

Summer 8-2023

The Lived Experiences of 911 Dispatchers With Compassion Fatigue: An Interpretive Phenomenology

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THE LIVED EXPERIENCES OF 911 DISPATCHERS WITH COMPASSION FATIGUE:

AN INTERPRETIVE PHENOMENOLOGY

by

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B.S. May 2014, Regent University

M.A. August 2017, Regent University

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELING

OLD DOMINION UNIVERSITY

August 2023

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ABSTRACT

THE LIVED EXPERIENCES OF 911 DISPATCHERS WITH COMPASSION FATIGUE: AN INTERPRETIVE PHENOMENOLOGY

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911 dispatchers are the “*first*” first responders in an emergency and play an intrinsic role in the public safety continuum. 911 dispatchers are exposed to daily and cumulative stress from the repeated empathic engagement of those they serve, and from shift work, staffing shortages, and inability to make mistakes. However, there is a dearth of peer reviewed literature on 911 dispatchers and compassion fatigue (CF). CF is described as the emotional and physical exhaustion experienced due to the constant exposure to the trauma of others. CF symptomology in 911 dispatchers has far reaching implications for not only the citizens who need critical lifesaving support but also the first responders who rely on the 911 dispatchers for detailed information relating to officer safety. In this study, I examined the lived experiences of 911 dispatchers with CF through an interpretive phenomenology lens. The data was gathered from one-on-one interviews and was analyzed on the individual level and from across participant themes while maintaining the integrity of the individual participant responses. Six superordinate themes emerged: 911 Dispatcher Challenges, Management/Agency, Physical Impact, Traumatic Calls, Clinical Symptoms, and When the Helpers Need Help. The results of this study highlighted the dire need for increased awareness of the challenges dispatchers experience, management support, mental health outreach, and research involving this essential population.

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This dissertation is dedicated to my three amazing granddaughters.

ACKNOWLEDGEMENTS

First of all, I would like to thank my committee members for their guidance through this dissertation process. My chair, Dr. Kristy Carlisle, I know you must have had many moments of just shaking your head. I appreciate your support, mentorship, direction, and patience you have provided me over the course of the past year, and I am forever grateful. I definitely could not have completed this without you! Dr. Jason Sawyer, methodologist, thank you for your wisdom and commitment to qualitative work. Our discussions have helped me conceptualize IPA research. Dr. Eric Brown, committee member, I appreciate your willingness to join my dissertation committee. I value your insight and direction that has helped me maintain the clinical focus.

Secondly, I would like to thank my family for their continued support, encouragement, and patience throughout my entire academic journey. Often, I doubted myself and wanted to quit but my family was always there providing the exact words I needed to hear to keep going.

Additionally, to my cohort, the support you have provided me has been invaluable. We came into this program at a challenging time and experienced many obstacles, but we have made it through and can see the proverbial light at the end of the tunnel. I will forever cherish our coffee time and sushi lunches.

Finally, I would like to send my heartfelt gratitude to all of the dispatchers who took the time to share their experiences and insight with me. To the thin gold line, the “first” first responders, always heard but rarely seen, we see you and appreciate everything you do and the sacrifices you make to serve the citizens of your community.

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Introduction

In this chapter I will provide an overview of the background of the proposed study, followed by a synopsis of the duties and responsibilities specific to 911 dispatchers and a brief summary of the challenges 911 dispatchers face daily. I will follow with a discussion of compassion fatigue and ramifications for dispatchers, also providing implications for mental health counselors. The chapter concludes with a description of the research design, research questions, limitations, future research, and key operational terms.

Background of the Problem

This dissertation examined the lived experiences of 911 dispatchers with compassion fatigue (CF). The study was essential to acquire an understanding of the experiences 911 dispatchers have with the psychological and physical ramifications of CF. Further, it shed light onto the subsequent implications for agency staffing shortages and retention, dispatcher performance that ensures high quality services in life-or-death situations, and how to best support this essential population as they serve our communities and guard our safety. Researchers agree there is a paucity of peer-reviewed literature and evidence-based practices related to 911 dispatchers (Anshel et al., 2012; Lilly & Pierce, 2013; Marks et al., 2017). Whilst some researchers address PTSD and secondary traumatic stress amongst dispatchers, who either dispatch for police or fire/EMS, they do not address compassion fatigue amongst dispatchers from primary Public Safety Answering Point (PSAP) agencies who routinely dispatch all three public safety emergency services. This study addressed CF symptomology in 911 dispatchers from primary PSAP agencies and deeply explores the numerous challenges 911 dispatchers experience daily. Many of the challenges and duties they must undertake during their shift are

often overlooked or unknown to those outside of the profession due to the dispatcher being heard but never seen.

911 Dispatchers and Their Duties

911 dispatchers, also referred to as calltaker, dispatcher, telecommunicator, emergency centre operative, etc. in the literature, (Meischke et al., 2020; Oldenburg et al., 2014) are the immediate first responders in the critical chain of survival when a citizen calls for emergency services (e.g., police, fire, and paramedics; Miller et al., 2017; Ramey et al., 2016). The term dispatcher is used throughout this study for continuity purposes. Each role in the communication center, (i.e., calltaker, police dispatcher, fire/EMS dispatcher) is filled by separate employees in the majority of larger jurisdictions whereas in some smaller jurisdictions the calltaker may also fulfill the role of the dispatcher and must simultaneously dispatch responding units while listening to multiple channels, and talking on the phone to the citizen in crisis.

The calltaker is tasked with answering the 911 call for service. The calltaker must assess the situation rapidly and deescalate callers in crisis while remaining calm in order to gather the pertinent information for the responding units. The most stressful time, as marked by an increase in cortisol levels, is when the 911 call comes into the communications center (Bedini et al., 2017). The sense of not knowing what is on the other end of the phone line can create an immediate heightened emotional and physical response. The calltaker is required to disseminate pre-arrival and post-dispatch medical instructions ranging from CPR and hemorrhage control to panic-stricken and oftentimes uncooperative callers. Delays in obtaining the correct address or related information can result in significant impairment or contribute to the death of the citizen (Oldenburg et al., 2014). The calltaker experiences the added stress of transitioning quickly

between types of emergency calls. For example, the first call may be a gunshot victim taking their last breath and the very next call might be a citizen who needs the operating hours for animal control. The calltaker experiences constant task switching all the while managing or suppressing their own emotions (Ramey et al., 2016).

The dispatcher is traditionally the individual who is responsible for dispatching police, fire, and EMS personnel to the scene of an emergency. The dispatcher is required to quickly read and disseminate all pertinent information of the call to the responding units. There may be multiple units and a constant influx of incoming calls the dispatcher is responsible for during their shift. The police dispatcher handles any requests from the field units including wanted checks, driving record requests, calling citizens, and, depending on the agency, calling for tow trucks and animal control. The fire and EMS dispatcher often work in unison with each other. This dispatcher manages the safety of the fire and EMS personnel, multi-jurisdiction notifications, responses, and incident chain of command structure in the event of a large-scale traumatic event (FEMA.gov).

911 Dispatcher Challenges

No single study summarizes all the challenges faced by 911 dispatchers; however, this study attempted to shed light on the extent of these challenges. Many counselors and researchers may be incognizant of the vast challenges dispatchers endure due to this lack of inclusion in research. Routine challenges are directly related to the types of traumatic calls received, abusive callers, and 911 hang up calls with insufficient information to send field units.

The other subset of challenges directly relates to workplace environments such as dimly lit communications centers, shift work, mandatory overtime, and critical staffing levels nationwide. Stress, shift work, and the overall sedentary nature of the profession increases the

negative consequences on the physical and mental health of the dispatcher (Smith et al., 2019; Wahlgren et al., 2020). Dispatchers do not receive the closure that field units are privy to. The dispatcher who becomes emotionally invested is left wondering what happened to the citizen.

Although the dispatcher is not on scene with the citizen, the dispatcher becomes an auditory witness to the traumatic event. The dispatcher is trained to dispatch by the worst-case scenario rule (Wang, 2017). By doing so, this has created a picture of the scene in the mind of the dispatcher. Typically, this scene is worse than the actual scene; however, this is the traumatic picture the dispatcher is left to emotionally process. Dispatchers have adopted, from the military, Emotion Code coping strategies which necessitate the dispatcher's ability to suppress and compartmentalize their own emotions to answer one traumatic call after another (Luber, 2015). In the communications center, due to staffing shortages, there is little down time for the dispatcher to step away from the console to consume their lunch let alone to process their own emotions; rather, the dispatcher must answer the next 911 call.

CF and Implications for Dispatchers

Repeated stress exposure increases negative coping mechanisms, intensifies poor family and co-worker relationships, and increases long term health effects (Anshel et al., 2012; Berger et al., 2015). Furthermore, due to repeated empathic engagement the dispatcher's ability to respond expeditiously to the crisis is impeded, which can have detrimental effects for the citizens and field units. Still, little is known about the lived experiences of 911 dispatchers with CF.

Compassion fatigue in the 911 dispatcher has significant implications for citizens who rely on the dispatcher to provide accurate pre-arrival and post-dispatch medical instructions and expeditious dispatch of emergency personnel. The implications extend to public safety

personnel, who require the dispatcher to remain alert and attentive when dispatching high priority calls with time sensitive information, and to communication centers facing staffing shortages creating budgetary concerns and concern over how to meet the needs of the citizens in their community.

Implications for Mental Health Counselors

Although the psychological and physical implications of CF are relatively known, mental health counselors are often unaware of the impact of CF on 911 dispatchers. The study provided mental health clinicians greater insight into the profession and daily life of the 911 dispatcher which can increase their comfortability and knowledge of best practices when partnering with this population and engaging in practitioner-based research. Figley (1995) discussed “scholars and clinicians require a conceptualization that accurately describes the indices of traumatic stress...” (p.7). Providing an in-depth view of the experiences of 911 dispatchers with CF, their daily and cumulative stressors, and their duties can help to acclimate clinicians to the complexities of the dispatcher’s role.

Considering the life-or-death responsibilities of 911 dispatchers, it is important to understand how counselors can support this population to optimize their performance in their life-saving roles. Furthermore, counselors often advertise their expertise with providing trauma informed care for police, fire, and EMS; however, they typically omit dispatchers in their outreach efforts rather than making them a priority, since police, fire, and EMS personnel cannot respond without the direction of the 911 dispatcher.

Research Design

In order to capture the essence of the lived experiences of 911 dispatchers with CF, this study incorporated an IPA research design. IPA, deeply rooted in Hermeneutics, Ideography, and Phenomenology, was selected due to the data analysis practice of convergence and divergence (Tuffour, 2017; Smith, 2004). The data was analyzed on the individual level and from across participant themes while maintaining the integrity of the individual participant responses. Furthermore, this method allowed the dispatcher's own voices to be at the forefront providing an opportunity for mental health counselors to understand the dispatcher's challenges and to structure their own clinical work with public safety personnel to include 911 dispatchers.

I incorporated purposive sampling methods by presenting at public safety conferences and speaking on podcasts as well as sending emails to one hundred forty-nine various communication centers across the United States to obtain a sample size appropriate for saturation of themes. Criteria for inclusion into the study was: dispatchers who are over the age of 18; employed full time with a primary PSAP agency; have been employed as a dispatcher for at least two years; and who work independently of a trainer. The participants were given the ProQOL-5 to determine CF symptomology for inclusion in the study (see Table 3). Those participants who scored in the medium to high range for CF symptomology were selected for the study and sent an acceptance email with links to schedule the interview. Those who did not score in this range were sent an ineligibility email. Eighty participants from across the United States completed the interview questions and ProQol5. Seventy-five participants met criteria to be included in the study. Thirty-four of the participants who met criteria for inclusion into the study scheduled interviews. IPA highlights the quality of interviews and participants versus quantity (Larkin et al., 2021). This smaller participant selection allowed for richer data collection and analysis. The questions guiding this proposed study are:

- RQ#1: What are the lived experiences of 911 Dispatchers with compassion fatigue?
- RQ#2: What was the 911 dispatcher's experience with peer debriefing availability or mental health treatment after experiencing compassion fatigue symptomatology?

Limitations and Future Research

While this study generated a wealth of information on the lived experiences of 911 has been criticized for being ambiguous and lacking standardization (Tuffour, 2017). To counter this limitation, I followed the seven-step guide for conducting IPA data analysis. The steps of this outline, as detailed by Smith (2009), are: (1) Data collection and detailed notes, (2) Re-read and listen, (3) Uncover emerging themes, (4) Search for connections across emergent themes, (5) Bracket previous themes and move to the next case, (6) Extract patterns across cases, (7) Deepen the analysis and start next transcripts. Repeat steps 1-6.

Secondly, although all reasonable efforts of transparency, related to my own prior experience as a 911 dispatcher was disseminated to the participants prior to the start of the interview, my own worldview may influence the data. IPA assumes the researcher will naturally have preconceived ideas and prior experiences regarding the phenomena in question and instead of attempting to eliminate them I created a reflexive journal to refer to prior and during the interview process and while examining and interpreting the data to record the personal experience of the process (Creswell & Miller 2000; Hays & Singh 2012; Horrigan-Kelly et al., 2016; Miller et al., 2018; Vagle 2018). The reflexive journal was created and maintained throughout the process from beginning to end of this study. I engaged in regular debriefings with my committee members to discuss emotions and biases that emerged. With the completion of this study, examining the lived experiences of 911 dispatchers with CF, future directions may focus on developing mental health support in the community with mental health clinicians

trained in trauma informed care, psychoeducational training programs, and peer support groups specifically for 911 dispatchers. Future directions for research may focus on the 911 dispatchers lived experience with receiving trauma informed care. This study may have implications for future policy making at the local and state levels for 911 dispatcher inclusion into the public safety continuum.

Operational Definitions

911 Calltaker

For the purpose of this study, 911 calltaker refers to the individual who answers 911 calls for police, fire, and EMS service. This is the individual responsible for answering the 911 call, entering the information into CAD, and ensuring all pertinent information has been gathered. The calltaker assures and calms the frantic caller, provides pre-arrival and post-dispatch medical instructions, and, depending on the nature of the call, remains on the phone with the caller until the units arrive.

911 Dispatcher

Dispatcher and calltaker are often used interchangeably in the literature and in many agencies. The dispatcher is the individual responsible for prioritizing the call and sending the closest available units to the scene. The dispatcher keeps track, via GPS locator, of all units assigned to their precinct channel. The dispatcher is responsible for running wanted inquiries, DMV checks and various other duties as requested by the field units.

Public Safety Answering Point (PSAP)

A PSAP is the primary location where 911 calls are received via landline or cellphone. The primary PSAP localities answer, and triage all calls for police, fire, EMS, and non-

emergency whereas secondary PSAP may receive calls for Fire/EMS transferred to them from the primary PSAP.

Compassion Fatigue

For the purpose of this study, Compassion Fatigue (CF) refers to emotional and physical exhaustion experienced due to the constant exposure to the traumatic calls of others and lack of perceived support limiting the empathic capability of the 911 dispatcher (Kindermann et al., 2020). Charles Figley (1995, 1996, 2002) introduced the term CF and viewed it as a less stigmatizing term than secondary traumatic stress. CF has been compared to eliciting negative emotional responses similar to PTSD except for route of traumatization (Stamm, 2009).

Summary

In Chapter 1, I provided a description of the background of the proposed study, followed by an overview of the nomenclature and responsibilities of 911 dispatchers, and an abridged discussion of the implications for mental health counselors. The chapter concluded with a brief explanation of the research design including research questions, limitations, implications for future research, and operational definitions.

LITERATURE REVIEW

In this chapter I provide a comprehensive summary of the literature related to 911 dispatchers and compassion fatigue. Compassion fatigue symptomology in 911 dispatchers has far reaching implications for not only the citizens who need critical lifesaving support but also the first responders who rely on the 911 dispatchers for detailed information relating to officer safety. I begin with an overview of the various nomenclature of dispatchers, professional job classifications, and insight into the 911 dispatchers job responsibilities and subsequent challenges faced daily resulting in compassion fatigue. Next, I review existing literature surrounding the mental health consequences of repeated exposure to traumatic calls resulting in Compassion Fatigue, Post-Traumatic Stress Disorder (PTSD), and secondary traumatic stress. I conclude this chapter with an examination of the dearth of literature surrounding 911 dispatchers, the need for the 911 dispatchers' inclusion into public safety mental health support and research, and the implications for the mental health counselors who would serve them.

Nomenclature, Classification, Responsibilities

911 dispatchers, also referred to as calltaker, dispatcher, telecommunicator, emergency centre operative, etc. in the literature, (Meischke et al., 2020; Oldenburg et al., 2014) are the immediate first responders when a citizen in crisis calls for emergency services (e.g., police, fire, and paramedics; Miller et al., 2017; Ramey et al., 2016). Each role in the communication center, (i.e., calltaker, police dispatcher, fire/EMS dispatcher) is filled by separate individuals in most larger jurisdictions whereas in certain smaller jurisdictions the calltaker may also execute the role of the dispatcher simultaneously.

911 dispatchers are often unofficially considered the *first*, first responders (Birze et al., 2020; Lilly & Allen, 2015; Lilly et al., 2019). Sometimes classified as sworn public safety or civilian executive or administrative personnel (Ramey et al., 2016), the knowledge and skill set required for entry into the profession varies depending on jurisdiction and job classification title. The lack of a standardized professional title and classification is widely presented in literature and amongst the numerous communication centers across the country.

It is relevant to understand not only the nomenclature but the various classifications and responsibilities of the 911 dispatcher as they are vastly different (Shakespeare-Finch et al., 2014). The various employment classifications, duties, and challenges faced by the 911 dispatcher combined create unique mental health challenges and increase susceptibility of experiencing compassion fatigue.

Employment Classifications

911 dispatchers represent a unique subculture of public safety personnel. As a profession, their job titles and duties vary based on locality. Although some duties are universal such as answering 911 calls, other responsibilities are determined by classification. Most primary public safety answering points (PSAP) will respond to police, fire, and EMS calls for service requiring the 911 dispatcher to be cross-trained in the several critical areas (call taking, police, fire, and EMS dispatching); however, certain jurisdictions will separate fire and EMS (Jacksonville Sheriff's office, n.d).

Telecommunicator

Besides dispatcher, the job classification title of Telecommunicator is one of the most frequently viewed in the literature (APCOintl.org; Camaro et al., 2020; Pierce & Lily 2012;

Wahlgren et al., 2020). The Association of Public Safety Communications Officials (APCO) describes the telecommunicator as the individual who answers the 911 call via telephone, text, or other media devices and disseminates the information and dispatches public safety personnel. The telecommunicator may or may not perform call taking and dispatching simultaneously (APCOintl.org). Baseman et al. (2018) describes the telecommunicator as the individual who “fields thousands of calls that are unpredictable in volume, length, and content every year” (p. 2).

Calltaker

The calltaker is the individual who operates a multi-line emergency telephone system while entering pertinent information into the CAD (Norfolk.gov). The calltaker may process emergency and non-emergency calls for service as well as handle calls for other agencies such as animal control. Most often in the literature, calltakers are referred to as a separate employment classification from dispatchers (Lum et al., 2020; Shakespeare-Finch et al., 2014; Turner et al., 2019;); however, Bourgeois et al. (2021) and Smith et al. (2019) included both terms in their research without differentiating between the two classifications. Kindermann et al. (2020) combined both calltaker and dispatcher resulting in the terminology applied in their research as *Emergency Call-takers and Dispatchers* (ECDs). The roles were combined whereas in many communications centers the roles are separated with the dispatcher role requiring extensive training to obtain this position (Jaxsherrif.org; VBGov.com).

Dispatcher

The dispatcher’s role is highly technical and skilled. Shakespeare-Finch et al. (2014) acknowledged the significant differences between call-takers and emergency medical dispatchers. Karunakaran (2021) reported 911 dispatchers “have higher functional authority over

the police officer” (p.2). The police, fire, and EMS dispatcher processes the call from the call-taker via CAD, dispatches the appropriate responding units based on priority and location, and maintains radio air traffic. The dispatcher is required to learn and comprehend law enforcement and fire/EMS general orders and standard operating procedures.

Even though many in literature may use the terms interchangeably there are notable differences between the classifications. Each role is essential in the chain of survival and in the day-to-day operation of the communication center. The skills required for their job duties are vast beyond their titles.

Duties and Responsibilities

The literature provides an overview of 911 dispatchers duties as an integral part of the public safety response team. However, a more detailed depiction of their unique responsibilities may provide insight into the challenges these professionals face daily culminating in compassion fatigue (Coxon et al., 2016). Many of the challenges the dispatchers face are unique to their profession and often go unnoticed by those outside of this subculture.

Calltaker

The primary responsibility for a 911 calltaker is to receive the emergency call from the citizen and process incoming information. Calltakers process thousands of calls per year ranging from the inconsequential (what time does the parade start) to life altering (mass shootings) (Meischke et al., 2015). The calltaker must accurately transmit the gathered information, apply the appropriate dispatch code with priority level, and enter the information into a Computer Aided Dispatch (CAD) system while keeping the caller on the telephone (APCOintl.org). Another of the calltakers functions is to manage the telecommunication device for the deaf and

hearing impaired (TDD/TTY) as well as NextGen 911 services such as text to 911 and video calls. (Baseman et al., 2018; CityofChesapeake.net; VBGov.com)

The calltaker is the first person a citizen in distress will speak with during an emergency situation (Bourgeois et al., 2021). The calltaker is required to remain calm no matter what the individual says or experiences. Additionally, the calltaker must maintain their composure even if that individual succumbs to their injuries prior to the arrival of the responding units (McAleavy et al., 2021). This stoic composure enables the dispatcher to focus and detect the most minute sound in the caller's background which may be of extreme importance to responding units' safety and the safety of the caller (APCOintl.org; HR1629).

The 911 calltaker is required to perform life and death decisions in a matter of seconds (Terrell et al., 2004). Imbens-Bailey and McCabe (2000) reported the goal of this communication between the caller and calltaker is not to create a story; rather, to gather only the most critical information to elicit a response to dispatch emergency personnel. Details and circumstances of the call can change dramatically during the timeframe of the call (Simpson, 2020). A call may start out as seemingly benign, nevertheless can rapidly change to life-critical in an instant invoking the requirement to strictly follow a different protocol for a higher priority call.

Calltakers are required to comprehend and follow professional best practices, general operating procedures, GPS mapping, automatic location identification (ALI), and automatic number identification (ANI) software (Kevoe-Feldman, 2019). Best practice standards now suggest 911 calltakers need to have completed basic life support and first aid training in order to provide life-saving cardiopulmonary resuscitation (CPR) instructions, Heimlich (choking) maneuver, childbirth, and various other critical care instructions. (Lilly et al., 2019; McAleavy et al., 2021; Meischke et al., 2020). Providing the life critical protocol of calltaker assisted CPR has

been shown to increase the rate of bystander CPR thus improving the survival rate of the patient (Clegg et al., 2014).

There are multiple individuals in the communications center, each playing a critical role in the survival of the patient. The primary responsibility of the calltaker is to answer 911 calls for service, assess the priority, and enter pertinent information into CAD. Once this is completed the emergency call is now the responsibility of the dispatcher. The dispatcher is now in control of the call and must send a response accordingly.

Dispatcher

Dispatcher can be viewed as an umbrella term that describes the individual who dispatches emergency personnel. There are typically three diverse types of dispatchers who differ in which emergency personnel they are responsible for assigning to calls, the protocols they follow, and their role in the communication center. The following details duties and responsibilities of the police, fire, and EMS dispatchers

Police

The responsibilities of the emergency police dispatcher consist of several components. First, the dispatcher is the individual who receives the call from the call-taker via CAD (APCOintl.org). Secondly, the dispatcher selects the responding units based on location and availability to send to the pending call. In summary, the dispatcher disseminates all pertinent information to the responding units, maintains radio air traffic, and processes officers' requests such as wanted checks and driving records (Preusse & Gipson 2016). The dispatcher is entrusted with the authority to make split second decisions without the ability to ask questions due to the

fast-paced nature and demands of the position; regardless of the expeditious pace, the dispatcher cannot make mistakes (Steinkopf et al., 2018).

The police dispatcher is committed to officer safety, ensuring details of the event are relayed to the responding officers as quickly and accurately as possible (Birze et al., 2020; Karunakaran 2021; Ramey et al., 2016). This position dictates the dispatcher is to multi-task under highly stressful cognitive situations such as traffic pursuits, assaults in progress, and unfortunately officer down calls (Bourgeois et al., 2021).

Within the communications center there is a routine collaboration between the police and fire/Ems dispatchers. Calls for services such as reported deaths, violent calls with injuries, or vehicle accidents with injuries warrant a dual response from both police and fire/Ems. Police are required to clear the scene of violent calls prior to fire/Ems making entry to the scene. The police dispatcher must relay pertinent scene safety information to the fire/EMS dispatcher. Even though the police dispatcher is primarily responsible for their own dispatch channel they play a profound role in ensuring the safety of all responding units.

Fire/EMS

Regardless of whether the call for a fire/Ems response was routed from the calltaker or police dispatcher, the dispatcher for paramedic and fire department services is required to ensure the responding apparatus is assigned appropriately based on the type and priority of the call (Oldenburg et al., 2014). The fire/Ems dispatcher is tasked with knowing the location of the fire stations and subsequent equipment housed at each station in the event of a CAD system failure (*Communications Officer (9-1-1) - MyJFRD*, n.d). Conversely, the dispatcher is well versed in the mutual aid policy and on scene incident chain of command structure as outlined by the

Federal Emergency Management Agency (FEMA; FEMA.gov 2018). The Fire/EMS dispatcher is in communication with the battalion chiefs and command staff at all times during major events such as a third alarm fire or active shooter.

The Fire/EMS dispatcher is charged with knowing when certain areas of the locality are without coverage due to a major fire or event (APCO Int'l.org). A longer response time due to distance traveled can gravely impact the patient. For instance, to mitigate the travel time, a dispatcher may be required to send an ambulance to back fill or to be temporarily housed at a station until the main unit clears their call.

The Fire/EMS dispatcher is simultaneously performing several duties at once such as listening to the units on the radio while talking on the phone to the citizen. The dispatcher is often required to contact the original caller to gain further patient information if specific details were omitted in the original call. Incorrectly relayed information to the responding paramedical or fire units can gravely hinder the continuation of care and mitigate attempts to save the life of the victim (Hosseini et al., 2018; Oldenburg et al., 2014).

Each of the 911 dispatcher's functions presents unique challenges while requiring the dispatcher to maintain flexibility to overcome the obstacles encountered during their shift. The dispatcher's ability to multitask quickly and efficiently and understand the hierarchical nature of the call is crucial to the overall response (Preusse & Gipson, 2016). The dispatcher never knows what lies on the other end of the call as events can change dramatically as soon as the dispatcher responds to the radio or picks up the phone (Simpson & Orosco, 2021). Considering the life-or-death responsibilities of 911 dispatchers, it is important to understand how counselors can support this population to optimize their performance in their life-saving roles. Furthermore, counselors often advertise their expertise with providing trauma treatment for police, fire, and

EMS; however, they typically omit dispatchers in their outreach efforts rather than making them a priority, since police, fire, and EMS personnel cannot respond without the direction of the 911 dispatcher.

Challenges

No single study summarizes all the challenges faced by 911 dispatchers. Many counselors and researchers may be incognizant of the vast challenges dispatchers endure. This dissertation summarized the challenges all in one place and highlights the breadth and depth of the extreme challenges they experience daily.

Cell Phone Usage

When 911 first became a national emergency number over 50 years ago, landlines were the primary mode of communication. Cell phones rapidly changed the face of accessing emergency assistance. It is estimated there are over 170 million cell phone calls made to 911 each year (Kevoe-Feldman & Sutherland, 2018). The issue is not the cellphone itself, rather it is the constantly changing technology and user error.

Multiple citizens are now able to call 911 from any location simultaneously. For example, when a vehicle accident occurs on a major roadway, every citizen who has witnessed the accident will access their cell phone and call 911. This increases the call volume exponentially in a matter of seconds. Callers not wanting to wait on hold or for the next available dispatcher often hang up. Communication centers were faced with creating a new policy to define cell phone hang up call response (NENA.org). The National Emergency Number Association (NENA) has developed an example of a standard operating procedure (SOP) on how

to handle 911 hang up calls from cell phones; however, each jurisdiction is responsible for creating their own SOP based on the needs of their service area.

Hang Up Calls

A 911 hang up call occurs when someone has dialed 911 either by accident, with the intent to maliciously harass the 911 dispatcher or due to the crisis situation the caller was unable to remain on the line. At times, the call will remain open without voice communication resulting in a silent 911 call. The dispatcher is tasked with determining which call is an emergency or nuisance call (Kevoe-Feldman & Sutherland, 2018). The dispatcher cannot simply ignore the 911 hang up, rather must investigate further to either make contact with the individual or gather an address (Norfolk.gov). The time spent following up on a 911 hang up call limits the time spent transitioning to the next person in need and places greater liability on the dispatcher especially if the call is deemed in error to be a nuisance call. Cell phones pose another barrier to access emergency service; the inability to automatically know the caller's location.

GPS Location

With the invention and overwhelming usage of cellphones, 911 dispatchers were faced with a new dilemma: how to determine the location of the caller (Kevoe-Feldman & Pomeranz, 2018). Time itself is a critical component during an emergency. Global Positioning System (GPS) capabilities are not always one hundred percent accurate, unbeknownst to the general public (Millard, 2016). Technology in the communications center cannot garner results as expeditious as what is displayed in television and cinema and cannot meet the expectations of the public (Federal Trade Commission, 2015).

The following is a common scenario. A cell phone call comes into the communication center. The dispatcher can hear what sounds like a cry for help. The caller hangs up. The dispatcher is tasked with frantically attempting to locate the caller. Many prepaid cell phones are not registered to any particular user, thus rendering any attempts at finding user information futile (FCC, 2020). Due to funding resources, communications centers may not function with the most up to date GPS technology (FCC, 2020). The dispatcher is required to “ping” or “rebid” the cellphone with hopes the ANI/ALI can render a location within so many meters of the actual caller (Millard, 2016). An address is obtained, and emergency units are dispatched to the location only to find a ten-story apartment building. ANI/ALI is incapable of pinging to the exact apartment (FCC, 2020). In the meantime, the dispatcher has been continuously attempting to call back the hang up call in attempts to receive a response to determine the exact apartment. In summary, GPS location is generally only accurate within 50 meters of the ANI/ALI location that is received by the communications center. It does not have the capability of determining an indoor location. The calltaker has to navigate several barriers to determine an exact location, exasperating resources, and eroding away precious time in an emergency situation.

911 Dispatchers face many challenges while performing their duty of serving the public in emergency situations. From cellphones to GPS location difficulties, each challenge presents its own unique modulation. Communication is essential to receive life-saving assistance; however, communication itself can become an obstacle.

Language Barriers

Our communities are comprised of a multitude of nationalities. Communications centers have partnered with translation services to assist individuals regardless of their language of origin ensuring equal access for all individuals (NENA, 2020). The inability to acquire accurate

information in a time-sensitive situation decreases the dispatchers' chances of sending responding units quickly.

If the communication center does not have calltakers on duty who can speak the caller's native language, individuals with Limited English Proficiency (LEP), must hold while the calltaker connects to a translation service (in911.net). Attempting to explain the reason for the pause, in order to connect to a translation service, can create frustration and confusion for the caller. Regardless of the translation service used, 911 dispatchers often bypass the translation services due to the time taken to connect with the third party and explain the situation. Sometimes, it is simply due to lacking confidence in the interpreter to translate pre arrival medical instructions accurately (Meischke et al., 2015). One of the lifesaving pre-arrival medical instructions calltakers are required to provide is CPR.

LEP hinders the caller's participation in performing lifesaving CPR, and at times, callers would hang up before the connection to the interpreter was established (Meischke et al., 2015). Sasson et al. (2015) discussed language as one of the various barriers to garner participation in bystander CPR and calling 911. The inability to communicate effectively with the caller can be traumatic for the distressed caller and calltaker. Unfortunately, the 911 dispatcher, due to no fault of their own, often faces the brunt of the caller's frustrations.

Face Attack

People calling 911 for police, fire, and EMS experience a wide array of distressing situations. The majority of 911 dispatchers are skillfully trained to converse and deescalate diverse types of situations; however, the dispatcher is not free from experiencing the stress associated with being on the receiving end of a verbal attack.

Often callers do not understand the process of the 911 call and erroneously think the responding units will be delayed by talking to the calltaker. For example, even after providing assurance, the caller can begin to become upset and yell “just send police” ending the call (Tracy, 2002). The caller is tasked with providing the critical information to the dispatcher who is required to ascertain certain information. (Kevoe-Feldman, 2019). Dispatchers are trained to ask specific questions not only for the safety of the caller but the safety of the responding units.

Since 911 dispatchers are the first person the caller will speak with in the face of an emergency, the dispatcher often receives the brunt of the caller’s frustration, fear, and anger. The dispatcher is unable to express their own emotions or even change the tone of their voice to insinuate frustration when speaking with the caller. Dispatchers are required to handle emergency calls in quick succession and compartmentalize any emotions from the prior call (Oldenburg et al., 2014). Considering the intense emotional and physical challenges 911 dispatchers face, understanding their experiences and how they can be supported is warranted and needed.

Workplace Environment

The overall workplace environment creates an additional stressor for the dispatcher. The workplace environment consists of the physical environment, staffing shortages, and shift work. Each aspect impacts the dispatchers emotional and physical well-being, increasing compassion fatigue symptomatology.

Physical Environment

911 dispatchers are subjected to dimly lit environments often in secure locations without windows and in confined workspaces with antiquated equipment (Birze et al., 2020). Mobility in

and out of the center is highly controlled. Everything that takes place in the communication center is recorded and monitored including the 911 calls, radio traffic, every keystroke on CAD, and how long a dispatcher takes on each call (Golding et al., 2017). The 911 dispatcher has very little control over their environment during their shift. The dispatcher cannot physically leave their workstation unless a relief has assumed the responsibility of their radio channel or call station. The environment limits mobility and requires the dispatcher to monitor numerous computer screens for an extended period (CityofChesapeake.net). The turnover rate is high, especially in the beginning years of the individual's career, as working in such a controlled environment proves difficult for many (Linos et al., 2021).

Staffing Shortages

Shouldering the responsibility of being the “*first*” first responder, is not without consequences. Communication centers are accessible 365 days a year, 24 hours a day. Nationwide staffing shortages were commonplace prior to the COVID-19 Pandemic; however, recent news outlets have reported an increase in the frontline worker staffing shortages (Linos et al., 2021).

On average, the time from entry into the profession to completion of training can vary from six to eighteen months depending on jurisdiction (VBgov.com). The national turnover rate ranges between 14-17% with many dispatchers exiting due to monetary constraints of starting salary and service issues (McAleavy et al., 2021). Answering 911 calls and listening to the trauma every day takes an emotional toll. This is not a profession where everyone can find personal and professional satisfaction. Staffing shortages have created a perfect storm of long work hours, mandatory overtime, and canceled days off.

Shift Work

Due to the 24/7 nature of 911, communication centers nationwide operate on several types of shift work schedules. Included in shift work is the requirement to work holidays, weekends, evenings, and nights. For instance, dispatchers are classified as alpha personnel which mandates, they report to duty in hurricanes, snowstorms, and other weather phenomena (VBgov.com). Due to staffing shortages, communications centers have transitioned to 12-hour work schedules (Jaxsherrif.org; Norfolk.gov)

Shift work has been identified as a possible influence on stress related disorders and post-trauma outcomes (Shakespeare-Finch et al., 2014). Often the dispatcher may be called back to work with little or no advanced warning (MyJFRD.com). Tuner et al. (2019) reported shift work of long hours and overtime is connected to increased stress levels and decreased physical and emotional health. Shift work has also been linked to chronic fatigue, obesity, lack of sleep, and increased negative health risks (Lilly et al., 2016; Wahlgren et al., 2020). Working night shift disrupts the natural circadian rhythms of the body leaving the dispatcher susceptible to increased risk of cardiovascular disease (Wong et al., 2012).

The basic nature of the profession is fast-paced without the structure of a traditional call center schedule. A crisis can occur at any moment which takes a toll on the emotional and physical well-being of the dispatcher. The dispatcher lacks control over their physical environment as well as not having the opportunity to process their emotions after a traumatic call.

Absence of Closure

Additionally, lack of closure is another challenge where the dispatcher has minimal control. Communication centers are barely meeting minimum staffing and the continuous incoming 911 calls, dispatchers, unlike their public safety counterparts, are unable to take a moment to destress between calls, process the emotions surrounding a traumatic call, or even at times to take a personal break (Turner et al., 2019). Dispatchers are required to handle emergency calls in quick succession and compartmentalize any emotions from the prior call (Oldenburg et al., 2014).

Due to the constant nature of the environment and the dispatcher not physically on the scene of the event, they often feel helpless and powerless due to not knowing the outcome of the call (Regehr et al., 2013). Baseman et al. (2018) reported this lack of final resolution may be a source of stress for the dispatcher.

The dispatcher experiences a constant state of hyperarousal as they transition from one 911 call to another. The lack of closure, especially after a call deemed traumatic, can leave the dispatcher feeling isolated and helpless (Regehr et al., 2013). Unlike the responding units who have the opportunity to witness the final outcome and to physically offer help to the caller, the 911 dispatcher must immediately answer another call (Turner et al., 2019).

Inability to Make Mistakes

Continuously transitioning from one call to another in such short succession without down time creates an opportunity for mistakes; however, one minute mistake can mean the difference between life and death for a citizen. With multiple lines ringing including non-

emergency, dedicated alarm companies, now NextGen 911 text to 911, and video calls, the 911 dispatcher is under great scrutiny to perform with precision and accuracy (VBgov.com).

Humans make mistakes; however, 911 dispatchers must be greater than human in a sense as they cannot make mistakes. The implications for transposing a number on an address or not accurately classifying a priority call are vast (Simpson, 2020). Failing to correctly assess the call and assign the appropriate response code creates liability issues for the 911 dispatcher (Clawson et al., 2018). Recent national events surrounding police officers have placed all public safety personnel under intense scrutiny, and liability has multiplied the amount of stress for the dispatcher.

Risk Management

Historically, it was rare for a dispatcher to be included in legal proceedings due to errors in judgment or a misclassification of a call; however, this immunity has been waning. To mitigate liability, 911 dispatchers are trained to adhere to strict protocols. Even the most seasoned and well-trained dispatcher may encounter calls that do not fit neatly into such protocols. The implications and liability are vast due to misclassifications of incoming calls for service (Oldenburg et al., 2014; Simpson & Orosco, 2021).

In an attempt to reduce the stress of ambiguous call types, communication centers have adopted an old adage in the profession which is “when in doubt, send em out”, loosely translated as it is better to send too many units than not enough, and the scene turns out to be worse than originally reported (Clawson et al., 2007). By adhering to this practice, there is hope that liability will be minimized. This worst-case scenario practice also protects the responding units to ensure they have immediate backup if the call turns disastrously violent (Gillooly, 2020).

Although the dispatcher is not on scene, they do bear immense work-related responsibility for the responding units (Oldenburg et al., 2014). The dispatcher is the gatekeeper of the public safety continuum of care. Not only are callers impacted by their performance, but the responding units are directly influenced as well.

Dispatcher Impact on Police Encounters

When a call for service is received, the calltaker will gather all or as much of the pertinent information as possible and assign a call type and priority to the call. The call is then assigned to the police officers to respond. The dispatcher is required to disseminate all the information to the responding units. There are several variables that influence how the units respond. Errors in communication, incorrectly assigned priority, change in tone of voice, modulation of pitch, or omitted words all influence how the units respond (Oldenburg et al., 2014).

Unfortunately, the case of Tamir Rice in November 2014 directly reflects dispatch errors that tragically impacted the police encounter. Preusse and Gipson (2016) reported the dispatcher received information Tamir was a child and the gun he was holding was not real; however, the dispatcher failed to disseminate this information to the officers, resulting in a horrific outcome. If the officers knew this information prior to arrival, would it have changed the trajectory of this call? We can speculate that it would have.

The dispatcher's role is multifaceted and impactful. The dispatcher is required to process and act quickly, remember protocols from police, fire, and EMS, and be compassionate and empathic with citizens experiencing an emergency. Stressful situations occur routinely as this is

the nature of the profession. Each stressful situation encountered has the likelihood of eliciting a negative emotional and psychological stress response.

Daily and Cumulative Stress

Traumatic Calls

The 911 Dispatcher faces numerous traumatic calls that invoke an intense emotional response during their tenure. The reactions range from helplessness to horror with the most traumatic type of call involving those involving children either from unexpected injury or death (Pierce & Lilly, 2012). Troxell (2008) reported 32% of the different types of calls the dispatcher receives daily created enough of a traumatic impact to elicit a peritraumatic response in the dispatcher. The dispatcher is exposed to citizens pleading for help, screaming, and crying while many will succumb and take their last breath while on the phone with the calltaker.

The dispatcher also contends with the screams for help from emergency personnel who they dispatched to the call that ended up with an officer or firefighter killed in the line of duty. Dispatchers manifest a sense of responsibility for the on-scene personnel and must be emotionally prepared for when a life-threatening situation evolves, and the dispatcher often internalizes the responsibility for the outcome of the call (Bourgeois et al., 2021; Ramey et al., 2016). A common misconception surrounding dispatchers is that since they are only hearing the sounds from the call and are not on scene of the actual crime, the emotional reaction and mental health consequences are not as distressful.

Auditory Witness

When the first 911 call comes into the communication center, the calltaker immediately becomes an auditory witness. During the terrorist attacks on the World Trade Center on

September 11, 2001, the calltakers and dispatchers were not physically at ground zero; rather, they were in the communications center listening to the pleas for help from the citizens who were trapped in the towers. Over three thousand calls came in just in the first few minutes with over 55,000 calls received before the day was done, each call leaving a significant emotional imprint on the dispatchers (Smith et al., 2019). The dispatcher learns to compartmentalize each call in order to pick up the next ringing 911 call. This practice of following the Emotion Code coping strategy, adopted from the military, is the ability to internalize, compartmentalize, and suppress any resulting fear, horror, or anxiety in order to complete the job (Luber, 2015).

The dispatcher spends anywhere from eight to sixteen hours a day listening to and emotionally absorbing the trauma of others. When the individual is not present at the time of the trauma, hearing the detailed accounts of the incident creates a vivid picture of the scene in the mind of the dispatcher. This visualization is often worse than the actual scene. Wang (2017) noted, “the dispatchers are trained to visualize by the worst-case scenario rule – to visualize the incidents worse than they actually are” (p. 106). The immediate and cumulative emotional effects of trauma have far-reaching consequences which can negatively impact the physical health of the dispatchers.

Physical Implications

Despite not having face-to-face interaction with the suspect or victim of the event, dispatchers still experience acute and chronic physical stress. Besides emotional influences, the dispatchers must contend with the physical toll. The sedentary physical environment of the communications center along with the demands of shift work, poor nutrition, and sleep disturbances places the dispatcher at risk for health issues (Smith et al., 2019). Anshel et al. (2012) and Zaluski and Markara-Studzińska (2022) reported the sedentary dispatcher working

lifestyle leads to obesity, decreased health, and diminished quality of life. Furthermore, Shakespeare-Finch et al. (2014) reported dispatchers were shown to have higher cortisol levels after traumatic calls and cumulative stress resulting in hypertension, dysregulation of insulin, weight gain, and thyroid related issues. The combination of negative emotional and physical impacts places the dispatcher in a position to become emotionally and physically exhausted and increases their susceptibility to developing compassion fatigue. Counselors routinely treat clients experiencing stress and trauma. Studying the specific needs of 911 dispatchers can influence counselors' important work with this population.

Compassion Fatigue

The 911 dispatcher is the first person a citizen will talk to in the event of a life altering emergency, yet much is unknown about how the traumatic calls received and processed daily increase compassion fatigue symptomology and impact the dispatcher's overall mental health. CF in the 911 dispatcher has significant implications for citizens who rely on the dispatcher to provide accurate pre-arrival and post-dispatch medical instructions and expeditious dispatch of emergency personnel. The implications extend to public safety personnel, who require the dispatcher to remain alert and attentive when dispatching high priority calls with time sensitive information, and to communication centers facing staffing shortages creating budgetary concerns.

Definition

For the purpose of this study, CF refers to emotional and physical exhaustion experienced due to the constant exposure to the traumatic calls of others and lack of perceived support limiting the empathic capability of the 911 dispatcher (Kindermann et al., 2020). Repeated

exposure to others' trauma via vivid imagery is an inherent risk for negative cognitive and emotional modifications (Bride et al., 2007). Charles Figley (1995, 1996, 2002) introduced the term CF as a way to describe the negative emotional impacts clinicians were experiencing after listening to the stories of traumatized clients and viewed it as a less stigmatizing term than secondary traumatic stress. Stamm (1995) acknowledged STS and CF have been used interchangeably especially by individuals who may be uncomfortable with being labeled as experiencing STS.

CF mitigates the individual's ability to experience compassion satisfaction in their work and their ability to cope with stressors. CF symptomatology is multi-dimensional and marked by lack of empathy towards others. Dispatchers are regularly overwhelmed with helping, anger, depression, anxiety, and frustration resulting in negative coping mechanisms (Cocker & Joss, 2016). CF is often erroneously used interchangeably with burnout. Although experiencing burnout is a cause for concern, CF is more psychologically problematic (Russo et al., 2020).

Compassion fatigue presents symptoms of emotional exhaustion with limited mental capacity to express empathy towards callers in distress, increased intrusive thoughts, sleep disturbances, and avoidance (Stamm, 2009). For instance, a dispatcher receives a call from an individual who has been a victim of a crime. The individual is frightened and alone. The dispatcher experiencing CF is incapable of providing words of comfort and may gather information needed to dispatch police; however, instead of staying on the phone with the caller to provide emotional support, the dispatcher hangs up leaving the distressed caller alone until units arrive.

Implications for Dispatchers

For many dispatchers, it may not be one event that triggers CF; rather, it is the repeated exposure to numerous traumatic events. Russo et al. (2020) reported 911 dispatchers are auditory witnesses to the true gravity of suffering and trauma which is consistently repeated over time. CF inhibits the very nature of the dispatcher which is to provide empathy and compassion to citizens in crisis (Phillips, 2020). CF not only inhibits the dispatcher's motivation to connect with callers, but it also has negative effects on their ability to empathize with coworkers and exhibit compassion towards family members (Khan et al., 2016).

911 Dispatchers and Compassion Fatigue

The 911 dispatcher experiences constant emotional expenditure, repeated empathic engagement, and lack of support which results in compassion fatigue (Miller et al., 2017; Russo et al., 2020; Wojciechowska et al., 2021). Repeated stress exposure increases negative coping mechanisms, intensifies poor family and co-worker relationships, and increases long term health effects (Anshel et al., 2012; Berger et al., 2015). Furthermore, due to repeated empathic engagement the dispatcher's ability to respond expeditiously to the crisis is impeded which can have detrimental effects for the citizen. And yet little is known about the impact of CF on 911 dispatchers.

Prior research has not been conducted on the lived experiences, through an interpretive phenomenological lens, of 911 Dispatchers and CF; rather, literature, which will be discussed in detail in following sections, has focused on Post Traumatic Stress Disorder, Secondary Traumatic Stress, and Well-being (Bourgeois et al., 2021; Kindermann et al., 2020; Lilly & Allen 2015; Lilly & Pierce, 2013; Marks et al., 2017; Pierce & Lilly, 2012). Lilly and Allen

(2015) reported on the underrepresentation of 911 dispatchers in literature despite meeting criteria for PTSD due to repeated exposure to trauma. Their study reviewed adverse post traumatic outcomes and impacts on the 911 dispatcher and concluded dispatchers reported a significant psychological burden including PTSD and depressive symptoms.

Even though the available research studies have documented the psychopathology of 911 dispatchers and trauma, there is still a gap in the literature surrounding effective treatment options for 911 dispatchers. Moreover, Bourgeois et al. (2021) discussed the lack of knowledge surrounding dispatcher stress and mental health treatment. The researchers' descriptive study revealed the types of traumatic calls and subsequent stress reactions the dispatchers experienced. Bourgeois et al. (2021) included an inquiry into whether the dispatchers were able to process their emotions after traumatic calls and if they received any type of follow up care such as peer support. The results of this study highlighted the need for inclusion in stress management, peer support options, and overall awareness of the trauma dispatchers during their tenure.

Conversely, Adams et al. (2014) explored the stress and wellbeing of Emergency Medical Dispatchers through an interpretative phenomenological lens; however, the participants of their study only provided support to callers needing medical assistance and not from a primary PSAP. This dissertation is the first to provide an in-depth investigation into the duties of the 911 dispatcher and calltaker from a primary PSAP along with the subsequent risk factors faced daily and culminating in compassion fatigue symptomatology. This study also provides mental health clinicians greater insight into the profession and daily life of the 911 dispatcher which can increase their comfortability and knowledge of best practices when working with this population and engaging in practitioner-based research.

911 Dispatchers and Post Traumatic Stress Disorder

911 dispatchers were routinely omitted from public safety research on the impacts of trauma and PTSD psychopathology. Pierce and Lilly (2012) reported their research was the only study published considering the relationship between duty related trauma exposure and post-traumatic stress symptoms in the 911 dispatcher. The types of calls routinely answered by the 911 dispatcher were shown to elicit intense emotions such as fear, anger, and horror especially if the call involved injury or death of a child.

Regehr et al. (2013) concluded that the severity of the trauma symptoms coincided with the number of years employed as a dispatcher and the rate of PTSD is higher in dispatchers than in police officers. The dispatcher's altruistic view tends to fade quickly once the dispatcher realizes they are unable to provide tangible assistance to many of the callers (Camaro et al., 2020). Marks et al. (2017) examined PTSD symptomology between 911 dispatchers and soldiers who have experienced combat. The researchers proposed 911 dispatchers were more likely than combat veterans to exhibit cognitive avoidance related symptoms of the trauma reminders. Due to the constant and fast paced nature of the 911 dispatcher's duties, the dispatcher is in a persistent state of emotional and physical exhaustion. One of the main purposes of their study was to highlight areas for improvement in intervention and treatment. The researchers noted the absence of literature surrounding 911 dispatchers and the negative effects of job-related stress. The researchers mention the dispatcher's requirement to transition quickly from one call to another without time to process emotions may in fact increase avoidance.

In addition, Kindermann et al. (2020) took their study a step further to include screening for PTSD, STS, depression, and anxiety related symptoms. Although their study only included ECD's dispatching for EMS and fire services, dispatchers presented with comparable rates of PTSD as veterans from the Iraq war. A unique aspect of this study is that the researchers inquired

about attachment styles and the effect on STS in the dispatcher. Those dispatchers who did not experience a secure attachment were shown to have a higher prevalence of STS. The researchers reported more mental health and peer support is greatly needed to assist 911 dispatchers in the early stages of emotional distress.

Furthermore, Lilly and Pierce (2013) included world assumptions and emotional distress from trauma exposure as a predictor for the increase of PTSD and depressive symptoms in 911 dispatchers. Although this study included 171 dispatchers, the researchers did not specifically state if the dispatchers were employed with a primary PSAP. The researchers discussed that the dispatcher's inability to control a highly distraught 911 caller may hinder the dispatcher's ability to come to terms with their own emotional responses, subsequently making them more susceptible to peritraumatic stress. Lilly and Pierce (2013) reiterated the dearth of empirical literature on this population despite notable and repeated exposure to trauma.

Subsequently, Pierce and Lilly (2012) published the first study examining the duty-related trauma exposure and the relationship to peritraumatic stress and PTSD in 911 dispatchers. This study specifically asked the participants about the type of calls and related emotional distress experienced by the dispatcher. Dispatchers reported feelings of helplessness, frustration, grief, and anger as a result of traumatic calls. The study positively measured a relationship between peritraumatic distress and PTSD in dispatchers. Being an auditory witness to the caller's trauma does not insulate the dispatcher from developing PTSD symptomology.

911 Dispatchers and Secondary Traumatic Stress

Although distinct definitions are lacking in literature, secondary traumatic stress (STS) can be defined as “socioemotional symptoms” (Greinacher et al., 2019). Trachik et al. (2015)

offers a distinction between secondary traumatic stress (STS) and CF; STS is “intrusion, avoidance, and sleep disturbances related to secondary trauma exposure” (p. 28). Greinacher et al. (2019) combined STS, CF, and vicarious trauma in their systematic review due to the challenges of finding a specific definition since many researchers use the terms interchangeably. Although the researchers in the literature cannot agree on the terminology, many have concluded the 911 dispatcher is chronically exposed to traumatic events and is not immune to the consequences (Bourgeois et al., 2021; Camaro et al., 2020). Kindermann et al. (2020) explored the prevalence of STS among rescue service dispatchers and concluded that dispatchers can experience both STS and PTSD to varying proportions. Despite the relevant findings of CF, PTSD, and STS, 911 dispatchers are often overlooked in the literature. This study aims to further explore the lived experiences of 911 dispatchers with CF, through their own voice, to gain an awareness of the gravity of the emotional and physical implications they endure daily which can potentially impact their ability to provide quality care to the citizens and public safety personnel they willingly serve.

Issues in Dispatcher Research

There is a general consensus among researchers in the literature surrounding the paucity of evidence-based practices and peer reviewed research related to 911 dispatchers (Anshel et al., 2012; Lilly & Pierce, 2013; Marks et al., 2017). Whilst the current literature addresses PTSD and secondary traumatic stress amongst dispatchers, who either dispatch for police or fire/EMS, the literature does not address compassion fatigue amongst dispatchers from primary PSAP agencies who routinely dispatch all three public safety emergency services. The current study is essential to explore the psychological and physical experiences of 911 dispatchers with CF, the subsequent ramifications for agency turnover, dispatcher performance to ensure high quality

services in life-or-death situations, and how to best support this essential population as they serve our communities and guard our safety.

Although they are consistently referred to as the “first” first responder, this professional group lacks recognition for their contribution to public safety (McAleavy et al., 2021). Simpson (2020) hypothesized that the lack of awareness of the critical nature of the 911 dispatcher’s role has hindered researchers and counselors from discerning their relevance. For example, after the devastating terrorist attacks on September 11, 2001, the dispatchers were not initially included in debriefing sessions offered by the fire department since the dispatcher was considered administrative personnel and not privy to mental health trauma services (Smith et al., 2019). Counselors made themselves available to the police and fire departments; however, omitted 911 dispatchers in their outreach efforts. Mental health counselors, who work with trauma and first responders, have the opportunity to gain a better understanding of the challenges faced by 911 dispatchers resulting in compassion fatigue and can begin to include the 911 dispatcher in their own clinical practices and outreach efforts.

Implications for Counselors

Historically, Critical Incident Stress Management (CISM) debriefings have been offered to public safety personnel after a critical incident to mitigate negative psychological reactions of traumatic events (Feuer, 2021; Hammond & Brooks 2001). Although debriefings provide a short-term intervention, it does not adequately address more complex and debilitating mental health concerns such as CF symptomatology that longer term mental health treatment can alleviate. CF has been described as nearly identical to PTSD except for the route of traumatization and the feelings of intense personal fear due to the threat to life (Flarity et al.,

2013) (See Table 2). Increasing the awareness of CF can influence how counselors educate and treat their public safety clientele, especially 911 dispatchers experiencing psychological trauma.

Routinely, mental health counselors are unaware of the unique challenges and the emotional and physical implications for 911 dispatchers. Currently, one peer reviewed research article discussed mental health treatment and 911 dispatchers with CF. Meischke et al. (2018) reported that clinicians who incorporate mindfulness techniques have been shown to decrease CF symptomology and increase compassion satisfaction in 911 dispatchers. Although not specific to CF, Marshall and Gilman (2015), reported in their book chapter, 911 dispatchers who experience the emotional consequence of trauma “respond well” to EMDR therapy. Other therapeutic evidence-based trauma informed interventions to treat psychological trauma include, but not limited to, Accelerated Recovery Program (ARP), Cognitive Behavioral Therapy (CBT), Mindfulness, and Eye Movement Desensitization and Reprocessing (EMDR; Barrett & Stone 2014; Flarity et al., 2013).

Due to the nature of CF, overall dearth of literature, and lack of recognition in the DSM-V, many clinicians treating CF symptomology in clients, such as nurses and other medical professionals, will assign a diagnosis of adjustment disorder in order to begin treatment (Flarity et al., 2013). Psychoeducation and validating the manifestation of CF has presented positive results in increasing compassion satisfaction, which is the positive internal process that mitigates the cost of caring (Grant et al., 2019; Lombardo & Eyre, 2011). Increasing the awareness of CF can influence how counselors educate and treat their public safety clientele, especially 911 dispatchers experiencing psychological trauma. Psychological trauma is described as a result of any impact, sudden or cumulative, that negatively affects the person's emotional, physical or psychological health (Papazoglou, 2017). This study details the challenges 911 dispatchers face

daily to encourage counselors to include 911 dispatchers and redefine their own role and mission when serving the public safety community.

METHODOLOGY

In this chapter I will describe and include the following information on the study: (a) the purpose and research questions that guide this study; (b) interpretive phenomenology rationale; (c) research plan to include confidentiality and ethical considerations, participant selection, sampling and interviewing, and instrumentation; (d) role of the researcher; (e) data collection and analysis; and (f) limitations.

Purpose and Research Questions

The purpose of this study was to examine the lived experiences of 911 dispatchers with compassion fatigue (CF). Thus, through this study I have gained a greater understanding of their experiences through an interpretive phenomenological lens. Furthermore, this method allowed the dispatcher's own voices to be at the forefront providing an opportunity for mental health counselors to understand the dispatcher's challenges and to structure their own clinical work with public safety personnel to include 911 dispatchers. The questions guiding this proposed study were:

- RQ#1: What are the lived experiences of 911 Dispatchers with compassion fatigue?
- RQ#2: What was the 911 dispatcher's experience with peer debriefing availability or mental health treatment after experiencing compassion fatigue symptomatology?

Rationale for Interpretive Phenomenological Analysis

In this study, I employed interpretive phenomenological analysis (IPA) to examine the lived experiences of 911 dispatchers and CF. IPA is similar to a phenomenological research design as it offers a unique opportunity to unearth the participants' meaning and interpretation of the phenomena (Frechette et al., 2020). Conversely, what sets IPA apart from traditional

phenomenology is the role of the researcher. Smith (2004) reported IPA can be viewed as incorporating double hermeneutics where “the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (p.40). Through this lens of interpretive phenomenology, the goal was to not focus solely on CF symptomatology; rather, it was to illuminate the experience of CF and the influence on the person, the complexities of the relationship, and how the participants make sense of CF (Tuffour, 2017). IPA does not assume or negate a hypothesis based on existing research; rather, the exhilaration of this type of design comes from the richness of the participants' experience and the unanticipated outcomes that cannot be boxed into a quantitative method (Smith, 2004).

Qualitative research methodologies are highly valuable and viewed as a trustworthy method when designing empirical research (Miller et al., 2018). IPA is a contemporary research method with structural principles rooted in phenomenology, hermeneutics, and ideography (Haskins et al., 2022). This method affords the counselor education and supervision researcher the opportunity to apply interpersonal and counseling skills to delve deeper into the participants lived experiences using the participants own words, feelings, and emotions thus keeping the narrative free from distortion (Alase, 2017). Moreover, Hays and Wood (2011) discussed that similarly to how counselors select theoretical approaches when working with clients, counselor researchers determine the appropriate qualitative design methods based on research traditions, one's own research orientation, and purpose of the study which in itself is a benchmark for trustworthiness. IPA focuses on the “why, what and how” versus the “how much and how many” and is a suitable paradigm for understanding the lived experience of 911 dispatchers with CF (Tuffour, 2017, p.1). The researcher should stay true to IPA's idiographic intention by

incorporating raw data in the form of vivid quotes and detailed texts into the final written results (Miller et al., 2018). Burns et al. (2022) reiterate the strength of IPA is to encourage a response for positive change which is paramount for clinicians who engage in mental health care for public safety personnel and the inclusion of 911 dispatchers in this population.

Research Plan

Confidentiality and Ethical Considerations

This study is in fulfillment of the requirements for the Counselor Education and Supervision Doctoral program at Old Dominion University (ODU). Prior to participant sampling, I sought Institutional Review Board (IRB) approval from ODU. The participants were provided with informed consent forms, limits of confidentiality agreement, risks and benefits of this study, and purpose of the study. To protect the confidentiality of the participants, each individual created a non-descriptive four-digit numerical pseudonym to protect their anonymity and place of employment. There is no monetary compensation for participating in this study.

Selection

Criteria for participation in this study was: (1) the 911 dispatcher must be over the age of 18 years old, (2) the 911 dispatcher must have at least two years of dispatching experience and work independently of a trainer, (3) the dispatcher is employed with a primary PSAP, (4) the dispatcher has or is experiencing CF in the moderate to high range as outlined in the Professional Quality of Life Scale -5 (ProQOL 5).

Sampling

For this study, I incorporated purposive homogeneous sampling by participating in podcasts and two separate public safety conference presentations (Alase 2017; Miller et al.,

2018). Emails were also sent to one hundred forty-nine communications centers across the United States. Email addresses were obtained via public records on 911 agency websites.

The recruitment email included a detailed description of the study, method, and procedure for participation, and a Qualtrics link to answer the demographics questions and to complete the ProQol-5 questionnaire. On the Qualtrics site, the participants reviewed and signed the informed consent form. Those individuals meeting criteria and who scored in the moderate to high range for CF were selected for the interview process. They were emailed a Calendly calendar link to schedule their first interview along with a Zoom link for the round one interview. The responses to the recruitment email were as follows: (1) Eighty participants completed the survey and ProQol-5; (2) Four participants began the study; however, they did not finish in its entirety; (3) Seventy-four participants met criteria for the moderate to high range for CF as outlined in the ProQol-5; (4) Thirty-four participants scheduled their interview.

Interviewing

Once the participants were identified, the participants were instructed to create a non-descriptive four-digit numerical pseudonym. The interviews were conducted virtually on a HIPAA compliant Zoom platform. To further enhance reflexivity and transparency during the interviewing process, participants were instructed on my past experience as a 911 dispatcher (Horrigan-Kelly et al., 2016). Prior to the start of the interview, the participants signed confidentiality and consent forms. Interviews were semi-structured in nature, which provided moments in the interview to ask follow-up questions based solely on the response of the participant (Smith, 2004). IPA instructs the researcher to incorporate reflective listening, silence, reflection of content, and paying close attention to non-verbal cues which, ironically, are also a part the foundational skills of a mental health counselor (Frechette et al., 2020).

An interview guide, consisting of six primary open-ended questions and twelve pollable follow-up prompts, was constructed, and followed to act as a template for all of the initial interviews as outlined in Table 4 (Smith et al., 2020). The interview questions were derived from key components of compassion fatigue symptomology based on existing literature. Follow up questions, centered on active listening, beginning with Tell me more about... or Am I understanding this correctly...allowed for further in-depth discussion (Seidman, 2019). Although in phenomenology research, Seidman (2019) recommends adhering to the three-interview format, IPA does not specify the number of interviews to be conducted; rather leaves the number to the discretion of the researcher (Miller et al., 2017). One initial interview was appropriate due to the willingness and transparency of the participants (Miller et al., 2017; Seidman, 2019). The majority of the participants offered raw emotional insight into their lived experiences with CF. I incorporated a person-centered approach to the interview itself which allowed the participant to become more emotionally involved versus a cognitive and logical approach that could have influenced the participant's overall comfortability with the interview process (Kvale & Brinkmann, 2009). Each interview lasted approximately 60-90 minutes. The interviews were digitally recorded, transcribed via Zoom transcription software, and checked for accuracy by the researcher. For security and confidentiality, all video recordings were destroyed once transcribed and all electronic coded data has been stored in a password protected drive (Alase, 2017).

Instrumentation

Although this study is an IPA design, the participants were given a Professional Quality of Life-5 scale (ProQOL 5) prior to inclusion in the study to determine their eligibility. The ProQOL 5, developed and standardized by Beth Hudnall Stamm in 1995, is an updated version of the Compassion Fatigue Self-Test (CFST) which was developed by Charles Figley (Bride et

al., 2007; McClure, 2022; Mottaghi et al., 2019). The ProQOL 5 was selected due to the ease of understanding and is an effective 5-point Likert scale screening tool. The ProQOL-5 is a self-test used for inclusion into the study and not used as a diagnostic tool for mental health treatment (Stamm, 2010).

Stamm, (2010) created a 30-item questionnaire measuring compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS), and reported Cronbach alpha scores of .88 for CS, .75 for BO, and .81 for STS. These subscales are described as being low (22 or less), moderate (23-41), or high (42 or higher). Positive feelings about helping ability (CS) are measured with scores of 22 or lower indicating problems. Exhaustion, frustration, and depression (BO) are measured with scores of 42 and higher showing impairment at work. Fear and trauma from work (STS) are measured with scores of 42 and higher indicating serious fear resulting from work. The questions concerning CF are structured as: (1) Because of my [helping], I have felt "on edge" about various things and/or (2) As a result of my [helping], I have intrusive, frightening thoughts, etc. (Stamm, 2010). The CF questions focus on feelings of exhaustion, frustration, fear, anger, and angst surrounding work related trauma.

The ProQOL 5 is the most “validated measure in the research literature to measure the effects (positive and negative) of compassion fatigue” (Grant et al., 2019, p.3). Even though this measure has three distinct subscales, they are rated independent of each other resulting in a clearer score for the compassion fatigue subset. The ProQOL is reported to have good construct validity and reliability across cultures and workplaces (Keesler & Fukui, 2020; McClure, 2022). The internal consistency supported the construct validity of the scale (Geoffrion et al., 2019). Although the ProQol-5 has demonstrated empirical validity as a screening tool for helping

professions, Fleckman et al. (2022) reported inconsistencies with the goodness of fit with various models. Conversely, Stamm (2010) stated as of 2010 there have been over 100,000 articles and two hundred published papers incorporating the ProQOL assessment.

Role of the Researcher

Although Giorgi (1994) has suggested the researcher bracket their own biases, pre-conceptions, and past knowledge in phenomenological research, IPA draws on the researchers own understanding of the phenomenon experienced by the participants and to “put themselves in the shoes of the participants” which can be achieved by in depth study of the phenomena or by their own lived experience (Alase, 2017, p.12; Vagle, 2018). IPA assumes the researcher will naturally have preconceived ideas and prior experiences regarding the phenomena in question and instead of attempting to eliminate them, the researcher can create a reflexive journal to refer to prior and during the interview process and while examining and interpreting the data to record the personal impact of the process (Creswell & Miller, 2000; Hays & Singh, 2012; Horrigan-Kelly et al., 2016; Miller et al., 2018; Vagle, 2018). The researcher is stated to have “self-knowledge and openness to others - elements that can be cultivated through reflexivity” (Frechette et al., 2020, p.4). The reflexivity journal served two main purposes for me as the researcher, (1) as a challenge and reminder for me, as the researcher, to remain focused on the topic being studied, and (2) to process any new understandings of the phenomenon (Horrigan-Kelly et al., 2016).

IPA concludes if the researcher attempts to eliminate their own biases surrounding the phenomena, then they are, in a sense, altering the meaning of the phenomena and may miss crucial interpretations of the participants' communication (Emiliussen et al., 2021). As a former 911 dispatcher and current mental health counselor, my knowledge does not directly challenge or

hinder the results of this IPA study. Rather my understanding of CF may conclude to be intrinsically valuable. Although I may have experience as a 911 dispatcher and can provide empathy to the participants, each individual's story is unique to them and I can never share in its entirety (Larkin et al., 2021). Conversely, a reflexive journal provided a space to process my former and current professional identities, as they are not the same as when I was employed as a 911 dispatcher, and how this impacts my view of CF (Vagle, 2018).

Data Collection

Procedure

The goal of data collection in IPA is to elucidate what was unknown (Frechette et al., 2020). Ideally, various forms of data collection would be used during this process; however, due to COVID-19 restrictions, in-person interviews and observations were not feasible. The primary method of data collection is the one-to-one interviews with the participants where a supportive and empathic environment was created by establishing rapport to facilitate ease when collecting individual experiences (Alase, 2017). Data collection was kept to one participant per interview. The participants were invited to a second interview to allow for member checking.

Data Analysis

Miller et al. (2017) makes note that when utilizing IPA, there is not one specific method for analysis that is considered the gold standard; rather, the importance of data analysis in IPA is derived from staying true to the essence of the lived experiences of the participants. For the purpose of this study, I followed the seven-step guide for IPA when conducting the data analysis (Charlick et al., 2016; Smith et al., 2009) shown in Figure 3. Steps one through four were completed separately for each participant's interview. IPA begins the analytic method by

determining “experiential statements” or commonly referred to in phenomenology as single case emerging initial and secondary themes, then traverses across cases to decipher theme commonalities (Miller et al., 2017; Smith et al., 2021). The researcher examined each initial case until “gestalt” has occurred or themes have been identified to the point of closure and only then is a cross-case analysis conducted for convergence and divergence (Smith, 2004). Larkin et al. (2021) discussed the importance of quality versus quantity when determining sample size for an IPA research study. Due to the complexity of CF and limited prior research on 911 dispatchers and CF, the sample size was determined by gestalt. This method was ideal as IPA’s analysis is detailed and distinct (Frechette et al., 2020; Miller et al., 2017; Smith 2004). The hallmark of a good IPA data analysis is the researcher’s ability to capture similarities and differences of individual themes and how a theme is unique to the person (Smith, 2011).

IPA encompasses the Hermeneutic analysis principle by incorporating the Hermeneutic circle which allows for a non-linear progression through the main story and its subsequent parts (Frechette et al., 2020). The circle is designed to provide the researcher with an avenue of gaining deeper insight into the convergence and divergence of the participants' explanation of their experiences with CF (Kvale & Brinkmann, 2009). Even though several of the participants experienced the same effect of CF, each reported the effects differently. For example, three out of five might have had difficulty with anxiety when the 911 phone rings, but one may interpret the anxiety as an increase of adrenaline with a more positive effect. IPA analyzes the data in a manner that paints a clear holistic picture, by including quotes and the verbalized expressions, of lived experiences of the participants where the reader can empathize and understand what the participants are experiencing (Alase, 2017).

Trustworthiness Strategies

Establishing mechanisms to determine trustworthiness through member checking, auditing, and incorporating the IPA Quality enhancement guide to strengthen the degree to which the qualitative study is credible (Alase, 2017; Haskins et al., 2022). Validity instructs the researcher to assess “the extent to which the design and approach used in a study are fit for purpose” (Smith et al., 2022, p.147). A quality IPA study should be an appropriate scholarly contribution to the literature. The trustworthiness strategies specific to the IPA framework guide the methodological design without compromising innovation.

Member Checking

Trustworthiness and validation in IPA are established through member checking. Traditionally, member checking has been a process in IPA to increase the critical element of validity (McGaha & D’Urso, 2019). Member checking enlists the input from the participants to confirm or reject the researcher’s interpretation of the collected data and is viewed as critical for credibility (Creswell & Miller, 2000; McGaha & D’Urso, 2019). The participants are free to comment, approve, or change any of the interpretations that are concluded from the interviews to ensure the essence of their lived experiences have been captured accurately (Iivari, 2017). Each participant was emailed the superordinate and subordinate themes to complete the member checking process. The participants were asked (1) if they heard their voice in the emergent themes, (2) were the quotes collected accurate, and (3) did the themes and collected data accurately capture their lived experiences with CF. Each participant approved the interpretations without changes in interpretation or the collected data.

External Auditor

Collaborating and bringing in an external auditor is an additional measure of trustworthiness of the findings and establishing rigor. The auditor for this research study was

recruited from Old Dominion University's Counselor Education and Supervision program who is well versed in phenomenological analysis. The auditor, an ODU alumnus, does not have any personal ties to this research or researcher. The role of the external auditor was to review the audit trail, collection procedures, and data findings (Creswell & Miller, 2000). The audit trail is a written account of the details encompassing the research design, collection measures, analysis, and findings as interpreted by the researcher (Carcary, 2020). The audit trail ties directly into the researcher's reflexivity and highlights the importance of transparency. The external auditor reviewed the audit trail documentation and approved the data collection process (see Appendix H).

IPA Quality Enhancement

An aspect that is unique to IPA, is the non-linear way data is analyzed. There is a flow between interpreting the whole meaning to diving deeper into individual participants experience and back to the whole. To further enhance trustworthiness, measure the quality of an IPA study, and aid in the flow between experiences, Smith et al. (2009), suggested incorporating a seven-step checklist (Figure 3) along with the following seven markers for quality enhancement. The seven markers are: (1) Consider the analytic span, (2) Make space to elaborate on each PET or GET, (3) Ensure high quality data, (4) Demonstrate your rigor, (5) Detail the complexity of the analysis, (6) Illustrate analytic depth and avoid description, and (7) Attentive and skilled writing (2009). The checklist for IPA, see Figure 3, acted as a guide to ensure robust data collection and interpretation of the 911 dispatchers experiences with CF.

Limitations

While this study generated valuable insight into the lived experiences of 911 dispatchers with CF, it is not without limitations. One potential limitation is the self-reported data which could be biased. There is the chance that participants may answer the questions on the ProQOL-5 in a manner consistent with social desirability to ensure inclusion into the study.

Furthermore, another potential limitation of this study may be the lack of diversity. Historically, the majority of 911 dispatchers are female. Meischke et al. (2015) reported 80% of their participants were female. There may be differences in experience and perspective between demographics. A larger study would need to be conducted to determine if the experiences expressed in this study were similar in nature to those in other communities. Lastly, a potential limitation is that IPA has been criticized for being ambiguous and lacking standardization (Tuffour, 2017). To counter this limitation, I will adhere to the seven-step guide for conducting IPA data analysis (Charlick et al., 2016; Smith et al., 2009).

Summary

In this chapter, I have described the research design and rationale for using IPA to examine the lived experiences of 911 dispatchers with CF. Details pertaining to participant selection and inclusion criterion were included. I have also discussed and detailed the data analysis, trustworthiness procedures, and limitations of this proposed study.

RESULTS

In this chapter I will report the results exploring the lived experiences of 911 Dispatchers with Compassion Fatigue (CF) through an Interpretive Phenomenology lens. The research was propelled by the following research questions: RQ#1: What are the lived experiences of 911 Dispatchers with compassion fatigue? RQ#2: What was the 911 dispatcher's experience with peer debriefing availability or mental health treatment after experiencing compassion fatigue symptomatology?

Data Collection and Analysis Review

Over the course of several weeks, I conducted semi-structured interviews with 911 dispatchers from across the United States. Each dispatcher met the criteria as outlined in this study. More specifically, each dispatcher has been employed as a dispatcher at a PSAP for at least 2 years, work independently of a trainer, and scored in the moderate to high range for CF as defined in the ProQol-5. Emails were sent to the dispatchers, who met criteria, to sign up for their first Zoom interview. The interviews were audio recorded and transcription was enabled through Zoom. The interviews (N=20) lasted approximately 60-90 minutes. Since they were semi-structured in nature, I did follow an interview question protocol; however, by incorporating a person-centered approach to the interviews, I found the participants were open to sharing their experiences and provided a wealth of information. Each participant was emailed a debriefing statement after their interview. The interviews were transcribed and coded after each interview.

Following the seven-step guide to IPA data analysis, as depicted in Figure 3, the interview transcript was read and re-read after each interview was completed. The transcribed interview was uploaded into Caqdas coding software. Although Caqdas was used, each transcript was hand coded to further facilitate my immersion into the data. The researcher's descriptive and

linguistic notes were combined with the interview data to understand and uncover emerging themes (Smith & Nizza, 2022). This process was conducted prior to moving onto the next participant interview. I was able to explore the 911 Dispatchers' unique experiences with CF and mental health treatment while identifying patterns across cases until "Gestalt" or saturation occurred (Smith et al., 2009). Although the exact number of participants vary for IPA, I was not identifying saturation until the 19th participant's interview.

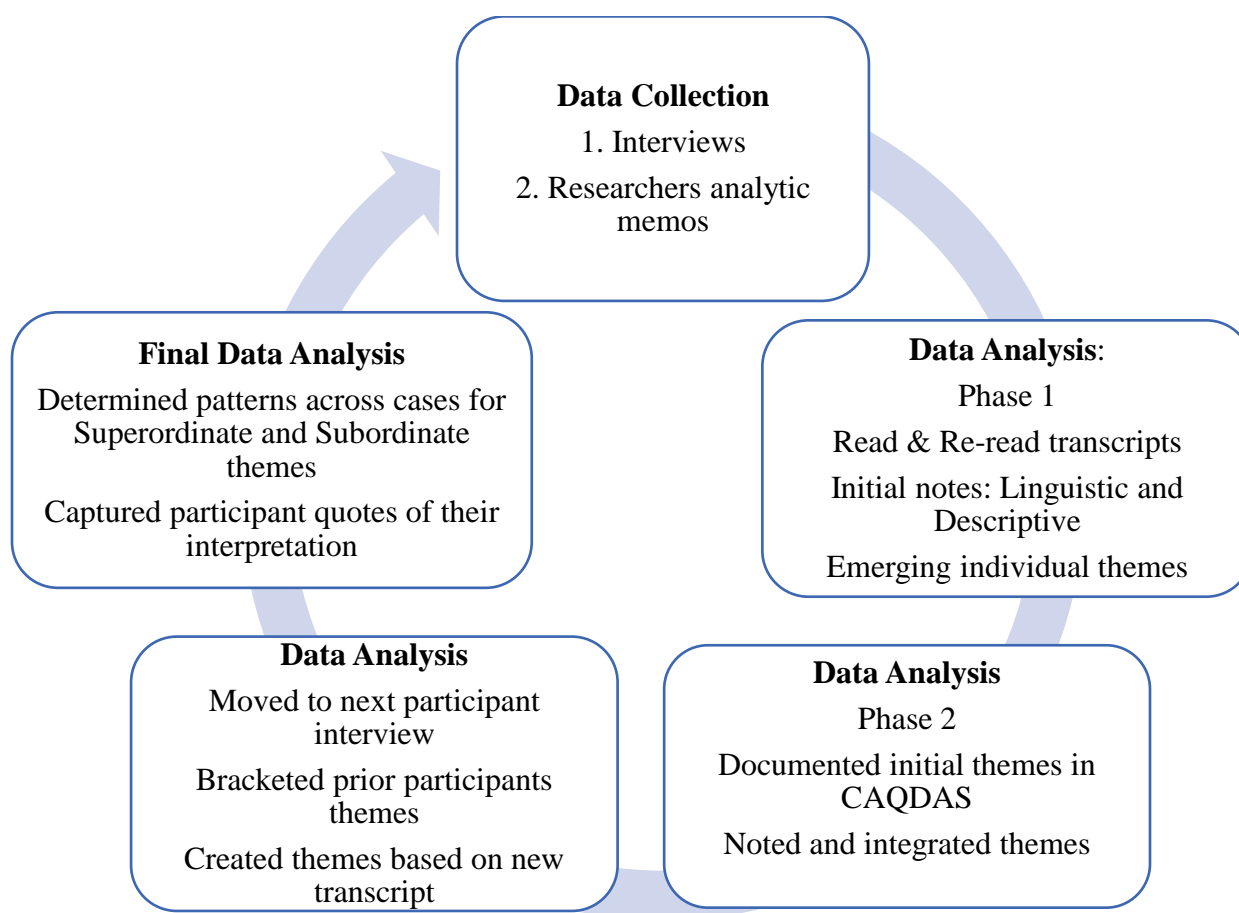
Superordinate and subordinate themes were captured through rich discussions with the participants and data analysis. The participants were emailed the superordinate and subordinate themes for member checking. For the purpose of this study, an external auditor was utilized instead of a research team. Creswell & Poth (2000) suggested, for validity and rigor, either invite a research team or an external auditor to review the narrative account. The decision to employ an external auditor to review the audit trail was based on two specific conditions: (1) the type of audience and their need for anonymity; (2) the overall availability of outside individuals to review the research process. Member checking and a clear audit trail are viewed as most important for credibility (Creswell & Poth, 2000).

The participant's own voice is shared through extracts to collaborate each theme. The identified themes were determined by the richness and prevalence represented in the data. Incorporating the criteria outlined by Smith (2011), each cluster of themes was either further reduced, eliminated, or combined resulting in six primary clusters. The six superordinate themes identified from the IPA methodology and analysis of the interview transcripts are: (1) 911 Dispatcher Challenges; (2) Management/Agency; (3) Physical Impact; (4) Traumatic Calls; (5) Clinical Symptoms; (6) When the Helpers Need Help. The superordinate themes, as suggested by Smith (2011), had at least three participants exemplifying their experiences for each category.

The subordinate themes were recorded if two or more participants were represented in the cluster.

Figure 1

Data Analysis Process



Participant Demographics

Each participant created a four-digit pin as their pseudonym prior to the interviews. There were twenty participants in this research study, six who identified as male and fourteen who identified as female. Eighteen of the participants identified as White/Caucasian and two identified as Hispanic/Latino(a). Four have been employed as a dispatcher between 2-5 years, three have been employed from 6-10 years, five have been employed from 11-15 years, four have been employed from 16-20 years, and four have been employed for over 21 years (see

Table 1 for demographic data). All participants scored in the moderate to high range for CF symptomology as outlined in the ProQol-5.

Table 1
Participant Demographics

Non-Descriptive Pin	Years of Service	Gender Identity	Racial/Ethnic Identity
0459	16-20 years	Female	White/Caucasian
9600	Over 21 years	Male	White/Caucasian
0412	2-5 years	Female	White/Caucasian
2895	2-5 years	Female	Hispanic/Latino(a)
8935	Over 21 years	Male	White/Caucasian
1498	6-10 years	Female	White/Caucasian
9646	16-20 years	Male	White/Caucasian
2406	16-20 years	Male	White/Caucasian
1784	11-15 years	Female	White/Caucasian
4171	11-15 years	Male	White/Caucasian
1609	6-10 years	Female	White/Caucasian
0428	11-15 years	Female	White/Caucasian
3229	11-15 years	Female	White/Caucasian
1024	2-5 years	Female	White/Caucasian
1947	16-20 years	Female	Hispanic/Latino(a)
2602	2-5 years	Female	White/Caucasian
1128	6-10 years	Female	White/Caucasian
5610	Over 21 years	Male	White/Caucasian
2960	11-15 years	Female	White/Caucasian
6355	Over 21 years	Female	White/Caucasian

Superordinate Themes

By adhering to the seven-step IPA data analysis procedures, I was able to identify six superordinate themes: *911 Dispatcher Challenges*, *Management/Agency*, *Physical Impact*, *Traumatic Calls*, *Clinical Symptoms*, and *When the Helpers Need Help*. The superordinate and corresponding subordinate themes are outlined in Figure 2.

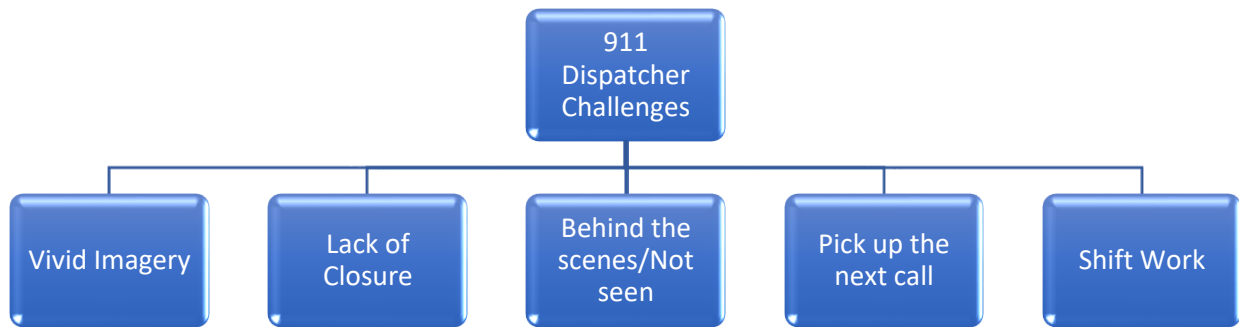
Figure 2
Superordinate and Subordinate Themes



1. Superordinate Theme One: 911 Dispatcher Challenges

Research question one explored the lived experiences of 911 dispatchers with CF. seventeen out of the twenty reported experiencing difficulty with what they expressed as challenges of the day-to-day job. From the interview discussions several rich subordinate themes emerged. The results of superordinate theme one, 911 challenges, solidified the various challenges they face daily and over the course of their career as a 911 dispatcher. Several participants reported challenges with experiencing vivid imagery, lack of closure, feeling as though they were not seen due to being behind the scenes, unlike their counterparts who respond to the scene of the emergency, difficulty with picking up the next call, and struggling with shift work schedules.

Figure 2.1
911 Dispatcher Challenges



1.1 Vivid Imagery

Participants reported similar feelings when they answered a 911 call and almost immediately began to create a picture of the scene in their minds. Compounding the challenge is being imprinted with that mental imagery in an attempt to emotionally process and come to terms with the mental picture that was created. Dispatcher 0428 reported, “we aren’t like the cops on scene, we hear it then make up these scenarios in our head.” Similarly, dispatcher 1128 discussed their struggles with vivid imagery and described it as, “Hearing it is 2,000 worse than seeing it.” In addition, Dispatcher 0459 described how emotionally challenging this aspect of answering a 911 call can be depending on what the dispatcher is listening to on the other end, “It depends on the calls and what you are listening to and what you are envisioning that messes you up.” Dispatcher 5610 discussed the long-term effects of vivid imagery “When they are explaining it to you, you’re picturing it in your head, and you don’t understand the real damaging side of that until you’ve been doing it for a long time and you’re like everything is not great in my head.”

1.2 Lack of Closure

In addition to creating a picture of the scene in their minds, participants reported the lack of closure and inability to know the outcome of a call greatly impacts their mental health and leaves the dispatcher always wondering if the caller survived. More specifically, dispatcher 0428 stated, “Not having closure with calls, you just soak it all in and internalize it all and after a while it just eats at you.” Dispatcher 5610 discussed the struggle with “We never get the answer and I want to know the answer, so I do not have to constantly think about it.” Likewise, dispatcher 9600 reported, “We don’t have closure for a lot of things that impact us, I get goosepimples just thinking about it and sometimes just triggered during a conversation.” The inability to know what has happened to the caller the dispatcher has become so emotionally invested in leaves an imprint on the dispatcher that can be emotionally distressing.

1.3 Behind the Scenes/Not Seen

The dispatcher’s voice is the first sound you hear when calling 911 in the event of an emergency, yet they are rarely physically seen unlike the field units who are routinely seen and acknowledged. The participants reported the challenge of feeling unrecognized for the arduous work that they do every day to ensure the safety of the citizens of their community. When discussing the challenges of being behind the scenes, dispatcher 2960 stated, “We are not seen but they don’t put it together that it started with us that we were on scene first.” The frustration of not being acknowledged was reiterated by dispatcher 2895, “I just want to be heard. I just don’t understand, I want to raise more awareness to what we do because we do a lot and we are never seen.” Conversely, dispatcher 9644 acknowledged being behind the scenes does not offer the public an opportunity to understand what the dispatchers’ duties entails, “no one knows what goes on in the

room.” Dispatcher 5610 seconded this sentiment when they discussed, “Because you’re behind the scenes, you’re always fighting to get some type of credit for what you do.”

When conducting the interviews, there appeared to be a mix of frustration and sadness in the dispatcher’s voice and demeanor when talking about not being seen and just wanting someone to recognize their contribution and hard work to the public safety profession.

1.4 Pick Up the Next Call

When discussing their lived experiences and challenges they experience, the participants reported, they are rarely afforded an opportunity to process any emotional reactions they may experience after a traumatic call. Nationwide communication centers are short staffed leaving the dispatcher to compartmentalize their emotions and pick up the next call for service expeditiously. Dispatcher 0412 expressed frustration stating, “You don’t have time to decompress ever, you answer the next call.” Similarly, dispatcher 5610 acknowledged this is just part of the job and “You do what you can, but you got to move on.” In addition, dispatcher 1498 expressed a similar statement, “You put your big girl pants on, and you get over it. you just keep going because that’s your job.” The feelings of this is just part of the job was also felt by dispatcher 1128 when they stated, “You have people yelling, screaming, and cussing and you know then you just move on to the next call like you just didn’t hear 20 minutes of pure torture for somebody, but it’s your job.” The dispatchers appear to normalize this challenge and lack of down time to process their emotions as just part of the job.

1.5 Shift Work

Another challenge that is just part of the dispatcher’s job is shift work. Two participants discussed difficulty with shift work. 911 Dispatchers staff the

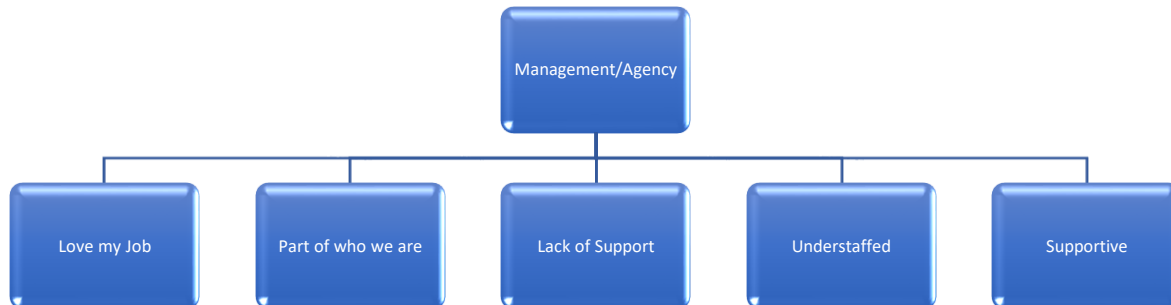
communication centers 365 days per year, 24 hours a day through major hurricanes, snowstorms, and other major events. The participants shared that even though they know their position requires shift work, it adds to the challenges and impacts their mental and physical health. Their schedule varies depending on their agency. Many have a permanent night shift while others rotate shifts. Dispatcher 0412 began to notice changes in their emotional well-being when on a night shift rotation, “Shift change and going to nights that was when things really started to take a toll.” In addition, dispatcher 8935 added their remedy when the challenge of shift work became too much, “shift work is so hard and, in some cases, you just call out sick just to take a break but yeah lots of times you have to work through it and be there.” Those dispatchers on rotating shifts may experience difficulty with adjusting to their shift due to how quickly they rotate. Switching too fast does not allow the body to become accustomed to any semblance of a normal sleep schedule as discussed by dispatcher 2602, “I sleep a lot less with our rotating shifts. We work two 12-hour shifts on days then immediately followed by two 12-hour night shifts. We have four days off in between; however, you are exhausted.”

2. Superordinate Theme: Management/Agency

The second superordinate themes surround issues relating to the communication centers management or agency. Despite the challenges of this profession, the participants reported they find this career to be rewarding and even acknowledge the profession becomes a part of who they are. Conversely, the participants discussed feeling a lack of support from their management. They shared their frustration and subsequent increased stress surrounding the staffing crisis facing a large number of agencies across the country.

Figure 2.2

Management/Agency



2.1 Love my Job

This subordinate theme was extracted from several participant discussions, especially dispatcher 9600. There was a sense of pride in the tone of their voice when describing how their career choice has become a part of who they are, “I love being the first, first responder, I like coming to work every day and making a difference and I help people like I love that, it becomes ingrained in you somehow.” In addition, dispatcher 2960, discussed, “I fell in love with the career and helping people through their problems.” Dispatcher 1128 reported, “This is a job that can be rewarding.” Conversely, dispatcher 2895, had mixed feelings about their chosen profession stating, “I love my job, I love the dispatching part of the job, but I’m getting to the point where I’m so frustrated because nobody has my back.” Whereas dispatcher 0428 acknowledged, “I love it more than I hate it.”

2.2 Part of Who We Are

As a result of our interview, dispatchers discussed the excitement they felt when they found out they were hired by their agency. They were enthusiastic to have the opportunity to help others and provide a tangible service to their community. Two dispatchers revealed dispatching is more than a job for them as dispatcher 0412 states, “It (the job) is definitely a part of who I am, it almost consumes me sometimes.” Secondly, dispatcher 1128 shared, “It’s nice to have visitors and to be able to share with them what we do, because we work so hard, and it is a part of who we are.” Dispatcher 0459 described mixed emotions when talking about their time in the communications center, “I’m disappointed for not leaving but it is etched into my soul.” From the interviews, the dispatcher’s tone of voice and demeanor showed their commitment to the profession; yet there appeared to be a sadness for the stress they must endure.

2.3 Lack of Support

Many recalled varying degrees of frustration with their agency and management involvement. Dispatcher 1128 offered their experience and possible solution for improving retention, “We almost feel like we are stuck now without support. If they spent a little money now and invested in our mental health in the long run it would be beneficial.” Similarly, dispatcher 2602 concluded that “Being acknowledged and increasing support is what is needed but we really aren’t acknowledged.” Again, when talking about the lack of agency support, the dispatchers who are completely anonymous to each other’s identities, have the same thoughts and corroborated each other’s statements. Dispatcher 2895 reported:

There is not a whole lot anyone can do if nobody listens. It just feels like my admin does not care about us. It would be nice if our director and assistant director would come on the floor every once in a while.

Dispatchers who are the “first” first responder are expressing an overwhelming feeling of lack of support from management as dispatcher1498 said, “I don’t think management gets it. And I think it is going to get worse if we start getting more of the text to 911 and the video feeds. I’m not trained to handle that type of trauma.” After a traumatic call, management never came into the communications center to check on their well-being and “There was nothing. I was on a bad call for 45 minutes and nobody even came to let me take a break to take a walk” expressed by dispatcher 2960. Simply stating their truth, dispatcher 3229 said, “I think the whole organization should be more supportive.”

2.4 Understaffed

Numerous participants discussed staffing shortages at their agency and the mental and physical toll those extra hours have taken on them. Agencies were short staffed prior to the pandemic, however, the pandemic has severely impacted staffing as observed by dispatcher 9600, “it has been worse post pandemic and that has added so many levels of stress” and dispatcher 1024 who stated, “We are at a ridiculous staffing crisis.” Dispatcher 0412 shared what their typical work week consists of, “We were working 48 hours a week then they upped our mandatory overtime to an additional 32 hours a week.” Similarly, dispatcher 1947 reported “We are so short staffed. We take calls back-to-back to back and it tends to just burn you out. I’m working my 12-hour shift we don’t get like a lunch break.” Dispatcher 1498, sounding exhausted, said “things are really bad with staffing.” Besides regular staffing and regular overtime, staffing shortages have forced

many agencies to enforce mandatory overtime such as the agency were dispatcher 4171 is employed, “we are extremely short staffed, and we do have mandatory overtime.” Days off are becoming a luxury for dispatchers due to staffing levels. Dispatcher 2895 expressed their frustration, “It’s frustrating because we are so understaffed. I ended up working 14 in a row and then I usually work on my day off.” The lack of management support, staffing shortages, and now mandatory overtime have severely impacted retention. Dispatcher 2406 discussed, “Every day is critical staffing. I got another staffing text today that someone quit.” In addition, dispatcher 8935 reported, “it’s definitely harder on people, and that’s why we’ve had an increase in resignations. The schedules are off and you are working 12 hour shifts 13 days in a row with mandatory overtime.”

2.5 Supportive

Conversely, only three dispatchers out of the twenty participants discussed how their agency have begun to recognize and support their employees. Dispatcher 9600 said:

I’ve had such a great director who is on board with taking care of our team because they are valuable to us, and we want to retain them. I’m hyper vigilant to keep an eye on my team to make sure my team isn’t going through things unnoticed.

Similarly, dispatcher 6355 reported on the recent changes their agency has made:

We have a quiet room now so dispatchers can go in there if they need a nap or if they have a headache or if they need to calm down after a bad call. It has been a godsend for nursing mothers.

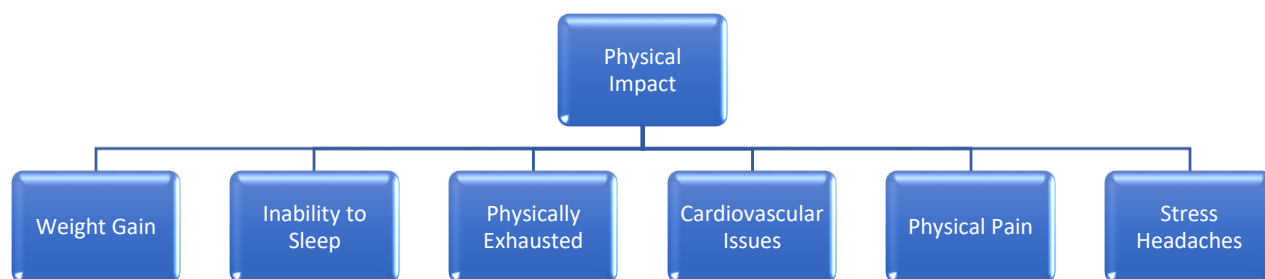
In addition, dispatcher 1609 stated, “They are pretty good about checking in a bit later or when we get off shift, they’ll check and make sure everything is ok”.

3. Superordinate Theme: Physical Impact

The sedentary nature of this profession creates physical challenges for the participants. Working long shifts with mandatory overtime resulting in twelve-to-sixteen-hour days does not equate to a healthy lifestyle. The participants discussed their struggles with weight gain. Many reported difficulties sleeping, either with falling asleep or the inability to turn off the ruminating thoughts of traumatic calls at night to sleep despite trying medicinal aids. The participants shared their overwhelming feelings of exhaustion regardless of how many hours of sleep and relaxation they may receive. The dispatchers shared their personal struggles with high blood pressure, heart related issues, physical pain, and headaches.

Figure 2.3

Physical Impacts



3.1 Weight Gain

Unfortunately, one of the hazards of this type of high stress sedentary job is weight gain. Several participants shared their struggles with weight gain. Dispatcher 2960 stated, “My appetite has changed, and my weight has gone up and down a number of times.” Similarly, dispatcher 8935 stated, “this sedentary lifestyle leads to the weight gain.” Additionally, dispatcher 9600 said, “I put on 100 pounds in my first 5 years behind the desk.” Furthermore, dispatcher 1609 added, “I’m sitting for 12 hours and dealing with weight is a hard thing especially on night shift.” Conversely, dispatcher 1498, added a plausible reason for their weight gain, “I lost a bunch of weight and I’ve gained a bunch of weight and my doctors are like it is the stress and anxiety associated with that due to the dread of not knowing.” With shift work, long hours, and physical exhaustion negatively impacting the dispatcher’s ability to manage self-care. During the interviews, the demeanor of the participants would change to one that appeared similar to feeling defeated as evidenced by lowered tone of voice and downward gaze. They know they should take care of their health, but do not have enough hours in the day to accomplish something so crucial as self-care.

3.2 Inability to Sleep

Unfortunately, another negative consequence of this profession appears to be the inability to sleep. Dispatchers appear to agree that the amount of sleep per night for each of them is approximately three to four hours. Dispatcher 0412 stated, “I think maybe on average, if I’m lucky I get maybe 3 to 4 hours.” Similarly, dispatcher 1024 expressed that, “I was getting about 4 hours of sleep at night if I was lucky.” Sadly, dispatcher 1498 had a similar experience, “I was sleeping about 3 to 4 hours a night then when I finally had a day off, I would sleep too much to try to catch up.” In addition, dispatcher 8935

stated, “that is the most common thing I notice is I don’t sleep well anymore. I don’t sleep more than 4 or 5 hours at any point in time.” Two of the participants noticed thinking about work related issues impacted their sleep routine. Dispatcher 1128 said, “I’ve had years of not sleeping good because I do get the being on high alert all of the time.” Dispatcher 1609 reported, “if there are things going on at work, like a high priority call, I noticed I will either sleep a lot or not at all.” Finally, dispatcher 9600 stated their struggle, “I keep thinking if I fall asleep right now before I have to go back to work, I can get 3 or 4 hours of sleep.”

3.3 Physically Exhausted

Feeling physically exhausted was also a prevalent subtheme with four of the interview participants. The dispatchers noticed their overall discomfort and the physical toll. More specifically dispatcher 0412 discussed, “It just physically takes a toll on me.” Dispatcher 0459 reiterated, that they will “get so physically exhausted.” Not stating a specific reason, rather, an overall feeling of exhaustion. Dispatcher 1784 was clear on their experience reporting, “I do know that I am just tired.” In addition, dispatcher 1128 said, “I don’t get a good night’s rest and just being constantly exhausted is hard.”

3.4 Cardiovascular Issues

Three dispatchers reported cardiovascular issues even after seeking medical attention to rule out underlying medical conditions. Dispatcher 1784 reported, “I get heart palpitations now from the job that I now have to take medications for.” Similarly, dispatcher 9600 shared their experience by stating, “My heart races because of what I’m dealing with. I have blood pressure issues, high cholesterol issues, etc. etc.”

In addition to the issue of heart palpitations, another dispatcher experienced issues with high blood pressure relating to the high stress of being a 911 dispatcher. Dispatcher 2960 stated, “My blood pressure is still up, and I still wanted to go vomit after the call involving one of my units.” The participants have experienced cardiovascular medical conditions and expressed their medical professionals have reported this is a result of their experiences as a 911 dispatcher.

3.5 Physical Pain

Two dispatchers shared their experience with feeling actual physical pain from the stress they experience on a day-to-day basis. Dispatcher 1128 shared, “I can tell that I carry my stress in my shoulds and in my back from work and sitting.” Conversely, dispatcher 2602 experienced physical pain but the pain increased after the traumatic call is over, “While I’m doing it, it’s fine but when the call is over my back will tighten.” Long hours of sedentary work and the stress they experience has manifested in physical conditions that can greatly impact their performance, emotional investment in their callers, and the dispatchers own stress tolerance.

3.6 Stress Headaches

Another physical impact felt by the participants is stress headaches. They speculate that this is a direct result of not only the sedentary nature of the profession but the type of calls they handle. Dispatcher 0412 stated, “I get stress headaches that lead to migraines where I am out for 2-3 days sometimes.” Moreover, dispatcher 1609 shared, “I usually keep my body under control for the most part, but, like I’ve noticed that I will get really bad stress headaches.” Additionally, dispatcher 6355 reported, “I do get headaches,

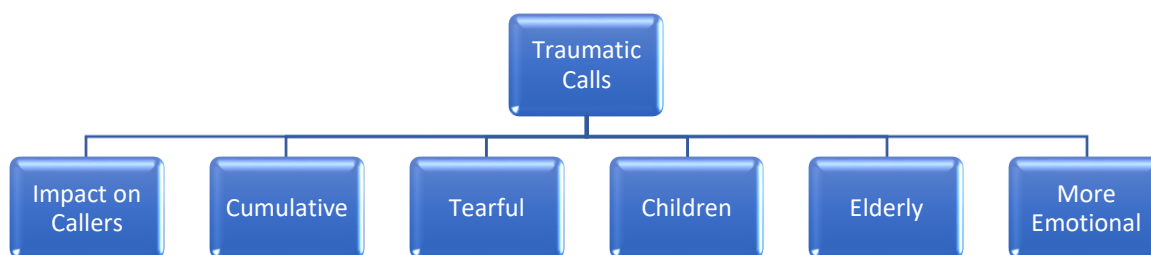
but that is the life of a dispatcher.” Similarly, dispatcher 1128 stated, “Headaches and migraines fluctuate like crazy.” Conversely, dispatcher 9644 recognized the prevalence of their headaches, “I used to get more headaches, but I have worked on them and narrowed them down.” The impact of the profession has manifested itself in various physical forms. Each aspect is taking a toll on the 911 dispatchers’ overall well-being, yet the general consensus is to shrug it off as it is part of the job.

4. Superordinate Theme: Traumatic Calls

The participants discussed the impact of the traumatic calls they receive daily. Many stated one call can have a negative impact on their mental health while others discussed the cumulative effect of hearing the worst of human nature. The dispatchers reported struggling with their own emotions and discouraged to find their own compassion diminishing when talking with citizens in crisis. The participants shared the type of calls they find most heart wrenching, the impact their emotional health may have on other callers, cumulative or singular calls, and becoming more emotional and tearful without a clear reason.

Figure 2.4

Traumatic Calls



4.1 Impact on Callers

Feelings that their own emotional health presented consequences for the next caller appeared within eight participant conversations. The dispatchers were aware of the emotional toll traumatic calls have taken but they expressed there is a disconnect between their desire to show compassion and their ability to do so. Dispatcher 6355 reported how traumatic calls have impacted them:

It has just hardened over time, I used to be a lot more compassionate towards people when they called but now, I'm just kind of matter of fact with everything and sometimes I just don't have the ability or time to be as nice as I want to be. You are not 100% because you are still dealing in your own mind or trying to work it out like you're multitasking your brain. You split it off like you are still trying to process the previous traumatic call while trying to give service to the new caller.

The fast-paced nature of the profession and constant back-to-back calls for service also impacts the dispatchers as reported by 1784:

So, there are calls holding and now I have to sit there and be patient with this person who can't get their story out quickly when there are other people who have emergencies. I get short with them which I feel bad about because they are in crisis and need me.

In addition, dispatcher 5610 reported it has been ingrained in them to get the facts as quickly as possible and when that does not happen the dispatcher may not be as compassionate as they need to be, "The more excited the callers are, I can remain patient

but if they are calm and they are not listening to you then I get impatient quickly.”

Moreover, repeat callers also impact the dispatcher’s ability to empathize with the caller and their situation. “It’s hard for me to support callers that, you know have called in every day of last week, and it’s hard to stay professional and stay and empathetic with them” shared by dispatcher 2895. Dispatcher 0459 acknowledged their own feelings when they feel the need to consistently go above and beyond on every call and at times when the dispatcher cannot extend themselves emotionally, they “feel sad for my callers that I’m not doing the above.” Whereas dispatcher 0412 only notices an overall impact on callers on rare occasions, “I would say 99% of the time it doesn’t impact caller but every once in a blue moon it will. I just feel like we’re not as patient and compassionate as we need to be with them” However, dispatcher 8935 preferred to distance themselves from any emotional involvement with the caller stating, “I don’t want to empathize. I don’t put myself in their situation.”

4.2 Cumulative

During the course of the interview, five dispatchers shared their insight regarding how it was the cumulation of traumatic calls and not necessarily one bad call that made a significant impact. Dispatcher 2406 shared, “that damage is done, and I think that’s the main thing is that people don’t understand that cumulative trauma that just continues to build up and continues to build up.” In addition, dispatcher 0459 reiterated, “It’s not one event but it keeps building up and building up.” Similarly, to their experiences, dispatcher 1024 agreed, “It build up over time.” Comparably to their experiences, dispatcher 9600 stated, “the rest is cumulative, you know, like you take one bad kid call, and you try not to think of every bad kid call I took.” Dispatcher 1128 added how they protect themselves

emotionally from the culmination of traumatic calls, “Horrific events, they just keep adding up and it’s kind of like you build this wall.”

4.3 Tearful

Traumatic calls are not without consequences. People cannot hear the worst that human nature has to offer without some type of an emotional impact. For three of the dispatchers, that emotional release comes in the form of letting the tears fall. Dispatcher 0428 shared, “Sometimes the calls, I just get this overwhelming sense of I just want to cry.” Similarly, dispatcher 0459 reported finding solace within an isolated office, “I literally sat in the office and cried for an hour and a half.” Dispatcher 2895 discussed their experience with stepping out of the communications center after traumatic calls, “I’ve gone to my car to cry about calls. It just makes me want to cry.”

4.4 Children

Each dispatcher has a type of call that triggers a stronger emotional response than other types of calls. These are the calls that we either have a personal connection with or simply tug on the heart strings a bit more than others. For five of the participants, the type of calls they found most traumatic involved children. Dispatcher 5610 reported it was not merely the type of call but what he could hear on the other end of the phone that made it more traumatic, “besides suicides the other calls that bother me are small children that need medical attention, and I can hear the child in pain.” In addition, dispatcher 2895 talked about the trauma response associated with knowing there is no hope but still following the Emergency Medical Dispatch (EMD) protocol. They stated, “child calls like child EMS calls are really hard for me when you are trying to give the parent CPR

instructions, but you know that child has been dead for the entirety of the call.”

Dispatcher 0428 summed up the difficulty with child calls, “Kids and DV tugs at my heart strings. When a kid dies, they haven’t really lived yet.” The trauma is due to the fact that the child has not lived a full life and the young life is cut short. Moreover, dispatcher 1609 felt calls involving children are more traumatic, “it is definitely like child calls and traumatic elderly calls that impact me.” Not only is it taking a call regarding a child in crisis but also the fear of the unknown for dispatcher 0459, “Nothing could be worse than that call about that child, but I know that there is going to be a call that is going to be worse and that’s what terrified me.” The dispatcher expressed dread for the next call that could be about a child.

4.5 Elderly

Another emergency call type which impacts and instills a sense of dread into the dispatchers pertains to calls involving the elderly. Two dispatchers spoke on the difficulty they experience when receiving calls involving elderly citizens. Dispatcher 0412 reported, “My heart drops to my stomach and I have a hard time dealing with calls involving elderly people.” Similarly, dispatcher 0459 shared, “it just breaks your heart when a husband finds his wife dead, I mean their elderly, but it is so sad, that heartbreak comes with the job.” The dispatcher openly discussed how heartbreak is something that does come with the job, but no one can adequately prepare them for this experience.

4.6 More emotional

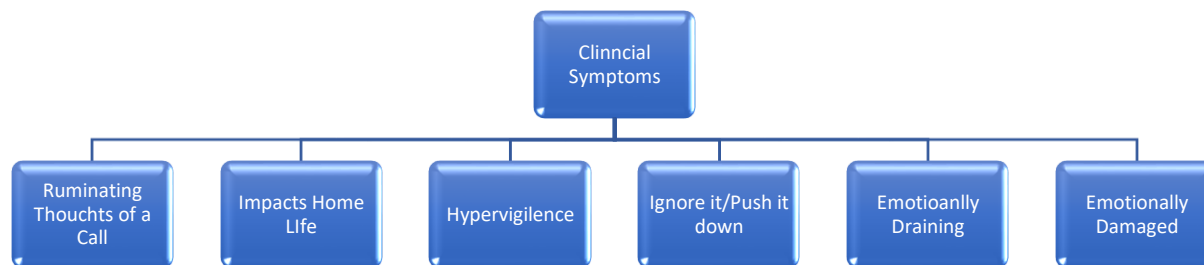
Three of the participants have noticed the impact of traumatic calls manifesting as a heightened emotional response to normal stimuli. Again, feeling the cumulative effect of traumatic calls, dispatcher 0412 reported, “It has weighed more and more on me. I am

more emotional about everything.” In addition, dispatcher 2895 reported feeling “more sensitive to things” in general all the time. Dispatcher 9600 described, “everything bothered me at work, but nothing bothered me before. There was a catalyst for me becoming an emotional wreck and crying for no reason.” Even though taking traumatic calls is part of the profession, it is not without consequences such as a change in their overall emotional regulation.

5. Superordinate Theme: Clinical Symptoms

To further explore research question one, the dispatchers reported several impactful aspects of their lived experiences with compassion fatigue and the presenting clinical symptoms. The participants shared their experiences when they are left with the screams of the caller in their mind and are unable to find solace. Ruminating on calls soon begins to impact their off-duty time with family and friends. Many found themselves becoming frustrated and attempt to push the call down into their subconscious in hopes of burying it deep enough to silence the caller’s voice. The participants experienced symptoms of hypervigilance and felt the need to always be on high alert. The impact of CF and subsequent clinical symptomology have left the dispatcher feeling emotionally drained and emotionally damaged.

Figure 2.5
Clinical Symptoms



5.1 Ruminating Thoughts of a Call

Overwhelmingly, numerous dispatchers reported reexperiencing thoughts of a call including hearing the screams of the caller to replaying the call in their mind to review if they did everything procedurally correct. Dispatcher 9600 reported routinely ruminating on calls:

You have all of these physical things going on after a 16-hour shift and you still can't sleep because you are still thinking about that caller, but I have a lot of memories of events from the past especially a couple with blood curdling screams. I think about what I did right and what I did wrong and what could I have done differently.

The traumatic screams of the caller appear to be what most of the participants struggle with such as dispatcher 2960, "When I train new people, I tell them you are going to take calls that are going to stick with you for the rest of your life, I can still hear these callers screams in my sleep." In addition, certain calls will always be with the dispatcher as stated by dispatcher 5610, "Because my brain can't process it, those calls

will be with me till I die” and dispatcher 8935, “There is a handful of those calls that just won’t go away.” Dispatcher 0412 discussed not always recognizing the impact of traumatic calls due to them occurring so frequently while on shift but nonetheless, the calls are always there in the back of your mind, “I do think that I carry those with me, and I didn’t recognize the calls are affecting me.” Moreover, dispatcher 1128 concluded “when you get those really bad calls, and you start going through that and your mind plays tricks with you.” Equally distressing for dispatcher 1609, as discussed by their experience with ruminating on traumatic calls, “I could feel just the tension of it, and like replaying things in my mind.” Dispatcher 1024, talked about the struggles with attempting to go to sleep but constantly replaying the calls repeatedly in their mind, “when I did sleep, I’ll be replaying things in my mind or thinking about that call that I took.” Even though dispatcher 1784 has not had a significant experience with ruminating on calls they acknowledge there are “a handful of calls that have really, really stuck with me and bothered me.” Conversely, dispatcher 0428 utilizes their family as a support system to help process the calls they carry with them. They stated, “I take all of my calls home, but I do have an outlet with my spouse. I am able to talk with him and he gets it. He doesn’t try to fix it he just lets me talk and get it out.”

5.2 Impacts Home Life

During the course of analyzing the data from the interviews, several participants reported realizing their emotional state impacts their family life. We would all like to have the appropriate work/life balance where it becomes easier to separate the two identities, however, due to the traumatic calls, daily challenges of being a 911 dispatcher, and subsequent CF impacting the dispatcher’s emotional well-being the dispatchers may

find this to be a luxury rather than a necessity. Dispatcher 0459 talked about how the “emotional exhaustion affects my home life as well and I’m sad for my family that I’m like just leave me alone.” Instead of enjoying family time, dispatcher 1128 stated, “The only thing I want to do when I go home is just be quiet.”

The dispatchers showed concern and the need to shield their family from the stress and trauma they are experiencing, “it’s hard, like I don’t really want to talk about it with my family, you know, I have kids and they don’t need that,” stated dispatcher 1784. Similarly, dispatcher 9600 often must walk back outside when they come home from work, “when I go home and walk through the door, I’m walking back outside crying cause I don’t want my kids to see me upset.” Regardless of the due diligence of shielding their family, this is not always successful as stated by dispatcher 8935. They reported, “You wake up very grumpy that first day you’re with family and you’re snipping at all of them, and I have to remind myself about that.” Dispatcher 0428 shared a similar sentiment, “Years ago, I was angry at home all the time because of work.” Dispatcher 0412 shared the impact on their family, “My family gets upset because I’m upset, and I’m so worn down.” In addition, dispatcher 6355 shared, “my husband knows that I don’t mean it personally, but it does come out. I’m just harsh sometimes and I’m just short, snappy, snappy, like chop, chop, get it done.”

5.3 Hypervigilance

The need to be always aware of your surroundings, or hypervigilance, is part of CF symptomology. Dispatchers in this study expressed experiencing the need to be overtly aware of the space they are occupying. Dispatcher 1498 shared, “I always need to know where the exit to a room is.” Furthermore, dispatcher 8935 discussed the

prevalence of hypervigilance, “Now it’s more of a constant thing that I’m watching doors, watching this and that and people walking through parking lots.” Additionally, dispatcher 9644 reported, “I notice everyone and everything. Public places make me nervous.” Hypervigilance is exacerbated by the dispatcher’s knowledge of what occurs in the city when everyone is sleeping. They become more aware of their surroundings and remain on high alert.

5.4 Ignore it/Push it Down

The lived experiences of nine participants shed light on how they process negative emotional impacts to function at a high level required as a 911 dispatcher. They attempt to ignore and/or push down any emotional reactions they encounter from the calls they receive. Dispatcher 0412 normalized this process as they must attempt this often:

I’ve programmed myself to push it down and walk into the building knowing that someone is going to die and walk out like ok it’s not a big deal. People die every day, I mean, that is not normal but It’s like a volcano, you push it down and it festers.

Similarly, dispatcher 2895 has normalized this process of pushing it down just to keep going and maintaining the ability to do your job, “you just push it down, just push it deep down and keep going you’ll be fine and just go to the next call.” Dispatcher 1609 stated ignoring it is a protective measure for them, “I just don’t have the energy to sit there and want to feel or go through the emotions of everything, and it’s just easier to turn it off.” Another form of self-preservation is pushing the thoughts and emotions down and in doing so the thoughts will lose their power to create any type of distress as discussed by

dispatcher 1128, “From what I’ve seen over the years and probably guilty of it myself that I think sometimes if you keep it to yourself then it’s not reality.” Dispatcher 5610 discussed being from the “old school” mentality where dispatchers had to have “this stoic approach to things and show them that you are ok, just push it down and bottle it up.” Similarly, dispatcher 1024 shared the need to have an outwardly stoic representation, “Some people, they definitely don’t let on if they’re suffering with something or if they are struggling with a call.”

5.5 Emotionally Draining/Exhausted

Long hours, lack of support, and experiencing CF leaves the dispatchers feeling emotionally drained. Seven dispatchers shared their experiences with feeling emotionally drained. The ability to provide an empathic response to callers in need is severely limited when the dispatcher is drained of all compassion. Dispatcher 0412 shared, “It is just putting yourself last in the sense of you are doing for everybody else around you and you have run yourself down and not taking care of yourself...emotionally sucks the life out of me.” Dispatcher 2406 shoulders dropped, he took a deep breath, and expressed “The raw emotion is just draining.” Similarly, dispatcher 0459 shared, “it’s desperately wanting to do your job and helping people but not having the emotional capacity to actually do it the way you are supposed to.” In addition, dispatcher 1498 discussed the inability to experience empathy, “There’s no more compassion from excessive empathy has drained it so now it’s lack of empathy.” Moreover, dispatcher 2960 expressed their struggle with feeling drained, “Because you just feel tired but not physically tired, just tired of people.” Dispatcher 9600 provided how they attempt to find relief, “you take a heavy call that drains you emotionally, and you get up and go for a walk...walk away.” Additionally,

dispatcher 8935 discussed, “There’s just some days where you just don’t want to be sitting in the chair.”

5.6 Emotionally Damaged/Not the Same

Six participants shared their lived experiences with feeling emotionally damaged from the profession. They expressed how nothing could have prepared them for the consequences. Dispatcher 0459 shared, “I’m angry because this job has taken something from me that I did not give it permission to do, and that’s where I’m at.” There was an equal expression of anger and sadness when they discussed their journey as a dispatcher. Similarly, dispatcher 4171 shared:

I’ve had some good experiences and really horrible experiences and it seems like no matter what as soon as you experience a call, good, better, or different you are done. You are changed and there is no going back to where you were prior to that event.

In addition, dispatcher 0459 discussed no amount of training can prepare the dispatcher for that they will hear:

When those bad calls come in, because they are going to come in, and they are going to affect you and you won’t be the same. I took a traumatic call 2 years ago and it annihilated everything in me. I didn’t sign up to be emotionally traumatized and damaged for the rest of my life.

Dispatcher 9644 expressed their sentiment bluntly, “If I want to say it frankly, my give a damn might be busted.” Moreover, dispatcher 2406 shared their experience and realization of the consequences, “there is a price to be paid and every call has a different

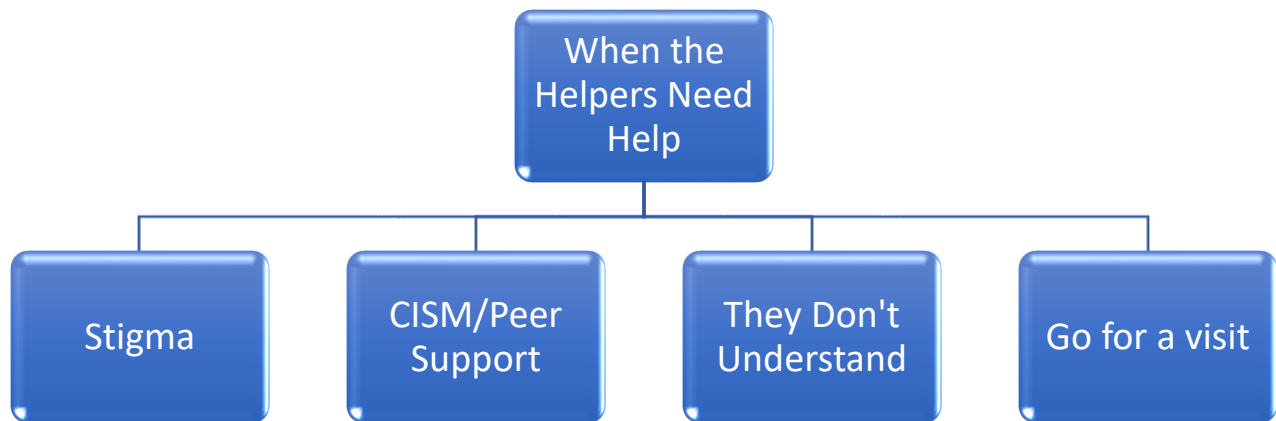
cost.” Conversely, dispatcher 3229 is grappling with an internal struggle over whether the emotional damage is worth it, “I want to help people but if it comes at the expense of my mental health and then having to figure out do, I really want to go to work.”

6. Superordinate Theme: When the Helpers Need Help

The second research question was to explore the lived experiences of 911 dispatchers and available mental health support for when the helpers need help. From the interviews, several themes emerged surrounding seeking mental health support. Many discussed the stigma in the profession surrounding seeking mental health treatment for fear of being seen unfit for duty or weak. In addition to stigma, the participants shared the lack of inclusion into debriefings after a traumatic event even though debriefings are offered to police, fire and EMS personnel. Several reported not being asked to participate and overlooked entirely for any type of after care. The dispatchers shared a disconnect between the more senior staff versus the younger dispatchers on their outlook for seeking mental health treatment. Unfortunately, the dispatchers do not feel mental health professionals understand what they experience on a day-to-day basis. This perceived lack of understanding leaves the dispatcher hesitant to seek mental health counseling. The dispatchers offered suggestions for mental health professionals to increase their level of insight on what it entails to work as a 911 dispatcher.

Figure 2.6

When the Helpers Need Help



6.1 Stigma

Surprisingly, seven dispatchers agreed there is a stigma in 911 communications surrounding seeking any type of mental health support. Several discussed feelings that if they sought counseling of any type, they might be found unfit for duty. Instead of speaking out, the dispatcher will attempt to hide their true feelings, as discussed by dispatcher 3229, “I just pretended and not going to say anything because I don’t want them to think I can’t handle my job.” In addition, dispatcher 0428 shared a similar experience, “I don’t want people to think that I am not a good dispatcher.” Similarly, dispatcher 9600 stated, “there is a stigma, we don’t talk about things like that.” Not trusting management enforces the stigma associated with seeking mental health support. Dispatcher 4171 shared:

and then, as soon as you admit to a little bit of weakness in this agency, it’s like sharks in a tank of water, beating the stigma is going to be the hardest thing ever especially with the old school mentality of you don’t seek mental health. We didn’t want to go to EAP because of the stigma associated with EAP.

Similarly, dispatcher 0412 discussed, “I think it is frowned upon, not just at my job but in the profession in general.” Part of the stigma may be due to an outdated generational norm and change is slow to occur as discussed by dispatcher 1784, “I feel like it’s kind of half and half with more of the senior staff definitely there’s a stigma and the younger staff is more open.” Dispatcher 5610 advised he is seeing slight improvements:

I think it has improved. We are definitely making progress and making it a priority to at least use the terminology of a work like balance but there will always be stigma because I’m the generation of suck it up buttercup and get over it.

6.2 CISM/Peer Support

There was an overwhelming consensus from the participants about the lack of inclusion in support options. One of the mental health support avenues available to public safety is peer support in the form of Critical Incident Stress Management (CISM) debriefings. Many departments have formed their own peer support programs while others utilize regional peer support programs. One of the disconnects occurs when dispatchers are not included in peer support debriefings after a critical incident. Dispatcher 9600 shared, “so when debriefings happen, we were never invited, never made to feel welcome no one asked, hey, how are you doing. You are just in dispatch.” Similarly, dispatcher 0428 stated, “we are supposed to be included but it doesn’t always happen, it’s like we are an afterthought.” Sharing the space with police, fire, and EMS, may make the dispatchers feel uncomfortable. Dispatcher 1128 reported, “Nobody went, and I find a lot of times that’s usually if we do get invited that’s usually what happens, as

they don't go, and I don't know if it's they don't feel comfortable going or what."

Additionally, dispatcher 1784 stated:

I can remember maybe three times that I know of for sure that they've invited up and some people just don't go because we don't have the staffing to go, and it depends if the field units that's involved have a good relationship with us then yes but most of the time not really.

Moreover, dispatcher 1498 discussed the lack of support, "The calls were bad, and there were no resources, and when you went to one of the resources, they were like it's your job and there was no support after the officer involved shooting." Dispatcher 2895 discussed their experience working a critical incident while on night shift:

I'm on graveyard shift and they don't think of calling us over to the other side of the building and it just not the same for PD. They have debriefings and we're not always thought of and included in those, but we do have 2 dispatchers that are a part of peer support in the center.

Furthermore, dispatcher 6355 experienced a debriefing that was not positive,

I went to a debriefing, where law enforcement, firefighters and other outside staff and everyone who was involved in the call and one (individual) started going off like saying I can't believe the 911 caller and just kept bashing them. I finally was like you have no idea what you are talking about and basically went off on that individual. So that probably scared me forever wanting to go to another debriefing.

Conversely, dispatcher 0412 added, “We do have peer support in our center.” Dispatcher 1609 shared a similar experience, “They are pretty good about checking in a bit later or when we get off shift, they’ll check and make sure everything is ok.” Similarly, dispatcher 5610 discussed improvements in their center, “at any time we can call and get immediate crisis or peer support from the fire department or the police department, but it wasn’t always that way.” Dispatcher 0459 summed up the disconnect between peer support and dispatchers, “there is a huge gap of taking care of people after and that is a problem.”

6.3 They don’t Understand

Besides breaking down the stigma and offering peer support to dispatchers in need, there appears to be another reason why dispatchers do not seek mental health treatment. They feel counselors do not understand the trauma they experience daily. Dispatcher 0412 shared their experience with attending counseling:

I don’t feel they have good feedback to get me through my job like they don’t understand. It would go a long way if they understood what I am telling them. If they had more of an idea of what we’re actually going through in addition to taking calls and working long hours, like just the stress that comes with it and not having time for family or friends because you are working 16-hour shifts.

Comparably, Dispatcher 5610 discussed:

In the clinical profession, I don’t think they understand what the exposure to this type of work does to a person, and because we are behind the scenes it makes it

even worse. I think most of the population has a very misguided view about what dispatchers do.

In addition, dispatcher 2960 experienced a comparable situation when seeking mental health counseling:

I've tried to explain to counselors and therapists in the past, because they are like that's not your fault, I know that fundamentally, but my nervous system doesn't. The need to understand this is not Hollywood.

Similarly, dispatcher 6355 discussed their experience attending counseling:

I do think it is important for therapists to understand what we do. We have a different level of humor and someone who doesn't know does not get it. They look at you crazy. I'm made a comment in front of a therapist before, and the person gasped stating how can you say that?

Moreover, dispatcher 0428 shared, "we are not on scene, and it would help if they understood our different experience." There appeared to be a consensus amongst the dispatchers. They want therapists to simply take the time to understand the unique challenges of working in 911. Dispatcher 1784 stated, "Having a therapist understand 911 would make me more open to talking about things because some of the stuff is, you know, really terrible." Equally, dispatcher 1498 offered this statement, "they think all you do is answer the phone but there is literally, 1000 things that you are doing and if you drop one of the things then something bad can happen." Furthermore, dispatcher 2895 reported, "They don't understand. It's so hard to talk to anybody that's not in this field."

6.4 Visit a Communication Center

While the dispatchers were discussing mental health counseling, three participants provided suggestions for mental health counselors to become more inclusive and engaged in the dispatcher population. A unanimous suggestion was for mental health professionals to contact their local 911 communications center and schedule an observation. Dispatcher 1128 stated, “What would help them understand is to go in and sit in a dispatch center with dispatchers and plug in and listen to them.” In addition, 1498 stated, “what can help is coming in and seeing, and observing the people.” Plugging in and listening to 911 calls is one of the best ways to gain a better understanding of the type of calls dispatchers experience. Dispatcher 6355 suggested:

Have therapists come sit in the dispatch center. I know they think dispatchers have their feet propped up, but even if they could listen to calls we take so they know and to give them an idea of what it is like hearing a mother scream because their baby is not breathing or the one spouse pleading for their dead spouse to not leave them.

From the data collections interviews, 911 dispatchers shared their lived experiences with CF and mental health treatment describing numerous challenges and consequences of being the “first” first responder. Six superordinate themes captured the essence of their understanding of their experiences. In the next chapter, I will elaborate on the findings and provide in-depth discussion, the implications for dispatchers experiencing CF, and their encounter with mental health services. I will also identify implications for mental health practitioners and make suggestions for future research.

DISCUSSION

This chapter highlights the findings of this IPA research study examining the lived experiences of 911 dispatchers with compassion fatigue. Based on the collected data from the one-on-one interviews, implications for dispatchers, mental health counselors, and communication center management are discussed. I will review the limitations and offer equitable suggestions for future research to support 911 dispatchers.

To date, there is a dearth of literature surrounding the mental health impacts and daily challenges experienced by 911 dispatchers from primary PSAP agencies (Bourgeois et al., 2021; Pierce & Lilly, 2012). This is the first study to systematically examine the nomenclature, responsibilities, challenges, and subsequent emotional and physical impacts. The goal of this Interpretative Phenomenology (IPA) study was to understand the lived experiences of 911 dispatchers with Compassion Fatigue (CF). This study was guided by two research questions: RQ#1: What are the lived experiences of 911 Dispatchers with compassion fatigue? RQ#2: What was the 911 dispatcher's experience with peer debriefing availability or mental health treatment after experiencing compassion fatigue symptomatology?

This IPA study sought to contribute to the body of counseling research by familiarizing mental health professionals with the unique challenges dispatchers experience daily and the subsequent negative impact on their mental health, their family, and the citizens they serve. Marks et al. (2017) acknowledged the overall lack of interventions and mental health treatment for this essential population. In this study, I provided an interpretation of the dispatcher's lived experience with CF, to better prepare mental health professionals to expand their practice to include this indispensable population.

In this IPA study, twenty participants, from across the United States, were interviewed to uncover their lived experiences. Through the use of semi-structured, one-on-one interviews, via Zoom, I was able to capture the essence of the lived experiences of twenty 911 dispatchers from various PSAP agencies from across the United States. Through the data analysis, six superordinate themes emerged that were descriptive of the dispatchers' lived experiences: *911 Challenges, Management/Agency, Physical Impact, Traumatic Calls, Clinical Symptoms, and When the Helpers Need Help.*

Superordinate Theme 1: 911 Dispatcher Challenges

Participants in this study experienced psychological challenges with vivid imagery, lack of closure, being behind the scenes, requirements of picking up the next call expeditiously, and shift work. The first prominent subtheme that emerged from this superordinate theme was vivid imagery, indicating long-term negative impact, feeling emotionally hardened, and numb over time, and the inability to process the traumatic imprint. Although this finding is congruent with research completed by other researchers that detail the worst-case scenario rule of dispatching (Bride et al., 2007; Wang 2017) this study offered new insight into how vivid imagery directly impacts the dispatcher. It is not as simple as not having closure and feeling powerless, rather it is the lack of information and understanding of the consequences that greatly impacts the dispatchers. They are left with disturbing images to process without the tools to adequately minimize the cost to their mental and physical health. Likewise, studies have shown that lack of final resolution leaves the dispatcher feeling powerless (Regehr et al., 2013); yet again, they are not receiving assistance to mentally unpack their emotions, rather they compartmentalize to the point of feeling something is broken inside of them. Stress increases when the dispatcher is left

in a state of perpetual wondering if the caller was saved or succumbed to their injuries (Baseman et al., 2018).

Furthermore, when required to immediately pick up the next call, the dispatcher is unable to decompress and may develop maladaptive coping mechanisms. Picking up call after call is the responsibility of the dispatcher job position; however, after hearing blood curdling screams from a citizen, having a moment to destress would be beneficial. The dispatchers inherently run the risk of increased emotional and cognitive fatigue (Anshel et al., 2012). Researchers have shown that dispatchers often have the inability to take a personal break between calls to process emotions from a previous call (Turner et al., 2019). Allowing for a short space to incorporate mindfulness activities or positive coping skills may improve the dispatcher's positive emotional state which will benefit not only the dispatcher, but the agency and the citizens (Anshel et al., 2012; Bride et al., 2007).

Compounding the inability to destress is the challenge associated with being behind the scenes and never acknowledged by their public safety counterparts and the public. Dispatchers want to be seen and acknowledged for their hard work as public safety personnel as they are often referred to as the "first" first responder (Birze et al., 2020; Lilly & Allen, 2015; Lilly et al., 2019). The participants in the current study also shared the frustration and heartache of always having to fight for any type of recognition. Indeed, dispatchers may be at risk for isolation from lack of acknowledgement as a professional public safety counterpart (Bourgeois et al., 2021).

Shift work, especially night shift, is another challenging aspect of dispatcher work. The impact is compounded if the assigned shift is not voluntary. Staffing shortages, due to exhausted dispatchers, directly impacts each agency. Nonetheless, the 911 communications center never closes and staffing must accommodate the needs of each center. Researchers have concluded

shift work has been connected to a decrease in overall physical and mental well-being (Shakespeare-Finch et al., 2014; Smith et al., 2019; Wahlgren et al., 2020). Night shift has been especially impactful due to the disruption in the natural circadian rhythms of the body (Wong et al., 2012). Often the dispatcher is not afforded a choice on the shift or how frequently the shifts rotate.

Superordinate Theme 2: Management/Agency

Although dispatcher research is limited, perceived co-worker and management support has been shown to directly correlate with lowered compassion fatigue symptomology (Miller et al., 2017). The current study offered additional information on the nuanced feelings dispatchers have towards their career choice and the management under which they work. Despite feeling omitted from certain choices and the overall public safety continuum, it is possible for dispatchers to absolutely love their job. In fact, dispatching can become engrained into their identity. The current study described 911 dispatcher's profession as "consuming" and "etched into their soul." 911 dispatching is a profession strictly about helping others but despite their dedication and pride, they may become disillusioned with the lack of support from management.

By taking a proactive approach to the well-being of their employees, agencies have the potential to reduce the technostress and traumatic effects when 911 starts real-time video calls (Baseman et al., 2018). This technological trend has fast forwarded agencies to adapt to text-to-911 and video-to-911, meaning 911 dispatchers must now be an eyewitness instead of auditory witness. Many agencies are still working with antiquated GPS technology that cannot even compare with common GPS Apps on smart phones. Agencies are now faced with integrating new software and training staff with limited workforce to complete the task. In 2013, the National Emergency Number Association (NENA) acknowledged communication centers need

“to conduct extensive research and testing – including input from front-line call takers” for text-to-911 (NENA.org). Conversely, there has been a lack of collaboration between management and front-line dispatchers. The dispatchers have not been adequately prepared for the overall psychological impact of witnessing crimes in progress. A couple of the dispatchers in this study have video-to-911 in their communication centers. They have not received appropriate training and are fearful of answering the call and bearing witness to a crime in progress. This has the potential to significantly impact staffing levels in a system that is already in the midst of a staffing crisis (Linos et al., 2021).

Nationwide, many 911 communication centers are experiencing a staffing crisis (Linos et al., 2021). Although researchers touch on the staffing shortages, it does not begin to describe the damaging effects felt by the dispatcher especially post-pandemic (Bourgeois et al., 2021). Faced with a staffing crisis and increased resignations, dispatchers are fearful of increased liability if mistakes, such as over or under triage, are made due to exhaustion (Furgani et al., 2021). The current study highlighted the emotional frustrations and physical exhaustion dispatchers, in an understaffed agency, may experience from working twelve to sixteen hour shifts fourteen days in a row without a break.

Agencies can provide support through policy and resources starting with a positive and open policy on mental health. They can incorporate a team atmosphere where no one feels isolated, alone, or forced to manage the stress silently. Resources include well-being checks after distressing calls, quiet rooms for the dispatchers to decompress after a traumatic call, take a quick nap for stress headache relief, or use as nursing mothers.

Superordinate Theme 3: Physical Impact

The 911 dispatcher profession has an alarming impact on their physical health. Prior researchers have touched on the negative physical effects of the sedentary nature of 911 dispatching and the health risks dispatchers experience including poor nutrition, sleep disturbances, obesity, cardiovascular problems, and headaches (Anshel et al., 2012; Lilly et al., 2016; Shakespeare-Finch et al., 2014; Smith et al., 2019; Zaluski and Markara-Studzińska 2022). Although the results of this current study correspond with prior research, this study highlighted the dispatcher's lived experiences with the negative physical impacts they have each personally experienced. Weight gain is a significant concern, especially with the increased work hours and lack of down time. Indeed, the environmental factors of the job place dispatchers at an elevated risk for myriad health complications including obesity. Smith et al. (2019) reported obesity amongst "83% of call-takers and dispatchers" in their study (p. 620).

In addition to the increased weight of the dispatchers, the high stress nature of the profession also impacts the dispatchers' ability to obtain adequate and rejuvenating sleep. Dispatchers may have inadequate or difficult sleep in light of shift work, always being on high alert, and inability to turn off their thoughts about a traumatic call. The physical impact takes a toll on their overall mental health (Oldenburg et al., 2014; Smith et al., 2019). Further, researchers have found chronic exposure to high cumulative stress increases vulnerability to experiencing negative physical outcomes (Lilly et al., 2016).

Superordinate Theme 4: Traumatic Calls

Previous researchers have discussed the impact of traumatic calls on the dispatcher (Birze et al., 2020; Kindermann et al., 2020; Pierce & Lilly, 2012; Troxell, 2008) including stress related disorders and limited empathic capability; however, the literature has not examined the

dispatcher's interpretation of their experiences with CF and the direct impact on the citizen reaching out in a crisis. In this present study, participants provided candid explanations of their experiences with CF, the challenge of being present with the caller, limited empathic capability, emotional hardening, and lack of emotional response. A lack of emotional response may be due to the multitude of daily and cumulative challenges escalating CF symptomology.

Pierce and Lilly (2012) and Troxell (2008) assessed the types of calls the dispatchers found the most distressing. Both research studies showed a significant stress response relating to calls involving injury or death of a child. In conjunction with their studies, the participants in this study also found calls involving children to be the most distressing and emotionally impacting. Hearing the child in pain or knowing the child has died at such a young age can be terrifying for the dispatchers leading to feelings of helplessness and hopelessness when instructing the parents to perform CPR all the while knowing the child was beyond resuscitation. Conversely, calls involving the elderly population negatively impacted the dispatchers in this study whereas this population is not specifically mentioned in prior research.

Regardless of how routine this experience may be for the dispatcher; emotion dysregulation is common. Without focusing on processing the trauma they have experienced, uncovering the emotional triggers, and creating a solid self-care plan the dispatchers may continue to feel the emotional weight of the traumatic calls.

Superordinate Theme 5: Clinical Symptoms

The current study offered new insights into the overall clinical symptoms experienced by the dispatchers. First, dispatchers may experience difficulty concentrating due to ruminating or intrusive thoughts of either a specific traumatic call or numerous calls over the course of their

career. Marks et al. (2017) demonstrated intrusive memories are more common in dispatchers than members of the Armed Forces who served in combat. The current study reported on the dispatchers' experience with ruminating thoughts about following protocol, a caller's screams, and the calls that will stay with them for the rest of their lives.

Unfortunately, the dispatcher's home life is not immune to the consequences of their lived experiences in the 911 communication center. Prior researchers suggested that the cost of caring has a direct impact on the family life of a 911 dispatcher (Camaro et al., 2020). Their study highlighted the noticeable changes in mood and social withdrawal. The dispatchers in this study offered their unique perspective on their lived experiences with the impact on their families, including routine anger, needing space to decompress, difficulty with conversation, and wanting to be alone. Active withdrawal may be related to the stress of the job and not wanting to burden their family.

Hypervigilance among dispatchers is a peritraumatic stress response related to PTSD symptomology (Pierce & Lilly, 2012). Although detailed and succinct, the previous literature on hypervigilance was quantitative in nature. This current study fills in the gaps with the dispatchers' own voice and their interpretation of their lived experiences with hypervigilance and feeling exhausted of consistently remaining on high alert.

One negative coping skill to circumvent hypervigilance and intrusive thoughts as part of CF is avoidance (Stamm, 2009; Trachik et al., 2015). Ignoring the trauma by compartmentalizing and pushing away the thoughts may erupt in various negative coping skills causing more emotional damage. Dark humor is a counterproductive coping skill acquired by dispatchers. In the moment, making light of a situation may alleviate distress; however, this is another maladaptive process that leads to avoidance.

The consequences of CF can leave dispatchers feeling emotionally drained (Kindermann et al., 2020; Stamm 2009). Many 911 dispatchers are helpers by nature and are accustomed to placing everyone else's needs before their own. Although they desperately want to help others, the daily and cumulative challenges this population experiences impact their emotional capacity to effectively offer help. In the current study, the dispatchers shared their experiences with the impact of everyone else's bad day and raw emotions. The exhaustion ranged from being tired of people in general to emotional and physical exhaustion that becomes a load too heavy to carry.

Furthermore, the current study uncovered the dispatchers' experience of feeling emotionally damaged by a profession that they feel is ingrained in who they are. Although prior literature has discussed various negative implications of CF and trauma exposure, this current study reveals their firsthand experiences of feeling changed forever. Dispatchers may have to grapple with staying in a profession and at what cost to their mental health.

Superordinate Theme 6: When the Helpers Need Help

There is still a stigma among dispatchers associated with seeking mental health counseling as a sign of weakness. This study had direct implications for the stigma associated with dispatchers seeking mental health treatment. First of all, dispatchers may feel seeking mental health help in any form is not accepted by the profession. Secondly, dispatchers may not want their peers or management to form the opinion that they are not capable of performing their duties. The antiquated norm of "just suck it up" may be a difficult barrier to break through leaving dispatchers hesitant to speak up. Changing this mindset may prove challenging unless there is open dialogue concerning mental health and incorporating mental health affirming terminology.

Critical Incident Stress Management (CISM) debriefings have been offered to public safety personnel to provide short-term mental health interventions after traumatic events (Feuer, 2021; Hammond & Brooks, 2001). A CISM team is typically comprised of public safety peers and mental health personnel. However, dispatchers report their omission from such debriefings prompted feelings of isolation and insignificance. The omission from debriefings may further exacerbate avoidance and negative coping skills.

Another mental health issue for dispatchers is their feeling of being misunderstood by mental health professionals. In this current study, clinicians did not understand the role significance and challenges experienced by 911 dispatchers. Counselors may not fully grasp the complexities of shift work, vivid imagery, and the impact of listening to the trauma of others. Fear of judgement, sharing dark humor, and disclosing details of traumatic calls may hinder the therapeutic relationship, thus impacting the efficacy of treatment. In addition, counselors may not understand the level of ownership a dispatcher feels regarding the outcome of a call. Initially, certain cognitive counseling techniques may not be effective to change this feeling without first recognizing how and why dispatchers internalize responsibility. To increase familiarity with the 911 profession and complexity of their role, counselors can visit their local communications center, sit side by side with a dispatcher, and listen to the type of calls they receive on a daily basis.

Implications for Dispatchers

Staffing shortages, daily and cumulative challenges, and physical implications leave a lasting, impenetrable weight on the dispatcher. CF in the 911 dispatcher may disrupt their ability to disseminate accurate and detailed information to responding units and alter their risk appraisal of the information gathered from the citizen resulting in over or under triage (Gillooly, 2020).

Their role can have a direct impact on citizen cooperation with responding units, how responding units perceive the situation, and how data is collected for initial investigations (Simpson, 2020). Dispatchers have been scrutinized in the media as of late. For example, dispatchers are facing increased litigation as qualified immunity is challenged and pressure increases to perform at near humanly impossible perfection (McAleavy et al., 2021; Wille 2005).

This study shed light on the risks associated with CF in 911 dispatchers. Along with highlighting the negative implications, this study reinforces the need for mental health psychoeducation for this critical population. Empirical evidence has shown healthy self-care and mindfulness practices can mitigate traumatic stress reactions (Owens-King, 2019). Providing psychoeducation to help dispatchers create and routinely engage in self-care has far-reaching benefits for not only the dispatchers but the agencies and citizens of the community.

Implications for Management/Agency

With staffing levels at an all-time low, mandatory overtime, and agencies struggling to meet personnel needs, communication centers are left to contend with dispatchers experiencing CF and questioning their motivation to remain in the profession. The findings of this study encouraged management to re-examine their responses to this essential population.

This detailed exploration of their experiences will facilitate investment by management and agencies in support of the 911 dispatchers and the impact on their mental health. Additionally, the description of their experiences will benefit agency management by incorporating mental health programs, peer support teams, and training into their communication centers. In return, by increasing compassion satisfaction and psychological resilience, through mental health support and policy initiatives, there may be a reduction of CF, sick time usage, and

resignations. Thus, personnel who are positively supported directly impact the citizens of the community by reducing liability, correcting over and under triage, and their ability to provide empathy during times of crisis.

For example, workplace mindfulness-based interventions (MBI) have shown positive results with reducing anxiety and overall cortisol levels (Chae & Meischke, 2021). MBI's have been incorporated into PTSD treatment to reduce hypervigilance and reactivity (Somohano et al., 2022). Mindfulness exercises can be implemented via computer or in person. Once trained in the technique, the dispatcher can incorporate them into their daily self-care routine. There is a potential role for MBI in communication centers as a preemptive practice for CF.

With the introduction of NextGen 911 video to 911, it is suggested by dispatchers in this study, for management to transition from reactivity to proactivity with contingencies in place to support the dispatchers with the heightened level of trauma they may experience from directly witnessing the crisis. Creating stress reduction supports prior to this transition, may assist with compassion satisfaction, and increase retention.

Implications for Clinicians

The current study emphasized, in the dispatchers' own words, the critical need for mental health services and peer support programs. Dispatchers are often omitted from CISM debriefings after a traumatic incident. Mental health providers routinely overlook the crucial role of the 911 dispatcher. Mental health scholars exclude 911 dispatchers in empirical research as evidenced by the scarcity of peer reviewed articles. Due to the generational stigma associated with seeking counseling, some dispatchers appear to be unaware of the nature of counseling.

For clinicians, dispatchers are an untapped population who are in dire need of mental health support. This population is the first heard yet rarely seen in an emergency, and frequently overlooked in outreach efforts by mental health professionals. One of the goals of this study was to familiarize mental health clinicians with the daily and cumulative challenges dispatchers experience to increase comfortability with this population. Counselors often advertise clinical expertise with public safety; however, oftentimes this does not include 911 dispatchers. Several dispatchers suggested mental health clinicians visit a communication center, put on a headset, and listen to the calls received to acquaint themselves with the trauma they experience to understand the impact. As additional outreach efforts, counselors can attend agency specific conferences, participate in empirical research, and legislative advocacy to propel dispatchers' inclusion in public safety classification. CF is negatively impacting this essential population, who are left with minimal support to counteract the devastating effects. The dispatchers cannot continue to perform, at an optimal level, this lifesaving role without direct interventions.

Limitations

This study examined the lived experiences of 911 Dispatchers with CF through an IPA lens. Although this study allowed for an in-depth case by case and cross case analysis, it is limited to the participants' recollection and interpretation of their experiences. Forgetting details due to feeling anxious about being recorded and the ability to remember specific details due to length of time since occurrence may hinder or influence their interpretation of events.

Secondly, this study incorporated purposive homogenous sampling methods to gather participants from primary PSAP agencies. Although the participants were all from primary PSAP's, the size of the agency may have varied resulting in divergent experiences. Smaller agencies may not experience the same type of call type and volume as larger agencies.

Thirdly, the number of experienced traumatic events may differ. The calls coming into the communication center are random. The dispatcher never knows what is on the other end of the phone line. One dispatcher may only have a few traumatic calls while another dispatcher has had an overwhelming occurrence of traumatic calls, and this study only collected data on their levels of CF.

Additionally, eighteen of the dispatchers identified as White/Caucasian while two of the dispatchers identified as Hispanic/Latino-(a). Cultural experiences and worldviews may impact their interpretations of traumatic events thus resulting in higher or lower response to CF. Similarly, the participants were comprised of six males and fourteen females. Historical gender role norms may have influenced the participants' discussion of the events.

Moreover, the self-report nature of this design means dispatchers may not have been forthcoming with certain nuances of their lived experiences out of respect for their agencies or fear of perceived repercussions. The fear of emotional distress by directly narrating their experiences may have prevented the participants from divulging specific details that have impacted their mental health.

In conclusion, this study examined the lived experiences of the 911 dispatchers, however, this study did not inquire into Adverse Childhood Experiences (ACES), prior trauma, or resiliency, all of which can impact coping mechanisms and emotion regulation resulting in differences in responses to their environment (Allen et al., 2016)

Future Directions

This is the first known research study to examine the lived experiences of 911 Dispatchers with Compassion Fatigue through an Interpretative Phenomenology Lens. The

current study has contributed to the limited body of literature involving this essential population by: (1) systematically highlighting the daily and cumulative challenges; (2) detailing the emotional, psychological, and physical health impacts of CF; (3) providing suggestions for management and clinicians to increase overall support for 911 dispatchers.

Dispatchers faced myriad challenges and CF symptomology, including vivid imagery, lack of closure, being behind the scenes, and the fast-paced nature of moving from one call to the other. Increased hypervigilance, avoidance, and feeling emotionally hardened impacts their emotional response to citizens, their family, and commitment to their agency. Future research could explore the efficacy of potential interventions to reduce CF symptomology in 911 dispatchers. The research can include applicability in a 24-hour communication center. Understanding the nature of shift work impacts the delivery of interventions as the dispatcher who works night shift may not have the luxury of waking up during the day to attend or engage in certain types of mental health programs.

Additionally, the findings of this study push for the development and availability of CISM/Peer support and mental health programs. The lack of mental health support discussed in this study demonstrates a gap in critical preventative and aftercare for dispatchers. Future directions could review protocols and implementation practices of various agencies that have CISM, peer, and mental health support, and how that may translate to other agencies needing to initiate peer support teams.

Finally, in this study I suggested expanding access to mental health counseling by strengthening management participation in advocating for the mental health of their employees and by encouraging outreach efforts by clinicians. Research on the efficacy of interventions, such as CISM, mindfulness, and trauma informed care, could be designed to examine the

proposed impact of 911 real time video calls, including how the dispatchers are trained, what impact will witnessing the crime in real time have on the dispatcher, and what supports are in place to counter the effects of this type of trauma. Traditionally, police and paramedics arrive after the event has occurred and do not witness the brutal crime taking place. Thus, the traumatic impact on the dispatcher may be incomprehensible.

Summary

This study examined the lived experiences of 911 dispatchers with CF through an interpretative phenomenology lens. The results of this study corroborated some of the major findings of the scant existing literature while introducing distinct findings based on the personal lived experiences of the participants. The results of this study highlighted the dire need for increased awareness of the challenges dispatchers experience, management support, mental health outreach, and research involving this essential population.

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Table 2
Comparison of PTSD and CF

PTSD	CF
A. Stressor	A. Stressor
Experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others	Experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others
The person's response involved "intense fear, helplessness or horror"; an event such as: <ul style="list-style-type: none"> a. serious threat to self b. sudden destruction of one's environment 	The person's response involved "intense fear, helplessness or horror"; an event such as: <ul style="list-style-type: none"> a. serious threat to traumatized person TP b. sudden destruction of TP's environment
B. Reexperiencing Trauma Event	B. reexperiencing Trauma Event
Recollections of event	Recollections of event/TP
Dreams of the event	Dreams of the event/TP
Sudden reexperiencing of event	Sudden reexperiencing of event/TP
Distress over reminders of event	Reminders of TP/event distressing
C. Avoidance/Numbing of Reminders	Avoidance/Numbing of Reminders
Efforts to avoid thought/feelings	Efforts to avoid thought/feelings
Efforts to avoid activities/situations	Efforts to avoid activities/situations
Physiologic amnesia	Physiologic amnesia
Diminished interest in significant activities	Diminished interest in significant activities
Detachment, estrangement from others	Detachment, estrangement from others
Diminished affect	Diminished affect
Sense of Foreshortened future	Sense of Foreshortened future
D. Persistent Arousal	D. Persistent Arousal
Difficulty falling/staying asleep	Difficulty falling/staying asleep
Irritability or outbursts of anger	Irritability or outbursts of anger
Difficulty concentrating	Difficulty concentrating
Hypervigilance for self	Hypervigilance for TP
Exaggerated startle response	Exaggerated startle response
Physiologic reactivity to cues	Physiologic reactivity to cues

Note: Adapted from "Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators", by B.H.Stamm, 1995, Sidran Press. Copyright 1995 by Sidran Press.

Table 3*Professional Quality of Life Scale (ProQOL-5)***Professional Quality of Life Scale (ProQOL)****Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)**

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

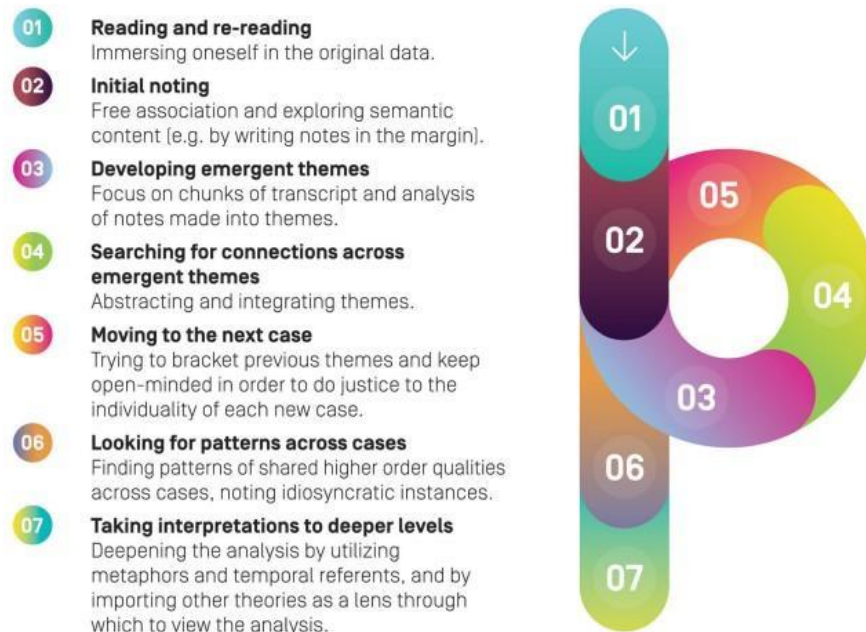
1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1.	I am happy.			
_____ 2.	I am preoccupied with more than one person I [help].			
_____ 3.	I get satisfaction from being able to [help] people.			
_____ 4.	I feel connected to others.			
_____ 5.	I jump or am startled by unexpected sounds.			
_____ 6.	I feel invigorated after working with those I [help].			
_____ 7.	I find it difficult to separate my personal life from my life as a [helper].			
_____ 8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].			
_____ 9.	I think that I might have been affect by the traumatic stress of those I [help].			
_____ 10.	I feel trapped by my job as a [helper].			
_____ 11.	Because of my [helping], I have felt “on edge” about various things.			
_____ 12.	I like my work as a [helper].			
_____ 13.	I feel depressed because of the traumatic experiences of the people I [help].			
_____ 14.	I feel as though I am experiencing the trauma of someone I have [helped].			
_____ 15.	I have beliefs that sustain me.			
_____ 16.	I am pleased with how I am able to keep up with [helping] techniques and protocols.			
_____ 17.	I am the person I always wanted to be.			
_____ 18.	My work makes me feel satisfied.			
_____ 19.	I feel worn out because of my work as a [helper].			
_____ 20.	I have happy thoughts and feelings about those I [help] and how I could help them.			
_____ 21.	I feel overwhelmed because my case [work] load seems endless.			
_____ 22.	I believe I can make a difference through my work.			
_____ 23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].			
_____ 24.	I am proud of what I can do to [help].			
_____ 25.	As a result of my [helping], I have intrusive, frightening thoughts			
_____ 26.	I feel “bogged down” by the system.			
_____ 27.	I have thoughts that I am a “success” as a [helper].			
_____ 28.	I can’t recall important parts of my work the trauma victims.			
_____ 29.	I am a very caring person.			
_____ 30.	I am happy that I chose to do this work.			

Table 4
Interview Protocol Questions

<i>Key Components</i>	<i>Interview Questions</i>	<i>Prompts</i>
Compassion Fatigue (CF) <ul style="list-style-type: none"> • Recollections of the event-TP • Efforts to avoid thoughts/feeling • Diminished affect • Difficulty sleeping/staying asleep • Irritability or outbursts of anger • Difficulty concentrating • Reminders of the event • Diminished interest in activities • Sense of foreshortened future • Hypervigilance • Exaggerated startle response • Physiologic reactivity to cues • Efforts to avoid activities/situations <p>Adapted from “<i>Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators</i>”, by B.H.Stamm, 1995, Sidran Press. Copyright 1995 by Sidran Press</p>	<ol style="list-style-type: none"> 1. What comes to mind when you think about compassion fatigue? 2. Talk about your experiences with CF 	<ol style="list-style-type: none"> 1. Tell me more about the emotional impacts 2. Talk about the impact on your body, how has it affected you physically? 3. Talk about the impact on you emotionally, How has compassion fatigue affected you emotionally? 4. What about physical exhaustion? Can you talk more about that? 5. Can you talk more about the emotional exhaustion and how that impacts you when talking to citizens. 6. How do you support the caller in need? 7. Tell me what is was like over time
Daily and Cumulative Stressors <ul style="list-style-type: none"> • Physical implications • Emotional Impacts 	<ol style="list-style-type: none"> 1. Can you talk about your experience after receiving traumatic calls? 	<ol style="list-style-type: none"> 1. Tell me more about what emotions you experienced. 2. Are there certain triggers that you experience? 3. How did that impact your shift?

Treatment <ul style="list-style-type: none"> • Mental health support • Agency policy • Peer support 	<ol style="list-style-type: none"> 1. Tell me about your experience with CISM debriefings. 2. Did you seek mental health treatment? Why or why not? 3. How can mental health providers support and work effectively with 911 dispatchers experiencing CF? 	<ol style="list-style-type: none"> 1. Have you experienced stigma associated with seeking mental health support? 2. What are some things that you would change?
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Figure 3
Seven Steps to IPA Analysis



Note: The seven-steps of IPA data analysis (Charlick, McKellar, Fielder, & Pincombe, 2015 adapted from Smith et al., 2009)

APPENDICES

Appendix A

911 DISPATCHER REQUEST FOR PARTICIPATION

Subject: The lived experiences of 911 dispatchers with compassion fatigue.

Dear 911 Communication Center Administration,

My name is Angela Johnson, I am a former 911 dispatcher, and a current doctoral candidate in the Counselor Education and Supervision program at Old Dominion University in Norfolk, VA. Under the supervision of Dr. Kristy Carlisle, an Associate Professor at ODU, I am conducting a research study to explore the lived experiences of 911 dispatchers with Compassion Fatigue (CF). I am asking for your assistance with disseminating this request to the 911 dispatchers at your communications center. Your participation in this study could inform mental health counselors of the challenges 911 dispatchers experience daily and to assist them with structuring their clinical work to include this population. This study is also aimed at providing insight into the 911 dispatcher profession for future research. Your participation in this study is strictly voluntary and confidential. You are free to withdraw at any time without consequence or penalty. There is no compensation for your participation. This study has been approved by the Institutional Review Board of Old Dominion University [2003991-1].

Eligibility: To be considered as a participant, you must meet the following criteria:

1. Be over the age of 18 years old.
2. Be employed with a primary PSAP.
3. Have been employed for at least 2 years as a 911 dispatcher.
4. Work independently of a trainer.
5. Have lived experience with CF

Participation: If you volunteer to participate in this study, you will be asked to read and sign a consent form as well as complete a demographic questionnaire, and Professional Quality of Life (ProQOL-5) self-assessment to determine experience with compassion fatigue via Qualtrics (link). Those individuals who rate on the ProQOL-5 as having experience with compassion fatigue will be selected to participate. All rounds of data collection will be conducted remotely via Zoom and every effort will be made to ensure anonymity and confidentiality for all participants including but not limited to name and communication center identity. Scheduling interviews will be based on the participant's availability.

Round 1: In this data collection round, you will receive a Zoom link and a Calendly link to schedule your first interview. The interview should last approximately 60 - 90 minutes. You will be asked a series of open-ended questions to discuss your lived experience with compassion fatigue.

Round 2: In this round of data collection, we will meet virtually or collaborate via email, depending on dispatcher's schedule, to participate in member checking where you will be able to verify the transcription of the data for accuracy.

I appreciate your time, consideration, and willingness to share your experiences with me. If you decide to participate, please use the following link (Qualtrics Link) to begin the process and complete the informed consent form, demographic questionnaire, and ProQOL-5 self-assessment.

If you have any questions, please do not hesitate to reach out to Dr. Kristy Carlisle at kcarlisl@odu.edu or Angela Johnson at a11johnso@odu.edu.

Sincerely,

Kristy L. Carlisle, Ph.D., LPC-R (VA), HS-BCP
Responsible Principal Investigator
Associate Professor
Addictions Education Coordinator
Department of Counseling & Human Services
2133 Education Building
Darden College of Education & Professional Studies
Old Dominion University

Angela M. Johnson, MA., LPC, CFTP
Graduate Student Investigator
Department of Counseling & Human Services
Old Dominion University
Norfolk, VA 23529
a11johnso@odu.edu

Appendix B

Demographic Questionnaire

Instructions: Select and/or fill in the blanks for each question and appropriate responses.

1. Are you over the age of 18?

- a. Yes
- b. No

2. How long have you been employed with your agency?

- a. 2-5 years _____
- b. 6-10 years _____
- c. 11-15 years _____
- d. 16-20 years _____
- e. over 21 years _____

3. Are you working independently of a trainer?

- a. yes
- b. no

4. Is your agency a primary PSAP?

- a. Yes
- b. No

5. What is your gender?

- a. Female
- b. Male
- c. Nonbinary
- d. Other (please specify) _____

6. How do you identify your racial/ethnic background?

- a. African American/Black
- b. Asian/Pacific Islander
- c. Hispanic/Latino(a)
- d. Native American/Alaska Native
- e. White (non-Hispanic)
- f. Other _____

7. What is your employment title/designation? _____

APPENDIX C

INFORMED CONSENT FORM

Project Title: The Lived Experiences of 911 Dispatchers with Compassion Fatigue: An Interpretive Phenomenology

Principle Investigator: Dr. Kristy Carlisle, Ph.D., LPC-R (VA), HS-BCP, Department of Counseling & Human Services, College of Education

Graduate Student Investigator: Angela Johnson, MA, LPC, CFTP, Doctoral Candidate in Counselor Education and Supervision, Department of Counseling and Human Services, College of Education

Description of the Research Study

In the study, the researcher will examine the lived experiences of 911 dispatchers with Compassion Fatigue. 911 dispatchers are at an increased risk of developing compassion fatigue due to daily and cumulative challenges they experience. There is a paucity of research surrounding this profession. This is the only study that details the systematic, physical, and emotional challenges dispatchers from primary PSAP locations face and their experiences with compassion fatigue from an interpretive phenomenological lens. Compassion Fatigue (CF) refers to emotional and physical exhaustion experienced due to the constant exposure to the traumatic calls of others and lack of perceived support limiting the empathic capability of the 911 dispatcher (Kindermann et al., 2020). The results of this study can be used to inform communication center management on the significance of providing mental health support for 911 dispatchers, inform counseling practices and inclusion in psychoeducation and outreach efforts of clinicians, and counseling researchers to develop further research to aid the “*first*” first responders.

If you volunteer to participate in this study, you are asked to read and sign the consent form as well as complete a demographic questionnaire and the ProQOL-5 self-assessment. Those participants meeting criteria for compassion fatigue will be selected for the first round of interviews in early 2023. The virtual interview will last approximately 60 minutes. The participant will be asked 6-8 open ended questions. At the second interview, the participants will be asked to review the transcribed data for accuracy.

Exclusionary Criteria

To participate in this study, individuals must meet the following criteria: (1) be over the age of 18 years old; (2) be employed with a primary PSAP; (3) have worked as a dispatcher for over 2 years; (4) work independently of a trainer.

Risks and Benefits

Risks: If you decide to participate in this study, then you may face a risk of minimum distress. The researcher tried to reduce these risks by removing any identifying information such as name and place of employment. All Zoom recordings will be deleted after transcription. Some of the lived experiences with compassion fatigue reflected during the interviews may result in

emotional distress. The researcher will provide additional mental health resources if further support is needed. And, as with any research, there is some possibility that you may be subject to risks that have not been identified.

Benefits: The main benefit to you for participating in this study is you will have an opportunity to reflect on your lived experiences with compassion fatigue. This study will have implications for counselors, counselor educators, researchers, and communication center administration. The findings will enlighten and advance our knowledge of the lived experiences of 911 dispatchers with compassion fatigue, their inclusion in mental health support services after traumatic events and measures that could be taken to support this vital profession.

Costs and Payments

There is no cost or compensation to participate in this study. Participation in this study is voluntary.

New Information

If the researchers discover new information during this study that would reasonably change your decision about participating, then this will be shared with you.

Confidentiality

The researchers will take reasonable steps to keep private information obtained in this study confidential, such as the demographic questionnaire and identifying information unless disclosure is required by law, court order, or by government bodies with oversight authority. The researcher will assign each participant a pseudonym to protect identity. All study data will be kept in a password-locked computer in a password-locked file accessible only by the researchers. Summarized data and responses to the open-ended questions will be presented at meetings, in presentations, reports, and publications. However, the researcher will not identify you or your agency in these presentations. Participants are responsible for the confidentiality of their setting during the interview process.

Permission to Audio and Video Record

During data collection, participants will be audio and video recorded. By noting your agreement with the consent, participants are giving the researcher permission to audio and video record the interviews. These recordings will be destroyed after data analysis.

Withdrawal Privilege

Even if you have agreed to participate in this study, you are free to withdraw at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observed potential problems with your continued participation.

Compensation for Illness and Injury

If you volunteer to participate in this study, your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury.

Voluntary Consent

By clicking and signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risk and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, then the researcher should be able to answer them.

If you have any questions, concerns, or complaints, please contact the Responsible Project Investigator, Dr. Kristy Carlisle, at kcarlisl@odu.edu.

This research has been reviewed and approved by the Old Dominion University Darden College of Education and Professional Studies IRB. [Adam Rubenstein, Research Compliance Coordinator].

Appendix D

Acceptance Email

Dear 911 Professional,

Thank you for your interest and the time you took to participate in the screening phase of this study “911 Dispatchers and Compassion Fatigue: An Interpretive Phenomenology”. I am contacting you to advise you that you have met criteria for inclusion into the study. Our next steps:

1. **Round 1:** In this data collection round, you will receive a Zoom link and a Calendly link to schedule your first interview. The interview should last approximately 60 minutes. You will be asked a series of open-ended questions to discuss your lived experience with compassion fatigue.

2. I have included the Calendly link (link) to schedule our one-on-one interview on zoom. You can use your four-digit pin to sign up for the zoom session. If you did not create a pin, you can create one to sign up. For confidentiality, I do not collect your name or the name of your agency. If you do not see a time that fits with your schedule, please email me a11johnso@odu.edu.

3. Zoom link for our meeting:

Angela Johnson is inviting you to a scheduled Zoom meeting.
(Zoom link)

Looking forward to speaking with you soon,

Appendix E

Debriefing Statement

Thank you for your participation in this study on the lived experiences of 911 dispatchers with CF. Your description of your lived experiences with CF are invaluable in advancing the inclusion in mental health support and research for 911 dispatchers.

In the event that your participation in this study has caused you emotional or psychological distress, I encourage you to reach out to a mental health provider for support. In the event you cannot reach a mental health provider, please reference the following resources:

National Suicide Prevention Lifeline: 988

Crisis Text Line: Text HOME to 741741

Dial 911

Or report to your local emergency room.

If you are interested in further mental health counseling, follow the link to search for mental health providers in your local area: [Psychology Today: Health, Help, Happiness + Find a Therapist](#)

Appendix F

Ineligibility Email

Dear 911 Professional,

Thank you for your interest and time you took to participate in the screening phase for the study of “911 Dispatchers and Compassion Fatigue: An Interpretative Phenomenology”. I am contacting you to advise you that, due to not meeting the criteria required for this study, you will not be selected for the next phase of interviews and data collection. I greatly appreciate your time and interest in participating in this study.

Should you have any questions please do not hesitate to contact Dr. Kristy Carlisle at kcarlisl@odu.edu or Angela Johnson at a11johnso@odu.edu.

Thank you,

Angela Johnson, MA, LPC, CFTP
Doctoral Candidate in Counselor Education and Supervision
Department of Counseling and Human Services, College of Education

Appendix G



April 6, 2023

TO: Kristy Carlisle, PhD
Associate Professor
Department of Counseling and Human Services
Old Dominion University

RE: Angela Johnson
Doctoral Candidate
Department of Counseling and Human Services
Old Dominion University

Dear Dr. Carlisle,

It is with great pleasure that we provide this letter of support for Angela's Dissertation on The lived experiences of 911 dispatchers with compassion fatigue. I have thoroughly reviewed her interview process, reflexive journal, and evaluation process. I find her methods to be appropriate for the research subject, participants, and overall scope of the project. As the outside evaluator, it is my opinion that this project should move forward in its current state. Please do not hesitate to reach out if you have any questions or if I can be further helpful. I can be reached at 757-446-7431.

Cory Gerwe, PhD, LPC, ACS
Director of Coaching, Leadership, and Wellbeing
Assistant Professor, OB/GYN
Eastern Virginia Medical School

4/06/2023

Date

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ANGELA JOHNSON

EDUCATION

Doctor of Philosophy, Counseling Old Dominion University Darden College of Education 4301 Hampton Blvd, Norfolk, VA 23508 CACREP Accredited Dissertation: The Lived Experiences of 911 Dispatchers with Compassion Fatigue: An Interpretative Phenomenology	August 2023
Master of Arts, Clinical Mental Health Counseling Regent University Virginia Beach, VA Certificate in Graduate Studies: Trauma CACREP Accredited	August 2017
Bachelor of Science, Psychology Regent University, Virginia Beach, VA Minor: Criminal Justice	May 2014

LICENSE/CERTIFICATIONS

Licensed Professional Counselor
Certified Family Trauma Professional
Approved Clinical Supervisor

TEACHING EXPERIENCE

Old Dominion University Counseling Assessment and Diagnosis COUN 645 Advanced Counseling Supervision COUN 846 Master's level Internship, COUN 667 Theories of Counseling and Psychotherapy, COUN 650 Group Counseling and Psychotherapy COUN 644 Human Services: Introduction to Human Services HMSV 341 Counseling and Psychotherapy Techniques COUN 633	August 2020 – Present
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GRANT ACTIVITY

International Institute for the Advancement of Counseling Theory (IIACT)
Grant: University Libraries 2021/2022 Resource Grant
Name of Funding Organization: Old Dominion University
Amount Awarded: \$10,000.00
Role: Coordinator of Grants, Scholarships and Awards