simultaneously conceal their strong cognitive and emotional reactions to a client while also being keenly aware of these reactions. Crisis counselors are thus tasked with performing a constant balancing act of self-awareness and self-regulation.

### **Burnout**

Burnout refers to “a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job” (Maslach & Leiter, 2016, p. 103). A form of occupational strain, burnout is characterized by emotional exhaustion, cynicism, and reduced personal accomplishment and self-efficacy (Maslach et al., 2001). Symptoms of burnout are cumulative, amassed over time, and characterized by a sense of powerlessness in achieving work-related goals. Those experiencing burnout can also exhibit psychophysiological arousal symptoms, such as insomnia and irritability, or relationship issues (Valent, 2002). Crisis work, by definition, involves regular and repeated exposure to interpersonal stress, likely placing crisis counselors at an increased risk for burnout. Crisis counselors may be particularly prone to burnout as a result of the emotional labor involved in crisis work. They may also experience

psychosomatic complaints, a factor that has been found to be positively correlated with emotional dissonance (Zapf et al., 1999). Burnout may result in a crisis counselor becoming “disillusioned with the profession or even with herself or himself” (Sadler-Gerhardt & Stevenson, 2011, p. 2). This sense of disenchantment may complicate the process whereby crisis counselors make meaning of their experiences. Crisis counselors may also experience negative feelings about their work given that overall job satisfaction has been found to be negatively correlated with emotional dissonance (Zapf, 2002).

### **Secondary Traumatic Stress**

Whereas burnout and the toll of emotional labor can be experienced in any profession, the terms I will discuss in the next two sections are unique to those who work in a helping profession. Both secondary traumatic stress and vicarious traumatization result “from actions of empathic compassion, caring, and a view of the client as someone who suffers” (Sadler-Gerhardt & Stevenson, 2011, p. 2). Despite their best efforts to maintain professional and ethical boundaries, crisis counselors are not protected from exposure to the painful and graphic stories of clients who are survivors of trauma (Helm, 2010). Exposure to the retelling of such stories can cause crisis counselors to present with trauma-related symptoms that may be similar to those experienced by their clients (Bober & Regehr, 2006). Disclosure of the strong emotional content present in client stories can leave crisis counselors susceptible to what is known as secondary traumatic stress, a set of symptoms closely mimicking those experienced by individuals diagnosed with Posttraumatic Stress Disorder (PTSD). Symptoms of secondary traumatic stress can include hyperarousal, avoidant behaviors, difficulties in interpersonal functioning, and a decreased ability to enjoy life (Halevi & Idisis, 2017). Secondary traumatic stress responses can



range from mild to extreme, and, as a result, can cause varying levels of distress or impairment in functioning (Molnar et al., 2017).

Secondary traumatic stress occurs when a counselor's own body responds to hearing about their clients' experiences of trauma. Like other trauma reactions, hearing about a client's traumatic experience can trigger physiological arousal in the crisis counselor by activating the autonomic nervous system (Rothschild, 2006). Similar to how the body would react if experiencing a trauma firsthand, the crisis counselor's autonomic nervous system may respond to the stress of hearing about a traumatic event with what is often referred to as the fight, flight, or freeze reaction (Duffey & Haberstroh, 2020; Frijling & Olf, 2012; Lating, 2012; Roberts & Yeager, 2009; Van der Kolk, 2014). This reaction can best be understood by considering how the two subdivisions of the autonomic nervous system function: the sympathetic and the parasympathetic nervous systems. The sympathetic nervous system becomes activated in response to a perceived threat as triggered by a part of the limbic system known as the amygdala, whereas the parasympathetic nervous system becomes activated when the body is in a relaxed state (Sadler-Gerhardt & Stevenson, 2011). The body's physiological reaction to stress is designed as a survival response; the heart rate increases, muscles tense, respiration becomes faster, and a cocktail of hormones and biochemicals, including cortisol, adrenals, and catecholamines, flood the individual's bloodstream as a means of preparing the body to either "flee from a dangerous situation or prepare to do battle" (Roberts & Yeager, 2009, p. 37). Both the sympathetic and parasympathetic nervous systems work to balance one another; however, both systems can also become activated simultaneously in response to a threat or stress resulting in the "freeze" response (Rothschild, 2006). In the case of crisis counselors, persistent

hyperarousal can lead to a secondary traumatic stress response. However, as Sadler-Gerhardt and Stevenson (2011) noted:

If an activated counselor can learn to become aware of her or his own body's state of arousal, that person can begin to manage or even halt the threat responses. Relaxation transfers the control of the sympathetic nervous system to the parasympathetic nervous system. Parasympathetic dominance in turn then produces increased bodily comfort, maximal motor and cognitive function, improved self regulation, with increased effectiveness. (p. 4)

Given that crisis counselors work in high stress environments and regularly interact with trauma survivors, they may be especially prone to experiencing secondary traumatic stress, particularly if they have existing difficulties with self-regulation.

### **Vicarious Trauma**

A related, although distinct, potential outcome for counselors working with trauma survivors is the experience of vicarious trauma. Vicarious trauma refers to a disruption in a counselor's cognitive schema as a result of hearing about their clients' experiences of trauma (McCann & Pearlman, 1990). Vicarious trauma involves alterations in a counselor's belief systems, expectations, and assumptions about the self and the world (Pearlman & Saakvitne, 1995). These disturbances in cognitive schema build over time and can lead to negative effects in psychological functioning, interpersonal relationships, and occupational performance (Trippany et al., 2004). Exposure to vicarious trauma can, therefore, lead to accompanying disturbances in thoughts, emotions, and memory systems (Halevi & Idisis, 2017). For crisis counselors, repeated exposure to the painful and graphic stories of clients may result in such changes to their cognitive schema, resulting in lasting changes to their psyche both personally and professionally.

This concept is especially relevant to this study given that a counselor's belief systems, expectations, and assumptions about the self and the world are inextricably linked to how they interpret and assign meaning to their experiences.

### **Ethical and Legal Implications of Crisis Work**

Crisis work also comes with its own set of ethical and legal implications, including issues related to confidentiality, duty to warn, multicultural considerations, and counselor safety, competence, and impairment. Crisis counselors regularly interface with high-risk clients who are actively suicidal, homicidal, or unable to care for themselves given their current mental health status. Such interactions put crisis counselors in a position that not only puts them at risk of being harmed physically, but also puts them at risk for potential ethical and legal liability. Responding to client behavioral health emergencies requires that counselors carefully consider professional, legal, and personal values and standards. Because ethical issues are rarely black-and-white, counselors must reflect on how their personal values, professional responsibility, and the potential for legal ramifications might influence the ethical decision-making process (Moorhead & Levitt, 2013). Although various ethical decision-making models have been proposed (e.g., Corey et al., 2011; Cottone, 2011; Forester-Miller & Davis, 2016; Kocet & Herlihy, 2014), few authors have addressed ethical decision-making within the context of crisis situations. Traditional ethical decision-making models are not well-suited to the fast-paced nature of crisis intervention. However, by virtue of the work itself, crisis work is fraught with the potential for ethical and legal liability. In fact, the fear of ethical and legal implications is so inherent to crisis counseling that it may make the work unappealing for some counselors, especially to more seasoned clinicians.

## **Coping Strategies**

Numerous studies have focused on preventative measures and strategies for reducing secondary traumatic stress and vicarious trauma. While some studies focused on organizational factors, such as limiting the number of trauma cases on a therapist's caseload or acknowledging the importance of support and supervision, others have focused on personal strategies, such as self-care and maintaining a healthy work-life balance (Cohen & Collens, 2013). One of the most commonly cited strategies for combating the negative effects of working with clients is engagement in self-care practices (Barnett et al., 2007; Cohen & Collens, 2013; Wicks, 2008). Self-care refers to deliberate and self-directed practices designed to enhance health and well-being. Engagement in such practices has been suggested by numerous authors as a means to reduce the distressing effects of working with trauma survivors (Figley, 1995; Hesse, 2002; Pearlman & Saakvitne, 1995; Yassen, 1995).

Although the general perception is that self-care is important to the well-being of counselors, there is conflicting evidence in the literature about its actual benefits. Participants in Killian's (2008) study cited self-care strategies, such as leisure time, exercise, quality time with friends and family, and spirituality as an important area of professional development. However, he also found that although most therapists in the study believed that individual self-care strategies were important to combating vicarious traumatization, there was no evidence to support that such strategies reduced the likelihood of experiencing the phenomenon. Similarly, Bober and Rogehr's (2006) study found no correlation between coping and self-care strategies and reduced levels of vicarious trauma. Bellamy et al.'s (2019) study yielded a different set of findings, however. Their study found that crisis clinicians involved with disaster recovery reported higher levels of stress and poorer job satisfaction in work environments that did not

stress self-care and stress management. Similarly, Bolnik and Brock (2005) found that all 175 school psychologists in their study reported engaging in at least one self-care activity when involved in crisis intervention, with 94% of participants rating self-care as “important” or “very important” during crisis intervention work. Such conflicting findings suggest that further research is needed to determine whether self-care practices do, in fact, contribute to higher psychological and subjective well-being in clinicians who engage in crisis intervention.

Other authors have suggested that personal counseling may be beneficial to coping with the strong cognitive and affective responses associated with working with trauma survivors (Bell, 2003; Hunter & Schofield, 2006; Lonergan et al., 2004; Pistorius et al., 2008). Pearlman and Saakvitne (1995) suggested that for therapists “personal psychotherapy can be extremely helpful. Among other things, it provides a regular opportunity to focus on oneself, one’s needs, and the origins of one’s responses to the work” (p. 166). Pistorius et al.’s (2008) analysis of unstructured interviews with ten female therapists working with sexually abused children found that eight therapists reported initiating therapy for personal issues, including their own personal trauma histories or interpersonal difficulties they experienced as a result of their work. Participants in Lonergan et al.’s (2004) study indicated that personal therapy helped them gain self-awareness, while participants in Bell’s (2003) study cited personal therapy as important for processing their own histories of trauma. These studies echo what Yalom (2002) suggested regarding the importance of therapists seeking their own therapy: “Psychotherapy is a psychologically demanding enterprise, and therapists must develop the awareness and inner strength to cope with the many occupational hazards inherent in it” (p. 41).

### **Clinical Supervision**

Supervision is also routinely recommended in the literature as a means for reducing and managing the effects of vicarious traumatization (Cohen & Collens, 2013; Lonergan et al., 2004; Pistorious et al., 2008). Counselors who work with clients experiencing behavioral health emergencies are tasked with maintaining a calm façade, yet must also deal with their own strong cognitive and affective reactions. Accordingly, it is necessary for counselors to have a space where they can process and come to terms with their own reactions to prevent them from inappropriately affecting the counseling process. Likewise, counseling supervisees may also require skill development specific to behavioral health emergencies, including risk assessment procedures and information regarding resources appropriate to a client's presenting issue. In Harrison and Westwood's (2009) study, participants identified supervision as helpful to decreasing isolation and feelings of shame associated with vicarious traumatization, while also acting as a medium for learning ways to address its symptoms. In essence for these participants, supervision represented a form of "relational healing" (Harrison & Westwood, 2009, p. 208). Similarly, Jackson et al. (2018) argued that supervision enables counselors to process feelings of countertransference and to walk the precarious line of empathizing with their clients while still maintaining an appropriate degree of differentiation of self. They further refer to a supervisor's "potential to facilitate posttraumatic growth of supervisees by ensuring that supervisees have the space needed to make meaning out of the crisis situation" (Jackson et al., 2018, p. 444).

Dupre et al. (2014) conducted a phenomenological study exploring the supervision experiences of licensed professional counselors providing crisis counseling. As would be expected, each and every participant noted the importance of supervision, stressing the need to process emotions and explore personal reactions to client crises. Effective supervision was

described by participants as including “immediate and specific feedback, clear guidance for navigating the crisis, opportunities for timely debriefing, and focused discussion on countertransference reactions” (Dupre et al., 2014, p. 90). Despite the fact that participants described supervision as necessary for successful resolution of crisis situations, fewer than half of the participants in this study reported receiving consistent clinical supervision (Dupre et al., 2014). Results of this study point to the need for supervision in crisis situations regardless of licensure status or years of experience.

### **The Positive Effects of Crisis Work**

#### **Vicarious Posttraumatic Growth**

If secondary traumatic stress and vicarious trauma existed on one end of the spectrum of possible effects of working with clients in crisis, vicarious posttraumatic growth would exist at the other end. Vicarious posttraumatic growth is described as the experience of positive changes in perceptions of the self and the world as a result of exposure to vicarious trauma (Cohen & Collens, 2013). To date, no specific theory has been developed to explain the genesis of vicarious posttraumatic growth (Brockhouse et al., 2011). However, numerous studies have documented the experience of the phenomenon among mental health professionals (Arnold et al., 2005; Bell, 2003; Brockhouse et al., 2011; Cohen & Collens, 2013; Hernandez-Wolfe et al., 2015; Hyatt-Burkhart, 2014). These studies outlined positive changes in the cognitive schema of mental health professionals related to self-perception, interpersonal relationships, spirituality, and philosophy of life. Hyatt-Burkhart (2014) noted that participants who experienced vicarious posttraumatic growth “talked about looking at their lives through a lens colored by a new awareness of what the world is like” (p. 456) and “all expressed finding value in their lives as a result of the work” (p. 457). Although no studies to date have examined the experience of

vicarious posttraumatic growth in crisis counselors specifically, the phenomenon is likely to exist in this population given its frequent exposure to vicarious trauma.

### **Well-being**

In considering the positive effects of crisis work, a discussion on well-being in crisis counselors is warranted, especially given the counseling profession's emphasis on wellness. Well-being is a multidimensional construct that incorporates both hedonic (subjective well-being) and eudaimonic (psychological well-being) elements. Despite some overlap between the two constructs, specific differences exist between subjective and psychological well-being (Joshanloo, 2016). The hedonic aspects of well-being refer to the pursuit of pleasurable experiences, while the eudaimonic aspects of well-being refer to the pursuit of meaning, self-realization, and optimal functioning (Ryan & Deci, 2001). The concept of psychological well-being itself is also multifaceted. Originally developed by Ryff (1989), psychological well-being consists of six individual factors: autonomy, environmental mastery, purpose in life, personal growth, positive interpersonal relationships, and self-acceptance. Subjective well-being, on the other hand, is concerned with what is more often thought of as happiness, or an individual's subjective assessment of life satisfaction (Diener et al., 2003). In either case, well-being is believed to be more complex than merely the absence of mental illness or pathology. Because this study is concerned with the meaning-making practices of crisis counselors, an understanding of psychological well-being in particular is important, as the construct is likely influential to how participants chose to tell stories related to their experiences.

### ***Psychological Well-being and Finding Meaning***

The concept of psychological well-being considers an innate drive toward self-actualization and the desire to find meaning, or the perception that one's life has purpose or a



larger significance (King et al., 2006). In considering the concept of psychological well-being in crisis counselors, an examination of previous research on factors that promote resilience and vicarious posttraumatic growth is warranted. As mentioned in the previous section, vicarious posttraumatic growth refers to positive changes in perception of the self and the world as a result of exposure to vicarious trauma (Cohen & Collens, 2013).

One theme that has emerged in the literature as influential to the experience of vicarious posttraumatic growth in clinicians who work with trauma survivors is engagement in an existential meaning-making process (Cohen & Collens, 2013). As Pearlman and Saakvitne (1995) suggested, managing vicarious trauma and secondary traumatic stress requires one to “address impairment or changes in the therapist’s sense of meaning and hope, connection with something beyond the self” (p. 174). Because crisis work exposes clinicians to distressing and potentially traumatic situations, an ability to find meaning in their work may prevent burnout, secondary traumatic stress, and vicarious traumatization. Consequently, finding meaning in their work may also contribute to higher levels of psychological well-being in crisis clinicians. Perhaps Frankl’s (2000) claim that “meaning can be found not only in spite of, but also because of, unavoidable suffering” (p. 131) also rings true in the case of crisis work. In fact, finding satisfaction and meaning in one’s work has been shown to predict overall perceived quality of life (Burke & McKeen, 1995). In the sections that follow, I discuss the ways in which the proposed theories, including social constructivist and existential perspectives helped to guide my approach to this study.

### **Theoretical Perspectives**

The social constructivist position holds that individuals create their own realities based on their interactions with others and the world around them (Edwards, 2013). From this perspective,

it is the interaction and collaboration with clients, colleagues, family members, collateral sources, and other emergency personnel that become significant to the construction of meaning. Consequently, this study aimed to illuminate the process by which crisis counselors perceive, interpret, construct, and assign meaning to their work with clients experiencing behavioral health emergencies. This study was further undergirded by the existential notion that meaning does not inherently exist; instead, it is constructed as a means to make sense of our experiences and is directly related to the ways we view ourselves in connection to others. In the sections that follow, I discuss existing theories of meaning making that were relevant to this study and the ways in which crisis counselors construct personal and professional meanings of behavioral health emergencies.

### **The Process of Making Meaning**

From an existential perspective, the quest to find meaning represents a given of existence, something with which we must all contend (Yalom, 1980; Yalom & Josselson, 2013). This viewpoint asserts that meaning does not inherently exist; rather, individuals must *create* meaning in their own lives. It further stresses the importance of freedom and choice in the overall construction of meaning. Research on vicarious posttraumatic growth has shown that individuals who engage in an existential meaning-making process frequently report positive changes related to self-perception, interpersonal relationships, spirituality, and philosophy of life (Cohen & Collens, 2013). However, it is not a phenomenon that is well-understood, nor has it been explored within the context of counselors who work with clients experiencing behavioral health emergencies.

Generally speaking, the process of making meaning refers to the ways in which people understand and make sense of their experiences (Merriam & Tisdell, 2016). A multitude of

theories have been proposed to explain the process by which individuals create meaning, particularly in response to stressful life events. Park (2010) proposed a model of meaning-making that incorporates the work of a number of theorists (e.g., Bonanno & Kaltman, 1999; Davis et al., 2000; Janoff-Bulman, 1992; Joseph & Linley, 2005; Lepore & Helgeson, 1998; Neimeyer, 2001; Taylor, 1983; Thompson & Janigian, 1988). She explained that although portions of these theories differ from one another, there are some basic tenets on which they all agree. Park's theory asserts that individuals possess cognitive frameworks, or global meaning systems, through which they interpret life events. Global meaning systems also include a person's individual valued goals and an overall sense of purpose, direction, or larger significance (Park & Folkman, 1997). Although modifiable, global meaning systems are believed to be established early in life and to have a strong influence on an individual's cognitive, affective, and behavioral responses. When individuals experience events that challenge these global meaning systems, they must attempt to make sense of these events, assigning them an appraised meaning. Individuals may experience distress due to the incompatibility between their global meaning systems and the appraised meaning of a given situation, causing them to make attempts to reduce this discrepancy. Attempts to reduce the discrepancy "restore a sense of the world as meaningful and their own lives as worthwhile," resulting in a more adaptive response to the stressful event (Park, 2010, p. 258). Individuals attempt to reduce this discrepancy by either changing their perspective of the given situation in order to match their global meaning system or accommodate the new experience by modifying their global meaning system (Park, 2017).

### **Constructivist Self-Development Theory**

Another theory that is useful as a means to conceptualize the meaning making process in response to stressful life events is Constructivist Self-Development Theory (CSDT). Developed

by McCann and Pearlman (1990), CSDT is commonly accepted as a means to understand why and how vicarious traumatization develops. The theory asserts that individuals create their own realities “through the development of complex cognitive structures which are used to interpret events” (McCann & Pearlman, 1990, p. 137). According to this theory, individuals create cognitive schemas according to their psychological needs for trust, safety, power, esteem, intimacy, and frame of reference (McCann & Pearlman, 1990). Individuals then use these cognitive schemas to interpret interpersonal, intrapsychic, familial, cultural, and social experiences. However, exposure to vicarious trauma can disrupt the therapist’s cognitive schemas, leading to accompanying disturbances in thoughts, emotions, and memory systems (Halevi & Idisis, 2017). CSDT asserts that these changes in cognitive schema amass over time and permeate all aspects of the therapist’s personal and professional life (Trippany et al., 2004). Both Park’s (2010) theory of meaning making and CSDT may be useful to the interpretation of participant narratives in this study given the fact that behavioral health emergencies, at least initially, may break with a crisis counselor’s existing global meaning systems and cognitive schemas. It is this process of reconciling such discrepancies that became apparent in this study in terms of the ways crisis counselors perceive, interpret, and construct meaning of their work with clients.

### **Chapter Summary**

In this chapter, I provided the reader with a review of the literature pertaining to crisis counselors, including their background and training. Specific attention was paid to what differentiates counselors from other mental health practitioners in terms of worldview, training, and supervision. Additionally, the underlying philosophies of counseling were explored, including a discussion of the specific values and ethics of the field. I provided the reader with

details about how counselors are prepared and trained, including required supervised clinical practice and an outline of state licensing standards. I further provided the reader with a discussion of the specific training requirements of crisis counselors as a means to contextualize counselor development and the significance of professional identity.

This chapter also provided the reader with a review of the literature on the effects of crisis counseling, including feelings of countertransference, burnout, secondary traumatic stress, vicarious traumatization, and vicarious posttraumatic growth. Possible coping strategies, including clinical supervision, were also discussed as they were expected to be significant to the meaning making process of crisis counselors. Finally, this chapter concluded with a discussion of this study's theoretical framework and how it guided the ways in which I approached this study, including my analysis of participant stories.

## Chapter Three

### **Methodology**

This study sought to uncover the ways in which crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. Because my research question was concerned with the subjective experiences of crisis counselors and how they make meaning of their work with clients, this study utilized a qualitative approach. While positivist perspectives view research as an “objective” process whereby some “truth” is uncovered, qualitative researchers believe in the existence of multiple realities that are dependent on individual perception (Heppner et al., 2018). Qualitative research is therefore concerned with how people interpret, construct, and assign meaning to their experiences (Merriam & Tisdell, 2016). This perspective is applicable to the current study in that it attempts to explore the phenomenon of interest from an emic perspective, one that stresses the subjective experience of participants. A qualitative approach was also appropriate for the current study as the nature of my research question called for an inductive rather than a deductive process, as I was not interested in testing any specific theory or hypothesis. Rather, my research aimed to develop an understanding of the experiences of crisis counselors and the ways in which they construct and assign meaning to them. Given my interest in the meaning-making process, this study was informed by a narrative approach.

#### **A Narrative Approach**

This study sought to develop an understanding of the ways in which crisis counselors make meaning of their experiences working with clients in the midst of behavioral health emergencies. In an effort to illuminate the meaning-making process, this study employed a qualitative design informed by narrative inquiry. Narrative inquiry is based on a relativistic

ontological perspective; that is, reality is not fixed, but rather is dependent on individual and social construction (Ponterotto, 2005). The perspective operates from an interpretivist/constructivist paradigm, one that focuses on the importance of context and subjective experience to an individual's construction of reality (Hoshmand, 2005). Narrative approaches also stress the bidirectional relationship that exists between researcher and participant, viewing knowledge as co-created within a social act (Heppner et al., 2018).

Narrative inquiry is based on the notion that individuals create meaning through storytelling (Merriam & Tisdell, 2016). Such an approach seeks depth rather than breadth of experience in an attempt to understand the complexities of lived experience (Riessman, 2003). In examining narratives, the researcher considers not only the content of participants' stories but also how they choose to construct them, attending to the linguistic tools they use and the ways in which context and culture inform and interact with their stories (Hyvärinen, 2011). Narrative inquiry considers stories along three dimensions of existence: time, place, and personal/social interaction (Clandinin & Connelly, 2000). Narratives, therefore, become both the phenomena and method of study. Meaning is both extrapolated from and constructed through the stories that participants share (Hays & Wood, 2011).

A narrative approach to research is particularly useful to examining the lived experiences of marginalized groups in that it gives voice to those who have historically been silenced (Riessman, 2003). Although crisis counselors may not be marginalized in the traditional sense of the word, they do make up a subgroup of mental health clinicians who have largely been neglected in the research literature (Carabello, 2013). Crisis work requires counselors to work in high-stress, low-paying positions, often asking them to work undesirable schedules as a result of the 24-hour nature of behavioral health emergencies. Additionally, responding to behavioral

health emergencies comes with increased risk for ethical and legal liability. These factors in many ways make crisis counselor positions undesirable, causing fewer clinicians to pursue them. To further complicate this experience, research has indicated that beginning counselors frequently report feeling underprepared to intervene in crisis situations (Allen et al., 2002; Morris & Barrio Minton, 2012).

Crisis counselors are required to work in a fast-paced environment that may limit their ability to reflect upon and fully process the intense interactions they share with clients. For this reason, a qualitative study informed by narrative inquiry was useful as a means for participants to reflect upon, make sense of, and articulate the meanings they attach to working with clients experiencing behavioral health emergencies. A narrative approach also enabled me as the researcher to not only analyze and reflect upon the content of participant stories, but also to consider the inherent meanings associated with the ways in which participants chose to tell them. Finally, the relational and collaborative nature of narrative research enabled me to interact with participants, functioning as a means to co-create knowledge (Riessman, 2003). This was especially relevant to my research question since meaning-making does not occur as a solitary process but rather in collaboration with others (Neimeyer et al., 2014).

### **Research Design**

This study utilized an interpretive/constructivist qualitative approach informed by narrative inquiry. The research question guiding this study aimed to illuminate the ways in which crisis counselors make meaning of their work with clients experiencing behavioral health emergencies. Accordingly, the subjective experiences of participants were analyzed through the stories they told during semi-structured interviews and the ways in which they chose to tell these



stories. In the sections that follow, I discuss the sampling, recruitment, and data collection strategies I utilized in my research design.

### **Participants**

Participants were identified based on predetermined criteria. Because this study was specifically interested in the experiences of counselors, crisis clinicians with other training backgrounds were excluded from this study. Only participants whose background, education, and training come from the counseling profession were considered. Participants consisted of a sample of counselors whose primary job responsibilities require them to regularly interface with clients experiencing behavioral health emergencies and who work within the context of a screening center or affiliated emergency service as described in chapter two. Participants possessed a master's degree or higher in counseling and had a minimum of one year of post-master's experience in a crisis setting. This requirement ensured that participants had the depth of experience necessary to contribute to this study. Participants were either currently working in a behavioral health emergency setting (screening center or affiliate emergency service) or had been employed in such a setting within the last year. This requirement also ensured that participants had the ability to share narratives that directly address the process of meaning-making in response to behavioral health emergencies. Please see Appendix A for Demographic Questionnaire provided to participants to determine eligibility requirements. Table 1 provides an overview of participant demographics. To summarize, criterion-based sampling was used to select participants who (a) possess a master's degree or higher in counseling, (b) have interfaced with clients experiencing behavioral health emergencies on a regular basis within the last year, (c) have one or more years of post-master's experience working in a crisis setting, and (d) were able to articulate their experiences.

Table 1  
*Participant Demographics*

#	Gender	Race	Ethnicity	Degree	Current Licensure Status	Total Years of Experience	Years of Crisis Experience
1	Male	White	Italian-American	MA Counseling	LPC	10	6
2	Female	White	Non-Hispanic	MA Counseling	LPC	9	9
3	Male	White	Irish- / Italian-American	MA Counseling	LPC	19	12
4	Female	White	Hispanic	MS Counseling	Not currently licensed	30	9
5	Female	White		MA Counseling	LAC	3	2
6	Female	White		MA Counseling Psychology	LPC	5	3
7	Male	White	Scottish	MA Counseling	LPC LCADC	22	14
8	Male	White		MA Counseling	LPC	27	15

While the selection of participants was rather direct, determining the sample size for this study proved to be somewhat more difficult. As Josselson and Lieblich (2002) noted, “the question of number of participants is one of the thorniest we have run into” (p. 267) in narrative research. Researchers have proposed a range of adequate sample sizes for qualitative research and for narrative studies in particular. Sample size for narrative informed studies range in number from a single individual to a much larger collection of participants (Creswell & Poth, 2018). Because narrative studies seek depth rather than breadth of experience, they typically consider the stories of fewer participants (Sheperis et al., 2017). Creswell (1998) suggested a sample of as few as five participants, while others, such as Boyd (2001), have suggested a sample size ranging from 2-10 participants. Sheperis et al. (2017) referred to their decision to utilize a sample of five participants for their dissertation as being “at the high end of number of participants in a narrative study” (p. 156). As Beiten (2012) noted, “researchers have shifted from a clearly defined, predetermined number of participants to a focus on the research process as informing the ultimate number of participants” (p. 243). Because sample size should be considered emergent and flexible (Patton, 2014), saturation was of particular importance in determining the appropriate sample size for this study (Guest et al., 2006). I elected to stop data collection after completing interviews with eight participants as I began to notice thematic redundancy. This was important given that I planned to conduct a thematic analysis of participant interviews, and was interested in examining key topics, issues, and storylines that emerged within participant narratives. As Polkinghorne (2005) suggested, my understanding of the experiences of crisis counselors was dependent on “intense, full, and saturated descriptions of the experience under investigation” (p. 139).

**Recruitment**

Participants were recruited using criterion-based and snowball sampling via email request (see Appendices B and C). In order to recruit eligible participants, I contacted New Jersey Designated Screening Center and Affiliate Emergency Services directors as listed on the New Jersey Department of Human Services Division of Mental Health and Addiction Services website ([https://www.state.nj.us/humanservices/dmhas/home/hotlines/MH\\_Screening\\_Centers.pdf](https://www.state.nj.us/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf)). In my email to the directors, I requested that they distribute information regarding my research to eligible participants among their staff. The study's purpose, eligibility requirements, and an explanation of possible contributions to the field were provided in the email to directors. When interviewing participants, I also asked that they pass information about my study along to acquaintances or colleagues who might be interested and eligible to participate. It is important to note that I faced considerable difficulty in recruiting participants for this study; however, the reasons for this remain unclear. One possibility is that this study was conducted during the course of the COVID-19 pandemic, a period of time that was especially stressful for crisis counselors given their positions as frontline workers. Another possibility is that this population would have been difficult to engage regardless of the circumstances given the culture of silence described by participants.

**Data Collection**

Because I was interested in the narratives of my participants, data were collected via semi-structured interviews. Due to social distancing requirements associated with the COVID-19 pandemic, semi-structured interviews were conducted via Zoom meeting. The first round of interviews lasted approximately 60-90 minutes to enable depth of participant disclosure. Follow-

up interviews lasted between 30-60 minutes, with an average length of 48 minutes. The second round of interviews not only covered additional topics, but also provided participants with an opportunity to reflect on and process what was discussed during the first round of interviews. Participants were asked to sign a consent form prior to participating in the first interview, which explained study aims, procedures, and potential risks (see Appendix D). Since my study was informed by narrative inquiry, interview prompts were kept to a minimum, allowing participants to share their stories with minimal interference. However, in order to ensure that specific topics of interest were covered, a basic interview guide was available to me during the interviews (see Appendix E). It should be noted that the interview guide served as a prompt rather than as a formalized schedule or structure for the interviews. This was intentional, as my aim was to elicit participant stories without influencing the ways in which they chose to tell them. Accordingly, I lead with only minimal probing, asking follow-up questions only after participants had shared their stories. The interviews were conducted in an informal manner in order to encourage a natural and flexible exchange. As a means to encourage full exploration of their narratives, participants were asked to participate in a second interview to allow them to address any missing aspects of their stories, which also functioned as a form of member checking. The second round of interviews also enabled me to address additional areas of interest that became apparent while analyzing the first round of interviews.

Interviews were audio recorded using the recording feature on the Zoom platform and then transcribed verbatim. The recordings were initially transcribed using the website <https://otter.ai>. The transcriptions were then checked for accuracy and edited to include all aspects of the exchanges that occurred within the interviews, including pauses, nonverbal sounds, and utterances. This ensured that subtleties in nonverbal communication (e.g.,

discomfort, emotionality, pauses) were preserved within the data and analyzed accordingly. For example, repeated hesitations or pauses often indicated that participants were thinking through concepts, while nervous laughter often corresponded to participant discomfort or that they were making light of a particular topic. Initial analysis of the interviews began immediately after collection. This process helped to inform subsequent interview questions and to correct for any identified issues with data collection.

### **Semi-Structured Interviews**

Consistent with an approach informed by narrative inquiry, this study employed the use of semi-structured interviews designed to elicit the subjective experiences of participants. Participants were encouraged to consider their experiences through the telling of personal narratives with the hope that storytelling would illuminate the meanings they make from their work with clients in crisis. Some basic questions guided the interview process and specific exchanges served as prompts for additional questions. Because this study was undergirded by narrative inquiry, the interviews were conducted with an understanding that the exchanges between researcher and participant would also result in the co-construction of knowledge (Heppner et al., 2018). Accordingly, the interviews were conducted in such a way so as to support a flexible and natural environment in which participants felt able to share their stories. Prompts were open-ended in nature, encouraging the participant to share more of their story. In order to avoid imposing my own perspective, pre-structuring of the interview was minimized to go beyond a typical question-answer arrangement (Jovchelovitch & Bauer, 2000). Interviews addressed a range of topics, including counselor identity and development, defining moment experiences, and supervision and self-care practices. Some of the following questions helped to

guide participants in sharing narratives related to these areas (see Appendix E for the interview guide):

- Describe for me how you came to work as a crisis counselor.
- Tell me a story about a work experience that personally impacted you?
- What sustains you in this type of work?
- What have you learned from your experiences as a crisis counselor?

The first round of interviews addressed the first two areas of interest to this study, counselor identity and development and defining moment experiences. The second round of interviews was used to explore supervision and self-care practices and to provide opportunity for participants to expand upon and clarify their responses from the initial round of interviews. This functioned to ensure that participants were able to address any missing aspects of their story during the follow-up interviews. Follow-up interviews also enabled participants to reflect on the content of the first interview as a means to more fully process the experience and to draw possible connections to their personal and professional lives. Finally, follow-up interviews functioned as member checking by enabling me to ask participants for feedback about my emerging understandings and initial analysis of the data.

### **Ethical Considerations**

Participants were provided with informed consent upon entering the study (see Appendix D). They were advised of any potential risks associated with the study, including the possibility of experiencing or re-experiencing distressing emotions. Although the intent of the study was not to cause mental or emotional distress, participants were advised that the material discussed during the course of interviews could potentially be upsetting or elicit strong emotional reactions. Participants were informed of the potential contributions this study may have to the field of

counseling in terms of future training and supervision practices. Efforts to minimize risk were taken, and participants were advised they would be provided with referrals to mental health resources, if needed. They were also made aware that their participation was completely voluntary and that they could withdraw from the study at any time.

Participant confidentiality was ensured by stripping all data sources of identifying information and digital consent forms were stored on a password protected computer. Audio recordings and transcripts were also stored on a designated password protected computer accessible only to the researcher. All data sources will be stored for a minimum of three years before being destroyed in accordance with Institutional Review Board (IRB) policies. From the onset, participants were advised that their participation would not incur any cost to them, nor would they be compensated for their time.

### **Data Analysis**

I utilized two methods of analysis in considering participant narratives. First, I describe my use of Gilligan's *Listening Guide*, which helped me to explore the inner world of participants through consideration of their stories at multiple levels. In doing so, I was able to identify the individual narrative threads present in participant stories. My second level of analysis involved engagement in a coding procedure I describe in detail in the sections that follow, a process that helped to illuminate reverberations across participant narratives and gave rise to the overarching themes identified in this study. Before turning to a discussion of these two levels of analysis, I first describe the ways in which I attended to the metacommunication patterns present in participant interviews.



### **Attending to Metacommunication Patterns**

Audio-recording and transcribing the interviews ensured that all aspects of participant responses were available for analysis, including pauses, nonverbal sounds, and utterances. The metacommunicative aspects of participant narratives, such as discomfort, emotionality, tone of voice, and other subtleties or nonverbal exchanges, were important to consider when analyzing the data. As mentioned previously, transcriptions were compared to all interviews to ensure accuracy. In order to inform subsequent interviews and identify any issues with data collection, initial analyses of the interviews began immediately after data collection.

### **Identifying Narrative Threads**

Several different typologies of narrative analysis exist in the research literature (Polkinghorne, 1995; Riessman, 2005). Given the focus of my study, I was particularly interested in considering thematic analysis of narratives as language “is a direct and unambiguous route to meaning” (Riessman, 2005, p. 2). Of interest to me were the narrative *threads*, or plotlines, that were present in each of the participant’s narrative accounts. According to Clandinin (2016), narrative threads can be thought of as specific plotlines that “threaded or wove over time and place through an individual’s narrative account” (p. 132). These narrative threads were identified with the help of Gilligan’s *Listening Guide*, an in-depth method of listening to both what is said and what is not said by participants. Because narrative threads are “complex and difficult to disentangle” (Clandinin & Connelly, 2000), the *Listening Guide* helped to unravel the sometimes frayed tapestries of participant stories. The *Listening Guide* was particularly useful as it helps to illuminate the complexities of the human psyche by specifically attending to voice (Woodcock, 2016). Further, the *Listening Guide* was appropriate for this study given its emphasis on meaning making within the context of human relationships.

## **Listening Guide**

Undergirded by feminist ideology, *The Listening Guide* is useful as a means to consider how individuals develop in relation to others (Gilligan et al., 2006). The guide functions as a means to explore the inner world of participants through consideration of their stories at multiple levels. My decision to utilize *The Listening Guide* was due to its focus on the co-construction of knowledge, specifically the notion that individuals assign meaning to their experiences within relational and cultural contexts. The following sections describe the various stages of data analysis that I employed using *The Listening Guide*. Such an approach enabled me to gain a deeper understanding of the lived experiences of crisis counselors and the ways in which they assign meaning to their interactions with clients during behavioral health emergencies.

### ***Plot***

During the first stage of data analysis using *The Listening Guide*, I considered the plot of the participants' narratives. This involved not only listening to the participants' stories but also attending to my own personal reactions to their narratives. Doing so required me to maintain a reflexive stance, being mindful of any feelings of countertransference I felt towards the participants and the ways in which those feelings could affect my interpretation of the data. Additionally, I needed to remain mindful of my own subjectivities and the ways participant stories resonated with me given my own experiences as a crisis counselor and my "insider" status in this research (Merriam & Tisdell, 2016). This stage of data analysis involved listening to participant responses, taking into consideration how actors, events, context, and reasoning interacted to affect the narrative.

### ***I Poem***

The second stage of data analysis using *The Listening Guide* involved careful examination of how participants used first-person language within their narratives. In considering the transcribed interviews, I highlighted “I” phrases, as well as any associated verbs or important accompanying words within the text to form lines like a poem. The reason for this was that I wanted to specifically attend to how participants spoke about themselves and the ways in which they perceived themselves in relation to the subjects being discussed. By analyzing *I Poems*, I was able to gain a deeper understanding of salient “themes, harmonies, dissonances, and shifts” within the participants’ narratives (Gilligan et al., 2006, p. 262). The use of *I Poems* helped me to identify specific narrative threads about the subjective experience of working with clients experiencing behavioral health emergencies that were woven into participant stories.

### ***Contrapuntal Voices***

During the third stage of analysis using *The Listening Guide*, I considered participant narratives with the goal of listening to content that specifically addressed my research question. In doing so, I attended to the aspects of participant stories that centered on the meaning-making process that occurs in response to working with clients experiencing behavioral health emergencies. This involved listening for the possible multiple meanings in each participant statement. By considering this multiplicity of meanings, including discrepant or inconsistent statements, I was able to gain insight into the larger meanings present within the participants’ stories.

### ***Composing an Analysis***

The final stage of analysis using *The Listening Guide* involved weaving together the threads of analysis from the previous three stages. I reflected upon what I learned from the

participants' stories and how I reached these conclusions. This final stage of analysis considered how listening to the multiple layers of participants' narratives illuminated how their individual experiences may have been shaped through interaction with their relational and cultural contexts.

### **Reverberations Across Narratives**

As mentioned previously, my goal in this study was to identify salient themes reflected across participant narratives. As such, my second level of analysis involved observing for emergent patterns across narrative accounts. After considering the narrative threads that coursed through individual participant stories, I "laid the accounts metaphorically alongside one another" in an effort to observe "resonances or echoes that reverberated across accounts" (Clandinin, 2016, p. 132).

### ***First Cycle Coding***

During the first cycle of coding, I assigned portions of participant narratives initial codes, ones I considered, at the time, to be tentative and provisional in nature. Because of the complexity of meaning making, I knew that one coding method was unlikely to suffice (Saldaña, 2016). I therefore utilized a number of different coding strategies during the first cycle of coding, including descriptive, concept, emotion, and in vivo coding as described by Saldaña (2016). With the use of Quirkos, a computer-assisted qualitative data analysis software program, I was able to identify the most frequently occurring descriptive codes, or commonly occurring basic topics that occurred across participant narratives. In engaging in concept coding, I categorized words or short phrases I identified as symbolic representations of intangible or abstract ideas. Emotion coding was used to highlight the affective intrapersonal and interpersonal experiences of participants, while in vivo coding called attention to specific participant generated words or phrases from the participants' stories (Saldaña, 2016).

### ***Second Cycle Coding***

My goal during the second cycle of coding was to further categorize and refine codes identified during the first cycle of coding. This involved combining and reconfiguring first cycle codes into more refined categories, as well as reorganizing existing codes conceptually and identifying emergent themes. Second cycle coding enabled me to consider the gestalt of the narrative accounts and to consider essentials of the data corpus. I achieved this by using pattern coding, condensing codes identified during the first cycle of coding into more meaningful and succinct categories. These categories helped to crystalize major themes identified across participant narratives. In addition to its function of maintaining trustworthiness (as discussed in the section that follows), analytic memo writing was also used throughout the coding process as a means for me to reflect upon my decisions to use certain codes. As Clarke (2005) explained, “memos are sites of conversation with ourselves about our data” (p. 202). Analytic memo writing and subsequent axial coding helped to illuminate links between codes identified during first cycle coding (Saldaña, 2016). Themes were then extrapolated from these codes, bringing meaning to the recurrent patterns observed in the data. The process of analysis was iterative in nature, enabling me to reflect upon, interpret, and synthesize my findings.

### **Research Integrity and Trustworthiness**

Given my own positionality and experience working with clients in the midst of behavioral emergencies, it was important for me to employ a variety of methodological techniques to ensure the trustworthiness and credibility of this study. To ensure trustworthiness, a combination of prolonged engagement, obtaining rich data, member checking, analytic memo writing, and consultation with critical friends was used (Maxwell, 2010; Morrow, 2005). Additionally, I chose to analyze participants’ narratives using both the *Listening Guide*, which

focused on the individual narratives, followed by the coding strategies described in the previous section to identify echoes or reverberations across participant narratives. This is consistent with Saldaña's (2016) recommendation that "more than one coding method and at least two different analytic approaches should be explored in every study to enhance accountability and the depth and breadth of findings" (p. 70).

### **Analytic Memo Writing**

As mentioned previously, I chose to engage in analytic memo writing as a means of reflecting on and dialoguing with myself about the research process. Such a practice enabled me to consider my reactions to the people and phenomena of this study. This was particularly important during the first phase of analysis using the *Listening Guide*, which required me to be mindful of my own reactions to participant stories and the ways in which I might interpret what was being said (Gilligan et al., 2006). Interrogating my own positionality was especially important to this study given my "insider" status (Merriam & Tisdell, 2016) and previous experience working in a behavioral health emergency setting. The process of writing helped me to not only trace the origins of my research question, but also to consider how my positionality affected what stood out to me as being significant when analyzing the data. Frequently, I found myself asking, why does this seem important to me? How are my own experiences reflected in what this participant is saying? How might my own positionality and experiences muddy my viewpoint? Although I made efforts to interrogate my own assumptions, I also came to realize that the focus of this study was a direct extension of myself. My decision to approach this research from a narrative perspective was fitting, and I realized through analytic memo writing that the intimate exchanges that occurred during participant interviews certainly resulted in the co-construction of knowledge. By guiding the conversation to certain topics, I as the researcher

prompted reflection and processing of areas that may not have spontaneously emerged had the participants and I not been engaged in a bidirectional exchange.

### **Member Checking**

Credibility was also established through the process of member checking, a process used as a means to identify any potential misinterpretations of the data by eliciting participant feedback (Hays et al., 2016; Merriam & Tisdell, 2016). Several different approaches to member checking have been described in the literature, including returning interview transcripts to participants, member check interviews, member check focus groups, and member checks of synthesized analyzed data (Birt et al., 2016). Because this study was undergirded by a constructivist/interpretivist paradigm, member check interviews were used due to their alignment with a social constructivist perspective. It was also important to me that I check back in with participants about whether their individual experiences were reflected in the themes I was noticing across participant narratives. For this reason, I engaged participants in member check interviews that incorporated synthesized analyzed data from the whole sample. This was accomplished during the second round of interviews, during which I brought my preliminary analysis back to participants, asking them to engage with and add to my interpretations of our initial interviews. Consistent with what Morrow (2005) noted, I did not use member checking solely as a means of confirming or validating my observations. Rather, member checking was viewed as “an elaboration on the emerging findings and treated as additional data” (Morrow, 2005, p. 252).

### **Critical Friends**

Another method I used to establish trustworthiness was engagement with critical friends. Costa and Kallick (1993) described a critical friend as “a trusted person who asks provocative

questions, provides data to be examined through another lens, and offers critique of a person's work as a friend" (p. 50). The use of critical friends was essential to maintaining a reflexive stance in that it forced me to interrogate my research process and my interpretations of the data. I was extremely fortunate to have both a critical friend with "insider" status and one with "outsider" status (Merriam & Tisdell, 2016). This enabled them to each challenge me from a unique point of view, asking me thought-provoking questions and challenging me to consider different perspectives. As Appleton (2011) advised, both critical friends were "people who believed in my abilities to successfully undertake this research, and, equally important, they were colleagues who were able to challenge and question my assumptions and interpretations in ways that would support critical reflection of my role and purpose" (p. 7). My understanding that data never stands on its own, and that my interpretation of the findings, both the implicit and explicit framing I brought to the task, required me to do justice for my participants.

### **Chapter Summary**

This chapter focused on the methodology I used to illuminate how crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. In it, I described my rationale for a qualitative study informed by narrative inquiry, as well as my research design. I detailed the ways in which participants were identified and recruited, and outlined my approach to the semi-structured interviews designed to elicit the subjective experiences of participants. My data collection strategy, ethical considerations, and methods to ensure trustworthiness were also addressed. The chapter concluded with a discussion of my decision to utilize Gilligan's *Listening Guide*, as well as the process in which I conducted a thematic analysis across participant interviews. In the chapter that follows, I provide a thematic analysis of the participant narratives related to their work with



clients in the midst of behavioral health emergencies. The fifth and final chapter will discuss the implications of the proposed study and provide possible recommendations for future research.

## Chapter Four

### **Findings**

As mentioned in previous chapters, the goal of this study was to uncover the ways in which crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. In the chapter that follows, I give the reader insight into the overarching narrative that emerged through the data analysis described in chapter three. The chapter begins with a description of the story's characters, the eight crisis counselors who participated in this study. I then present the findings of this research through a consideration of individual narrative threads that when woven together formed a collective tapestry of thematic experience. The collective narrative highlighted a plotline that ran through all participant stories and informed the larger thematic consistencies that arose across narratives.

### **Description of Participants**

I conducted interviews with eight participants, four White males and four White females. Of the participants who provided their ethnic identity, one male identified as Italian-American, another as Irish- and Italian-American, and a third as Scottish. Of the female participants, one identified as Hispanic. Participants had varied years of experience, ranging from 2-15 years in a crisis setting. The average number of years of experience in a crisis setting was 8.75. Six of the participants were Licensed Professional Counselors (LPCs) at the time of interview, one participant was a Licensed Associate Counselor (LAC), and one participant was not currently licensed. All of the participants possessed a master's (MA or MS) degree in Counseling. See Table 1 in chapter three for a full description of participant demographic information that includes gender, race, ethnicity, highest academic degree, current licensure status, total years of clinical experience, and years of experience in a crisis setting. Each participant was interviewed

on two occasions at least two weeks apart. The first interview lasted approximately 60-90 minutes, while the second interview lasted an average of 48 minutes.

### **A Collective Narrative**

The aim of this research was to highlight the voices of the eight crisis counselors who participated in this study, with a focus on how they make meaning of their work with clients experiencing behavioral health emergencies. Through conducting several sequential “listenings” of each transcribed interview, I was able to attend to the multilayered voice present in each participant narrative. Although participant stories were varied and complex, a collective storyline gradually emerged across participant accounts. This collective narrative was gleaned by first listening for plot (Brown & Gilligan, 1992), which revealed a series of events and experiences that existed in connection to one another. During the second listening, I was interested in considering how participants understood themselves in relation to their work and their interactions with clients. In order to uncover the complexities, subtleties, and nuances of their subjective experiences, I attended to each participant’s use of first-person language, pulling out any “I statements” and corresponding verbs or phrases to construct *I poems* (Brown & Gilligan, 1992; Gilligan et al., 2006). As a means of demonstrating the value these brought to my analysis, I include a participant *I poem* as an introduction to each section in the body of this chapter. Although these *I poems* highlighted only one individual voice at a time, they also captured the gestalt of experiences described by participants. During the third listening, I focused on the contrapuntal voices present in participant narratives, which allowed me to see the multiplicity of meanings, both the conflicting and the complementary, that were evident in their stories. The fourth and final listening enabled me to compose an analysis of how each participant’s story related back to my research question. In doing so, reverberations across narratives revealed the

intricacies involved in how participants make meaning of their work with clients experiencing behavioral health emergencies.

The collective storyline of participant narratives chronicled a dramatic framework consisting of a rising action, climax, and falling action that created a dynamic of tension and resolution both in and across participant stories. The story begins with what I refer to as *The Dance of Crisis Work*, a theme that provides the reader with an intimate look at the complexity of working with clients experiencing behavioral health emergencies and sets the stage for the unfolding of the remainder of the collective narrative. *The Dance of Crisis Work* reveals participant accounts of the profound intimacy of being with a client during their darkest hour, and the magnificence of igniting even the smallest flame of hope within them. Participants described both the ups and downs of crisis work, sharing stories of both celebration and defeat. I refer to this theme as *The Dance of Crisis Work* as the word *dance* highlights the conscious intention behind the work coupled with the emotional expressivity of the movements associated with it. The rising action of participant stories gives the reader a glimpse of the excitement and allure of crisis work, as well as the intense intimacy and rawness of working with clients experiencing behavioral health emergencies. The theme *In the Quiet Room* sheds light on participants' experiences of feeling unprepared and unsupported in their roles, forced in many ways to face the challenges of their work completely on their own. This theme further highlights the skills participants described as developed in isolation as a means to survive and the culture of silence surrounding crisis work. Despite their best efforts to protect themselves from the harsh realities of crisis work, the collective narrative climaxes with the theme *The Cases They Carry*, which reveals the remnants of crisis work, heavy emotional loads composed of shock, disbelief, grief, trauma, powerlessness, and self-doubt but also gratitude, humility, sensitivity, and hope.

The story's falling action consists of participant accounts of what sustains them in their work with clients experiencing behavioral health emergencies. It is important to note that the collective narrative is not linear but rather iterative in nature, with participants describing the rising action, climax, and falling action of this storyline in recursive terms. In the sections that follow, I detail the collective narrative that took shape across participant interviews by describing the three primary themes that emerged from this research, *The Dance of Crisis Work*, *In the Quiet Room*, and *The Cases They Carry*. The story begins with the theme *The Dance of Crisis Work*, a theme that highlights the complexity, movement and rhythm of working with clients experiencing behavioral health emergencies.

### **The Dance of Crisis Work**

I like emergency services.

I like acute care, I guess. But

I like working in a fast-paced environment.

I think that in emergency services and acute care you get a variety of patients too. Like, I'm not stuck to just seeing peds or adolescents, or, you know, even just like, general adult patients, you know?

I get patients anywhere from, you know, six years old to like, 99.

- Participant 6

Participant narratives referred to crisis work as complex and multidimensional, accounts that were often reminiscent of how one might describe a complicated dance. Although body language of any kind can be emotionally expressive, the practice of dance is characterized by the dancer's use of conscious and intentional movement. Participants very much referred to their work in this way, describing a very deliberate approach while also recognizing that their positions allowed them to bring their own styles and personas to it. The comments of participants suggested that they knew the rhythm and complexity of crisis work; however, they were also keenly aware that the steps did not always remain the same and were dependent on context and

partner. Sometimes their dance steps were regimented, adhering to a strict choreography. At other times, they were looser, more interpretive, and improvised. Participants described *The Dance of Crisis Work* as both the reason for and the outlet by which they were able to express themselves. They alluded to a dance that required them to twirl and leap along a continuum of connection and disconnection, work that simultaneously hardened and softened them.

Participants danced in time with their clients, tasked with connecting with individuals experiencing behavioral health emergencies quickly and on a very deep level. Their accounts also revealed their connections with themselves and their own responses to the work sometimes occurred more superficially, a kind of estrangement from their experience that enabled them to continue functioning despite the stress of their positions. They described a fusion of both the technical and artistic elements of crisis work, a kind of stepping through a series of movements full of beauty, rawness, and grace. Participant narratives also revealed a sense that they were well aware of the risks involved in crisis work. Yet, they also knew that stepping perilously close to the edge is simply just part of *The Dance of Crisis Work*.

In an attempt to more fully understand the meaning-making process of crisis counselors, I explored what drew participants to a line of work that is so often considered undesirable. Crisis counseling is a specialty area rife with emotional labor and the potential for great ethical and legal liability. Participant narratives revealed the emotional labor involved in crisis work, a task that required them to regulate their own emotions and emotional expression as a requirement of their job (Hochschild, 1983). Participants were tasked with maintaining a calm façade while managing their own intense cognitive and affective responses to clients experiencing behavioral health emergencies. In doing so, participants engaged in what is known as surface acting, a task

that results in emotional dissonance between their inner emotional experience and the emotions that they display during a given interaction (Miller & Sprang, 2017; Zapf, 2002).

Crisis counseling is a specialization that often requires counselors to work long hours, undesirable schedules, and, at times, in dangerous and unsanitary conditions. Overwhelmingly, participants discussed that their interest in crisis work stemmed from a desire to participate in a fast-paced environment with high-risk clients exhibiting severe symptomatology. Participant 3 shared: “I think initially, what drew me in was really more the adrenaline of it, high acuity cases. There's something very fascinating about that and seeing more severe pathology, especially when I was younger and newer in my career.” Participants often made reference to the fact that engaging in crisis work gave them a kind of high unparalleled by what they would encounter in other treatment settings. Participant 6 described her love for the “hustle and bustle” of crisis work, while Participant 1 mentioned the “excitement” and “stimulation” he gets to experience in his position and the joy he receives from working with diverse clientele. Participant 8 also discussed his love for the unpredictability of crisis work, the fact that no two cases or days are the same: “Everybody's story is different, for the most part, and every day is different.” Similarly, Participant 4 described the excitement of “truly never knowing what I'm going to get when it [the client] walks in the door.” This exposure to varied clinical presentations coupled with the unpredictability of crisis work excited participants and resulted in an effect that almost bordered on intoxication. The enticing qualities of crisis work even left Participant 1 wondering whether he would ever be able to adjust to the “monotonous” nature of working in an outpatient setting, forced to discuss “really kind of like mild stuff about relationship challenges or stuff like that.” The allure of crisis work very much hinged on participants’ desire for intensity and dislike for the mundane. Participants also valued the opportunities crisis work afforded them in terms of

deepening their rapport building skills. Collective participant narratives described the stage that crisis work sets for them in terms of their ability to connect emotionally with diverse clients.

Participant 4 shared:

That's the best part of the emergency room. Not a single day is the same because today I may have had four depressed people. But tomorrow, I may have two acutely psychotic people. And last week, I had, you know, three postpartums. And so, every day is different. And you're moved in a variety of different ways emotionally, which I think is probably the neatest thing about it, you know?

All eight participants described the importance of being able to quickly connect and develop trust with clients in order to be successful in their positions.

The comments of participants also suggested that crisis work is very much an intellectual pursuit for them, motivated by curiosity and a desire to learn. Participants discussed the benefits of exposure to varied clinical presentations and the ways in which this enhances not only their assessment and diagnostic skills, but also, as Participant 5 noted, their ability to understand the connection between mental and physical health symptoms. Working alongside medical personnel broadened participants' understanding of the etiological factors involved in particular clinical presentations, as well as how to distinguish between symptoms that have psychiatric or organic origins. This quest for knowledge was also evident in the ways in which participants described their experiences of assessing clients and formulating treatment recommendations. Participants in many ways likened themselves to detectives, tasked with cracking a case by piecing together bits of evidence, including a client's current symptoms and clinical presentation, personal and family history, and information gleaned from collateral sources.



Participants frequently referred to crisis work as complex, requiring a lot of skill and attention to nuance. Participant 1 articulated the tendency of newer crisis counselors to be very “formulaic” in their approach, while Participant 3 mentioned the dangers of adhering to a strict “algorithm” when conducting risk assessments. Participant 8 also explained the need to tailor each assessment to the individual client, keeping in mind that a “cookie cutter” approach only sets the stage for a poor interview. Participants appeared to be nodding to the notion that a fundamental aspect of crisis counseling is remembering that a “one size fits all” approach is not possible. Participant 1 additionally cautioned that with an over-standardization of protocol, the “art” of crisis work can be lost. The comments of participants suggested that they took pride in their profession and felt a sense of responsibility to the clients with whom they work, many of them mentioning how important it was for them to do everything in their power to advocate for their clients. Participants in many ways described the work as a complicated, sometimes choreographed, sometimes improvised dance, merging technical assessment skills with a sense of empathy and creativity.

Participants were also careful when describing their interest in crisis work, wanting to make clear that although they enjoyed the fast pace and exposure to severe psychopathology, their attraction to the subspecialty was not based in voyeurism. The comments of participants often suggested how much they valued not losing sight of the human side of the work, an understanding that the clients with whom they come in contact are suffering and that their pain always remains palpable to them. Participants recounted a kind of beauty in the rawness and vulnerability of crisis work, a different sort of intimacy they enter into during what is often the worst or darkest time of their clients’ lives. Participant 7 described crisis work as “humbling,” an environment that requires you to never lose sight of the client’s experience and to remember

what it must feel like to “sit in the other seat.” Participant 2 also explained the importance she places on treating clients with dignity and respect, while Participant 1 cautioned about the need to remember that when “you're working with somebody that they are somebody's mother or father, son or daughter.” Participant 3 talked about the realization of the pain of some of his clients:

It's someone who's suffering who can't make sense of reality or doesn't, you know, can't distinguish between reality and the sort of psychotic state they're in. You sort of get the sense of the amount of pain that must be for that person. If you spend some time with them, you get more of that underlying pain or confusion. And, you know, you start to realize what a horrible state it is for someone to live life in that way. Even some of your characterological disorders who drive a lot of us sideways because of their presentations. When you really spend time thinking about the internalized state they must always be in, it sticks with you for a while.

The comments of participants suggested that they were keenly aware of both the fragility and the strength of their clients, and that in many ways they view the intense connections they share with clients in crisis as sacred.

Participant narratives often seemed to suggest that crisis work allowed them to enter into their clients' worlds differently than they would in other treatment settings. They spoke about how crisis counseling requires that they work to unearth aspects of their clients' experience that are often deeply buried beneath the surface. Participant 6 described the vulnerability her clients display as a kind of “unfolding” and, with it, the realization that she then becomes the keeper of these intimate disclosures. Participant 1 talked about the conflict crisis counselors sometimes feel in having to use what a client has disclosed “against” them when determining their disposition,

the decision about whether they will be admitted for inpatient treatment or discharged to the community with referrals or linkages to appropriate services. He described it as a process involving “seduction” and then, at times, “betrayal.” In his description of the crisis assessment, he explained that as a crisis counselor, he often asks clients to reveal their “deepest, darkest secrets,” to expose parts of themselves they may have long kept hidden from the outside world. Participant 1 explained that as a crisis counselor, it is sometimes necessary to advocate for clients in ways they may not always agree with, such as recommending inpatient admission when a client is not voluntary for services. He recounted that these interactions can sometimes feel duplicitous:

To get a good read on somebody and to get a true sense of their internal thought process and psyche you need to, there's like that seduction to get there. But the problem is, once you get there, and they start being honest, and giving you that information, it's then what you have to do with it as a crisis counselor, and sometimes it feels like a betrayal.

Participants clearly understood the seriousness of their positions as crisis counselors and the potential consequences of their decision-making. Participant 5 referred to the burden of responsibility such a position entails, frequently referring to the work as “serious.” Others described it as “heavy,” “intense,” and “draining.” Perhaps most apparent in participant narratives was the sense of isolation they feel in their positions, a fact that emerged as one of the main themes of this study, what I refer to as *In the Quiet Room*.

### **In the Quiet Room**

I kind of got thrown to the wolves.  
I mean,  
I just felt like  
I have this master's degree now.  
I've been through internship.  
I've worked in a psychiatric inpatient unit

I felt like  
I should have been prepared, but  
I didn't feel wholly prepared.

- Participant 1

Also referred to as seclusion or time-out rooms, quiet rooms involuntarily isolate and confine a client to a specified space with the goal of reducing behaviors that may result in harm to themselves or others. The use of quiet rooms in psychiatric settings is controversial and has been shown to result in both physical and psychological injury, including significant trauma (Askew et al., 2020; Knox & Holloman, 2012; Ponte, 2019). Participants were in many ways placed in their own metaphorical quiet rooms, secluded during perhaps their most difficult moments as crisis counselors, left to their own devices to deal with the emotional complexities of their work. Participant narratives detailed this sense of involuntary isolation, the times in which they were forced to contend with the difficulties of crisis work without support. They described feeling unprepared and often siloed in their positions, left with only the skills they had developed on their own to use when faced with difficult situations. Like clients secluded *In the Quiet Room*, participants were left to their own devices to self-soothe, at times faced with unsettling thoughts and overwhelming emotions. While alone *In the Quiet Room*, participants made attempts to cope with the challenges associated with crisis work, a sub-theme I refer to as *Makeshift Psychological PPE* that I discuss in the next section of this paper.

All of the participants discussed feeling ill-prepared by their graduate training for work in a crisis setting. Each talked about the brief overview they had gotten of how to conduct a risk assessment, noting that the material was often introductory and insufficient for use with real clients. Participant 2 described it as “really kind of sad. I think it's...you really don't get much in graduate...you don't get any training in that whatsoever. If you do, it's extremely rudimentary.”

Similarly, Participant 5 recalled: “I got some training in crisis intervention. Very brief. There was like an extra, an elective course, that you could take for crisis counseling, but it would never run. Like they would never offer it [Laughter].” Participant 6 also described feeling dismay that her master’s training “didn’t really prepare you for the real world.” The comments of participants suggested that much of their training and preparation for crisis counseling occurred on the job in real time. As Participant 8 described, “It was really trial by fire.” For Participant 7, although his schooling did not leave him feeling prepared for crisis work, he explained that “the true training comes by just doing it.” Participant 4 shared a similar sentiment, explaining “specifically for crisis, other than the occasional class I may have had, all the training I got was really on site.” Participant 5 also described her experience as a lot of “hands on training” and “learning as I go.” Interestingly, participants described this sense of being ill-equipped as sort of a double-edged sword. On the one hand, they felt unprepared and caught off guard by the work. On the other hand, they took pride in their ability to figure it all out, developing the skills on their own they needed to successfully do this kind of work.

Unfortunately, the feeling of being ill-prepared did not solely apply to participant training and preparation for crisis work. Participants described a lack of formal clinical supervision within their crisis settings, leaving them without the time or space to process the intense emotional work they do on a daily basis. Many of the participants discussed this lack of support facetiously, using humor to deflect how truly challenging it was to face this kind of work on their own. Participant 8, who had experience working in multiple screening centers and affiliated emergency service departments, shared: “I've never worked at a screening center that's had any kind of supervision, like a working model for supervision, it's always...it's never been the case ever, anywhere I've worked.” Participant 3 also discussed the lack of supervision in crisis work:

And those settings, by nature just don't have any type of supervision structure for clinicians. You're just sort of, you know, "just do a job, just go in and do it." And, you know, I think it's a real deficit in crisis programs, because the culture that arises out of them is, the staff have been there a long time and get used to not having that.

Participant 3 went on to describe the lack of supervision as being so commonplace, in fact, that the silence around processing cases may actually become baked into the culture: "When you try to do supervision with crisis people, they all buck and they get like, you know, wild and like, why are we doing this?" This culture of silence was reflected across participant narratives, an unspoken consensus that to speak of the emotional challenges of crisis work was to show weakness. Participant 2 noted that although she did receive administrative supervision, a formalized clinical supervision structure did not exist within her department. Many of the participants noted that the structure and fast-paced nature of crisis work does not allow time for processing and reflecting on their experiences. Participant 4 mentioned the toll this can take on crisis counselors: "I don't think a lot has been done about how to take care of the staff when they're the front liners dealing with this thing, day in and day out." Participant narratives also revealed the difficulties associated with not having an outlet supervision might provide to process the intensity of crisis work. Participant 6 stated: "Once you get home, it's kind of swept under the rug until the next day I go back to work. So, I'm not taking the time to reflect or process or think about these things. I don't really do it." Similarly, Participant 3 expressed the challenge of having to quickly transition from one task to another within the crisis setting, which does not allow for the time or space needed to reflect upon and make sense of the emotionally charged work:

You have patients who are acutely agitated. Patients who are, you know, just in general, extremely difficult to work with or hostile towards you, or events of physical takedowns or physical assaultiveness. And then sort of having to basically brush those episodes off, you know you put someone in restraints and then literally have to just sort of brush it off and go back to answering the hotline or seeing the next person. All these things I think they add up over time. And you don't get a chance to realize them when you're in the middle of a busy shift. And if you're in a constantly busy shift, you just end up coming home with that stuff day after day.

Although participants described a culture of silence and isolation, the emotional toll of crisis work was also apparent in their stories. As a means of coping with the intensity of the work, participants described a variety of coping skills they developed to protect themselves from these experiences. In the section that follows, I discuss the techniques participants described to distance themselves from the intensity of crisis work. These skills were not taught but rather were developed out of necessity for each participant *In the Quiet Room*.

### ***Makeshift Psychological PPE***

I don't...  
I feel like the longer you're in the profession, the more you...  
I don't want to say numb to it.  
I'm never numb to it. That, that sounds, you know, indifferent.  
I definitely,  
I just forget the stories a lot quicker.

- Participant 8

Personal Protective Equipment (PPE) is designed to minimize exposure to a myriad of workplace hazards. Participants discussed using a variety of coping mechanisms they each developed while *In the Quiet Room*, a sort of *Makeshift Psychological PPE* they utilized in an effort to safeguard their own mental health. Given that this study was conducted during the

height of the COVID-19 pandemic, it seemed fitting to refer to these coping mechanisms in this way. These techniques were developed in isolation, an attempt by participants to protect themselves from the emotional toll of crisis work. To function effectively, however, PPE must fit properly and be utilized correctly each and every time the wearer is vulnerable to potential injury or infection. Sufficient training and practice are essential for both donning and doffing physical PPE in order to minimize possible exposure. Unfortunately, participants received no such training in how to use psychological PPE and instead were forced to make do with their own impromptu strategies.

One such technique participants frequently mentioned was the need to have “good boundaries” in crisis work. Participant 2 noted that having firm boundaries is “something that all of our staff build at some point. If they don't have that, they either figure out how to do that or they don't last.” She went on to explain:

I think you need to be able to...not barricade yourself, but kind of just like be able to wall yourself off to not respond emotionally to what's happening. And you need to be able to not take cases home with you. Because if you don't have a way to kind of get away from it for a bit, you're just gonna burn out way too fast.

Participant 4 also described her tendency to separate her personal from her professional life. She explained that this was a skill she developed out of necessity, a means of “managing my own stress level, my own anxiety, my own fear, and my frustration.” For Participant 5, choosing to forget certain professional experiences helped her to cope with the emotional labor involved in crisis work. She explained that she frequently compartmentalizes what has happened during her shift in an effort not to “bring all of this home with me.” Likewise, Participant 6 noted feeling “like I do a good job of like, keeping work at work and like, still like keeping my home life at



home.” Each participant described the importance of keeping their personal and professional lives distinct from one another, acknowledging that allowing any crossover could spell disaster.

Participants also described ways in which they dissociated themselves from their work in screening centers or affiliated emergency services. The comments of participants suggested that without the ability to remove themselves to an extent from the work, they would not be able to function in their positions. Participant 2 mentioned that for those who become too emotionally enmeshed with clients, it becomes too much for them and they are unable to continue in crisis work: “We've had people not make it through training because they just, they feel like emotionally, it is too much for them. They connect too much to the consumers.” For Participant 6, she described this as an ability to “emotionally shut off” as a means of protecting herself from the sometimes disturbing experiences of crisis work. Similarly, Participant 1 talked about choosing to forget certain clients or situations:

So, when I swipe out of work, I think my mind, just like, it's like that, the thing in *Men in Black*, where you kind of just like erase somebody's memory. You just, I mean, I think it's my own defense and coping that I have developed over time because I think if you brought that stuff home with you every day you'd be so burnt out and just emotionally exhausted. So, I think I've gotten really good at that.

This kind of motivated forgetting was present in many of the participants' narratives, some describing clients or cases that became a “blur.” These comments suggested that in order to continue in this line of work, participants' brains had adapted by dulling the memories of client stories and interactions. For Participant 1, crisis work conditioned him to be less reactive:

My neurons aren't like firing the same way they used to. So, it's like, you're used to seeing so many disturbing things. You know, when basically my brain has been able to

retrain itself so that when somebody is like yelling and screaming in my face, that I'm not getting the same firing of neurons.

Participant 3 noticed that participating in this study brought up “stories that are always kicking around in my head,” experiences he is normally careful to not keep in the forefront of his mind. Participant 5 described her 45-minute commute home as an opportunity to reflect on the day so that by the time “I'm home, I'm like, good.” Her drive seemed to function as a transition ritual of sorts that helped her to shed the stress of the day by taking the time (in isolation) to reflect on what had transpired. As participants became more experienced, and, in many cases, desensitized to working with clients experiencing behavioral health emergencies, some described feeling that some cases started to “blur together.”

Another method participants used to distance themselves from their work with clients experiencing behavioral health emergencies was to intellectualize cases, or, at times, refer to client stories in very clinical terms. The comments of participants often suggested that using thinking as a means to avoid feeling enabled them to return to crisis work day after day. Participant 2 explained that focusing on her own curiosity helped her to avoid becoming emotionally entwined with clients: “I just get very interested in a clinical sense and that kind of overpowers anything else.” By distancing themselves from the affective elements of their work, participants described the ability to address client situations more purposefully and rationally. While discussing specific cases, participants frequently discussed the “clinical” of the case rather than the emotional reactions they had to them. Some even had difficulty accessing their own emotional states when asked to speak about them.

A final coping mechanism participants used as makeshift psychological PPE was humor. Participant 7 described bonding with coworkers over their “sick sense of humor.” He explained:

“we would find the sickest things to talk about. And, and it, it, it lightened up things, and it gave a different slant on things.” Similarly, Participant 6 described the importance humor has in helping her to cope with the work:

We work in such an emotionally draining, maybe even physically draining, you know, job and I could not do it without the staff that I work with. My coworkers, the psychiatrists, you know? We use a lot of humor. And that probably makes it, you know, it helps for sure. To get you through the day and to not...Everything's always so serious. Not everything's about like wanting to kill yourself, you know? And taking, making things a little bit lighter.

Participant 3 spoke about how humor in some ways allows him and his coworkers to process emotional trauma without actually having to talk about it: “So, I think that humor gives you that sort of chance to decompress and bring some of these things out in the open without being like, hey, let's really talk about this.” Likening the culture of crisis work to that of law enforcement, he reflected on how openly discussing the emotional difficulties of crisis work is taboo: “You can make a joke about it and that's sort of a way to decompress. But God help you if you're like, ‘I'm really struggling with this case.’ Like four people would roll their eyes and tell you to quit.” Again, the culture of silence is apparent in his description of this form of makeshift psychological PPE. Humor represents yet another method of consciously removing themselves from the emotional aspects of crisis work, what seemed to be an almost necessary skill for participants.

In becoming more experienced with crisis work, participants found that they took fewer cases “home with them.” Unfortunately, as is also the case with physical PPE, the use of their makeshift psychological PPE was not foolproof, and, in some instances, not enough to protect

participants from experiencing the negative effects of crisis work. It was these cases that regardless of years of experience, participants all identified as triggering or otherwise touching to them. In the section that follows, I discuss this as the third overarching theme of this study, what I refer to as *The Cases They Carry*.

### **The Cases They Carry**

I think in the moment they stay with me, um, they inform my future.  
I find it very difficult to believe that you can do this work and not be touched in some way.  
You have to be or else you're not human.  
You're touched by the sadness,  
You're touched by the anger,  
You're touched by the violence, the agitation, grief, whatever it may be,  
You're touched in some way.  
Now what meaning you attach to that, that's, that's a whole other thing.

- Participant 4

Regular engagement with clients experiencing behavioral health emergencies exposed participants to acutely stressful situations involving high levels of emotional distress brought forth by their clients and their own individual experiences. In circumstances where their use of the makeshift psychological PPE they developed *In the Quiet Room* was insufficient, participants described the weight or heaviness of the work as *The Cases They Carry*. Participants used a variety of linguistic devices when describing the emotional impact of certain clients or cases, many of which remained with them long after their shifts had ended. Some participants described these as cases they “carry” or that “stay” with them. Participant 6 described the burden of carrying these memories: “Um, but like, it's just, you'll never forget it. That moment, that feeling, that experience, that conversation, that hand holding, you know, or whatever it was. You just don't forget it.” Participant 3 talked about cases that “leave a mark,” as well as the ones that “follow” him in his work. Likewise, Participant 4 described the ways in which certain clients

impact her and influence the way she conducts herself in her work moving forward: “You take it with you and you, you hold on to it. It motivates you for the next patient that comes your way. What you could have, should have, would have done differently.” Each participant described something abstract they retained from the experience of crisis work, an intangible cargo packed deep within their psyche. Participants described a variety of cases they carry with them, personal accounts of clients, circumstances, and interactions that fit into the three categories I describe in the sections that follow.

### *Striking a Personal Chord*

I don't know.  
 I mean, it's funny.  
 I had like three Hells Angels at my wedding.  
 I'm not ignorant to that world.  
 I mean  
 I was in that world.  
 I've been in fistfights here and there over my life.  
 I know about that world, but then on the opposite side  
 I'm very quick to start crying when  
 I see genuine sadness.  
 I see, you see it a lot.  
 I've welled up when I've been talking to somebody, or when  
 I come back to discuss the case with a coworker or the doctor.  
 I'll be halfway through talking about the case and  
 I'll just, like start tearing up and  
 I've got to go to the bathroom or something like that to wash my face or something like  
 that. So yeah, it does take an emotional toll. Yeah.

- Participant 7

In telling the stories of their work with clients experiencing behavioral health emergencies, participants frequently discussed the emotional labor of their positions and the ways in which they were touched on a personal level by their clients. Participants noted, in particular, the difficulties of working with cases that strike a personal chord with them. Oftentimes, participants talked about the effects of working with a client whose story or

circumstances hit “close to home.” In these cases, participants were affected deeply by their clients on a personal level, causing them to feel unsettled and uncomfortable. For Participant 1, the challenges of working with clients who have recently experienced the death of a close family member sometimes felt overwhelming:

I've had loss in my life when I was younger. Someone really close to me in my family.

And I would say those moments are probably the most triggering.... If it's a situation that I can relate to, or if it's like a mother grieving their son...those are two situations that are sort of triggering for me, and I don't even like to have to be involved in those situations, ideally.

Similarly, Participant 4 mentioned the difficulties she faced the very first day she returned from bereavement leave following the death of her mother. She described meeting with a client who, after more than a year, had still not been able to come to terms with the death of her mother:

“And here I am trying to interview and do an assessment on this woman. She has no idea what's been going on with me. But here I am trying to assess this woman, while I'm still grieving.” For Participant 4, assessing that woman that day was in many ways like looking into a mirror; the pain her client felt was just too similar to her own. Participant 2 shared a similar sentiment in her discussion of how her own mental health history gave her a window into the experiences of severely depressed clients: “I know what it's like to be very badly depressed. And I don't want people to have to go through that.” Participant 7 also shared how his personal life experiences and struggles with his own mental health impact him in his work as a crisis counselor. In telling his story, Participant 7 also articulated how his ability to empathize with parents who had recently lost a child increased after the death of his own son. His experiences with clients presenting with suicidal ideation as a result of their immense grief was something that he, in

some ways, could understand due to the depth of his own pain. He stated simply: “so those things hit home.” Participant 5 also shared her observations of how close-hitting cases impacted her coworkers. In recounting the aftermath of a shooting that killed several people and wounded several more, she shared what it was like to see her coworkers, many of whom lived in the same community, respond to the tragedy. She discussed the impact it had on her to be able to feel useful during that time: “There were a lot of different reactions. So even just to be able to, like support one of my coworkers who's like, ‘I really can't do this. Like it's just too hard on me right now.’” Participant 5’s recollection demonstrates the vulnerability crisis counselors face in going to a job everyday knowing that today may be the day they see their own personhood and experiences staring back at them. It is that same thrill of “never knowing what you get when it walks through the door” that leaves these crisis counselors open to unexpected countertransference and emotionally triggering material.

Participants also discussed the struggle involved in working with clients whose stories reminded them of the fragility of someone close to them. In these situations, participants discussed cases that reminded them of what could potentially befall their loved ones. For example, Participant 4 discussed the difficulty she faced in working with youth when she had children of her own: “I think anything that involves children, I think is, is, not that it's harder than adults. It's just very different. And when you have children of your own, it just hits you in a more, in a very profound place.” For some of the participants, working in a crisis setting was a constant reminder of mental health’s fragile nature. Participant 6 detailed this very idea: “I think that people think that psych patients are like, you know, it's a taboo, right? But in reality, it could be your best friend, it could be, you know, your, your mom or anyone.” Participant accounts seemed to suggest that the experience of coming face-to-face with the unimaginable so regularly

made them more sensitive to the possibility of catastrophe. Perhaps it is because of the intimacy crisis work requires that participants were reminded of the precarious nature of mental health, that at any moment someone for whom they care deeply could suffer a behavioral health emergency of their own.

Some participants also described the gravity of engaging in work that often requires them to make life or death decisions. Participant 2 shared: "I mean, there's definitely been consumers where I've seen them and like, I discharged them because clinically, it makes sense for me to discharge them. But I had that thought, like, was that really the right decision?" Similarly, Participant 4 recalled often telling herself: "I need to make sure that I don't make a bad decision." She explained the importance of processing every case to make sure she is not "blindsided by something that I didn't pick up on, or I didn't see." In some cases, participants reflected back on their interactions with clients, asking themselves whether they did enough. Participant 3 spoke about a case he was involved in early in his career as a crisis counselor. He recalled meeting with a client who was transported to the ER after expressing suicidal ideation while intoxicated with alcohol. Participant 3 described that at the time he felt "there was some sense of improved hopefulness in his [the client's] point of view," and that after some convincing the man consented for voluntary admission. Tragically, the man hung himself two days later while on the unit. One of Participant 3's *I Poems* illustrates the anguish and self-doubt he felt upon learning that the client had killed himself:

I can still remember talking to that individual.  
I think did  
I do enough? Could  
I have done more to reach that person? Could  
I have said just one more thing that maybe would have negated or driven that drive  
towards suicide out of their mind in that moment?  
I think cases like that stick with you because it's always a question of did  
I miss something?



I think as seasoned as you get...It still lingers with you years later.  
I still think about it.  
I can still picture the person in my head.

For Participant 3, feelings of self-doubt that perhaps he could have done something differently to prevent the untimely death of his client still haunt him even ten years later. He lamented, “whatever I said was lasting enough to get them to sign into a unit, but not lasting enough to get them through two more days. So that's, I think, what stays with me and follows me.” In recalling the cases they carry, participants often described what seemed to be experiences that will forever remain frozen in time in their minds.

### *The Psychological Residue of Exposure*

I think it's powerful.  
I think you, you know, some cases stick with you because of the horrible outcome, you know? But when  
You really start to think about it, there's probably a thousand other cases behind that case that are still kicking around in  
Your head that have never really gone away.  
I think these are the questions that  
We don't ever talk about.  
You just don't talk about them.

- Participant 3

Participants shared stories involving both firsthand and vicarious experiences of trauma. According to the DSM-5, a traumatic event involves “exposure to actual or threatened death, serious injury, or sexual violence” through either direct experience or the witnessing of such an event occurring to others (APA, 2013, p. 271). The Substance Abuse and Mental Health Services Administration (SAMHSA; 2020) defines a traumatic event as “a shocking, scary, or dangerous experience that can affect someone emotionally and physically.” Some participants shared experiences that undoubtedly fit into this category. In Participant 8’s accounts, he discussed the need for crisis counselors to be hyper vigilant about possible dangerous situations when

outreaching clients in the community: “There's always the, you know, the threat of weapons and animals and unsafe housing situations.” For Participant 5, feeling unsafe in the aftermath immediately following the shooting described in the previous section, was part of her experience. She described feeling “truly in shock” and concerned for her personal safety during the time that the shooter’s whereabouts remained unknown even though the ER where she worked was filled with police officers. She explained:

So, we were probably the most safe we've ever been. We have cops everywhere. But it still didn't feel that safe. And if I'm honest, we're probably like...our crisis unit is probably the safest because we're a locked unit with no windows [Laughter]. But I still think it's that moment where you're kind of like, "Am I okay? Is this safe? Like, can this get worse than it already is?"

These experiences were further complicated by the fact that participants were left on their own *In the Quiet Room* to process and make sense of these events.

Despite possible risks to their physical safety, participants frequently minimized these concerns when speaking about their work, perhaps indicative of the emotional distance they created through their use of their *Makeshift Psychological PPE*. Participant 1 described himself as “non-reactive,” while also describing the environment of crisis work as “combative.” Participant 2 referred to herself as having a “neutral personality” and explained that her experience working in the crisis setting has “made it very easy for me to deal with a lot of very severe things.” She continued that she tends to be “very apathetic/numb” in her reactions to clients, a comment that echoed back to the *Makeshift Psychological PPE* she had developed *In the Quiet Room*. Participant 7 described the threat of exposure to COVID-19 during the pandemic: “There was like three COVID patients on the unit. And you know, some of these

psychotic COVID patients, they don't want to wear a mask or anything. And, you know, you joke around. You do your best to protect yourself and your co-workers.” This comment too reverberated back to the coping skills he had developed as a means of safeguarding his own mental health. Participant 5 shared: “I'm not like afraid to go to work or anything, but I think sometimes, like, if you, if you even just, like casually share, like, ‘Oh, yeah, like my coworker got assaulted today. He has a black eye’ [Laughter]. It sounds bad.” Participant 6 explained that she does not often feel unsafe at work but feels prepared to handle the possibility of a client who presents as assaultive:

I've never been, knock on wood, in a very difficult predicament where I thought I was in danger. I felt like I've...you know, stand close to the door. You know, I'm able to verbally deescalate if I have to. And if I... if I can't, because the person is, you know, too psychotic or whatever, I have great staff to be there with me if this person does get agitated.

In discussing how safe she feels at work, the language Participant 6 used, as well as the starts and stops to her sentences, seemed to indicate that she recognized that her ability to stay safe during her shifts had, in some ways, been purely a result of good luck. Participant 3 discussed how situations of agitation and violence are just part of “a normal day in the ER.” He described himself as “much less alarmist” and able to maintain “a sense of calmness in situations that may throw people off.” In doing so, he went on to explain the dichotomy of outpatient versus crisis settings and their responses to client behaviors. Recounting the story, he laughed about an outpatient office’s decision to close the following day so that staff could “debrief” after a client presented as “out of control” in the waiting room. Chuckling to himself, he noted the stark contrast of how such an incident would be treated in a crisis setting: “In the ER, you know, we’re putting people in restraints, tackling people in the hallway. And it's literally like, okay, there’s

16-year-old Claire. Who's next?" Again, the comments of participants often suggested that they made light of their concerns and used humor to cope with and make meaning of their work. Their nonchalance further reinforced that a culture of silence had grown out of their time spent *In the Quiet Room*. Participants frequently made reference to the need for clients to be placed in physical restraints or receive intramuscular (IM) medication for the safety of themselves and others. This fact, in and of itself, increases the safety risks to staff in mental health settings as it has been associated with higher rates of injury than observed in those who work in high-risk industries (SAMHSA, 2019).

Although the experience of firsthand trauma arose within some narratives, participants more commonly described the experience of vicarious trauma. As discussed in chapter two, vicarious trauma occurs when therapists "take on" the cognitive, affective, and emotional states of their clients through the process of hearing about their experiences of trauma (Figley, 1995). The enormity of these experiences was evident in one of Participant 4's *I poems* in which she described the night a mother was transported to the ER following the accidental drowning of her two children, ages two and four, in their next-door neighbor's pool. She described the night as "horrific," recalling the "piercing screams" of the mother echoing throughout the ER:

I could hear a mother.  
I remember that night, just oh my gosh, the screams.  
I can still hear the screams.  
I remember that night, sending a note out to my girlfriends that had young children.  
I remember saying, just remember to hug your kids tonight. Just remember to do that.  
Because tonight, some mom is not gonna be able to do that.  
I'm getting all teary-eyed talking to you about it.  
I carry that with me. I carry that with me.

The repeated exposure to the painful and graphic stories of their clients often resulted in participants feeling overwhelmed with exhaustion, what Participant 4 described as being "emotionally just saturated." Participant 6 also described the effects of secondhand trauma, even

in cases where she herself did not meet with the client individually. In retelling the story of a coworker's client, she explained that her whole department was impacted by the client's story that day. She described a young woman who came to the ER struggling on the day that marked the anniversary someone broke into her house, murdered her father, and brutally raped both the client and her sister in front of their mother. Participant 2 also shared a story that exposed her vicariously to the trauma of a new mother. She described the night a woman was transported to the ER following the death of her infant child: "She was breastfeeding the infant while intoxicated and somehow the infant died while still on her chest." Participant 2 recounted feeling that the woman was "very clearly dead inside" during the assessment, noting that the "severity" of the case caused it to "stay with her." Likewise, Participant 8 explained that because of the frequency with which he is exposed to varied clinical presentations, it is the "shocking" and "extreme" cases that stand out to him. Because he feels he has "seen or heard it all," Participant 8 reported feeling that it is the cases that are "above and beyond, which I can't even imagine or haven't seen before" that are the cases that "stick with my memory" and truly "resonate" with him. For Participant 8, one such story involved a woman in her sixties who was brought into the ER in a fugue state. In retelling the story, he recalled that the woman had never spoken about the incest she experienced as a child, but while in the fugue state had "regressed back to age five." The woman was admitted to a psychiatric unit on two occasions but ultimately killed herself after writing "a suicide note as if she was a five year old." Participant 8 stated that he felt the case "stuck" with him because it was unlike anything he had ever witnessed. In recalling these stories, participants frequently spoke very clinically about their respective cases, again pointing to the makeshift psychological PPE they had developed in an attempt to distance themselves from the gruesome and shocking details of their clients' experiences. This was something many

of the participants did while recounting their interactions with clients, an action that appeared to help them cope with the extreme and disturbing stories to which they are so regularly exposed.

### *Moral Injury*

I feel like  
I'm pretty good about holding space for people.  
I noticed that when  
I do, hold it with me, and like, it'll kind of be on my mind for like, a few days afterwards.  
    It's usually when  
I feel like the system is failing them. Like, it's usually when  
I feel like we're not able to do anything to help them.  
I know that they're not going to be in an ideal situation.

- Participant 5

Participants often described the importance of doing what they felt was “right” in their work with clients experiencing behavioral health emergencies. Cases or situations that involved either having to go against what participants felt was “right” or those in which they bore witness to such acts were often deeply embedded in the stories of *The Cases They Carry*. Participants frequently made mention of the frustration of working within a “broken system,” one that does not always put the needs of the client first. In doing so, participant narratives frequently alluded to a syndrome originally identified among war veterans, the experience of moral injury. Moral injury occurs as a result of “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 700). For those that work in mental healthcare, perhaps the most fundamental moral belief is that the needs of the client should come first. In situations where participants felt either limited or unable to advocate for the best interests of their clients, they reported feelings of frustration, anger, sadness, and powerlessness.

Participants frequently described situations in which they felt limited by the bounds of their positions, frustrated by the hierarchical structure of the mental health system and the

demands imposed on them by various stakeholders. Participant 1 explained: “There's the governing system of a hospital and all the protocols that they have in place and things like that, but sometimes there are more higher level...like value, like a value system that I operate under.”

Participant 7 described the frustration associated with having to work in a system in which clients are not always able to get the services they need because of the obstacles created by insurance companies. He explained that at times he has had to “embellish” a client’s symptoms in order to have their hospital stay approved. While recalling a recent occasion in which he had to fight for prior authorization for a 21-year-old suicidal client’s admission, Participant 7’s dismay was readily apparent:

What I had to do is...I had to embellish, okay, the case. Meaning that I had to embellish her suicidal ideation. I had to embellish the violence that she displayed last night during the argument with her mother and stepfather, okay? So I did all this stuff and I don't like having to do that. But if it means me getting authorized in order for this poor girl to get the help that she needs, okay, then I'll do it. Okay. But I don't like doing it. You know, it's, it's a bullshit way of getting help for people.

In retelling the story, Participant 7 was unable to hide the frustration he felt that even after everything he went through to advocate for the client, the insurance company approved her for a mere two days on an inpatient unit. At times, participants tipped the scales of justice by doing what they felt was necessary to protect and advocate for their clients. In these cases, participants referred to “workarounds” they had developed in response to what they perceived as a “broken system.” Participant 1 also recounted the anger he felt when insurance companies refused to approve clients for the treatment they so desperately need. He described these situations as having “a clear right and wrong,” stating “sometimes we need to take the hit when it comes to

insurance reimbursing, or if my boss is gonna, like, get on my case about it, because their length of stay went up an extra week.” For Participant 3, part of his disenchantment in crisis work stems from wondering whether it is always the client’s best interests that motivate the decision to hospitalize them. On numerous occasions during the interviews, he grappled with this question, pointing out that the decision to admit a client can sometimes instead be made to mitigate potential clinician or hospital liability. He described feeling like his position as a crisis counselor can sometimes feel rote or mechanical as a result:

But yeah, I think there is this constant...you put, it's sort of like Sisyphus. You're pushing against this rock that's just gonna keep coming back down. So funny. So like, you know, maybe every now and then you get a case that you feel like you really did something and that stays with you in a good way. But then there's all these other cases where you just sort of feel like you're almost in the factory after a while, like okay, here comes the assembly line.

Participants often described this same sense of disillusionment as a result of the limited power or authority they have in their positions. Participant 5 noted that regardless of her opinion about a case, “it is ultimately the doctor’s decision.” Participant 2 described what she sees as “a lot of black-and-white rules” designed to limit liability but that do not always create the best outcomes for clients. She explained that sometimes decisions “look good on a piece of paper” but disregard “all these mitigating things we can do instead. And I feel like they [higher ups] are not as willing to see that part because they're much more [concerned] about the liability.” One of Participant 2’s *I poems* highlights this sense of powerlessness:

I ended up seeing her and we ended up committing.  
I didn’t totally agree with it.  
I know my supervisor wanted me to commit.  
I ended up recommending commitment.



I mean, still today  
I don't,  
I don't really think it was the right decision.  
I don't think I really pushed for it.  
I was much quieter back then.  
I think it was more just, "Okay, well this is my job."  
"I'll just do it."  
I'm much more vocal now.  
I think  
I feel  
I have more power to be vocal now.  
I'm not just a line staff member.  
I'm actually management.

Participant 2's recollection of having to disregard her own feelings about what was best for her client in favor of what her supervisor instructed demonstrates just how profoundly the wound of moral injustice can ache.

The moral injury participants exhibited did not necessarily occur as a result of isolated situations. Instead, the experience of moral injury was often insidious and amassed over time through repeated exposure to moral injustices. For example, participants frequently described the experience of moral injury in witnessing the mistreatment of clients or the mishandling of client behaviors. Many of the participants discussed cases or situations in which clients were treated disrespectfully or dismissed as being "just psych patients." Participant 3 explained:

Most medical professionals, and just the medical setting in general have very low thresholds for tolerance of behavioral health patients, let alone behaviors exhibited by certain pathological or characterological patients. And what you end up witnessing is just really poor interactions that you know are going to eventually culminate into an episode of agitation or self-harming or some type of just episode that could have been avoided simply by someone intervening sooner.

Similarly, Participant 4 described the frustration of witnessing clients whose physical symptoms or health concerns were dismissed by medical personnel as being part of their psychiatric presentation. She explained: “So that's, that's a challenge for me is negotiating the competing needs and the competing demands, when you have so many different teams working together on just one single patient.” Similarly, Participant 8 described the outrage he felt that security guards frequently looked at his clients “like second-class citizens.” Likewise, Participant 5 noted “a lack of tolerance” for behavioral health clients in the ER, an attitude that she feels has prevented some of her clients from getting the medical attention they need.

A number of participants shared stories in which they felt clients were inappropriately given intramuscular (IM) medication or placed in physical restraints when they could have been verbally de-escalated. Participant 6 expressed the discomfort she feels when clients are treated in such a way:

I think that some of the staff is very quick to, to IM sometimes. Or security is too quick to jump on people because they're not listening or not redirectable or what have you. And when I find that that's happening, or I see it personally, I get...I get upset. Because, you know, there should have been opportunity for verbal de-escalation.

Participant 1 also described the ways in which witnessing such events can be demoralizing. He explained how “it's hard to feel like you're still doing a good job and that you're helping people” when being pulled in various directions by different stakeholders. In considering the possible long-lasting effects an adolescent might suffer in being placed in four-point restraints and administered IM medication, Participant 1 expressed his concerns: “There's times when I... I'll sit there and watch this, and I'm like, this kid's gonna be traumatized. Like, is this really...does this really need to happen? Like, is this really the best way to do this?”

The comments of participants often suggested that they felt ineffectual in their ability to disrupt a system that does not always put the needs of clients first. Participant 8 discussed feeling powerless to effect any real change. He described feeling that attempts to bring his concerns to administrators resulted in nothing more than what he described as “feather stroking.” He explained, “It's usually just like, you know, fixing my ruffled feathers and having me move on, you know? It's not...it doesn't really make you feel better.” Similarly, Participant 1 described at different times feeling like “one small cog in this larger machine” or simply a “puppet” at the mercy of those pulling his strings. Participant 2 noted that sometimes the reason a client is even in crisis is because they have in some way “fallen through the cracks” and had to go without the services they so desperately need:

I think that's something we see a lot in crisis work. Just because I mean, there's a sense of powerlessness just doing it because there's so many consumers we see just because the system has failed them in some way.

The hurt that participants suffered was often rooted in the fact that they routinely experience the inability to put the needs of their clients first. As Talbot and Dean (2018) described, these events equate to “death by a thousand cuts,” small lacerations that eventually amass into the gaping wound that is moral injury.

Participants were not naive to the potential risks involved in crisis work, the fact that the makeshift psychological PPE they had developed *In the Quiet Room* might malfunction or provide insufficient coverage, resulting in *The Cases They Carry*. Yet, something kept them coming back to their jobs in screening centers and affiliated emergency services day after day. The collective narrative pointed to the unexpected benefits of crisis work, the ways in which these experiences enriched participants' lives, both personally and professionally. In the final

section of the collective narrative, I describe the shift in perspective that participants referenced as being significant to their experiences as crisis counselors.

### **A Newfound Perspective**

I think crisis work has made me a lot stronger.  
My empathy is greater.  
My tolerance is greater.  
I can multitask like nobody's business [Laughter].  
I'm a lot more forgiving of people.  
I don't sweat the small stuff. And everything is small stuff. Yeah. Because when you see people at their worst, your life doesn't compare to that. Even on my worst day, I've been so fortunate to not feel like that. You know, so out of control. So scared, so confused, so alone.  
I think that's what crisis gave me. It's made  
Me more humble.  
My life isn't that complicated.  
My life isn't that acute.  
I don't worry about certain things anymore, you know?  
I just,  
I don't.  
I feel very, very lucky and honored that  
I can take care of people in my professional life.

- Participant 4

Although participants frequently discussed the burden of crisis work, they also spoke of the ways it has enriched their lives, a recognition on their part that *The Cases They Carry* are part and parcel of *The Dance of Crisis Work*. Participants recognized that *The Dance of Crisis Work* was repetitious and recursive, that the choreography eventually brought them back to a sense of purpose and fulfillment or they would not have continued its steps. The comments of participants often suggested that the time they have spent working as crisis counselors has not only made them better clinicians, but also, in some ways, better people. Participants frequently referred to feeling “honored” and “humbled” by their work with clients experiencing behavioral health emergencies. Participants frequently alluded to the beauty and intensity of the work, noting that although it can be heartbreaking at times, it can also be incredibly rewarding and fulfilling.

Many of the participants talked about how their experiences working in a crisis setting made them become better clinicians. Participant 1 mentioned how the work has improved his diagnostic skills, as well as his comfort with risk assessment. Similarly, Participant 3 articulated that his experiences as a crisis counselor have improved his interviewing skills, and specifically his ability to work with forensic clients. Participant 6 also discussed how crisis work has strengthened her clinical skills: "I feel like it's exposed me to a lot, and I've seen a lot. I've dealt with a lot and I've...I feel more confident clinically." Participant 2 discussed the ways in which crisis work has made her a better thinker: "I feel like it's made it easier for me to make quick decisions. Like I don't have to like, kind of evolve. I kind of just like, very quickly piece things together, conceptualize things and go from there." Many of the participants spoke about how exposure to varied clinical presentations made them not only stronger interviewers and diagnosticians, but also better rapport builders. Their experiences in crisis work also enabled many participants to feel more confident about working in other treatment settings. Participants discussed how crisis work enhanced their tolerance for certain "buzz words" that many other clinicians might react more strongly to whether out of fear, inexperience, or concerns about liability. Participant 5, who also works in a private practice setting, discussed how her crisis experience benefits her other clients:

Actually, a lot of my clients, have history of self-injurious behaviors or suicide attempts and things like that. And they are, or they were, terrified to say, "I was having suicidal thoughts." Or, like, "I really had an urge to cut." Because they're like, "In the past, they've sent me to the hospital." And so, I think that, you know, and this is kind of like a fine line, but to be able to, like, really discuss it and like, dive into it without just jumping to the conclusion of hearing the statement, and saying, "You need to go [to the hospital]."

Likewise, Participant 3 shared: “I think as a therapist, I'm much less alarmist, and much less quick to react than therapists who've never worked in an ER setting.” Participants recognized the value of having crisis experience and the ways it could benefit them as clinicians working in other treatment settings.

Participants also shared how their experiences in crisis work have made them more sensitive, empathetic, and less judgmental. The comments of participants often suggested that crisis counseling has in many ways changed their frame of reference, that bearing witness to the suffering of their clients has made them more appreciative of what they have in their own lives. For Participant 7, crisis work reinforced a sense of appreciation: “I'm grateful for what I have. I'm grateful I have a roof over my head and there's food in the refrigerator.” In a similar vein, Participant 4 shared that in some ways crisis work has made her impatient with people who complain about insignificant things:

They'll complain about something, or they'll think that, you know, their situation is like, so horrific. And I'm like, wow, I, you know, I just saw a kid who tried to kill themselves, you know what I mean? I just, like...it's just really interesting, you know? You don't know how tough something is until you walk in somebody else's shoes. And so, when you see something like that, believe me, you not getting your groceries delivered on time is not the end all be all the world, you know? And that's hard, you know? Maybe it makes you a little bit more critical of people in your personal life, you know, if you do this kind of work?

For Participant 4, crisis work had, in many ways, opened her eyes to a different world, one that she cannot unsee even when she is off the clock. Her comments very clearly displayed the contrapuntal voices present in her narrative, viewing her experience as both a gift and, in some

ways, a burden as her newfound perspective simultaneously made her less and more judgmental depending on the context and the players involved. Participant 8 also discussed how crisis work has impacted his personal life. He spoke about how crisis work has made him “open” in a way that has very much guided his parenting style. For Participant 8, crisis work taught him to be less judgmental as a parent, more accepting, and better prepared to listen with the intention of truly understanding. Participant 5 also shared how crisis work has made her less likely to make assumptions:

I feel like it's opened my eyes to a lot of things. Um, probably caused me to be like, a lot less judgmental about things right off the bat, right? Because like, without having a lot of details about things, like we have no idea what people are going through on any given day.

Participant stories frequently described crisis work as enhancing their sense of empathy, sensitivity, and ability to connect with others. Their narratives often revealed that crisis work had altered their frame of reference and self-perceptions and instilled within them a sense of gratitude and appreciation.

Participant narratives frequently highlighted the ways in which crisis work satisfies them and gives them a sense of purpose. For many, the work allows them to feel that they are making a difference, even if it is, as Participant 1 described, “just moving the needle.” Participant 1 spoke of the “gratification” he gets from helping others, while Participant 2 described her work as “fulfilling.” Participant 3 referred to the work as “rewarding,” while Participant 7 shared: “I think every day and every week, every month, there's multiple stories of hope, you know?”

Despite the challenges and intensity of crisis work, Participant 4 shared:

And I'm not going to say that there are days that I don't hate my job. There are. But I've got to say those are few and far between in comparison to the, to the true joy of doing something that you know you were born to do, that you really believe in and that you really feel whether it's just one person that you make a difference to for that moment in that day, that's enough for me.

Participant 5 noted that crisis work allows her to feel that she is “doing something to help” by choosing to really hear a client’s story and connecting them to the treatment they need.

Participant 6 described the work as “very significant” and “such an important role.” The comments of participants seemed to suggest that one of the most significant ways they made meaning of their work was in finding a connection to something beyond the self.

It is important to note that the collective narrative described in this chapter does not have some fairytale ending. In this section, I described the newfound perspective many participants developed in response to crisis work; however, the story does not end there. Stories are not linear, nor do they fit neatly into boxes. Rather, the storyline described in this chapter is iterative and likely will continue for participants as long as they engage in crisis work.

### **Chapter Summary**

The purpose of this study was to understand how crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. In this chapter, I discussed how the narrative threads of individual participant stories were woven together into the collective narrative presented in this chapter. I detailed the rising action, climax, and falling action that created a dynamic of tension and resolution both in and across participant stories. Participants detailed the experience of being siloed in *In the Quiet Room* where they were forced to develop a kind of makeshift psychological PPE in an effort to



protect themselves from the emotional cost of crisis work. However, these techniques were not foolproof, and, in some cases, participants were unable to safeguard themselves from the psychological effects of their work. In these situations, participants described what I referred to as *The Cases They Carry*, an invisible weight or heaviness that remained with them long after their shift had ended. Participants described experiencing cases that struck a personal chord or resulted in some form of psychological residue or moral injury. Yet, despite these workplace hazards, participants chose to return to crisis work day after day and year after year. They described what sustains them in their work and the ways their crisis experience has enriched their lives, both personally and professionally. In the fifth and final chapter, I discuss the narrative and narrative themes in greater depth and provide implications for counselors, supervisors, and counselor educators. The chapter concludes with a discussion of the limitations of this study and also provides suggestions for future research.

## Chapter Five

### Discussion

The purpose of this study was to uncover the ways in which crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. Utilizing a qualitative approach informed by narrative inquiry, this study considered the subjective experiences of eight participants whose work requires regular exposure to clients in crisis. By analyzing participant stories, individual narrative threads were identified using Gilligan's *Listening Guide*. Reverberations across participant narratives gave rise to the larger storyline and themes that were identified through the coding process described in chapter three. Both levels of analysis outlined in chapter three culminated in a collective narrative and three overarching themes, *The Dance of Crisis Work*, *In the Quiet Room*, and *The Cases They Carry*. The theme *In the Quiet Room* was further divided into one subtheme, *Makeshift Psychological PPE*, while the theme *The Cases They Carry* was further divided into three sub-themes, *Striking a Personal Chord*, *The Psychological Residue of Exposure*, and *Moral Injury*. In the chapter that follows, I explore the collective narrative and overarching themes more in depth, connecting them to and building upon the existing research in this area. I then discuss the study's implications, attending to how the findings are significant to counselors, supervisors, and counselor educators. The chapter concludes with a discussion of the significance and limitations of this study and recommendations for future research.

### Summary of the Findings

Given that little to no research exists on the experiences of counselors whose jobs require regular interaction with clients experiencing behavioral health emergencies, my goal was to highlight the voices of the eight crisis counselors who participated in this study. More

specifically, I was interested in understanding the ways in which these counselors make meaning of the intense and often emotionally demanding work they do on a daily basis. Based on prior research in this area, elements of the collective narrative and some of the identified themes were expected, including the intense emotional reactions participants described and their experiences of countertransference and vicarious trauma. However, some of the study's findings came as a surprise. Through the process of storytelling, participants revealed the complexity of working with clients experiencing behavioral health emergencies in *The Dance of Crisis Work*.

Participants also described an overwhelming sense of isolation in their work, times in which they looked to another for partnership, a sense of guidance that was so integral to their client relationships but was so clearly lacking in their professional support. The theme *In the Quiet Room* shed light on this experience, with participants describing how they felt involuntarily secluded, often left to handle the emotional complexities of the work on their own. Significant to their ability to continue in a setting that frequently exposes them to client suicide, homicide, and violence was their use of what was identified as a subtheme of *In the Quiet Room*, their use of *Makeshift Psychological PPE*. Participants described using a variety of coping mechanisms in an effort to distance themselves emotionally from the intense affective experiences of working with clients in the midst of behavioral health emergencies.

Unfortunately, as is also the case with physical PPE, participants' use of their *Makeshift Psychological PPE* was not foolproof, and it was not always enough to protect them from experiencing the intense emotional effects of crisis work. Regular engagement with clients experiencing behavioral health emergencies exposed participants to acutely stressful situations involving high levels of emotional distress, both their clients' and, at times, their own. In circumstances where their *Makeshift Psychological PPE* was insufficient, participants described

the weight or heaviness of the work, an experience that culminated in the climax of the collective narrative in the theme, *The Cases They Carry*. This theme encompassed three additional subthemes, including cases described as *Striking a Personal Chord*, those that led to the *Psychological Residue of Exposure*, and those that resulted in the experience of *Moral Injury*. The falling action of the collective narrative was characterized by participant descriptions of the unexpected benefits of crisis work, a piece of the story participants understood as being part and parcel of *The Dance of Crisis Work*. Participants detailed the ways their interactions with clients experiencing behavioral health emergencies have enriched their lives, both personally and professionally. They revealed the ways in which crisis work made them stronger and more empathic clinicians and how it taught them to be more sensitive, less judgmental, and more appreciative. Their stories revealed that the work had altered the participants' frame of reference and the ways in which they perceive their own lives. Participants shared how crisis work gave them a sense of fulfillment, purpose, and a connection to something beyond the self.

Both the individual narratives and the reverberations identified across narratives revealed the ways in which participants make meaning of their work with clients experiencing behavioral health emergencies. Although participants shared stories of very different experiences, they were more often than not in tune with one another, producing a chorus of voices that came together in harmony to construct the collective narrative described in chapter four. In the sections that follow, I put the collective narrative and identified themes in dialogue with the existing research in this area, focusing on the similarities and differences that emerged from this study.

### **The Construction of Meaning**

Simply put, the process of making meaning refers to the ways in which people understand and make sense of their experiences (Merriam & Tisdell, 2016). From a social

constructivist perspective, individuals create their own realities based on their interactions with others and the world around them (Edwards, 2013). Through this lens, meaning making does not occur as a solitary venture; instead, it takes place in collaboration with others (Neimeyer et al., 2014). In approaching this research through a social constructivist lens, I considered that each participant's individual reality was created in response to the ways they perceived and assigned meaning to their work with clients experiencing behavioral health emergencies. Participant interactions with their clients, colleagues, and me as the researcher were therefore significant to the meanings they constructed. Many of the participants noted that the interviews created an opportunity for them to talk through and process their experiences, something they have not often had the opportunity to do given their lack of supervision and the fast-paced nature of crisis work. By speaking about their experiences and telling their stories, participants described not only a sense of catharsis, but also a deeper understanding of the ways in which crisis work has affected them, both personally and professionally. As a result, meaning was both extrapolated from and constructed through the stories participants shared (Hays & Wood, 2011).

### **The Dance of Crisis Work**

In exploring the theme *The Dance of Crisis Work*, participants provided a nuanced description of the complexities of their experiences. While “doing the dance” is idiomatic, in this sense the usage is quite telling of the complexities involved when engaging with a client in crisis. To dance is in fact to know multiple dances and be prepared to transition from one movement to another at a moment's notice. Interaction is subtle and predicated on *feel*, an awareness of what is happening and what effect is elicited both with regard to the counselor and the client. At times, the dance is simply about setting the wheels in motion, engaging through steps that are well-known to the counselor and applicable to the majority of interactions. In other moments, to dance

is to be part of a mutual act between two parties, an interaction that at times is slow and steady and at others feels like frenzied movement.

This theme illuminated crisis work as a complicated, sometimes choreographed, sometimes improvised dance, merging technical assessment skills with participants' individual styles and personas. Participants described the dance as amorphous at times, the steps dependent on context and partner. In some instances, their dance steps were regimented, adhering to a strict choreography. At other times, they were looser, more interpretive, and improvised. When to rely on conditioning or electing to move in a new pattern was learned over countless hours in this rhythmic setting. There were no predetermined moments when this should occur. Instead, participants developed nuance through guiding and being guided by their clients. This learned balance emphasized the profound intimacy of being with a client in crisis, as well as the magnificence of finding a shared pace that ignited even a small flame of hope within either or both individuals.

Perhaps most striking was the tension that existed for participants between connection and disconnection. Counseling, in general, requires a great deal of empathic engagement with clients. Yet, participants talked about how connecting with clients experiencing behavioral health emergencies requires an even deeper, more intimate connection. Participants made clear that the work sometimes required them to lean in, to join with clients intensely and deeply, offering themselves up to the rawness and vulnerability of sitting with someone in a moment of crisis. At the same time, participants understood that they also needed to break clasp from their clients, and at times their own emotional reactions, in order to protect themselves. Participants also understood meaning making to be a joint exercise, particularly in these moments. Accordingly, participants described the need to step back and away from their clients in order to take direction,

to be led instead of feeling compelled to always take the lead. In short, to dance means to surrender to the moment. *The Dance of Crisis Work* revealed a continuum of emotional experience, at times ranging from inspiration to disillusionment, and, at others, from hope to despair. In this sense, the trope is much larger than this section alone, indicative of the collective story, a thread that runs throughout the accompanying sections. To dance is indicative of progress; however, as described in the following section, stasis also loomed. *In the Quiet Room* serves as a moment when participants were left to stand alone, with no partner in sight to engage in order to make progress.

### **In the Quiet Room**

Participants frequently made reference to the involuntary seclusion they felt in their positions, both in terms of their training and in their opportunities to reflect on the intensity of their work with clients experiencing behavioral health emergencies. Across the board, participants described feeling ill-prepared for their positions as crisis counselors. All eight participants reported receiving little to no training in crisis intervention or risk assessment during their graduate programs. While existing research addresses the lack of crisis preparation and the importance of clinical supervision for counselors, the qualitative nature of this work teased out the great degree to which these issues existed for participants. In many ways, the study's interactions functioned as a much-needed space for the participants to seek the support that they identified as being glaringly insufficient in the field, opportunities for them to talk about and work through ideas that they had previously been left to consider on their own. Participant narratives also revealed a culture of silence in crisis work, an unspoken rule that existed in their respective settings that prohibited even the suggestion that they might be struggling with the emotional burden of the work. Not having a frame of reference as they entered the world of crisis

work, combined with the fact that participants had no formal outlets for processing the work they do, left them to make sense of their experiences in isolation.

This lack of preparation is also reflected in the existing research literature, with several studies showing that crisis and risk assessment have been insufficiently covered in counselor education programs (Allen et al., 2002; Barrio Minton & Pease-Carter, 2011; Morris & Barrio Minton, 2012). Guo et al.'s (2016) study found that fewer than one third of CACREP-accredited counselor preparation programs required students to take a standalone course in crisis counseling. As a result of this lack of preparation, beginning counselors frequently report feeling underprepared to intervene in crisis situations (Allen et al., 2002; Morris & Barrio Minton, 2012). Past research has indicated the need for training and subsequent supervision in the area of crisis intervention. Participant narratives also revealed an understanding of such practices as valuable but went on to expose a complete absence of such practices in their work settings. The feeling of being ill-prepared led participants in this study to learn everything they needed to know on the job, from the particular skill sets unique to crisis work to how to process and cope with the emotional labor required of them. Participants described feeling that their lack of preparation left them with little frame of reference by which to understand their experiences.

The interviews thus functioned as an opportunity for participants to process and make meaning of their experiences in real time. The act of telling their stories alone helped them to work through ideas they had previously grappled with completely on their own. Likewise, the lack of preparation caused participants to have to develop and implement their own ways of coping with the challenges associated with crisis work. In the next section, I discuss the participants' use of this *Makeshift Psychological PPE*, tools and techniques that were not taught, but were developed in isolation out of necessity.



***Makeshift Psychological PPE***

Crisis work requires a significant amount of what Hochschild (1983) referred to as emotional labor, a process in which individuals must regulate their emotions and emotional expression as a requirement of their job. For the eight participants in this study, working with clients experiencing behavioral health emergencies involved managing their own often extreme and distressing emotional responses in order to successfully carry out their work responsibilities. Regardless of how they felt about a case, participants had to interact with clients, client families, other service systems, law enforcement, emergency services personnel, medical staff, and hospital security guards in a calm and professional manner. In order to navigate the demands of their positions, the participants in this study described a variety of coping strategies they developed in isolation while *In the Quiet Room* to safeguard their own mental health. In exploring the sub-theme of *Makeshift Psychological PPE*, participants described establishing strong boundaries, using humor, and engaging in compartmentalization, dissociation, and intellectualization as methods of coping with and separating themselves from the strong emotions they felt in response to their work.

Participant narratives made reference to the importance of setting appropriate boundaries, a concept that is well known to counselors. Participants frequently suggested that those who did not establish firm boundaries in a crisis setting “don’t last,” comments that alluded to the importance of differentiation of self. Although empathy is generally considered to be one of the core conditions of the therapeutic relationship (Rogers, 1957), an overly empathic crisis counselor may become too involved with a client, potentially losing the ability to remain objective (Cavaoila & Colford, 2006). Likewise, an excessively empathic crisis counselor may tend to over identify with a client, a factor that has been found to lead to an increased risk for

experiencing vicarious trauma (Lonn & Haiyasoso, 2016; Rothschild, 2006). Previous research has shown that clinicians who are able to maintain a strong emotional balance between sense of self and sense of togetherness with others are less likely to experience vicarious trauma (Halevi & Idisis, 2017). Participants seemed to recognize the need to create emotional distance and space from their clients, an awareness they likely developed out of the experiences delineated in *The Cases They Carry*. The comments of participants suggested they were intimately aware of the high cost of becoming overly entwined with their clients.

Participant stories suggested that many of them engaged in what appears to be a form of dissociation whereby they attempt to distance themselves from the affective elements of their interactions with clients. Dissociation is a complex and multifaceted construct. Research suggests that dissociation occurs on a spectrum, ranging from the mild and commonplace observed in non-clinical populations to the more extreme and pathological as exhibited by individuals who have experienced severe trauma (Bowins, 2004; Mazzotti et al., 2016; Ross et al., 1990, 1991). As Bowins (2012) noted, milder forms of dissociation can be useful as a means of diminishing the impact of disturbing emotional states. In their discussion of *Makeshift Psychological PPE*, participants described two means of coping that fit somewhere in the spectrum of dissociation. The first, what some referred to as an ability to “compartmentalize,” involved segregating distressing information from more easily retrieved memories, a process that involved storing this information in the far recesses of their minds. A number of participants noted that the first time they had really openly discussed their feelings about these cases occurred during the course of this study’s two interviews. For many of the participants, the ability to separate their work experiences from their home lives is essential given that the burden of “taking the work home” would be too much to carry. Participants also described an ability to

distance themselves emotionally from their work, a concept known as “emotional numbing” or “emotional constriction” (Brierre et al., 2005; Shin et al., 2019). Participants described attenuating their emotional response to crisis work, some referring to the fact that cases eventually started to “blur together” and that they were unable to recall the specifics of some cases.

Another coping strategy described as being developed *In the Quiet Room* was the use of humor. Participant comments suggested that they used both lighthearted humor and what is often referred to as “gallows humor.” Gallows humor is humor that makes light of life-threatening or frightening situations, treating serious, upsetting, or painful subject matter in a sardonic manner. In some instances, participants described how having a “sick” sense of humor helped to lighten the load of crisis work. In considering the research that examines the coping strategies of emergency services personnel, including paramedics, physicians, nurses, police officers, and other first responders, the fact that participants described the use of humor as a coping mechanism does not come as a surprise. Rowe and Regehr (2010) noted that gallows humor functions in a multiplicity of ways, helping those who work in emergency services to vent their feelings, gain social support from colleagues, and distance themselves from their work so they are able to function in high-stress situations. Others, however, have suggested that gallows humor may be indicative of psychological distress (Craun & Burke, 2014; Moran, 2002). Craun and Burke (2014) suggested that excessive use of gallows humor in task force personnel in the area of sexual violence should be considered a “yellow flag,” potentially indicating that symptoms of secondary traumatic stress may be negatively affecting workers.

Participants also referred to attempts to distance themselves emotionally from upsetting situations by focusing instead on the intellectual aspects of the work. The comments of

participants suggested that thinking was used as a means to avoid feeling. By focusing on the facts and logic involved in a case, participants were able to separate themselves from the work, a necessary skill when making the life and death decisions often involved in behavioral health emergencies. Studies involving medical students' first experiences dissecting medical cadavers revealed similar cognitive coping strategies, including rationalization and intellectualization (Charlton et al., 1994; Sándor et al., 2015) and mechanisms of detachment (Tseng & Lin, 2016). What is interesting to note is that these attempts to distance themselves from the work contrasted sharply with what many described as the importance of not losing sight of the human aspects of crisis work. Participants noted the striking difference between their training as counselors from that of their medically trained colleagues in terms of their ability to separate from the work. Their stories suggested that as counselors they had been taught to enter into their client's experiences more, whereas the doctors and nurses they worked alongside appeared to be trained to move away from over identification with clients. Participant comments suggested they longed for guidance in this area, a sentiment that highlighted the ways their training diverged from their lived experiences. Participants developed this *Makeshift Psychological PPE* while secluded *In the Quiet Room* out of necessity in order to continue functioning in their positions as crisis counselors. However, their *Makeshift Psychological PPE* was far from foolproof, and it did not always protect them from the intense emotional aspects of their work with clients experiencing behavioral health emergencies. Their exposure to these workplace hazards resulted in the theme I discuss in the next section, *The Cases They Carry*.

### **The Cases They Carry**

Before turning to a discussion of *The Cases They Carry*, it is important to revisit the two meaning-making theories discussed in chapter two. According to Park's (2010) model,

individuals interpret life events using cognitive frameworks referred to as global meaning systems. Global meaning systems, which also consist of individual valued goals and an overall sense of purpose, are believed to be developed during childhood and have a strong influence on an individual's cognitive, affective, and behavioral responses (Park & Folkman, 1997).

Individuals assign events appraised meanings in an attempt to make sense of their experiences. However, when an individual experiences an event they interpret as falling outside of their global meaning system, they experience distress and attempt to reduce the discrepancy by either modifying the event's appraised meaning or by accommodating the new experience by altering their global meaning system (Park, 2017).

Constructivist Self-Development Theory (CSDT) is commonly accepted as an explanation for how and why clinicians develop vicarious trauma. The theory asserts that individuals interpret events through complex cognitive structures in line with their psychological needs for trust, safety, power, esteem, intimacy, and frame of reference (McCann & Pearlman, 1990). Individuals use these cognitive schemas to interpret interpersonal, intrapsychic, familial, cultural, and social experiences. However, exposure to vicarious trauma can disrupt a counselor's cognitive schemas, leading to accompanying disturbances in thoughts, emotions, and memory systems (Halevi & Idisis, 2017). CSDT asserts that these changes in cognitive schema amass over time and permeate all aspects of a counselor's personal and professional life (Trippany et al., 2004).

Although participants described using the *Makeshift Psychological PPE* they developed while *In the Quiet Room* to protect themselves from the negative effects of crisis work, the strategies were not always foolproof. Participants described experiencing three discrete categories of *The Cases They Carry*. In the sections that follow, I discuss the larger significance

of the sub-themes, *Striking a Personal Chord*, *The Psychological Residue of Exposure*, and *Moral Injury*, as they relate to the participants' meaning-making process.

### ***Striking a Personal Chord***

Despite their best efforts to maintain strong boundaries and to distance themselves from the emotional aspects of their work, participants were not always able to do so. In situations where they experienced countertransference or encountered cases that struck a personal chord, participants struggled with managing their own reactions to these clients. Some participants described these as situations they found “triggering” or that “hit too close to home.” This kind of emotional mirroring and identification with clients is reflected in studies examining the experiences of those who work with trauma survivors, in particular those that have their own trauma histories, share similar cultural backgrounds, or have shared experiences with clients (Splevins et al., 2010). In these situations, participants were faced with clients and situations that very closely reflected their own experiences, muddying the waters and creating an additional layer of complexity for them to wade through during their shifts.

Participants also discussed the challenges of cases that reminded them of the fragility of those close to them. The comments of participants often suggested that working in a crisis setting reminded them that the clients they see on a daily basis could easily be someone close to them. Their understanding that we all walk a precarious tightrope of mental wellness was apparent, and participants frequently referred to the fact that any of us are vulnerable to falling from that tightrope at any time. Participant accounts suggested that the experience of coming face-to-face with the unimaginable so regularly made them more sensitive to the possibility that someone they love could suffer a behavioral health emergency of their own at any moment.

Counselors who work in agency and private practice settings typically begin seeing clients with some knowledge of their presenting problems. In these settings, counselors or supervisors may decide whether a client is a “good fit” for a particular counselor depending on the counselor’s background, training, and area of expertise. Counselors in these treatment settings have the opportunity to articulate whether certain clients or cases may be better suited to another clinician, particularly if they are facing personal struggles that may impede their ability to provide adequate services. Within the crisis setting, however, counselors must be prepared to see clients with a variety of presenting problems with little to no advanced notice. This can leave crisis counselors vulnerable to unexpected countertransference or exposure to personally triggering material. To complicate this fact, participants reported lacking opportunities to debrief, reflect upon, make sense of, and process feelings of countertransference within the safety of a supervisory relationship.

Participants also discussed feelings of uncertainty in their positions as crisis counselors. Their comments often suggested feelings of self-doubt and a fear of “missing something” in their work, a sense of disquietude that often lingered with them even when they were off the clock. Some discussed this anxiety directly, articulating their fears about making a “wrong decision” that could result in a negative outcome. Others discussed this sense of unease more subtly, reassuring themselves that they had done the job to the best of their abilities and had been certain to dot their I’s and cross their T’s before the end of their shifts. At times, these feelings of uncertainty left participants questioning themselves and their competency as counselors. Again, participants did not receive the support they needed to work through these feelings. Instead, they were forced to face the uncertainty in isolation, cordoned off *In the Quiet Room*, left to wonder why their *Makeshift Psychological PPE* may have failed them.

### *The Psychological Residue of Exposure*

Participants described situations that resulted in exposure to both firsthand and vicarious trauma, which resulted in alterations to their belief systems, expectations, and assumptions about themselves and the world (Pearlman & Saakvitne, 1995). In both cases, participants were reminded of their own mortality and tasked with making sense of situations that often fell far outside the bounds of their global meaning systems. This sharp divergence from their previously held cognitive frameworks resulted in participants experiencing high levels of distress when faced with these situations. In circumstances in which participants were unable to reconcile these events by either modifying their appraised meanings of client situations or accommodating their global meaning systems, these experiences continued to affect them long after their shifts had ended.

Participants described experiencing a variety of emotional reactions to crisis work, including anger, fear, frustration, powerlessness, shock, and despair. These emotions were not unexpected and are consistent with previous research in the area of vicarious trauma (Cohen & Collins, 2013; Etherington, 2007; Pistorius et al., 2008; Satkunanayagam et al., 2010; Splevins et al., 2010). The comments of participants also suggested that they had experienced changes to their cognitive schema, some participants describing themselves as “jaded” or “cynical” as a result of their work. Participants were haunted by those experiences resulting in either firsthand or vicarious trauma despite their attempts to compartmentalize and hide them away in the far recesses of their minds. The sub-theme *The Psychological Residue of Exposure* paints a chilling picture of the lasting effects of crisis work. Participants described attempts to cleanse themselves of the work at the conclusion of their shifts, attempting to enact strict boundaries between their work and personal lives. However, despite their best efforts to do so, participants were often left



with the psychological remnants of the work, left to contemplate such experiences on their own while secluded *In the Quiet Room*.

### ***Moral Injury***

The third and final sub-theme in *The Cases They Carry* was the experience of *Moral Injury*. Participants described various situations in which they felt unable to do what was “right” or bore witness to acts that violated their sense of morality. In some cases, participants devised workarounds that allowed them to act in accordance with what they believed was in the best interests of their clients. In other cases, the comments of participants highlighted the frustrations of working within a “broken system,” one that does not always put the needs of the client first. Participants described various situations in which they felt powerless in their positions as crisis counselors, confined by the limits of the hierarchical structure of the mental health system and the demands imposed on them by various stakeholders. The sting of moral injustice was apparent in participants’ descriptions of the conflicts they felt in a world of insurance pre-authorizations and calculated behaviors aimed at reducing legal and financial liability. Participants also described moral injury as a result of bearing witness to the mistreatment of clients or the mishandling of client behaviors. In these cases, participants described cases or situations in which clients were treated disrespectfully, dismissed as being “just psych patients,” or inappropriately given intramuscular (IM) medication or placed in physical restraints when their behaviors could have been managed instead with verbal de-escalation. Participants often described feeling powerless to effect any real change in their positions, forced to stand by and bear witness to moral injustices that, over time, amassed into moral injury.

Moral injury has been described as occurring as a result of “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and

expectations” (Litz et al., 2009, p. 697). In healthcare workers, moral injury has been conceptualized as resulting from the violation of the deeply held and fundamental moral belief that the needs of the patient should come first. As Dean et al. (2019) made clear, the competing demands of various stakeholders, including the hospital and larger healthcare system, insurance companies, and even the clinician’s own financial interests, can sometimes interfere with putting the needs of the patient first. It is these kinds of situations that may produce moral injury in healthcare workers, resulting in feelings of betrayal, guilt, shame, and self-condemnation, as well as moral concerns, religious struggles, loss of religious/spiritual faith, loss of meaning/purpose, difficulty forgiving, and loss of trust (Mantri et al., 2020). As Griffin et al. (2019) described, the impact of moral injury can be “devastating” for affected individuals in the areas of emotional-, social-, and health-related areas of functioning.

Participants were certainly not unaware that the *Makeshift Psychological PPE* they had developed *In the Quiet Room* would eventually malfunction and result in the experience of *The Cases They Carry*. Participants experienced these cases or clients as *Striking a Personal Chord*, *The Psychological Residue of Exposure*, or as *Moral Injury*. Yet despite these clear occupational hazards, participants still found themselves returning to their positions day after day and year after year. The collective narrative pointed to the unexpected benefits of crisis work, a newfound perspective that enriched participants’ lives both personally and professionally.

### **A Newfound Perspective**

Despite the complexity of crisis work and the potential for exposure to adverse effects, all eight participants described the ways in which crisis work has benefited them. Participants discussed feeling that crisis work afforded them a newfound perspective, one based in gratitude and appreciation. The comments of participants suggested that they felt their work with clients

experiencing behavioral health emergencies made them not only better clinicians but also better people. Participants described the work as making them more sensitive, empathetic, and open, while also making them less judgmental, more tolerant, and less reactive. Many described feeling “humbled” by the work and a sense of purpose in knowing that they were making a difference in the lives of their clients. Participants described the work as “fulfilling,” “rewarding,” “very significant,” and “such an important role.” Their commitment to crisis work is suggestive of the fact that they view their work as a calling, or as something they are meant to do. This echoes Duffy et al.’s (2012) qualitative study of eight counseling psychologists who described their work as being synonymous with their life’s purpose, and as tied to helping or serving others. Perception of one’s purpose and desire to engage in advocacy efforts have been found to be strong predictors of choosing a career in counseling and other helping professions (Duffy et al., 2012; Freeman, 2007; Lent, 2010).

Although research has pointed to a sense of purpose as being connected to one’s religion or spirituality (Duffy et al., 2010; Hall et al., 2014; Hirsbrunner et al., 2010), these topics did not arise during participant interviews in this study; rather, participant stories supported a more humanistic theory of calling, such as that described by Hall and Chandler (2005), who conceptualized calling from a “broader secular view characterized by an individual doing work out of a strong sense of inner direction” (p. 160). From this perspective, participants’ decisions to enter and remain in crisis work was based not on a desire to fulfill a religious or spiritual obligation or duty, but rather as a means to satisfy an inner drive of purpose and meaning to them as individuals. The comments of participants suggested that one of the most significant ways they made meaning of their work was in finding a connection to something beyond the self. Prior research supports this notion as engagement in an existential meaning-making process has been

shown to be influential to the experience of vicarious posttraumatic growth, or positive changes in cognitive schema as related to self-perception, interpersonal relationships, spirituality, and philosophy of life (Cohen & Collens, 2013).

Participants did not attempt to paint a fairytale ending in describing what sustains them in their work as crisis counselors. Instead, it became clear that the collective narrative described by participants was iterative in nature and that the story was both rooted in and always returned to the rising action described in *The Dance of Crisis Work*. The storyline continued to build *In the Quiet Room* where in seclusion participants developed their *Makeshift Psychological PPE*. The story climaxed with *The Cases They Carry* and the sub-themes of *Striking a Personal Chord*, *The Psychological Residue of Exposure*, and the experience of *Moral Injury*. The falling action, or resolution of the collective narrative was characterized by the newfound perspective participants described as a result of their experiences working as crisis counselors. In the next section, I highlight the significance of the study's findings and provide implications for counselors, supervisors, and counselor educators.

### **Study Implications**

This study's findings provide valuable insights for various stakeholders in the counseling profession, including counselors, clinical supervisors, and counselor educators. The collective narrative and identified themes present in participant stories may help to inform the work of all counseling professionals regardless of area of specialization, not only those working in crisis settings. In the sections that follow, I discuss these implications and their relationship to best practice involved in working with clients experiencing behavioral health emergencies.

### **Implications for Counselors**

Counselors are likely to encounter clients experiencing behavioral health emergencies at some point during their careers regardless of treatment setting or area of specialization (McAdams & Keener, 2008). Participant descriptions of feeling siloed in their positions, involuntarily secluded *In the Quiet Room*, point to the importance of counselors seeking support when working with clients experiencing behavioral health emergencies. The culture of stoicism evident in this study's finding further undergird the importance of connectivity. This applies to forming connections with both colleagues and supervisors alike to ensure counselors are afforded opportunities to process and reflect upon their work with clients in crisis. Counselors should be aware that consultation and collaboration with others is important given the seriousness of risk involved, as well as the potential for negative outcomes. Seeking support when working with clients experiencing behavioral health emergencies can enable counselors to reflect more carefully on their clinical decision-making and ensure that they are not vulnerable to missing pertinent information. Furthermore, obtaining peer consultation or seeking supervision can enable counselors to process and come to terms with their own reactions to prevent them from inappropriately affecting the counseling process. Given the fast-paced 24/7 nature of crisis work, it may be necessary for counselors working with clients experiencing behavioral health emergencies to seek outlets for nontraditional supervision. Counselors working in this field may do well to form peer support groups or set up informal meetings to debrief with coworkers after particularly challenging cases. Additionally, involvement in special interest groups, such as the ACA's Traumatology Interest Group, may help to foster connections with others doing similar kinds of work.

Participant narratives also revealed that participants felt unprepared for working with clients experiencing behavioral health emergencies, a finding that is consistent with previous research that suggests graduate coursework does not adequately prepare counselors in this area (Dexter-Mazza & Freeman, 2016; Kleepsies et al., 1993; Morris & Barrio Minton, 2012; Ruth et al., 2013; Schmitz et al. 2012; Wozny, 2005). Counselors working in any area of specialization should be aware that they may need to seek continuing education in order to obtain adequate education and training in the area of crisis work and behavioral health emergencies. Previous research also supports this, given that even a one-day continuing education training on suicide risk assessment and intervention can lead to increased participant knowledge and confidence in these areas (Mirick et al., 2016).

The findings of this study, in particular *The Cases They Carry*, speaks to the importance of counselors developing and engaging in activities that support their own mental health when working with clients experiencing behavioral health emergencies. Given the emotional toll of crisis work, it is important for counselors to be aware of the possible negative effects such work can have on them, including the experience of countertransference, burnout, firsthand and vicarious trauma, and moral injury. Counselors should practice positive self-care, seek clinical supervision and support from colleagues, and obtain their own personal counseling when needed. Those working with clients experiencing behavioral health emergencies should also make attempts to maintain a healthy work-life balance to prevent counselor impairment that may impede their ability to provide professional services to clients.

### **Implications for Supervisors**

Participant narratives supported previous research about the possible negative effects of working with clients experiencing behavioral health emergencies, including counselor burnout,

secondary traumatic stress, and vicarious traumatization (James & Gilliland, 2013; Kleepsies, 2014; Kleepsies & Ponce, 2009). Although supervision is routinely recommended in the literature as a means for reducing and managing the effects of vicarious traumatization (Cohen & Collens, 2013; Lonergan et al., 2004; Pistorious et al., 2008), participants in this study were not provided with the opportunity to engage in regular supervision, forcing them to process and make meaning of their experiences in isolation. Given the culture of silence participants described in working within crisis settings, supervisors can help to normalize the experience of vicarious trauma, thereby reducing feelings of shame and secrecy. Supervision can function as a means to decrease the isolation participants described, as well as provide crisis counselors with a form of “relational healing” (Harrison & Westwood, 2009, p. 208). Participants who were unable to reconcile their appraised meaning of a given situation with their global meaning systems experienced distress in the form of countertransference, firsthand and vicarious trauma, and moral injury. Supervisors should be aware of the importance supervision has in helping counselors to explore, understand, and process these experiences more fully, enabling them to make sense of and integrate these experiences in healthier and more productive ways. This is supported by what Jackson et al. (2018) suggested in terms of helping counselors to successfully balance empathic engagement with differentiation of self, a strategy that has shown to be significant to preventing vicarious traumatization (Halevi & Idisis, 2017). Jackson et al. (2018) suggested that supervision also provides a possible medium for facilitating the experience of vicarious posttraumatic growth as it can assist counselors in making meaning of crisis situations. For some of the participants in this study, the two interviews represented their first real opportunities to reflect on, process, and make meaning of their experiences. Providing a safe environment for supervisees to openly discuss their reactions and debrief after behavioral health

emergencies may help to prevent the experience of negative countertransference, vicarious trauma, and moral injury while helping to promote the experience of vicarious posttraumatic growth.

Supervisors should also be aware that supervisees may not possess the skills necessary to successfully navigate a behavioral health emergency. They should be prepared to provide supervisees with psychoeducation and skill development specific to behavioral health emergencies, including risk assessment procedures and information regarding resources appropriate to a client's presenting issue. Hipple and Beamish (2007) suggested that the first step to managing a crisis situation is for the supervisor to be aware of the skill level and training of the supervisee in order to formulate an appropriate supervision intervention. Supervisors should be prepared to discuss specific and formalized crisis policies and procedures prior to encountering crisis situations, as well as ensure that supervisees are aware of specific state regulations around issues such as involuntary commitment. Supervisors should also help to bolster the supervisee's sense of self-efficacy and foster learning by debriefing after a crisis and discussing how crisis protocols might be improved in the future.

Supervisors can further support supervisees by providing specific recommendations for self-care and stress management. Lonn and Haiyasoso (2016) suggested teaching supervisees to incorporate "transition rituals" into their daily routines as a means to decompress and disengage from their work. Participants discussed developing *Makeshift Psychological PPE* on their own; however, supervisors can support counselors in developing and utilizing strategies to support their mental health in working with clients experiencing behavioral health emergencies. Supervisors should also reinforce the importance of engaging in regular self-care activities and can also serve as models in this regard. Helpful self-care and other coping strategies, including



engagement in advocacy efforts, work-life balance, and maintaining a stance of hope and optimism have been shown to reduce the experience of vicarious traumatization (Harrison & Westwood, 2009). Finally, as Lonn and Haiyasoso (2016) suggested, supervisors can assist supervisees in establishing and maintaining appropriate boundaries by modeling such behaviors.

Adequate supervisor training in the area of behavioral health emergencies is also imperative. Given the nuances associated with crisis work, supervisors should ideally have experience working in these settings prior to functioning in a supervisory capacity. For example, newer crisis counselors may benefit from being mentored by more senior crisis counselors as they acclimate to the unique demands of these positions. If direct experience in crisis counseling is not available to supervisors, specialized continuing education for supervisors in the area of behavioral health emergencies is essential given the complexity of the work and its effects on those who do it.

### **Implications for Counselor Educators**

Counselor educators can also learn a great deal from participant narratives and the themes identified in this study. Perhaps most importantly, counselor educators should be aware that across the board, participants felt ill-prepared by their graduate education and training to handle behavioral health emergencies. Prior research in this area supports this, and indicates that without training specific to crisis situations, including behavioral health emergencies, beginning counselors frequently lack the self-efficacy to perform adequately in these types of situations (Morris & Barrio Minton, 2012; Sawyer et al., 2013). Counselor educators can utilize their positions to advocate for greater inclusion of behavioral health emergencies when revising program curriculum. They can also make it a point to support students in developing the necessary knowledge and skills in this area by incorporating training on behavioral health

emergencies into existing coursework. Furthermore, they can prepare students for the emotional labor involved in such work, and provide education regarding how to cope with the potential negative effects of working with clients in crisis.

Counselor educators can also be instrumental in helping students to develop skills that will assist them in protecting their mental health. As participants made clear, they were forced to develop *Makeshift Psychological PPE* while secluded *In the Quiet Room*. Counselor educators can help to support students in developing strategies aimed at promoting differentiation of self, a factor that has been shown to be significant in preventing the experience of vicarious trauma (Halevi & Idisis, 2017; Jackson et al., 2018). Other coping strategies can also be taught to students, including what Bowins (2012) has termed “therapeutic dissociation,” which includes encouraging milder forms of dissociation for the purposes of diminishing disturbing emotional states. Such techniques may include compartmentalization and absorption, which involves “disconnecting from one’s current circumstances, both external and psychological, and becoming immersed in another focus” (Bowins, 2012, p. 309). Counselor educators can help students to hone these skills in preparation for the possibility that they may be exposed to emotionally disturbing material in working with clients experiencing behavioral health emergencies.

*The Dance of Crisis Work* illuminates yet another opportunity for counselor educators. The theme highlights the importance of teaching future counselors about the *art* of counseling, emphasizing the ways in which subtlety and nuance are essential to their work with clients. Counselor educators can help prepare students for the dance of connection and disconnection inherent to the counseling relationship, stressing when it is necessary for them to join with clients and when they must break clasp as a means to protect themselves from burnout or vicarious trauma. Finally, counselor educators can stress the importance of striking an essential balance of

both taking and allowing their clients to take the lead, guiding students to understand that the rhythm of counseling is dependent on context and partner.

### **Study Significance and Limitations**

This study shed light on the lived experiences of crisis counselors and the meanings they attribute to their work with clients experiencing behavioral health emergencies. In exploring the narratives of eight crisis counselors, the findings offered insight into a population seldom discussed in the literature. Given that little to no research has been conducted on the experience of crisis counselors, it was appropriate to utilize a qualitative design informed by narrative inquiry. The narratives of the eight crisis counselors who participated in this study gives insight into their experiences and highlights the need for additional research in this area. However, given the limited sample size, it is important to note that the findings of this study cannot be generalized. The inclusion of eight participants, although appropriate to the methodology, offered depth but not breadth of experience. Although there was some variability in the gender of participants, the racial identities of participants were homogenous. A more heterogeneous sample in terms of race and cultural background may have provided additional perspectives that were not offered by participants in this sample.

Another possible limitation of this study was that participants were all crisis counselors at screening centers or affiliated emergency service programs in the state of New Jersey. The inclusion of crisis counselors from other geographical locations may have also yielded more diversity in the perspectives of participants. Although participants in this study had varied years of experience in a crisis setting ranging from 2-15 years, the average was 8.75 years. Because participants had been doing this kind of work on average for a number of years, their viewpoints may differ from crisis counselors who are newer to the field. It is worth noting that those who

chose to participate in this research may view crisis work as more central to their professional identities than those who view the work as more of a “steppingstone,” such as those who do this kind of work to obtain the clinical hours necessary for licensure. Finally, because of my own experiences working as a crisis counselor and my “insider status” (Merriam & Tisdell, 2016) in this research, it is possible that participants did not elaborate on their experiences to the same degree they would have had I as the researcher not been familiar with the kind work that they do.

It should also be noted that due to the COVID-19 pandemic, participants were both recruited and interviewed through online platforms. This likely resulted in limitations in recruitment and participation. Additionally, participant interviews were conducted solely via Zoom rather than in person. Despite these limitations, the study’s rigorous attention to design and analysis provides a strong basis for future research in this area. Additionally, although the findings are not generalizable, they provide valuable insights that can inform best practice in the practice, supervision, and training of both crisis counselors and those working in other specialty areas given the likelihood they will encounter clients experiencing behavioral health emergencies at some point during their careers.

### **Recommendations for Future Research**

This study highlighted the fact that participants felt siloed in their positions as crisis counselors and that they felt ill-prepared by their education and training in the area of behavioral health emergencies. Future research in the areas of counselor preparation and training is needed to determine best practice in these areas as they relate to crisis counselors and those in other treatment settings alike. The field of counseling as a whole would also benefit from research on specific supervision strategies and models to best support counselors working with clients experiencing behavioral health emergencies. Such research could add to the body of knowledge

about how to best support counselors, prevent the experience of vicarious trauma, and promote the experience of vicarious posttraumatic growth. This study also shed light on the experience of moral injury in crisis settings. Research on moral injury in healthcare settings has become more predominant as a result of the COVID-19 pandemic; however, at the time of this research there were no known studies on the experience of moral injury in counselors. Future research would do well to focus on how moral injury presents amongst counseling professionals, as well as how to prevent and manage the experience of it in different treatment settings.

Although the helping professions emphasize the importance of self-care throughout their training programs, conflicting research exists as to whether such practices actually reduce the likelihood of suffering from burnout, secondary traumatic stress, and vicarious traumatization. Accordingly, future research is needed to determine whether self-care practices do, in fact, contribute to greater subjective and psychological well-being in crisis clinicians. A study aimed at considering how personality characteristics and self-care practices might relate to the subjective and psychological well-being of crisis counselors would enable a greater understanding of whether people possessing certain personality characteristics may be better suited to this kind of work. Additionally, such a study would assist the mental health field's various stakeholders in identifying how to best educate, train, and provide supervision to crisis counselors.

Future research considering how the coping strategies of crisis counselors compare to other frontline workers, such as those of police, firefighters, and paramedics would also be beneficial to the field. Such research might consider this kind of work through a gendered lens, one that focuses on the culture of silence and stoicism that is so often present in these professions. Research in this area could shed light on how to best prepare and supervise

counselors working in these settings, as well as ways to break down potential barriers that limit their ability to seek necessary outlets for support. Finally, the findings of this study stress the importance of future research in the area of counselor preparation as it relates to teaching counselors about the art or *dance* of counseling. Such research would help to identify best practice involved in preparing future counselors for the complexity and nuance of working with clients.

### **Conclusion**

The aim of this study was to shed light on the ways crisis counselors make meaning of their work with clients experiencing behavioral health emergencies. The narratives of the eight participants in this study suggested that their work was complex and multidimensional, a realization that was made clear in the theme *The Dance of Crisis Work*. Participants described feeling isolated in their positions *In the Quiet Room*, forced to develop methods of coping, or *Makeshift Psychological PPE*, completely on their own. Participants were not afforded opportunities to reflect upon or process their work with others and were thus left to make meaning of their experiences in isolation. At times, their *Makeshift Psychological PPE* failed to function properly, and participants were faced with clients and situations that became *The Cases They Carry*. However, participants were not naive to *The Dance of Crisis Work*, and they continued in their positions because of the sense of purpose and the newfound perspective the work affords them. The study provided important insights into the world of crisis work, and provides implications for counselors, clinical supervisors, and counselor educators. The collective narrative and identified themes present in participant stories may help to inform the work of all counseling professionals regardless of area of specialization, and provides some important directions for future research.

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*Appendix A*

## IRB Approval Letter



**Institutional Review Board**  
School of Nursing & Graduate School Building  
Room 333  
Office: 973-655-7583  
Fax: 973-655-3022

Sep 30, 2020 7:57 AM EDT

Ms. Rachel Sugerman  
Dr. Dana Levitt  
Montclair State University Department of Counseling  
1 Normal Ave.  
Montclair, NJ 07043

Re: IRB Number: IRB-FY20-21-1876  
Project Title: SS Constructing Personal and Professional Meanings of Behavioral Health  
Emergencies

Dear Ms. Sugerman,

After an expedited review:

6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Montclair State University's Institutional Review Board (IRB) approved this protocol on September 29, 2020. With the implementation of the new federal rule, expedited studies no longer have an expiration date. Instead, we will ask that you complete an Administrative Check In, every two years, updating our office with the status of your research project. Your check in date is September 29, 2022. We will send you a reminder prior to that date.

This study has been approved under the conditions set forth by current state regulations due to COVID-19 and Montclair State University [Restart Plan's Research](#) guidance. You are required to follow the approved plan for face-to-face research interactions. If you have any questions about the impact of COVID-19 with regards to the methods proposed in your study, please do not hesitate to contact us.

All active study documents, such as consent forms, surveys, case histories, etc. , should be generated from the approved Cayuse IRB submission.

When making changes to your research team, you will no longer be required to submit a Modification, unless you are changing the PI. As Principal Investigator, you are required to make sure all of your Research Team members have appropriate Human Subjects Protections training, prior to working on the study. For more clarification on appropriate training contact the IRB office.

If you are changing your study protocol, study sites or data collection instruments, you will need to submit a Modification.

When you complete your research project you must submit a Project Closure through the Cayuse IRB electronic system.

If you have any questions regarding the IRB requirements, please contact me at 973-655-2097, [cayuseIRB@montclair.edu](mailto:cayuseIRB@montclair.edu), or the Institutional Review Board.

Sincerely yours,

Amy Krenzer  
Senior Human Research Protection Analyst

cc: Ms. Deborah Reynoso, Graduate School, Academic Services Coordinator



*Appendix B*

Demographic Questionnaire

Please complete this questionnaire prior to the interview. The information you disclose will be kept confidential but please refrain from listing your name on this questionnaire. If you would prefer not to answer a question, please leave it blank. Thank you.

Date: \_\_\_\_\_

Gender: \_\_\_\_\_

Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Highest level of education completed: (please mark in the appropriate space)

Master's: \_\_\_\_\_

PhD: \_\_\_\_\_

Licensure status: (please mark in the appropriate space)

Licensed Associate Counselor (LAC): \_\_\_\_\_

Licensed Professional Counselor (LPC): \_\_\_\_\_

Total years of clinical practice: \_\_\_\_\_

Years working in a behavioral health emergency setting: (please specify) \_\_\_\_\_

Current job title: \_\_\_\_\_

Previous clinical experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Appendix C*

## Recruitment Email to Screening Center Directors

Dear \_\_\_\_\_:

I am writing to let you know about an opportunity for your staff to participate in a research study examining how crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. This study is being conducted by Rachel Sugerman from the Department of Counseling at Montclair State University under the supervision of Dr. Dana Heller Levitt. This study will involve two audio- or video-recorded interviews conducted via Zoom. The first interview will be approximately 60-90 minutes in length and the second interview will be approximately 30-60 minutes in length.

If your staff (a) possess a master's degree or higher in counseling, (b) have interfaced with clients experiencing behavioral health emergencies on a regular basis within the last year (c) have one or more years of post-master's experience working in a crisis setting, and (d) are able to articulate their experiences, they may be eligible to participate.

Participation in this study may add to the body of literature that pertains to best practice involved in the education, training, and supervision of counselors. It may also add to a greater understanding of how best to support the healthy development of counselors, and, by extension, their clients.

If you have any questions, please contact Rachel Sugerman (732-216-7773; [sugermanr1@montclair.edu](mailto:sugermanr1@montclair.edu)) or Dr. Dana Heller Levitt (973-655-2097; [levitt@montclair.edu](mailto:levitt@montclair.edu)).

Thank you for considering participation in this study. This study has been approved by the Montclair State University Institutional Review Board, Study no. IRB-FY20-21-1876.

Sincerely,



Rachel Sugerman, LPC, ACS, NCC  
Doctoral Candidate  
Department of Counseling, Montclair State University

*Appendix D*

## Recruitment Email to Potential Participants

Dear \_\_\_\_\_:

I am writing to let you know about an opportunity for you to participate in a research study examining how crisis counselors make meaning, in their personal and professional lives, of their work with clients experiencing behavioral health emergencies. This study is being conducted by Rachel Sugerman from the Department of Counseling at Montclair State University under the supervision of Dr. Dana Heller Levitt. This study will involve two audio- or video-recorded interviews conducted via Zoom. The first interview will be approximately 60-90 minutes in length and the second interview will be approximately 30-60 minutes in length.

If you (a) possess a master's degree or higher in counseling, (b) have interfaced with clients experiencing behavioral health emergencies on a regular basis within the last year (c) have one or more years of post-master's experience working in a crisis setting, and (d) are able to articulate their experiences, they may be eligible to participate.

Participation in this study may add to the body of literature that pertains to best practice involved in the education, training, and supervision of counselors. It may also add to a greater understanding of how best to support the healthy development of counselors, and, by extension, their clients.

If you would like to participate, please contact Rachel Sugerman (732-216-7773; [sugermanr1@montclair.edu](mailto:sugermanr1@montclair.edu)). Should you have any questions about this study, please contact Rachel Sugerman (732-216-7773; [sugermanr1@montclair.edu](mailto:sugermanr1@montclair.edu)) or Dr. Dana Heller Levitt (973-655-2097; [levittd@montclair.edu](mailto:levittd@montclair.edu)).

Thank you for considering participation in this study. This study has been approved by the Montclair State University Institutional Review Board, Study no. IRB-FY20-21-1876.

Sincerely,



Rachel Sugerman, LPC, ACS, NCC  
Doctoral Candidate  
Department of Counseling, Montclair State University

*Appendix E*

## Consent Form

*College of Education & Human Services*

Department of Counseling

Voice: 973-655-7216

**ADULT CONSENT FORM**

Please read below with care. You can ask questions at any time, now or later. You can talk to other people before you sign this form.

**Title:** Constructing Personal and Professional Meanings of Behavioral Health Emergencies

**Study Number:** IRB-FY20-21-1876

**Why is this study being done?** This study aims to develop a deeper understanding of how crisis counselors make meaning, in their personal and professional lives, of their experiences working with clients in the midst of behavioral health emergencies. Participation in this study may add to the body of literature that pertains to best practice involved in the education, training, and supervision of counselors. It may also add to a greater understanding of how best to support the healthy development of counselors, and, by extension, their clients.

**What will happen while you are in the study?** You will be asked to complete a short questionnaire to provide some basic demographic details. You will then participate in an interview conducted via Zoom lasting approximately 60-90 minutes. The interview will be audio- and/or video-recorded. You will also be asked to participate in a second interview at a later date during which you may be asked to clarify and/or add to what you discussed during the first interview.

**Time:** The initial interview will take approximately 60-90 minutes. The second interview will take approximately 30-60 minutes.

**Risks:** While the intent of this study is not to induce mental or emotional distress, some of the material discussed during the interviews may elicit strong emotional reactions from participants.

**Benefits:** There are no anticipated personal benefits associated with this study. However, participation in this study may add to the body of literature that pertains to best practice involved in the education, training, and supervision of counselors. It may also add to a greater understanding of how best to support the healthy development of counselors, and, by extension, their clients.

**Compensation** There is no compensation associated with your participation in this study.



*Appendix F*

## Interview Guide Session #1:

Hello, \_\_\_\_\_. Thank you for agreeing to participate in this study and thank you for your time today. My name is Rachel Sugerman and I am currently a doctoral candidate in the Counseling Program at Montclair State University. Before we get started, I'd like to give you a little overview about what to expect. This interview will take approximately 60-90 min. My goal is to understand your story and the ways in which you make meaning, in your personal and professional lives, of your work with clients experiencing behavioral health emergencies. You have already signed an informed consent form agreeing to be interviewed for this study. Do you have any questions about the informed consent before we get started? I would also like to ask for your permission to record this interview. If, at any time, you wish me to stop recording the interview, please let me know and I will stop the recorder. If, at any time, you wish to end the interview, simply let me know and we can discontinue the interview. Your responses in the interview will be confidential. Also, when discussing actual people, please do not use their real names.

Your participation in this study is completely voluntary and you can opt out of participation at any time. If you have any questions or concerns that come up after the interview, you can reach wither me or my faculty sponsor by phone or at the email addresses provided to you in your consent form.

## Interview Questions:

Counselor Identity and Development:

- Describe for me how you came to work as a crisis counselor.

Defining Moment Experiences:

- Tell me a story about a work experience that personally impacted you?

- How do you think your work with clients experiencing behavioral health emergencies has changed you?

Depending on depth of participant responses, possible probing and/or clarifying questions may include those such as the following:

Counselor Identity and Development:

- Tell me about your education and training experiences as a counselor.
- Tell me about your counseling philosophy.
- Tell me about your clinical experiences prior to working in this setting.
- Describe for me what your training experiences were like as a crisis counselor.
- Tell me about your long-term career plans.

Defining Moment Experiences:

- Tell me about a work experience you found particularly fulfilling? Particularly difficult?
- Tell me about a work experience that personally impacted you?
- When thinking about your work as a crisis counselor, what is the most significant memory you have?
- Tell me about the clinical aspects of your work?
- Tell me about the emotional aspects of your work?
- What have you learned from your experiences as a crisis counselor?
- In what ways has your work with clients experiencing behavioral health emergencies changed you? What about your outlook on life?
- How do you explain what kind of work you do when you meet people for the first time?

## Interview Guide Session #2:

Hello, \_\_\_\_\_. Thank you for agreeing to participate in this follow up interview today. As you know, this interview will include questions regarding your experience as a crisis counselor and your experiences working with clients in the midst of behavioral health emergencies. During this interview, I will ask you clarifying questions based on your responses from the first round of interviews. It will take approximately 30-60 minutes. Before we get started, I'd like to revisit our conversation about the informed consent you signed prior to participating in the first interview. Do you have any questions about the informed consent? I would also like again to ask for your permission to record this interview. If, at any time, you wish me to stop recording the interview, please let me know and I will stop the recorder. If, at any time, you wish to end the interview, simply let me know and we can discontinue the interview. As a reminder, your responses in the interview will be confidential. I'd also just like to remind you that when discussing actual people, please do not use their real names.

Your participation in this study is completely voluntary and you can opt out of participation at any time. If you have any questions or concerns that come up after the interview, you can reach wither me or my faculty sponsor by phone or at the email addresses provided to you in your consent form.

Interview Questions:

Self-Care:

- Tell me about what sustains you in this type of work?

Depending on depth of participant responses, possible probing and/or clarifying questions may include those such as the following:

- Tell me about your relationships with your coworkers.



- Tell me about how you decompress between shifts? What kind of self-care do you practice as a means to sustain you in this type of work?
- What do you think are the aspects of your work that would be hard for someone to understand who doesn't do this type of work?
- In what ways, if any, has your work affected your personal life?
- Tell me about what a shift is like for you if you are experiencing your own personal problems outside of work.
- Tell me about your experiences with supervision.
- Tell me about what you have found to be most challenging about your work.
- Tell me about what you have found to be the most satisfying parts about your work.

Clarifying Questions:

- Clarifying questions based on responses and data from first round of interviews.