145666

POST TRAUMA RESPONSE

AND

PEER SUPPORT

DEPARTMENT OF CORRECTIONS

DIVISION OF PRISONS

November 4-6, 1992

Washington State Penitentiary

AGENDA

NOVEMBER 4, 1992

8:30 - 8:45	*Welcome and Introductions*	*Tana Wood*
8:45 - 9:00	*Training Overview*	*Cyndi Walters*
9:00 - 11:30	*Stress Response* *Critical Incident* *Post Trauma*	*Jim Shaw and Nancy Bohl*
11:30 - 1:00	*Lunch*	
1:00 - 4:00	*Feelings and Emotions* *Listening Skills* *Paraphrasing* *Self-Disclosure* *Summarization*	*Nancy Bohl and Jim Shaw*
**5:00 - 7:30*	*Washington State Penitentiary Tour*	

* *Optional*

AGENDA

NOVEMBER 5, 1992

8:30 - 9:00	*Introductions and Division Update*	*Tana Wood*
9:00 - 11:30	*Introduction to Peer Support*	*Nancy Bohl and Jim Shaw*
	Peer Counseling Issues	
	Gender and Culture Issues	
	Grief and Bereavement	
11:30 - 1:00	*Lunch*	
1:00 - 3:45	*Substance Abuse*	*Nancy Bohl, Jim Shaw and Cyndi Walters*
	Debriefing	
**6:00*	*Dinner at the Pioneer Park Garden Center Courtesy of WSP Culinary Arts Program*	

* *Optional*

AGENDA

NOVEMBER 6, 1992

8:00 - 12:00	*Assessment*	*Nancy Bohl and Jim Shaw*
	Major Crisis	
	Depression	
	Suicide	
	Record Keeping	
12:00 - 12:30	*Lunch*	
12:30 - 2:00	*Referrals*	*Jim Shaw and Cyndi Walters*
	Questions and Answers	*Jim Shaw with Post Trauma Policy Committee*
	Certificates and Closure	

FACULTY

*Dr. **Nancy Bohl** is the owner/director of The Counseling Team in San Bernardino, California. She has provided a variety of psychological support services to more than sixty police, sheriff, fire agencies, and ambulance companies for the past nine years and is a nationally recognized authority on the subject of Critical Incident Trauma for emergency services personnel. Dr. Bohl has responded to more than one thousand critical incidents involving emergency services, 700 of these which were shootings. Her services were also used during the San Bernardino Train Derailment and Pipeline Explosion, PSA Air Disaster in Northern California, Convict Lake drownings, the Lomas Prieta Earthquake and the City of Los Angeles Riots. She was also a debriefer for personnel returning from Operation Desert Storm. Dr. Bohl received a Bachelor of Arts Degree in Sociology/Social Science and a Master of Arts Degree in Education and Counseling from the California State University and a Doctor of Philosophy in Clinical Psychology from the California Graduate Institute.*

225 West Hospitality Lane, Suite 100, San Bernardino, California 92408, (714) 884-0133.

*Dr. **James H. Shaw** has been helping city, county, state and federal public safety agencies since 1961. He coordinates the Thurston County Critical Incident Team and a national network of police psychologists who provide service to the Postal Inspection Service, the Boarder Patrol and the Immigration and Naturalization Service. He consults and teaches internationally on the subject of critical incident trauma and annually is selected to provide teaching and counseling at the National Police Survivors' seminar for survivors of law enforcement officers who were killed during the prior year. Dr. Shaw received his bachelor of arts and master of science in Psychology from the University of Idaho and a doctor of philosophy from the California Coast University. He is the author of numerous articles on critical incident stress and other law enforcement issues.*

7519 Atchinson Drive S.E., Olympia, WA (206) 456-4818.

POST TRAUMA POLICY COMMITTEE

* ***Al Bowman*** *is the Post Trauma Program Manager for the Washington Corrections Center, where he is currently a Living Unit Supervisor. He has previously served as the Administrative Segregation Correctional Unit Supervisor for three years, following seven years as Custody Unit Supervisor in the facility's living units. He came to Washington Corrections Center after two years as a Correctional Officer at Geiger Pre-Release. He was a Correctional Officer at the Washington State Penitentiary from 1974 to 1980. Mr. Bowman is currently working on an M.B.A. at City University.*

  Washington Corrections Center, P.O. Box 900, WS-01, Shelton, WA 98594. (206) 426-1011.

* ***Steve Rawlins*** *graduated from St. Martins College in 1973. He has been working in the correctional environment for the past seventeen years. In his seventeen years in Corrections, he has held positions at DOC Headquarters, at the Washington Corrections Center, and at Cedar Creek Correction Center as a Correctional Program Manager since May of 1988.*

  Cedar Creek Corrections Center, P.O. Box 37, Littlerock, WA 98556. (206) 753-7278.

* ***Steve Ruhl*** *holds a Masters Degree in Counseling Psychology and currently operates a private counseling practice. He has worked in the corrections field for eighteen years and is presently a Sergeant at Indian Ridge Corrections Center in Arlington, Washington. Steve has taught classes at the Criminal Justice Training Commission and has been active in numerous speaking engagements within schools and the community. He is also a current member of the Sedro Woolley School Board and serves as a volunteer on the Diving Rescue Unit for the Skagit County Sheriff's Department.*

  Indian Ridge Correction Center, 19601 Nicks Road, Arlington, WA 98223-9515. (206) 339-1860.

* ***Lindy Simons*** *has been with Washington Corrections Center for Women as a Psychiatric Social Worker 3 for over eight years. She came to adult corrections following a brief stint with the Division of Juvenile Rehabilitation. She began her graduate studies in Social Work at the University of Washington and finished her Masters Degree in Social Work in 1972 at Michigan State University.*

  Washington Corrections Center for Women, P.O. Box 17, Gig Harbor, WA 98335. (206) 858-4224.

* *Dan Snyder is the Associate Superintendent for Security/Operations at the Washington Corrections Center. Prior to that he was a member of the Department of Corrections' Siting Unit, which did initial planning for three new facilities. He has been Acting Chief of the Classification and Treatment Unit, and departmental liaison for the Population Management and Facilities Plan. From 1985 to 1989, he was Associate Superintendent of the McNeil Island Corrections Center and Correctional Program Manager at the MICC Annex and at the Division of Prisons. He was the Coordinator of the Criminal Justice Training Center's Corrections Officers Academy and a Counselor with the Division of Juvenile Rehabilitation. Mr. Snyder has a Bachelor of Arts from St. Martins College and a Master's Degree in Social Work from Rutgers. He is a faculty member for the Institute for Reality Therapy.*

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Cyndi Walters *has been employed by Washington State Penitentiary as Staff Counselor/Academic Advisor since August of 1990. She provides general counseling and therapeutic interventions for employees, along with staff development and academic advisement. For the past year she has also served Washington State Penitentiary as the local Post Trauma Response Provider and Program Manager. Cyndi has fourteen years of crisis counseling experience. She has been on faculty at Eastern Washington University in the Alcohol/Drug Studies Program for the past six years and serves on various advisory boards at Eastern Washington University, Walla Walla Community College and within the community. She received her Master of Education in Counseling and has completed two post graduate years in addiction studies. She is a National Certified Addictions Counselor.*

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POST TRAUMA TRAINING SPONSOR

***Tana Wood** is the Superintendent of Washington State Penitentiary. She held the position of Assistant Director of the Division of Prisons from March 1989 through August of 1992. She has been the Director of the Department's Division of Offender Program, Acting Superintendent of the Washington Corrections Center for Women, and from 1981 to 1987, Associate Superintendent of the Washington State Penitentiary. Prior to that, she was a Classification and Parole Supervisor at Geiger Pre-Release, and Correctional Unit Supervisor and Classification Counselor 3 at the Washington Corrections Center. Before entering corrections, she spent nearly a decade with the Department of Social and Health Services as a counselor specializing in mental health, family problems, and child protective services. Mrs. Wood has a Bachelor of Arts in Psychology from Whitworth College and a Master of Arts in Sociology/Criminal Justice from Pacific Lutheran University.*

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June 15, 1992

Welcome to the Division of Prisons' first Post-Trauma Program training.

Corrections has always been a stressful occupation. It has never been more challenging than it is today.

Within three years, Washington's inmate population will be double what it was at the end of the 1980s. These offenders now come to us with more years of debilitating drug use than ever.

The public still expects us to change in a few years the well-entrenched habits of a lifetime and undo, through attention in prisons, a decade of parental neglect and abuse.

All this should happen somewhere well out-of-sight and with little demand for public funds.

It all happens, in fact, at considerable cost and under the gaze of the judiciary, which can deliberate at length the decisions which correctional officers often have only seconds to make.

Correctional workers have responded by becoming better educated, more professional and increasingly vigilant. Today's Corrections Officers are better prepared for these challenges than any in our history. I am very proud of them.

Despite this preparation, however, many of our colleagues will at some point in their careers experience situations which test their ability to cope. In response, last year the Division of Prisons took steps to provide correctional staff with specialized psychological services following critical incidents. That program has proved its value on several occasions.

We should do more. Our co-workers often need our help after the psychologists go home. And many events which do not meet the definition of a critical incident are very significant for those to whom they happened. Fortunately, the latter are far more common. Such episodes should not be ignored.

We must help each other. I hope your work over the next three days will establish the framework of a program which will demonstrate our concern for our staff and mobilize our own resources to provide them with the support they deserve.

Sincerely,

James C. Spalding

James C. Spalding, Director
Division of Prisons

JCS:dms

TERMINOLOGY

Acute:	Term used to describe a disorder of sudden onset and short duration, usually with intense symptoms.
Adjustment:	Outcome of the individual's efforts to deal with stress or meet his/her needs.
Affect:	Experience of emotion or feeling.
Affective Disorders:	Abnormal states of manic elation or depression.
Agitation:	Marked restlessness and psychomotor activity.
Agoraphobia:	Excessive anxiety associated with leaving familiar settings such as home, fear of open places.
Alarm Reaction:	First stage of the general-adaption syndrome characterized by the mobilization of defenses to cope with a stressful situation.
Altered Affect:	Inappropriate emotional responses that do not fit circumstances; may be exaggerated, inappropriate, or absent.
Anxiety:	A similar psychological and physiological reaction to fear but in response to relatively non-threatening events as evaluated by others and the individual.
Bruxism:	Grinding or clenching of teeth, particularly during sleep.
Compensation:	Reactions that are defenses against feelings of inferiority and inadequacy growing out of real or imagined personal defects.
Compulsion:	A stereotyped, repetitive motor act that appears to be irrational and beyond the control of the individual.
Contagious anxiety:	Anxiety in children resulting from modeling anxious adult behavior.

Critical Incident: Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later.

Debriefing: A structured group meeting between the staff directly involved with a critical incident and the Post Trauma Response Team. It is a confidential non-evaluative discussion of the involvement, thoughts, and reactions resulting from the incident. It provides support, reassurance, and education. Debriefings accelerate recovery in individuals who are having normal reactions to abnormal events.

Decompensation: Resulting from severe or sustained stressors, the organism is overwhelmed and there is a lowering of integration of functioning.

Defusing: The purpose is to offer information, support, allow initial ventilation of feelings, to set up or establish a need for a formal debriefing, and to stabilize correctional officers and staff so they can go home or report back to duty. A defusing may eliminate the need for a formal debriefing.

Delirium: A state of mental confusion; a rapid onset of disturbances of attention, memory, and orientation that may result from fever, drugs, or shock.

Denial: Defense mechanism where the individual protects self from unpleasant aspects of reality by refusing to acknowledge them.

Depersonalization: Loss of sense of personal identity.

Depression: Emotional state characterized by extreme dejection, gloomy ruminations, feelings of worthlessness, hopelessness, and often apprehension.

Desensitization: Therapeutic process by means of which reactions to traumatic experiences are reduced in intensity by repeatedly exposing the individual to them in mild form in either reality or fantasy.

Disorientation: Mental confusion with respect to time, place or person.

Displacement: A shift of emotion away from the person or object toward which it was originally directed; often involves hostility and anxiety.

Emotion:	A complex reaction involving a high level of activation and visceral change accompanied by strong feelings or affects.
Emotional Insulation:	One reduces emotional involvement in difficult situations.
Fantasy:	Overcoming frustration or trauma by imaginary achievement of goals and meeting of needs.
Homeostatic Mechanisms:	Physiological mechanisms that attempt to maintain constancy of internal states regardless of environmental conditions.
Identification:	Enhancing feelings of worth and protecting self against self-devaluation.
Introjection:	Accepting others values and norms as one's own even when they are contrary to own values.
Insomnia:	A common sleep disturbance characterized by an inability to get to sleep, frequent awakenings, inability to go back to sleep, short sleep cycles.
Intellectualization:	The emotional reaction is avoided by a rational explanation for traumatic event.
Night Terror:	Arousal during sleep accompanied by expressions of intense fear and emotions; individuals often awake screaming but have no recall of the experience other than intense fear.
Nightmare:	Vivid, horrifying dreams.
Obsession:	Though, wish, plan or admonishment that intrudes persistently into consciousness and that the individual considers irrational.
Paranoia:	A rare conditions usually delusional fear often proceeding from misinterpretation of reality.
Phobia:	Irrational fear of specific objects, situations or organisms.

Post-Trauma Stress: A normal psychological and physiological response that may be demonstrated by individuals exposed to perceived or actual potentially life-threatening situations. The resulting trauma can create immediate and short-term symptoms which may last for up to three months.

Post-Traumatic Stress Disorder: A diagnosis of persistent and specific symptoms resulting from exposure to a traumatic event or a series of events, including nightmares, flashbacks, withdrawal, avoidance, insomnia, depression, hyper-vigilance, panic, anxiety, etc.

Projection: Viewing others as to blame for one's own shortcomings or mistakes or misdeeds; and seeing others as harboring one's own unacceptable impulses, thoughts, and desires.

Psychic Trauma: Any painful event that causes serious and lasting damage to oneself.

Psychogenic Amnesia: A dissociative disorder characterized by extensive memory loss that may endure for a few hours, days, or months.

Rationalization: Justifying maladaptive behavior by faulty logic or false noble motives.

Reaction Formation: Protecting oneself from dangerous desires by actually developing conscious attitudes and behaviors that are just the opposite.

Regression: A return to a more developmentally immature level of mental functioning. A mechanism of defense.

Repression: A defensive process by which an idea or event is excluded from consciousness.

Stress: A state of physical or psychological strain.

Trauma: Exposure to an exceptionally terrifying, horrific, or devastating event which results in a psychophysical response.

CRITICAL INCIDENT STRESS

THE COLD WITHIN

Six humans trapped by happenstance, in bleak
and bitter cold.
Each one possessed a stick of wood, or so
the story's told.

Their dying fire in need of logs, the first
man held his back,
For of the faces round the fire, he noticed
one was black.

The next man looking cross the way, saw one
not of his church,
And couldn't bring himself to give the fire
his stick of birch.

The third one sat in tattered clothes, he
gave his coat a hitch.
Why should his log be put to use to warm
the idle rich?

The rich man just sat back and thought of
the wealth he had in store,
And how we keep what he had earned from the
lazy, shiftless poor.

The black man's face bespoke revenge as the
fire passed from his sight.
For all he saw in his stick of wood was a
chance to spite the white.

The last man of his forlorn group did
naught except for gain,
Giving only to those who gave was how he
played the game.

Their logs held tight in death's still hand
was proof of human sin,
They don't die from the cold without -
They died from the cold within.

(by James Patrick Kenny
an Indianapolis High School Student)

CRITICAL INCIDENTS

The below listings are considered critical incidents. Immediate intervention should be given when....

Serious injury, death, or suicide of a fellow co-worker.

Any shooting or other serious threat of life of correctional officers.

Serious injury or death of an inmate resulting from emergency service by correctional officers.

Rescue situations where it is impossible to reach the victim.

Loss of life following extraordinary and/or prolonged expenditure of physical and emotional energy during rescue efforts by the correctional officers.

Any incident in which circumstances are so unusual or the sights and sounds so distressing as to produce a high level of immediate or delayed emotional reaction.

Any catastrophic event/major disasters.

Treating an inmate, where pain and suffering is obvious.

Mass casualty incidents.

Any unexpected event.

Knowing the individual.

Death or serious injury of a child.

Incidents that attract extremely unusual or derogatory news media coverage.

Lack of promotion.

Contact with blood and body fluids.

CRITICAL INCIDENT INFORMATION FOR EMERGENCY MEDICAL PERSONNEL

Handout #1: *PROCESS*

a. *Denial*
b. *Anger/Hostility*
c. *Guilt/Bargaining*
d. *Withdrawal/Depression*
e. *Accepting/Gradual Testing and Retesting*

Handout #2: *FEELINGS*

a. *Emotional Numbing*
b. *Isolation*
c. *Intrusive Thoughts/Flashbacks*
d. *Sleep Disturbance*
e. *Anxiety and Fear*
f. *Loss of Interest/Burnout*
g. *Reconsideration*

Handout #3: *HOW TO PSYCHOLOGICALLY SURVIVE*

a. *Available Psychological Services*
b. *Critical Incident Group*
c. *Ability to Vent Fears*
d. *Tell Hospital your Fears*
e. *Be Aware of Performance*
f. *Re-referral if Problems Continue*

PROCESS

Being involved in a traumatic situation, regardless whether or not it was a fire, a traffic collision, or emergency medical aide, produces feelings equal in intensity and similar reactions to those which an actual death of a loved one can cause.

THESES REACTIONS ARE:

INITIAL DENIAL *- that the traumatic incident took place, "this couldn't have happened to me", and produces at first a retreat into a fantasy life where it never happened. Many feel that the event happened in slow motion. After the traumatic incident, it took them quite a few moments to realize what happened.*

HOSTILITY AND ANGER *- which can be non-directed (just mad that it happened), or directed toward the person who caused you to be involved in the traumatic incident. This hostility is short-lived, but returns several times during the adaptation process.*

FEELINGS OF GUILT/BARGAINING *- internalized or projected, over things you did or didn't do (wishing the traffic accident didn't occur), or things you might have done differently during the traumatic incident. Fear of loss of job is also common.*

WITHDRAWAL/DEPRESSION *- from those happenings too painful to cope with. The depression lasts the longest and may go on for weeks or months in degrees. The length of time depends on your basic personality, the type of traumatic incident, how the hospital deals with the incident, the availability and use of psychological intervention services, and the handling of the incident by the media.*

GRADUAL TESTING AND RETESTING REALITY *- to feel out the possibility of being able to cope with future situations that are similar. This leads to final ACCEPTANCE, acknowledging that this incident happened and that you have survived it. The pattern ends with an eventual letting go from the influence of the past experiences so that a new part of your life can begin.*

NOT ALL OF THESE REACTIONS ARE EXPERIENCED BY EVERYONE, AND NOT NECESSARILY IN THIS ORDER. ALTHOUGH, THIS IS THE MOST COMMON FORM OF REACTION TO A TRAUMATIC INCIDENT. *Some feelings may return, usually anger and resentment, but not to a debilitating degree after the final acceptance.*

FEELINGS

The feelings involved after a traumatic incident consist of seven basic reactions. These are:

EMOTIONAL NUMBING *- Correctional Officers distance themselves from the incident and make an effort not to feel anything. They almost deny having any emotional component, and therefore give the appearance that they are in a state of shock. They usually say, however, that they are in control and are having no problems dealing with the situation.*

ISOLATION *- The experience the feeling of being alone and that no one else knows what they are going through. They may experience irritability and agitation, and may again deny that anything is wrong.*

INTRUSIVE THOUGHTS/FLASHBACKS *- They will relive the event in their minds, over and over again. If it continues, they begin to wonder or question whether they have complete control of their thoughts. This can change their final outlook, for better or worse.*

SLEEP DISTURBANCES *- Disturbances which can result from a traumatic incident, can cause inability to sleep, nightmares and waking in a cold sweat. In the nightmares, the theme is fear or guilt. Guilt is common in 95% of traumatic incidents to varying degrees. This guilt can be translated into anger or depression.*

ANXIETY & FEAR *- The fear most commonly felt is that of returning to the exact job duties as before.*

LOSS OF INTEREST/BURNOUT *- Loss of interest in work or difficulty in returning to it. Mundane activities suddenly become boring.*

RECONSIDERATION *- Re-evaluation of each person's value system, goals and status is often the final step which determines the person's abilities to cope and how he will continue his future activities. Some consider giving up their current careers. They may also re-evaluate their marital situation. Some make a stronger commitment and others get divorced.*

HOW TO PSYCHOLOGICALLY SURVIVE

AVAILABLE PSYCHOLOGICAL SERVICES - *Have available psychological services immediately, before the Correctional Officers go home. On-Call counselors are ideal. This allows them to verbalize their feelings and concerns while they are still fresh, and in an atmosphere that is "safe".*

CRITICAL INCIDENT GROUP - *Many times they can relate to a group of their peers with whom they can share their experiences. The counselor will arrange this group session, which allows the ventilation process to occur.*

ABILITY TO VENT FEARS - *The opportunity and ability to talk to their peers and/or family members about their feelings is very important. It prevents hiding negative feelings.*

TELL YOUR NEEDS - *Let the institution know what you would like to do: You may wish to take a few days off, work light duty for a short time, take sick leave or vacation.*

BE AWARE OF PERFORMANCE - *When a Correctional Officer is on the job or doing light duty after a trauma incident, it is important to be aware of his/her performance and his/her feelings about it. They should examine their feelings, identity those parts of their job which can cause anxiety and then work on alleviating that anxiety.*

RE-REFERRAL IF PROBLEMS CONTINUE - *If the initial counseling session(s) do not completely ease the tension and help the Correctional Officer return to productive duty, re-referral to the same source, or to another source may be necessary. Counseling may also be needed for the family members, so they can also work on their feelings.*

DEFINITION OF CRITICAL INCIDENTS

GENERATES PROFOUND EMOTION

IMPACTS PRESENT OR FUTURE PERFORMANCE

SURPASSES COPING SKILLS

EVOKES DISTRESS IN ANY NORMAL HEALTHY PERSON

INITIAL PHASE

INTRODUCES CONFIDENTIALITY AND FACILITATOR.

FACT PHASE

FOR ELICITING FROM MEMBERS OF THE GROUP WHAT ACTIVITIES THEY PERFORMED DURING A CRITICAL INCIDENT AND WHAT THEY HEARD, SAW, SMELLED AND DID AS THEY WORKED AT THE SCENE.

THOUGHT PHASE

WHERE THE FACILITATOR ENCOURAGES MEMBERS TO SHARE WITH OTHERS THE FEELINGS THEY HAD AT THE SCENE AND ARE HAVING NOW, AND WHETHER THEY HAVE EVER HAD THESE FEELINGS BEFORE.

REACTION PHASE

WHERE THE FACILITATOR ENCOURAGES MEMBERS TO SHARE WITH OTHERS THE FEELINGS THEY HAD AT THE SCENE AND ARE HAVING NOW, AND WHETHER THEY HAVE EVER HAD THESE FEELINGS BEFORE.

SYMPTOM PHASE

WHERE THE FACILITATOR FOCUSES ON THE PSYCHOLOGICAL AND PHYSICAL AFTER EFFECTS THAT THE MEMBERS EXPERIENCED SINCE THE INCIDENT.

UNFINISHED BUSINESS PHASE

WHERE THE MEMBERS DISCUSS THOSE PAST EMOTIONAL EXPERIENCES WHICH HAVE NOT BEEN RESOLVED.

TEACHING PHASE

WHERE MEMBERS ARE REMINDED THAT THE SYMPTOMS THEY HAVE EXPERIENCED ARE NORMAL RESPONSES TO EXTRAORDINARY CIRCUMSTANCES AND THE RATIONALE FOR STRESS RESPONSE IS EXPLAINED.

WRAP-UP PHASE

TO CONCLUDE THE GROUP'S ACTIVITIES, ANSWER QUESTIONS, AND ALLOW THE GROUP TO DEVELOP A PLAN OF ACTION IF IT WISHES.

ROUND-ROBIN PHASE

WHERE MEMBERS OF THE GROUP MAKE ANY LAST COMMENTS TO EACH OTHER.

DEBRIEFING PROVIDES

---PEER SUPPORT

---VENTILATION OF FEELINGS

---BETTER COMMUNICATION

---FOCUSES ON SUPPORT SYSTEM

PHYSICAL EFFECTS

EARLY WARNING SIGNS

DIZZINESS
FLUSHED FACE
POUNDING HEART
COLD HANDS/FEET
SHORTNESS OF BREATH
WEAKNESS
TIGHT THROAT
TIGHT STOMACH
TREMBLING
TIGHT CHEST
EXCESSIVE PERSPIRATION
IRREGULAR BREATHING
MUSCLE TENSION
RIGID POSTURE
HYPERVENTILATION

SHORT-TERM REACTIONS

NAUSEA
INDIGESTION
BLURRED VISION
VAGUE BODILY COMPLAINTS
HIGH BLOOD PRESSURE
GAS
BACKACHE
CHEST PAIN
DIARRHEA
HEADACHE
COLDS THAT LINGER
IRREGULAR HEART BEAT
MENSTRUAL PROBLEMS
CONSTIPATION
FATIGUE

LONG-TERM REACTIONS

DIABETES
ULCERS
MIGRAINE HEADACHES
COLITIS
ARTHRITIS
HYPERTENSION
ALLERGIES
HEART ATTACKS
STROKES

PSYCHOLOGICAL EFFECTS

EARLY WARNING SIGNS

(EXCESSIVE OR INAPPROPRIATE):
SADNESS
ANXIETY
GUILT
BOREDOM
DISCOURAGEMENT
FRUSTRATION
OBSESSING
RESENTMENT
IRRITABILITY
FEAR
ANGER
WORRY
EUPHORIA
RIGIDITY
IMPATIENCE
CYNICISM
AGITATION
NEGATIVITY

SHORT-TERM REACTIONS

DEPRESSION
DESPAIR
HOPELESSNESS
CONFUSION
POOR JUDGEMENT
GRIEF
EMPTINESS
HELPLESSNESS
LONELINESS
LOSS OF CONFIDENCE

LONG-TERM REACTIONS

DIVORCE
ALCOHOLISM
SUICIDE
JOB-LOSS
DRUG ABUSE
HOMICIDE

BEHAVIORAL EFFECTS

EARLY WARNING SIGNS

NERVOUS LAUGHTER
YELLING
TIGHT JAW
FOOT TAPPING
SLURRING WORDS
NAIL BITING
HYPERACTIVITY
GRINDING TEETH
STARING INTO SPACE
NERVOUS TICS/TWITCHES
CLENCHED FIST
WRINGING HANDS
WORRIED LOOK
CRYING
STUTTERING
RIGID/SLUMPED
EASILY STARTLED
HIGH PITCHED VOICE

SHORT-TERM REACTIONS

AGGRESSIVENESS
INAPPROPRIATE ANGER
EXTREME DEFENSIVENESS
RAPID MOOD SWINGS
DENIAL
THROWING OBJECTS
OVER-HOSTILITY
BLAMING OTHERS
WITHDRAWAL
ISOLATION

LONG-TERM REACTIONS

(Non-effective coping strategies)
SEXUAL DISTURBANCE
SLEEP DISTURBANCE
OVERWORKING
OVER/UNDER EATING
OVER SMOKING
EXCESSIVE DRINKING
RECKLESS BEHAVIOR
ACCIDENT PRONENESS
EXTREME CHANGES IN BEHAVIOR

REMEMBER:

CORRECTIONAL OFFICERS ARE NOT IMMUNE TO HORRIBLE HUMAN TRAGEDY.

GUIDELINES FOR OFFERING SUPPORT

1. *Learn about Critical Incident Trauma - Know that people respond to Critical Incidents differently.*

2. *Be Available - Take responsibility for initiating contact, but avoid intruding.*

3. *Accept the response you get from the person. Do not judge their feelings. Be interested in the person, not just the situation. Be empathic and supportive.*

4. *Listen to what is being said. Active listening is letting the other person know you hear what is being told to you by reflecting back, in your own words, what is being said and felt, without judgement or criticism. Avoid "biased questioning: - talking to the person from your interests, which gets the person off track from their experience.*

5. *Be a resource - Listening and validating emotional reactions is very helpful. Sharing your feelings and experiences can help to legitimize another person's reactions. Avoid "Laying a Trip" on the person - inundating them with your experiences and reactions or telling them how they are going to, or supposed to react.*

6. *Advice Giving? - It may be helpful to offer that you think may help or share what has worked for you and others you know. Avoid relating in a condescending way and telling the person how to handle things.*

7. *Be sensitive to changes in behavior and mood that indicate person is not coping well. Gently challenge effectiveness of maladaptive behavior.*

8. *You are not responsible for how the person handles the Critical Incident - the person is. You are there for support, encouragement, and validating emotions - no treatment.*

9. *Know your limits - Steer the person to appropriate help when you notice a lack of resolution maladaptive behavior, declining emotional condition, and other "heavy" reactions that let you know you are in over your head. As a Peer Supporter, you are not a Mental Health Professional.*

FEELINGS AND EMOTIONS

FALLEN BROTHER

For Ted

There are hundreds of verses to this song,
There are hundreds of visions from one dream,
Today, by chance, I feel them all.

The sky is painted sad today,
Swollen clouds emptied for your and for me.
Many hearts have been leveled,
Many dreams have been denied.

But you, my friend, lived your life the fullest,
That is all that any of us could ask.
Your family will understand, and so will we.
That you have traveled on a trip to peace,
On the sirened wings of fate.

When will the next time be?
Will we feel such sorrow again?
There will be other storms
Followed by drifting souls.

Yet, I know it's not so far
To touch your memory,
There are not stones cast
Only intensified faith in each other.

Just as we are illusions in this world
We have touched the truth.
We have learned from you
And you have learned from us.

And when all is said and done
Snow stills falls in silence;
Flowers bloom in Spring
And love will bloom in us.

And because of you, Fallen Brother,
You have left footprints
Deep in our minds
Deep in our hearts.

by

Wayne D. Thompson
3/14/83

HOW DO YOU FEEL TODAY?


AGGRESSIVE


ANXIOUS


APOLOGETIC


ARROGANT


BLISSFUL


BORED


CONFIDENT


ECSTATIC


ENRAGED


EXASPERATED


EXHAUSTED


FRUSTRATED


GUILTY


HUNGOVER


HYSTERICAL


INDIFFERENT

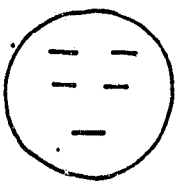

INNOCENT


INTERESTED


LOADED


LONELY


LOVESTRUCK


MEDITATIVE


MISERABLE


NEGATIVE

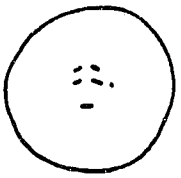

OPTIMISTIC


SATISFIED


SURLY


TURNED-ON


TURNED OFF


WITHDRAWN

COMMUNICATION

Things are not always as they appear to be... check it out!

FEELINGS THAT PERSONS HAVE BUT OFTEN FAIL TO IDENTIFY

Abandoned
Adequate
Affectionate
Ambivalent
Angry
Annoyed
Anxious
Apathetic
Astounded
Awed

Bad
Betrayed
Bitter
Blissful
Bold
Bored
Brave

Calm
Capable
Challenged
Charmed
Cheated
Cheerful
Childish
Clever
Combative
Competitive
Condemned
Confused
Conspicuous
Contented
Cruel
Crushed

Deceitful
Defeated
Delighted
Desirous
Despair
Destructive
Determined
Different
Disappointed
Discontented
Distraught
Disturbed
Dominated
Divided

Eager
Ecstatic
Embarrassed
Empty
Enchanted
Energetic
Enjoy
Envious
Excited
Evil
Exasperated
Exhausted

Fascinated
Fearful
Flustered
Foolish
Frantic
Frustrated
Frightened
Free
Full
Furious

Glad
Good
Gratified
Greedy
Grief
Guilty

Happy
Hate
Heavenly
Helpful
Helpless
High
Homesick
Horrible
Hurt
Hysterical

Ignored
Imposed Upon
Impressed
Infatuated
Infuriated
Inspired
Intimidated
Isolated
Irritated

Jealousy
Joyous
Jumpy

Kind

Lazy
Lecherous
Left out
Lonely
Longing
Loving (love)
Low
Lustful

Mad
Mean
Miserable
Mystical

Naughty
Nervous
Nice
Nutty

Obnoxious
Obsessed
Odd
Outraged
Overwhelmed

Pain
Panicked
Peaceful
Persecuted
Petrified
Pity
Pleasant
Pleased
Pressured
Proud

Quarrelsome

Rage
Refreshed
Rejected
Relaxed
Relieved
Remorse
Restless
Righteous

Sad
Sated
Satisfied
Scared
Screwed up
Sexy
Shocked
Silly
Skeptical
Sneaky
Solemn
Sorrowful
Spiteful
Startled
Stingy
Stuffed
Stupid
Stunned
Suffering
Sure
Sympathetic

Talkative
Tempted
Tense
Terrible
Terrified
Threatened
Tired
Trapped
Troubled

Ugly
Uneasy
Unsettled

Violent
Vehement
Vulnerable
Vivacious

Wicked
Wonderful
Weepy
Worry (ied)

QUESTIONS TO ASK WHEN IDENTIFYING YOUR ANGER

At what are you angry?

Have you expressed this anger before? When? Why didn't it resolve the problem?

Who has hurt you?

Did you tell him/her? If not, why not?

Will the person let you express your hurt freely or will you have to pay for it?

Why do you put up with a relationship that restricts you?

Listen to the voice telling about its anger. Is it withholding part of the feeling? If so what? Why?

Does one particular source of anger repeat?

If so, why do you let the hurt continue?

What keeps you from acting to protect yourself?

What are you so afraid of losing?

What would you say or do if you could do exactly what you wanted?

What would be the consequences? Are you sure?

SEVEN EXERCISES FOR EXPRESSING ANGER INDIRECTLY

1. ***Angry Letter*** - *Write a letter to each person you are angry with. Begin as follows: "I am angry with you."*

   List your complaints as completely as possible. Be sure the recipient will understand you. Place the envelopes where you can see them, you may want to use a bright colored envelopes so you can see them easily.

   Later, if you feel any additional anger, reread the letter and add to it if you feel like it.

   After a while dispose of the letter - throw it in the ocean burn it with ceremony - bury it in the woods - tear it into shreds - do something you will remember.

2. ***Safe Anger Acts*** - *Write the name of the person you're angry with in large letters on a piece of paper.*

   Tear the paper into as many pieces as possible as quickly as possible. Burn the scraps, thinking, "You deserve my anger." Repeat as necessary.

3. ***Taking Angry Steps*** - *Write the person's name on the sole of your shoe. All day long, remind yourself that it's there. Take delight in getting rid of the anger with every scrape and step you take.*

4. ***Acting Out The Anger*** - *Close yourself in a room and scream your worst opinion of this person. It helps to beat a pillow with your fists at the same time. Don't be afraid to get worked up.*

   Don't be afraid, even if you begin to cry. Letting the anger out won't hurt you or anyone else.

   When you have completed this, sit quietly for ten minutes with your eyes closed, breathing deeply and easily. Wash your face, hands and go for a walk. Repeat in a few days if necessary.

5. ***Partial Contact*** - *Pick up the telephone and dial the number of the person you are angry with. When they answer, push down the button to break the connection and start your tirade, pretending the other person is still on the line. (Make sure you keep the button down.)*

6. ***Symbolic Menial Task*** - *Allow your anger to find expression in positive menial tasks that consume your energy. Cleaning the attic, the extra room, the garage.*

Baptize each weed in your garden with the name of the person you are angry with and then weed with vengeance.

Invent your own exercise, keeping in mind that you need to do some thing to get your anger out, making sure you do no harm to another person or to property.

7. ***Ridiculous Imagery*** - *Image the person who irritates you as a large rubber duck, but with real feathers and webbed feet, and hear their jabs and irritating remarks as mindless quacking. Make up any character that gives you a laugh and implant them on the irritating person's face.*

WHAT TO DO ABOUT ANGER

Recognize that you are angry.

Identify the source of the anger.

Understand why you are angry.

Deal with the anger realistically.

When you hold anger in, you cease to be your own master. When your feelings are lost, so is your direction.

BEING IN TOUCH

WITH YOUR FEELINGS

IS THE ONLY WAY

YOU CAN BECOME

YOUR HIGHEST SELF

THE ONLY WAY

YOU CAN BECOME

OPEN AND FREE

THE ONLY WAY

YOU CAN BECOME

YOUR OWN PERSON

LISTENING SKILLS

LISTENING

LISTENING IS THE MOST IMPORTANT COUNSELING/SUPPORT SKILL

LISTEN ON 3 LEVELS

A. *Content*

B. *Feelings*

C. *Perspective or point of view*

1. *Take practice to listen on all 3 levels*

    a. *Example: Daughter very late, father waits up and puts her on restrictions, next day she runs away.*

D. *Content*

E. *Feelings - a variety of possible feelings*

1. *Angry at being disobeyed*
2. *Frustrated at being unable to control daughter*
3. *Hurt by being left*
4. *Worried about what will happen*
5. *Insecure about daughter's love*

F. *Perspective or point of view*

1. *Have I done something wrong?*
2. *How can I fix this?*
3. *What's wrong with her?*

LISTENING INVOLVES ATTENDING TO BOTH VERBAL AND NON-VERBAL CUES

A. *Verbal content*

B. *Words chosen and voice tone - eg., "Seem to have problem here" or "Oh no! What happened."*

C. *Non-Verbal*

   1. *Facial expression*
   2. *Body posture*

PURPOSE OF LISTENING

A. *Allows the peer to direct the session*

B. *Gives the peer the responsibility for what happens in the session*

C. *Encourages the peer to continue expressing his/her ideas and feelings*

D. *Helps the peer relax and be more comfortable*

E. *Contributes to the peer's sense of security*

F. *Enables the peer supporter to draw more accurate inferences about the peer.*

ADDITIONAL SKILLS THAT CONTRIBUTE TO MORE EFFECTIVE LISTENING

A. *Eye contact*

B. *Accurate verbal following*

C. *Posture*

D. *Empathetic responses*

1. *Non-verbal*
2. *Verbal*

E. *Assessing peer's problems and whether he is in control, listen - don't give advice*

TWO OR MORE IMPORTANT ASPECTS OF LISTENING

A. *Extra emphasis or "english" on words, eg, "She didn't talk to me, just packed a bag and was gone when I got home." Peer Supporter: "You sound angry."*

B. *A pattern or reoccurring theme in consecutive seemingly unrelated incidents, eg., Father talks about failing promotional exam, then about a bad performance evaluation, then about his daughter running away. Peer Supporter says: "Are you feeling like a failure?"*

PLEASE LISTEN

When I ask you to listen to me
and you start giving advice,
you have not done what I asked
nor heard what I need.

When I ask you to listen to me
and you begin to tell me that I shouldn't feel that way,
you are trampling on my feelings.

When I ask you to listen to me
and you feel you have to do something to solve my problems,
you have failed me - strange as that may seem.

Listen, please!
All I asked was that you listen.
Not talk nor "do" - just hear me.
Advice is cheap. A quarter gets both "Dear Abby" and
astrological forecasts in the same newspaper.
That I can do for myself, I'm not helpless,
maybe discouraged and faltering - but not helpless.

When you do something for me that I can and need to do for myself,
you contribute to me seeming fearful and weak.

But when you accept as a simple fact that I do feel what I
feel, no matter how seemingly irrational, then I can quit
trying to convince you and can get about to understanding
what's behind what I am saying and doing - to what I am
feeling.

When that's clear, chances are so will the answer be, and I won't
need any advice. (Or then, I'll be able to hear it!)

Perhaps that's why, for some people, prayer works, because God is
mute, and doesn't give advice or try to fix what we must take care
of ourselves.

So, please listen
and just hear me.

And if you want to talk, let's plan for your turn,
and I promise I'll listen to you.

Anonymous

HOW TO COMMUNICATE EFFECTIVELY

Effective communication skills are essential in determining our ability to have rewarding relations with others and to achieve satisfaction in life. The quality of our relationships with friends, spouses, children, and colleagues are all dependent upon sound communication skills. In fact, it is often our failure to communicate effectively that leads to personal disappointment and the breakdown of important relationships. Unfortunately, we often leave the success of important relationships to chance - until communication fails and the relationships begin to deteriorate. By then, however, it may already to too late. This brief guide outlines important characteristics of effective communication and offers practical suggestions for improving these skills. It will not solve all of your communication problems and it is certainly no substitute for professional help. However, it will give you some important basic ideas and suggestions.

Listening Effectively: *The first step in developing skilled communication is effective listening. Relating to others is impossible unless you can "fully hear" what they are saying. To begin, try squarely facing and making eye contact with the person with whom you want to communicate. Next, let him or her talk freely while you simply try to comprehend what is being said. Listen for both the feelings and the content of what the person is saying. If you are not sure you have heard everything or understand what is meant, it is often helpful to paraphrase what has been said and then allow the other person to clarify and misunderstanding of the message. Try not to let your own feelings interfere at this points or you might miss something important.*

Respond Descriptively: *Be careful not to respond to an important message with an valuative statement. Our culture has programmed us to think largely in valuative terms - we like something or we don't; we feel things are either "right or wrong." Effective communication is not designed to determine winners or losers. In communicating, the goal is to learn all we can about someone else's thoughts and feelings and let that person better know the same things about us. This process is quite different from that of negotiation in which individuals may view each other as adversaries. Hence, descriptive statements about the other person's communication and your reaction to what is said will be most helpful. Valuative statements are not helpful and tend to elicit defensiveness.*

Use your Feelings: *Feelings are important in communicating. Often it takes practice to be able to identify them (and use them constructively), but there is hardly any interpersonal issues about which we do not have some feelings. When you communicate your feelings it is important to be specific and to take responsibility for them. Sometimes this is referred to as an "I" message. For example, "I feel angry because you just left without me, and I really wanted to go along." Note that the statement is descriptive and includes a statement of feelings. It allows the receiver of the communication to respond without feeling accused or threatened. Contrast that with possible reactions to a statement such as, "How could you leave me there like that!" or, "You are selfish and inconsiderate," or "Everyone says you don't care about me." In short, express your feelings, negative or positive, as clearly as possible and be responsible for what you say.*

Assess Needs: *Effective communication considers the needs of all involved. If you are giving someone feedback about your reactions to an event, be sure that you are addressing something over which he/she has control. If you do not consider the other persons needs and ability to deal with your communication your efforts could be destructive.*

Make Timely Responses: *Effective communications are delivered at a time when the issue to be discussed is most important, usually as soon as possible after the behavior which requires discussion has occurred. It can be destructive to save old or unresolved concerns for discussion at a later time or to use them as a weapon ("remember when you...") On the other hand, it is important to decide if the other person is ready to handle your communication immediately. Sometimes, it is best to delay sensitive communications until an appropriate setting can be found for the discussion. Avoid discussing emotional issues until you are in a place where there is privacy and you can talk freely.*

Effective communication skills are not easily obtained. They require practice and feedback from another person to be sure that communication is occurring. However, as you develop better skills in communicating, they can help you learn more about yourself from others and can greatly enrich the quality of your relationships. The sort checklist which follows may be useful in assessing your need for help in developing better skills and your progress in enhancing your ability to communicate.

PARAPHRASING

PARAPHRASING

FEEDBACK: PARAPHRASING

Definition of paraphrasing:

Paraphrasing is a peer supporter response that restates the content of the peer's previous statement and/or feeling. Paraphrasing concentrates primarily on cognitive verbal content, that is content which refers to events, people and things. In paraphrasing the peer supporter reflects to the peer the verbal essence of his/her last comment or last few comments. Sometimes, paraphrasing may involve simply repeating the peer's own words, perhaps emphasizing one word in particular. More often, paraphrasing is using words that are similar to the client's, but fewer in number.

In paraphrasing, the peer supporter must identify the peer's basic message, either cognitive or affective (pertaining to feeling or emotion), and give that message back to the peer using his/her (the peer supporter's) own words.

Purpose of Paraphrasing

1. *It communicates to the peer that the peer supporter understands or is trying to understand what he/she is saying. Paraphrasing can thus be a good indicator of accurate verbal following.*

2. *It sharpens a peer's meaning to have his/her words rephrased more concisely and often leads the peer to expand his/her discussion of the same subject.*

3. *It often clarifies confusing content for both the peer supporter and the peer. Even when paraphrasing is not accurate, it is useful because it encourages the peer to clarify his/her remarks or feelings.*

4. *It can spotlight an issue by stating it more succinctly, thus offering a direction for the peer's subsequent remarks.*

5. *It enables the peer supporter to verify his/her perceptions of the peer's statements or feelings.*

Components of paraphrasing

Paraphrasing has two components: determining the basic message and rephrasing. The peer supporter uses his/her judgment to determine the basic verbal or feeling message communicated. Much of the time, peers tend to speak in short paragraphs, they seldom state a single thought and wait for a reply. So the peer supporter must attend to all of the peer's verbal content, but decide on the basic message being expressed in the "paragraphs."

After the peer supporter determines the basic message to be responded to, he/she attempts to give this content back to the peer in more precise way by rephrasing it. The peer supporter may want to combine several of the peer's related comments into one response to the peer.

To paraphrase effectively, then, the peer supporter determines the basic message from the content and rephrases it, usually in similar, but fewer words.

Checking Out

To minimize the possibility of the peer supporter's letting his/her assumptions distort what the peer is saying, the peer supporter should get in the habit of checking out his/her paraphrasing. This can be done by adding phrases such as, "Is that right?", "Am I correct?", or "Have I heard you correctly? to the paraphrase. This procedure will usually evoke a response from their peer, and the peer supporter can then judge whether he/she is making assumptions or inaccurately attending to the peer. Checking out may not be necessary, however, if the peer is clearly indicating agreement either verbally or nonverbally.

Assessing the Outcome of Paraphrasing

How effectively a peer supporter has use paraphrasing can best be judged by the peer's next response after a paraphrase. If the paraphrase is effective, the peer may indicate agreement by the word or gesture and may continue to talk further on the same subject.

Sometimes the peer supporter will not succeed in accurately distilling the peer's comments, and the peer may reply, "No, that's not what I meant". When this occurs, the peer supporter's attempt at paraphrasing has still been useful because it allows the peer supporter to see immediately that he/she has erred either in determining the basic message or in rephrasing the content.

In other instances, the peer may confirm the accuracy of the peer supporter's paraphrase, but, having heard his/her meaning expressed in different words, decides to modify or even reverse the meaning entirely to reflect a changed point of view or feeling.

Each of these outcomes can be regarded as evidence that the peer supporter's paraphrase has been effective.

Examples of appropriate phrases with which a peer supporter might begin a feeling response are:

It seems that you feel.....
Are you saying that you feel.....
You seem to feel.....
It is possible that you feel.....
I'm picking up that you feel.....
You appear to be feeling.....
Perhaps you're feeling.....
I sense that you feel.....

YOUR REACTIONS, THOUGHTS OR FEELINGS MAKE SENSE TO ME

An important concept to understand with regard to verbal and feeling paraphrasing is empathy, which has been identified as one of the essential conditions in counseling. Empathy, in everyday language, means putting oneself in the other person's shoes. More formally, it might be defined as the counselor's attempting to perceive the world through the client's frame of reference. Thus, the counselor manifests empathy through his/her ability to perceive what is happening in regard to the client. Paraphrasing is one of the ways empathy can be communicated.

Examples of Paraphrasing

Four examples of client statements and possible paraphrasing response follow. After reading the examples, (a) indicate next to each response whether it is appropriate or poor paraphrasing response for at least one of the examples.

Client: *I think I'm going to move out this weekend. All she ever does is complain about my drinking. Never does any housework, just nags me.*

Counselor: *Nagging and drinking don't mix* _____

Counselor: *Sounds like things are bad at home and you're trying to decide whether to leave.* _____

Counselor: *It seems you've made the decision that you can't take it anymore.* _____

Counselor: _____

Client: *My boss doesn't understand me at all. He doesn't realize I always have a hard time getting up in the morning.*

Counselor: *I hear you saying that your boss can't see your situation the way you see it.* _____

Counselor: *Your boss is firm about work starting at 6:00.*

Counselor: *Mornings are a tough time for you.* _____

Counselor: _____

****
*

Client: *I got in trouble again for my drinking and may lose my job.* _____

Counselor: *So your right to work could be in jeopardy.* _____

Counselor: *Sounds like this new offense could mean trouble for you.* _____

Counselor: _____

****
**

Client: *I didn't want to come here. There is nothing wrong with me. I only came to see you because my wife insisted.*

Counselor: *You seem resentful about coming here.* _____

Counselor: *You feel that you're a perfectly normal.* _____

Counselor: *I get the impression that you're annoyed.* _____

****
*

Summary of Paraphrasing

To paraphrase is to determine the basic message in the client's cognitive or feeling statement and concisely rephrase it. The rewording should capture the essence of the cognition or content. Occasionally, an exact repetition of the client's remarks may be an appropriate paraphrase. More commonly, the counselor determines similar, but fewer, words. Usually the counselor offers fresh words that capture the basic verbal or nonverbal feeling message of the client.

SELF-DISCLOSURE

I. DEFINITION

The peer counselor shares his/her own feelings, experiences, attitudes, or opinions for the benefit of the client.

II. GUIDELINES

A. A self-disclosure should relate directly to the client's situation (counselor is not there to tell war stories).

B. Usually, the counselor only discloses experiences that have happened to him/her.

C. Two rules-of-thumb are:

1. Will this benefit the client?
2. Can the counselor comfortably reveal this?

III. PURPOSE OF SELF-DISCLOSURE

A. To deepen the relationship and help build a sense of trust and rapport.

B. To reduce the client's feeling of being alone or unique in the situation, e.g., by telling the client that you were afraid in a similar situation, the client is encouraged to look at his/her own fears.

C. To encourage the client to explore a situation further, e.g., (See #2)

D. To foster a feeling of empathy as the client sees that the counselor may be able to see the client's point of view.

E. To help the client express content or feelings that he/she has previously avoided.

IV. PROBLEMS OF SELF-DISCLOSURE

A. A Self-Disclosure may shift the focus of the session away from the client and onto the counselor. (Remember that the self disclosure is for the benefit of the client.)

B. The counselor runs the risk of being ignored or ridiculed and the client's perception of the counselor may change.

C. By using self-disclosure, the counselor stands to gain by being seen as an honest, open person. Self-disclosure fosters a climate of trust and openness.

V. NOT ALL COUNSELORS FEEL COMFORTABLE SHARING PERSONAL EXPERIENCES. SOME OF US ARE MORE PRIVATE PEOPLE.

VI. THE COUNSELOR SHOULD DECIDE FOR HIMSELF/HERSELF IN EACH SITUATION, IF SELF-DISCLOSURE FEELS COMFORTABLE TO USE AND WILL ASSIST THE CLIENT.

EXAMPLES OF SELF-DISCLOSURE

Below are three client statements, followed by possible self-disclosure responses. After reading the examples, (a) indicate next to each response whether it is appropriate or poor self-disclosure and why, and (b) formulate an appropriate self-disclosure for the third client statement. (Assume that the appropriate conditions in the relationship have been established.)

****

Client: *You know, I feel so ashamed. All my friends are going to find out that I have a drinking problem and I don't know how I can face them.*

Counselor: *I think I'm aware of how you might be feeling because I can remember how ashamed I felt, at first, when I had to admit to my friends that I am an alcoholic.*

_____

Counselor: *I think I know how you might feel. I'm not an alcoholic, but my father is and I can remember my shame and embarrassment about the secret getting out.*

_____

Counselor: *I know how you feel. I felt really embarrassed when my father came to my graduation in jeans.*

_____

****

Summary of Self-Disclosure

Self-disclosure involves the counselor sharing his/her own feelings, attitudes, opinions, and experiences with a client for the benefit of the client. The self-disclosure of the counselor might be revealing a present feeling or relating a relevant past experience. Both timing and appropriateness of content are central to effective self-disclosure. Used appropriately, counselor self-disclosure should increase the level of trust, genuineness, and empathy in the counseling relationship and reduce the client's feeling of being unique in his/her problems or difficulties.

COMMON STAGE I PROBLEMS

Moving Too Quickly

Supporters can retard the helping process by getting ahead of themselves; moving on too quickly to Stages II and III before adequately doing Stage I work. For instance, they introduce advanced-level empathy too soon (thus confusing or threatening the peer), confront without laying down a base of understanding and support, or give advice. These premature responses sometimes indicate a lack of respect for the peer ("I want to move ahead at a pace that pleases me, not one that is good for you").

Moving Too Slowly

Supporters sometimes feel very comfortable in Stage I and tend to remain there. They constantly encourage peers to explore themselves further and further until this self-exploration becomes so rarified as to be meaningless. It no longer contributes to the clarification of the problem situation. In this case, helping can degenerate into a game of "insight hunting." Insights into one's experiences, behaviors, and feelings certainly play an important part in the helping process, but searching for insights should never be allowed to become an end in itself.

Fear of Intensity

If the Supporter uses high levels of attending, accurate empathy, respect, concreteness, and genuineness, and if the peer cooperates by exploring the feelings, experiences, and behaviors related to the problematic areas of his or her life, the helping process can be an intense one. This can cause both helper and peer to back off. Skilled helpers know that counseling is potentially intense. They are prepared for it and know how to support a peer who is not used to such intensity.

Peer Rambling

One reason helpers may be moving too slowly in Stage I is that they are allowing their peers to ramble. Rambling destroys the concreteness, the focus, and the intensity of the helping experience. If the helper punctuates the peer's rambling with nods, "uh-huhs," and the like, then the peer's rambling is merely reinforced. Frequent use of accurate empathy gives direction to the counseling process. Although peers should explore those issues that have greatest relevance for them (this is another way of saying that the peer's determine the direction of counseling), effective helpers, because they attend and listen well, are quickly in touch with what is most relevant to their peers.

SELF-EXPLORATION

Because what peers are being influenced to do in Stage I is to talk about themselves and explore themselves and their problem situations in terms of concrete and specific experiences, behaviors, and feelings, it is useful to take a closer look at self-disclosure as a human process. Psychologists have only begun to study self-disclosing behavior scientifically. It is difficult, then, to situate the kind of self-disclosure that is associated with training groups and the helping process in a wider context of "normal" self-disclosing behavior.

Jourard, among others, claims that responsible self-sharing is a part the normal behavior of the healthy actualized person. According to him, persons who cannot share themselves deeply are ultimately incapable of love. Some theoreticians, taking a common sense approach to self-disclosure, have hypothesized that there is a curvilinear relationship between self-disclosure and mental health: very high and very low levels of self-disclosing behavior are signs of maladjustment: moderate (and appropriate) self-disclosing can pour a great deal of energy into building and maintaining facades so that their real selves will not be discovered. The over discloser discloses a great deal even when the situation does not call for it; the under discloser remains closed even when the situation calls for self-disclosing behavior.

Self-disclosure, either within the helping relationship or outside it, is never an end in itself. I assume here that self-disclosure, to promote growth, must be appropriate to the setting. Derlega and Grzelak outline seven aspects of self-disclosure that we can use to explore appropriate self-disclosure in a helping context.

Informativeness. *This refers to both the quantity (breadth) and quality (depth or intimacy) of the information provided. This counseling refers, as we have seen, to the experiences, behaviors, and feelings that need to be explored to define the problem situation adequately. This will, of course, differ from peer to peer.*

Accessibility: *This refers to the ease with which information can be obtained from the peer. Some peers need more help than others in getting at relevant experiences, behaviors, and feelings. As we have seen empathy and probing are important skills in the regard.*

Voluntary: *This refers to the peer's willingness to provide relevant information. Peers who are fearful about revealing themselves need support and encouragement to do so.*

Reward Value: *This refers to the extent that revealing information provided positive (reinforcing) or negative (punishing) outcomes of the peer. If you fail to listen to what a peer is saying or you respond in a way that the peer finds punitive, the peer's self-disclosing behavior will most likely diminish. On the other hand, if you attend and listen well and if you deal carefully with his or her revelations, then self-disclosing behavior is likely to be maintained.*

Truthfulness: *This refers to the extent to which the peer's messages provide information about his or her actual psychological state. If you discover that the peer is not telling you the truth, it may be that he or she is afraid of telling you or fears other punishing consequences. If this is the case, accusations of being a liar will not help. What is needed are both support and reasonable challenge.*

Social Norms: *This refers to the extent to which what is disclosed conforms with or deviates from cultural expectations about appropriate disclosing behavior. Some peers are very low discloses in their everyday lives (in fact, this may be part of the problem situation). It is sometimes hard for them to realize that the "rules" are different in the counseling setting. His is especially true to group counseling. Providing such peers with some kind of facilitative structure for self-disclosure can help.*

Effectiveness: *This refers to the extent to which the messages revealed contribute to the peer's goals. It makes little difference if peers talk intimately and at length about themselves if such disclosures do not contribute ultimately to management of the problem situation. Through empathy, probing, and summaries, you can help peers make their disclosures focused and goal-directed.*

No claims are made here that self-disclosure in itself "cures," for it is a stage in a developmental helping process. But self-disclosure can in some cases release a great deal of "healing" forces or resources in the peer. For instance, it helps a peer get out from under a burden of guilt. Therefore, adequate self-disclosing behavior predicts therapeutic outcome. If we can find a way to expand the statement of a problem to a concrete list of specific behaviors which constitute it, one major obstacle to the solution of the problem will have been overcome. In other words, the initial ambiguity with which most people analyze their interpersonal problems tends to contribute to their feeling of helplessness in coping with them. Knowing which specific behaviors will solve the problem, provides a definite goal for action and having that goal can lend a great sense of relief.

Self-disclosure does not "cure," but it does contribute significantly to the overall process. Let's look at the difference between the self-disclosing behavior of two different peers.

> *Peer A: Things just don't seem to be going right. My personal life is at low ebb. I'm overloaded with work. And a lot of other things intervene to clog up the work. I tend to give up.*

This peer expresses his feelings in a vague way; he does not delineate or own his experiences clearly; and he fails to indicate his concrete behaviors.

> *Peer: I'm depressed, really down, and this is unusual for me. I find it hard to get out of bed in the morning and I feel groggy most of the day. I try to read but keep putting the book down and wandering around the house. I think I should go to a movie or visit a friend, but I don't do it; I don't even want to. I have even lost my appetite. This has been the pattern for a couple of weeks now. I think I know what's going on. Two weeks ago I received my dissertation back from my committee. They turned it down for the second time. And I really thought I had made the corrections they wanted before. Now I'm beginning to think I'll have to get an entirely new topic, collect new data - the whole bit. But I don't think I have the energy, the drive, the motivation to do so. Yet I don't want my graduate education to go down the drain. Maybe what bothers me even more is that when I began working on the dissertation, I began to withdraw from my friends. I didn't invite anyone over to my place and I turned down their invitations to dinners and parties. I didn't even hang around after class to talk to anyone. I left as soon as class was over to get to my typewriter. No nobody calls me up anymore or comes over. I don't blame them. Why should they? I put the dissertation before them for months. So, on top of everything else, I'm lonely. I just want to pack to New York.*

This peer's statement is filled with specific feelings, experiences, and behaviors. The difference in self-disclosure ability between Peer A and Peer B is obviously vast. Because many peers will not have the ability to reveal themselves as Peer B does here, your probing and empathy skills are needed to help them bridge the gap.

HELPER SELF-SHARING

Another way of challenging your peers is to share with them something about yourself. Like other forms of challenging, helper self-disclosure is not an end in itself. It must contribute something to getting the work of helping done. Helper self-disclosure can have two principal functions.

First it can be a form of modeling and, as such, a way of showing peers how to disclose themselves and a way of encouraging them to do so. Most of the research on helper self-disclosure stresses this function: "Overall...the research weighs in favor of the conclusion that therapist modeling of self-disclosure can be an effective method of denoting...for peers what is to take place behaviorally in psychotherapy." It is most useful with peers who don't know what to do or who are reluctant to talk about themselves in an intimate or personal way. Therefore, this kind of helper self-disclosure would seem to be most useful early in the helping interviews, but it could also be used by any time a peer gets "stuck" and is having difficulty revealing himself or herself. Both Jourard and Mower were pioneers in urging this kind of helper self-disclosure. Self-help groups such as Alcoholics Anonymous use modeling extensively as a way of showing new members what to talk about and of encouraging new members to talk freely about themselves and their problems.

Second, helper self-disclosure can help peers develop the kind of new perspectives need for goal setting and action. If your experience can help peers develop useful alternate frames of reference, then sharing yourself seems to be a question of common sense.

> *Ben is a counselor in a drug rehabilitation program. He was an addict for a number of years but "kicked the habit" with the help of the agency where he is now a counselor. It is clear to all the addicts that are not only rehabilitated but intensely interested in helping others both rid themselves of drugs and develop a kind of lifestyle that helps them stay drug-free. Ben freely shares his experience, both of being a drug user and his rather agonizing journey to freedom.*

Ex-alcoholics and ex-addicts can make excellent helpers in programs like this. Sharing their experience is central to their style of supporting and is accepted by their peers.

Weigel, Dinges, Dyer, and Straumfjorn found evidence suggesting that helper self-disclosure can frighten peers or make them see helpers as less well adjusted. In view of this and other difficulties, it seems that helper self-disclosure should follow certain principles. Helper self-disclosure can be part of the contract. Derlega, Lovell, and Chaikin found that helper self-

disclosure can well be misunderstood by naive or uninformed peers and prove counterproductive. However, if, as in the case of the drug counselor just mentioned, it is clear from the start to peers that "high self-disclosure by the supporter is part of the professional role and is appropriate for effective treatment," than peers are not put off by it. In short, if you don't want peers surprised about your sharing your experience with them, let them know that you might do so.

Sharing yourself is appropriate if it helps peers achieve the treatment goals outlined in this helping process-that is, if it helps them talk about themselves, if it helps them talk about problem situations more concretely, if it helps them develop new perspective and frames of reference, and if it helps them set realistic goals for themselves. Helper self-disclosure that is exhibitionistic or engaged in for "effect" is obviously inappropriate. Here are some principles to be followed to ensure that self-sharing is appropriate.

1. ***Selective and focused.*** Helper self-disclosure is appropriate if it keeps peers on target and does not distract them from investigating their own problem situations. It may be that selective bits of the supporter's experience might be useful in helping the peer get a better conceptual and emotional grasp of his/her problems.

2. ***Not a burden to the Peer.*** Helper self-disclosure is appropriate if it does not add another burden to an already overwhelmed peer. One supporter thought that he would help make a peer who was sharing some sexual problems more comfortable by sharing some of his own experiences. After all, he saw his sexual development as not too different from the peers. However, the peer reacted by saying, "Hey, don't tell me your problems. I'm having a hard enough time dealing with my own. I don't want to carry yours around, too!" This novice supporter shared too much of himself too soon. He was caught up in his own willingness to disclose rather than its potential usefulness to the peer.

3. ***Not too often.*** Helper self-disclosure is inappropriate if it is too frequent. This, too, distracts the peer and shifts attention to the supporter. Research suggests that if helpers disclose themselves too frequently, peers tend to see them as phony and suspect that they have ulterior motives.

In summary, then, even though the research on helper self-disclosure is somewhat ambiguous, it is still a skill or response that should be part of any helper's repertory. That is, helpers should perhaps be willing and able to disclose themselves, even deeply, in reasonable ways, but actually do so only if it is clear that it will contribute to the peer's progress.

THE CONTENT OF THE PEER'S SELF-DISCLOSURE

What should peers talk about? They should talk about both their problems in living and the resources or potential resources they have to handle them. The goal of self-exploration is not merely quantity, or even intimacy, of self-exploration which includes (1) problem-related information and (2) solution-oriented resources. Resources exploration provides a positive dimension of the self-exploration process. Consider the following example:

Peer:	*I practically never stand up for my rights. If I disagree with what anyone is saying-especially in a group I keep my mouth shut. I suppose that when I do speak up, the world doesn't fall in on me. Sometimes others do actually listen to me. But I still don't seem to have any impact on anyone.*
Supporter A:	*It's frustrating to be afraid to speak up and to get lost in the crowd.*
Supporter B:	*The times you do speak up, others actually listen, and you're annoyed at yourself for getting lost in the crowd so often.*

Supporter A misses the resource the peer mentioned. Although the peer habitually fails to speak up, he does have an impact when he does speak. Others listen sometimes. And this is a resource.

There are certain areas of life that are worth investigating with almost every peer. The following areas or topics are so pervasive that they relevant to almost any problem the peer might mention.

SUMMARIZATION

FEEDBACK: SUMMARIZING

Definitions of Summarizing

Summarizing is the tying together by the counselor of the main points discussed in a counseling session. Summarizing can focus on both feelings and content and is appropriate after a discussion of a particular topic within the session or as review at the end of the session of the principal issues discussed. In either case, a summary should be brief, to the point, and without new or added meanings.

In many respects, summarizing is similar to, or an extension of, paraphrasing in that the counselor seeks to determine the basic meanings being expressed in content or feelings and give these meanings back to the client in fresh words. Summarizing differs primarily in the span of time it is concerned with. In paraphrasing, a statement or feeling occurring over a short period of time is rephrased. In summarizing verbal or feeling content, several of the client's statements, the entire session, or even several sessions are pulled together.

In summarizing, then, the counselor is pulling together a greater number of statements and/or feelings that have come out over an extended period of time.

Purposes of Summarizing

1. *It can ensure continuity in the direction of the session by providing a focus.*

2. *It can clarify a client's meaning by having his/her scattered thoughts and feelings pulled together.*

3. *It often encourages the client to explore an issue further once a central theme has been identified.*

4. *It communicates to the client that the counselor understands or is trying to understand what the client is saying and feeling.*

5. *It enables the counselor to verify his/her perceptions of the content and feelings discussed or displayed by the client during the session. The counselor can check out whether he/she accurately attended and responded without changing the meanings expressed.*

6. *It can close discussion on a given topic, thus clearing the way for a new topic.*

7. *It provides a sense of movement and progress to the client by drawing several of his/her thoughts and feelings into a common theme.*

8. *It can terminate a session in a logical way through review of the major issues discussed in the entire session.*

As with paraphrasing, the counselor should make a practice of checking out the accuracy of a summary with the client to minimize the chances of making unwarranted assumptions.

Examples of Summarizing

To a divorced female correctional officer exploring problems that she is having with a teenage son, who is smoking marijuana:

> *As I understand what you've been saying during the past few minutes, you seem to be struggling with the three possible ways to handle the situation: you might continue trying to reason with your son yourself; you might ask his father to help you deal with the boy; or you might stop discussing the problem with your son and punish him by taking away his privileges.*

****

At the end of a session with a male correctional officer:

> *Let's take a look at what we've covered in today's session. It sounds like you've felt inadequate in dealing with several areas of your life - your family, your job, and now your new girlfriend.*

****

Summary of Summarizing

To summarize is to <u>select</u> the key points or basic meanings from the client's verbal content and feelings and succinctly <u>tie them together</u>. The summarization should accurately reflect the essence of the client's statements and feelings and should not include assumptions of the counselor. Summarizing then, is a review of the main points already discussed in the session to ensure continuity in a focused direction.

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WASHINGTON DEPARTMENT OF CORRECTIONS
TRAINING -- CRITICAL INCIDENT TRAUMA
WALLA WALLA, NOVEMBER 4,5,6, 1992

A critical incident is the witnessing or involvement in any traumatic event which is outside of the emotional experience of the individual and which produces strong emotional responses which effect their emotional and physical functioning. Witnessing a shooting death is certainly a traumatic incident, however, other incidents such as an assault, hostage taking incident, threats, vehicle accidents, body recovery, assault, rape, and other serious injury or life threatening incidents are also considered to be critical incidents. It is common for these symptoms to develop following incidents where situation control is minimal such as accidents, continued work without proper rest as with a disaster, and following an incident where vulnerability is faced and situation control is lacking.

An individual who has recently been involved in a critical incident may display some or all of the following:

Physical Symptoms: Hyperactivity, headache, elevated blood pressure, nausea, diarrhea, indigestion, heartburn, muscle stiffness, shaking, hyperventilation, shock, profuse sweating, chest pains, and pounding heart.

Emotional Symptom: Inability to concentrate, failure to comprehend, memory problems, emotional numbing, feeling of "going crazy," flashbacks, anxiety, a feeling of isolation, crying, paranoia, anger, fear, remorse, depression, guilty, homicidal and suicidal thoughts, and loss of emotional control.

Sleep Disturbances: Inability to get to sleep, nightmares, waking up several hours before usual time, and perhaps fear of going to sleep because of the nightmares.

Perceptual Distortions: Visual, auditory, olfactory, tactile, time, and location and sequence of events.

Fears and Concerns: Abandonment by the system, liability issues, continuation of employment, welfare of others, family concerns, what happens "next time," and what will my peers and supervisors think.

Attempts to Control: What if's, denial and emotional over-control. Putting on a macho facade. Graveyard humor.

Purpose for immediate intervention:

- Assists employee in dealing with traumatic incident.
- Maintains employee productivity
- Identifies concerns & provides assistance when indicated.
- Reduces sick leave costs.
- Liability issues

If the employee does not deal effectively with the emotional impact of the traumatic incident delayed stress symptoms or POST TRAUMATIC STRESS DISORDER may occur up to several years following the incident. The following symptoms are common with individuals having PTSD.

Intense anger which is usually non specific in its direction and often is directed at the "establishment," a sense of guilt, intrusive flashbacks of the incident, fear and anxiety about future situations which are similar to the incident, sleep disturbances, withdrawal from support systems, substance abuse, thinking about and acting upon suicidal and homicidal feelings, inability to daydream without being interrupted with intrusive thoughts, emotional numbing, depression, impulses control difficulties, sexual problems, headaches, feeling of a loss of emotional stability, and physical problems. There are also difficulties dealing with authority figures, cynicism and distrust of others, fatigue, and avoidance of activities related to the critical incident.

MEASURES TO REDUCE THE IMPACT OF A TRAUMATIC INCIDENT:

- Prior training and trauma inoculation.
- Exercise
- Immediate individual or group debriefing will:
  - Deal with emotions resulting from the incident.
  - Provide an understanding of the symptoms.
  - Provide therapeutic assistance/referral.
  - Determine fitness for return to duty.
- Psychotherapy, including peer support.

PERSONALITY TYPES RELATED TO CHRONIC HEART DISEASE

TYPE A - TYPE B

Each line below is composed of a pair of adjectives or phrases separated by a series of horizontal lines. Each pair has been chosen to represent two kinds of contrasting behavior. Each of us belongs somewhere on the lines between the two extremes. Since most of us are neither the most competitive (7) nor the least competitive (1) person we know, put a check mark on the line where you think you belong between the two extremes (1-7).

TYPE A	7	6	5	4	3	2	1	TYPE B
Highly competitive	__	__	__	__	__	__	__	Not competitive
Must get things finished once started	__	__	__	__	__	__	__	Doesn't mind leaving things temporarily unfinished
Never late for appointments	__	__	__	__	__	__	__	Calm and unhurried about appointments
Anticipates others in conversation (nods, interrupts finishes sentence for the other)	__	__	__	__	__	__	__	Listens well, lets others finish speaking
Always in a hurry	__	__	__	__	__	__	__	Never in a hurry, even when pressured
Uneasy when waiting	__	__	__	__	__	__	__	Able to wait calmly
Always going full speed ahead	__	__	__	__	__	__	__	Easy going
Tries to do more than one thing at a time, thinks about what to do next	__	__	__	__	__	__	__	Takes one thing at a time
Vigorous and forceful in speech (uses a lot of gestures)	__	__	__	__	__	__	__	Slow and deliberate in speech
Wants recognition by others for a job well done	__	__	__	__	__	__	__	Concerned with satisfying himself, not others
Fast doing things (eating, walking, etc.)	__	__	__	__	__	__	__	Slow doing things
Hard driving	__	__	__	__	__	__	__	Easy going
Holds feelings in	__	__	__	__	__	__	__	Expresses feelings openly
Few interests outside work	__	__	__	__	__	__	__	Has a large number of interests

TYPE A	7	6	5	4	3	2	1	TYPE B
Ambitious, wants quick advancement on job	__	__	__	__	__	__	__	Satisfied with job
Often sets own deadlines	__	__	__	__	__	__	__	Never sets own deadlines
Always feels responsible	__	__	__	__	__	__	__	Feels limited responsibility
Often judges performances in terms of numbers (how many, how much)	__	__	__	__	__	__	__	Never judges things in terms of numbers
Takes work very seriously (works week-ends, brings work home)	__	__	__	__	__	__	__	Casual about work
Very precise (careful about detail)	__	__	__	__	__	__	__	Not very precise

SCORING: Assign a value of 1 to 7 for each of your twenty checks, depending upon the value of the line it is on. Total these twenty numbers and write this figure in the TOTAL SCORE BOX.

	TOTAL SCORE

You can interpret the meaning of this score according to the following categories:

SCORE	TYPE	
110 - 140	A_1	If you are in this category, and especially if you are over 40 and smoke, you are likely to have a high risk of developing cardiac illness. Take action right away.
80 - 109	A_2	You are in the direction of being cardiac prone, but your risk is not as high as the A_1. You should, nevertheless, pay careful attention to the advice to all type A's by Friedman & Rosenman.
60 - 79	AB	You are a mixture of A and B patterns. This is healthier than either A_1 or A_2, but you have the potential for slipping into A behavior and should recognize this.
30 - 59	B_2	Your behavior is on the less cardiac-prone end of the spectrum. You are generally relaxed and cope adequately with stress.
0 - 29	B_1	You tend to the extreme of non-cardial traits. Your behavior expresses few of the reactions associated with cardiac disease, you lucky dead fish!

[redacted]st Name First MI Date

AGE: _____ Years Employed In Law Enforcement _____

Below is a list of comments made by people after stressful life events.
Please check each item, indicating how frequently these comments were true.

FREQUENCY

	NEVER	Before Entering Law Enforcement	NOW
Sick leave of more than six days a year			
Severe and/or frequent headaches			
Frequent problems with digestion			
Elevated blood pressure			
Night sweats			
Nightmares			
Difficulty getting to sleep			
Awakening one or more hours before the alarm			
Difficulty concentrating			
Memory problems			
Communication difficulties with spouse			
Difficulty with close relationships			
Crying			
Anger			
Depression lasting at least a week			
Anxiety			
Alcohol or other substance abuse			
Excessive weight gain or loss			
Suicidal and/or homicidal thoughts			
Intrusive flashbacks of incidents			
Low frustration tolerance			
Impulse control difficulties			
Sexual performance problems			

FREQUENCY

	NEVER	Before Entering Law Enforcement	NOW
Fatigue and decreased energy			
Guilt feelings			
Lack of interest in outside activities			
Extreme irritability			
Chronic aches and pains			
Productivity problems			
Difficulty making decisions			
Feelings of helplessness			
Difficulty maintaining employment			
Apprehension/panic at phone ringing or a knock at the door			
Other:			

STRESS REDUCTION WORKSHOP

STRESS RESPONSE FORM

	NEGATIVE STRESSORS		POSITIVE STRESSORS	
	I Control	Outside my Control	I Control	Outside my Control
WORK				
POLITICAL				
ADMINISTRATIVE				
CAREER DEVELOPMENT				
HEALTH				
LEISURE TIME				
HOME LIFE				

LISTENING FEEDBACK FORM

As observer, your job is to pay attention to the counselor's use of this skill. During the interaction, give your full attention to what the counselor and client say and do. At the end of the demonstration or practice period, quickly check the behaviors you observed. After the practice period(s), report to the counselor the behaviors you have checked.

Guidelines for effective attending are:

- to communicate listening through frequent and varied eye contact and through facial expression,
- to physically relax and lean forward occasionally, using natural hand and arm movements, and
- to verbally "follow" the client, using a variety of brief encouragements such as "um-hum", "yes", or repeating key words.

Indications that effective attending is <u>not</u> taking place include:

- little eye contact, a fixed stare, a frozen expression,
- stiff or tense posture, no head movements, no hand movement, slouching, and
- topic jumping, cutting off the client.

Behavior

1. Maintained frequent and varied eye contact. _____
2. Looked away from the client when talking or maintained a fixed stare. _____
3. Displayed varied facial expressions. _____
4. Showed little or no facial animation or alertness. _____
5. Used affirmative or encouraging gestures. _____
6. Had relaxed body posture, leaning forward occasionally. _____
7. Sat in a fixed or rigid position throughout. _____
8. Slouched or leaned away from the client. _____
9. Offered brief vocalizations that encouraged the client to continue talking. _____
10. Interrupted the client or changed topics arbitrarily. _____

Listening feedback form cont...

On each of the following scales, put a check at a location on the continuum to reflect your judgment of the qualities displayed by the counselor.

WARM_____COLD

CONCERNED, INVOLVED_____UNINTERESTED

UNDERSTANDING_____NOT UNDERSTANDING

OPEN, SHARING_____CLOSED

RELAXED, AT EASE_____TENSE

COMMUNICATION BASICS CHECKLIST

	OK	USUALLY	I NEED TO WORK ON THIS
I physically attend to others	_____	_____	_____
I listen carefully before talking	_____	_____	_____
I speak in descriptive terms	_____	_____	_____
I discuss positive feelings	_____	_____	_____
I discuss negative feelings	_____	_____	_____
I own my feelings ("I" messages)	_____	_____	_____
I speak clearly and specifically	_____	_____	_____
I use good timing	_____	_____	_____
I consider other's needs	_____	_____	_____
I encourage others to communicate with me	_____	_____	_____

PARAPHRASING FEEDBACK FORM

Instructions: As observer, your job is to pay attention to the counselor's use of this skill. During the interaction, give your full attention to what the counselor and client say and do. At the end of the demonstration or practice period, quickly check the behaviors you observed. After the practice period(s), report to the counselor the behaviors you have checked.

The basic components of paraphrasing are:

- to determine the basic message that is being expressed in the verbal content of the client's communication, and
- to rephrase the verbal content in similar but fewer words.

Indications that effective paraphrasing is not taking place include:

- missing the basic message of a client statement,
- rambling on at length after a client statement, and
- assuming the client accepts a paraphrase without checking it out.

1. Responded to the basic cognitive message of the client. _____
2. Responded to the essence of feelings of the client. _____
3. Used fewer words than the client to restate the same thought. _____
4. Reflected the client's feelings at the same level of intensity expressed by the client. _____
5. Checked out directly with the client the accuracy of the reflection of feeling response. _____
6. Responded to only the last few words in the client's verbal content. _____
7. Sharpened the client's meaning, which encouraged the client to talk further on same subject. _____
8. Used more words than the client in feeding back client statements. _____
9. Clarified confusing content. _____
10. Used a variety of forms of paraphrasing (e.g., exact wording, rephrasing statement). _____

SELF-DISCLOSURE FEEDBACK FORM

Instructions: As observer, your job is to pay attention to the counselor's use of this skill. During the interaction, give your full attention to what the counselor and client say and do. At the end of the demonstration or practice period, quickly check the behaviors you observed. after the practice period(s), report to the counselor the behaviors you have checked.

Guidelines for counselor self-disclosure are:

- to relate the disclosure directly to the client's situation,
- to disclose only first-hand experiences which are true, and
- to keep the level of intimacy comfortable for the counselor and client.

Indications that appropriate self-disclosure is not taking place include:

- allowing focus of session to shift and remain with counselor, and
- signs of anxiety in client after a counselor self-disclosure.

Behavior

1. Related experience of a friend for client's benefit. _____
2. Revealed very intimate level material which seemed to make client uncomfortable. _____
3. Allowed focus of session to remain on counselor after a self-disclosure. _____
4. Disclosed only material directly relating to the client's situation. _____
5. Used self-disclosure as a confessional or to meet a need of the counselor. _____

SUMMARIZING FEEDBACK FORM

Instructions: As observer, your job is to pay attention to the counselor's use of this skill. During the interaction, give your full attention to what the counselor and client say and do. At the end of the demonstration or practice period, quickly check the behaviors you observed. After the practice period(s), report to the counselor the behaviors you have checked.

The basic components of summarizing are:

- to select the major points or basic meanings which have been discussed, expressed, or displayed; and
- to tie together and major points or basic meanings concisely in fresh words.

Indications that effective summarizing is not taking place include:

- missing main theme of client content,
- not pulling together several ideas or feelings, and
- pulling together several ideas but adding new meanings.

Behavior

1. Responded to the basic meanings the client expressed over an extended period of time. _____
2. Tied together several feelings statements or nonverbal cues of feelings. _____
3. Clarified meanings expressed by the client, which resulted in further talk on the same topic. _____
4. Missed a main theme expressed by the client or responded only to a minor point. _____
5. Added meanings to content expressed by the client. _____
6. Checked out directly with client the accuracy of the summary. _____

INTRODUCTION

PEER SUPPORT

FOR CORRECTIONAL STAFF

PRESENTED

TO

DIVISION OF PRISONS

WASHINGTON STATE PENITENTIARY

Prepared by:

THE COUNSELING TEAM

PEER SUPPORT - THE PROGRAM

Why Do We Need The Program?

A. *Macho image, distrust of professionals - inhibits seeking professional help -- seen as a sign of weakness. Discussing with fellow employees may be acceptable.*

B. *Most physicians agree - 70 to 90 percent of all illness is either caused by or made worse by STRESS factors.*

1. *Physical symptoms range from minor headaches or upset stomachs, coronary heart disease and heart attacks, (#1 killer of emergency responders).*

2. *Emotional symptoms include the range from minor sleep disturbances to chronic psychological problems.*

3. *Greatest problem comes from unresolved stress.*

   a) *May be a result of a shooting or a crisis in the family -- the situation itself does not cause stress; it is caused by how we perceive the situation - how it effects us.*

4. *Note increased number of stress - related retirement applications over all previous years.*

   a) *Clinical/legal approach versus what is really best for the individual.*

C. *Stress brought about by several factors.*

1. *<u>Department</u>*

   a) *To perform within acceptable guidelines - rules.*

   b) *Shift work, overtime, pay.*

   c) *Burnout.*

2. *<u>Public</u>*

   a) *Expected to be all things to all people - cop, firefighter, social worker, mediator, doctor, lawyer.*

   b) *First to criticize your behavior under stress.*

3. *Family*

a) *Difficulty balancing job and social commitments.*

b) *Bring job home - "always the cop" mentality.*

c) *Shift work, choir practice, etc.*

4. *Court*

a) *Ever-changing laws, technicalities, continuances, etc.*

5. *Physical/Emotional Demands of Job*

a) *Must be in good physical condition to perform in emergencies.*

b) *Can't let any sentiments "out" for fear it will be seen as a sign of weakness; macho image.*

c) *Must be able to handle "fix" all situations encountered on the job - carries over to home life.*

D. *One of the "given" in the understanding of stress and how we react to it is that those who are affected will find a way to cope with it.*

1. *May be good, worthwhile, socially acceptable manner.*

a) *Relaxation, physical exercise, talking it out with friends, etc.*

2. *May be a temporary solution which will lead to future, additional stress.*

a) *Alcohol, drugs, gambling, suicide.*

E. *There is usually an abundance of people who are willing to listen to a person in crisis - partners, friends, family, etc.*

1. *problem comes in when each gives advice and tries to "fix" the person.*

2. *Often advice is poorly timed or inappropriate.*

3. *Many just don't know how to help.*

4. *Training is for those who want to go on helping without making wrong decisions or giving bad advice.*

F. *Law enforcement and fire agencies and private industry realize the benefits of providing a way for employees to overcome their problems before they affect job performance.*

1. *Decreases absenteeism.*

2. *Reduces accidents.*

3. *Positively affects morale.*

4. *Increases productivity.*

5. *Cost effective.*

All types, even trauma stress and long-term stress, can be released or resolved given a proper channel. (Pressure cooker)

1. *Two things not to do.*

   a) *Ignore it, hoping it will go away.*

   b) *Put a "band-aid" on it.*

H. *A peer support program can work - other law enforcement and fire agencies' programs have succeeded.*

1. *L.A.P.D. 1983 Statistics*

   2001 Interviews

   4859 hours Donated (133 OT)

2. *L.A.P.D. 1984 Statistics*

   2038 Interviews

   4728 Hours (168 OT)

3. *L.A.P.D., S.F.P.D., Boston, all programs report success.*

4. *L.A.F.D., C.D.F., report successful peer support (counselling) programs.*

ROLE OF PEER SUPPORT

PEER SUPPORT/COUNSELORS

A. *Peer support provides a way for employees and their family members to confidentially "talk out" personal and professional problems with specially trained co-workers who understand and want to help.*

B. *Peer support (Counselors) are para-professional counselors whose primary function is to LISTEN, ADDRESS, and whenever necessary, REFER to professional counselors. They should NEVER be used as a replacement for required professional care.*

C. *Peer support counseling complements that provided by professionals from within or outside your department. The program expands available department resources by offering a greater field of choice to personnel who want to talk to someone who has "been there" and understands what it is like to work "their jobs".*

D. *There is no limit as to the types of "life problems" which can be discussed with Peer Support (counselors).*

   1. *Most problems will resolve themselves when those involved are given a chance to be heard.*

   2. *From March through June 1985, marital problems were the most common concerns brought to Peer Support (counselors) attention. The next most common, in descending order of times seen, are: bereavement, alcohol dependency, career concerns, stress-related issues, critical incidents, relationships with children, retirement concerns, disciplinary problems, problems with co-workers, financial concerns, supervisor/subordinate issues, relationships with step-children and off-duty disability.*

SPECIALIZED TRAINING

A. *Peer Support (counselors) will acquire supportive counseling skills designed to help them assist co-workers who are experiencing any of a variety of life crises.*

B. *New/different ways to listen and communicate will be learned.*

C. *Techniques for dealing with emotionally charged sessions will be shown.*

1. *How to cope with one's emotions.*
2. *How to help another deal with his/her emotions.*

D. *Peer Support (counselors) will learn, by practice in group sessions, how to know when a situation requires professional intervention.*

1. *A crisis is a crisis.*
2. *What to do with a counselee that does not need referral.*
3. *Referral and resource agencies.*

E. *Special attention will be paid to recognizing major crises.*

1. *Suicidal.*
2. *Major Depressive Episode.*

F. *Peer Support (counselors) responsibilities to themselves, the program and the department will be discussed.*

1. *Limitations.*
2. *Moral, Civil, Ethical Considerations.*
3. *"Risk Taking".*

SPECIFIC SKILLS RECOMMENDED FOR PEER SUPPORTERS

Personal Qualities Desired:

1. *Humility, modesty, integrity, respect, sympathy, curiosity about people.*
2. *Sincere appreciation of people.*
3. *Satisfaction in being with, listening to and in trying to understand people and society.*
4. *Ability to take a passive role.*
5. *Ability to make a good first impression.*
6. *Ability to accept people with differences.*
7. *Ability to endure being misunderstood.*
8. *Ability to give support to respondent even though they say malicious, prejudiced and false statements.*
9. *Sense of humor.*
10. *Empathy while maintaining emotional stability.*
11. *Ability to keep personal projections at a minimum and yet retain insight.*
12. *Openly friendly, avoiding resentment in interview.*
13. *Ability to tolerate love and/or hostility.*
14. *Ability to take rebuffs.*
15. *Ability to accept not being accepted.*
16. *Gaining satisfactions outside the job for a whole personality.*
17. *No feeling of need to use people to show power.*
18. *Not aggressive.*
19. *Respect for sub-cultural values and taboos.*
20. *Non-judgmental.*
21. *High sense of ethics: A professional attitude giving an impression of confidentiality and security or records, non-gossiper, non-judgmental.*

HIGH FUNCTIONING COUNSELORS

Establish trust and rapport.

Enable client to express feelings.

Practices good listening behavior - verbal and non-verbal.

Understand value of good listening.

Gains necessary information effectively without changing relationship.

Identifies high stress and poor adaptive behavior.

Distinguishes between crisis or short-term problems and chronic problems.

Identifies suicide risk.

Follows up on progress of client in carrying out possible remedies to situation (outreach).

These abilities are most easily accomplished by:

listening
paraphrasing thoughts and/or feelings
summarizing and self-disclosure.

Combined with treating people with:

respect,
emphatic understanding, and guidance.

APPENDIX I (A)

THE EFFECTS OF SELF-CONCEPT AND DEFENSE MECHANISMS ON INTERPERSONAL RELATIONSHIPS

It is generally believed that how we feel about ourselves is directly related to how we interact with other people. The more we like who we are, the easier it is to relate in most interpersonal situations. Conversely, the less we can accept ourselves, the most difficult it will be to deal with other people's insecurities and hostilities. It is a complicated chain of psychological events that connects these two phenomena, but one worth knowing something about if you are going to be dealing with people's emotional problems.

It is important to make clear that we have been talking about perfectly normal people in this discussion on peer counseling. This is not a short course in Abnormal Psychology. We're not dealing with neurotics or characterological disorders, nor will you be, typically, in your work as peer counselors. You'll be working with generally well - functioning individuals who are in periods of high stress and need some help getting through a tough time in their lives. We are, essentially, talking about people like you and me. In one sense, the first step you can take in your training is to admit that you don't always have it all "together", that sometimes you may feel less than good about yourself. If you can admit that to yourself, it will give the counselee more confidence that he's talking to an open and human person, and will hopefully disarm him or her of some of their defenses.

From our earliest years we are confronted with people and situation that have an impact on how we feel about ourselves. The feedback we receive from our parenting figures (mom, dad, aunts, older siblings, grandparents, significant teachers, etc.) or caretakers have been taken out on us in the form of being put down, criticized, undeservedly punished and the like. It results in us developing unrealistically low opinions of who we are, i.e., low self-concepts.

Another process by which people develop low self-esteem is by having parents manipulate them to do and feel what they (the parents) want them to, even when it is very different from what the child is really feeling. The child is then told that he (or she) is a "good boy (girl)", but down deep the child know that they aren't really feeling what they are being reinforced for. They think that if they really acted the way they felt, they would be no good. This confused feeling may continue into later life when it turns into the twisted feeling that "if people like me, they really don't know me; if they knew who I really was, they wouldn't like me at all." I have conducted many group therapy sessions when, to a person, every member shared this fear about their own likability as

a person: It is a tragic, but universal part of the human condition. The way most people deal with this deep-seated fear of lack of self-worth is to develop defense mechanisms to ward off their feelings of doubt. The primary purpose of all defense mechanisms is to protect us from feeling badly about ourselves. A certain level of self-protection is normal and healthy. It is when the defenses become too much a part of our daily functioning that we get into psychological trouble. Different people tend to use different types of defenses - that determines what we refer to as their personality style. You will undoubtedly recognize many of these mechanisms in yourself or others you know.

1. ***Projection:*** *Attributing to others feeling or thoughts that are really your own. "I'm not angry at my wife: she's that hostile bitch". It's easier to see the other person as having the hostility rather than yourself.*

2. ***Displacement:*** *Feeling something toward one person when it is really directed toward someone else. Coming home and hassling your girlfriend instead of yelling back at your supervisor is an example. It is safer on your ego (and your job) to take it out on someone on whom you have more leverage than on a superior.*

3. ***Rationalization:*** *Making an excuse for a failure. "I wasn't that interested in getting promoted anyway--it's all politics". This makes it easier on our self-concept if we say we don't care or blame it on external uncontrollable events (which are often, of course, valid reasons): it makes it easier not to focus on our own fallibilities. Failing tests is another common breeding ground for rationalization.*

4. ***Repression:*** *Unconsciously motivated forgetting of an unpleasant event. This often occurs after going through traumatic experiences: On the job, as a young child, and the like. This is personal pain, or wrong doing that the person would rather "forget" about. As with the other defenses, it makes it easier on the self-concept or ego.*

5. ***Denial:*** *Refusing to admit the existence of a reality. People's first reaction to being told that they or a loved one has a possibly fatal illness is sometimes to say, "It's not true". It makes it easier on the person's psyche to deal with horrible reality when they are ready to. Denial is often used on being confronted with a spouse's infidelity - it is easier to pretend it is not there.*

6. ***Intellectualization:*** *Dealing with highly emotional events in a cool, rational way. After a shooting in which his partner was killed, the officer says, "The SWAT Team did a great job, but it's just part of the hazards of our profession. It was a fascinating experience" You can see that this is closely related to denial and in correctional work may be highly useful in coping with traumatic situation.*

7. ***Reaction Formation:*** *Substituting an opposite feeling for the unacceptable one the person really has. A parent who feels angry and rejecting toward their child overcorrects by expressing lots of worry and concern about he child's safety. Another example would be a person attracted by the excitement and brutality of war who becomes a pacifist.*

8. ***Passive Aggression:*** *This is not a classical defense mechanism, but is a first cousin and deserves mentioning. It refers to indirect, often subtle ways of expressing anger with having to do it directly. Examples are: Being constantly late for appointments, "losing" others' valuables, "forgetting" to tell people important messages, being "too tired" to have sex, etc. All of these "excuses" can have an element of validity to them and are thus not easy to confront, and that is the purpose: To get anger out without having to own it. Because of the difficulty many people have in expressing anger, passive aggressive behaviors are fairly common ways of protecting our ego from admitting we are angry at someone.*

9. ***Alcoholism:*** *This, too, is not a classical defense mechanism, but it is such a problem in correctional institutions and elsewhere that it must be discussed. It is, as are the other mechanisms, a way of protecting the person from feeling badly out--true escape. In fact, alcoholism is a type of slow suicidal behavior. The person wants out, but doesn't want to leave for good. Drinking obliterates reality; it makes it less painful to deal with the misery of one's life. It is, of course, the most dangerous defense mechanism because it can kill. It kills the drinker, his relationships with his family, ultimately contact with the person on the job and often destroys many lives around him. It is included in this discussion to put alcoholism/chemical dependency into the context of a defense mechanism that is designed to protect the drinker against dealing with who he is as a person.*

10. ***Sublimation:*** *This is the only purely "healthy" defense mechanism. It refers to expressing a socially unacceptable impulse in a socially acceptable way. Boxing or other physical contact sports are excellent ways of sublimating anger (as opposed to punching out your child, which is displacement and not so excellent). People sometimes become teachers to demonstrate that they are intellectually competent; or they become correctional officers to work out their hostile feelings toward authority; or accountants so that they can be obsessive/compulsive and make money with it; or performers to feed an insatiable need for recognition.*

The point to remember is that people develop defenses for very good reasons; to protect themselves against feeling badly about themselves. They need them, or they think they need them. So respect them when you see them in others. They will give them up when they begin to feel better about themselves.

But why do we have trouble feeling good about ourselves in the first place? A general but useful answer to this question is that to the extent that we are prevented from being ourselves as we grow up, we will develop problems, defenses and a low self-image. The reverse is equally true: To the extent that we are allowed to be ourselves as youngsters we will develop a positive and congruent self-concept. There are, of course, problems, but if there is one theme that recurs time after time, it is that of suppression of the self. Parents do it for all kinds of reasons. I do it with my child when I am tired and don't want to keep answering his questions; or when I don't want to hear him cry and tell him to "be a big boy and stop crying".

Children must learn realistic limits in the world, that is obvious. What happens with most of us, however, is that we are prevented from expressing ourselves much more than is actually necessary, and we "learn" that parts of us are not acceptable, are not to be expressed, and are not good. Typical areas of societal repression have to do with anger and sexuality, both which are often said to be "bad" by parents and teachers, so that we have to relearn that those parts of ourselves are okay when we're grown up.

One result of these assaults on our self-esteem is that we take this unrealistically low self-concept into our relationships as adults and have to "pretend" we're something we're not to others we meet. In marriages what often happens is that two people who are struggling to feel good about themselves meet, each one looking for validation from the other, but unable to provide it because they are so needy themselves. They have put on a facade of "togetherness" prior to the marriage but as the months and years roll by, their real feelings about themselves surface and they have to work to redefine their relationship in a more real way. This leads either to an improved marriage, a marriage of mutual loneliness or divorce.

What does all of this have to do with peer counselling? Lots. The people you'll be dealing with are, as I stated above, basically norma, well-functioning people. However, they are human, and they will come to you not only in some kind of crisis which you can help them sort out, but also with a whole host of feelings about themselves, defenses against those feelings, and relationships that have been affected by their individual psychological styles. You need to recognize some of the patterns I've discussed here, not to do therapy on them, but to see them as normal, as part of the human condition. If you suspect, for instance, that a counselee is using rationalization to explain away his third divorce ("I didn't love her anyway"), you may simply ask him if he really feels that way or if saying that makes it easier to deal with another terminated relationship. Or, if a counselee says that he has been unduly impatient with his teenage son lately and you suspect he's displacing some aggression from somewhere else, you may ask how he's feeling toward his wife or toward people at work, and if he is perhaps taking out angry feelings toward others on his son.

To summarize: *As we grow up, how we feel about ourselves is determined not only by our own accomplishments, but by the messages we get from significant others about who we are. The more unconditional acceptance we feel from others, the less we need to rely on defense mechanisms to make us feel okay. The better our self-image, the ore likely we'll be able to develop positive relationship with others. The more we will let others know us and the less difficulty we'll have relating with others.*

The goal of peer counseling, in fact of any counseling or therapy, is to provide an atmosphere in which the person feels totally accepted and is able to explore who he or she is in the context of a caring relationship. As I stated at the beginning of this manual, this is at once a very modest and very ambitious goal. I feel confident that you will do it well.

APPENDIX I (B)

JO-HARTS WINDOW

A MODEL FOR LEARNING MORE ABOUT MYSELF AND HELPING OTHERS LEARN MORE ABOUT ME

MYSELF

1. ***Things about myself that I know.***
   a) *Free and Open Areas - I know and they know.*
   b) *My Secret or Hidden Self - Things I know, they don't.*
   In order for others to learn things about me that they don't know, which I would like for them to know, I must take RISKS and tell them.

2. ***Things about myself that others know but which are unknown to me.***
   a) *My Blind Self - They know things about me which I don't.*
   In order to learn what others know about me that I would like to know, I must ask for and receive FEEDBACK!
   b) *My Subconscious Self - Things about me I don't know and they don't know.*
   There are some things about me which I, or anyone else, may never know.

OTHERS

1. ***Things others know about me that I know also.***
   a) *Free and Open Areas - I know and they know.*
   b) *My Blind Self - They know things about me which I don't.*
   In order to learn what others know about me that I would like to know, I must ask for and receive FEEDBACK!

2. ***Things I know about myself which others do not know.***
   a) *My Secret or Hidden Self - Things I know, they don't.*
   In order for others to learn things about me that they don't know, which I would like for them to know, I must take RISKS and tell them.
   b) *My Subconscious Self - Things about me I don't know and they don't know.*
   There are some things about me which I, or anyone else, may never know.

PEER COUNSELING ISSUES

PEER SUPPORT ISSUES

I. SELECTION OF PEER SUPPORTERS

A. Peer Supporters are selected, on a volunteer basis, from all ranks and positions within the Department.

II. PEER SUPPORTER SERVICES

A. Anyone in the correctional officer profession and their family members may utilize the services of this program.

B. Counseling sessions are conducted on the Peer Supporter's/Peer's own time, absent exigent circumstances.

1. Emergency response while on-duty requires the approval of the concerned or his/her designate.

C. All communication between a Peer Support Supervisor and a peer is confidential, <u>except</u> for those matters which involve a life threat, or a serious/dangerous violation of the law.

1. Peer Supporters shall not be interviewed, nor shall they discuss details of counseling sessions, with the institution's personnel conducting an investigation, without the written authorization of the investigator's Superintendent or the member being counseled.

a. This policy in no way inhibits the Superintendent from ordering a member to cooperate with an outside agency involved in a criminal investigation.

D. An individual's decision to seek Peer Supporter services shall be voluntary.

1. Although supervisors may suggest, out of concern for the individual, that he/she may want to see a Peer Supporter, referral shall not be made under duress or promise of reward.

2. The above in no way alters the institutions ability to administer discipline, or a supervisor's responsibility to supervise.

3. Peer Supporters' name and business telephone numbers are available on posted lists at each unit of assignment.

E. *Monthly Statistics*

1. *Peer supporters submit monthly statistic sheets, which indicates the number of counseling sessions performed as well as the general nature of those sessions.*

2. *Names of peers and specifics about peer support sessions are not submitted.*

III. FOLLOW-UP TRAINING SESSIONS

A. *After completing the three-day training seminar, Peer Supporters should have an updated training once a year.*

BASIC SUPPORT MODEL - OVERVIEW

We all have problems in living. Usually we find a way to cope with our problems. However, there are times when our usual coping skills do not work to remedy the problem, or the problem overtaxes our usual resources. Talking it out with someone helps mobilize coping resources. Keeping everything inside, and isolating oneself emotionally, usually intensifies the problem and makes things worse. As peer support personnel, your role is to help a fellow employee reduce the level of stress through emotional support, facilitate the mobilization of coping resources, and facilitate constructive problem solving.

Helping is providing purposeful assistance to other people which makes their lives more pleasant, easier, less frustrating, or in some other way, more satisfying.

Some people confuse helping others with satisfying their own desires. Hopefully you are not such a person. Certainly people do gain much personal satisfaction from helping, but hopefully within a context which values and respects those receiving help.

The helping process is a series of events which assists people to make desired changes. The process has a beginning and an end and involves a person with a concern, and a helper who uses information, concepts, and skills.

I. There are three main aspects of the peer support process.

A. Defining Problems - "Things are not as I want them to be" situations.

1. *Labels may be used to categorize problems (examples -- loneliness, depression, confusion, anger, etc.). Labels vary in tremendous degrees.*

2. *Because of the variance, avoid labels and deal with feelings, thoughts, and behavior.*

3. *Be specific in clarifying problems.*

B. Assisting - Involves helping tools (concepts, skills, and information) and helping strategies (a plan for using the tools to help obtain the desired outcomes).

1. There are four helping tools categories

a. Basic Communication Tools - Assist you as a helper to:

(1) Communicate acceptance of people you are helping.

(2) Help clarify their thinking, feeling, and behaving.

(3) These two tools are for "active listening" which requires the listener to pay attention to two levels of communication.

(a) Understand the issues being described.

(b) Understand the feelings of the person about those issues.

(4) The active listener makes predictions about what the speaker is trying to express and then takes some kind of verbal action as a means of helping.

b. ***Goal-gaining Tools*** - Used to help people take specific actions.

(1) Contracting - an individual arranges or "contracts" with the helper to do certain activities. Reviews are done periodically to see how well the contract is being fulfilled. Contracting makes the relationship explicit and eliminates the vagueness.

(2) Modeling and role playing - trying out new behaviors in non-threatening situations.

(3) Reinforcing - giving persons support when they take action toward desired outcomes.

(4) Decision-making - helping people define their objectives, identify alternative means for achieving goals, and develop procedures for analyzing risks and predicting needed resources.

c. ***Behavior observation and Description Tools***

(1) In talking with an individual or a group, an impartial observer can be effective. He is neutral and objective and can help others focus on facts and information instead of getting entangled in bias.

(a) *Arguments often take place when people have different understandings and perceptions of the meaning of their own behavior as well as others.*

(b) *People cannot often perceive how they are coming across, or how they contribute to a problem. "Can't see the forest through the trees."*

(c) *Resource Development Tools - Identify resources and make them more available to people.*

(1) *In the long run, these tools may be the most useful ones to you as a helper.*

(2) *They consist of getting information to people, establishing sources of help for specific problems, and facilitating the uses of resources.*

2. ***Helping Strategies***

a. *Developing effective strategies requires imagination, sensitivity, and good perceptional abilities.*

b. *Know why you are using particular helping tools at a particular time.*

c. *What is your purpose?*

d. *Are you doing active listening as a means for aiding self-understanding, reducing anger, or establishing a relationship?*

e. *Strategies can enhance your helping efforts and make better use of your time.*

C. ***Achieving Outcomes*** *- Outcomes are desired changes in the life of the person being helped. They may vary in extreme.*

1. *There are four main outcomes to deal with.*

a. *Change in feeling states*

(1) *A feeling state is an emotional condition you experience for a period of time.*

(2) *It is more than a brief emotional reaction, and stronger or more specific than a mood.*

(3) *It may last for part of an hour, a day, or several days longer.*

(4) *It's usually associated with a given event or experience.*

(5) *Negative feeling states are psychologically uncomfortable, sometimes painful. Some negative feelings would include frustration, depression, anger, self-pity, resentment.*

(6) *The placement of feeling states on the positive-negative and intensity continues determine their debilitating effect.*

(7) *Sometimes reducing the intensity of the feeling may eliminate its debilitating effect.*

(8) *When we have negative feeling states, usually someone has violated our values or ignored our underlying assumptions. We cause our own feelings.*

(9) *The source over which one has the most control is oneself. It is usually more productive to focus on our own behavior than on others.*

(10) *Clarifying underlying values and assumption often works toward changing negative feeling states. After the clarification process, people can often turn from preoccupation with negative feelings to action aimed at dealing with circumstances to which they object.*

(11) *Often feelings may be changed to neutral or positive feeling states without doing anything at all about the precipitating events or circumstances.*

Lack of understanding seems to be about three subjects.

(1) ***Self***

(a) Self-understanding is an ongoing challenge because we constantly change throughout the life span.

(2) ***Others***

(a) Understanding significant others involves knowing their interests and values and their perceptions of us. This can be difficult because people tend not to be frank about how they feel about each other. They sometimes confuse being open with being obnoxious.

(3) ***Circumstances***

(a) *Understanding of environmental circumstances is for instance, knowing laws, policies, and "how-to" information. Lack of understanding can be caused by incomplete information, inaccurate information, and misperception.*

(4) *Increased understanding does not always require the helper to provide new information. Sometimes the individual can be helped to recognize his perception of what is already known.*

C. ***Decisions*** *- a major source of unhappiness for many people is their inability to make decisions.*

(1) *Part of the difficulty in making decisions is lack of decision-making skills.*

(2) *Deciding - A five step decision-making model.*

(a) ***Defining:*** *What is my specific problem or concern? Use your listening skills to help the person define their problem and situation, and what they want to happen? Is it realistic?*

(b) ***Investigating:*** *What are alternatives and consequences of each? In every decision there are many alternatives. Peer helpers can assist in highlighting choices and shedding light on alternative choices. Peer Support can be helpful in identifying the consequences, both positive and negative, for each alternative.*

(c) ***Choosing:*** *Which of the alternatives should I choose? Exploring and clarifying one's values is an integral part of making a thoughtful and personally rewarding decision. The impact of each alternative on others, other consequences, and follow-through on one's choice are important to discuss. Realistically means the ability to "carry it off". More information may have to be gathered. Peer support personnel can help others identify what information is needed and where they can get it.*

(d) ***Acting:*** *When and how will I act upon my choice? Procrastination is a self-defeating behavior that plagues most of us. Even after a decision has been made, special attention must be given to implement the decision. A plan of action can be discussed that outlines various steps which will move a person toward a goal.*

(e) ***Evaluating:*** *How will I know I made the right choice? One's personal values system will influence the evaluation procedures and the interpretation of results. Ask the question, "How am I feeling about what has happened?" If the internal feedback received is compatible with the value system, positive feelings should result.*

(3) *The desire or need to make a decision is often associated with both a negative feeling state and lack of understanding.*

(d) ***Implementing Decisions*** *- the most carefully thought out decision is usually little more than an exercise in futility if satisfactory action does not follow. It is often difficult to separate a decision from the action necessary to implement it. Often when we decide not to pursue a course of action it is because of our prediction we cannot perform the tasks involved. It is often easier for people to decide upon goals than to find ways to pursue them.*

II. ***Problem ownership*** *- You, as helper, do not take over the client's responsibilities. Each person is responsible for their own actions. One moves into the helping relationship with the clear intention of moving out as soon as appropriate. It is often important to clarify "problem ownership" with the person being helped. Make it clear you are not inviting a partnership arrangement.*

A helper is a resource and the people being helped may need to be reminded that the problems are theirs. No one can solve our problems for us, we need the increased freedom associated with directing our own lives. Do not fall into the trap of worrying about another's problem because you begin to assume part ownership of it. Worrying is non-productive and foolish.

III. ***The change or outcome*** *is not the only result of helping skills (e.g., active listening), but certain attitudes that facilitate the helping/communication process.*

A. ***The Facilitative Conditions.***

1. ***Caring commitments*** *- Demonstrate some degree of caring for the person. Working with someone requires you shift the focus away from your own needs and interests to those whom you are helping.*

2. ***Accepting*** *- Recognize that others have a right to their feelings, although you may not approve of their behaviors. Accepting others assumes that they are doing the best they can to get along in their lives and to satisfy their basic needs. If they could do better, they would. Remember, however, that accepting others is not the same as approving of people's actions or agreeing with them. Moreover, it does not mean that you are encouraging them to continue their personal worth and dignity as a person. Conveying acceptance tells the person that both what he/she has to say is important and worthy of another's attention. It also acknowledges your willingness to listen and encourages the speaker to continue.*

3. ***Understanding*** *- Understanding is not only grasping what a person is talking about; but, also sensing what the person is feeling and experiencing. While you are trying to understand another, avoid labeling, judging, and evaluating. You are too busy "being with the person." You are trying to see things from the other person's point of view. Empathy, understanding a person's world from their point of view, is another word for understanding.*

4. ***Trusting openness*** *- As people experience caring, acceptance, and understanding, they gain a sense of security and confidence. They can take more risks, explore more ideas without fear of being judged or devalued. An openness is fostered that invites self-disclosure. Respecting confidentiality and the trust of the person is crucial.*

5. ***Respecting*** - *People who are respectful of others give them common courtesies, including the right to express their own decisions, to solve their own problems, and to shape their own lives. When people feel respected, they are more likely to share their feelings and talk more openly about matters. They know that their contributions will be acknowledged and that they will not be "put down" for their efforts.*

GRIEF/BEREAVEMENT

JOURNALING DIRECTIONS

Acquire a notebook of your choice. Divide it into the following sections:

Now

Losses in Childhood

Losses in Adolescence

Losses in Adulthood

Hurting

Healing

Beyond Now

Under the above headings do the following:

Now - Record your feelings evoked by the Grief Recovery sessions each week after you get home. Each day make an entry about your feelings.

Losses in Childhood - Record how you felt when you suffered loss as a child and how you feel now about those losses. What made it easy? What made it difficult?

Losses in Adolescence - Same as above except for the age.

Losses in Adulthood - Same as above except for the age.

Hurting - Record the present hurts and compare them to earlier times.

Healing - Record your resources and healings after past losses. Record healing you experienced in this time of the Grief Recovery program. Record your growth.

Beyond Now - Record your musings about the future. Write about plans for bringing meaning back into life again.

(Your journal is private. You are the only one who needs to see

GOALS FOR GRIEF RECOVERY

Goal #1 - Believe that it really happened.

Goal #2 - Be willing to experience the pain.

Goal #3 - Adjust to familiar environments associated with the person you lost.

Goal #4 - Say good-bye to the relationship that you once had with the person, but that can now no longer exist.

Activities to Help You Achieve the Goals

1. ***Think.***

   Take a memory trip through the house or other areas that remind you of the lost person. Relive many experiences in your mind. Think the thoughts fully when they come. Refuse to accept the advice of people who tell you to stop thinking about it. The time will come when this will happen naturally.

2. ***Write.***

   Keep a journal. Write about your feelings. Don't expect too much of yourself--as in feeling that you "have" to do it every single day. Write as often as you can, as much as you can, and as honestly as you can. Your journal is only for your eyes.

3. ***Talk.***

   Details should be told over and over, but you need to express feelings. Talk about the immediate loss. Move back through your total relationship with the person. Express the deep feelings.

4. ***Weep.***

   Don't hold back the tears. It is therapeutic to cry. It is much better to allow the tears to dry slowly from within, than to try to suppress them artificially from without.

COPING WITH ACUTE GRIEF: WHAT TO EXPECT

Grief is your response to a great loss in your life. When persons close to you die, you not only lose them, you also lose all the things they offered you in return. You lose the objects of your affection, your love returns to you like a "dead letter:, with no forwarding address. Grief is the feeling that comes in response to the experience of amputation, whether it be physical or emotional. It is your reaction to having part of your life cut off from you. Whether you lose an arm or a close member of your family, the grief is similar. Both are parts of you, and you mourn your loss with great sorrow and distress. Most grief is anticipated. Family members know in advance that death is coming and begin their mourning before the actual moment of death. But acute grief, sudden grief, is like a fist slamming into your chest. It is unannounced. You are unprepared for the blow, and you are left battered and shaken in the aftermath.

Acute sudden grief hurts deeply. The pain will last a long time. You can't escape from it, but you can help it run its course. You must be willing to face the pain head on, accepting the full force of it. Only by working through it and sharing it with others will you be able to finally let it go. That may be a couple of years down the road if all goes well. During his time, you must be careful not to get "stuck" in your grieving by freezing the process at one particular spot.

Getting stuck in grief is like trying to drive in a winter ice storm. You know where you want to go, you know how to get there, but you find yourself miles away from your destination, hopelessly spinning your wheels in one place. You find yourself frozen solid in an emotion from which you can't get free. You are the one who sets the pace and limits of your grief. You can shorten or lengthen it, depending on your willingness to work through it.

I want to help you realize and see what you can expect in the weeks and months ahead for yourself. These different grief phases or stages do not occur automatically. Not every person will move directly from one to another. Your own phases of grief may not all occur in this order. However, almost everyone will experience these particular emotions sometime during the grieving process. The phases overlap and will even recur at later times. Take a good look at them now and begin to get ready to face them.

SHOCK

While you are reading this, you are probably in your shock stage, during the acute grief. During this time you felt numb and cold and as if you were far away from the other people and out of touch with reality. Your mind was in shock, just as your body would be if you suffered a serious physical injury. In this stage, your mind anesthetized you against the tremendous blow that hit you. You may have felt as if you were in a dream, helpless to change the events happening around you. You probably repeated over and over again that you just couldn't believe it. Physical symptoms are common in this stage of shock. Survivors complain of tightness in the throat, upset stomach, diarrhea, shortness of breath and general feeling of slowness in moving around. In these first few days of acute grief, you begin to ask yourself the questions that plaque survivors. "Why did this happen?", "What did I do to cause this?", "Was it my fault?" If you were a "stranger to death", you may have refused to believe that the death was caused by an accident. Even in the face of overwhelming evidence to the contrary, many survivors deny the fact that an accident took place. It is one way of holding at arm's length the specter of pain and suffering coming your way.

CATHARSIS

A Greek word meaning "purging" or "purification", catharsis follows shock in most grief experiences. In this phase the numbness begins to wear off and you realize the great loss that has occurred in your life. This emotional flood feels uncontrollable. You feel swept away by overpowering emotions. These feelings tend to peak at the funeral, and they will usually be quite strong for another week or two. You might well be reading this during your period of catharsis. Here is some of what you can expect during this phase of grief. When one emotion is let loose, others will soon follow. You will feel floods of fear, denial, guilt, anger, relief and depression, all at once. An emotional mob scene. This is normal. Most survivors are more "emotional" than those experiencing normal grief. What may seem abnormal, or "hysterical" to you is actually quite natural for people in your situation. Remember, you need to let these feelings come out. If you don't let them out, they will come out some other time, some other way. That you can count on. You won't suffer nearly as much from "getting to upset" as you will from "being brave" and keeping your honest emotions all locked up have to deal with two crucial questions. One, whether to admit that the death was an accident and whom to tell about it. How you answer these questions can determine the course of your latter mourning. By this time the work will be out and your decisions can help or hinder your "grief work" in the days ahead.

Let me add one further word. None of your emotions are forbidden. If you feel something, express it. I agree with Elizabeth Kubler-Ross' suggestion that you find a "screaming room" where you can "let your hair down" and "come unglued". Coming unglued can be healthy and honestly good for you, especially if the "glue" was a mixture of repression and denial. I recommend that you share your "ungluedness" with supportive loved ones as often as you feel the need.

DEPRESSION

Catharsis is a gut-wrenching experience. It will drain you until fatigue and sleep take over. When you have gotten it all out, and cried your eyes dry, depression comes with the realization that this thing really did happen, that your loved one is really dead. Others who have survived, who understand what you are going through, say that this depressed feeling will last for about six months.

Every person has a different experiences with depression. Some withdraw and isolate themselves and get stuck there for months or years. They feel that the death has ruled out any hope of something better for them. It may happen that you will even contemplate dying yourself during this time. Many do, especially after the third month or so, when they hit rock bottom. I urge you to get help if you start feeling that way. You are not losing your mind, you are reacting to the blow of a terrible emotional injury, and you can be helped.

A major concern during this depressed period will be your health. Don't be surprised if you don't feel well physically during this time. Other survivors report hundreds of physical symptoms that appeared in the weeks and months following death. These begin during the stage of shock with complains like those about which you read above. Survivors complain about things like nervousness and fatigue, general tiredness, breaking out in rashes and hives distorted vision, upset stomachs and spastic colons. Even the symptoms of asthma and rheumatoid arthritis appear in the after shock of the death. Women report menstrual difficulty as common among their physical problems. In fact, well over half of the female survivors in one study said that they were sick more often after the death than before.

Of course, you need to see your doctor if you begin to feel poorly. Acute grief can often give its warning signs through the symptoms of quite serious illnesses. Most likely, however, your physician will tell you that your symptoms are "psychosomatic" and will give you a prescription for your "nerves". You need to know what that means and whether such treatment is for you.

The word "psychosomatic" is not a medical put-down. The doctor doesn't mean that you are only imagining this illness. You are not a hypochondriac. A psychosomatic symptom is a physical problem brought on by an emotional reaction. It is real. You really feel the pain and distress, because it is really happening. Just as normal stress and strain may bring on a tension headache, or "butterflies" in an upset stomach, the heavy shock of the death can also result in more intense physical reactions.

Beware of simplistic medical treatment at this point. Most of us tend to be like sheep before a physician, especially when we are grief-stricken. Remember, M.D. stands for medical doctor, not minor deity. Drugs may certainly service a purpose in your situation but they won't cure your grief. In fact, they may complicate the healing process as much as they aid it. If the doctor gives you a "nerve pill", ask for which "nerve" it is intended. What you are getting is most likely a tranquilizer, like Valium, to sedate you and make you groggy.

I agree with those physicians and counselors who believe that grief is handled best when you are awake, not drugged into sleeplessness. Tranquilizers won't end the pain. They only mask it for a while. I urge you to resist "zoning" yourself out during this period. Grief work is done best when you are alert, not off on a medicated cloud.

GUILT

When the shock of the death first hits you, you begin to ask questions such as "What did I do to cause this?" "Could I have prevented it?" "Is this my fault?". Feelings of guilt are common in all grief, but they are compounded among accident survivors. A great majority of people who have grieved over accidental deaths indicate that their grief was complicated by massive guilt feelings and for some, the guilt never goes away. Either they let it rule their lives, or they allow it to diminish to the point where they can handle it. Guilt comes in many forms, wearing many different disguises. You start to relive all the angry words and harsh encounters you had with the deceased, drawing on how bad they were and how guilty you feel. You think about how much more you could have done for the deceased. If you had an argument shortly before the death, you blame yourself for directly causing the death. If you express anger over the death, you feel guilty for being angry at the dead person. Either way you look at it, you can lose. If you try hard enough, you can replay the fourth quarter, so that the loss is always on your shoulders.

PREOCCUPATION WITH THE LOSS

During the time of depression, you will find many of your waking moments to be dominated by thoughts of the death. This is a normal occurrence in grief. It appears in a variety of ways. Many of these emotional reactions are harmless and to be expected. Others are potentially destructive. All your alertness will be needed to avoid getting stuck in this phase of grief. I share with you here some facets of preoccupations on a road map for the way ahead.

DAYDREAMING

Fantasizing about the death is common and should not be of concern to you. You will find yourself pretending that it didn't happen, that you were able to prevent it, and that soon, everything will be back to normal. Another common fantasy is that the person is just away on a trip, soon to return safe and sound. Such daydreams are emotional breathers and they help you keep your balance when your feelings are getting overloaded. They will fade in time as long as you don't dwell on them and retreat into a dream world.

IDENTIFICATION

Survivors often unconsciously mimic the lost family member, adopting his mannerisms or tone of voice. This isn't particularly unusual. We usually pick up similar habits and peculiarities from many people who are close to us. However, it can be destructive if it turns into a rigid denial of the death. I happen to think that this can be a helpful way of keeping in touch with cherished memories as long as you don't overdo it and get stuck there. Think of it as a way to "incarnate" the things about the deceased that are precious to you.

BEREAVEMENT

You have probably already awakened in tears a couple of times as you relived the death, in your period of shock and catharsis. These dreams are quite normal. They will subside in time and should not alarm you. They will show you a lot about yourself, often allowing you to express feelings that you are unwilling to admit to yourself while awake. As Wayne Oasts points out, the bereavement dream helps you "renegotiate" your life on the emotional levels that exist beneath the surface.

SHRINE BUILDING

This drive toward creating a "museum to the deceased" is one way to insure a lifetime of grief. Visiting the grave every day may be helpful for a while, but it can soon become your method of refusing to let go. I know families who have had color photographs of the deceased imbedded in the granite grave stone. I have seem them place ornate benches at the grave for their daily visits. For many families, visiting the grave becomes an after church ritual each Sunday for years and years. One man reportedly visited his wife's grave every day until the day of his own death. In the meantime, he remarried and was subsequently divorced by his second wife, who wouldn't join him in his daily vigil.

Another method of shrine building is the preservation of a room in the house "just like it was when he died". Clothes are kept in the closet, furniture is never moved, the walls are lined with photographs and mementoes of the deceased. Dean Schuller tells of a couple who bought a new house soon after the death of their son. The mother insisted that a bedroom be set aside in the new house as a shrine to her child. This is "frozen" grief. It promises a lifetime of mourning for those who succumb to its nostalgic temptations.

Therapists make some helpful suggestions about this tendency. They suggest that you resist the compulsion to create a memorial shrine by 1) giving away the clothes of the deceased, and 2) re-arranging the furniture of the bedroom, and perhaps even the entire house. Donate the clothes to the Salvation Army or Goodwill Industries, not to a neighbor, close friend, or other family member. You don't need to see the clothes being worn by someone you know. Move the furniture so that it creates new traffic patterns in the house. This will help you combat the fantasies of "seeing" the deceased in familiar places in the home. They caution against throwing away your photographs and mementoes. You don't want to make a shrine of them, but you also don't want to repudiate the memories they represent. A good rule of thumb is to keep what you must have to live, give to friends or family what you treasure, but can't live with, and donate to charity what you can live without.

SELECTIVE MEMORY

You will have flashbacks of the deceased and the death from time to time. Even though your life will return to some degree of normalcy, something you may see, someone who resembles your family member, hear a favorite song, smell cologne or tobacco used by him/her, or see someone driving the same color and model car. When his happens you "flashback" into a kind of mini-grief that can last for several days. These feelings of overwhelming sadness may surprise you with their intensity. You will wonder where they were hidden. The answer lies in your memory. It is re-adjusting, and that takes time. An individual named Oates describes this phenomenon: "These periods of reflectiveness and heavy-heartedness tend to become less frequent with the passage of time and for a reason. Each person, place, thing, activity, event, item on the daily agenda of a person's life must eventually be associated with the present reality "My loved one is dead". These items are innumerable to begin with, but their number is gradually wilted down as day by day they are associated with new realities in one's present life. As this happens, habits of thought and behavior are being reconditioned. In other words, your mind and emotions are "retooling" for the remainder of your life ahead.

IDEALIZATION

No hard and fast deductions can be made about the Idolatry of the dead by other survivors. In many instances, people think of the deceased as some sort of God. They make this lost family member the center and focus of their entire lives. This is really a more entrenched form of denial. The family members decide to think only good thoughts about the deceased, and they make him a martyr in their sight.

Preoccupation, as you have seen, doesn't have to be destructive. As you recall, again and again, the stored-away memories of your loved one as you remember the death and your reaction to it, this repetition will help you work through your feelings of loss and sorrow. Gradually your "unfinished business" will be completed and your memory will heal as well.

ANGER

Although your feelings of rage may be tumultuous for you and those around you, they represent something positively healthy. Anger shows that you are coming out from the depths of depression. You can express your feelings again without fear. Getting that anger out should be one of your major goals in your process of "postvention".

It seems silly to discuss whether or not you have a right to be angry, and it is. That kind of question ignores the rage you feel inside. It ignores pent-up emotions that are labelled "right" or "wrong", "good" or "bad". Others like yourself report a great deal of anger in the months after the death. You many feel terribly guilty for those feelings, but you need to know that it's perfectly OK for your to express them. You do, indeed, have that right.

From what memories does all this anger come from after death? What causes the rage to boil over? Several factors come readily to mind. One, survivors feel rage toward the deceased for publicly rejecting them. Accidental death is a form or desertion, a way of saying "I abandoned you for all to see". Anger is the natural response to such treatment. When we are treated so unfairly, we usually do "get mad". Wives, husbands, mothers and fathers often find themselves furious after the death has left them to be full-time mourners with a life full of responsibilities. Two, many people respond to accidental death by shaking their fists at God, usually through a nearby minister, rabbi, or priest. Here the survivor is raging at God for singling him out for special punishment. He screams, "Why did you do this to me?" As though every minute action in the universe was directly ruled by some kind of deterministic deity. As I say at greater length, God is the only one prepared to handle all your anger at him. If you are "ticked off" at the Almighty, for his sake, tell him. Three, anger is directed toward others. It is easy to get into a "me against

the world" mentality after an accidental death. If you can find just one person on whom you can unload for what he "did" to your family member, you may not be able to resist giving him hell for his transgressions. What this amounts to is a convenient form of denial. If you can project your rage on everyone else, you may not have to aim it at the deceased, and you may be able to escape it yourself. Four, survivors get angry with themselves for what they did or didn't do to change the destructive course of events that led to the accidental death. But this is through self-destructive acts. This is one type of anger that you should obviously refrain from expressing physically. Cutting your wrists or drowning yourself won't solve anything, and may well demolish your already crippled family.

All your hostility needs to come out. Yelling and screaming is one way to ventilate it, tearing towels, punching pillows and chopping wood are also recommended. I even think that hauling of and "cussing a blue streak" is beneficial if it will help you through this difficult period of grief. Express your rage without feeling guilty. In other words, you can be angry with confidence. Burn your fire and put it out - smoldering coals are dangerous to everybody.

GAMES FAMILIES PLAY

Families play games together just as you and I do individually. One of these games is called the silent treatment. It is a kind of a "cold war" where most communication is cut off. Family members do to each other, they don't touch. Each grieves alone behind closed doors, they avoid each other's gaze, raising their eyes or staring down at the ground in passing. This can be the most devastating game of all. Such silence has at least five negative effects on the family. One: it keeps helpful grief work from happening within the whole group, two: it stifles catharsis, the outpouring of emotions in normal grief, three: it limits the opportunity for each member to check out his/her fears and fantasies with those of the other members, four: it allows misconceptions and wrong information to flourish, since one's own view of what happened is never tested, five: it lets guilt and anger rage on quietly with no hope for resolving the problems that are hurting each person.

Another game is "let's grieve forever". This games involves a perpetual state of mourning. I call it the "black arm band" reaction. The family members wear their grief as a badge for all to see and they do it without end. All this is seen as the only loving way to grieve over the deceased. Anything less would be evidence of selfishness and lack of devotion. Widows swear on their husbands' graves never to remarry. Daily trips are planned to the cemetery. Shrines are created in the deceased's bedroom. Laughter is outlawed. Pained expressions are required.

This extended mourning is primarily an attempt to alleviate guilt to make up for the shortcomings in life and death. Parents of young children have an especially hard time here. They continue to see their child as "needing Mommy and Daddy", and they feel guilty because they can't be of any help. Families often get stuck in this kind of internal grief to the extent that they are never able to bring it to a close in any respectable way. Life with them cannot go on without the deceased. Internal bereavement is their way of "freezing the action".

SURVIVING TOGETHER

The destructive games I have mentioned all have a common denominator, that is, most of the families who play these games have blocked off all effective communication among themselves. If they could all sit down together, just once, to cry, rage, and feel guilty together, they could build a foundation of support that might prevent the games from ever being played. Communication is the key to surviving together in the aftermath of an accidental death. It occurs in your family in two different forms. Verbal communication involves speaking and listening, not just speaking and hearing. Active listening on your part can make a difference in the way your family gets along in the months ahead. Here are some hints on how to make healthy verbal communication work for you and your loved ones:

1) *Be sensitive to how the others feel. Communication depends more on feelings than on facts, so resist the urge to prove your point at all costs. Your ego may feel better, but your family relationships may be seriously harmed.*

2) *Listen not only to what the other person is saying, but also to who they are. In other words, respond to your children in ways important to them, even though the desires seem insignificant to you.*

3) *Pay attention to your family members when you are with them. Save your daydreaming and fantasizing for some other time. Give your undivided attention to whom you are with.*

4) *Listen to what is being said. Remember, we often send two or three messages when we talk to each other. Be sure you hear what is being meant as well as what is being spoken.*

5) *Open your heart to the other person. Honesty has no substitutes. However, it does have a partner, known as acceptance. Be willing to accept what the other person honestly shares with you. That doesn't mean that you must agree with what that person says, it does require that you agree with who they are.*

6) *Let others be around you. Be careful not to so dominate things that others are left out. If you are a compulsive talker, or a pushy type, learn the value of sitting back and listening to what others are saying.*

Not all communication is verbal, as we have seen. Families who don't touch are also sending messages. Non-verbal communication is transmitted through the senses of sights, smell, and touch. When family members declare a cold war on closeness, communication is just as blocked as if they weren't speaking. Many of the things that your family needs to communicate cannot be put into words. How can you talk about a hug, for instance? Sometimes, comfortable silence is the answer to the deep hurts of a family. The difference between such a silence and the deep freeze or the silent treatment is dramatic, because here you are, able to communicate through touch, and "silent eyes". You can help cultivate this kind of communication in your family by doing it yourself. Try "saying" things without speaking, as a start.

ELIZABETH KUBLER-ROSS'S FIVE STAGES OF DYING

1. ***DENIAL*** *"No not me." This is a typical reaction when a patient learns that he or she is terminally ill. Denial, says Dr. Ross, is important and necessary. It helps cushion the impact of the patient's awareness that death is inevitable.*

2. ***RAGE AND ANGER*** *"Why me?" The patient resents the fact that others will remain healthy and alive while he or she must die. God is a special target for anger, since He is regarded as imposing, arbitrarily, the death sentence. To those who are shocked at her claim that such anger is not only permissible but inevitable, Dr. Ross replies succinctly, "God can take it".*

3. ***BARGAINING*** *"Yes me, but..." Patients accept the fact of death but strike bargains for more time. Mostly they bargain with God -- "even among people who never talked with God before. They promise to be good or to do something in exchange for another week or month or year of life. Notes Dr. Ross: "What they promise is totally irrelevant, because they don't keep their promises anyway."*

4. ***DEPRESSION*** *1. (Past losses) The person mourns past losses, things not done, wrongs committed. 2. (Future losses) Getting ready for the arrival of death. The patient grows quiet, doesn't want visitors. "When a dying patient doesn't want to see you anymore," says Dr. Ross, "this is a sign they have finished their unfinished business with you, and it is a blessing. He/she can now let go peacefully.*

5. ***ACCEPTANCE*** *"My time is very close now and it's all right." Dr. Ross describes this final stage as "not a happy stage, but neither is it unhappy. It's devoid of feelings but it's not resignation, it's really a victory."*

Some aspects of the experience of dying are:

1. *Fears of the unknown*
2. *Fears of loneliness*
3. *Fears of the loss of family and friends*
4. *Fears of the loss of body*
5. *Fears of the loss of identity*
6. *Fear of regression (dependency)*

Most of these, fear of the unknown, loneliness, family, friends, identity, and becoming dependent upon someone else can be applied to the fears most of us experience with any loss...such as the loss of a friendship, love, career, goal or dream, or any loss, or threat of loss, of any person, place or thing.

FEAR LONELINESS HELPLESSNESS ALONENESS

The tools you have as a Peer Supporter include:

1. ***ACTIVE LISTENING*** *(allow the caller to empty the bucket)*

2. ***ESTABLISH RAPPORT....CULTIVATE HOPE BY:***

    1. *Brainstorming - choices....*
        a) *Stay where you are and stay lonely*
        b) *Take the loneliness out of being alone, "What do you like to do when you have the place all to yourself?"*
        c) *Not stay alone...join a club or team, take a class in something, adopt a fish, bird, kitten, puppy, or pen pal.*

3. ***RECALL PAST SOLUTIONS,*** *help the caller to recall other times that they faced being alone, or taking the risk of doing something new...like the first day of school, the first date, the first time they had intercourse, etc... We forget that during our growing up we faced and coped with many unknowns and took a variety of risks.*

The human mind can cope with various degrees of pain, physical or emotional. Each individual has specific threshold and capacity. The unknown, is the most difficult for most of us...we exhibit this in many ways. For example we conjure up labels for people or things that we are unfamiliar with. Some use superstitious gestures or statements. Aloneness is frightening, scary, and overwhelming. To experience any kind of death, death of a career, relationship, or other kind of loss, one experiences both aloneness and facing the unknown. Actually life itself is full of "little deaths" and little "births". Where an individual feels some amount of control over their life coping with the "little deaths" are manageable...when an individual feels powerless...impossible. Example: someone bigger than you holds you down and tickles you...what are your feelings? ANGER

1. *The first death I can remember was the death of:*

2. *I was age:*

3. *The feelings I remember I had at the time were:*

4. *The first funeral (wake or other ritual service) I ever attended was for:*

5. *I was age:*

6. *The thing I most remember about that experience is:*

7. *My most recent loss by death was (person, time, circumstances):*

8. *I coped with this loss by:*

9. *The most difficult death for me was the death of:*

10. *It was difficult because:*

11. *Of the important people in my life who are now living, the most difficult death for me would be the death of:*

12. *It would be the most difficult because:*

13. *My primary style of coping with loss is:*

14. *I know my own grief is resolved when:*

15. *It is appropriate for me to share my own experiences of grief with a client when:*

WRITING AS THERAPY - HANDOUT

1. *We all have the innate ability to heal ourselves. Realize that all you need to set yourself free is already within you. Writing can serve as a particularly effective means of externalizing the internal.*

2. *Writing takes time. Explain to other family members your need to put thoughts on paper. Understand that the nature of grief is inherently selfish, and allow yourself the same indulgence that you allow others around you who are working through their own grief.*

3. *Learn to trust and follow the internal leads that are available to you. When you sit down to write, you will find yourself writing what you need to write, not necessarily what you expect to write.*

4. *Capture all random thoughts and fleeting memories with the first draft. The polishing can come later.*

5. *Realize how very important your experience is. Your writing will mirror the special qualities of the relationship that you share with yourself and with your child. Cherish the uniqueness of your words.*

6. *"Forgotten" memories become surprisingly available. The meditative state that results from heavy concentration allows some deeper level of our consciousness to come to the surface. Do not be surprised if you feel your child "writing through you."*

7. *When prose seems too complicated, try poetry. Poetry can condense thoughts and feelings into a manageable size when emotions and words are overwhelming you.*

8. *Read aloud from your written work. Reading aloud can often have a greater emotional impact, and, therefore, a greater cathartic effect, than silent reading.*

9. *Expect and welcome tears. Tears are a release that wash away the pain.*

10. *Consider sharing your writing with at least one other person whom you trust. Sharing our pain adds to the healing process and is a gift to one another.*

11. *Writing is a learned skill. The more frequently you write, the more easily you will be able to express yourself. The sense of accomplishment gained through writing can bolster a fragile ego when self esteem may already be at low ebb.*

12. *Expect miracles from your writing. Each written word opens doors. . . to the past and to the future, and to a heightened sense of peacefulness and emotional well-being.*

"WHY"

Why did he die? Why did he live?
Why did he care? Why did he give?

Why do we cry if it's all for the best?
Why wonder "why"? Why can't we rest?

They say there's a plan
Though we can't see it now

But till we can see it
We'll remember just - "how".

How he did what he did
in his own special way

How we shared in the good
and the bad of each day.

How no matter whatever
may come now to pass

The memories we hold in our hearts
...will last

For no matter the answers
to the questions of "why"

If he lives on in us...
then he <u>didn't</u> die.

He lived not in vain
But left his life's mark.

He lighted a candle
where once there was dark.

And thus is the Torch
rekindled through Time.

His light has been added
to yours and to mine.

Then let us continue
to carry it high

Trusting that someday...
we'll understand "why".

B. H. Conley

SUBSTANCE ABUSE

APPENDIX I

Below is a description of the different signs that may alert the Supervisor to alcoholism and other substance abuse. It is difficult, and inappropriate, to diagnose substance abuse on the basis of deteriorating work performance and the other signs described below. These signs can be due to stress, relationship problems, personal problems, as well as substance abuse. It is also important to keep in mind that some of the signs may be applicable for one person, but not another.

VISIBLE SIGNS OF ALCOHOLISM/SUBSTANCE ABUSE

ABUSE STARTS:

Work pattern inconsistent; sometimes pretty bad, sometimes outstanding (employee may be playing "catch-up" and show a good performance after a period of poor performance). But over time:

Productivity starts to become lower and lower.

More mistakes through inattention, forgetfulness, and poor judgement.

Increase in sick days, especially before and after days off.

Increase in coming to work late.

Beginning of memory blackouts.

Signs of marital and family discord.

AS CONTROL OVER DRINKING (OR OTHER SUBSTANCES) LESSENS:

Excessive use of mouthwash, mints, cough drops, or chewing gum to disguise alcohol on breath.

Deteriorating performance.

Increase in irritability, nervousness, and moodiness.

More aggressive, shorter temper.

Increased complaints and disciplinary action, (e.g., poor quality violator contacts).

Increasing marital and family problems.

Difficulties in peer relationships.

Avoidance of Supervisors and peers (fear of discovery).

Longer meal breaks.

May work a half-shift, not returning after lunch.

Behavior change - depressed and non-talkative before lunch, elated and outgoing after.

Increased memory blackouts.

Statements and behavior become more and more undependable; loss of peer credibility.

Unable to talk about problems, talks around them and avoids them.

Less neatness in dress and appearance (e.g., may violate uniform policy), personal hygiene deteriorates.

Increasing financial problems, creditors calling up.

Sick leave abuse.

Unreported absences.

More accidents on and off job; may have exaggerated medical complaints on the job (e.g. looking for disability).

Family and friends avoided.

Obvious signs of drinking (e.g., hangover; red, blurry, or glazed eyes; flushed face; shakes; slurred speech). May wear sunglasses inappropriately and use a lot of eye drops. Smell of alcohol on breath or clothes.

Has spouse or other family member "calling in sick" for him/her.

Increased defensiveness relative to work deficiencies, more elaborate alibis for poor performance. ("It's not my fault.")

AS ABUSE BECOMES CHRONIC AND TAKES OVER THE PERSON'S LIFE (RESPONSIBILITIES INTERFERE WITH MY DRINKING"):

Radical deterioration of family relationships.

Work has significantly deteriorated.

Unreasonable resentments/indefinable fears (paranoia).

More complaints and discipline.

Drinking on the job.

Physical and moral deterioration.

Unreliable judgement.

Avoidance of others, hides at work. May start associating with lower quality people.

Loss of willpower, onset of lengthy drunks.

Chronic fatigue.

Impaired thinking, memory loss, irrational and irresponsible behavior.

Unable to initiate action, extreme indecisiveness.

Unable to work/all alibis exhausted/"I don't care."

Excessive risks, unnecessary heroics (person may be suicidal and just not care anymore).

Abuse of other drugs.

Criminal activity.

APPENDIX II - SIGNS OF DRUG DEPENDENCY

1. *Growing Preoccupation.*

   A. *Anticipation of drug usage (e.g., keeping track of prescribed times for dosage).*

   B. *Growing number of physical complaints which would require more drugs to relieve them.*

   C. *Growing need during times of stress.*

2. *Growing Rigidity in Lifestyle.*

   A. *Has particular times during day for drug usage (e.g., cannot sleep without a pill).*

   B. *Cannot go anywhere without supply of medication.*

   C. *Resents attempts made by others to limit drug intake.*

3. *Growing Tolerance.*

   A. *Increasing dosage and/or number of different drugs.*

   B. *Ingenuity around obtaining the drug without others being aware (e.g., seeking out a variety of physicians or dentists without informing them about each other, attempting to get refillable prescriptions, use of several drug stores.)*

   C. *Using several drugs in combination of the synergistic effect (e.g., alcohol and barbiturate).*

   D. *Using the drug for longer than the original prescription called for.*

   E. *Protecting the supply (e.g., purchasing more before current supply is exhausted, storing pill bottles at home, work, and car).*

4. *Loss of Control.*

   A. *Increasing blackouts and memory distortion.*

   B. *Larger and more frequent dosages than prescription calls for.*

   C. *Continuous dosages (e.g., red pill every three hours, blue pill every two hours, green capsule twice daily, etc...).*

   D. *Repeated harmful consequence resulting from drug usage (e.g., family problems, legal problems, loss of friendships because of antisocial behavior, work problems, increased physical problems.*

APPENDIX III - COCAINE AND OTHER STIMULANTS...MARIJUANA AND DEPRESSANTS

Cocaine is currently the "in" drug and used by virtually every aspect of society. Twenty million Americans use cocaine on a regular basis, at least monthly, with consumption figures at 110-130 metric tons. The percentage of correctional officers who engage in cocaine experimental or abuse is not known. We do know, however, that it is definitely a rising number.

Cocaine has two main seemingly contradictory effects. It is a central nervous system stimulant and it is a local anesthetic. Because of these qualities, it is called a "cure-all." Pains and discomfort are reduced and the effect on the central nervous system gives the person a feeling of well-being. Other symptoms of the drug are a sense of euphoria, self-satisfaction, and comfort of mind and body. The person high on cocaine perceives his capabilities as increased and self-confidence levels raise. Hyperactivity is a common symptom of early cocaine abuse. Cocaine is now known as a physically addictive drug and one can build a rapid tolerance to it. Over time, it takes more and more of the drug to achieve the above effects. Eventually, as with alcohol and other drugs, one needs the drug to feel normal.

Cocaine is also highly psychologically addictive. As the high wears off, the abuser feels restless, unable to concentrate, irritable, depressed, fatigued and lazy. When the depression becomes extreme, one may become suicidal. Prolonged cocaine use can lead to paranoia, depression, and irrational behavior. For correctional staff who become involved, cocaine use means contacts with felons, and compromise of public safety values, as well as breaking the law.

SIGNS OF COCAINE ABUSE

The deterioration of job performance is very similar to that of alcoholism. Although the signs described in APPENDIX I are applicable to cocaine, there are some specific effects of cocaine that can be detected by supervisory personnel.

As cocaine use begins, the supervisor may initially observe a boost in the employee's activity level and overall productivity. The employee may seem more enthusiastic, talkative, friendly, and excited due to the drug. However, the employee may take more risks due to over-confidence. With regular use, this increase in activity and mood should continue for approximately three to six months.

After this phase, however, the employee's energy and activity will be restricted to the first few hours of his/her shift and then drop off rapidly to substandard levels not normally associated with that individual. This drop in energy along with the onset of depression and irritability is due to the body's own systems once again taking control and compensating for the drug-induced effects.

Denial of abuse is very similar to alcoholism. Once again, however, there are some important differences. Cocaine artificially elevates and enhances perception of the employee's capabilities. Consequently, an employee will not be able to recognize mistakes or poor performance. The cocaine abuser becomes highly sensitive to criticism, whether real or perceived, tends to project blame, and deny feedback and direction that contradicts the artificially raised sense of self. This over-sensitivity to criticism that the chronic user experiences leads to a downward spiral of peer and Supervisor relationships, increased complaints, poor judgement, and irrational behavior.

Over time, the employee will perhaps experience financial problems to support the cocaine habit. The Supervisor may find creditors calling the office. The employee may also start liquidating assets to support the habit.

As drug use becomes more chronic, and tolerance builds up:

1. *The "high" periods become shorter and the "down" periods become longer.*
2. *Ever decreasing periods of energy and productivity, and longer periods of depression.*
3. *Increasing irritability.*
4. *Lethargy, and fatigue during the work day.*
5. *Severe mood swings become increasingly noticeable.*
6. *Peer relationships and work performance deteriorate.*
7. *Increasing family problems.*
8. *Increasing financial problems.*
9. *Hypersensitivity.*
10. *Dilated pupils and increased sensitivity to light, inappropriate wearing of sunglasses.*
11. *Chronic nasal discharge.*
12. *A flushed appearance.*
13. *Hyperactive, unable to sit still, nervous fidgety movements.*

MARIJUANA

Marijuana, a depressant drug, is widely used in the United States. It is not known how many correctional officers abuse it. Marijuana is not classified as physically addictive, although it is psychologically addictive. The use of the drug is difficult to detect in the casual user. With the chronic abuser, the Supervisor will observe lethargy, little motivation, low drive, and a slower pace of work.

Signs of being "stoned" on marijuana are:

1. *Impaired perception and divided attention.*
2. *Impaired coordination and balance.*
3. *Odor of burnt marijuana, red eyes, marijuana debris in mouth.*
4. *Thick, slurred speech.*
5. *Relaxed inhibitions.*
6. *Euphoria.*
7. *Disorientation.*

BARBITURATES

Barbiturate addiction is very similar to alcoholism. However, barbiturates have a faster onset of physical addiction than alcohol. Hence, the deterioration in work performance and personal relationships takes place in a matter of weeks, as opposed to years with alcoholism.

Signs of depressants are:

1. *Drunken behavior with no odor of alcohol.*
2. *Slurred speech.*
3. *Impaired coordination and balance.*
4. *Impaired divided attention.*
5. *Disorientation.*

SYMPTOMS OF CHEMICAL DEPENDENCY
ALCOHOLISM

I. *Signs of alcoholism*

A. *Growing preoccupation*

1. *Anticipation*
   a. *During daytime activities*
   b. *Vacation times (fishing trips become drinking binges)*
   c. *Growing involvement in drinking activities (bar bills, receipts)*
2. *Growing need during times of stress*
   a. *On job*
   b. *Family and marriage problems*
   c. *Emergencies*

B. *Growing rigidity in life-style*

1 *Particular time for drinking during the day*
2. *Self-imposed rules beginning to change (Saturday lunch)*
3. *Will not tolerate interference during drinking times*
4. *Limits "social" activities to those which involve drinking*

C. *Growing tolerance*

1. *"Wooden Leg" syndrome (ability to hold liquor without showing it)*
2. *Ingenuity around obtaining the chemical without others being aware*
   a. *Gulping drinks*
   b. *Ordering "stiffer" drinks (doubles, martinis, etc...)*
   c. *Self-appointed bartender at social gatherings*
   d. *Sneaking drinks*
   e. *Drinking prior to social engagements*
   f. *Purchasing liquor in greater quantities (cases instead of six-packs)*
   g. *Protecting supply*
      (1) *Purchasing more well before current supply is exhausted*
      (2) *Hidden bottles (at home, car, on the job)*

D. *Loss of Control*

1. *Increasing blackouts*
2. *Drinking a larger quantity than planned*
3. *Binge drinking*
4. *Morning drinking*
5. *Repeated harmful consequences resulting from chemical use*

a. Family
   (1) Broken promises involving "cutting down"
   (2) Drinking during family rituals (Christmas, birthdays)
   (3) Sacrificing other family financial needs for chemicals
   (4) Fights (physical) or arguments about drug usage
   (5) Threats of divorce
b. Legal
   (1) Traffic violations (D.W.I., etc...)
   (2) Drunk and disorderly
   (3) Lawsuits caused by alcohol-impaired judgement
   (4) Divorce proceedings
c. Social
   (1) Loss of friendships because of antisocial behavior
   (2) Previous hobbies, interests and community activities neglected as a result of increased chemical use
d. Occupational
   (1) Absenteeism (hangovers)
   (2) Lost promotions due to poor performance
   (3) Threats of termination
   (4) Loss of job
e. Physical
   (1) Numerous hospitalizations
   (2) Medical advice to cut down
   (3) Using alcohol as medication
      (a) To get to sleep
      (b) To relieve stress
f. Growing defensiveness
   (1) Vague and evasive answers
   (2) Inappropriate affect around consequences of drug usage
   (3) Frequent attempts at switching to other areas of concern

II. Signs of Drug Dependency

A. Growing preoccupation

1. Anticipation of drug usage
   a. Keeping track of prescribed times for dosage
   b. Growing number of physical complaints which would require more drugs to relieve them
2. Growing need during times of stress
   a. Begins to attempt to prevent stress ("It's going to be a rough day so I'll take a couple just in case.")
   b. Minor family and marriage problems
   c. Emergency situations

B. *Growing rigidity in life-style*

1. *Has particular times during day for drug usage, e.g., can't sleep unless he/she takes a sleeping pill*
2. *Cannot go anywhere without supply of medication*
3. *Will resent attempts made by others to limit drug intake*

C. *Growing tolerance*

1. *Increasing dosage and/or different medications (drugs)*
2. *Ingenuity around obtaining the drug without others being aware*
   a. *Seeking out a variety of physicians and dentists for prescriptions but not informing them about each other.*
   b. *Attempting to get refillable prescriptions*
   c. *Use of several drug stores*
   d. *Using several drugs in combination for the synergistic effect, e.g., a barbiturate and alcoholic drink*
   e. *Using the drug for longer than the original prescription called for*
   f. *Protecting the supply*
      (1) *Purchasing more before current supply is exhausted*
      (2) *Storing pill bottles at home (suitcases), car, at work*

D. *Loss of control*

1. *Increasing blackouts and memory distortion*
2. *Larger and more frequent dosages than prescription calls for using another person's prescription*
3. *Continuous dosages, e.g., red pill every three hours, white pill every two hours, green capsule twice daily, etc...*
4. *Repeated harmful consequences resulting from drug usage*
   a. *Family*
      (1) *Frequent blackouts which lead to many "broken commitments"*
      (2) *Inappropriate behavior during family rituals (Christmas, birthdays)*
      (3) *Sacrificing other family needs for doctor appointments and prescriptions*
      (4) *Changing family duties due to physical incapacity (increased time in bed, lack of motivation and drive)*
      (5) *Drug induced mood changes create uncertainty and suspicion in family members*

b. *Legal*
   (1) *Buying and/or selling illegal drugs*
   (2) *Buying from illegal sources*
   (3) *Traffic violations*
   (4) *Disorderly conduct violations*
   (5) *Lawsuits caused by chemically impaired judgment*
   (6) *Divorce proceedings*

c. *Social*
   (1) *Loss of friendships because of past antisocial behavior*
   (2) *Previous hobbies, interests and community*

d. *Occupational*
   (1) *Absenteeism*
   (2) *Lost promotions due to poor performance*
   (3) *Demotions due to impaired and inappropriate behavior*
   (4) *Loss of job*

e. *Physical*
   (1) *Numerous hospitalizations*
   (2) *Increasing number of physical complaints*
   (3) *Physical deterioration due to chemical use*

f. *Growing defensiveness*
   (1) *Vague and evasive answers*
   (2) *Inappropriate affect around consequences of drug usage*
   (3) *Frequent attempts at switching to other areas of concern*

PHENCYCLIDINE

EYES:

Horizontal and vertical nystagmus
Nystagmus with strong bounce (up to 11 hours)
Pupil size near normal
Lack of convergence (Stribimus)
Droopy eyelids (Ptosis)

VITAL SIGNS:

Elevated Blood Pressure
Increased pulse rate (more than 100 BPM)
Elevated temperature

OTHER EFFECTS:

Blank stare
Cyclic behavior
Repetitive and difficulty in speech patterns
Muscle rigidity of extremities (Progression to upper limbs at elevated doses)
Incomplete verbal responses
Non-communicative or non-responsive
Thick, slurred or slurred
Disorientation as to depth, time and environment
Hear colors/see sounds (Synesthesia)
Confusion
Agitated/aggressive behavior (Cyclic)
Impaired/divided attention
Moon walking (Gait ataxia)
Failure to follow directions
Perspiring (Possible toxic level)
Increase in pain threshold

OVERDOSE:

Possible death

DURATION:

Onset 1-5 minutes 1/2 Life - 11 hours
Peak 15-30 minutes
Loaded 4-6 hours
Normal 24-48 hours

ADMINISTRATION:

Smoked, snorted, injected, orally

NOTES: *Citric acid (used for possible overdoses)*
****Analogue - Ketamine Hydracoride***

HALLUCINOGENS

EYES:

No nystagmus
No strabismus
Pupil size dilated (more than 6.5mm Mydriasis)

VITAL SIGNS:

Elevated blood pressure
Increased pulse rate (more than 100 BPM)
Elevated body temperature

OTHER EFFECTS:

Dazed appearance
Visual hallucinations
Sweating
Memory loss
Impaired time and depth perception (disorientation)
Impaired divided attention
Change in perception of self (Hypersensitivity)
Nausea
Difficulty with speech
Dizziness
Fine tremors in fingers and hands
Blurred vision
Headaches
See sounds-hear colors (Synesthesia)
Moon walking (Gait ataxia)
Tearing
Decreased muscular coordination
Muscle twitching
Flashbacks
Facial flushing
Mood changes (Mescaline)
Paranoia (LSD)
Goose flesh - LSD (Piloerection)
Impaired hearing

OVERDOSE:

Longer more intensive trips
Psychosis
Seizures
Possible death

DURATION:

Variable - to 12 hours

NOTE: *There are thousands of hallucinogens, so there may be different patterns.*

**Elevated body temperature - symptoms of overdose*

MARIJUANA

EYES:

No nystagmus
Strabismus (Lack of convergence)
Marked reddening of the conjunctive
Eye lid tremors
Possible dilated or near normal
*Rebound dilation**

VITAL SIGNS:

Elevated blood pressure (systolic)
Elevated pulse rate
Near normal body temperature

OTHER SIGNS:

Moon walking (Gait ataxia)
Impaired perception and divided attention
Impaired coordination and balance
Odor of burnt marijuana
Marijuana debris in mouth
Thick slurred speech
Relaxed inhibitions
Euphoria
Disorientation
Muscular tremors
Transient muscular rigidity

DURATION:

Onset 8-9 seconds
Peak 10-30 minutes
Loaded 2-3 hours
Normal 3-6 hours

No laboratory data to support symptom

INHALANTS

EYES:	*Horizontal and vertical nystagmus* *Strabismus* *Pupil size near normal* *Bloodshot, watery and inflamed*
VITAL SIGNS:	*Elevated blood pressure* *Increased pulse rate (more than 90 BPM)* *Elevated body temperature (Possible)* *Hypertension*
OTHER EFFECTS:	*Odor of substance on breath* *Thick, slurred speech* *Moon walking (Gait ataxia)* *Disoriented or confused* *Impaired/divided attention* *Impaired coordination and balance* *No muscle rigidity*
OVERDOSE:	*Coma*
DURATION:	*6-8 hours*

CNS DEPRESSANT

EYES:
*Horizontal nystagmus and strabismus**
Impaired smooth pursuit
*Pupil size near normal***
Slow pupillary reaction

VITAL SIGNS:
Lowered blood pressure
Decreased pulse rate (less than 60 BPM with elevated doses)
*Near normal body temperature***

OTHER EFFECTS:
Drunken behavior with no odor of alcohol
Thick slurred speech
Moon walking (Gait ataxia)
Impaired coordination and balance
Impaired divided attention
Disorientation
Knee tremor (Methaqualone)

OVERDOSE:
Shallow respiration, weak rapid pulse, cold, clammy skin
Dilated pupils
Coma

DURATION:
Barbiturates - 1-16 hours
Methaqualone - 4-8 hours
Tranquilizers - 4-8 hours
Chloral hydrate

**Possible nystagmus with regular doses of Benzodiazepin (Valium). With tranquilizers generally, no nystagmus at therapeutic doses.*

***Methaqualone - dilated pupils more than 6.5 millimeters and elevated body temperature.*

CNS STIMULANTS

EYES:

No nystagmus
No strabismus
Pupil size dilated - Mydriasis (More than 6.5 mm)

VITAL SIGNS:

Elevated blood pressure
Increased pulse rate (More than 100 BPM)
Elevated body temperature (variable)*

OTHER EFFECTS:

Increased alertness
Talkative, rapid and rambling speech Anxiety
Loss of appetite
Euphoria (Pleasurable sensation)
Exaggerated reflexes - Speed (Hyperflexia)
Body and extremity tremors
Hypertension
Nasal redness (Cocaine)
Runny nose (Cocaine)
Dry mouth
Grinding teeth - Speed (Bruxism)
Insomnia
Time misrepresentation
Moon walking (Gait ataxia)
Excitation
Risk taking due to over confidence
Evidence of malnutrition (Chronic user)
Impaired divided attention (Extreme symptom)

OVERDOSE:

Elevated body temperature
Visual hallucinations
Agitated
Cardio-vascular collapse
Respiratory failure

DURATIONS:

Amphetamine (Oral)
Onset 30-40 minutes
Loaded 4-8 hours
30 mg. - normal dose
100-200 mg. under the influence
800 mg. possibly fatal

Cocaine (Snorted)
Onset 15-30 seconds
Peak 5-15 minutes
Normal 60-90 minutes
Rush 5-30 seconds

NARCOTIC/ANALGESICS

EYES:

No nystagmus or strabismus
Constricted pupils (Miosis - less than 2.9mm)
Droopy eyelids (Ptosis)
Hippus (Withdrawals)
Methadone (May not cause constricted pupils)
Demerol (Possible dilation)

VITAL SIGNS:

Lowered blood pressure
Decreased pulse rate (less than 60 BPM)
Lowered body temperature (variable)

OTHER EFFECTS:

Fresh puncture marks
Sedation - nodding
Flushed complexion
Drowsiness
Slow or slurred speech
Deepening of the voice (Pylorospasm)
Moon walking (Gait ataxia)
Euphoria (Pleasurable sensation)
Facial itching and scratching (Urticaria)
Dry mouth (Dehydration)
Constipation
Impaired/divided attention
Infrequent urination (Antidiuretic affect)
Poor motor coordination (New user)
Nausea (New user)

OVERDOSE:

Slow, shallow breathing
Weak rapid pulse
Convulsions
Coma

DURATION:

Heroin 4-6 hours
Methadone 12-24 hours
Codeine 3-4 hours
Normal doses
Emprine 30-60mg
Cough medicine 8mg
2.9mm pupil size 260mg

ENABLING BEHAVIOR

1. *Denying: "He's not an alcoholic," As a result:*

   a. *expecting the alcoholic to be rational*
   b. *expecting the alcoholic to control his/her drinking*
   c. *accepting blame.*

2. *Drinking with the alcoholic.*

3. *Justifying the drinking by agreeing with the rationalizations of the alcoholic, i.e., "Her job puts her under so much pressure."*

4. *Keeping feelings inside.*

5. *Avoiding problems - keeping the peace, believing lack of conflict makes a good marriage.*

6. *Minimizing: "It's not so bad." "Things will get better when..."*

7. *Protecting the image of the alcoholic and drug user from pain; myself from pain.*

8. *Avoiding by tranquilizing feelings with tranquilizers, food, or work.*

9. *Blaming, criticizing, lecturing.*

10. *Taking over responsibilities.*

11. *Feeling superior. Treating them like a child.*

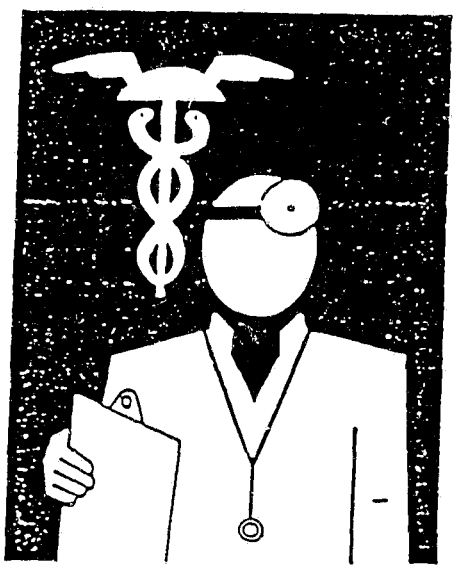
12. *Controlling: "Let's skip the office party this year."*

13. *Enduring: "This too shall pass."*

14. *Waiting: "God will take care of it."*

Alcohol and Drug Abuse — A National Health Problem

By Fern Asma, M.D.



Did you know alcoholism is a terminal illness — the third leading cause of death in the United States?

But long before health is destroyed, the alcoholic may be unable to hold a job, or have problems functioning as a professional. Memory loss and "blackouts" can cause serious problems, not to mention a decrease in judgment and a general mental slow down since alcohol depresses brain function. At this point, loss of income and possibly divorce are real possibilities.

Drug abuse is many things. It can be the heroin user injecting a bag of heroin, or a person high on speed, or the cocaine addict free-basing cocaine. However, it may also be the person starting the day with an amphetamine for a "get me up," pausing for a three-martini lunch, "unwinding" with a few drinks before dinner and ending the day with a barbiturate in order to sleep.

The misuse of drugs, both legal and illegal, is one of the most crucial social and medical issues of our time. *Taking a drug for any purpose other than treating a particular medical condition is considered drug abuse.*

The 1970's glaringly revealed to many of us that we were living in a drug-oriented society. Many took drugs to wake up, to keep awake, to go to sleep, to take away anxiety and for whatever.

We were a "turned on" country, from adults who were lawyers, physicians, stock brokers and corporate executives who used liquor, nicotine and prescription drugs, to the young people with their "pot," their psychedelics, their heroin and their bennies. It was the "in thing" to do — an instant source of gratification, of so-called happiness. To many, drugs were a means of solving or avoiding life's problems. However, using drugs, whether to find happiness, relieve anxiety, cure loneliness or escape boredom was a flirtation with death, a form of either acute or chronic suicide.

Today, we are apparently seeing somewhat less drug abuse. Some of this can no doubt be attributed to the constructive programs of wellness and physical fitness, and the extensive health education programs of corporations and the media.

However, drugs have been used since antiquity and abuse is an ongoing problem. Coffee, tea, liquor and tobacco are drugs, as are aspirin and Alka-Seltzer. Drugs can promote and help preserve good health when they are taken precisely as needed for a specific condition. But, they should be taken as directed and no more or less than is necessary to treat the condition.

No one is sure how many people are misusing drugs. We do know the figure is high. We know too that such misuse includes every educational, social, economic, religious, age and occupational group. Most authorities also agree that young people are becoming increasingly involved with drugs and at an earlier age. There are heavy concentrations of abusers living in the nation's large cities, but drug abuse can crop up anywhere. The crime factor linked to the drug habit costs the United States an estimated six billion dollars a year or more.

All drugs are harmful if used to excess. The drug abuser is a sick person in need of professional help. Alcohol-

ism as well as drug addiction fall in the same category as diabetes, that is, all three can be controlled but not cured.

Alcoholism is most likely the most prevalent disease and perhaps the most misunderstood one. Unfortunately, the symbol of alcoholism to most of us is the skid-row drunk. Our concepts of alcoholism are all too often influenced by this view and our actions in prevention, treatment and rehabilitation are geared to this completely false concept.

It is true that the exact number of alcoholics cannot be determined. It is equally true that excessive drinking is known to be fairly prevalent in the United States. A relatively large percentage of heavy drinkers are alcoholics or are on the road to becoming alcoholics. Most authorities agree that about 10 percent of any given population (which includes the legal profession) has the disease of alcoholism. In Illinois alone there are estimated to be well over 300,000 alcoholics.

The effect of alcohol does not stop with the alcoholic, but spreads to affect adversely the lives of at least four people, that is, family members, relatives and friends. The number can be considerably higher if co-workers and those affected by accidents and crime are included.

The toll taken by alcoholism is difficult to measure. Several studies show that serious understatement exists in reporting deaths due to alcoholism. This is presumably due to the social stigma involved — other causes of death are sometimes certified. In spite of this, it is quite clear that alcoholics are subject to a two and one-half to three times higher than average death rate.

This fact was born out in a survey of a well-run corporate rehabilitation program. Here a review of the workforce losses of those whose drinking was not controlled and were, therefore, placed on disability showed that one-third died within the first year. Another 50 percent managed to survive past the first year. However, of the 74 people in that part of the survey, not one was able to survive long enough to reach the third year.

The neglect of alcoholism as a public health problem appears to be nearing an end. Rehabilitation programs set up within corporations to help their employees with these problems have led the way. Hospitals followed when insurance coverage for treatment became available. Today, treatment facilities have several levels of care designed to meet the needs of each individual. They vary from specialty hospital care for the more seriously impaired alcoholic to more ambulatory but in-patient care in a free-standing facility. Out-patient facilities and family recovery programs have become a part of the initial treatment as well as of on-going treatment.

Today, many professional groups have programs to help with these problems. Impaired physicians' groups are available in every state. The clergy has had programs for many years. There is also a program for lawyers. They too are human beings and are vulnerable to these problems.

". . . it is quite clear that alcoholics are subject to a two and one-half to three times higher than average death rate."

Of special note is the contribution Alcoholics Anonymous has made to the treatment of this disease. Founded in 1935 by two alcoholics — a physician and a stock broker — it continues to grow. More contemporary alcoholics have found sobriety through the fellowship of Alcoholics Anonymous than through all other agencies combined. Although the secret of AA's success is difficult to analyze, it certainly combines understanding fellowship and on-going involvement with AA's Twelve Steps as the way to recovery. Their conspicuous success has also contributed greatly to a change in public attitude toward the compulsive drinker.

Alcoholism is a family illness. Helping spouses and children to understand the illness has benefited many of these people. The suffering, anger, confusion and, for some, the acting-out behavior while trying to cope with the problem drinker can be understood. Constructive solutions then can be found, as well as learning the "tough love" necessary to deal with the alcoholic. Al-Anon, Alateen and Family Anonymous are self-help groups available to give help to the family.

Other problems are frequently seen in conjunction with alcoholism and substance abuse. There are self-help groups available to meet these needs as well. These include Gamblers Anonymous, Cocaine Anonymous, Narcotics Anonymous, Drugs Anonymous, and even Over-eaters Anonymous, to mention a few.

There are some serious obstacles to the treatment of alcoholism. (1) Because of society's attitudes contributing to the stigma of this disease, many alcoholics are hidden and protected. The family feels powerless and is reluctant to disclose the problem for fear of shame, loss of income and even violence. (2) The main symptom of the illness is denial. The alcoholic denies the problem and, therefore, is not motivated to seek help on his or her own. (3) Many physicians, including psychiatrists, avoid taking alcoholics as patients. The denial of a problem, plus the lying and game playing, cause considerable difficulty and frustration in office treatment.

Not everyone who drinks is an alcoholic, or compulsive drinker, but some people get caught up in heavy social drinking, which can be just as devastating. More research regarding

ABOUT THE AUTHOR

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alcoholism and the effects of alcohol on the body physiology is being published. One of the outstanding contributions to the field was Dr. Charles Lieber's research on "The Metabolism of Alcoholism in the Liver."

Before starting his research, he selected a group of people who had perfectly normal liver tissue found on liver biopsy. This group agreed to drink 10 oz. of alcohol every day for 30 days. At the end of the 30 days, their livers were biopsied again. In every one, the tissue showed early fatty degeneration, i.e., the precursor of cirrhosis of the liver. Further study revealed the changes to be present even within 18 days. It seems prudent that anyone consistently drinking three drinks (i.e. martinis) every day should seriously consider discontinuing this habit. Should you find you cannot stop, an evaluation by an expert in alcoholism may be in order.

Currently, there is a trend toward jogging and other forms of physical fitness. However, this is only one facet of good health. For example, 2 oz. of absolute alcohol has direct toxic effects on the heart muscle. It is a poor idea to make the heart muscle sick and then exercise it strenuously. For those in an extensive physical fitness program, good judgment would warrant no alcohol, or only on infrequent occasions.

Excess in one area of our lives without balance in others can be damaging to our health. Alcohol and drug abuse are serious health problems that need to be faced by everyone.

The Family and Alcoholism

By RAY SIDDONS, M.A.

Although much has been written about alcoholism, relatively little has focused on the family. Recently this has begun to change, and treatment programs are finding more favorable results as family involvement is increased.

The first goal for the family is to assess the problem so they can decide what kind of help is needed. This means that a family first must know the basics about alcoholism.

Please get this information yourself. It may seem strange, but many families become so confused that the family member suspected of being alcoholic is relied upon for the facts about alcoholism. This rarely results in a family heading on a positive course.

Many years ago alcoholism was seen only as a psychiatric symptom, and treatment consisted of working on the underlying problems, figuring that alcoholism would disappear. Most professionals now working in the field take a different approach, seeing alcoholism as the primary problem.

The alcoholic has a disease, some unknown physiologic difference that results in an unpredictable and destructive drinking pattern.

Alcoholism can be diagnosed when any area of life functioning is negatively affected such as:

A) Physical: Problems here include anything from sleeping and eating disruptions to specific medical complaints.

B) Legal: Ranging from simple fines to driving under the influence to child abuse.

C) Spiritual: Decreased interest, or conflict over spiritual and religious issues.

D) Occupational: Any problem with job performance, not just losing a job, since most are working.

E) Psychological: When emotions and thinking are interfered with: examples include depression and anxiety.

F) Family: When use of alcohol is creating any conflict with family, including the areas listed above, as family are often the first to feel the impact. The problems above fit or apply not only to the alcoholic but to each family member.

This leads into the most crucial issue in the family—each member identifying their own individual problems and not just remaining fixed on the alcoholic.

In our treatment program, families must go beyond "being here for their alcoholic" to "being here for me". This attitude is so difficult, because families then become vulnerable to painful emotions, whereas if the focus remains elsewhere the problems are thrown onto the alcoholic.

Alcoholism is an equal opportunity employer—the entire family is hurt, and the entire family must participate fully for positive change to occur.

The family members and the alcoholic have strikingly similar characteristics. Alcoholism is a chronic, progressive, and potentially fatal disease.

Alcoholism is *chronic*, a lifelong issue the family must attend to. This does not have to be a burden, for as time goes by the investment becomes a joy. The problem comes when the family or the alcoholic "forgets" the importance of a recovery program, drifts back into the old patterns, and the destructiveness returns.

A recovery program includes the therapy, support groups, and actions that individuals must be involved in to stay on top of the situation. Think of it like a diet. It takes some extra effort to get down to the desired weight, and some monitoring to stay there. Forgetting just doesn't work—for dieters or recoving families.

This disease is also *potentially fatal*, and to the alcoholic this means premature disability or death. The death the family experiences frequently is a decline in intimacy and communication and, for some, separation or divorce.

Alcoholism is *progressive*, and goes through predictable stages. Progressive for the alcoholic means that any use of alcohol continues the downward spiral, and this is why complete sobriety is necessary. Progressive for the family means that problems will continue to worsen until help is sought.

Families initially go through a stage of denial that alcohol is creating problems. This denial or minimizing of problems continues unless intervention occurs and also comes up at various times even for families in treatment. Most families do not enter therapy during this first denial stage.

The next period involves recognizing that problems exist and trying control techniques to reduce the severity of the effects. Children often spend time away from home with friends or in activities to avoid the alcoholic. The spouse may encourage isolation from friends or avoid parties where liquor will be served.

These control attempts typically fail and the tenuous family becomes more conflicted. It seems like one disaster after another with little peace. This is frequently when the spouse or family seeks help.

The next period involves trying to regain some type of family stability. Members try to handle problems without the alcoholic; children adopt parental roles and the spouse increases responsibilities "as if" the alcoholic were not there. This stage results in families heading toward either a healthy resolution of the problem or maintenance of the unhealthy status quo.

A healthy resolution happens when the family is willing to risk confronting painful emotional issues in order to gain lasting comfort in the family. Unfortunately, some families have gone beyond the point of repair and separation occurs. Families use separation as a last resort, and although separation is a traumatic event, a family can rebound and grow in a healthy direction.

Most families will not need to separate if proper help is given. Much like a car that is sputtering, most families can undergo a "tune up" to repair the problems. Where problems are especially severe, a "major overhaul" may be necessary. But problems can be resolved if the family is willing to keep going for help and not stop before the job is done.

Resentment, often seen as angry outbursts directed at the alcoholic or within, is the most painful issue for families to work through. To do this, family members must look inside and deal with the hurt and sadness underlying the anger. If families don't deal with the hurt and sadness, the underlying anger persists and closeness is never regained.

The important question now becomes Where do families go for help? The most crucial factor is seeking help from someone who knows about alcoholism.

A combination of efforts is usually best. Support groups such as Al Anon are offered at no charge to those with an alcoholic family member or friend.

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THE WARNING SIGNS OF ALCOHOLISM

When does the social drinker become a problem drinker? Although it is impossible to draw a definitive line, experts agree that an important clue is when someone begins to lose control over his actions. For instance, the alcoholic may know that he is drinking too much--but be virtually unable to stop. The following quiz from the National Council on Alcoholism, Inc., will help you recognize if you are suffering from the disease.

		Yes	No
1.	*Do you occasionally drink heavily after a disappointment, a quarrel, or when the boss is difficult?*	_____	___
2.	*When you have trouble or feel under pressure, do you always drink more heavily?*	_____	___
3.	*Are you able to handle more liquor than you did when you were first drinking?*	_____	___
4.	*Did you ever wake up on the "morning after" and discover that you could not remember part of the evening before, even though your friends say you didn't "pass out"?*	_____	___
5.	*When drinking with other people, do you try to have a few extra drinks when others will not know it?*	_____	___
6.	*Are there certain occasions when you feel uncomfortable if alcohol is not available?*	_____	___
7.	*When you begin drinking, are you in more of a hurry to get the first drink than you used to?*	_____	___
8.	*Do you sometimes feel guilty about drinking?*	_____	___
9.	*Are you secretly irritated when your family or friends discuss your drinking?*	_____	___
10.	*Have you recently noticed an increase in the frequency of your memory "blackouts"?*	_____	___
11.	*Do you often find that you wish to continue after your friends say enough?*	_____	___
12.	*Do you usually have a reason for the occasions when you drink heavily?*	_____	___

The Warning Signs of Alcoholism	*Yes*	*No*
13. *When you are sober, do you often regret things you have done or said while drinking?*	_____	___
14. *Have you tried switching brands or following different plans for controlling your drinking?*	_____	___
15. *Have you often failed to keep the promises you made about cutting down on your drinking?*	_____	___
16. *Have you ever tried to control your drinking by making a change in jobs or moving?*	_____	___
17. *Do you try to avoid family or close friends while you are drinking?*	_____	___
18. *Are you having an increasing number of financial and work problems?*	_____	___
19. *Do more people seem to be treating you unfairly without good reason?*	_____	___
20. *Do you eat very little or irregularly when you are drinking?*	_____	___
21. *Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink?*	_____	___
22. *Have you recently noticed that you cannot drink as much as you once did?*	_____	___
23. *Do you sometimes stay drunk for several days at a time?*	_____	___
24. *Do you sometimes feel very depressed and wonder whether life is worth living?*	_____	___
25. *Sometimes after periods of drinking, do you see or hear things that aren't there?*	_____	___
26. *Do you get terribly frightened after you drink heavily?*	_____	___

If you have answered "yes" to any of the questions, you have some of the symptoms that may indicate alcoholism. "Yes" answers to several of the questions indicate the following stages of alcoholism: Questions 1-8: Early Stage. Questions 9-21: Middle Stage. Questions 22-26: The Beginning of Final Stage.

CROSS CULTURAL SUPPORT ISSUES

Cross Cultural Support Issues

1. *Know your biases and belief systems*

2. *Try to place yourself in person's position and view the problem through his/her eyes*

3. *Avoid judgements*

4. *Cultural expectations are different*

5. *If bias interferes, refer or deal with your issues*

6. *Consider what issues you wish not to handle*

The following was presented May 13, 1991, at the 1991 Concerns for Police Survivors Seminar, held at Washington, D.C.

THIS CRAZY THING CALLED GRIEF

James H. Shaw, Ph.D.
Police Psychologist

What a title! When Suzie asked me to give this presentation the title came with it. My first response was how do I make the presentation reflect the title, but as I was preparing, the title became more and more appropriate.

Death is the natural progression in life. There is a time to live and a time to die, however, for the people in this room, it was not the time for their loved ones to die. Felons and events took healthy, productive, officers who were doing their job, and cheated them out of the remainder of their and our lives. We grieve for our loss.

Grief has many definitions, some technical some simplistic. Grief is certainly not a disease or any thing abnormal. Technically it is the term usually used to describe the psychological and physiological reactions you are experiencing. simply, it is our response to the loss of the person we have loved. It can result from any separation that takes a loved one from us, such as a divorce, however, because death is final and irreversible, and because it permanently removes any hope of further reunion, the grief that follows this loss is usually most intense. When we speak of grief we also speak of bereavement which is the process or state of grieving.

There is not any "magic pill" to achieve a quick recovery. Grief is a long, agonizing process, but it does have an end. Experiencing the pain of grief at the appropriate point in time prevents the deeper pain of delayed grief. Thus, well meaning advice such as "you have the whole world to live for, put your mind on something else, or keep a stiff upper lip" if followed, actually can be harmful if it delays the grieving process.

Some people delay the grief process by denial, some lose themselves in work and have hectic schedules which consume them from dawn to midnight. They can lose themselves in attempting to provide everything for their children, which is also detrimental to the children. Denial is a defense mechanism where the obvious is ignored, reality is not so painful--I just won't think about it. An obvious example of denial is refusal to recognize that the person is really dead. Grieving is normal and natural, it should start shortly after death and it should last until the process is complete. The absence of grieving symptoms is a danger sign.

Not everyone responds the same to the death of a loved one. Bereaved people of all ages pass through a series of stages in coming to grips with the death of someone close to them. Who the grieving person is at the start of the process and their relationship to the deceased, influences what these stages will be like.

Some of the more common grief responses to the first stages of grief ar shock, denial, emotional numbness, intense crying or perhaps an inability to cry. Shock is a normal defense against the emotional devastation that can result from a sudden death. To protect us from overwhelming emotional pin, the body and mind shut down, and we function as if we were on "automatic pilot." By insulating us from the pain, shock helps us buy time in which to adjust to a new and terrible reality. As one leaves the "shock" phase, it is usually impossible to control the racing thoughts in your mind and you wonder if you are "going crazy." There are so many things to do, so much is going on. What about the responsibilities? Everywhere you look there are reminders of the loved one and you keep asking yourself is this a nightmare? I am really asleep, I will wake up from this dream soon and everything will be OK. Each member of the extended family is affected in a similar manner, but each has their won specific relationship and individual feelings of personal loss.

The parents loss is also profound. It is wrong for a child to die before its parents. It's hard enough to bury our parents, but we expect that, as our parents belong to our past, our children belong to our future. We do not visualize our future without them. How can I bury my son, my future, one of the next in line? He was meant to bury me. The mother has lost a child. The memory of all those years from the first moments of life, childhood, the specific events of the teen years, marriage, and then the child becomes a parent. Fathers see the dreams and hopes, that they put into their child, lack realization. Fathers often have other issues to deal with such as their role of protector. The dynamics of grief after a murder are not different from those we see in all parental grief, but in murder, the sense of powerlessness and rage is stronger.

The grief is often prolonged by the mechanics of the Criminal Justice System. it is a death that did not have to happen. It was a death that was directly caused by someone. Parents of murdered children experience an overwhelming anger and desire for revenge. The survivors often know of the killer and the anger has an immediate focus which transforms itself into feelings of revenge. The parents' power to protect their child has been challenged and they have a desire to reassert that power in some act of vengeance. The Criminal Justice System is charged with providing the justice the parent's seek, but often the system fails. The victim's family find they have no legal standing and the system is designed to protect the rights of the accused, whereas the survivors have few rights. The burden of proof rests with the prosecution and the parents have no power. Parents often feel strongly that a conviction and a harsh sentence are psychologically necessary and until the trial and appeals are completed the parents often are unable to begin to resolved their grief.

They also resent an insignificant time value, regarding the number of years of a sentence, being equated with their child's life and know long sentences generally mean only a few years served, but even an execution will not restore the life. The legal system appears to promise the satisfaction of revenge, but often does not make good on that promise.

In their grief, it is not unusual for friction to develop between the parents and spouse of the victim. It is ironic that family members who strongly love the same individual are in conflict rather than providing mutual support in their time of need.

Today and tomorrow Dr. John Allen and Deborah Gold will facilitate discussion groups and a workshop for surviving mothers and fathers entitled "Resolving Our Grief Together." John and Debby have considerable experience in this area, can be of assistance to you, and i urge your attendance.

Brothers and sisters of a deceased officer also have their specific grief agenda. They have lost their childhood playmate--they stuck together as children and now that sibling has suddenly been taken away. Resultant feelings of anger and revenge are common and often the siblings are required as the emotional support system for both the parents and the officer's spouse and children, which often affects their own grieving.

The co-worker of the fallen officer is often the forgotten member in the extended family grief process. They have a need to grieve and often have difficulty coping with their feelings. Officers typically have the belief they have to be strong emotionally, never show their feelings, and be the support for the others. In reality, co-workers, especially those present at the death of their friend, have considerable stress problems which if not resolved can result in the development of Post Traumatic Stress Disorder. Often there are feelings of guilt about the incident or even survivor guilt. Officers who always know the right thing to say become speechless and confused when they have to talk about the death of their comrade.

Recently, in our state, a mentally ill man was attacking a police officer with a knife. The officer was lying on his back on the street trying to fend off the knife with one hand while holding his handgun out of the way with his other hand. In the struggle, the weapon discharged and the slug struck his patrol partner who had come to assist him. The partner, who was close personal friend, was dead a the scene. The officer had to deal with both his feelings and the emotions elicited by the widow and young children. Fellow officers who had known both officers for years and had never lacked for words, would approach me and ask "what do I say or should I just say nothing?" The answer of course is to share your feelings, to let them know you care and that you will be there for them when they need you. Officers who are not properly debriefed and who do not fully grieve, go through life carrying an unnecessary burden of grief. This afternoon the will a breakout session for surviving co-workers and

tomorrow a session is scheduled for bringing together co-workers and surviving families. The co-workers should attend both of these sessions.

I have not forgotten about the spouse and the fact that a partnership has been forcibly dissolved. The souse has lost their marriage partner, their best friend, their accountant, mechanic, gardener, bed partner, confidant, etc. Most of you have worked through the shock, the denial, and are into resolving your depression and your anger. The emotional numbness has passed and you are more clearly seeing your responsibilities and making plans for the future. Friends and family have resumed their former commitments, others are not as attentive as they have been and it appears that for everyone else, life has returned to normal. At this point you start to feel loneliness, emptiness and more strongly miss intimacy. You may still have difficulty concentrating for even short periods of time without being overwhelmed by thoughts about your loss. You may not have developed many interests outside the home. you are being deluged with new responsibilities and question if you have the resources to cope. Vehicles need maintenance, the house has those switches and faucets which suddenly seem to need repair more often, and financial decisions need to be made. You still have the personal objects of your spouse around the home. Have the closets been cleaned out? Favorite chairs, cups, etc are obvious reminders, his magazines continue to arrive, and everywhere you turn you are reminded of your loss. There is that empty space at the dinner table, the empty "special" chair in the living room, and of course the empty bed. You find some comfort in sleeping with a special object and perhaps, wearing his bathrobe or slippers. These "treasures" give you comfort not only for what they meant to the owner, but they still have memories and familiar odors. As recovery progresses, the numbness and depression, which tended to protect you from reality are now gone and you began to feel a deep sense of loneliness and sorrow. Sometimes it is this stage before individuals can actually have a good cry. Feeling sorry for oneself is normal and a necessary part of grief.

It is time to deal with anger. In the initial stages of bereavement anger was present, but now it seems to take more of your time. Anger is a very normal emotion and it can be a healthy emotion if used correctly, as it can have a purging effect. Some survivors are surprised to find they have a feeling of anger toward their spouse. Commonly there is anger at the situation in which he left the family, the fact he put himself in the position to die, why didn't he better prepare for his death, etc. There is also anger at the agency, policy, administration, equipment, the ways I was treated and so on. However, anger can also be very self-destructive and in fact, stop the bereavement process. I have seen survivors at this seminar who have lost a loved one, four or five years ago, but they are not getting better because they cannot let go of the anger. Often the anger is inappropriate, misdirected and intense. It tends to drive others away and the survivor is left more alone, which fosters more anger and solidifies the belief that others do not care. Intense, long term anger destroys the individual, provides no therapeutic value, and in itself can be disabling. It is necessary to deal with the anger, put it behind you and get on with your life.

Now is the time to deal with guilt. Why guilt? You did not have anything to do with the death. you have had a lot of time to think and remember. you recall their request for you to assist with something and you didn't. you remember the disagreements you had, especially the disagreements prior to his going off to work for the last time. You remember your thoughts about what a klutz he could be, and you remember all the things you wished you had been able to tell him and didn't. Yes, guilt is a universal feeling and therapy is often necessary to sort out some of the issues which surround this emotion.

Do you have dreams and feelings your spouse is not really gone but will soon return? You imagination allows you to hear the car coming into the driveway, the familiar footsteps, and even seeing their image or hearing their voice calling to you. That is normal and the dreams and feelings will continue for a while because it is something you want, at least on an unconscious level. Recognize this for the desire it is an get on with reality. It is tempting to stay too long with the fantasy of your spouse returning and thus inhibiting the bereavement process.

Some survivors think they are becoming mentally ill in this phase of bereavement because of the dreams, voices and visions. This is different from a short time after the death when you though you were losing your mind because of the shock, emotional trauma, and feeling of lack of control. Now life is becoming more organized and you cannot rationally explain these behaviors. Be assured if you had good mental health before the death, the symptoms you are experiencing are part of grief and you will recover. Remember the title of this presentation! The mind can play tricks and if you are concerned, your local mental health counselor can set your mind at ease. I once had a woman come to me with the concern she had writing all over her body and also the writing was all over the body of her dog. She showed me the writing on her arms, but all I could see were freckles so I asked her to read it to me. The writing concerned some of the "bad things" she had done in her life. She lived alone with her dog and was fairly well isolated, by her own choice, from others. After a few sessions, her guilt was resolved and the writing disappeared from both her body and the body of her dog. The mind can play powerful tricks.

You need to be assured that there is light at the end of the tunnel. The bereavement process and dealing with the symptoms of grief take many months. In fact, long after you have your life well integrated and all the grief symptoms have subsided, you will discover the bereavement process has not been concluded. Years later you will look back at the time in your life that you spent with your spouse and find the bad thoughts have long gone, and you remember the good times, the quality time. You realize the value of your relationship, realize it can never be duplicated, and will appreciate the time you had together.

At this time in your bereavement, the grief process is taking a significant emotional toll. It is reassuring to know just how helpful this organization, known as COPS, can

be to you, especially as a gigantic support system. This afternoon you will have the opportunity to experience this support system in the breakout sessions. Your time here will be emotionally draining, but very valuable. After you return home you will look back at this seminar, its support and the new friends you have made here. On Wednesday morning when you place your flower in the wreath, you will be participating in the Nation's honoring of your spouse, but also you will be passing a milestone, and providing some closure, which should assist you in your bereavement.

I have left the issue of surviving children till last because their needs are often not recognized and indeed they have very significant and unique needs. Children do not readily understand death and parents usually do not want to discuss this issue. It is the wise parent who takes the opportunity of the death of a family pet to dialogue with the child about death. To the child, death of a parent may be taken as the ultimate rejection. Part of the magic of being a child is to be able to spend short times in a fantasy world where everything is fund and nice, and the way you want it. It is very easy for the child to deal with death in fantasy and they can show few symptoms of the grief process--because they are not grieving. In their thinking, death may occur because of their past deeds or their wishes, and some children are convinced they may have contributed to the death. Consequently they may feel guilty for the remainder of their lives. also children are very sensitive tot he feelings and statements of their parents, and are often times much more sensitive than the parents realize. They see their parent grieving and do not know how to act. Well meaning people tell them "you are the man or woman of the house now and you will have to be strong in order to help your parent." What a terrible responsibility to give a child! These negative feelings are reinforced when the child attempts to talk to the parent about their feelings of loss and the parent begins to cry. Parents don't cry, children cry, there is something very wrong here, and the child typically withdraws. Children do not usually feel depressed on a conscious level, but it is common to notice an increasingly apathetic attitude. Children do not begin the first stage of grief immediately, but usually weeks or months after the death. They are initially concerned with their personal state and question who is going to take them camping or fishing. Often the child will not talk about their feelings and loss, but it comes out in their bad dreams, bed wetting, asocial interactions and behavior at school. It is very common for the child to have a hidden fear concerning the loss of the surviving parent.

In the past, children attending this seminar were given the opportunity to draw. It does not take a mental health professional to look at the drawings and recognize some of these children have not dealt well with the death and are in dire need of psychotherapy. This part of my presentation is to make you aware of this possibility and to assure you that there are psychologist, and other mental health professionals, in almost every city who have special training and experience to deal with the grief process of children. But be aware, they typical mental health professional does not have the expertise to successfully deal with the grief process of a child.

Psychotherapy is not expensive, is usually covered in most insurance plans, but if not, the Ronald McDonald Foundation has recognized this need and has given COPS a grant to pay for psychotherapy of any child where the parent does not have the financial means for obtaining psychotherapy. I was surprised to realize that very little of the fund has been utilized. I would like to believe that all survivors had the means to provide this needed psychotherapy, however, if there is anyone in the audience who needs financial assistance, please talk to the person who is manning a table in the hallway, who will explain the process to receive Ronald McDonald Foundation grant funds.

Most adults respond to the terrible news of death by becoming numb. This initial phase can last from a few hours to a few weeks. The numb feeling can be pierced with intense emotions of extreme distress, crying, and/or anger. As the initial phase passes the adult enters the disorganization state, which can last for months, and then to the reorganization stage. These stages for the teenager are similar, but can be very different in some respects. It typically takes teenagers longer to truly begin to mourn. While adults generally experience the first year as the time of the most intense emotional pain, adolescents are frequently numb for a significant part of this period, however, months later, when confronted with some crisis, they can be flooded with overwhelming emotions. Teenagers generally have their hands full just trying to separate themselves from their families and to establish their own identity and place in life. To accomplish this, they need to feel that life is basically safe and that their parents will be there if needed. Therefore, the death of a parent is more than just a horrible loss and the cause of great emotional pain. The tearing away of their sense of security through the death makes it more difficult for them to break away from their family, to find themselves, and to become independent adults. Adolescent bereavement is different from that experienced by either younger children or adults and bereaved teenagers face special problems in dealing with their loss.

Perhaps because of their lack of experience and family dependency, the enormity of their loss is far too much for many bereaved teenagers to face initially and the period surrounding the death is usually marked by denial, shock and depression. These responses serve to repress painful and overwhelming emotions to a level where they can be tolerated, and allowing the bereaved adolescents to regain the necessary strength to deal with their devastating feelings later on. Teenagers, with their much greater emotional vulnerability than adults, seem to require a much longer period to recuperate before attempting to deal with the emotional reality of the death.

Because of the teenager's lack of emotional experience, they sometimes act in ways that under other circumstances would seem inappropriate, and often cause them considerable guilt. For example it is not uncommon for the adolescent to smile when they mean to cry, or to be unable to cry, or to have conflicting thoughts about the death such as that it was no big deal, or perhaps that it was deserved. These conflicting emotions and feeling will usually not be openly discussed and later my lead

to unnecessary feelings of guilt. In some cases, the initial shock and sense of unreality last longer than usual because the teen is trying very hard not to face the painful feelings--It just hurts too much--and the feelings are repressed.

Returning to school sometimes presents a terrifying prospect to the teen. Because of the news media coverage of the death, it is usually a well known fact by the other students. Teens can be cruel, sometimes without meaning to be cruel. Bereaved teenagers feel especially lost when it comes to handling the death in public. They have no idea what to expect or how to respond to their classmates reactions. The classmates, like the bereaved teen are not equipped to comfortably handle the situation and not knowing what to do or say, they often don't do or say anything. If the bereaved teen wants to talk about their feelings, often the classmates can not handle their own emotions and fears, cannot be supportive to the bereaved teen, and in an awkward attempt to make things better often make statements which are destructive rather than helpful.

It is very difficult for the teen to deal successfully with the loss of a parent without assistance. the teen often will not full share their feelings with the surviving parent because they may fear rejection for saying the wrong thing or asking the wrong question. As with a child, I believe mandatory counseling is indicated as soon as they are able to deal with some of the issues of the death./ The counseling need not and probably should not be continuous. New issues arise as time goes along and it is very comforting for the child/teen to have the ability to talk with a supportive, neutral counselor whenever they have the need.

Sitting down at my computer and writing this presentation brought back emotional memories and the first time when my eyes started to burn and the tears began to run down my cheeks, I stopped and questioned why I was putting myself through this emotional process since I do not have to do this as my participation in COPS is purely voluntary. The answer was quick to come. The survivors int his room represent officers who have given the ultimate sacrifice in their effort to make our country a better place to live. They are family and you are family. Law enforcement needs to come together and support each other in our time of need. COPS was formed to provide that support and it is a great comfort to me to know that if I should die in the line of duty, my wife would be sitting out there and others would be looking after her needs. Quite frankly, working with you keeps me in touch with my own feelings and I return home, somewhat depressed, but feeling good about our accomplishments at the COPS seminar.

In closing I would like to leave you with the following thoughts written by a survivor:

I was a victim, I am a survivor.
I have been victimized
I was in a fight that was not a fair fight
I lost
There is no shame in losing such fights, only in winning
I have reached the stage of survivor and an mon longer a slave of victim status
I look back with sadness rather than hate
I look forward with hope rather than despair
I may never forget, but need not constantly remember
I was a victim--I am a survivor!

THE DEATH OF A POLICE OFFICER - - SURVIVING THE FIRST YEAR

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ABSTRACT

The death of a police officer presents a living nightmare for the spouse. As with bereavement from any death, the manner in which the bereavement is undertaken can contribute to the effectiveness of the recovery process. This handout provides an understanding of some of the issues involved in recovery and may contribute insight and assistance.

When your spouse was killed, you may have felt all alone, but, in fact, you have the support of many members of the law enforcement profession and the members of the Concerns of Police Survivors (COPS) whose membership came through the death of their police officer spouses. These women and men offer a unique and valuable support system.

The writing of this paper was assisted by two COPS members - - Patty Nollmeyer whose husband Craig was shot by a mental health patient January 24, 1985, and Joyce Mavity whose husband Alex was shot by a felon he was arresting on Valentines day, 1989.

Each death is unique, the subsequent events are different and the bereavement issues will likewise differ. The purpose of this handout is to present some common events, to indicate some issues, to assure and reassure you that your reactions are normal, and to hopefully assist you through your period of recovery. The bereavement road from death to recovery is long and has some unexpected turns, however, with the assistance available to you, recovery can be timely and complete.

According to the Uniform Crime Reporting Program statistics, in the past ten years 590,822 officers were assaulted, 204,584 were injured, and 1525 feloniously and accidentally killed in the line of duty. During 1988, 161 police officers lost their lives. An officer dies every 59 hours. The average age of these officers is 25 years, which means they often leave young children.

These are statistics your spouse never discussed with you because officers do not like to look at their own mortality. To feel vulnerable is make the job more difficult and they do not want their families to worry about their safety. Nevertheless, you sometimes wondered, as he left for work, if he was going to return home safely. You tried not to be too possessive and usually kept your concerns to yourself. You sometimes had the premonition that something was wrong, however, you have had that feeling before and he has always returned home.

This evening, however, the doorbell rings, you answer the door and there stands the chief of police and your husband's captain. They don't have to say anything - - this is not a social call - - and you know there is a serious problem.

The chief has difficulty looking you in the eye when he advises you your husband was killed a short time ago. As he describes the circumstances you are barely listening, your mind is racing and all this seems unreal. The chief asks if there is anything he can do, assures you the department will be providing assistance and advises an officer will arrive shortly to stay with you and act as liaison between you and the department. The chief and captain excuse themselves as they have to return to the department to deal with the details of the shooting.

They leave and you feel all alone now. You can't believe this is really happening and think it must be a bad dream. You are in shock. A few minutes later you hear footsteps on the porch and check your watch. You feel an immediate sense of relief that it is your husband coming home and this has been all your imagination. You run to open the door and find your liaison officer who cannot think of the right words to express his true feelings.

Your children are asleep, you think about going into their bedroom, hugging them and telling them about their father, but decide to let them sleep. The next person at your door is the chaplain who tries to comfort you and as you listen to his words, you have difficulty concentrating. Friends and relatives begin calling and arriving now that the media is carrying the news of the shooting.

The phone is constantly busy with persons concerned with your welfare. You are fortunate to have assistance with the phone so that you do not have to take all the calls.

Morning comes rapidly, there are still several people remaining and someone is in the kitchen making a fresh pot of coffee and you smell breakfast cooking. The whole scene seems unreal and you see yourself somewhat distant from the room looking in at yourself and the others in the room. You notice that you feel numb, but not necessarily like crying.

At this time, your young children come into the room, see all the people, come running up to you and want to sit in your lap. They ask what is going on and you have difficulty telling them what has happened. They do not seem to comprehend anyway.

People continue to come and go and the chief returns and tells you about the department plans for the funeral. As he reviews the details, your input is considered but perhaps not implemented. Food is arriving and the kitchen table and refrigerator are both full. You don't feel like eating, but try to be a good hostess and invite the others to eat.

The funeral is a real production with officers representing departments from all around the area. It crosses your mind that you may not be an important part of the funeral as so much attention has been devoted to protocol. The body of your husband is placed in the grave, you return home, and for the first time in four days you and your children are alone. Returning home has caused you to think about the future and you feel a real sense of emptiness, loneliness and fear.

You are still somewhat numb emotionally and will learn this numbness is a form of shock which acts as a measure of emotional protection. Still you cannot help asking yourself, "why me" and you are noticing an anger which is directed at the assailant, the Department, and even at your husband. You reflect on the unfairness of life, but it is hard to concentrate on any one train of thought too long.

You wonder where to turn now that you no longer have your primary support system. You have lost your best friend and confidant.

You consider yourself fortunate because of the support provided by his parents. However, it is not unusual for friction to develop between spouse and the mother-in-law.

The Department attempts to assist you and you cannot help noticing how uncomfortable the officers act around you. They often do not look at you directly and their speech is awkward. Their behavior is atypical from the self-assured, highly verbal officers you are familiar with. You are uncomfortable with their discomfort. Later, you are to learn that you are a reminder of their vulnerability, their mortality, and you are living proof of that factor. They see their wives and children in you, and yes, they are indeed uncomfortable in attempting to deal with their own emotional reactions.

The Department has numerous papers for you to sign and you are following their directions with a kind of numb, almost zombie-like obedience. They have arranged grief counseling for you and you keep the appointment. You learn there are stages of grief, there is a healing process, the emotions you are experiencing are normal, and it is a relief to know you are not going crazy. You learn that bereavement is a necessary healing process and wonder when the numbness will leave and you will complete that process.

You are referred to a group of widows and it is helpful to hear others experiencing similar emotions. Shortly after the death was announced, you were contacted by a member of Concerns of Police Survivors - - a police officer widow like yourself. That person recontacts you and suggests a meeting. Here is a person with who you have some close identification, as her husband was also a police officer, and her experiences help you to cope with some of the issues not found in the widows' group.

You have taken some time to go through the letters and cards received following the announcement of the death and are surprised to receive so many cards from concerned citizens who did not know you husband, but recognized his sacrifices in keeping them safe, and their support is appreciated.

You are experiencing a unique set of emotions. You want to maintain emotional control as now you have the primary family responsibility and may find difficulty crying in front of others, but do find time to cry when you are alone. It is at this time when your thoughts go back to your husband: The good times, thinking about the last week before his death and the day he died. You remember the things you said, wished you had said, and deal with the "what if's" which, although fantasy, are common in attempting to deal with a situation over which you have no control. Your thoughts go back to the last minutes of his life, you wonder what his last thoughts were and if he was in much pain. You need to fully grieve and get these emotions out, but you also need to be in control. You later realize that it is ok to fully grieve and until you do the healing process is encumbered.

A police officer devotes his career to public service and, if killed in fulfilling that duty, will be remembered. An appropriate memorial will be dedicated to his memory to assure that his devotion will not be forgotten. You attend the ceremony and are reminded of your emotions at the funeral.

You are aware that police officer's wives often go through the transformation during the first months of marriage. Police officers, being "take charge" people, generally marry very feminine women who tend to defer to their wishes. One of the officer's desires usually involves your handling the home responsibilities and the children. Their shift work, overtime, and often second jobs gives you no choice but to take full charge. Now, however, you are somewhat disorganized and otherwise minor problems seem insurmountable. You often wonder how you will be able to cope. Support systems are helpful and you find friends who can teach you how to change the washer in the dripping faucet or what to do when the car needs to be serviced - - projects that were the domain of your husband.

Although your husband liked "his toys" and there was not usually a lot of extra money in the budget, finances are not usually a crucial worry at this time. Personal, departmental, and Federal insurance will alleviate financial problems. Now you must face another decision; how best to deal with this fairly significant amount of cash which as to be properly managed to provide for the years to come. You get lots of financial advice, but the decision is yours.

Sometimes, when people are depressed, it can be helpful to spend some money on themselves. You realize that the matching shoes and purse somehow, magically, make you feel a little better momentarily. Your grief counselor might suggest a trip for you; it sounds like a good idea and you leave. You are amazed at how valuable this trip is to get away where you can indulge yourself, actually do some good honest grieving, and without the home pressures can more objectivity look at taking control of your life.

When you return home, you realize decisions must be made about the house. What do you do with his clothes, guns, tools, and other personal effects? There are his favorite chair, foot stool, and lamp which renew emotional pain whenever you walk into the house. Then there is the matter of the bed. Difficult decisions are made over which items from the past must be discarded. New furniture is an obvious option, but what about the pictures, and the coffee table he made whose imperfections are now a very special part of the table.

Let's be careful not to forget about the children. They often appear to be coping well and although not openly showing grief, may in fact be having considerable difficulty. They may have been told, or believe, that not showing emotion is proper, that they now have responsibility to help mother, and "now you are the man of the house". They may not have a good understanding of the circumstances of their father's death and they do not have the answer as to WHY. They usually have considerable anger, but it is often internalized and not expressed. The anger later comes out in problems at school, interpersonal problems, withdrawal, and with the need for discipline. Children typically feel the same emotions as their mother which include abandonment, guilt, anger, depression, frustration, and yet they do not know these feelings are normal or how to properly express them. They need to be given the permission to talk about their father, to ask questions about him, express guilt ("if only I hadn't wished he were dead when he made me mad, he might be alive"), and frustration that things are not as they were when he was alive. They may have no way to deal with these emotions and in fact usually need assistance and permission to grieve. Grief counseling should be started soon after the funeral and include both individual and family involvement. Children should be referred to a therapist who is experienced in assisting children in grief. Your child will usually tell you and the therapist when there is no further need to continue therapy.

The children need support from their mother and relatives which is ongoing. Sometimes, when we are absorbed in our own grief, we are not as sensitive to the needs of others, which includes those who are very close. Sometimes we tend to overdo the attention and affection shown the children which is also confusing to them.

What about your role in attending the inquest and/or the trial of your husband's assailant? These are very formal and structured proceedings. If you feel an absolute need to know all the details of the death, then the inquest is one good opportunity to obtain that data. However, you may learn more than you wanted to know and some of that information may well result in additional emotional problems which would not have otherwise been a factor. Other sources to obtain this information are through the police department or perhaps from the medical examiner or coroner.

If the death was felonious and a suspect was charged, there will be a criminal trial. The trial is different from the inquest. There exists an absolute controversy concerning the survivor's attendance at the trial. Many survivors believe their attendance at the trial will help them to understand what happened, to represent their deceased spouse and to bring about closure to the death. On the other hand, during the trial, the defense attorney will then attempt to justify the taking of the life of a police officer. Generally after sitting through the trial, you will become angry and come away with disillusionment of the system your husband gave his life to support.

If not attending the entire trial, the survivors may wish to make a short visit on one of the first days of the trial. Seeing that deceased police officer, who is not now allowed to defend his actions, is a real person with a wife and children, who has to have profound effect upon the jury. Whether or not you decide to attend the trail, you should be sure to be thoroughly debriefed by the lead trial prosecuting attorney immediately prior to the beginning of the trail so that you will not be surprised to learn of unknown issues through the media.

If you want to attend the sentencing of your husband's assailant, that may also be valuable. Until this person is sentenced, the death of your husband has not been death with and the closure of this part of your grieving has not been fully accomplished.

Shortly after your spouse's death, you received a lot of attention from the other officers who made certain you were ok. As they see you are "capable" they will come less often, but usually will remain available if needed.

As your progress in your recovery, you make new friends. Your old friends are very important, but you realize some of the police officers and their wives who used to be close friends don't come around as much. You become aware that as a police widow you make these friends look at their vulnerability and if they cannot deal well with that responsibility, they feel uncomfortable being around you with the reminder that "but for the grace of God, go I."

You may have also noted that you don't have the same attraction to men that existed before his death. You feel somewhat empty emotionally, not at all interested in a romantic relationship, and find a lot of support from other women and from those men who listen and are understanding. You wonder if you will ever be able, or want, to establish the type of close relationship you had with your husband.

As you are recovering, you understand that life can never be the same. You have been changed by this death and certain anniversaries take on a different meaning. His birthday, your anniversary and the day he died take on a new meaning. As these dates of these anniversaries approach, your thoughts go back and relive some of the emotions which were so intense shortly after his death. Traditionally happy holidays such as Thanksgiving, Christmas, and Valentines Day are now days for feeling melancholy. You reflect upon the past and are thankful for the support given by your faith, children, family and others whose assistance has been so important to your recovery process.

In the year after the death of your husband, you are invited to attend the COPS Seminar and the National Peace Officer's Memorial Day Service in Washington D. C. You have mixed feelings about attending, but upon your arrival are overwhelmed with the support system which exists for you. You soon become aware of the relationship and bonding that takes place between women who share the common bond of having lost their spouse, best friend, and last but not least, a police officer who was killed making his world a better place. You leave the conference with a sense of hope and usually a strong desire to help other police officer widows.

You have survived the first year. As you review the events you see that your support system has included your faith in God, relatives, friends, counselors, the Department, children, members of COPS, co-workers and yourself. Some of your grieving has been completed and you're well on your way to recovery. However, as Patty Nollmeyer so succinctly stated: "The first year is only the rehearsal, the second year you live the loss."

DUTY-RELATED DEATHS--FAMILY POLICY CONSIDERATIONS

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ABSTRACT

The process of recovery by the spouse and immediate family of a deceased officer is directly related to events that follow the death notification. The primary purpose of this paper is to offer insight and to suggest procedures that foster rather than inhibit the survivor recovery process. These procedures should be considered in the development of agency policies for use in the event of a duty-related death.

The duties of law enforcement personnel contain many distasteful elements; however, the most negative is the heath notification to the spouse of a police officer.

The method in which this message is delivered, and the agency support to the survivors, has a significant impact on the bereavement process. Inappropriate actions can result in serious psychological consequences for both the spouse and the immediate family. The importance of a positive process was emphasized, during the Concerns Of Police Survivors seminar, by the survivors of deceased law enforcement officers.

PREPLANNING FOR DUTY-RELATED DEATHS

Advance planning and a written standard operating procedure are essential, as with other contingency planning, prior to an incident. It is not unusual for agencies to have procedures for dealing with fiscal and insurance issues in the event of an officer death, but seldom are there procedures for emotional support of the surviving spouse, children, and extended family.

A planning and resource group should be established that includes a cadre of persons who will assist the agency and the survivors in the event of a duty-related death. These resources include:

1. The agency psychologist, legal advisor, fiscal officer and chaplain.

2. A member of the Concerns Of Police Survivors organizations.

3. A financial planning expert who is known to be reputable and who will donate his/her services.

4. A representative of the 100 Club and/or other law enforcement oriented community support service organization.

The manual provisions should outline the process for the fiscal officer to notify the Bureau of Justice Assistance to process the death benefit in a timely manner; to process other job-related death benefits; and to determine procedures for payment of funeral expenses. The agency should determine, in advance, who has responsibility for payment. Involvement of the agency in the funeral often impacts the cost of the service and those costs should not be passed on to the spouse. In fact, it is recommended the agency pay all the basic funeral expenses.

As a product of this planning process, it would be helpful if each officer and spouse are furnished with

a copy of the procedures along with a listing of all duty-related death benefits. This information will allow informed decisions concerning need for supplemental insurance coverage.

Police officers seldom consider their own vulnerability, and many times that issue is only focused upon at the funeral of the fellow officer. Often that concern is as much a reality confrontation for themselves as a concern for the slain officer and his/her family. due to a preference to ignore the possibility of death, officers may not have prepared wills, considered adequate insurance needs, or addressed other death-related issues. Therefore, it is recommended the agency provide a mechanism to encourage the officer to complete a will and to discuss insurance needs. The legal advisor and agency fiscal officer can facilitate the procedure. There should also be a procedure to have the officers review their insurance beneficiary at least annually. It is all too common to have death benefits awarded to a former spouse instead of the intended beneficiary.

DEATH NOTIFICATIONS

The spouse often comments that the officer who delivered the death message was not a friend of the deceased, or the messenger was not held in favor by the slain officer or the spouse. Thus, the notification procedure may lack the compassion the survivors desire.

It is recommended the agency require each officer to complete a death notification from. The form should be maintained in a sealed envelope in each officers' working file where it is immediately available. The form should contain the following information:

1. A listing, in order of preference, the names of three officers who would deliver a message of serious injury or death.

2. A listing of who should be notified by the agency, giving home and work addresses, telephone numbers, and their relationship to the officer. This can become complicated with multiple marriages.

3. The names of officers who would served as the liaison between the agency and the family. It is recommended both a male and a female officer be assigned.

4. The name of the officer who would clean out the deceased officer's locker and return issue equipment to the agency from both the locker and residence.

5. If clergy are to be involved, their names and telephone numbers.

6. Any special requests to the agency regarding the notification, pall bearers, funeral, burial or memorial.

In the event of a serious injury or death, immediate personal notification is essential. Many families have scanners and the media will pick up immediately on an injury or death of a police officer. Learning about the injury or death from a friend or the media can have a devastating effect upon the spouse and the family. It is also essential to protect the family from the media which, on occasion, has shown an appalling lack of sensitivity.

When notifying the spouse, two officers should be dispatched--one to transport the spouse and one

to remain at the home to be with the children, answer the telephone, etc. Often, the police chief makes the notification personally. His presence at the notification is not essential; however, personal contact by the chief as soon as practical is recommended. The family of the officer must never be allowed to feel the administration is non-caring. Further, the family should be provided continuous departmental support by liaison officers until after the funeral.

When the notification is made, it is obvious to the recipient it is not a social call. The spouse is aware the problem is serious and the use of any delaying tactics are not appropriate. Although, it is natural for the notification officer to attempt to help resolve the grief, well meaning comments are often offensive to the spouse. The spouse should be provided with an accurate account of the events surrounding the incident and the current medical condition. There are few exceptions to this rule as later the survivors will usually learn they have not been told the "whole story" and may feel angry and betrayed. Immediately after notification, the spouse will usually want to be taken to the hospital and this request should be honored.

Sometimes well meaning officers will want to protect the spouse from seeing the deceased until after the body has been prepared at the funeral home. If the spouse wishes to see the body, at the hospital, this should be allowed. If the body is mutilated or burned, that fact should be presented; however, if the spouse insists upon seeing the body, the request should be considered.

From the time of the death until the funeral, the agency should offer continued appropriate support services such as child care, telephone answering, notifications, assistance in dealing with the response from the public and other agencies, meal assistance, transportation, etc. Some of the support services will be required for some time following the funeral.

It is essential for the family to be actively involved in planning the funeral arrangements and their wishes fully considered. A common complaint is that the agency determined the funeral to be their "event" and disregarded the wishes of the survivors.

Immediately following the death, two valuable outside sources of support are members of the Concerns Of Police Survivors organization and the clergy. The COPS volunteers have first-hand knowledge of the needs of survivors following the death of a police officer. Experience has indicated the ability to recover from the death is enhanced when the spouse and family have a strong religious faith. Even if the spouse is not religious, appropriate support by the clergy can be comforting. Of course, if the survivors request the clergy not be involved, that request should be honored.

Officers dedicate a portion of their lives to the law enforcement profession and would like to believe they have had a positive influence in helping their community to be a better place in the which to live. It is essential to convey to the survivors that the officer's life made a difference. It is necessary that the spouse and immediate family be assured that the death has some positive meaning, the officer was important to the agency, and the memory of the officer will be preserved. It makes little difference to the family if the officer died as a result of shootout, was killed by a drunk driver or died as a result of an accident on the agency firearms range. The important issues are that the officer was on duty and the duty was related to the mission of protecting and serving the public. Therefore, it is recommended that all duty-related deaths be acknowledged by a permanent memorial at the agency or other appropriate public area.

The average age for duty-related deaths is approximately 25 years. At this age there are often young children left without a parent. The parents of the slain officer are also intimately affected by the death. Following the death, there is often friction between the parents and the spouse and it is not unusual for open hostility and competition to the present when the agency presents the officer's badge and/or memorial plaque. It is suggested the agency make a joint presentation to both the surviving spouse

and the parents of the officer. This action is inexpensive, extends a measure of condolence and appreciation for the life of the slain officer, should go a long way toward eliminating the competition and friction that may be present between the parents and the spouse, and reduces the anger that may be directed toward the agency. If the officer is not married, but has a fiancee, provisions should be provided to include that person in the memorial service.

Because many officers attempt to over control their emotions, often there is a false belief the family knows the risks of the job and the survivors are emotionally strong enough to handle the death with very limited support and intervention by the agency. This view is not realistic with most law enforcement families as their social support system is often directly related to the agency. Research has shown that spouses of deceased officers often develop symptoms to those included in the diagnosis of Post Traumatic Stress Disorder. some of these symptoms may have developed because of improper handling of the details after the death. Therefore, it is recommended the agency provide support services from the time of the death until several months following the funeral.

It is comforting for the widows to know there is someone they can call for assistance. Some widows express their appreciation that officers check with them on an ongoing basis to determine that no assistance is needed, or to assist them with requested tasks. However, the support can be overdone. For example, some widows have complained they were overprotected by officers who have run background checks on new male friends, have provided advice on who they consider to be appropriate companions, or who have attempted to protect them by not sharing pertinent facts with the family concerning the incident and/or legal proceedings.

Children are often neglected when it comes to post death counseling. They can have unresolved conflicts and feel personal guilt over the loss of their parent. Children need to be give the opportunity to express their concerns with the death or to resolve angry prior thoughts and comments concerning the deceased parent. For example, children, when they are angry, often think about or state that they wish their parent were dead. These thoughts and statements take on major emotional consequences when that parent is killed.

It is recommended both the surviving parent and children be encouraged to seek psychotherapy shortly after the funeral. The selection of a therapist is critical for the success of the bereavement. The therapist should be licensed by the state and also have an in-depth knowledge of the philosophy and workings of the agency as well as the typical interactions present in a law enforcement family. An inexperienced counselor can easily say the "wrong thing" thus increasing the difficulty of bereavement.

The children's therapist should be experienced in working with children who have lost a parent through death. This is a fairly specific especially and it should not be assumed that the therapist who treats the surviving parent can also successfully treat the children. The police psychologist who advises the agency is usually the best referral source for locating an appropriate therapist.

FINANCIAL IMPLICATIONS

The surviving spouse is confronted with varied essential decisions shortly after the funeral, which include the problem of investing death benefit funds. The $100,000 Department of Justice death benefit, pension funds, other insurance, and donations represent a sizable income that must be carefully invested in order to provide for the future. It is a common complaint from survivors that numerous persons representing various investment schemes begin calling shortly after the funeral. Most spouses do not have experience dealing with large sums of money nor the knowledge necessary to select an appropriate financial planner.

The names of pre-selected planners who have been screened by the agency, are greatly appreciated.

TRIAL

If a suspect has been charged in the death, a trial will be scheduled. During the trial process, it is important to keep the family advised. It is essential to provide the family with a complete briefing just prior to the start of the trial to ensure they will be aware of critical issues before learning of them through the media. If, during the trial, additional issues are to be raised, the family should be so advised, in advance.

The family will be making a decision concerning attendance at the trial. There is an absolute controversy as to the benefits of the survivors attending the trial. Attendance is an individual decision of each survivor as he/she may feel a need to represent the deceased spouse and/or to bring closure to the death. On the other hand, if they have been thoroughly briefed, they may not see the need to attend.

RESOURCES

The information for this paper was taken from actual incidents, concerns and recommendations related by surviving spouses of law enforcement officers who were killed in the line of duty. The spouses were attending the Concerns Of Police Survivors annual seminar, held during the month of May, in Washington D.C.

Agencies planning to develop or modify policies and procedures have several additional resources to contact for assistance. These include: The International Conference of Police Chaplains, the Psychological Services Section of the International Association of Chiefs of Police, and the Concerns of Police Survivors organization. Additional information can be gained from the following resources:

International Association of Chiefs of Police, (1989, May) "Support Services for Survivors." POLICE CHIEF, pp. 20-27.

Stillman, Francis A. "Line of duty deaths: Survivor and Departmental Responses." National Institute of Justice, U.S. Department of Justice, Concerns of Police Survivors, Inc., Grant #85-IJ-CX-0012. January, 1987.

Support Services to Surviving Families of Line of Duty Deaths. Concerns of Police Survivors, Brandywine, Md., October, 1988.

Published 1991, Critical Incidents in Policing, U.S. Department of Justice Federal Bureau of Investigation.

ASSESSMENT

ASSESSMENT

I. *WHAT IS ASSESSMENT AND WHY IS IT IMPORTANT?*

Assessment is the process of looking both at and behind what the person is saying to fully understand from his/her point of view. It requires stepping into the other person's shoes, looking at verbal and non-verbal communications. At times you will need to be vigilant to spot clues and hidden meanings. People are not always able to define to us or to themselves what the problem is. Making an accurate assessment is the key to helping the person move toward resolving his/her problem(s).

II. *HOW TO ASSESS "THE PROBLEM"/WHAT TO LOOK FOR/WHAT TO ASK?*

Listen for common themes, issues the client returns to, information that appears conspicuous by its absence. Look at non-verbal behavior, does the client appear calm (ex: moody, relaxed and quiet) or anxious (ex: moves around a lot, taps foot, plays with paper clip, takes deep breaths, stretches); angry (ex: sits with hands clenched, lips tight or nostrils flared) or sad (ex: eyes down, watery, low energy); emotional (ex: rapid speech, fighting back tears, a lot of affect) or over controlled (ex: closed body posture, stiff, monotone voice, little facial expression). Look for congruence between verbal and non-verbal messages, between what the client sways and what you see. Question incongruencies but be gentle. If the client denies the feeling, back off. You may be wrong or the client may be unwilling or unable to admit it. Either way, now is not the time. Don't assume, don't jump to conclusions. Check out what else is going on in his/her life. Look for a precipitating event or stressor - why is he/she seeking help now. How long has the problem been going on. Sometimes people are unable to connect the events (example).

III. *ASSESSMENT - A CONTINUOUS FEEDBACK SYSTEM*

Assessment is an ongoing process; you need to continually take in information and review your assessment and your approach. Each interaction by the peer counselor can be seen as an intervention. The job then is one of evaluating each intervention and, based on the client's reaction, modifying or continuing on course. We all have different ways of handling our worlds and defending against "unacceptable" feelings. Some of us use denial, others tend to see others as doing what they themselves do without admitting it as a personal style. Whatever is the individual's own style, we must respect it and back off. It is often as much a denial to the person as to others.

When you assess incongruencies between verbal and non-verbal messages, probe gently. Point the incongruencies out delicately (ex: "you say you're not angry, yet your sitting with your legs crossed and your hands across your chest with fists clenched"). If the individual denies it, back off. Attempting to pull more out of him/her than s(he) is willing to give will only make the person close up tighter. Interventions can also be on a non-verbal level. You can help someone calm down or relax by matching and then modeling the behavior (ex: match the person's breathing rate and then breath slower. Despair, match the client's body posture and then slowly modify your own to a more relaxed position. The client will generally modify his/her position to match.

IV. DANGERS OF TAKING ON TOO MUCH RESPONSIBILITY

Your job is to help the other person get his/her life back on track, not fix it for him/her. Be aware of the pitfalls of rescuing and talking on too much responsibility. Don't lend money, housing, car etc. Unless the person is out of control or incapacitated by depression, don't be too directive and don't do it all for him/her. There are counter-therapeutic effects in terms of both your life and theirs.

V. NORMAL REACTIONS V.C. MILD TO MODERATE CLINICAL SYNDROMES V.S. SEVERE PSYCHIATRIC DISORDERS

In the process of your interviews you will be assessing 1) the level of dysfunction the person is experiencing 2) the degree of interference in occupational and/or social symptom(s) have been going on 4) what was the precipitating stressor, if not to the problem then to the person's seeking help now and 5) if the individual is depressed, then how depressed. Normal reactions to depressed stressful events are more transient and are not as severe, nor do they result in significant impairment in social or occupational functioning as clinical syndrome or psychiatric dysfunction (See "Common Sign and Symptoms" and Criteria for Major Depressive Episode"). Any stressor, depending upon the individual, the time in his/her life, etc., can produce any level of reaction. Common stressors are: loss of a loved one, divorce, job difficulties, relationship problems, illness, getting married, becoming a parent, failing to obtain professional or occupational goals, retirement, etc. Reactions to stress may typically include depressed mood, tearfulness, hopelessness, nervousness, worry, jitteriness, inhibition of work or social withdrawal, disturbances of conduct such as reckless driving, fighting or defaulting on legal responsibilities or any combination or the above. In more severe psychiatric conditions, there is greater frequency and intensity of these feelings.

In general, problems that do not have a clear precipitant and/or have going on for some time or frequently reoccur (chronic) are more difficult to assess and reaction.

VI. ASSESSMENT OF FUNCTIONING: SOME GUIDELINES

A. *What is the person's level of stress? What is the level of tension and agitation? What stress symptoms are being experienced, e.g., headaches, stomachaches, difficulty sleeping, appetite changes, anxiety, worry, agitation, depression, etc?*

B. *What is person's mood, e.g., angry, depressed, scared? Is mood relatively constant or shifting rapidly? Rapid shifting of mood can contribute to sing poor judgment, behaving impulsively, to acting-out inappropriately, and is indicative that things are not settled, e.g., the emotional impact is not totally understood and has not settled down. Is the person open emotionally or emotionally blocked and numbered?*

C. *How is the person's intellectual state? Is he/she thinking clearly, preoccupied about the incidents, not able to think of the incident, appears confused?*

D. *Is the person alert and oriented? After a traumatic event, some people have impaired ability to focus attention, concentrate, and think things through. How is the person's memory? Are there clear recollections of event, or are there lapses? Lapses may represent suppression, repression, isolation, or other ways of avoiding the painful and traumatic memories. Often going over the event several times on different occasions may bring back memories. The step by step technique often crystallizes memory of details.*

It is not unusual to have short-term memory difficulties after a critical incident, e.g., the person is forgetful and finds it difficult to concentrate. This is indicative of stress, anxiety, and preoccupation with the event, and of course, is quite normal during the first few days following a critical incident.

E. *What is the person's attitude? Is he/she open and receptive toward talking about their situation or suspicious? How is the "world" being experienced? Is it alright to experience feelings or is the person putting on a "macho" front? What is the attitude toward coping? Does the person believe in passive coping (don't think about it and it will go away) or active coping (talking it out, working it through)?*

F. *What is person's behavior like? Is he withdrawn, hyperactive, talkative, (coherent or rambling), fidgety, or calm?*

G. *What does non-verbal behavior communicate?*

H. *Does the person have a support system? If not, you may be the primary resource for the officer and may need to coordinate a support system. Is assistance needed in keeping the person's social life together?*

I. *Does the person have positive relationships within the institution? If not, you may have to be more available as well as encouraging him/her to make use of support systems that are available (e.g., other officers on the support team, officers who know you will be supportive).*

Assess institutional reaction. Many peers second guess, offer negative comments, or engage in vicarious thrill seeking. Such comments compound the stress of the incident. You may need to talk to fellow officers and your Supervisor about the negative consequences of such comments.

J. *What is the family's response? What affects one member of the family can affect all members of the family. Family difficulties can compound the critical incident and create more pressure. You may have to find support for the family and arrange professional counseling.*

K. *Are there other significant people in the person's life that he/she can trust and rely on for support?*

L. *Is special assistance needed? Financial, legal, and psychological support may be needed.*

THE FOLLOWING IS A GUIDE FOR SHORT-TERM INTERVENTIONS:

1. *Rank order the complaints and symptoms that the person considers most upsetting to him and that he would like to resolve. Verbalize how the person must feel about these to communicate concern and understanding.*

2. *Identify any important immediate problems that were associated with and perhaps continue to be related to the person's present complaint.*

3. *Explore what the person has done about his complaints and symptoms. Why has he been unable to solve his present difficulty by himself?*

4. *Inquire into previous upsets that were similar to the present one, and see if a relationship between symptoms and precipitating events can be established. Is there a similarity to the present crisis?*

5. *Inquire into other complaints and symptoms, including what measures have been taken to alleviate these. Were any tranquilizing or energizing drugs used? Ask about sleep and eating patterns. Weight loss?*

6. *Avoid too involved probings into the past.*

7. *Explore the person's ideas of how he can handle his problem.*

8. *Clarify the person's problem, and attempt to get him to think.*

MAJOR CRISIS ISSUES

FEELINGS, EMOTION, AND SENSITIVITY

I. *What is a crisis?*

A real or perceived set of circumstances that makes a person feel that they are unable to appropriately resolve the situation.

A. How do you feel about someone else's crisis?

B. How do you feel about the crisis that you have lived through?

1. Evaluate your body responses

a. Sinking feeling

b. Feeling of heaviness in shoulders

c. Squeamish

d. Presence of stomach

e. Momentary weakness

C. Compare feelings

1. Your crisis

2. Their crisis

3. Ultimately, a feeling of mutual understanding can be established: your past crisis, you peer's present - compassion, empathy, association.

II. *Where do crises come from?*

A. As mentioned a crisis can be real or perceived.

B. Real crisis

1. Drowning

2. Choking

3. Severe physical injury

4. Pending danger

C. *Perceived crisis*

1. *Loss of a loved one through*

a. *Separation*

b. *Divorce*

c. *Death*

2. *Performance (Functioning Application)*

a. *Failure to react in emergency situations*

b. *Intimacy (fear of failure)*

c. *Self worth (relationships)*

d. *Loneliness*

III. *Crisis Onset*

A. *Rapid overwhelm*

Example - An immediate onset of problems that leave a person unable to deal with the situation: i.e., death of family members, unwanted pregnancy, notice of pending death, termination from a job.

B. *Prolonged agony*

Example - A problem that has grated on a person for such a prolonged period of time that their system is overtaxed; i.e., alcoholic spouse, physically handicapped or retarded child, infidelity, wife or spouse abuse.

C. *Combined onset*

Example - Bernard Goetz, a resident of New York, took great offense to the fact that the streets were not safe for walking and that the subways were havens for juvenile gang activity. He was previously robbed (mugged) and when the second near attempt was made, he reacted in violence - the vigilante killer.

IV. *Predisposition*

A. *Immediate physiological responses*

1. *Sweaty hands*

2. *Racing heart*

3. Faintness

4. Change of body temperature

5. Shortness of breath

6. Vomiting/gastrointestinal

7. Shock/What do I do?

V. *What happens to our empathetic/compassionate response?*

A. It gets in the way of our functioning. We <u>suppress</u> our feelings.

VI. *What happens to our ability to feel our response to our problems?*

A. We control emotion, ours and the citizens we deal with.

B. Our role is to solve problems, not get involved in the emotions of a situation.

VII. *What gets to us as correctional officers? (List)*

A.

B.

C.

VIII. *What gets to you? (List)*

A.

B.

IX. *Emotions are a very powerful process of our daily lives. As correctional officers we experience strong emotionally charged situations. Think how powerful these emotions are and how they make you feel.*

A. Fear

B. Anger

C. Worry

D. Annoyance

E. Jealousy

F. Shame

G. Elation

H. Dejection

X. *Couldn't all of these be experienced to a major degree in one 8-hour or 24-hour shift? But do we? No! They happen, but we don't experience them. Sure, all the input is there, but we refuse to complete the feeling.*

XI. *Feeling about feelings.*

A. The needing peer discusses the above.

B. The helping peer:

1. Recognizing the process of crisis:

   a. Bodily functions.

   b. Ability to function appropriately and safely on a daily basis.

   c. Refer "UP" if unsure.

2. Recognize your own feelings about your peer feelings.

   a. A brief recalling of your own situation may occur but <u>don't dwell upon it</u> and don't deny it.

   b. Start re-listening to your peer.

   c. Draw upon your past experience to engender compassion, empathy, understanding.

XII. Summarize

Life is a series of highs and lows. When there are too many lows and too few highs, we then develop a survival mechanism. Simultaneously we suppress our appropriate handling of emotionally charged situations. We create inappropriate responses. We falsity, deny, distort, etc...and unfortunately we fail at dealing or coping with our own problems.

As peer support (counselors) we must remember that sometimes Corrections Staff have forgotten how to cope: they are out of control either because of a sudden onset of problems or because the prolonged load is too heavy. Either way, we have an individual loosing control, or soon to be out of control.

Remember the feelings that you experienced here today needs to be recognized as those possibly being suffered by your peer.

Be open with him/her. Provide a non-threatening environment. Jokes will be made to disguise the awkwardness of feelings. Be strong, shoulder the joke. You're there to help. You're in control. Lead your peer to safe ground or the appropriate resource. Be fair, <u>non-judgmental</u>, compassionate, and sensitive to your peer. Don't be afraid of him or her and they won't be afraid of you.

CRISIS

I. PROBLEM SOLVING EXPLANATION

A. Occurs when person's rational, usual method of solving problems fails.

B. Person continues to try this method.

C. When method repeatedly fails, person may try an emergency method.

D. When this fails, the result is agitation, anxiety, panic - the person is in crisis.

II. AREAS AFFECTED BY CRISIS

A. **Thinking** - typical reactions:

1. Over-inclusive - can't identify problem - disorganized, chaotic. Can't sort out significant from insignificant problems.

2. Overly narrow - obsessed about irrelevant details. Fails to look at reasonable alternatives - become preoccupied.

3. In general, the person seems unable to exercise appropriate judgment and to utilize reality testing, problem solving strategies.

B. **Emotions** - will exhibit some of these:

1. Panicky, scared

2. Anxious, agitated

3. Depressed

4. Hopeless

5. Overwhelmed

C. **Behavior** - See behavior that is out of the ordinary for the individual:

1. Acting out: excesses

2. Temper tantrums

3. Paralyzed - withdrawn - doesn't carry out normal routines.

III. RECAP

A. Crisis occurs when the habitual backup methods of solving problems fail. The result is a breakdown in the judgment control of affect, and ability of person to act appropriately to the crisis.

IV. WHEN DO CRISIS OCCUR?

A. Situational - examples:

1. Loss of relationship
2. Job difficulties

B. Developmental - examples:

1. 30's crisis; re-evaluation of goals and values - stuck in place
2. Middle age 40's; decline of power, loss of youth
3. Retirement; can't stand nothing to do - self-image

V. AS IN ANY COMMUNICATION, IT IS IMPORTANT TO:

A. Establish rapport and trust.

B. Allow for ventilation and validation of feelings.

C. Show empathy, respect, genuineness, caring, and sincerity.

D. Summarize to client's satisfaction.

E. Assessment for:

1. In or out of control

F. Problem solving

1. Prefer non-directive or cooperative
2. Directive if client is out of control.

VI. KEY CONCEPTS IN CRISIS THEORY

A. Immediacy - open door policy

B. Deal with particular problem

C. *Time limited approach*

D. *New situations are potential hazards and can cause crisis.*

E. *Maximum amount of change with minimum amount of work. There are both danger and opportunity in crisis situations.*

F. *Most people in crisis go blank when attempting to consider alternatives - they say they've tried everything.*

Little help at strategic time
better than a lot of help
at a less crisis laden time.

VII. *STEPS FOR WORKING WITH PEOPLE IN CRISIS*

A. *Understand present situation the person finds himself in. Meet on his ground.*

B. *Understand importance to individual.*

C. *Try to determine precipitating event - straw that broke the camel's back.*

D. *Examine coping attempted - has it happened before?*

1. *Why isn't it working now?*

2. *What is different about this situation?*

E. *Explore alternatives - person decides if at all possible - structure and detail situation if needed. Example: suicide.*

VIII. *PRIORITIZING*

A. *In all planning - short range, middle range, long range you:*

1. *Make a list*

2. *Set priorities*

a. *Setting priorities is a simple A B C process.*

B. *Items on your list that have the highest value in terms of your time RIGHT NOW, results RIGHT NOW, are labeled with an A. Those that have least value are labeled with a C.*

C. *Planning is done to GAIN CONTROL to free up time for you to concentrate on high priority items.*

D. *By failing to plan:*

1. *You do not free up time.*

2. *You do not make wise choices.*

3. *You almost certainly will not discriminate among the A's, B's, and C's.*

E. *There will always be more C's on a list than A's.*

F. *Without planning and prioritizing, we very likely end up doing mostly the C's and not enough time is left for the A's.*

1. *A's should always be done first, then B's, and - if there's enough time - C's.*

G. *C's can usually be delegated to someone else if they haven't already resolved themselves.*

CRISIS INTERVENTION
GENERAL PROFILE OF CRISIS:

1. *Sense of **Bewilderment*** *(I never felt this way before)*
2. *Sense of **Danger*** *(I felt so nervous and scared - something terrible is going to happen)*
3. *Sense of **Confusion*** *(I can't think clearly, my mind isn't working right)*
4. *Sense of **Impasse*** *(I feel stuck, nothing I do seems to help)*
5. *Sense of **Desperation*** *(I've got to do something - don't seem to know what though)*
6. *Sense of **Apathy*** *(Nothing can help me, I'm in a hopeless situation)*
7. *Sense of **Helplessness*** *(I can't manage this myself, I need help)*
8. *Sense of **Urgency*** *(I need help now)*
9. *Sense of **Discomfort*** *(I feel miserable, so restless and unsettled)*

UNDER INVESTIGATION

I. *FEELINGS OF CORRECTIONAL OFFICERS*

A. *Betrayal*

B. *Distrustful*

C. *Abandonment*

1. *Department*
2. *Public*
3. *Fellow officers and support staff*
4. *Disillusioned*
    1. *Bitter - there is no justice*
5. *Isolated*
    1. *Separated from job functioning*
    2. *Separated from partners*
    3. *Separated from friends*
    4. *Separated from family*
    5. *Possible alcohol abuse/suicidal ideation*

D. *Embarrassed*

1. *Concerned about reputation*
2. *Treatment by others*
3. *Self conscious*

E. *Paranoia*

1. *Critical self-examination of everything they've ever done that is questionable.*
2. *Can't trust anyone.*
3. *Change in behavior - become more secretive.*
4. *Difference between reality and paranoia is a fine line at times.*

F. *Panic*

1. *Job termination*

2. *Financial loss*

3. *Life disruption*

4. *Transfer*

5. *Demotion*

(They may have to accept these possibilities - usually not reality)

G. *Vengeance*

1. *Try to make them aware that acting out exacerbates the problem - low profile is the way to go.*

II. ISSUES

A. *If they haven't done anything wrong, chances are very high conclusion will be favorable; but, being under investigation can be hell.*

B. *Time*

C. *Rationale for investigation*

III. APPROACH

A. *It's important for all counselors to realize that they must remain responsive, compassionate, and empathetic to the person's feelings.*

B. *The officers may feel that they are unappreciated, not backed by the department, or that the investigator is out to get them.*

C. *Officers have a deep sense of and commitment to being right. Many times they have difficulty coping with being accused of wrong doing.*

D. *Help the person cope with the situation.*

E. *Do not get involved in moral judgments - don't deal with issues of guilt or innocence.*

F. *Do not be judgmental.*

G. *Maintain confidentiality.*

H. *Right or wrong is not important.*

I. *Lies may be abundant. It's okay, we are not sitting in judgment.*

J. *"Confronting" can be dangerous.*

K. *Deal with how the clients feel about the treatment that they are getting and give them a place to vent their feelings.*

DEPRESSION

MENTAL STATUS EXAMINATION FINDINGS OF DEPRESSED PERSONS

Most persons who are potentially suicidal reveal their distress in terms of mental status examination (MSE) findings. For that reason, it is important for you to be thoroughly familiar with MSE findings typical to depressed persons. Keep in mind that depressive symptoms may vary in type and intensity from person to person, and that depression may occur in association with a variety of psychological disorders, for example, schizophrenia, organic brain disorders, manic-depressive illness and others. Some combination of the following MSE findings are likely to be present in most depressed patients.

Appearance: *A patient's attention to individual grooming and appearance often depends on their emotional state. Indications of self-neglect which represent a change from usual grooming habits may be diagnostically significant. Accordingly, individuals who are depressed and preoccupied may show signs of personal neglect, perhaps in the form of disheveled hair, lack of makeup, unkept clothing, or being unshaven. However, some depressed patients may demonstrate no significant change in their appearance.*

Behavior: *Depressed individuals typically behave in ways which convey the feelings that they are emotionally and physically overburdened, fatigues and apathetic. Facial expression is blank or suggests sadness. Their movements are slowed, posture is usually slumped and use of gestures decreased. Speech is likely to be decreased in quantity, or low amplitude and either depressed or monotone in quality. To the degree that they are able, depressed patients usually are cooperative and compliant with respect to your questions. However, profoundly depressed persons may be unresponsive to questions asked. Signs of restlessness and agitation associated with depression are often indications of serious psychopathology and signify an increased suicidal risk.*

Feeling (Mood and Affect): *Although individuals who are mildly depressed may show variation in feeling, the affect of those who are more severely disturbed in that of unchanging sadness, hopelessness and helplessness. Feeling responses may be noticeable dulled or of marked depression. Some patients describe feeling "empty" and devoid of any feeling. The feelings of depressed persons usually are contagious and may evoke similar, but transient, feelings in you.*

Perception: *Illusions may occur, but depressed individuals rarely experience hallucinations. When hallucinations occur, they typically are auditory in nature and indicate the presence of psychosis and an increased risk for suicidal behavior.*

MAJOR DEPRESSIVE EPISODE

A. *If the client is depressed and out of contact with reality, contact the DOP Post Trauma Provider/s and/or the EAP/s for your region.*

B. *If the client is reality-based, and at least four of the following symptoms are present almost every day for two weeks or longer, a major depression is being experienced:*

1. *Poor appetite or significant weight loss (when not dieting), or increased appetite or significant weight gain.*

2. *Great difficulty sleeping, or sleeping much more than usual.*

3. *Noticeable more restless than usual, or noticeably less active than usual.*

4. *Loss of interest or pleasure in usual activities, or decreased sexual drive.*

5. *Loss of energy, tired most of the time.*

6. *Feelings of worthlessness and self-blame, or excessive, inappropriate guilt.*

7. *Complaints of evidence of difficulty thinking or concentrating, ex: slowed thinking or difficulty making even simple decisions.*

8. *Repeated thoughts of death or suicide, wishing to be dead or suicide attempts.*

REMEMBER: ***Is client reality - based?***

(Normal to have floating thought-but not daily or planned out--ex: guy who thought it was "normal" to think of suicide as a legitimate alternative.)

COMMON SIGNS AND SYMPTOMS OF DEPRESSION

Emotional Changes

Sadness
Guilt
Anxiety
Diurnal mood variation

Cognitive Changes

Negative self-concept
Negative view of the world
Negative expectations for the future
Self-blame
Self-criticism
Indecisiveness
Helplessness
Hopelessness
Worthlessness
Delusions

Physical Changes

Sleep disorder
Eating disorder
Constipation
Menstrual irregularity
Impotence/Frigidity
Weight loss
Weakness
Easy fatigability
Pain, unexplained origin
Diminished sexual drive

Behavioral Changes

Crying
Withdrawal
Retardation
Agitation
Hallucinations

Thinking: *As you might expect, your patient's thinking and intellectual functioning are affected roughly in proportion to the intensity of their mental pain and self-preoccupation. In most non-psychotic depression, mental responses may be slowed but usually there is no significant impairment of alertness, intellectual functioning, orientation, memory or judgment. Depressed patients typically describe feeling apathetic about activities or work which they formerly enjoyed. Their thought content may reveal a sense of hopelessness, helplessness, guilt, sadness or self-doubt. Ideas of self-harm may be present.*

In profound depression and/or when psychosis is present, intellectual functions may show considerable impairment. Alertness, abstract thinking, orientation, memory and judgment all may be disordered. At such times the impairment may be so great that it is difficult to distinguish symptoms of a marked depression from those of an organic brain disorder. The impairment is not caused by an actual disorder of the brain functioning, but rather intense self-preoccupation, decreased concentration and a loss of interest in their surroundings. If the patient is able to verbalize, he likely will mention feelings of profound hopelessness, despair and helplessness. Delusions about bodily functions, personal wrong doing and nihilistic ideas about the "end of the world" may be described. Associational disturbances then are characterized by marked slowing of speech, thought patterns and mid-sentence interruptions of thinking (blocking).

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Negative view of the worked
Negative expectations for the
Self-blame
Self-criticism
Indecisiveness
Helplessness
Hopelessness
Worthlessness
Delusions

COMMON CRISIS AND PSYCHIATRIC SYMPTOMS

A. ***Post-Traumatic Stress*** *is caused by a stressor that is of such intensity that it would evoke significant symptoms of distress in most people and is one that is generally outside the range of common experiences (ex: rape, assault, officer involved shootings, fire deaths, natural disasters, etc...). Symptoms include, but are not limited to, all or some of the following: re-experiencing the traumatic events, nightmares, feeling detached or estranged from others, diminished interest in usual activities, constricted affect, hyperalertness or exaggerated startle response, nausea or upset stomach, headaches, fatigue, increased drinking, loss of appetite, sleep problems, changed in the way the person sees self, life, or job, difficulties concentrating, tension, tendency to isolate self, apathy.*

B. ***Panic Attacks.*** *Anxiety attacks that occur at times and are often unpredictable, though certain situations may become associated with a panic attack. They are manifested by sudden onset of intense apprehension, fear, or tension often associated with feelings of impending doom. Most common symptoms experienced during an attack are: palpitations, chest pain or discomfort, choking or smothering sensations, dizziness, vertigo or unsteady feelings of unreality, tingling in hands or feet, hot or cold flashes, sweating, faintness trembling or shaking, fear of dying, going crazy, or doing something uncontrolled during an attack. Attacks usually last a few minutes.*

C. ***Generalized Anxiety*** *results in motor tension autonomic hyperactivity, apprehensive expectation, vigilance and scanning and is a more pervasive and longer lasting feeling than that which occurs with panic attacks. Symptoms of tension, fatigability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle, sweating, heart pounding or racing, clammy hands, dry mouth, dizziness, lightheadedness, tingling in hands or feet, upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of stomach, lump in throat, flushing, pallor, high resting pulse and respiration rate, worry, fear, rumination, anticipation of misfortune to self or others, difficulty concentrating, distractibility, insomnia, "on edge" irritability, impatience.*

We have all, at one time or another, experienced these feelings. What is important, then, are the intensity and frequency with which they are felt and their effect on the individual's functioning. It is normal to at times be anxious or sad; these emotions only become problematic when they are the predominant and most pervasive feelings.

D. ***When to Refer And to Whom.*** *Referral to a professional should considered whenever the client talks of feeling incapacitated, overwhelmed, or out of control and there exists moderate to severe impairment in social or occupational functioning or there are symptoms clearly in excess of a normal and expectable reaction to the stressor. Individuals who have more than fleeting thoughts of suicide (particularly if they have attempted in the past or have family members who have themselves committed suicide) and/or are experiencing vegetative signs of depression should also be referred.*

Referrals can be made to:

1) *outside agencies and professionals*

2) *self help groups when a support network is needed and the individual would benefit from talking to others who have experienced similar circumstances*

3) *physician/s, when the individual experiences physical problems (colitis, ulcers, etc...) maybe in addition to emotional problems*

4) *sometimes people or support systems in the person's own environment that she/he has forgotten about or never thought to use*

5) *DOP Post Trauma Provider/s and/or EAS Person/s in your region.*

SUICIDE

INTENSITY OF RISK

BEHAVIOR OR SYMPTOM	Low	Moderate	High
Anxiety	Mild	Moderate	High, or panic state
Depression	Mild	Moderate	Severe
Isolation/ withdrawal	Vague Feelings of depression, no withdrawal	Some Feelings of helplessness, hopelessness and withdrawal	Hopeless, Helpless withdrawn, and self-deprecating
Daily functioning	Fairly good in most activities	Moderately good in some activities	Not good in any activities
Resources	Several	Some	Few or none
Coping strategies/ devices being utilized	Generally constructive	Some that are constructive	Predominantly destructive
Significant others	Several who are available	Few or only one available	Only one, or none available
Psychiatric help in past	None, or positive attitude toward	Yes, and moderately satisfied with	Negative view of help received
Life style	Stable	Moderately stable or unstable	Unstable
Alcohol/drug use	Infrequently to excess	Frequently to excess	Continual Abuse
Previous suicide attempts	None, or of low lethality	None to one or more of moderate lethality	None to multiple attempts of high lethality
Disorientation/ disorganization	None	Some	Marked
Hostility	Little or none	Some	Marked
Suicidal Plan	Vague, fleeting thoughts but no plan	Frequent thoughts occasional ideas about a plan	Frequent or constant thought with a specific plan

LETHALITY

TECHNIQUE			
Assess emergency	*No plan to commit suicide within next 24 hours*	*No plan within next 24 hours*	*Plans suicide next 24 hours. What?, When?, Where? What has already been done*
Focused on hazard	*Primary*	*Primary after emergency is ruled out*	*May be secondary until client is safe*
Clarify the hazard or crisis	*Assist client to arrive at clearer idea*	*Clients needs more help from caregiver*	*Client needs most help from caregiver*
Reduce imminent danger	*Help client reduce future danger. Obtain verbal contract to avoid suicide*	*Help client reduce danger. Obtain verbal contract*	*Direct client to reduce danger. Provide first aid if necessary. Obtain verbal contract*
Access need for publication	*Evaluate*	*Evaluate*	*Most often - but must be monitored*
Assess need for someone to stay with client	*Often a good idea to have someone available for support*	*Frequently necessary*	*Essential precaution to prevent hospitalization or suicide*
Mobilize internal and external resources	*Very important; usually can mobilize internal resources*	*Very important. Can mobilize internal resources*	*Essential. Few internal resources. Need help to mobilized external resources*
Contact significant others	*Important*	*Very important*	*Essential*
Harness coping devices	*Minimal help needed*	*Needs more help*	*Needs command and direction*
Give structure	*Minimal help needed*	*Needs more help*	*Needs specific directions*
Continue daily activities	*Needs encouragement*	*Needs encouragement and some direction*	*Needs direction and assessment of what is possible*

SUICIDE ASSESSMENT

	LOW RISK	*HIGH RISK*
SOCIAL RESOURCES	*Concerned family/friends Stable finances*	*Lives alone, no close friends, poor finances*
MEDICAL HISTORY	*Few or mild medical problems No drug/alcohol dependency*	*Severe medical problems/ pain drug/alcohol dependency*
HISTORY OF MENTAL HEALTH	*Generally stable, good life adjustment*	*Prior psychiatric hospitalization. Suicide attempts, poor life adjustment familial suicide*
PRECIPITATING EVENTS	*Occurred recently, potentially solvable*	*Long-term problems, no solution in sight*
PSYCHOLOGICAL STATUS	*Mild to moderate problems, cooperative, wants to help*	*Severe problems, blames self, reluctant to accept help*
PHYSIOLOGICAL STATUS	*Mild to moderate symptoms: Little disturbance of sleep, appetite, energy, sex drive, few/mild somatic complaints*	*Severe symptom: Trouble eating sleeping, low energy, many somatic symptoms*
DAILY ACTIVITIES	*Mostly continues usual routine, remains involved with people and activities*	*Less and less daily activity, withdrawing from people*
SUICIDAL IDEATION	*Occasional, no specific plan, low lethality*	*Persistent, specific detailed plan, high lethality*

RULE OF THUMB: *Does the client have a detailed, workable, well thought out suicide plan?*

SUICIDE ASSESSMENT

Suicide assessment should be routinely done whenever a client talks of being depressed and you assess the severity of the depressive symptomology to the moderate to severe (ie: the individual meets the criteria for Major Depressive Episode). Be direct - ask them right out "Have you thought about killing yourself?" "How often?" "Have you thought how you would do it?" Get the person to talk about it. Don't worry, if the idea is not there, you won't plan it. Most people think about suicide occasionally but as a fleeting thought. Individuals with symptoms of major depression who think about it regularly and/or have a well alienated plan with the means available are at risk. Individuals who talk of using guns are more dangerous that those who talk of slitting their wrists, but all should be taken seriously.

THE MYTHS AND REALITIES OF SUICIDE

The following are taken from a talk delivered by Dr. Marsha Linehan, Suicide Research Specialist from the University of Washington:

1. *Someone attempts suicide once every minute in our country.*

2. *Suicide is defined as any self-inflicted, self-intentioned act that ends in death.*

3. *Para-suicide is any self-inflicted harm as above that does not end in death (Suicide attempt presumes a person wants to die.)*

4. *Some suicide statistics:*
   25,000 plus in our country die by suicide each year.
   (probably many more)
   76 died by suicide in Pierce County in 1988. This was down from 109 in 1987.
   90% who complete the attempt at suicide have tried only once.
   50% to 80% have planned well ahead of time.

5. *Some para-suicide statistics:*
   The rate for para-suicide is 10 to 100 times greater than suicide.
   The suicide risk for a para-suicide is 80 to 200 times greater than the general population.
   From 9 to 16% of the population have para-suicide.
   From 10 to 20% who para-suicide go on to commit suicide.

6. *Suicide threateners have a suicide rate 40 times greater than the general population.*

7. *Suicide Ideators (those who think about it or have thought about it) comprise about 40 to 65% of the general population.*

8. *Some **MYTHS** about suicide:*

   MYTH: *People who talk about suicide do not commit suicide.*
   FACT: *Most people give definite warning signs that they will attempt suicide.*

   MYTH: *Suicide is inherited and is passed on from generation to generation.*
   FACT: *Suicide is not transmitted genetically although chances are much greater if a significant other has committed suicide.*

   MYTH: *After depression begins to subside the suicide danger is passed.*
   FACT: *In actuality, most suicides take place within the first three months after depression lifts.*

THE WHY'S OF SUICIDE

The following, taken from notes given by Dr. Marsha Linehan, University of Washington Suicidologist, sees suicide as a problem solving behavior.

Physiological Factors:

- *Physical illness plays a part in many suicides.*
- *Many people kill themselves who are angry, not depressed.*
- *Extremely high arousal with its attendant physical symptoms should be considered as a factor in suicide. If extreme arousal cannot be reduced, suicide may result.*

Cognitive Factors:

- *Emotional disorders/though patterns contribute to suicide. (Note article by Sheinin on manic-depressive).*
- *Rigid thinking people are more prone to suicide. (They often cannot or will not allow themselves to see or accept a solution other than suicide.)*
- *Interpersonal problem solving skills are often lacking. They are sometimes passive problem solvers or are the opposite, impulsive, action oriented people.*

Behavior Factors:

- *Addictive behaviors contribute to suicide. Someone has wisely said: "There is nothing bad that is not related to alcohol."*
- *Drugs, licit and illicit are behavioral as well as causative in suicide.*

Environmental Factors:

- *Loss in the environment of the suicidal person should always be considered as a factor.*
- *Suicide is often triggered by "one more loss".*
- *Any present or past negative environment can be causative in suicide.*
- *Being a minority in any of four categories greatly increases the suicide risk: Sexual, racial, social, economic.*

Spiritual Factors:

- *Suicidal people often feel estranged from the "God of the Universe".*
- *When associated with a mental illness, the suicidal feelings may be that God is telling them to end their life.*
- *Loss of hope in this life, may make moving into "the next life" -- very attractive to the suicidal person.*

The following profile of the suicide "attempter/para-suicide" will provide some clues as to the Why's Of Suicide:

She (90% of attempters are female) is her parents' first born child. She is very dependent upon their mother and feels ambivalent about that. Her father is absent or emotionally unavailable to her. In her relationships she has developed little trust. She may see her troubles as causing her parents' problems. Her parents' divorce is correlative but not causative in nature. She generally has a boyfriend exclusively. She feels like he should be everything to her. He is smothered and breaks off the relationship. She sees that as the final blow in her life. She has constricted thinking, feeling that he is the <u>only</u> boy in the world and that this problem will never be over. It is this boyfriend or nothing. Running away is too hard. Suicide is the only way out. There is this boyfriend or nothing. Running away is too hard. Suicide is the only way out. There is a fragile balance..."No one was there when I called so I did it." Calmness comes with the slashed wrists as endorphines are released into her system. It feels good. (It is this feeling that repeaters are looking for.)

-Taken from notes by Pamela Cantor, PH.D.
Suicidologist

SUICIDE ASSESSMENT AND INTERVENTION

When dealing with a potential suicide:

1. *Check up on yourself to make sure you really do care about this person. If you do, go ahead; if you don't, find someone else to intervene.*

2. *Seek to reinforce the person for confiding in or calling you. "You did the right thing in calling for some help."*

3. *Be accepting and non-judgmental of the person.*

4. *Sound confident as well as concerned. "It will be ok, we will work it out. I will be here to help you all the way."*

5. *Let the person know how good you are at this work.*

6. *Whether in person or on the telephone, get as much identifying information as possible. Especially if by phone, find out where the person is so that if the intervention does not appear to be succeeding you can get help.*

Some things you have in your favor when dealing with the suicidal person are:

1. *Suicidal people are most frequently ambivalent about suicide.*

2. *Most people lack knowledge of how to cause death.*

3. *In most instances you will have the ability to move the person in a positive direction.*

4. *You will have positive caring authority.*

5. *You will possess knowledge, training, experience, sincerity and self confidence.*

6. *You have faith.*

7. *All of the combined resources of the community and the suicidal person may be drawn upon to assist.*

A primer in suicide assessment:

S *Specific details of the suicide plan*

L *Lethality of the plan*

A *Availability of the means of suicide*

P *Proximity. How close is the person to potential helpers?*

Assessment cont...

If there has been a previous attempt, use the acronym DIRT.

D *Dangerousness. How dangerous was the attempt?*

I *Impression. What was the person's impression of how dangerous the attempt was?*

R *Rescue. Did the person do anything to rescue him/herself?*

T *Timing. How long ago did the previous attempt take place? The more recent, the more dangerous the present threat.*

Some questions to assist in your assessment:

1. *Have you been thinking of harming yourself?*
2. *How would you kill yourself? Do you have a gun? Or?*
3. *Have you ever tried to kill yourself before? Anybody close to you ever killed themselves? Who? When?*
4. *Are you using any drugs or alcohol now?*
5. *Is anyone with you right now?*
6. *What do you think the odds are that you will kill yourself?*
7. *What has been keeping you alive so far?*
8. *What is the hurry, why kill yourself now?*
9. *What do you think that the future holds in store for you?*

THE "DO'S" OF SUICIDE INTERVENTION

1. *Act quickly and decisively.*

2. *If there is a physical emergency do not hesitate to use the police or paramedics.*

3. *Express caring openly.*

4. *Listen to and recognize the problems but emphasize their temporary nature as that is appropriate.*

5. *Try to see life from the person's point of view.*

6. *Talk about suicide openly and matter-of-factly, particularly using words like, kill yourself or commit murder, in place of gentler terms like, take your own file. (Do not use words like succeed or fail in reference to suicide.)*

7. *Confront the person with realistic expectations about others.*

8. *Avoid pejorative explanations about suicidal behavior motives.*

9. *Maintain a stance that suicide is an ineffective solution to a problem they may have. "It is a permanent solution to a temporary problem."*

10. *Clarify and reinforce non-suicidal responses to problems.*

11. *Insert hope at every turn. You can have hope for them.*

12. *Try to make a suicide contract with them.*

13. *Try to involve significant others.*

14. *Be accessible. Give the person a "crisis card" with numbers and names. (Please, not just agencies!) Your own home and office numbers are a must.*

15. *Keep the person's phone number and address with you at all times until the crisis is past.*

16. *Do not require suicidal talk or ideation for the person to get your attention.*

17. *Maintain contact with suicidal people even if they reject your suggestions for long term help.*

18. *Maintain contact with people <u>you</u> can talk to. Working with suicidal people is hard, gut wrenching work.*

NOTE: ***There is no data that says putting a suicidal person in the hospital reduces ultimate suicidal risk. It <u>may</u> lower self esteem, increasing risk.***

BUILDING A SUPPORT SYSTEM FOR THE SUICIDAL PERSON

The suicide ideator/threatener plus only the one intervenor leaves the intervenor with a big load and the threatener at great risk.

Suicidal people are often very fragile. Note: "I called you and you were not there so I did it!"

More than one person is needed for the sake of both the suicidal person and the intervenor.

A support group is appropriate even if the person is now saying, "Yes, I guess I do want to live."

Let the suicidal person suggest their own support group. It may be based on "Who cares? Who is available to you? Who do you trust?"

Gain their support in "breaking confidence" to form the support group.

Some support group suggestions:

1. *Do not count on "8 to 5" agencies.*
2. *Walk the suicidal person through a "get help" experience accessing his support group.*
3. *If it is a juvenile who is suicidal, the parents should always know, even if they are not considered supportive.*
4. *The more resources named and listed the better.*

REFERRALS

REFERRALS

I. PURPOSE OF REFERRALS

A. *Referral is process of getting clients the best help as quickly as possible.*

B. *Many problems that you encounter will be successfully resolved as a result of talking to you.*

C. *Other problems identified to you by clients may be of such a nature that another Peer Support Counselor or professional is best able to handle. For example: drugs, some marital problems, alcohol problems, grieving, sexual problems, etc.*

D. *Your decision should be based on your evaluation of the circumstances and your abilities.*

1. *There is a degree of "risk-taking" involved.*

E. *If a referral is effective, the client will feel better, work better and be thankful. Future problems may be reduced.*

1. *Takes the "Monkey" off your back.*
2. *Civil, legal, ethical considerations.*

F. *If a referral is appropriate, it should be the highest priority disposition.*

G. *If a referral is appropriate, it is the least time consuming and best disposition for the client.*

H. *It offers clients the best opportunity to get specialized help for their problems.*

II. REFERRAL PROCEDURES

A. *Before referring, consider the following:*

1. *Will the referral help?*
2. *Is the client willing to seek assistance other than Peer Support (Counseling)?*

B. *Do not force referral - sell them.*

1. *Don't become a "guardian".*

III. RESOURCES

A. Local Institution Referral System

1.

2.

3.

IV. CHOOSING A REFERRAL AGENCY

A. Counselors should stay in touch with resources they intend to use.

1. Make sure the quality of the program is maintained, the program has not been discontinued or moved, etc...

2. Keep an eye out for new resources, particularly within counselor's home area.

B. Pick person/programs that can deal with the specific problem. Need to understand the problems and how the referral will benefit the client.

1. How do they work with Correctional Staff?

C. Know insurance coverage for client. Different policies, etc.. EAS can be a tremendous help.

D. Money is always a problem.

E. Hours/availability.

F. It helps to know referral personnel on first name basis.

G. Check up on referral sources periodically.

H. Ask for feedback for future reference.

C. *Making a specific referral.*

1. Determine referral program. Identify persons or programs appropriate for dealing with specific problem.

   a. Tailor program to individual.

      1. Proximity to home, cost, hours, etc.

2. Once program is decided upon, Peer Support (Counselor) should make initial contact with resource.

   a. Obtain a name.

   b. Get specific program requirements, cost, availability, facilities, etc.

   c. Give all essential information about referral eg., Self-help groups, when and where meetings are held, and go with client if necessary.

3. Have counselee contact resource.

4. Tell the client that you want to know how it goes.

5. Check back with him/her in a few days.

6. How do counselors handle arranging time off for counselees.

   a. Normally counselee arranges.

   b. Note: Division Directive (DOP 410.170) and the Field Instruction at your local institution.

7. What to do with recalcitrant counselee?

   a. Keep in mind you can't save everyone and the person is not your charge/responsibility. Best we can do is recommend.

   b. Acute (life threat cases) Note: Division Directive (DOP 410.170) and the Field Instruction at your local institution.

8. After a referral is made, offer your continuing support - stay involved.

HELPFUL INFORMATION NUMBER RESOURCES AND REFERRAL SERVICES

You can get referrals and information about a wide variety of problems by picking up your telephone. Many of the numbers listed are toll-free, but we've included a few that are not, because they offer much needed information or support about difficult issues. There may also be organizations in our community that can help. Most numbers do not answer 24 hours a day, so keep trying to get through.

Aging

Alzheimers and Related Disorders	(800) 621-0379
Within IL	(800) 572-6037
Alzheimer's Respite Line	(800) 648-COPE
Medicare Information	(800) 332-6146
Natl. Eye Care Helpline (over 65)	(800) 222-EYES

AIDS

AIDS Hotline	(800) 343-AIDS
In Spanish	(800) 342-SIDA
Natl. AIDS Information Clearinghouse	(800) 458-5231
Natl. Gay Lesbian Crisisline (AIDS)	(800) 221-7044
Within AK, HI & NY	(212) 529-1604
NIDA AIDS Helpline (drug abusers)	(800) 622-HELP

BIRTH DEFECTS

American ASSN. on Medical Deficiency	(800) 424-3688
Within DC	(202) 387-1968
American Cleft Palate Assn	(800) 24-CLEFT
Within PA	(800) 23-CLEFT
Cystic Fibrosis Foundation	(800) 344-4823
Within MD	(800) 951-4422
Natl. Down Syndrome Congress	(800) 232-NDSC
Within IL	(800) 823-7550
Natl. Down Syndrome Society	(800) 221-4602
Within NY	(800) 460-9330
Spina Bifida Assn. of America	(800) 621-3141
Within MD	(301) 770-7222

Cancer

American Cancer Society	(800) 227-2345
Within Florida	(800) 226-6611
Cancer Information Hotline	(800) 525-3777
Cancer Information Service	(800) 4-CANCER
Oahu, HI (other islands call collect)	(808) 524-1234

CANCER CONT...

Within AK	(800) 638-6070
Natl. Alliance of Breath Cancer Organizations	(800) 221-2141
Within IL	(800) 799-8228

CARDIAC HEALTH

American College of Cardiology	(800) 253-INFO
Heartlife	(800) 241-6993
Within GA	(800) 523-0826

CHILD HEALTH (SEE ALSO BIRTH DEFECTS

American Sudden Infant Death Syndrome (SIDS) Institute	(800) 232-SIDS
Within GA	(800) 847-7437
Brass Ring (terminally ill children) (tone 227)	(800) 523-2729
Children's Hospice Intl	(800) 242-4453
Within VA	(703) 684-0330
Children's Wish Foundation Intl	(800) 323-9474
Healthy Baby Hotline	(800) 522-5006
Natl. Center for Prevention of SIDS	(800) 638-SIDS
Natl. Information Center for Children & Youth with Handicaps	(800) 999-5599
Natl. Information System for Health Related Services Disabled/chronically ill (under 21)	(800) 922-9234
Within SC	(800) 922-1107
Natl. Reye's Syndrome Foundation	(800) 233-7393
Within OH	(800) 231-7393
Natl. Sudden Infant Death Syndrome Foundation	(800) 221-SIDS
Within MD	(800) 459-3388
Shrines Hospital Referral Line	(800) 237-5055
Within FL	(800) 282-9161

CONSUMER

Bankcard Holder of America	(800) 638-6407
Conservation & Renewal Energy Hotline	(800) 523-2929
Within AK, & HI	(800) 233-3071
Consumer Product Safety Commission Information Service	(800) 638-CPSC
Federal Tax Information	(800) 424-1040
Natl. Highway Traffic Safety Admin.	(800) 424-9393
Within DC	(202) 366-0123
Safe Drinking Water Hotline	(800) 426-4791
Within DC	(800) 382-5533

DERMATOLOGY AND PLASTIC SURGERY

Acne Help Line	(800) 222-SKIN
Within CA	(800) 221-SKIN
American Board of Cosmetic Surgery	(800) 221-9808

DERMATOLOGY AND PLASTIC SURGERY CONT...

American Society of Plastic and Reconstructive Surgeons . . . . . (800) 635-0635

DISABILITY

HEALTHY Resource Center (postsecondary education for the handicapped . . . . . (800) 554-3284
Job Accommodation Network . . . . . (202) 939-9320
Within WV . . . . . (800) 526-7234
Information Center for Individuals . . . . . (800) 526-4698
with Disabilities . . . . . (800) 462-5015

DISEASES AND CONDITIONS

American Diabetes Assn . . . . . (800) ADA-DISC
Within VA & DC . . . . . (703) 549-1500
American Kidney Fund . . . . . (800) 638-8299
Within MD . . . . . (800) 492-8361
American Leprosy Missions . . . . . (800) 543-3131
Within NJ . . . . . (201) 794-8650
American Liver Foundation . . . . . (800) 233-0179
Within NJ . . . . . (201) 857-2626
Arthritis Answer Line . . . . . (800) 422-1492
Arthritis Medical Center . . . . . (800) 327-3027
In Ft. Lauderdale, FL . . . . . (305) 739-3202
Cooley's Anemia Foundation . . . . . (800) 221-3571
Within NY . . . . . (212) 522-7222
Epilepsy Foundation . . . . . (800) EFA-1000
Within MD . . . . . (301) 459-1000
Baltimore Affiliate . . . . . (800) 492-2523
Huntington's Disease . . . . . (800) 345-4372
Within NY . . . . . (212) 242-1968
Juvenile Diabetes Foundation . . . . . (800) 223-1138
Within NY . . . . . (212) 889-7575
Lupus Foundation . . . . . (800) 558-0121
Within DC . . . . . (202) 328-4550
Lupus Research Institute . . . . . (800) 82-LUPUS
Within CT . . . . . (203) 852-0120
Lymphedema Network . . . . . (800) 541-3259
Natl. Headache Foundation . . . . . (800) 843-2259
Natl. Headache Foundation . . . . . (800) 541-3259
Within IL . . . . . (800) 523-8858
Natl. Information Center for Orphan Drugs and Rare Diseases . . . . . (800) 336-4797
Within MD . . . . . (301) 565-4167
Natl. Organization for Rare Disorders . . . . . (800) 447-NORD
Within CT . . . . . (203) 746-6518
Peyroine's Society of America . . . . . (800) 346-4875
Within KS . . . . . (316) 283-2456
Scleroderma Research Foundation . . . . . (800) 541-0200
Urology problems (incontinence) . . . . . (800) 23-SIMON

DISEASES AND CONDITIONS CONT...

United Scleroderma Foundation . . . . . (800) 722-HOPE
Within CA . . . . . (408) 728-2202

EATING DISORDERS

Anorexia Bulimia Treatment and Education Center . (800) 33-ABTEC
Within MD . . . . . (301) 332-9800
Bulimia/Anorexia Self-Help . . . . . (800) 227-4785
Bulimia/Anorexia Self-Help Crisis Line . . . . . (800) 762-3334
In St. Louis, MO . . . . . (314) 768-3838
Rader Institute (makes local referrals) . . . . . (800) 255-1818

FAMILY

Batterers Anonymous . . . . . (714) 383-2972
Child Abuse Hotline . . . . . (800) 4-ACHILD
Child Care Information Service . . . . . (800) 424-2460
Child Find of America . . . . . (800) IAM-LOST
Domestic Violence Hotline . . . . . (800) 333-SAFE
Missing Children Help Center . . . . . (800) USA-KIDS
Missing Children Network . . . . . (800) 235-3535
Natl. Center for Missing & Exploited Children . . (800) 843-5478
Within DC . . . . . (202) 644-9836
Natl. Child Safety Council Childwatch . . . . . (800) 222-1464
Natl. Committee for Citizens in Education . . . . (800) NETWORK
Parents Anonymous (stressed parents) . . . . . (800) 421-0353
Within CA . . . . . (800) 352-0386
Parents Without Partners . . . . . (800) 638-8078
Prison Families Anonymous . . . . . (516) 538-6065
Project Share . . . . . (800) 537-3788
Within MD . . . . . (301) 231-9539

HEALTH REFERRAL

American Hospital Association . . . . . (800) 621-6712
Hill-Burton Hospital Free Care . . . . . (800) 638-0742
Within MD . . . . . (800) 492-0359
Hospice Education Institute . . . . . (800) 331-1620
Within CT . . . . . (203) 767-1620
Medic Alert Foundation International . . . . . (800) IDALERT
Natl. Assn. of Rehabilitation Facilities . . . . (800) 368-3513
Natl. Rehabilitation Information Center . . . . . (800) 34-NARIC
Within MD . . . . . (301) 588-9284
Office of Disease Prevention and Health Promotion (800) 336-4797
Within MD . . . . . (301) 565-4167
Second Surgical Opinion Hotline . . . . . (800) 638-6833
Within MD . . . . . (800) 492-6603

HEARING AND SPEECH

Deafness Research Foundation	(800) 535-DEAF
Dial A Hearing Test	(800) 222-EARS
Within PA	(800) 345-EARS
Grapevine (voice and TDD)	(800) 352-8888
Within CA	(800) 346-8888
Hear Now (financial aid)	(800) 648-HEAR
Hearing Aid Helpline	(800) 521-5247
Within MI	(313) 478-2610
Hearing Helpline	(800) EAR-WELL
Within VA	(703) 642-0580
Hearing, Speech Action Natl. Assn	(800) 638-8255
Within MD, HI & AK	(800) 897-0039
Internal Revenue Service (TDD users)	(800) 428-4732
Within IN	(800) 382-4059
Stutters Hotline	(800) 221-2483
Within NY	(212) 532-1460

INJURY/TRAUMA

American Paralysis Assn	(800) 225-0292
Within NJ	(201) 379-2690
American Trauma Society	(800) 556-7890
Within MD	(301) 925-8811
Natl. Head Injury Foundation	(800) 262-9500
Natl. Spinal Cord Injury Assn	(800) 962-9629
Within MA	(617) 935-2722
Spinal Cord Injuries Hotline	(800) 526-3456
Within MD	(800) 638-1733

LEARNING DISORDERS

Dyslexia Society	(800) 222-3123
Within MD	(301) 296-0232
HEALTH Resource Center	(800) 544-3284
Within DC	(202) 939-9320

LUNGS/ALLERGIES

Asthma/Allergy Information Line	(800) 822-ASMA
Lung Line	(800) 222-LUNG
In Denver, CO	(303) 355-LUNG

MENTAL HEALTH

American Mental Health Fund	(800) 433-5959
Within IL	(800) 826-2336
Natl. Foundation for Depressive Illness	(800) 248-4344

MINORITY HEALTH

Minority Health Resource Center	(800) 444-6472
Natl. Black Women's Health Project	(404) 753-0916
Natl. Assn. for Sickle Cell Disease	(800) 421-8453
Within CA	(213) 936-7205

NEUROLOGICAL

American Parkinson's Disease Assn	(800) 223-2732
Cornelia de Lange Syndrome	(800) 223-8355
Within CT	(203) 693-0159
Epilepsy Foundation of America	(800) EFA-1000
Multiple Sclerosis Society	(800) 334-7812
Natl. Multiple Sclerosis Society	(800) 624-8236
Natl. Neurofibromatosis Foundation	(800) 323-7938
Within NY	(212) 460-8980
Natl. Parkinson Foundation	(800) 327-4545
Within FL	(800) 433-7022
Natl. Tuberous Sclerosis Assn	(800) CAL-NTSA
Within MD	(301) 459-9888
Parkinson's Disease Foundation	(800) 457-6676
Parkinson's Education Program	(800) 344-7872
Within NY	(714) 640-0218
Tourette Syndrome Assn. of America	(800) 446-1211

ORGAN TRANSPLANTS

American Council of Transplantation	(800) ACT-GIVE
Living Bank (organ donations)	(800) 528-2971
Within TX	(713) 528-2971
Organ Donor Hotline	(800) 24-DONOR

SEXUALITY

Birth Control Information Line	(800) 468-3637
Herpes Hotline	(800) 227-8922
Impotent Anonymous	(615) 983-6064
Medical Aspects of Human Sexuality (ext. 42612)	(800) 553-4355
Natl. Gay and Lesbian Task Force	(800) 221-7044
Natl. VD Hotline	(800) 227-8922
Within CA	(800) 982-5883
Planned Parenthood	(800) 223-3303
Rape Crisis Hotline	(800) 527-1757
Recovery of Male Potency	(800) 835-7667
Within MI	(313) 966-3219
Sexual Addiction Information	(800) 321-2273

SUBSTANCE ABUSE

Al-Anon Family Group Headquarters	(800) 356-9996
Within NY and Canada	(212) 245-3151
Alcohol & Drug Addiction Treatment Center	(800) 382-4357
Alcoholics Anonymous World Services	(212) 686-1100

SUBSTANCE ABUSE CONT...

Cocaine Hotline	(800)	COCAINE
Cottage Program (alcohol)	(800)	752-6102
Just Say No Kids Clubs	(800)	258-2766
Within CA	(415)	939-6666
Natl. Council on Alcoholism	(800)	NCA-CALL
Natl. Federation of Parents for Drug Free Youth	(800)	554-KIDS
Within MD	(301)	585-5437
Natl. Institute on Drug Abuse	(800)	662-HELP
Natl. Parents Resource Institute for Drug Education	(800)	241-7946
Within GA	(404)	658-2548
Substance Abuse Information	(800)	732-9808
Target Resource Center (education)	(800)	366-6667

TEENAGERS

Covenant House (runaways)	(800)	999-9999
Natl. Runaway Switchboard	(800)	621-4000
Runaway Hotline	(800)	231-6946
Within Texas	(800)	392-3352
Teen Line (teens can talk to other teens about their problems)	(800)	522-TEEN
Teen Pregnancy Hotline	(800)	522-5006
United Student Aid Funds	(800)	428-9250
Youth Development, Inc. runaways	(800)	MISS-YOU
Within CA	(800)	HIT-HOME

VIETNAM ERA VETERANS

Children of Vietnam Veterans (birth defects)	(800)	422-2940
Pearl S. Buck Foundation (Amerasian Children)	(800)	523-5328
Veterans of the Vietnam War	(800)	VIETNAM
Within PA	(800)	NAM-9090
Vietnam Veterans (Agent Orange)	(800)	521-0198
Within CT	(800)	228-5940

VISION/BLINDNESS

American Council of the Blind	(800)	424-8666
Within DC	(202)	393-3666
American Foundation for the Blind	(800)	232-5463
Within NY	(212)	620-2147
Assn. of Radio Reading Services	(800)	255-2777
Helen Keller Intl.	(800)	ICANSEE
Intl. Guiding Eyes	(800)	824-9726
Within CA	(800)	528-2552
Library of Congress National Library Services for the Blind and Physically Handicapped	(800)	424-8567
Within DC	(202)	287-5100
Library of Congress Talking Book Service	(800)	424-8567
Natl. Assn. for Parents of the Visually Impaired	(800)	225-0227
Natl. Federation of the Blind	(800)	638-7518
Natl. Society to Prevent Blindness	(800)	221-3004
Retinitis Pigmentosa Foundation		

WOMEN

American Academy of Husband Coached Childbirth	(800)	423-2397
Within CA	(800)	423-IRTH
ASPO/Lamaze	(800)	368-4404
Within VA	(703)	524-7802
Endometriosis Assn	(800)	992-ENDO
Within WI	(414)	962-8972
La Leche League	(800)	LA-LECHE
PMS Access	(800)	222-4767
Within WI	(608)	833-4767
Pregnancy Nutrition Information	(800)	MOM4NEWS
Shelter for Battered Women	(800)	333-SAFE
Women's Sports Foundation	(800)	227-3988
Within AK, HI & CA	(212)	972-9170

MISCELLANEOUS

Aerobics and Fitness Foundation	(800)	BE FIT86
American Animal Hospital Assn	(800)	252-AAHA
American Dental Assn	(800)	621-8099
Debtors Anonymous	(212)	964-8934
Environmental Protection Agency Hotline	(800)	424-4000
Within DC	(202)	382-2090
EPA Hazardous Waste Hotline	(800)	424-9346
Within DC	(202)	382-3000
Natl. Center for Pathological Gambling	(800)	332-0402
Natl. Criminal Justice Referral Sys. (crime victims)	(800)	851-3420
Natl. Safety Council	(800)	621-7619
Within IL	(312)	527-4800
Office of Refugee Resettlement	(800)	327-3463
Within FL	(800)	432-0908
Pesticide Telecommunications Network	(800)	858-7378
US Coast Guard Boating Safety	(800)	368-5647
Within DC	(202)	267-0780
We Tip (crime solving)	(800)	73-CRIME
Within CA	(800)	78-CRIME

OUTLINE FOR CRITICAL INCIDENT STRESS DEBRIEFING

(Jeffrey Mitchell's Material)

Tone for the meeting: Positive, supportive and understanding. Each person has feelings and needs the opportunity to share and be accepted.

* No one criticizes another's sharing, all listen to each other!

A. Introductory Phase

1. The facilitator introduces him/herself.

2. The rules are explained.

   a. The need for absolute confidentiality is stressed.

   b. The participants make a pact with each other.

   c. All need to be assured that this is not a critique of performance, but an opportunity for personal feelings about the incident to be shared.

B. The Fact Phase

1. Each tells who they are and how they are involved in the incident.

2. State rank, where they were, what they heard, saw, smelled and did as they worked in and around the incident.

3. Each person takes a turn in sharing details as they remember them.

C. The Thought Phase (Experiencing, Awareness)

After the factual material is shared, the facilitator asks feeling oriented questions.

1. How did you feel when that happened?

2. How are you feeling now?

3. Have you ever felt anything like that in your life before?

CONCERNS:

1. Make sure that each person has a chance to talk.

2. Do not allow anyone to dominate the discussion.

3. People will discuss their fears, anxieties, concerns, feelings of guilty, frustration, anger and ambivalence.

   All feelings: positive/negative, big or small, are important, need to be expressed and need to be listened to.

D. The Symptom Phase (Reaction)

This phase has to do with "the unusual things that happened . . at the time of the incident and any unusual things that are happening now." Also, "has your life changed in any way since the incident." What is going on in their homes, jobs, etc. as a result of the experience. All of this is a personal version of stress response syndrome.

E. The Teaching Phase

The emphasis here is to help the group learn something about stress response syndrome.

It is to see how normal and natural it is for emergency service people to experience a variety of signs, symptoms and emotional reactions to the critical incident they lived through.

Restlessness, irritability, excessive fatigue, sleep disturbances, anxiety, startle reactions, depression, moodiness, muscle tremors, difficulty concentrating, nightmares, vomiting, diarrhea and suspiciousness.

F. Re-Entry Phase

This is to wrap up loose ends, answer questions, provide final assurances and make a plan of action. If symptoms persist, referrals can be made.

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FIRE ENGINEERING

Posttrauma Response Programs

Instead of playing catch-up with posttrauma stress, departments should implement an ongoing program.

BY TIMOTHY BARNETT-QUEEN AND LAWRENCE H. BERGMANN

The psychological result of exposure to duty-related trauma is now receiving considerable attention in the emergency services. Articles, workshops, and other presentations concerning posttraumatic stress disorder, or critical incident stress, are now common. However, information concerning the planning, development, implementation and maintenance of posttrauma programs is lacking. This is the first of three articles that will focus on the practical lessons we've learned by assisting fire, emergency medical, health care, and corrections organizations to develop and maintain posttrauma programs.

This article will review basic information concerning duty-related trauma, the benefits of posttrauma programs, and how they're planned and developed.

Before planning a program, it's important to have some knowledge about the impact of trauma on emergency personnel.

Emergency personnel are likely to face potentially traumatic experiences while on duty. Events which involve death, exposure to extensive destruction, severe injury, or threat to life will be traumatic for many. In our training sessions, emergency personnel have identified certain incidents as most likely to be traumatic: death or injury of children, particularly multiple deaths of children; unsuccessful rescue attempts after great effort; certain types of injuries such as burns or amputations; and responding to calls where friends or family members are the victims. Catastrophic events such as the death or severe injury of fellow emergency workers and mass casualty events are also often mentioned and will likely be experienced as traumatic.

Posttraumatic stress disorder may cause normal psychological consequences in many emergency personnel. These usually fall into three general categories:

- Reexperiencing consequences include flashbacks, anxiety, fear of reoccurrence, hyperalertness, and thoughts of the event.
- Withdrawal consequences include emotional numbing, depression, withdrawal from family, friends, and important activities and avoidance of activities that are reminders of the event.
- Other consequences include irritability, sleep difficulties, problems concentrating, and exaggerated startled response.

In most cases posttrauma psychological consequences aren't long-lasting and don't seriously impair emergency personnel. However, long-term problems, including severe depression, substance abuse, divorce or family problems, or chronic anxiety, may develop.

Such problems may be prevented through a combination of preincident training that provides information about duty-related trauma; offers support within the organization; and encourages the use of specific coping skills. Effective coping skills for personnel should include the ability to predict potentially critical events and to realize that the onset of post-

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trauma psychological consequences is normal.

Reducing the impact

Adequate research isn't yet available to substantiate the effectiveness of posttrauma programs used by emergency-response departments. However, work with other groups, such as Vietnam veterans and crime victims, has shown that intervention following traumatic events is helpful. Effective interventions seem to have certain common features, including administrative support, the opportunity to discuss the event, the support of other personnel and family, and the availability of posttrauma mental health services.

There's no substitute for a planned and coordinated posttrauma program that includes trained and experienced peer and mental health personnel working with prepared and educated emergency personnel. Yet unfortunately, a posttrauma response is most often planned after a particularly devastating critical incident. Such "reactive" responses may lack departmental support, be poorly coordinated, use mental health personnel who aren't experienced with posttraumatic stress, risk poor personnel participation, and may not include adequate follow-up.

In general, posttrauma program effectiveness relies on a combination of careful planning, implementation, and training. Administrators and mental health professionals may hesitate to provide posttrauma services after incidents which impact only an individual or a single crew. Locating knowledgeable mental health professionals, shuffling work schedules, and planning follow-up meetings are time-consuming tasks. However, valuable time can be saved if groundwork for the posttrauma program is done ahead of time. With a functional program in place before the critical incident occurs, all members of the department—regardless of number—can be helped.

Basic elements

Four services should be included in a complete posttrauma program.

- All personnel should receive *duty-related trauma training* to provide basic information concerning CIS/PTSD and the department's posttrauma program.
- A *peer support* component that uses trained personnel from all ranks should be available to monitor potentially traumatic incidents, remain in supportive contact with those involved in incidents, and assess the need for debriefings and posttrauma counseling.
- *Debriefings* (structured group meetings with mental health professionals and peer supporters in attendance) provide opportunities to discuss critical incidents and learn coping skills necessary for the prevention of long-term psychological consequences.
- *Posttrauma counseling* provided by trained mental health professionals allows those in need of additional assistance to have special support.

Through this combination of services, the needs of each individual can be met, regardless of the seriousness of the posttrauma psychological consequences.

Size and administration

Should the program include other departments? There are some obvious advantages to joining forces with other emergency organizations. Initial training expenses can be shared. Mental health professionals and peer supporters have the opportunity to provide more posttrauma services; as a result, they can keep intervention skills current. Peer supporters can themselves receive support from other departments.

However, there may be drawbacks to large programs. These include difficulty in responding to individuals and small crews, as well as difficulty in developing a close relationship with mental health professionals. Moderately sized programs tend to be more flexible and responsive to incidents of varying intensity.

Once the question of whether the program will serve one department or several, realize that there's more than one way to organize it. Some departments find that an informal organization coordinated by the chief or other administrators is most effective. Others use an advisory committee representing all facets of the department to coordinate the program. It's also possible for the department or municipality's employee assistance program to assume coordination responsibilities. The program's administration relies on its size, the specific needs of the department(s), and finances.

Who will pay?

As you make plans for program implementation, plan for the costs of all services, including training, printing, and public relations. Try to predict the approximate number of debriefings your department will have by reviewing calls during the past year that might have benefitted from instruction. It's also important to have sufficient funds for the unexpected traumatic event.

Determine the cost of mental health professionals. Some are paid a flat fee; others are paid by the hour. Be sure to shop around. Fees vary greatly and you may be able to locate competent professionals at relatively low cost. Some may even volunteer their time.

Be creative in obtaining financial support; grants, workers compensation funds, insurance carriers, and donations from private business have all been utilized to support posttrauma programs.

The mental health professionals—psychologists, counselors, psychotherapists, social workers, psychiatric nurses, psychiatrists, and pastoral counselors—are required for debriefings and posttrauma counseling. Each has a specific area of expertise. These services require established generic mental health skills as well as special posttrauma skills.

Not all mental health professionals have worked with those experiencing posttrauma consequences. Fewer have experience with emergency service professionals. Before

agreeing to work with any mental health professional or agency, ask them about their posttrauma and emergency services experience. If they haven't provided such services, make sure that they receive proper training. This could delay the start of the program, but the correct training is essential. Mental health professionals should also have the right kind of personality. They shouldn't be stuffy or use psychological jargon with personnel.. Look for a combination of good professional skills, posttrauma experience, and an ability to relate well to emergency personnel.

Some final advice: Don't rush implementation; while you can make adjustments and changes in your program, errors such as breaches of confidentiality can seriously impact effectiveness.

In the second part of this series, we'll discuss issues important in the implementation of posttrauma program. including training, publicity, and policies. ■

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September 1988 Volume 141, Number 9

FIRE ENGINEERING

Implementing Posttrauma Programs

Part two in a three-part series which will help you to implement and maintain an effective program *before* trauma strikes.

BY TIMOTHY BARNETT-QUEEN AND LAWRENCE H. BERGMANN

A posttrauma program, to be successful, must be supported from within the department by personnel at all levels. Without that support, the confidentiality, the willingness to discuss personal issues, and the full participation in training required to operate the program won't be possible. How can this be accomplished?

Encourage participation. Give people decision-making positions in the program. Using an advisory council or some other group to spread responsibility for program-related tasks will ensure that a large core group will have a stake in the program's outcome.

Spread the word. Make sure that the people who are supportive of the posttrauma program are letting others know why that support is so important. "Cheerleaders" should be respected members of the department of various ranks and responsibilities.

Be consistent. It will be much easier to promote confidence in the program if deadlines are kept and policies are respected. For example, plans and announcements should be made only when an activity is ready to begin.

Find reasons to celebrate. Have a get-together to introduce the mental health professionals and formally announce the names of the peer supporters. Use the department newsletter or magazine to announce training sessions. Use every opportunity to keep the program in the spotlight.

Posttrauma program components

In the first part of the series, we briefly described the types of services necessary to create an adequate posttrauma response program. The best intervention is one that is relatively inexpensive, takes the minimal amount of the firefighter's time, and reduces the probability of long-term psychological consequences. Duty-related trauma training, peer support, debriefing sessions, and posttrauma counseling are all components of this "continuum of care." (The word "continuum" refers to the concept that not all those experiencing duty-related trauma require the same response.)

Posttrauma program components vary in cost and time. Training can be provided by a training officer or other staff person, and it's relatively inexpensive compared to the cost of a mental health professional providing posttrauma counseling to an individual firefighter. If having a peer supporter make contact with personnel is all that's required in a given situation, a more expensive intervention might be circumvented. In some situations, only posttrauma training and peer support will be necessary to prevent long-term problems.

Posttrauma training

The goals of posttrauma training are to prepare personnel for the normal psychological consequences of exposure to potentially traumatic incidents; to teach basic, after-the-incident coping skills; to assist in creating a supportive environment throughout the department; and to describe the components, procedures, and regulations of the posttrauma program.

Personnel at all ranks should receive no less than three hours of training that includes information on: the nature and definition of duty-related trauma and the iden-

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tification of potential critical incidents in the fire service; the normal results of trauma after exposure to critical incidents; suggestions for recovery skills if duty-related trauma is experienced; and building support skills for firefighters.

Posttrauma training is somewhat different from other kinds of fire service training. Instructors should allow discussion of personal experiences and feelings rather than relying solely on lectures and materials. Firefighters not only learn important information about duty-related trauma, but also begin to discuss their feelings with others.

The mental health professionals who will be providing debriefing and counseling services should, if possible, participate in the training. This allows all personnel to meet and begin to interact with those who will be providing posttrauma services. Mental health workers will seem a little bit less like strangers during debriefings and posttrauma counseling if they've met with personnel during training sessions.

Since firefighters know the most about potentially traumatic calls, they're the logical choice as peer supporters.

Although mental health professionals can participate, it's possible for others to conduct the training. (A detailed outline of the training procedures and materials is available in the March and April 1988 INSTRUCTOGRAM, published by the International Society of Fire Service Instructors, or by contacting the authors.)

The more quickly all personnel can receive posttrauma training, the sooner the program can be fully implemented.

Peer support programs

The peer support component's purpose is to ensure that all personnel involved in potentially traumatic incidents will receive the support and services necessary to make a successful recovery. Without individuals in the organization to monitor potentially traumatic calls, some incidents will certainly be overlooked. Those who know the most about the calls being run are firefighters, so they're the logical peer supporters.

Peer supporters are not counselors. Their task is to contact their fellow emergency professional, remind him or her that others in the department are concerned about their welfare, allow them the opportunity to discuss the incident, assess the need for further posttrauma services, and remind the firefighter about productive coping skills taught in the training sessions. They may also participate in debriefings to assist mental health professionals.

Peer supporters act with the consultation and advice of the program's mental health professionals and should receive about 20 hours of training from them. On occasion, a department asks for assistance from counseling services in developing a peer support program without professional backup. The rationale is usually financial: The department wants to save money.

A peer support group without professional backup is a very dangerous proposition. While not common, individuals experiencing the consequences of duty-related trauma may have severe depression and anxiety, and may even consider suicide. Even effective and trained peer supporters shouldn't be expected to handle these difficult situations alone.

Peer supporters must be carefully selected and trained. The most important characteristic of peer supporters is the ability to maintain confidentiality. A peer supporter who — even once — shares information with others in the department can easily destroy a posttrauma program's credibility.

Other selection criteria for peer supporters include:

personality style: Peer supporters should be the type of people others will feel comfortable talking to. It's hard to define this quality, so it's important to trust your instincts in making the selection;

listening ability: A major task of peer supporters is to listen to others talk about the traumatic event and their feelings. The listener must be able to hear and respond appropriately without interrupting. The ability to listen should exist to some extent before peer support training begins;

openness to new ideas: The whole concept of posttrauma services is based on the importance of understanding and talking about potentially traumatic events that have normal and inevitable consequences. These ideas are in opposition to the "macho" myths suggesting that personnel shouldn't let anything bother them and that it's their job to "tough it out." Those who find it hard to accept these new ideas will find it difficult to complete their peer support tasks;

different ranks: Those involved in potentially traumatic incidents should have options concerning with whom they discuss their feelings. Some like the idea of the peer supporter being someone with higher rank. Others have said that they'd refuse to talk to an officer, crew chief, or supervisor. The inclusion of peer supporters of all ranks means that even the chief or director of an organization will have support available;

ability to follow through: potentially traumatic incidents may not occur in departments for some time after the program begins. This means that peer supporters may have to wait and continue in training for a period of time. Patience and the ability to follow through — do what they say they'll do — is an important quality for a peer supporter to have.

The actual selection process can be accomplished in different ways. In some departments the chief simply chooses the peer supporters. It's also possible to use a selec-

tion committee or have personnel nominate potential peer supporters. Remember, it's not always the individuals who volunteer that make the best peer supporters. People may volunteer for this important position for many different reasons, some of which may not be helpful to the program.

Use the selection process that seems to best fit your situation. One chief gave those selected as peer supporters the opportunity to withdraw after the training. Many of those he chose weren't sure about what peer supporters were actually going to do but gave it a try. Only those who were committed to and comfortable with the role of peer supporter actively participated in the program.

Peer supporters must not only understand the consequences of exposure to duty-related trauma, but must also have the skills to assess the need for debriefing and posttrauma counseling. They must also be able to effectively listen to personnel. Thus, the training of peer supporters should include basic information about duty-related trauma, listening and crisis intervention skills, methods for assessing the need for posttrauma counseling and debriefings, and working with mental health professionals as co-debriefers.

Peer supporters won't feel 100% prepared after their initial training period and will benefit from continued training and regularly scheduled meetings. The content of and need for this training will be discussed in the last installment of this series. Peer supporters often find it helpful to discuss their contacts with personnel with mental health professionals.

Debriefings

Debriefings are carefully structured meetings which occur after a potentially traumatic incident. Dr. Chris Dunning of the University of Wisconsin at Milwaukee determined that there are two main types of debriefings, didactic and psychological. Didactic debriefings may include large numbers of personnel and focus on educating participants about posttrauma consequences and effective coping skills. Some who participate in didactic debriefings choose to seek the services of mental health professionals. Psychological debriefings, on the other hand, are designed for smaller groups of personnel (a maximum of 20) and focus on preventing long-term posttrauma consequences and the need for additional services.

It's been our experience that the psychological debriefing is the more effective of the two (especially when part of a planned and coordinated posttrauma program), although there are some disadvantages. The main disadvantage of the psychological debriefing — the time it takes to detail and discuss the traumatic event, posttrauma consequences, and coping skills — also translates into its main strength. Psychological debriefings of three to five hours aren't unusual. Most who participate in this type of debriefing need no further services other than a routine debriefing follow-up. Those who might require posttrauma counseling can easily be identified by the mental health professionals.

The most serious difficulty with the didactic debriefing is that it doesn't allow all participants to discuss their personal experiences. Our posttrauma counseling experience with many other survivor groups — such as rape and other crime victims, automobile, home, and industrial accident survivors, and those experiencing sudden family losses — has shown the importance of each individual sharing his or her experience during a traumatic event and posttrauma consequences with one or a group of people. Didactic debriefings with large numbers of participants don't allow such discussion.

Didactic debriefings also require personnel to determine for themselves if counseling is required. Since some individuals may deny the traumatic nature of the event or numb their feelings after an incident, they may not be aware that they might benefit from these services.

Finally, the mental health professionals conducting the didactic debriefing may have difficulty ensuring the psychological safety of all involved. When the didactic debriefing has many participants, it's virtually impossible to monitor the responses of all involved. In particularly difficult incidents, posttrauma consequences can be quite severe and personnel should be monitored as closely as possible.

There's no one way for mental health professionals to conduct psychological debriefings. There should be, however, discussion of ground rules and agenda for the debriefing (including confidentiality), description of each person's experience of the incident, description of each person's posttrauma consequences, and presentation of information concerning duty-related trauma (including coping skills for recovery, a contract for recovery, and time to discuss the debriefing and offer comments).

Talk to the mental health professionals about the debriefing process they plan to use to make sure it will work best for your department. Don't hesitate to make suggestions, and ask for the rationale of various components. There should be logical and understandable reasons for each element.

Scheduling and arranging for debriefings must be planned before the incident so that the debriefing occurs within two to four days after the incident.

The following decisions must be made:

Who will make the final decision to plan and schedule a debriefing? Usually, this is a joint decision between peer supporters, mental health professionals, and administrators.

Who will be responsible for ensuring that all participants are notified of the debriefing and scheduling for coverage, if necessary?

Where will the debriefing take place, and who will be responsible for preparing the site? The debriefing site should be away from other personnel and as comfortable as possible. Participants must not be on duty and radios should be shut off. Restrooms should be available;

offer refreshments, if possible. Debriefing materials must also be prepared.

How will follow-up be ensured? The debriefing leaders and responsible administrators should plan the follow-up before the debriefing begins to make sure that the time and date are acceptable. All participants are required to attend the follow-up session.

Coordinating the debriefing component of the posttrauma program requires the most planning, and it's important that all the details have been arranged before the first traumatic incident.

Posttrauma counseling

Very few firefighters who participate in a debriefing require further services in the form of counseling. Those who do generally require three to four sessions of special posttrauma counseling.

The mental health professionals leading the debriefing generally are the ones who recommend further counseling for a firefighter. Such a recommendation is made if: 1) severe posttrauma consequences are reported; 2) there is evidence of serious levels of depression or suicidal ideas; or 3) some aspect of a firefighter's participation in the debriefing has indicated that counseling would be helpful. Recommendations for counseling are made by the mental health professional either during breaks during the debriefing or after the session is over. All discussions of this type are confidential.

Counseling sessions are extensions of debriefings and include continued discussion of the traumatic event and posttrauma consequences. There's a heavy focus on coping skills for reducing the probability of long-term posttrauma consequences. Posttrauma counseling sessions are different from many other kinds of counseling and psychotherapy in that they are almost exclusively oriented to the "here and now." While some mental health professionals spend considerable time with clients discussing events in the distant past, those working with traumatized firefighters deal almost exclusively with the traumatic event and efforts toward recovery.

Confidentiality

Firefighters participating in posttrauma counseling are not mentally ill or "crazy." Rather, for various reasons, they've experienced an event that's quite traumatic and, as a result, will benefit from a longer period of support during their recovery period. All counseling sessions must be confidential. Any breach of confidentiality by administration or mental health professionals will seriously impair the program and the recovery of those involved.

There are two exceptions to confidentiality. If a firefighter is considered a risk for suicidal or homicidal behavior, mental health professionals must ensure the safety of all involved. Also, they must inform the appropriate officials if there is a genuine concern for the job performance of the individual. Serious impairment is a risk to firefighters and the public.

Other considerations

It's important that program requirements and operations be described in the department's policies and procedures manual. This legitimizes the functions of the program and describes the responsibilities of all personnel.

Some departments choose not to keep records of posttrauma program operations. Others require written reports of debriefing sessions to be submitted to administration. It's best to clear the content of all written reports with those involved before submission, allowing areas of disagreement or discomfort to be rewritten.

In Part III of this series, the maintenance of posttrauma programs will be discussed. Since a department may go through periods with no incidents requiring the operation of the program, it's critical that departments plan maintenance strategies along with the other program components. ■

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The purpose of this three-part series is to provide a practical guide for fire departments that are planning to implement critical incident stress/posttrauma programs. Part I, which appeared in August's issue, reviewed basic concepts concerning duty-related trauma and guidelines for planning posttrauma programs. Part II, in the September issue, suggested methods of gaining support and implementing program components—training, peer support, debriefings, and posttrauma counseling. In this last installment, methods for maintaining posttrauma programs will be discussed.

HEALTH AND SAFETY

Maintaining Posttrauma Programs

How to keep your program effective after it's up and running. Last of a three-part series.

BY TIMOTHY BARNETT-QUEEN AND LAWRENCE H. BERGMANN

ANY PROGRAM must be carefully nurtured if it's to be as effective five years from now as it was at the start. Posttrauma programs in fire departments may be difficult to maintain for several reasons:

Personnel would rather not think about the possibility of experiencing duty-related trauma. The publicity needed to maintain the program may at the same time trigger memories of critical incidents that may have occurred and increase existing posttrauma psychological consequences;

In many cases, posttrauma programs may be idle for a period of time. While training of recruits and new personnel will continue, posttrauma responses may be infrequent;

Posttrauma programs are still somewhat controversial and may not enjoy 100% support within a department. Detractors may hurt the program over a period of time by talking it down or saying that it's not needed;

The posttrauma program depends on relationships between management/administration, advisory council, mental health workers, peer supporters, and personnel. All must communicate effectively for the program to operate. There may be a tendency for these important contacts to diminish over time, in which case the program will suffer.

These elements work against the long-term maintenance of a posttrauma program. However, with creative planning and work, it's possible to ensure that an effective posttrauma response will be available.

GUIDELINES FOR MAINTAINING POSTTRAUMA PROGRAMS

The quality of posttrauma services and the amount of its exposure to personnel will determine success or failure in maintaining the program.

An effective program helps keep itself alive. The first few times a peer supporter contacts a firefighter or a debriefing occurs, word spreads about the general experience ("It helped to talk about it" and the like.) Positive feedback will make personnel feel more comfortable and more willing to participate again.

It's crucial to emphasize the importance of confidentiality. Nothing harms a posttrauma program more than when personal information is communicated to others. Confidentiality must not only be stressed to management and peer supporters, but to the debriefing participants as well. If information that was shared in private becomes known by

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HEALTH AND SAFETY

MAINTAINING POSTTRAUMA PROGRAMS

others, the level of trust will be greatly reduced.

Exposure to the program must occur at all levels of the department. Some communication and training efforts should be specifically directed at upper-level officers, who will be playing an important role in referring firefighters to peer supporters and mental health professionals. Options for reaching supervisors include program updates at officers' meetings and one-on-one discussions.

Efforts to reach other personnel are limited only by creativity. Some have placed articles in departmental newsletters or magazines, distributed posters to be placed on bulletin boards, and had peer supporters speak at staff meetings. One program created buttons that read, "CIS?—Ask Me."

Not all publicity need be extremely serious. Using tasteful humor in posters or cartoons, for example, can be an effective reminder that duty-related trauma is a risk of the fire service. Be creative and have *fun* while promoting the program.

THE TRAINING COMPONENT

It's important to ensure that all personnel receive the initial critical incident stress training; any recruits or newly hired individuals should participate as soon as possible. In this way, all members will be knowledgeable about the posttrauma program and the psychological results of trauma.

The training of new recruits is especially critical. Recruits tend to have a much lower threshold of trauma than veteran members, and they're more vulnerable to posttrauma psychological consequences until they gain experience and coping skills. It's a good idea to modify duty-related trauma training for new members and to have veterans talk about their experiences on the fireground.

Recruits represent the future of the fire service, and most will support the addition of psychological care made available by the department. Recruits who receive the training will come to consider posttrauma services as routine and be supportive of the program.

> Peer supporters are the heart of any posttrauma program, so special efforts should be made to keep their enthusiasm high and improve their skills by offering additional training.

PERPETUATING PEER SUPPORT

Peer supporters are the heart of the posttrauma program. Special efforts should be made to maintain their enthusiasm and to improve their skills.

It's not uncommon for peer supporters to request additional training after the posttrauma program is implemented. The most requested topics include practice sessions, where mental health professionals give feedback concerning their work; substance abuse; debriefing skills; and suicide prevention. The added training enhances skills and increases confidence. Contact with other peer supporters builds morale and gives them the opportunity to discuss their experiences.

Meetings should be routinely scheduled to discuss administrative aspects of the program, both good and bad. Mental health professionals should attend so that questions on specific responses can be discussed.

At least once each year, peer supporters should meet for their own debriefing—a time for debriefing the debriefer. When especially traumatic critical incidents occur, a debriefing should also be planned. Peer supporters may be more vulnerable to chronic stress when they spend time and energy on others.

New peer supporters will be required at regular intervals. Some departing peer supporters will retire, find new jobs, or tire of the responsibility. New peer supporters must be trained so that all shifts and functions are represented.

DEBRIEFINGS AND COUNSELING

The big hurdles in keeping the debriefing and counseling functions of a posttrauma program running well are maintaining the skills of the mental health professionals and their relationship with personnel.

Mental health workers can get rusty if their skills aren't used. They'll be working with people every day, but may only occasionally have contact with firefighters experiencing traumatic stress. In some departments, mental health professionals and peer supporters refine their skills by planning a mock debriefing; a feedback session afterward helps them to improve their skills.

It's also important for department personnel to continue getting to know the mental health professionals. Where we provide posttrauma services to departments, we attend meetings, conferences, and social gatherings where we can informally meet with personnel. When in the area, we'll stop by departments to talk to personnel. They know that we're concerned and interested in what's happening in the departments, and that "shrinks are people, too."

EVALUATING YOUR POSTTRAUMA PROGRAM

Posttrauma programs must be evaluated to ensure effectiveness and satisfaction among personnel. At regular intervals, personnel should be surveyed to determine the rate at which program services are being used, as well as their perception of peer supporters and mental health professionals. Informal discussions can help unearth problems in confidentiality and what's being said in the rumor mill.

The perceptions of mental health personnel and peer supporters will also be useful. If possible, the mental health professionals should follow up with debriefing and counseling participation to monitor any long-term posttrauma consequences that may have developed.

Finally, compile a list of all incidents where responses have taken place. A determination can then be made about the appropriateness of a decision to provide posttrauma services. The evaluation's results should be given to the advisory council for any decisions on how to make the program better for the department.

In this series we've expressed our understanding of the issues regarding duty-related trauma as well as our experience in making posttrauma programs operate efficiently. It's our hope that this will make it easier for all departments to protect their employees from the long-term psychological risks of the fire and emergency service. ■

Critical Incidents in Policing, Rev., U.S. Department of Justice, Federal Bureau of Investigastion, Reese, Horn and Dunning, eds., Washington, D.C., 1991.

PEER SUPPORT AND TRAUMATIC INCIDENT TEAMS: A STATEWIDE MULTIAGENCY PROGRAM

Eugene Schmuckler, Ph.D.

ABSTRACT

Although public safety agencies are beginning to accept stress as an occupational fact of life, recognizing the impact of traumatic incidents upon personnel still meets resistance. Organizational reluctance is expressed in statements such as "If they can't stand the heat let them stay out of the kitchen." Organizations refuse to deal with what it means for an individual to experience a psychological injury. This paper will describe the program developed by the state of Georgia to deal with these issues. It will address the resistance displayed not only from within the agency but also from what may be viewed as surprising sources. Furthermore, it will examine the means by which individuals from different types of agencies are molded into a unit.

INTRODUCTION

During the past fifteen years, stress and its consequences have been the focus of national and international concern. This concern does not stem exclusively from altruistic motives. The effects of negative stress have been identified as contributing to cardiovascular ailments, gastrointestinal problems, dermatological conditions, and a wide range of behavioral and emotional sequelae. The economic impact of stress is measurable in terms of absenteeism, accidents, substance abuse, and turnover.

Stress is of particular concern when the affected individual is a public safety officer entrusted with weaponry; the ability to make life-and-death decisions; and is charged with responsibility for the public's safety. Economic concerns draw attention to the fact that many stress reactions are costly to the employing agency in terms of increased liability risks and thus higher insurance premiums, loss of valuable personnel, low levels of morale, high absenteeism, reduced competency levels due to substance abuse, and increased public displeasure from those on the receiving end of physical or verbal abuse.

Recognition of the effects of stress has not led to a groundswell of stress management programs in the public sector. A number of factors contribute to this relatively low response. For public safety employees, helping professionals (psychologists, psychiatrists, social workers, EAP counselors) are viewed with suspicion. Many public safety officers question the professional's competency with statements such as, "He/she needs help more than I do." Sitting in waiting rooms in which they may encounter persons they have met in pursuit of their duties adds to the discomfort of seeking help. Officers may doubt the service's confidentiality. Officers cite the fact that they often know when one of their colleagues receives professional counsel within moments after the individual leaves the professional's office. Insurance claim forms can inadvertently become a matter of public record, further adding to the resistance to seeking help.

Many agencies are also reluctant to allow affected individuals to seek professional assistance. Senior officers are of the opinion that "They aren't making them like they used to." Allegedly able to handle any stressors they might encounter, they are unable to understand why their charges are not able to function in the same way. There is also concern that the public will lose respect for the agency if it becomes known that officers seek and receive assistance from helping professionals. Still another concern is that which deals with the ability of one who has been to a "shrink" to function in a line-of-duty situation.

All of these concerns were and still are present within the public safety ranks in the state of Georgia. The geopolitical structure of the state is another element that may frustrate an individual's ability to seek help. There are over 150 counties in the state, many of which are rural in nature. Mental health facilities may not be readily available. The majority of law enforcement agencies consist of less than 10 sworn officers. For an individual to take time off from work to seek help results in the agency functioning shorthanded.

Awareness of these circumstances, along with serendipity, is in part responsible for the program in Georgia. The efforts of several progressive law enforcement agency chiefs and a representative of the Georgia Department of Human Resources led to the writing of a proposal presented to a gubernatorial candidate, Mr. Joe Frank Harris. Upon his election, Governor Harris issued an Executive Order directing that the Georgia Peace Officer Standards and Training Council (POST) conduct a study "for the purpose of identifying the specific symptoms of law enforcement personnel distress." Further, the Council was directed to develop a program "to assist law enforcement executives in managing stress-related personnel problems within their agencies and to make recommendations to the Governor concerning the appropriate role of the state in implementing such programs." To assist in this effort the Executive Order directed POST to enlist the expertise of the Department of Human Resources, the Criminal Justice Coordinating Council, the Department of Community Affairs, law enforcement executives from both the state and local level, local government officials, academicians, and knowledgeable members of the general public to participate in this study. The Council in turn established a Law Enforcement Stress Task Force to be coordinated by the Governor's Office of Planning and Budget. By having representatives from all the above-mentioned agencies involved at the onset, the task of persuading the legislature to implement the recommendations became significantly easier.

During the course of the study it was found that some individual departments were already making attempts to provide services designed to help officers overcome the effects of negative reactions to stressors. In a majority of instances the programs focused on the use of a department chaplain who may or may not have had specific training in counseling peace officers. Only a few agencies maintained a referral relationship with a mental health agency or a mental health professional.

The completed study offered a number of recommendations. This paper will focus only on two of the categories. The first concerns the individual's stress-coping ability. Centered mainly in a didactic modality, the approach focuses on increasing the stress awareness of individuals. The second category is concerned with providing assistance to stressed individuals. The study stated, "In close relation to the self-help technique is the peer counseling where officers help each other. Peer counseling becomes a kind of first line of defense that does not replace existing programs such as AA or drug programs, but aids the affected officer in accepting that there is a problem and in finding appropriate assistance."

Armed with the results of the study, the Task Force went before the state legislature requesting a Project Coordinator be named to continue the program on a full-time basis. The combined support of all participating agencies was a major reason for the legislature creating the requested position.

THE GEORGIA PROGRAM

The position of Stress Management Supervisor became operational on July 1, 1984, and was housed in the George Police Academy. Placement within a training facility dictated that the primary focus would be on providing training as opposed to psychological services. It was further dictated that programs would not be restricted to law enforcement but would be available to all Georgia public safety personnel, i.e., firefighters, EMTs, and correctional officers. In 1987, the position was moved from the Police Academy to the Georgia Public Safety Training Center. This organizational change made the program more accessible to non-law-enforcement personnel. Initial course offerings provided training in stress awareness and management. Programs were tailored for line personnel, first-line supervisors, and for chief executives of public safety agencies. A special program was designed for members of the helping professions to make them aware of the specific stresses confronting public safety personnel. These programs are still an integral part of the stress program. In addition, specialized blocks of instruction on stress-related matters are included in most course

possible for agency heads to observe what they may expect should their agency have the misfortune of being involved in a catastrophic situation. Offsite training also encourages mental health professionals to attend. Finally, the regional emergency health service training coordinator attends and plans for follow-up training. As with peer counselor training, debriefer training includes an extensive amount of practical experience. A program has been initiated with the Georgia Emergency Management Agency (GEMA) to include debriefings as part of their disaster management drills. Hospitals in the state are required to conduct disaster drills, and debriefings are now included as part of those programs. As a result, debriefing is now considered something to be expected after a disaster and not an afterthought. By having local individuals serve as the debriefers, continuity of service is maintained. Having the program's overall supervision housed at the Public Safety Training Center provides debriefers with a readily accessible resident individual to contact should problems develop. This arrangement has also led to the inclusion of debriefings as part of First Responder, Extrication, and elements of State Patrol training. This "first generation" training is being met with a highly favorable response by the trainees and their respective agencies.

It would be nice to say that the programs are totally successful. Unfortunately, that is not the case. The programs require constant marketing efforts. Public safety agency executives do not always enjoy job security. Participation of an agency during the tenure of one chief does not necessarily assure the programs' continuation under a new chief. Stress is still a four-letter word to many public safety officers. The Supervisor of Behavioral Sciences (an expansion of function from the Stress Management position) addresses as many groups as possible. The dominant theme presented during the presentations focuses on economics such as lost productivity and liability resulting from stress and trauma-related problems.

The programs face resistance in subtle as well as direct ways. A number of private practitioners view the programs as something that infringes upon their domain. The concern voiced is not one of peer counselor competency, but the potential loss of income. As a result, peer counselors are encouraged to meet with private practitioners in order to allay the practitioners' fears. The experience has been that when practitioners understand that the peer counselor is a potential referral source for new clients, the resistance softens significantly. A surprising and distressing amount of resistance has been displayed by individuals associated with Employee Assistance Programs (EAP) and Community Mental Health Centers (CMHC). These individuals view the peer counselors as competitors, not for dollars, but for clients. This resistance is difficult to dissipate, especially on the part of EAP personnel. CMHC personnel are critical members of the debriefing teams, and once their roles are explained to them the resistance is usually overcome. When it is not overcome, the already existing schism between the helping professional and the public safety officer is widened. To further aid in dissolving the threat to the CMHC, a Stress Referral Directory has been published by the Public Safety Training Center. This directory lists every agency in the state, public and private, offering mental health services to the community. This directory has served to indicate to the centers that the Peer Counselor Program does not compete with but instead serves as an adjunct to their services.

CONCLUSIONS

Although still in their infancy, Georgia's programs have made a good deal of progress. The basic Peer Counselor Program has been expanded to include a very strong debriefing component. Following the model of the U.S. Navy Special Psychiatric Intervention Team (SPRINT), Georgia has developed the Traumatic Incident Group Emergency Response (TIGER) team. Members of this team have been called upon to serve their colleagues in a variety of instances. Examples include providing debriefings postshooting, death of an officer killed while directing traffic, a quick response EMS unit colliding with a civilian vehicle resulting in death to the civilians, and several calls involving deaths of youngsters. Having individuals trained as debriefers from a variety of different services greatly expands the pool of debriefers from which to draw. The early successes of the debriefers has led to an increased interest in the program. This is reflected in the number of inquiries and requests for services received. It appears that the battle to persuade the officer and the agency of the beneficial effects of the services peer cCounselor and debriefings) is being met. The battle to convince professionals in the public and private sector of the mutual benefits of the program is still being waged. The overall beneficiaries of the program are Georgia's dedicated public safety employees.

offerings. For example, the judgmental shooting class includes a block of instruction relating to postshooting trauma.

Child abuse and family violence classes deal with stress awareness and prevention of burnout. Inclusion of these instructional blocks provides stress management information and also makes class participants aware of the other programs available to them. It has been found that providing line officers and first-line supervisors with information concerning the stress programs leads to a high likelihood of agency acceptance.

Long-term evaluation of the stress management and awareness programs indicated that their effectiveness was of relatively short duration. Officers returned to a work environment or a domestic situation identical to that which they left. The sources of stress were still present. They sought out social and peer support as suggested in class but found it to be unavailable to them. Their receptivity to seeking help was frustrated.

The POST study called for development of peer counselor programs. A number of elements needed to be taken into consideration before this program could become operational. Many agencies are too small to have their own peer counselors. It is recognized that in spite of assurances of confidentiality, individuals might still be reluctant to speak to a member of his/her own agency. Also, the program needed to be available statewide to all public safety agencies. Serendipity again came into play. The Emergency Health Unit of the Department of Human Resources recognized the need to develop a traumatic debriefing program. At a steering committee meeting it was decided that a preliminary requirement for one to serve on a debriefing team was successful completion of the Peer Counseling Training Program. As a result of the strong commitment on the part of this group, it was decided that the Peer Counselor Program would be undertaken on a regional basis using the 10 emergency health regions. In this way it was assured that every part of the state would have a pool of peer counselors, and with additional training, debriefers would be available. The regional concept is an important one and has been an important element in the program's success. Each emergency health region has a regional coordinator and a training coordinator. This facilitates communication and mobilization and leads to a sense of program "ownership" in each region.

Individuals may attend peer counselor training either by self-nomination or through selection by the agency head. Classes are limited to 18 participants. Class makeup includes individuals from different services and functions. This fact is not made known to participants until the afternoon of the first day of class. The initial peer counselor training class was held in June 1987. To date over 300 peer counselors have been trained. The training is not unlike that presented in other peer counselor programs. The participants are advised that their role is that of a counselor and not of a therapist. They are encouraged to work with professionals and refer whenever possible. The training includes basic communication skills, group dynamics, dealing with resistance, and problem solving. Specific issues covered include assisting suicide survivors, substance abuse intervention, dealing with death, and domestic relationships. A large segment of the 40-hour training course includes practical experience. Sessions are videotaped for evaluation. In the main, the response of participants has been extremely favorable. Even individuals who choose not to become peer counselors at the completion of the training have indicated that the training has had a marked impact upon their lives. Of greater significance is the fact that in those agencies in which the program is supported by management there have been marked reduction of stress-related problems. When a peer counselor leaves one of those agencies, the chief executive immediately seeks to have another individual go through the training.

Having firmly established the peer counselor training, it was possible to go on to the second phase, developing traumatic incident briefing teams. As stated above, members of the team must have first completed peer counselor training. It is strongly felt that the communication skills taught in peer counselor training classes are a necessary first level for debriefers. Individuals who are to be trained as debriefers must first receive endorsement from their agency. Without this endorsement they are ineligible to attend. Another way in which debriefer training differs from that given to peer counselors is that the training is presented at a facility in the region as opposed to having debriefers attend class at the Training Center. This makes it

Critical Incidents in Policing, Rev., U.S. Department of Justice, Federal Bureau of Investigation, Reese, Horn and Dunning, eds., Washington, D.C., 1991.

LAW ENFORCEMENT APPLICATIONS OF CRITICAL INCIDENT STRESS TEAMS

Jeffrey T. Mitchell, Ph.D.

INTRODUCTION

Although police departments have been utilizing peer support teams for shooting incidents for a number of years, it is only recently that law enforcement agencies are joining with their counterparts in fire and emergency medical services to develop multiagency critical incident teams. The critical incident stress teams do not replace the postshooting trauma teams, nor do they replace the services of police psychologists. Instead they incorporate those support services or work in very close association with them. In addition, critical incident stress teams more closely utilize specially trained mental health professionals in direct group services to emergency personnel than peer support shooting teams have, in general, utilized in the past. Another factor that differentiates critical incident stress teams from postshooting trauma teams is that a broader scope of distressing events beyond shootings have been identified as being stressful. In addition, critical incident stress teams have shifted the emphasis from posttrauma intervention to pretrauma prevention programs. This paper will explore the recent utilization of critical incident stress teams in the law enforcement arena.

BACKGROUND

Wittrup (1986) and Blau (1986) report marital and family disruption and an increased use of alcohol and drugs after a shooting incident. Mantell's work with police officers involved in shooting episodes certainly supports the concept that this particular critical incident has significant negative short- and long-range impact on the officers (1986).

Recent experience with a variety of distressing events has clearly indicated that shootings are only one of a variety of situations that have the potential to disrupt the police officer's life and happiness (Lippert & Ferrara, 1981). Pierson (1988) points out that a critical incident is one in which "the coping mechanisms are overwhelmed by what is experienced" (p. 26). He goes on to list co-worker deaths, child victims of violence, victims of traumatic events who are known to or who remind the officer of a loved one, disasters, prolonged rescues, or events in which there are extreme dangers to the officers at the scene.

Fowler (1986) states that a significant critical incident for law enforcement is a situation in which the officer's expectations of perfect performance are suddenly tempered by fallibility, imperfection, and crude reality. For example, when a prolonged negotiation with a suicidal person breaks down and the intention to die becomes a harsh reality, the officer's expectation of success becomes crushed and a loss of self-confidence and increased self-doubt ensues.

Wagner (1986) further indicates that serious injury to an officer, which might be caused by a vehicular accident or a fall, can be a critical incident that may need intervention. Other critical incidents might be a situation in which an officer's life is in danger. Hostage taking and hazardous material incidents come to mind as life-threatening circumstances.

This author has identified traumatic deaths to children, significant child abuse cases, witnessing a person's traumatic death, disasters, accidental death or serious injury to a civilian as a result of police action, intensive media interest in a particular event, or virtually any event that has sufficient power to overwhelm

the usually effective coping mechanisms of the officers involved as critical incidents (Mitchell, 1982, 1983, 1988a, and 1988b; Mitchell and Donahue, 1985).

THE CRITICAL INCIDENT STRESS TEAM

The seeds of critical incident stress teams were actually planted during combat situations in World Wars I and II. Brown and Williams (1918), Salmon (1919), Appel, Beebe, and Hilger (1946), Pittsburgh Post Gazette Staff (1984) found that the soldiers in the great wars were more prone to return to combat when given immediate psychological support after combat than when managed later in hospitals where they were well behind the combat lines.

More recently, the Israeli Defense Forces began to utilize group and individual psychological support after fire fights in the Middle East. They concluded that the incidence of psychiatric disturbance was trimmed by as much as sixty percent since the inception of their support services (Breznitz, 1980; Solomon and Horn, 1986; Pughiese, 1988).

Many emergency services personnel, including law enforcement officers, were initiated into critical incident stress teams after such horrific events as airplane crashes, tornadoes, floods, and large fires. It was through these types of events that police frequently learned that there was something very positive to be said for immediate support from teams of specially trained mental health professionals and peer support personnel (McMains, 1986; Somodevilla, 1986).

Many critical incident stress teams were begun in fire and emergency medical services units and these organizations experienced great benefits from the teams (Mitchell, 1988). However, police were initially slow to accept the potential benefits of such teams despite the fact that they saw the benefits of postshooting trauma teams for police officers. For some unknown reason, it was more difficult for law enforcement to accept the fact that more than one type of event (namely shootings) could be highly stressful for law enforcement personnel. Perhaps experiences coming out of other emergency service organizations were not easily accepted by police departments because they thought that no other experience compares to law enforcement. Perhaps some resistance was founded in the "macho" image that many police have developed (Baruth, 1986).

In any case, disasters and other major events such as line-of-duty deaths, serious injuries to emergency workers and very traumatic deaths to children tend to strip away the usual defenses and equalize emergency service providers. What remains then is a realization that they are all very much the same regardless of the uniforms or the equipment. They are human beings first and they are vulnerable to being hurt by their jobs.

TEAM COMPONENTS

Critical incident stress teams are in actuality a partnership between mental health professionals and emergency workers who are interested in preventing and mitigating the negative impact of acute stress on themselves and their fellow workers. They are also interested in accelerating the recovery process once an emergency person or a group has been seriously stressed.

Mental health professionals who serve on the teams have at least a masters degree in psychology, social work, psychiatric nursing, psychiatry, or mental health counseling. They are specially trained in crisis intervention, stress, posttraumatic stress disorder, the personality of emergency workers, and the critical incident stress debriefing process.

Peer support personnel are drawn from emergency service organizations--police, fire, emergency medical services, dispatch, disaster response personnel and nurses (especially those in emergency or critical care centers). Both the mental health professionals and peer support personnel form a pool of critical incident team members from which a response team is developed. An incident that is predominantly police oriented

is worked by police peers with the support of mental health professionals who are familiar with police activities and procedures. Likewise an incident that is predominantly fire in nature will have fire peers who provide the support services. If an incident involves various response agencies, then a mixed cadre of peers is developed to provide support services (Mitchell, 1988a, 1988b).

There are currently 175 teams in 34 states around the United States. There are also teams serving emergency personnel in five foreign nations. Since the first multiagency, multijurisdictional teams were developed in 1983, over 8,000 critical incident stress debriefings have been provided (Mitchell, 1990).

PREINCIDENT STRESS EDUCATION

Perhaps the most important element of a critical incident stress team is preincident stress education. From inception of the critical incident stress team concept, stress and crisis intervention programs formed a base from which most other support services were established (Mitchell, 1987; 1990).

Providing stress education before the crisis event strikes helps to reduce the impact of traumatic events on the personnel. There is some truth to the statement, "forewarned is forearmed." Personnel involved in distressing situations generally are better able to avoid stress reactions or they are able to better control their reactions should they occur. It has been found that they are usually better able to recover from acute stress reactions because they recognize the symptoms and call for assistance sooner (Miller and Birnbaum, 1988; Bandura, 1985; Meichenbaum, 1974).

Stress training should begin with new recruits (Ellison and Geny, 1978). New police recruits are generally more open to hearing the message that they are vulnerable too and need to take precautions to control their stress. In Howard County, Maryland, every police recruit class receives a minimum of six hours of stress control training. Anecdotal reports from participants encourage the continuation of the stress program because it is "useful," "practical," "interesting," and designed to give information that protects the officer from excessive stress. The majority of attendees believe that the program was personally helpful to them. In addition, all police officers in the county are given three hours of stress training when they cycle through the academy for required in-service programs. Command personnel are also given stress training to enhance their skills in picking out officers with symptoms of distress.

The stress training, which is a potent part of stress prevention (Jeremko, Hadfield, and Walker, 1980), includes an overview of general stress theory, some differentiation between routine stress and the stress encountered during police operations, the signs and symptoms of distress, stress survival skills, referral strategies for additional help, and methods of dealing with cumulative stress (Mitchell, 1990). It should be noted that peer support personnel and mental health professionals on critical incident stress teams provide the stress education programs in between their activities related to crisis events.

FAMILY SUPPORT

There are incidents in the careers of police officers that leave a profound effect not only on the involved officers but upon their family members as well. With police work, it is virtually impossible to "leave it all at the job." Side effects of traumatic events tend to have a way of making it home in the form of anger, depression, frustration, grief, insecurity, confusion, and disillusionment. Family members frequently become the convenient target of displaced emotions.

A significant other stress course is helpful when officers first enter the department and periodically during the course of their career. In this way spouses feel less left out. They also gain valuable insights into the behaviors and reactions of their loved ones.

When a major event occurs that distresses those at home, debriefings are provided to significant others as well as the affected personnel. However, significant others and the emergency personnel are never mixed together since the issues encountered by significant others are markedly different from the issues encountered by emergency personnel.

On occasion, critical incident stress teams may need to provide support services to the children of officers. Critical incident stress team members have also provided assistance by means of general support and counsel to bereaved family members after a line-of-duty death (Mitchell, 1990).

ON-SCENE SUPPORT SERVICES

Some police events are powerful enough to produce virtually immediate, noticeable stress reactions at the scene of an incident. Delayed assistance in such cases almost assures difficulties in both maintaining one's function at the scene and in achieving a full recovery in a timely fashion.

Several police departments around the country are sending police peer support members of a critical incident stress team to actual or potentially disruptive incidents such as barricaded subjects, hostage takings, and major SWAT operations. Although the team members are not always utilized in such incidents, their mere presence has been favorably accepted by police because the officers feel positive about the support given by fellow police officers. If a situation goes bad, peer support personnel can go into action immediately and provide support to officers during the height of the crisis. Maintenance of the officer's on-scene function or a quick restoration to duty are the goals of on-scene support services (Dean, Taber, Collier, 1989).

Peers who are present at the scene provide three general areas of support.

1. They assist individual officers who may be seriously stressed by an event. They may, for example, move a distressed officer a short distance away from the scene to cut down auditory, visual, and olfactory stimuli. Group work is not provided since officers are at various emotional levels during operations.

2. They provide suggestions and advise commanding officers. For example, they may recommend that certain tactical units be given a break to enhance their overall performance.

3. They may assist actual victims of the event or their family members. For example, if an hysterical person is interfering with a police operation, critical incident stress team members may intervene to free up operational officers.

INDIVIDUAL CONSULTATION

Many services of critical incident stress teams are provided to groups. However, individuals frequently need to talk to someone. Peer support and mental health professionals therefore make themselves available for one-to-one consultations. Several police officer suicides across the nation were averted because of the support rendered by fellow officers trained as critical incident stress support personnel or peer counselors. The group on the critical incident stress team which, as a whole, appears to have the greatest success with law enforcement personnel is the peer support group. Several authors have praised the success of peer support programs (Klyver, 1986; Linden & Klein, 1986). Peers are certainly vital to the critical incident stress team functions in every aspect from education to debriefings.

SMALL GROUP MEETINGS AND DEFUSINGS

After a distressing incident, police personnel frequently get together and talk things over among themselves. These meetings are usually helpful as a ventilation mechanism and are encouraged. On occasion, trained peer support personnel are present and may informally assist their fellow officers. When properly trained, police peer support officers are knowledgeable about telltale signs that indicate that a group meeting is going sour. They are advised to change the topic or otherwise divert the conversation when members of the group are being personally attacked or when the humor is forced and no longer spontaneous and natural.

A more structured meeting is called a defusing. These meetings usually take place within twenty minutes or up to a few hours after the incident. Eight to twelve hours after the incident is about the limit of the window of intervention. After that time, emergency personnel have managed to seal over their distress and their defense system is fully mobilized.

The defusing takes place away from the scene. Police frequently gather at someone's home or in some other area with limited interruptions. A defusing lasts between twenty minutes and one hour and has three main parts. They are:

1. A brief introduction that sets the ground rules for the defusing. Confidentiality is emphasized. Defusings are not an operations critique and should not be mixed with one.

2. Personnel are asked to describe what happened. They are reminded that a defusing is not part of an investigation, but instead is a meeting designed to assist police officers in recovery from a distressing event.

3. Police officers are then given information that may be helpful to them during the next 24 to 72 hours as they return to routines.

The defusing meeting is typically led by peer support personnel but it may also be led by mental health professionals or a combined team of peers and mental health personnel (Mitchell, 1990).

DE-ESCALATION PROGRAM

A de-escalation is a process of transition from a major event, such as a disaster, back into the usual routine. It is sometimes called a "demobilization" although police officers generally do not appreciate that term because "demobilized" has certain negative connotations of being incapacitated.

The de-escalation is reserved for large-scale incidents only. A great many emergency personnel must be involved in a single event for a considerable period of time before a de-escalation center is established. The usual criteria call for 40% to 60% of available emergency resources to be committed to a single action for longer than eight hours.

In the de-escalation, personnel are brought to a large meeting room by a working unit such as a tactical unit, a perimeter control team, or a K-9 unit. They are seated with their own unit and given a ten-minute talk on critical incident stress, the signs and symptoms they may encounter, and the techniques they may use to control and reduce their stress. Police officers or any other emergency personnel do not have to talk if they do not want to. They are given an opportunity to ask questions or to make comments if they wish at the end of the ten-minute talk, but no pressure is exerted on them for any discussion.

Once the ten-minute stress survival talk is completed, they are given a handout that outlines the general signs and symptoms of distress and offers numerous suggestions that the officers might utilize to reduce

and control stress. There are phone numbers at the bottom of the handout that may be used to obtain additional assistance should that be necessary.

Officers are then given twenty minutes to eat and rest before they are given instructions regarding a return to their usual routines. The entire de-escalation process takes a total of thirty minutes and only ten minutes spent on the stress information talk (commonly given by a mental health professional) and the remainder is dedicated to eating and rest (Mitchell, 1990).

CRITICAL INCIDENT STRESS DEBRIEFINGS (CISD)

Another service of the critical incident stress team is debriefings. Debriefings are group meetings that have been designed with two major goals in mind. First, they mitigate the impact of a critical incident. Second, they accelerate the recovery process in normal personnel who are experiencing normal reactions to abnormal events.

The debriefing process has both psychological and educational elements, but it should not be considered psychotherapy. Instead, it is a structured group meeting or discussion in which personnel are given the opportunity to discuss their thoughts and emotions about a distressing event in a controlled and rational manner. They also get the opportunity to see that they are not alone in their reactions but that many others are experiencing the same reactions.

There is always some question as to whether a debriefing should be made mandatory. The answer is a command decision and not one to be made by the critical incident stress team. However, it should be recommended as a mandatory process because many who could benefit from the debriefing will not show up unless it is mandated. If an organization decides to mandate the debriefing, it must also be willing to provide either release time or pay to the officers.

The manner in which a debriefing opportunity is presented to the personnel is crucial. If the leadership downplays the importance of a debriefing, or if it criticizes the process, command staff may, in effect, be denying their personnel the opportunity for rapid recovery from trauma. They may be setting their officers up for longer term distress than would occur if they encouraged a positive involvement in the debriefing process.

The debriefing is structured with seven major phases. It has been carefully structured to move in a nonthreatening manner from the usual cognitive-oriented processing of human experience, which is common to law enforcement personnel, through a somewhat more emotionally oriented processing of their experiences. The debriefing ends up by returning the personnel to the cognitive-oriented processing of their experiences where they started.

The first segment of the seven-phase process is the **Introduction**. The trained critical incident stress team lays out the ground rules of the debriefing process, describes an overview of how a debriefing works, and encourages active involvement on the part of the participants. Confidentiality is emphasized throughout the process. Space available for this paper does not permit a full discussion of the introductory remarks that are made to the participants. Additional details of the process can be found in Mitchell (1990).

The second phase of the debriefing is the **Fact phase**. Officers are asked to discuss the general facts of the incident (not aspects that would jeopardize an investigation or cause them difficulties with their supervisors). The usual questions that begin this discussion are "Who are you? What was your job during the incident? and What happened?" If the group is small enough (below 35) the team leader simply has everyone in the room answer the same questions one after the other around the room. If the group is larger than 35, then a different technique may be utilized. The leader may then ask "Who arrived first, what

happened?" then "Who arrived next and what happened?" until enough people have spoken to recreate the incident for the purposes of the debriefing.

The third phase is the **Thought** phase. Officers are asked what their first thoughts were about the incident once they got off the "auto pilot" mode. This phase personalizes the experience for the officers. It makes it part of themselves rather than a collection of facts outside of themselves.

The fourth phase, **Reaction**, is the phase in which the debriefing participants discuss emotions by means of answering the question "What was the worst part of the event for you personally?" This segment may last between thirty minutes and an hour depending on the intensity of the event.

The fifth phase is the **Symptom** phase in which the participants describe the signs and symptoms of distress. Usually three occurrences of signs and symptoms are discussed. Those symptoms that appeared immediately during the event, those that arose during the next few days, and those that are left over and still being experienced at the time of the debriefing.

The sixth phase is the **Teaching** phase. In it, the critical incident stress team teaches a great deal of practical, useful information that can be utilized to reduce one's stress at work and/or at home.

The seventh and final phase of the debriefing process is the **Reentry** phase. In it, officers may ask whatever questions they may have. They may repeat certain portions of the incident and review those aspects that still bother them. They may also bring up new pieces of information that were not brought out earlier in the debriefing. Advice, encouragement, and support are offered by the critical incident stress team members. Participants are given referral resources should they need additional assistance. Handouts including resource phone numbers are also distributed.

CAVEATS FOR CRITICAL INCIDENT STRESS TEAMS

Reading an article or chapter on stress teams does not constitute appropriate training to perform the work associated with a critical incident stress team. There are too many details that are too lengthy to include in a single chapter or article. People who wish to function on a stress team should receive appropriate training in crisis intervention, stress, posttraumatic stress disorder, stress survival strategies, disaster psychology, human communications, conducting a debriefing, and other related topics. The minimum time frame for training to become even barely adequate for critical incident stress debriefing team functions is two days.

The services of a critical incident stress team have to be relatively comprehensive. Teams should include education of their personnel, defusings, de-escalations, debriefings, follow-up services, significant other services, individual consultation, on-scene support services, and referral services as a part of their general activities.

A debriefing may not be necessary if a defusing is performed immediately after a distressing incident. A debriefing, if it still needs to be provided after a defusing has been given, is enhanced by the discussion that took place in the defusing when the intensity of the incident that was still vivid in the minds of the officers.

Debriefings are not therapy per se in spite of the fact that they have therapeutic elements. They should never be used as a substitute for therapy. They can also not be expected to be equally effective for all people under all circumstances. Some police personnel will need referrals for therapy after debriefings have been completed. Provisions for additional help such as that provided by the department's psychologist should always be made when a debriefing is planned (Mitchell, 1983, 1990).

Personnel may be mandated by their commanders to come to a debriefing but they can never be mandated to speak if they choose not to. The right of refusal to disclose one's reactions to an event is always respected.

PRELIMINARY STUDIES

Preliminary studies in the United States and Australia are pointing to considerable benefits that are being derived from the critical incident stress teams (Kennedy-Ewing, 1989; Robinson, 1989). In her study of those who participated in crisis debriefings, Robinson (1989) indicated three main benefits of critical incident stress teams. They are:

1. The chance to learn from others how to mobilize one's own resources and coping behaviors.

2. The ability to gain a greater understanding of critical incident stress, its ramifications, and the methods to deal with it.

3. The opportunity to express oneself and be reassured that one's reactions are normal.

Robinson reported that 75% of the personnel involved in a debriefing felt that it was between moderately and extremely helpful. No one reported negative effects of the debriefing process.

More research will be necessary in the future but the preliminary results are quite encouraging for continuation of the work of critical stress teams.

CONCLUSION

Police critical incidents are likely to occur with regular frequency. The choice facing police departments is to either make believe that police officers are never affected by their work or to take the more realistic stance of recognizing the need for critical incident stress teams and the valuable services they can perform. The key to success for police departments is to maintain a healthy and satisfied working force. One way to achieve that task is to provide support to them when the situations they face become bad enough to hurt. Critical incident stress teams make the tasks easier to accomplish.

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A DEVASTATING EXPERIENCE: DEATH NOTIFICATION

Father William R. Wentink

ABSTRACT

You've got eight years on the Police Department. You're on patrol. You get an assignment from the Dispatcher. You pull up to the location, ring the doorbell, and wait. You know just what you're going to say. The door opens and there's a young woman in her late twenties with three little kids hanging onto her. You look into her eyes and the eyes of those three little children, and you know you are going to destroy their lives. You must deliver the painful fact that her husband is dead. You can't chicken out. You do a disservice to people if you don't deal with facts. In death notifications, the Officer or Chaplain is the stabilizing force in that person's life at that moment. This paper will deal with the proper way to handle notifications, personal experiences, and the importance of "doing it right."

You've served eight years on the Police Department, you're on patrol, and you get a call from the dispatcher. "Call for an assignment." As you go to the phone to make the call, a number of things run through your mind. "Why don't they want to put it out on the air? Probably somebody wanted on a warrant who has a scanner or maybe it's a bomb threat somewhere and they don't want to scare or alert everybody who listens to scanners." So you go to the phone, call the dispatcher, and get all the information you need. You return to your vehicle and start over to the location they gave you. You're thinking about some of the other calls you've been on during your eight years on the Police Department. How you've caught burglars in buildings. You think about searching buildings in the dark, about the times you've been scared. And you think about how you got through that by yourself. You're thinking about this call. You pull up to the location, walk to the front door, and ring the doorbell. You know just what you're going to say when they answer the door. The door opens and there's a woman in her late twenties with three little children hanging onto her side and she says, "Yes Officer, what can I do to help you?" And everything that you've prepared to say is now completely forgotten. You don't know what to say. You're moving back and forth on your feet, your palms are sweating, you have butterflies in your stomach. And she says again, "Officer, what's the matter?" And you reply, "Ah, um, ah, I'm here because your husband has been in an accident."

"An accident? What happened?"
"Well, I don't know. They just told me he's been in an accident, a real bad accident."
"Real bad?"
"Ma'am, it's a real, real bad accident. It's very serious."
"How bad is he? Is he at the hospital?"
"He's at the hospital, ma'am. It's real bad. It's critical."
"It's critical?"
"It's real, real bad ma'am."

You look into her eyes and you look at those three little children who are looking at you. And the wife finally asks you, "Is he dead?" You say, "Yes he is."

The entire time you were driving over there, the whole time you were standing there, you knew that what you had to say was going to destroy her life. And when it came right down to it, you didn't say it. She said it. She was the one who had to tell you, because when you arrived there and saw that woman and those three kids, you chickened out.

This incident was obviously handled wrong. In death notification it's very important to "do it right." This paper is based on my nineteen years as a Police Chaplain with the Rockford Police Department, my experiences during that period, and the training I have received from my membership and seminars with the International Conference of Police Chaplains.

There is no easy way to go to somebody's home and tell them that someone they love has been killed or died in a tragic way. Our police officers are the most valuable resource we have within our agencies, whether they are federal, state, or local. Because they are so important, police officers need to be physically, mentally, and emotionally healthy. Many of the things they handle take their toll on our officers. And one of the most difficult things an officer has to do is a death notification.

In death notifications, the person who delivers the news is the stabilizing force at that time. It's very important that notifications are made as soon as possible after the death occurs for various reasons: people might hear about it through the news media; in a traffic fatality, a relative or friend might drive by the scene, see the vehicle and call the people without any details. Speed is of the utmost importance.

Again I stress "do it right." The entire family should be told at the same time whenever possible, regardless of the hour. That's extremely important. Often parents feel it is best not to wake young children if it is late. They think the children should be told in the morning. It is vital that the whole family be told at once. When some family member is told at a later hour, he or she feels separated from the family. They feel that they were not important enough to be included. If the children are told with the rest of the family, they consider themselves a part of the group. They can begin the grieving and healing process with their family.

I find it is also important to recheck your information. Check with a neighbor to see if the person is going to be alone when you deliver your message. You also need to know if the person being notified has any health problems that might need to be considered. See if a neighbor will accompany you. Be sure of your information. Many times information will not be accurate when it passes through various jurisdictions. By the time it is relayed from officer to sergeant to communications and finally to you, inaccurate messages can be received. The best thing to do is call the agency back and speak to someone as close to the incident as possible. Try to get your information first hand.

When delivering the message, get people in a comfortable or relaxed setting. Get off the doorstep. Ask to come into the home. As a last resort, at an accident or fire scene, put the people in your vehicle. Let people act out their emotions as long as they don't injure themselves or anyone else. Start a support system immediately. The sooner a chaplain can be involved in the death, as a clergy, minister, or priest, the better he or she can help the people deal with their problems. As part of the support system, contact their own clergyman if possible. Also contact relatives or friends. Don't leave people without a support system.

Another important thing is to help people deal with the present. Many times it's "if only" and they want to deal in the past. Or they look to the future and deal with "what if." But I think one of the things we really have to do is deal with the present. As part of this, I believe it's crucial that the family be allowed to see the body, touch the body, and sometimes hold the body. There have been times when the body has been so mangled, that I prepare the family for this and then suggest that they see a hand or a foot. It's imperative that they see the body as soon as possible. Otherwise this death is not a reality. They think it's not true, and often they will hold out in their mind for years that this death really didn't happen.

One of the most difficult types of death notifications is a death with no body, such as a drowning in which the body has not been recovered. I think the real key here is to keep the people informed as to what type of recovery operations are being done, how the body might be recovered, and how long it might take. Again, deal with facts. Never say, "I don't know." Instead, use statements such as: "I will find out for you"; or "It's under investigation."

It has been my experience in notifications, that after presenting the facts, it is best to say no more. Sometimes hysteria follows. Let people act out their own personal feelings. Don't rush people. Give them time to absorb the information and work it through. Your presence is important. Stay there. Make calls for them if they request it. Encourage talking about the deceased. Include and comfort the children. They must not be excluded. They also need to act out their grief. Listen to people. Listening is so important.

When you make a death notification, you have no idea how people are going to respond emotionally. My experience has been that about ten percent of the people are going to be physically violent. They might kick, scream, or shove. I've even been sprayed with a can of mace. I've seen people pick up chairs and break them, throw things through windows, throw glasses, etc. Let them experience these violent emotions as long as they do not physically hurt you or themselves. I'm not advocating letting them harm you. But if you, as the authority figure, make them repress their emotions, these feelings will seethe within them. Whereas if you let them act out their violence, it will pass in five or ten minutes.

Another ten percent of the people show absolutely no emotion. They say "Thank you very much for coming, my daughter has been killed. You can go now." Don't leave these people without a support system.

It's necessary to use words such as killed or dead. My experience has shown that this is the way it should be done: I knock on the door, identify myself as a Chaplain with the Police Department and say that I want to come in and talk with them and their whole family. Most of the time when a person of authority appears, people will comply. I then sit down with the people and relay the information. For example, "There has been an accident involving your son, John. He has been killed in an accident." It is only fair to the family to get the facts out as quickly and accurately as possible. If you don't do that, you are doing a real disservice to people.

A death notification is compounded when it's a police officer who has been killed. This is because the person making the notification, often another officer, knows the family. It's much more emotional and difficult to do in cases like that.

In conclusion, I again stress the importance of "doing it right." Your initial response will stay with people the rest of their lives. Death notification must be done in a professional, caring, and understanding manner. If the notification is done properly, the healing process can begin sooner. Death notification is one of the most dreaded assignments a police officer can receive. But if it's "done right," you can be the biggest support at the most devastating time in a person's life.

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IMPACT OF THE DEATH NOTIFICATION UPON A POLICE WIDOW

Richard Pastorella

ABSTRACT

The subject of this paper is to investigate the impact of the death notification upon a police officer's widow. A pertinent aspect of this investigation centers on the effects of the isolation that are directly due to the manner of notification. Sources used for this paper were personal interviews with widows of slain officers of various police departments; an organization called Concerns of Police Survivors, which was organized specifically to help these widows deal with their loss; and various sources of published literature.

The death of a spouse is a traumatic, emotionally devastating event that can change the remaining partner's life in many ways. Its occurrence can incur emotional as well as physical illnesses and can cause an upheaval difficult, or even impossible, for the surviving spouse to cope with.

This paper will focus on a very minute aspect of this problem, the effect of the death of a police officer upon his wife; specifically, the manner in which she is apprised of her husband's death, and the effects that the manner of notification will produce. I will explore the way in which the wife is told of her husband's death, the effects upon her of the hospital visit, which she is forced, in most cases, to endure, and the overall emotional impact of the suddenness of the situation.

I will be including in this paper case vignettes to point out the different effects that this traumatic situation has had on various widows of slain police officers in the eastern portion of this country. I have been in contact with an organization called Concerns of Police Survivors, which is a support service to help the widows of these officers in coping with such a devastation. Much of my information will be provided by the personal interviews of the widows in terms of what they actually went through when apprised of the death of their husbands and subsequent emotions and coping mechanisms that are idiosyncratic to each yet common to all.

Usually the manner in which a police officer's wife is informed of her husband's death is handled as best as possible, under the worst of possible circumstances. Every wife dreads the radio car pulling up in front of the house, lights flashing, with three officers in blue exiting the car and knocking on the front door. Statistics have shown that this usually occurs in the evening, or late night when the largest percentage of crime occurs in the city (FBI, 1987). Therefore, the impact of the situation is such that the wife is being informed usually at the end of the day when the body and mind are both in need of rest. The impact therefore hits doubly hard, when resources are depleted both physically and mentally.

Glasser and Strauss (1965) refer to this type of bereavement as the reaction to unexpected, sudden, or shocking death. In their theory, they state that if there is no expectation of the death, the spouse cannot have developed any method for dealing with it. Simply stated, if the husband has never been wounded before, where the wife has been put into the position of nurse, she may have denied the prospect of death, unconsciously blocking the fears and emotions connected with it. In this case, when informed of her husband's death, the wife is using the mechanism of denial. Statements like, "It can't be true," or "But he was never hurt before," are indicative of this denial. In their study, Ramsay and Happee (1977) suggest several stages that are preeminent early in grieving, denial being a relatively immediate one. They state that during this phase, even psychotic-like hallucinations can occur.

Case Illustration

> I received a telephone call. They (the Capital Police Department) called me and they said, "Your husband has been shot and it doesn't look good, and now that we know you're home, we'll send somebody to pick you up." So immediately, of course, denial set in, and I'm thinking, "Oh, he's been shot in the foot." You know, you don't think the worst. And I'm putting on some makeup and fixing my hair, thinking that I wanted to look nice for him when I got to the hospital. And I no sooner got that done when this incredible panic set in. And I was getting ready to just jump into the car and try and find him somehow, when there was a knock on the door. It was two County police officers, and they said, "We understand that somebody's going to come and pick you up. We'll just stay here with you."

Lindemann (1944) describes this denial as a change in the victim's attitude of reality to a sense of unreality--"Feelings of not being there, of watching from the outside; that events in the present are happening to someone else" (p. 141).

Case Illustration

> I very much had a feeling like I was outside of myself, watching all of this go on; as if it wasn't quite real. And for a long time, for several weeks, any time the phone rang or any time there was a knock on the door, I mean the split-second reaction was, "It's him. He's going to tell me it's OK. There's been a mistake."

Therefore, when death occurs, it produces a reduction in control of the emotions, often bringing on an hysterical reaction. Lipinski (1980) views this type of reaction as separation anxiety, which is "the feeling of distress, be it a passing sense of disquietude, or overwhelming panic, which is felt at the threat of loss and at the time of loss" (p. 5). This view is shared by Dr. John Stratton, who believes that there are usually two possible reactions seen from widows of police officers at the time of notification--either an outburst of emotion or a dazed, controlled reaction. Stratton (1984) believes that the controlled reaction may be due primarily to shock. However, he also presents a conflicting idea that this calm, controlled reaction may be due to fear; fear of the future without the husband who was, most likely, the dominant partner. The widow has, in a sense, lost her identity by losing her husband. She has lead a protected existence; therefore, the abrupt loss of the spouse leaves the widow feeling insecure, vulnerable, and terrified about being able to cope with life alone. It is therefore important for the notifying officers to be aware of these possible reactions in the widow to be able to deal effectively with her. If this is done incorrectly, the officer can enhance these feelings of fear and inhibit the widow from expressing her true emotions, which would thereby release the pent-up anxiety.

Another unfortunate aspect of the situation in which the wife is informed is the lack of trained personnel in making the notification. It is interesting to note that although the New York City Police Department has rules, regulations, and training for the handling of every type of emergency or situation that a police officer may encounter, it has none regarding death notification. Not only are there no procedures or guidelines in the Patrolman's Guide, Administrative Guide, or Interim/Operations Orders, there is also no training given to the rank and file or supervisors handling such a situation. A notifying officer is required to handle the situation with no previous experience and with little time to prepare. Consequently, these conditions may in themselves serve to foster the crisis rather than to alleviate it.

The police department handles the notification in the following manner. Usually two police officers, one male and one female (the addition of the female officer is only a recent one) are sent to the deceased officer's house along with a supervisor. This supervisor is generally the deceased officer's commanding officer. While it is an improvement in having a female officer present, there is a lack of training on the part of all three

in handling the situation. Danto (1975), in his study of the widows of slain police officers of the Detroit Police Department, offers a typical scene of the notification procedures of that department:

> Once she undid the lock and opened the door, she saw them. The two police officers were somber faced, blowing vapors of cold breath, with cheeks that turned blue and then red from the light reflected from the blinking flasher of the police car. "Janice, Jack's been hurt. We gotta take you to the hospital." "Is he hurt badly? How did it happen?" The same face said, "We gotta take you to the hospital. We don't know more than that." (p. 150)

Most officers who are put into the position of having to make a notification are quite young, having only two to six years on the job, and this type of situation is not a common one that they have dealt with before. Under better circumstances, sometimes a department chaplain is sent along to provide spiritual comfort for the widow. However, the chaplain is not the one who makes the notification since he or she cannot officially apprise the wife of all known facts.

Case Illustration

> When I got there [the hospital], the hospital chaplain said, "Let's go into this room and wait for the doctor." And it still didn't hit me what was going on. The chaplain knew, but she said nothing. So I just figured, "Well, we're just waiting for the doctor to come in and tell me how he's doing."

Another issue that must be addressed in this situation is the theory of the notifying officer being a "co-victim." The officers who are making the notification are themselves under considerable stress, and have probably been working several hours. They have had to deal with the situation that a fellow officer has been killed, and this in itself is causing a high level of anxiety. Juda (1985) coined the term "co-victim" and states, "Co-victims experience the victim's crisis as their own unique crisis, and not only as reactions to the victim's needs and responses to the crisis" (p. 4). While Juda is talking about the co-victim of a crisis rape, this theory also seems to fit into these circumstances, the co-victim being the police officer whose life is also altered by the devastating event of another officer's death. According to Juda, the complexities of both "intrapsychic and interpersonal processes (which the co-victim goes through) will significantly hamper the co-victim from successfully adapting to the crisis and to his victim mate's needs" (p. 46). In this case, since the officers are under considerable anxiety, it is difficult for them to be empathetic to the anxieties of the widow. Therefore, the responding officers cannot really meet the needs of the widow adequately. This creates a deplorable situation for both the informing officers and the widow.

How then do these co-victims (the officers) deal with the victim (the wife)? In some cases, this is done by holding back and staying aloof from the victim; by putting distance between what they feel and what the victim is experiencing. Suzie Sawyer, executive director of Concerns of Police Survivors, believes that the reasons for this are twofold. First, there is fear in the officer who is going through the trauma of losing a co-worker. Second, there is confusion as to how the officer should act (Sawyer, 1988). In effect, the defense mechanism that the officer is using is isolation of affect; divorcing his emotions from the event.

Case Illustration

> I wasn't too pleased with him [one of the officers making the notification]. He seemed, and I know it was a hard time for everybody, but he seemed so . . . cold. And I guess maybe it was just his job, I don't know. But he came across to me as being so cold. "Give me the phone numbers of the family. Give me this. The phone is busy." He actually came over to me to tell me that my in-laws' phone was busy. And I'll never forget looking up at him and saying, "So make an emergency phone call." But at that time, he had to do this to me? And out of all the people in my house, I picked him out to hate because he was so cold.

The officer here seems to be denying any emotional stake in the situation in order to stay in control of the situation. This has the effect of isolating the wife, making her feel alone at a time when she most needs comfort and understanding. This isolation may be caused by the misconception that the spouse is somehow more prepared for the loss due to the nature of her husband's work. Since the wife was aware of the danger in the work, it is assumed that she is somehow emotionally stronger and better prepared for the tragedy than other people. This misconception, along with the reticence of the police officer in dealing with the grief of the wife, would further give the impression of abandonment to the wife. Coupling this isolation with the intense feelings of loneliness for the lost spouse can create anger or hostility toward the notifying officers.

According to Lindemann (1944), this anger may even be an indication of the anger that the wife feels toward the dead husband. In essence, the loneliness and anxiety that the wife is experiencing from the notification is only an extension of the feeling of having been left alone by the husband. However, since the husband is gone, the wife will unconsciously choose the most convenient avenue to vent her anxiety, those immediately surrounding her. Stratton (1984) concurs with this opinion about displacement of anger when he states, "There might be emotions about a husband who was so dedicated to his job that at times his family suffered" (p. 325). I believe that this hostility is in one way or another present in any person whose spouse identifies so completely with his profession. Thus through the mechanism of displacement, the wife may use these feelings of hostility and blame the officers indirectly or directly for the husband's death. "It's all your fault. Why didn't you protect him. You let him die," may be statements heard from the wife. This type of reaction only serves to further isolate the wife. Sensing the hostility, the officers will further withdraw, creating what seems to be a vicious cycle of withdrawal and isolation where no one is getting the needed support.

The effects of this isolation may serve to further another symptom of grief in the wife, that of guilt. The feeling of guilt is common, in one form or another, to those who experience grief. It can encompass self-blame about past events, feelings about behavior toward the partner who is dead, real or imagined negligence, or even regret for not having expressed enough love. If the wife is experiencing isolation or withdrawal by the notifying officers, she may interpret this as disapproval or blame. This may enhance the feelings of guilt that she is already experiencing. Freud (1917) interprets this self-blame as blame against the lost love object, ". . . by perceiving the self-reproaches as reproaches against a loved object which have been shifted onto the patient's own ego" (p. 128). Therefore, since the wife in reality blames the husband for dying, she then shifts this guilt to herself and blames herself. The blame, which she is then perceiving from the officer, serves to confirm this guilt, possibly intensifying it.

Such intense feelings of guilt can lead to pathological grief or bereavement. Lindemann (1944) argues that this pathological grief may involve alternations or distortions in the bereaved's behavior (e.g., acquisition of symptoms of illness belonging to the deceased, or hostility). "These alternations may be considered as the surface manifestations of an unresolved grief reaction, which may respond fairly simply and quickly when psychiatric management is recognized" (p. 142). In relating this to the notifying officer's situation, it would seem that feelings of isolation can enhance the guilt feelings within the wife, having a maladaptive effect on her that can lead to pathological grief.

Another aspect of the notification that can seriously harm the wife is the effort of the police officer to somehow check or block the emotions of the wife--"You have to be strong." A reason for this blocking may be that as a society we are taught to conceal our emotions. Instead of offering support, we seem to avoid the feelings of others during the time of bereavement. It is easier for us to intellectualize problems away, thereby avoiding them. We use the cliche, "Time heals all wounds," instead of saying, "Share your emotions with me and let's work them out." Two reasons for this are:

1. It shows us a vulnerability that all people, including ourselves, have, and that we are afraid to face.

2. If we share another's feelings, it makes us fear that we too will have to open up.

In her book, Necessary Losses, Judith Viorst (1986) states that if we do succeed in deceiving ourselves into thinking that we are "taking it very well" by blocking our emotions, we are in reality not doing well at all. This blocking of emotions or unresolved grief may at some later time give rise to somatic symptoms such as headaches, nausea, cramps, or palpitations (Stroebe, 1983).

Most of the actions and reactions discussed thus far have centered upon the notifying officer and the wife of the deceased officer, before reaching the hospital. I have also found that the notification procedures in the hospital itself are conducive to blocking the emotions of and creating isolation in the wife.

Hospitals are impersonal places at best. The sterile, severe surroundings are conducive to feelings of alienation. However, this alienation is multiplied in terms of the effect upon the widow when the hospital personnel or physician do not convey humanism, must less empathy. An example of this is described very well in the following illustration where the widow was informed by a callous doctor.

Case Illustration

> So the doctor walked in. He sat down in front of me and said, "I tried everything I could. Your husband is dead." And he walked out of the room. So I could feel these emotions start to roll up inside of me, but I immediately pushed them down because my thought was, "Oh my God, I've got to get my children. I've got to get my people in." And all of a sudden, I had to be in charge. I couldn't afford to be emotional because there was nobody there to help me. . . All of a sudden I withdrew into myself. I guess what I was doing was I was setting up my own walls so I could function. Because I knew that there was nobody else there to function.

A final effect of isolation produced by the notification process to which the widow is susceptible is the kind where a person is too sheltered, too protected. In many cases I have encountered, I have found that this has the effect of isolating the widow from her own emotions or her own capacity to cope.

Case Illustration

> They [the police],had guys over here twenty-four hours a day. That night [the night of the notification] there must have been ten guys in the house. And they asked me, "If the phone rings, do you want us to get it?" And I said, "Yes, I would." They were just here. I didn't even have to take care of them. They were there to take care of me. It got funny after a while, because one would be sleeping in the bed with my son, another one on the love seat, another one on the floor. They had the doctor here, and I was sedated most of the time.

The overprotectiveness on the part of the police department, in this case, had a very damaging effect. The widow had a hard time expressing her emotions or making even the smallest decision once the entourage of police officers left. This problem persisted for a very long time. The anger that she suppressed finally erupted one day several months later when, upon hearing that her husband's killers were apprehended, she repeatedly pounded her hand on a door, breaking her wrist, knuckles, and several fingers. This suppression of emotions due to the initial overprotectiveness also served in helping to forge a new "self" in the widow. In her own words, she refers to this new self as "the front." "That was the day I learned to put on "the front." My kids walked in the door and all of a sudden I sucked in my gut, dried my tears, and I became 'mother.' And I learned to do that very well from that point on."

In researching the reactions and likely reactions of a police widow upon being informed of the death of her husband, I have found that the manner of notification can have long-range effects. Lindemann (1944) cites one of these effects as delayed grief, which ". . . takes place when a normal or chronic grief reaction occurs only after an extensive delay, during which the expression of grief is inhibited" (p. 145). It is therefore imperative for the notifying officers to be aware of likely reactions from the widow and to be prepared for

them. It is equally important for the widow to be able to vent her feelings in order to work them out. Therefore, the notifying officers must make an effort to establish a relationship with the widow, where the widow is given support, while at the same time she is allowed to develop her own sense of autonomy. Personnel training would seem to be the key, and would seem to be indicated for any profession in which there is a present danger that could incur loss of life.

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CRITICAL INCIDENT DEBRIEFING: RITUAL FOR CLOSURE

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ABSTRACT

The need for psychological intervention with police officers and other emergency personnel following exposure to a traumatic event has been widely accepted by police personnel. Debriefing has been the most common method of intervention used because it provides an opportunity to process the event both cognitively and emotionally, and because the concept fits well within the police culture. This paper focuses on the aspect of debriefing for closure and the importance social "ritual" plays in providing that sense of closure.

The importance of early psychological intervention following a traumatic event has been widely accepted in working with law enforcement and other emergency personnel. Mitchell (1983), Barnett-Queen and Bergmann (1988), as well as others, have written extensively about the purposes of such intervention, which include ventilation, validation, and education. What has not been focused on is the need for closure following a traumatic event, and the importance social "ritual" plays in providing that closure.

Throughout the course of civilization, social rituals have been created and utilized to facilitate a sense of closure and aid in integrating loss into the ongoing lives of survivors. According to Vernon (1970), rituals generally represent an opportunity for "controlled expression of anger and hostility, and also for a lessening of guilt and anxiety." Whatever the particulars, rituals serve as a culturally condoned means for coping with the fact of death or other significant loss and provide a vehicle for closure.

Social ritual also mitigates the sense of vulnerability people feel in the face of death or other trauma. Gallows humor, an oft-employed ritual used by police officers, is a way of thumbing one's nose at death. It tends to diminish anxiety and helps confront fear. The essayist E. B. White wrote, "to confront death, in any guise, is to identify with the victim and face what is unsettling and sobering" (in Guth, 1976, p. 558). Gallows humor is an attempt to create distance and thereby avoid identifying with the victim. However, gallows humor is often ineffectual with certain kinds of trauma or when the magnitude of the traumatic event is great.

Dealing with the trauma of war also requires some social ritual to provide closure. For example, Schwartz (1984) writes that:

> Primitive societies intuitively knew the value of cultural ceremonies that marked the end of hostilities. Rites of passage were provided for the soldiers and the society to make the transition from the regression of combat to the structure of integrated living. These rituals acknowledged and sanctioned the otherwise forbidden acts of war. They thanked the soldier for his protection, forgave him his crimes, and welcomed him back to life.

Schwartz notes that "Our failure to provide such a cleansing for our warriors and ourselves has left our culture struggling for closure." In some ways police officers are warriors of modern urban society, and it has only been in recent years that the police community has recognized that officers are affected by the traumatic situations they encounter. It has been even more recently that we have begun to respond to that recognition and those needs and to provide opportunities for validation and closure.

In the last two decades, police psychologists and police managers have been addressing the issue of the psychological impact of the use of deadly force and have had to incorporate the concept of the police officer as a secondary or tertiary victim. They have come to realize that the emotional aftermath of a shooting incident, even a nonfatal one, can be traumatic. Since then, other potentially traumatic incidents for police officers have been identified. Such incidents include, but are not limited to, death or serious injury of a fellow officer, death or serious injury of an infant or child, a particularly bizarre or gruesome traffic accident or homicide, multicasualty event, a failed rescue, e.g., suicide--especially a protracted incident involving a great deal of energy and commitment of resources--or accidental death caused by the officer or emergency equipment. Though there are many other incidents that would likely be traumatic or "critical" to the average citizen, because of the nature of their work and frequent exposure to trauma, police officers generally have a higher tolerance or threshold for trauma. Mitchell (1983) defines a "critical incident" as "any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later."

Support groups are increasingly providing assistance to those faced with loss or trauma. Smaller families and increased mobility have changed the traditional support systems once available. In modern times, survivors of trauma have sought this much-needed support by finding others with similar concerns and experiences. Such groups as widows' groups, families of suicide victims, parents who have lost children to sudden infant death syndrome or drunk drivers, extend support beyond the initial burial ritual and provide resources and help that might otherwise be unavailable. The Lo Dagaa people of Africa, for instance, assign a "mourning companion" to the grieving family. This "mourning companion" assumes responsibility for the bereaved's behavior during the period of intense grief (DeSpelder & Strickland, 1987).

Survivor support groups are based upon the concept of perceived similarity of experience or background. An additional, though often unrecognized, function is to diminish or break the shame cycle. That is, feeling victimized in any significant way threatens or contradicts one's self-image as a survivor, which, in turn, causes shame, and one of the most common responses to shame is withdrawal and isolation. Thus the support group also functions to break the isolation and allows the person to reconnect with peers. Though support groups differ in emphasis, approach, and methodology, they share a similar purpose and function.

Historically, the law enforcement culture has fostered the myth of individuality and superiority. Training, too, has created and maintained the image of being able to handle any crisis without being affected. Control has been the essential theme. Further, the fact that police officers are often isolated from the larger community makes a private ritual with members of the police community that much more essential.

Police officers have been "debriefing" themselves, e.g., "choir practice" or "attitude adjustment," for as long as anyone can remember. Such "rituals" are at least partially effective. "Critical incident debriefing," a formal, structured, psychoeducational approach, is a more effective and constructive method of dealing with the aftermath of trauma.

The debriefing structure outlined by Mitchell (1983) involves six phases, beginning cognitively, working through emotions, and ending with participants receiving information about successful coping. This model and variations of it provide the basis of an ideal ritual: It is culturally condoned (i.e., police culture) and shared by individuals of similar backgrounds and experience. (A variation the author uses is asking each participant to imagine a snapshot of the worst part of the incident. After a few seconds, the participants are asked to picture themselves tearing up the snapshot and throwing it out.) Further, these individuals have all been exposed to the same incident. Processing the same incident together allows the participants to be "mourning companions" for one another during and following the ritual of debriefing. Finally, an opportunity for feelings to be validated as normal and common to most, if not all, of the participants, mitigates feelings of shame and the group experience prevents isolation. The experience of participating in a shared social ritual with one's community and of knowing one has the ongoing support of colleagues greatly facilitates closure and integration even of traumatic events.

The importance of psychological intervention following exposure to trauma is expanded when considering and including the concept of social ritual as an essential vehicle for closure. The ritual of debriefing is exceptionally well-suited to police officers and other emergency personnel as it is a discrete process whose effectiveness is maximized by the fact that the support group members are all known to one another prior to the debriefing and continue to work together following it. Thus, the debriefing becomes another shared experience, one that is positive and validating.

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Rescue team searching through rubble of last September's San Diego air tragedy

Photo reprinted with permission of Tony Kombody/Sygma

Behavior

Crash Trauma

Nightmares plague rescuers

For police and firemen who rushed to the scene of San Diego's disastrous air crash last September, the tragedy is not yet over. Months after a Pacific Southwest airliner collided with a small plane and plunged into a downtown neighborhood, claiming 144 lives, many of the emergency workers who confronted the human carnage were still trying to shake off the trauma. A few were paralyzed with anxiety whenever they tried to put on the uniform they wore on the day of the accident. Others suffered from hellish nightmares, insomnia, stomach ailments, migraines and partial amnesia about the terrible event. Says Alan Davidson, president of the Academy of San Diego Psychologists: "This has had an impact on the human psyche beyond what we can humanly know."

Davidson thinks that extensive dismemberment among the victims made the San Diego crash even more horrifying than most major accidents. Parts of bodies were strewn over lawns, houses and roads, and police said they could not walk down the street without stepping on human tissue. Emergency personnel were overwhelmed. They spent their first minutes in a semi-daze, trying to cover up the bloodiest scenes. Police who arrested people—for taking airplane parts or for not leaving the scene of a disaster—coped better. For such officers, says Psychologist Steven Padgitt, "there was some sense of purpose, some sense of being able to express the rage they were experiencing."

Twenty-five local psychologists provided free counseling to city workers and witnesses to the crash. About 100 sought treatment, most of them veteran police officers haunted by their inability to control the chaos and hysteria at the scene of the carnage. The first 16 policemen who came for help all used the word "macho" and talked of themselves as possible failures for seeking therapy. Most urged that the psychologist look at video tapes and photographs of the site, partly to share their sickening feeling, partly to convince the therapist of their manliness. Says Davidson: "They didn't want it to appear that they'd been overcome by some small thing."

To unleash that suppressed rage, the psychologists prescribed jogging, target shooting or other sports. Explains Davidson: "We wanted the anger to come out in an appropriate, directed way rather than when they are arresting somebody." Standard behavioral modification techniques were used for sleeplessness and physical symptoms, and some psychologists tried hypnosis to deal with amnesia about the disaster. The most successful treatment, however, was simply empathy. Says Davidson: "They seemed to need to hear initially that they are normal, adjusted individuals who were put into a completely abnormal situation." Adds Gentry Harris, a San Francisco psychiatrist who has worked extensively with disaster witnesses: "It's important to let the person know he's not some kind of screwball. He's still within the human family. We just need to make people recognize that they do have limitations." ■

FINDING MEANING IN TRAUMA

Finding meaning in a traumatic event can be a long and difficult process, but it's very important. Without putting the event into some sort of perspective, it can be difficult or impossible to let the wounds heal and move on with your life.

While you may never forget the trauma, you can recover and rebuild your life. The points below are some things to think about.

- *Remember that you are not a "target."* When tragedy strikes, it's easy to feel as if you're being punished or singled out by some evil force. But the fact is that bad things can happen randomly—to good people, to bad people, and to everybody in between. Don't add to the pain you're already feeling by trying to lay blame or establish your own "guilt."
- *Reach out to others.* It's very natural to withdraw and think that no one can understand what you're going through. But human contact can help you heal. People who care about you want to help, although often they don't know how. They may keep their distance, afraid they'll upset you more. Now is the time to contact the people who mean the most to you.
- *Get in touch with your spiritual dimension.* "Spirituality" doesn't have to mean religion, although religious beliefs can provide comfort and a framework for dealing with traumatic events. A tragedy can cause you to re-examine your values and the basic beliefs that give meaning to your life. Ask the questions that have no answers: "Why does it always happen to the good guy?" "What's the point of living if we can be struck down so suddenly?" "If there is a God, then why does He allow things like this to happen?" Talk it over with people who went through the trauma with you, or with others that you trust.
- *Give it time.* It may take some time before you can find any meaning in a traumatic event. First the shock, then the pain may prevent you from being able to think clearly about the event and put it into some sort of perspective. Normally, however, the pain will begin to subside, and you'll find it easier to think about the incident.
- *Seek professional counseling if necessary.* If you're not getting over it on your own, if things seem to be getting worse instead of better, or if you're worried that it's affecting your life and work, then you may want to seek professional help. Some places you can turn for referrals are your company's Employee Assistance Program, the crisis consultant (if any) who has been called in to work with your company, your community mental health center, your physician, local hospita, or friends and family who have seen a counselor themselves.
- *Don't expect to be the same as you were before.* "Healing" after a tragedy doesn't necessarily mean going back to exactly the way things were. Circumstances have changed, and chances are, you've changed, too. While the pain will eventually recede, you probably won't forget about the event. That's why it's especially important to find a way to understand the event and make it part of who you are.

IDENTIFYING TRAUMATIC REACTIONS AT THE WORK PLACE:

Billie Z. Lawson, ACSW
Associate Director, Social Work Department
Harborview Medical Center, Seattle, Washington
November 1988

CHANGE IN PHYSICAL AND COGNITIVE FUNCTIONING

* Continuing to experience somatic symptoms without there being a medical explanation for their persistence.
* Having original symptoms which get worse or generalize to other situations.
* Feeling out-of-control of their bodies: Unexpected episodes of tearfulness, disrupted sleep patterns, appetite disturbances, panic attacks.
* Having difficulty concentrating
* Experiencing memory loss or impairment
* Being hyper-vigilant: very tense and easily startled
* Having gastrointestinal disturbances separate from any injuries related to the trauma.
* Increasing consumption of alcohol or drugs.

CHANGES IN RELATIONSHIP TO CO-WORKERS:

* Feeling Isolated: "everyone else continues as though nothing has happened."
* Fearing blame for the occurrence of the event.
* Feeling angry about actions (or in actions) of co-workers.
* Losing sense of personal and professional self-esteem around colleagues.
* Feeling marked or exposed: "different".
* Losing sense of humor.
* Withdrawing from usual kinds of peer interactions.

CHANGES IN RELATIONSHIP TO THE WORK-ENVIRONMENT

* Being afraid of returning to the work place
* Becoming concerned and anxious about the safety of the physical work environment.
* Changing regular work routines to avoid physical reminders of the traumatic event, e.g., avoiding performing job activities related to the traumatic event or refusing to use equipment or follow policies or procedures associated with the trauma.
* Experiencing flashback of trauma which are triggered by auditory, visual, and olfactory cues in the environment.
* Decreasing time spent at work (sick leave, vacation, unexplained absences).
* Questioning whether or not to remain working at "this" profession.
* Feeling foggy and numb.
* Being inattentive to the task at hand which lead to increased accidents and errors.
* Deteriorating performance/customer relation.
* Wondering whether they are competent to perform the job.

CHANGES IN RELATIONSHIP TO MANAGEMENT:

* Increasing conflicts with authority figures.
* Feeling betrayed and abandoned.
* Becoming 'Militant' about policy and procedural deficiencies.
* Seeking some evidence of 'justice' in management response to incident.
* Turning to legal action if their distress is not recognized and dealt with.

Post Traumatic Stress Among Fire & EMS Workers: Proactive Intervention Programs

The above is a survey of Fire and EMS workers for the Los Angeles City Fire Department. These graphs are from a report by Russel Boxley, Ph.D., ABPP of LACFD. This proactive plan includes:

Pre-Incident Phase
Liaison with Management
Prevalence Survey
Pre-incident awareness and education
Supervisor's awareness program
CISD Team and continuing education
Utilizing existing systems for activation

Post Incident Response
Defusing
Debriefing
Briefing/Counseling
Peer Support
Referral to EAP program

RESOURCES

The International Society for Traumatic Stress Studies, 435 North Michigan Avenue, Suite 1717, Chicago, IL 60611-4067 (312) 644-0828. Cost $80/yr. Journal and yearly convention (Los Angeles, October 1992).

The International Association of Trauma Counselors, 4231 Spicewood Springs Road, Suite G-6, Austin, TX 78759. Costs $45/yr. Provides certification, training.

Northwest Region CISD Network, C/O Linda Culley, 110 Prefontaine Place South, Suite 500, Seattle, WA 98104. 2 yearly conferences, newsletter.

American Critical Incident Stress Foundation, P. O. Box 204, Ellicott City, MD 21401 (Jeffery Mitchell). Publishes "LifeNet", the ACISF Newsletter.

CISD TEAMS IN WASHINGTON STATE:

Whatcom County
Snohomish County
King County
Kitsap County
Seattle Fire Departrnent
Seattle Police Department
Clark County
Lewis County
Thurston County
Washington State Patrol
South East Washington - Tri-Cities
Central Washington - Wenatchee, Ellensberg, Yakima, Columbia Basin Inland Empire

DEPARTMENT OF CORRECTIONS
DIVISION OF PRISONS

DIVISION DIRECTIVE

NUMBER	
DOP 410.170	
ISSUE DATE	EFFECTIVE DATE
April 15, 1991	May 15, 1991
Page 1 of 2	

TITLE

POST-TRAUMA RESPONSE

AUTHORITY:

DOC Policy 410.100

PURPOSE:

The Division of Prisons recognizes that employee involvement in specific work-related incidents may cause serious physical and/or emotional trauma to an employee. The goal of this program is to minimize the effect of trauma to involved employees by providing immediate intervention so they can return to duty as soon as possible.

APPLICABILITY:

This applies to all DOP facilities.

DEFINITIONS:

Critical Incident: Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later.

Post-Trauma Stress: A normal psychological and physiological response that may be demonstrated by individuals exposed to perceived or actual potentially life-threatening situations. The resulting trauma can create immediate and short-term symptoms which may last for up to three months.

DIRECTIVE:

Each Superintendent shall establish a field instruction which complies with this directive.

PROCEDURE:

A. The Director of Prisons shall designate a post-trauma provider(s) for evaluation and care of any Division of Prisons employee(s) who has experienced post trauma as described in this directive. The Superintendent may request an exception to this requirement for unique situations. The exception must be approved in advance by the appropriate Deputy/Assistant Director and Director of Prisons.

B. Each Superintendent shall designate a staff person responsible for a Post-Trauma Response Program. Responsibilities include ensuring staff are trained; ensuring referral to the post-trauma provider; ensuring follow-up care is provided as recommended; and assisting the affected employee in matters of relevant concern (i.e., payroll/leave issues, L & I claim, etc.).

C. Evaluation by the designated trauma professional shall be <u>mandatory</u> for an employee involved in any of the following on-the-job incidents:

   1. Use of force that results in serious injury/death.
   2. Witnessing or involvement in any incident where serious injury or death occurs.
   3. Sexual assault.
   4. Serious injury due to an inmate assault.
   5. Involved in a shooting incident, in which it is necessary to shoot at a person.
   6. Taken hostage.
   7. Other incidents that the Superintendent believes have a potential for post-trauma effects.

D. The post-trauma provider shall inform the Superintendent if the employee's functioning is impaired in such a way to make the employee a risk to himself/herself or to substantially interfere with his/her ability to perform on the job. All other information obtained in the post-trauma evaluation/care/

treatment shall remain confidential. The employee shall be informed of the scope of this section at the time of the initial interview.

E. The initial evaluation session will typically occur within 24 hours of the incident, if possible.

F. The trauma evaluation will take priority over routine work assignments and should occur during the normal work hours of the effected staff, if possible, and will be considered work time.

G. If the post-trauma provider believes that an employee needs more in-depth or extended assistance, he/she will refer the employee to a source qualified to provide such assistance. The referral must be coordinated with the Superintendent or facility staff person responsible for the Post-Trauma treatment program. The responsibility for payment of continued treatment (i.e., institution, employee, insurance, etc.) must be clearly specified prior to the first appointment. In cases where the institution assumes the cost of further care, the provider must clearly understand the scope of services expected. In general, it is not the intent of the Department to assume the cost of ongoing mental health treatment for anything other than immediate post-traumatic symptoms.

H. All new employees will receive a briefing on the Post-Trauma Response program as a part of new employee orientation. This briefing will be documented in the employees personnel record.

REFERENCES:

SUPERSESSION:

None

Larry Kincheloe, Director
Division of Prisons
April 1991

DEPARTMENT OF CORRECTIONS

DIVISION OF PRISONS

FIELD INSTRUCTION

NUMBER	
WSP410.170	
ISSUE DATE 8/4/91	EFFECTIVE DATE 9/4/91
PAGE 1 of 3	

TITLE

POST-TRAUMA RESPONSE

I. AUTHORITY: DOC Policy 410.100

II. PURPOSE: Employee involvement in specific work-related incidents may cause serious physical and/or emotional trauma. The goal of this program is to minimize the effect of trauma to involved employees by providing immediate intervention so they can return to duty as soon as possible.

III. APPLICABILITY: To all staff.

IV. DEFINITIONS:

A. Critical Incident: Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later.

B. Post-Trauma Stress: A normal psychological and physiological response that may be demonstrated by individuals exposed to perceived or actual potentially life-threatening situations. The resulting trauma can create immediate and short-term symptoms which may last for up to three months.

V. FIELD INSTRUCTION: Staff involved in a critical incident shall be evaluated by the DOP-designated trauma professional, and referral and/or follow-up care provided by the WSP Post Trauma Response Manager or other qualified source, if recommended.

VI. PROCEDURE:

A. The Director of Prisons has designated a post-trauma provider for evaluation and care of any Washington State Penitentiary employee(s) who has experienced post trauma as described in DOP410.170 or this Field Instruction (see Attachment A).

1. The Superintendent may request an exception to this requirement for unique situations. The exception must be approved in advance by the appropriate Deputy/Assistant Director and Director of Prisons.

B. The Superintendent has designated a staff person responsible for a Post-Trauma Response Program (see Attachment A). Responsibilities include

1. ensuring staff are trained
2. ensuring referral to the DOP post-trauma provider
3. ensuring follow-up care is provided as recommended; and
4. assisting the affected employee in matters of relevant concern (i.e., payroll/leave issues, L & I claim, etc.).

C. Evaluation by the DOP designated trauma professional shall be **mandatory** for an employee involved in any of the following on-the-job incidents:

1. Use of force that results in serious injury/death.
2. Witnessing or involvement in any incident where serious injury or death occurs.
3. Sexual assault.
4. Seriously injured due to an inmate assault.
5. Involved in a shooting incident, in which it is necessary to shoot at a person.
6. Taken hostage.
7. Other incidents that the Superintendent believes have a potential for post-trauma effects.

D. The DOP post-trauma provider shall inform the Superintendent if the employee's functioning is impaired in such away to make the employee a risk to himself/herself or to substantially interfere with his/her ability to perform on the job. All other information obtained in the post-trauma evaluation/care/treatment shall remain confidential. The employee shall be informed of the scope of this section at the time of the initial interview.

E. The initial evaluation session will typically occur within 24 hours of the incident, if possible.

F. The trauma evaluation will take priority over routine work assignments and will occur during the normal work hours of the effected staff, if possible, and will be considered work time.

G. If the DOP Post-trauma provider believes that an employee needs more in-depth or extended assistance, he/she will refer the employee to a source qualified to provide such assistance. The referral must be coordinated with the Superintendent through the WSP Post-Trauma Treatment Program. The responsibility for payment of continued treatment (i.e., institution, employee, insurance, etc.) must be clearly specified prior to the first appointment.

a. In cases where the institution assumes the cost of further care, the provider must clearly understand the scope of services expected.

b. In general, it is not the intent of the Department to assume the cost of ongoing mental health treatment for anything other than immediate post-traumatic symptoms.

H. All new employees will receive a briefing on the Post-Trauma Response program as a part of new employee orientation. This briefing will be documented in the employee's personnel record.

VII. REFERENCES: None

VIII. SUPERSESSION: None

IX. REVIEW:

A. This instruction will be reviewed annually by the Superintendent or his designee for update and/or any required modifications.

B. When there is any modification or change to this procedure, it will be sent for review and approval by the Deputy Director.

C. This instruction will become effective 30 days from the date of the Superintendent's signature.

APPROVED: _____ DATE: 8-4-91
Superintendent, Washington State Penitentiary

WSP410.170
APPENDIX A

DIVISION OF PRISONS POST-TRAUMA PROVIDER:

Dr. James H. Shaw
7519 Atchinson Drive, S.E.
Olympia, WA 98503

WASHINGTON STATE PENITENTIARY POST-TRAUMA RESPONSE PROGRAM PROVIDER

Cyndi Walters, MEd
Staff Counselor
ext. 424

6/91

WSP Post Trauma Response Team

APPLICATION FOR TEAM MEMBERSHIP

I. Personal Information

Name _____

Address _____

_____

Phone (Home) _____ (Work)_____

II. Education Information

	School Attended	Dates of Attendance	Degree Attained & Major Area of Study
High School	_____		
College or University	_____		
Advanced Degree and/ or Training	_____		

If degrees are not within areas of sociology or psychology, please describe courses or training you have taken in these areas.

_____

_____

_____

III. Employment Information

Current Position _____

List your last 3 positions and include any duties which were relevant to Emergency Services or Crisis Counseling - present position first

	Dates & Place of Employments	Brief Job Description	Reason for Leaving
1.	_____		
2.	_____		
3.	_____		

POST TRAUMA RESPONSE TEAM

MEMO OF UNDERSTANDING

I _____ the undersigned agree to serve as a volunteer with the WSP Post Trauma Response Team for a minimum period of one year. I understand that serving as a team member requires the following commitment:

1. Attend a mandatory three-day training session as scheduled.

2. Schedule at least 10 hours of ride-along experience with emergency service agencies for mental health professionals.

3. Participate in approximately 10-12 hours of defusing/debriefing per quarter and/or in-service presentations when scheduled and assigned.

4. Attend monthly team meetings and meet the attendance requirement.

5. Complete required records of activities. Also submit the total number of hours engaged in the team activities.

6. Maintain strict confidentiality regarding defusings/debriefings held, including topics discussed and personnel involved. Any breech in confidentiality will result in my immediate removal from the team and the program.

7. Abide by the established team protocols and operational guidelines.

The WSP Post Trauma Response Team agrees to the following commitments to team members:

1. Provide three-day training session for new members.

2. Provide administrative support through Washington State Penitentiary.

3. Provide, if necessary, defusing/debriefing for the team members after an incident.

4. Reevaluate the team operation and personnel each year.

I have read and understand these commitments and agree to serve as a on the WSP Post Trauma Response Team for a one year period.

(Signed)_____

(Date) _____

IV. In what activities outside of your profession are you currently involved, or do you anticipate involvement in the next year?

_____

_____

_____

_____

V. Additional Information

1. a. Have you ever needed assistance from an emergency or crisis service?

_____

b. What happened? _____

_____

_____

_____

c. How do you feel about the encounters?

_____

_____

_____

2. What exposure you had to crisis situations, multiple trauma, or critical incidents?

_____

_____

_____

3. Do you have experience in providing any of the following? (Include a description of types of clients and amount of direct service time spent in this area.)

a. Individual Counseling: _____

_____

b. Small group work: _____

c. Stress Management: _____

d. Training or education in other areas (please specify areas):

4. How did you hear about the Team?

5. Why do you want to be a member of the Post Trauma Response Team?

6. What assets would you bring to the process if you were a team member?

7. What deficits would you bring to the process if you were a team member?

VI. **Comments or additional information you would like to have to aid in the Team selection process.**

_____

_____

_____

_____

_____

_____

_____

VII. **How much flexibility do you have to go on defusings/debriefings on a 24-48 hour notice?**

_____

_____

_____

VIII. **List stress management techniques that you have utilized effectively.**

_____

_____

_____

IX. **Please list three (3) references, not related to you. Include name, address and phone number.**

1. _____

_____

2. _____

_____

3. _____

_____

INSTITUTION ORIENTATION PROGRAM

POST TRAUMA RESPONSE

Trainer Manual

DEPARTMENT OF CORRECTIONS

DIVISION OF PRISONS

July 1992

OVERVIEW

Subject: Post Trauma Response Program

I. **Purpose:** To provide orientation/in-service training for staff on (1) the causes and effects of post trauma stress, (2) the DOP and local Post Trauma Response Programs and (3) how to properly access the program following a critical incident involving oneself or other employees.

II. **Attendees:** All staff.

III. **Time:** 1 hour

IV. **Location:** Posts, training office and other appropriate places.

V. **Training Aids:** Flip chart, overhead projector or blackboard and a participant handout.

VI. **Instructor:** Determined by local facility.

VII. **Type of Instruction:** Lecture, employee participation and discussion.

VIII. **Summary of Presentation:**

A. Definitions and examples of critical incidents and post trauma stress.

B. Characteristics of Critical Incident Situations and how individuals respond to them.

C. The importance of a Post Trauma Response Program.

D. Key components of the DOP and local Post Trauma Response Programs.

E. How to properly access the Post Trauma Response Program.

F. Summary.

1. Critical incidents do happen.

2. Immediate and short-term symptoms are a normal response to such incidents.

3. Immediate and proper intervention prevents or reduces the likelihood of long term consequences.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
Forward to the Trainer: This course must be presented in a very supportive, non-judgmental manner to ensure that victims of post trauma stress are not revictimized by the process.	
The trainer should use high levels of self-disclosure to explain stress and its impact. The trainer should frequently emphasize the point that the process is normal and that it is okay to talk about reactions/share feelings on the subject.	Disclosure needs to be for the benefit of the trainees, not a "war story" for its own sake.
Be prepared for at least one, if not more, of the participants to begin demonstrating or at least experiencing symptoms of an active crisis state during the class. This will occur more frequently if you have participants who: 1. Have recently experienced/witnessed an assault, riot, hostage or similar situations. 2. Are experiencing or recently experienced critical events in their lives, such as divorce or death of a loved one. 3. Have experienced a critical incident which has not been resolved even though it may have occurred years ago, such as serving during a war or held hostage.	
Tips for Managing the Process 1. Know your participants. 2. Make yourself available. 3. Observe participants closely. If they appear to be having difficulty, attend to them immediately, privately and with compassion. 4. Identify a local skilled professional participants may be referred to if they need assistance. 5. Do not approach the training as just information and leave participants hurting without some help.	Trainers are cautioned not to use the phrase, "I know how you feel."
The trainer is not expected to be a therapist or a counselor, but rather to educate with sensitivity.	
I. INTRODUCTION Post Trauma Stress is called by many names: 1. Post-Crisis Trauma 2. Critical Incident Stress 3. Delayed Stress Syndrome The last name is probably what you are most familiar with because there was a lot of publicity during the mid to late 70s regarding delayed stress and the Vietnam veteran.	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
Like Vietnam veterans, correctional workers operate in an environment not well understood by others. It is often hard for them to talk about their work, even with family members. They may feel that society does not recognize or value what they do.	
In corrections, employees sometimes find themselves in situations that for a short time resemble combat situations: riots;hostage situations; assaults; or fires.	
The aftermath of living through these situations can be tougher than the incident itself, especially, if you are not prepared for the physical and emotional symptoms that follow.	
This class has been developed to give you information on post trauma stress so that you can be better prepared yourself and have information on how to help yourself and others through the process.	Refer participants to **Handout #1**
II. CRITICAL INCIDENTS	
Definition:	
Critical Incident - An event an individual has experienced which is outside the range of usual human experience that would be markedly distressing to almost anyone. (American Psychiatric Association)	Refer participants to **Handout #2.**
Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later, whether at work or away from work. (DOP Directive 410.170)	Stress that these events typically affect one's ability to function at work or away from work.
Certain events are almost universally traumatic. These events are called **"critical incidents."**	
A. General examples.	
1. Serious threat to one's life.	Refer participants to **Handout #3.**
2. Physical or sexual assault.	
3. Serious threat or harm to one's children, spouse or close relatives or friends.	
4. Sudden destruction of one's home or community.	
5. Seeing another person who is being (or has recently been) seriously injured or killed as a result of an accident or physical violence.	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
B. Corrections examples. 1. Use of force resulting in serious injury or death. 2. Witnessing or involvement in any incident where serious injury or death occurs, i.e., employee, visitor or inmate. 3. Sexual assault. 4. Serious injury due to inmate assault. 5. Involved in a shooting incident in which it's necessary to shoot at a person. 6. Taken hostage. 7. Other incidents.	The instructor should have his/her participants identify corrections specific examples of "critical incidents." As identified, they should be recorded on a flip chart, blackboard, overhead projector, etc. Indicate these examples are listed in DOP 410.170 - **Handout #17.** Refer participants to **Handout #4 & #5.**
These are situations that make a deep emotional impact and potentially overwhelm one's ability to cope. It's important to note that critical incidents are somewhat personal; an incident which might be minor for one person may be critical for another. Also, it's important to understand the ripple effect with regard to such events. People not directly involved in the incident - family, friends, onlookers - may be affected by it.	Reiterate that these events affect our ability to cope.
III. POST TRAUMA STRESS * A <u>normal</u> and <u>likely</u> human response exhibited by people who have been exposed to one or more critical incidents. * DOP 410.170 defines it as "a normal psychological and physiological response to perceived or actual life threatening situations." * Reaction to situations where an individual comes face to face with his/her vulnerability or sense of mortality. * The resulting trauma can create immediate and short term symptoms which may last for up to three months. * Symptoms may last a few days, a few weeks or a few months. They occasionally last longer depending on the severity of the traumatic event. * With the understanding and the support of loved ones, the stress reactions are typically temporary, i.e., gone after a few months.	\ Refer participants to **Handout #6.** Stress that the resulting trauma and symptoms are * normal * likely * usually temporary The body goes through a natural process to cleanse itself/cope.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
IV. CHARACTERISTICS OF CRITICAL INCIDENT SITUATIONS Sudden and unexpected. Disrupt one's sense of control. Disrupt beliefs, values and basic assumptions concerning how the world works. Involve the perception of a life damaging event. May include element of physical or emotional loss. To give you some idea what your body goes through when it experiences a critical incident, think about the last time you almost got hit on the freeway or felt out of control in a threatening situation (the latter may be more appropriate for rural folks). What were some of the things that happened?	Put on flip chart, overhead projector, blackboard, etc. Give personal examples or examples from a correctional setting to explain crisis. Refer participants to **Handout #7.**
Typical responses include the following. 1. Breathing becomes rapid and shallow. 2. Hands perspiring/excessive sweating. 3. Adrenalin rush. 4. Rise in body temperature. 5. Blood goes to the trunk and away from the extremities (hands and feet feel cold). 6. Accelerated heart rate. 7. Blood pressure rises. 8. All senses are heightened. 9. Muscles tense. 10. Tremors, shaking. 11. Crying. 12. Bowel/bladder release. 13. Perceptual distortion - time slows down or speeds up. 14. Super strength. 15. Lack of or reduced response to pain.	List group responses on a flip chart. Use the list at left to add to list if needed. Trainer should note that the body's natural reaction to such incidents is meant to be a "short term" response. When these responses become chronic, "burn out" takes place.
This stress reaction, or "Fight or Flight" response, helped early man and woman survive in a physically hostile environment. As a short-term response, it was very useful. In modern life, and especially in our jobs, there are few times when either "Fight" or "Flight" are successful strategies. Our behavior is constrained by law, policy, and watchfull supervisors. We are expected to cope with difficult situations calmly and professionally. In a situation like a riot, hostag- taking or assault, however, an individual may experience several of these responses. They may appear just after the event or much later and may last for months, depending on the duration and intensity of the event. Some signs of the event may linger for years if the situation is not dealt with at the time.	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER

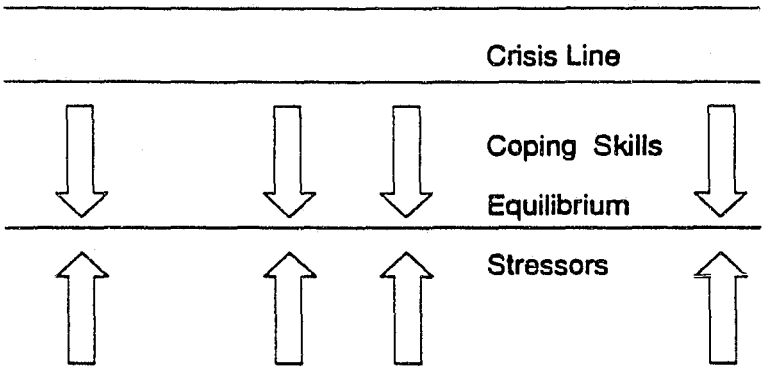
These unresolved stress responses deplete our ability to cope with daily life. They may adversely affect our personal relationships and job performance, and they can make us physically and mentally sick.

To give you some idea of how this works, let's look at a drawing of what occurs.

Put normal state on one flip chart, overhead, etc., crisis state on another.

Refer participants to **Handout #8**

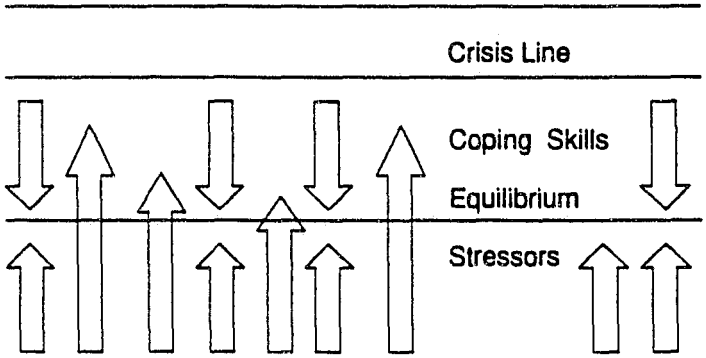
Normal State



In the normal state, our ability to cope or to maintan our equilibrium balances out with the stress we encounter on a daily basis. This is particularly true if we are actively involved in some type of stress management program that includes eating right, getting enough sleep and exercising.

Refer participants to **Handout #8**

Crisis State



In the crisis state, the amount of stress overwhelms our ability to cope, and we go out of balance for a period of time. Virtually, all people will experience this at one time or another in their lives. It may feel as if some invisible force suddenly stepped into your life and threw it up in the air. Recovering from the event takes time and work to put all the pieces back trogether again.

Give personal examples of when this has occurred in your own life, or that of other correctional staff you know. Emphasize your thoughts and feelings at the time.

Stress that this is <u>a normal reaction to an abnormal situation.</u>

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
Critical Incident Flow Chart	Refer participants to **Handout #9.**
Another way to visualize a loss of equilibrium or a reduced ability to cope is by looking at the Critical Incident Flow Chart.	
* Following a critical incident, individuals experience a loss and symptoms of stress. * Recovery takes work and time. * Setbacks can be expected. * Recovery begins to take place as the incident is talked about and coping skills are employed.	
- Some days will be better than others, i.e., individuals will believe they're making progress one day and losing ground the next day.	Emphasize that feeling a loss of control is natural, very uncomfortable, and that recovery takes effort and time.
- This is the most dangerous time period.	
- Caution should be used during this time, and professional help may be helpful in preventing long term consequences/symptoms.	
- This is the time period during which peer support and the use of coping skills is critical.	This will be covered later in the presentation and is described on **Handouts #15 and 16.**
V. TYPES OF CRISIS	
Exhaustion crisis is when an individual has been coping with an intense stressful situation(s) or event(s) for a long period of time and reaches the point of exhaustion and can no longer do so.	
Shock crisis is when a sudden change or event, like a fire or assault, occurs.	
Both of these types of crises can occur during critical incidents in the field of corrections.	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
VI. Individuals respond differently to the same situations.	
How you as an individual respond will depend on several different factors. 1. Your personal history and personality. 2. Coping skills you have. 3. Other stressors you are already dealing with. 4. The number and type of stressful events that you deal with during a critical incident and the nature of "your involvement" in the incident, i.e., your perception of the threat, the intensity and duration of the event, your geographical/psychological proximity to the event. 5. What you do after the event to help your body get rid of the stress you have experienced.	Put factors on flip chart. Refer participants to **Handout #10.** Note that sometimes people who have an indirect role in a critical incident may have as strong a response as those directly involved.
VII. Let's look now at some of the symptoms individuals experience. One person may exhibit as few as one or two or as many as all of those listed. <u>Immediate Symptoms</u> <u>Psychological and Emotional Reactions</u> * anxiety * irritability, restlessness, hyperexcitability * depression, moodiness, periods of crying * anger, blaming * apathy, diminished interest in usual activities * isolation, detachment, estrangement * guilt about surviving * denial or constriction of feelings * "flashbacks," intrusive and distressing recollections/memories of event or amnesia for the event * recurrent distressing dreams of the event or other traumas; other sleep problems * numbing of general responsiveness * feelings of hopelessness /helplessness	Solicit participant input and put identified symptoms on flip chart, overhead, etc. Refer participants to **Handout #11.** Instructor should indicate that: (1) these symptoms are often caused by fear; and (2) fear is anormal response to a critical incident.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER

Physical Reactions

* headaches
* weakness in parts of the body
* nausea, upset stomach, other gastrointestinal problems
* soreness in muscles
* hot or cold spells, sweating or chills
* lower back pain
* faintness or dizziness
* numbness or tingling in parts of the body
* heavy feeling in arms or legs
* feeling a "lump in the throat"
* pains in chest
* increased heart rate and blood pressure
* trouble getting breath
* exaggerated startle reaction
* tremors
* fatigue/exhaustion
* increase in allergies, colds, flu
* difficulty falling or staying asleep
* appetite disturbance
* loss of coordination
* hyperactivity or under activity

Thought/Cognitive Reactions

* poor concentration/distractibility
* confusion
* impaired thinking
* loss of objectivity
* forgetfulness/short term memory impairment
* inability to make sound judgements and decisions
* loss of ability to conceptualize alternatives or prioritize tasks
* obsession with the incident
* distorted sense of time

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
Behavioral Reactions * hyperactivity; hyperalertness * outbursts of anger or frequent arguments * inability to express self verbally or in writing * withdrawal, social isolation, "distancing" * increased use of alcohol, tobacco, other drugs; self-medication * inappropriate use of an addictive behavior, i.e., sexual promiscuity, gambling, etc. * avoidance of activities or places that arouse recollection of traumatic event * family problems	
Long-Term Symptoms * Family problems/divorce * Chemical dependency * Work problems - absenteeism, disability * Withdrawal from activities/people * Burn-out * Severe depression * Chronic anxiety * Domestic violence * Difficulty with the law and/or authority	Instructor should emphasize that critical incidents are family events and that surviving them takes family planning. It's critical to communicate with loved ones, to tell them what you feel and to understand that the incident affects the people around you. Participants need to understand these possible symptoms are <u>not</u> inevitable and may also be the result of causes other than the critical incident.
VIII. WHY A POST TRAUMA PROGRAM? A. While not inclusive, the reasons, at a minimum, include the following points. 1. Employee involvement in specific, violent, work-related situations may cause serious physical and/or emotionall trauma to the employee. Procedures to assist affected employees are an appropriate response to a predictable problem.	Have participants identify reasons for a Post Trauma Program and record on flip chart, overhead, etc. Refer participants to **Handout #12.**

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
2. There is a difference between PostTrauma Stress and post traumatic stress disorder (PTSD).	Instructor should emphasize this point.
* PTSD is a pathological <u>end state</u> that indicates a person got stuck and is not recovering. PTSD develops slowly and may not result in significant emotional symptoms for several months or years following the incident.	
* <u>Post Trauma Stress</u> may be a <u>starting point</u> for PTSD.	
* While the short-term results of PostTrauma Stress cannot be prevented (they are normal), effective and immediate post-trauma responses reduce and may prevent long-term debilitating symptoms (PTSD) which may result in severe depression, substance abuse, divorce or family problems, chronic anxiety or work-related problems, such as absenteeism, disability.	Instructor should emphasize this point.
* According to current research, the symptoms of Post Trauma Stress occur among 100 percent of children and approximately 90 percent of adults who are exposed to a critical incident.	
* It's possible that the percentage of adults who suffer from Post Trauma Stress symptoms after a critical incident is closer to 100 percent, but some adult sufferers may escape identification because of denial and shame.	
3. Cost Effectiveness of Early Treatment	
* Several studies have been carried out in this area. The results/conclusions of these studies indicate that:	
a. when they are treated properly, employees are generally satisfied and feel cared for by their employers;	Instructor should tress the importance of taking care of our co-workers before, during and after critical incidents.
b. when intervention occurs early, employees return to work sooner, permanent disability is uncommon and the potential for litigation is reduced; and	
c. consequently, early detection and intervention results in significant savings, both financial and in staff resources.	Instructor should emphasize points #2 and #3.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
B. Summary 1. Why a Post Trauma Program? a. It's the right thing to do. b. Staff are our Department's most valuable resource. 2. Purpose of Post Trauma Program a. Educate staff about critical incidents and post trauma stress. b. Provide staff with the tools to alleviate PostTrauma Stress- related symptoms.	
IX. ELEMENTS OF A POST TRAUMA PROGRAM A preventive approach called "Continuum of Care" has four components. The idea of "continuum" reflects the necessity of a flexible response with services of increasing intensity if they are needed. This is critical, as staff react differently to both the corrections environment and critical incidents and, consequently, will have different needs. The four components are these.	
1. **Trauma Preparation Training and Education** Trauma preparation, or Post Trauma Stress training, provides the information which appears to be necessary to preclude the development of long-term consequences/PTSD. The goals of this training areas follows. a. Provide information on the nature and definition of duty- related trauma and on the types of potentially critical incidents that may occur in corrections. b. Prepare personnel for the normal psychological consequences of exposure to traumatic incidents; i.e., to help involved staff to understand that their post trauma feelings are "normal." c. This "normalization" reduces anxiety about post trauma consequences; thus, a "recovery cycle" which prevents major post-trauma problems begins.	The instructor should refer participants to **Handout #13.**

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
d. Teach basic recovery and coping skills; i.e., suggestions for action if post trauma stress is experienced.	
e. Assist in creating a supportive environment throughout the organization.	
f. Describe the components, procedures and regulations associated with the post trauma program. In this regard, all personnel should receive related orientation/in service training.	Instructor should note today's class is to accomplish this goal.
Note: It's important to ensure all personnel receive the initial post trauma training.	
* Training of **new staff** is especially critical as they tend to have a much lower threshold for trauma than veteran staff.	Instructor should note supervisors and veteran line staff all share the responsibility to ensure our new staff are properly prepared to work in a correctional environment.
* Hence, they are more vulnerable to post trauma psychological consequences until they gain experience and coping skills.	
* The purpose for training all staff is to achieve a sort of **"stress inoculation."**	
* Many of the psychological problems people experience following a traumaticevent are the result of <u>not</u> being emotionally and mentally prepared for such an event.	Instructor should emphasize this point.
* Our greatest protection against the development of significant psychological problems is a knowledge of what to expect.	
* If people believe they can influence or take some action in response to an event, they will adjust better to the stress of the situation.	
* Hence, we tell them in advance:	
What to expect and why with regard to critical incidents and post trauma stress.	Instructor should emphasize again the importance of providing training up front, i.e., "An ounce of prevention is worth a pound of cure."
What to do if they need assistance.	
This training/information is critical, because recovery time is shortened, and the development of complications are reduced/prevented if the involved individuals:	
Are acquainted with typical reactions following exposure to a critical incident; and	
Acknowledge that their own emotional reactions are normal, natural and temporary.	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
2. **Debriefings**	
a. These are carefully structured meetings that occur after the traumatic incident They are conducted by Division of Prisons' Post Trauma Provider or professionals designated by him/her.	
b. Designed for one-to-one or small groups (20 maximum).	
c. A debriefing is not an incident critique.	
(1) An incident critique is a review of one's actions in a given circumstance. Decisions and perfor mance are evaluated and corrective action taken as appropriate.	
(2) An incident debriefing is a venting of feelings, fears and stress related to the incident. There is no investigation of motives and performance. Attention is paid to the emotional and physical injuries or trauma suffered by those involved and the focus is on prevention of long-term post-trauma consequences and the need for additional services.	
d. Debriefing generally should occur 1-4 days after the incident. DOP 410.170 says "The initial session will typically occur within 24 hours of the incident, if possible."	Options regarding the ideal interval for debriefing very. The DOP Directive emphasizes a quick response.
e. They are most effective when part of a planned and coordinated program.	Instructor should emphasize this point.
f. PTSD is difficult to treat but fairly easy to prevent through immediate and proper intervention. Without it, or with improper intervention, there is a greater chance of PTSD developing.	
g. The **main disadvantage** of debriefing is also its **main strength**: the time it takes to detail and discuss the traumatic event, post trauma consequences and coping skills. Debriefings of 3 - 5 hours are not unusual.	
h. Immediate intervention has several advantages. They include:	Instructor should note earlier comment (page 4) that symptoms often persist in the absence of a debriefing.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
(1) assist the individual in coping emotionally with the traumatic event;	
(2) prevent or at least significantly reduce the potential to develop PTSD;	Instructor should inform participants that **Handout #14** identifies various coping techniques.
(3) present an understanding of the symptoms normally present following a critical incident;	
(4) assist the individual in effectively dealing with the resulting symptoms; and	
(5) identify those who need additional treatment.	
i. **Note:** Most who participate in this type of debriefing need no further services other than a routine debriefing follow-up.	
* Those who need post-trauma counseling can easily be identified by the mental health professional, and they generally require 3-4 sessions of individual, special post trauma counseling.	
j. Because PTSD is such a common occurrence, we need to be vigilant with respect to employees who have experienced trauma. They should be closely monitored for a minimum of 6 weeks following the incident and followed up for several months thereafter.	Instructor should emphasize the importance of peer support and follow-up.
k. A **formal debriefing**, following a critical incident, may be **provided to:**	
(1) Staff directly involved in the incident. For these individuals, it is **mandatory** for the specific incidents listed in the Directive.	Trainer should reiterate that he-she is talking about an incident debriefing, not an incident critique or fact-finding. Trainer should make reference to DOP 410.170 Handout #18 which requires mandatory debriefing in certain cases.
(2) Coworkers not directly involved but who are affected by the incident.	
(3) Spouses and family members of employees directlyinvolved.	
(4) Inmates	Instructor should refer participants back to **Handout #13** for additional information on debriefings, and to **Handout #16** regarding the stages of adjustment/recovery.
* Numbers (1) and (2) on the previous page may apply to inmates involved in or affected by critical incidents.	
Note: These different combinations of people are	

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER

typically debriefed in different groups as their issues are different.

l. A **follow-up session** may be scheduled about 4 weeks after the formal debriefing. The purpose is to assess the level of recovery and to discuss experiences since the original meeting.

3. **Peer Support Programs**

   a. **Purpose** - to ensure each person involved in a potentially traumatic incident will receive the support and services necessary to make a successful recovery.

   b. Without individuals in the organization to monitor potentially traumatic incidents, some incidents will likely be overlooked.

   c. Peer supporters are <u>not</u> counselors. Their tasks may include the following.

      (1) Participate in on-going peer support training.

      (2) Represent the post trauma program to other personnel.

      (3) Outreach to personnel after potentially traumatic events; i.e., contact co-workers to remind them that others in the organization are concerned about their welfare.

      (4) Allow staff the opportunity to discuss the incident.

      (5) Reinforce the use of productive coping skills taught in the training sessions.

      (6) Assess the need for post-trauma services and making appropriate referrals.

      (7) Peer supporters may also assist mental health professionals by participating in debriefings.

      (8) Follow up with each person through the recovery process.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
d. Peer supporters are the heart of the post trauma program.	Instructor should emphasize this point.
e. Peer supporters must be carefully selected and trained.	
* The most important selection criteria is the ability to maintain **confidentiality.**	
* Other important and desirable criteria include:	
(1) Communication skills; i.e., natural listening, rapport-building and support skills.	
(2) Willingness to be involved with others in need.	
(3) The ability to learn specific interpersonal skills.	
(4) Peer supporters of different ranks so those involved in potentially traumatic events will have options concerning with whom they discuss their reactions/feelings.	
(5) Patience and ability to follow through.	
(6) Previous personal experience in a critical incident.	
(7) Experience and training in crisis intervention.	
(8) Knowledge of post-trauma stress and its possible effects (i.e.,PTSD).	
(9) Ability to work as a team member.	Nonetheless, the trainer should remind participants who to contact at their institution if they would be interested in being considered as a peer support team member.
(10) Ability to project leadership, confidence and comfort in others.	
(11) Volunteers don't necessarily make the best peer supporters.	Instructor should inform participants that **Handout #15** offers guidance for providing support to others.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
4. **Counseling** a. Recommendations for counseling are made by the mental health professional and/or DOC post trauma providers. • Generally, a recommendation for further counseling is made in the following cases. (1) Severe consequences are reported. (2) There is evidence of serious depression or suicidal thoughts. (3) Some aspect of an individual's participation in the debriefing has indicated counseling would be helpful. b. Counseling sessions are extensions of debriefings and include continued discussion of the event, post-traumaconsequences and coping skills. (1) They focus heavily on coping skills for reducing the probability of long-term consequences. (2) They are almost exclusively oriented to the "here and now." (3) They deal almost exclusively with the traumatic event and efforts toward recovery. c. They are often done immediately following the debriefing. d. Follow-up counseling is usually provided by community mental health providers. e. All debriefing and counseling sessions are kept confidential. (1) Any breach of confidentiality will impair the program and the recovery of those involved. (2) There are two exceptions to confidentiality. (a) If someone is considered a risk for suicidal or homicidal behavior. (b) If there is a genuine concern that the staff's reaction to the critical incident would substantially interfere with his/her ability to perform on the job. Serious impairment is a risk to other staff, inmates and the public.	The trainer should indicate these sessions are not conducted by local peer support team members. The trainer should reference DOC 410.170 **(Handout #17)** and emphasize the limit of the Department's responsibility for the costs of counseling: i.e., only those costs for treatment of immediate post-traumatic symptoms.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
X. DOP 410.170 POST TRAUMA RESPONSE	
1. The Division of Prisons specifies post trauma providers. The local facility Post Trauma Response Program Manager knows how to contact them.	The instructor should refer participants to **Handout #17** and should stress the points listed in this portion of the lesson plan.
2. Each facility has a local Post Trauma Response Manager/Coordinator.	
A. The local Post Trauma Response Program Manager/Coordinator needs to be informed of critical incidents and staff involved in them. He/she will ensure that a referral(s) to the post trauma provider is processed.	The instructor should identify the local Post Trauma Manager/Coordinator
(1). If you are personally involved, or not involved but aware of an individual(s) involved in a critical incident at work, report it to your immediate supervisor and/or to the shift lieutenant, who will ensure your local Post Trauma Response Program Manager is informed.	
(2) If after involvement in a critical incident, you begin to experience symptoms, contact your immediate supervisor. He/she will contact your local Post Trauma Reponse Program Manager who will evaluate the circumstances involved and make a referral to the post trauma provider as appropriate.	
(3). Evaluation by the designated post trauma provider is <u>mandatory</u> for any employee involved in any of the on the-job incidents identified in this Directive, i.e., corrections specific incidents identified earlier in this training session.	Instructor should indicate that staff's level of disclosure at a debriefing is discretionary but attendance is not.

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER
a) As identified earlier, information shared in the post trauma evaluation is confidential except as identified in Section "D" of this Division Directive. The post trauma provider is obligated to inform the Superintendent if the employee's functioning is impaired in such a way as to: 1. Make the employee a risk to himself/herself; or 2. Substantially interfere with his/her ability to perform on the job.	
4. The Department of Corrections will assume counseling costs for the treatment of immediate post traumatic symptoms only. The Department of Corrections will not assume the cost of treatment for causes unrelated to work related post traumatic symptoms.	May trigger old experience(s). While not necessarily happening at work initially a work related situation may trigger the reaction.
XI. **SUMMARY**	
1. Class participants should be given an opportunity to ask for clarification on any points covered or ask any additional questions. 2. If questions are asked at any time for which you don't know the answer, indicate you'll find out the answer and inform them later. In that event, contact your local PostTrauma Program Manager. Upon receiving the answer, convey it to all participants in that class. 3. Close by reiterating the following points. a. Critical incidents do happen. b. Post Trauma Stress is a very serious and little understood dynamic that affects people who work in corrections.	Instructor should refer participants to **Handout #18.**

POST TRAUMA RESPONSE PROGRAM LESSON PLAN	NOTES TO TRAINER

c. Immediate and short-term symptoms (Post Trauma Stress) are a normal response to such incidents.

(1) Experiencing and working through such symptoms is a normal and necessary part of the recovery process.

d. Immediate and proper intervention (i.e., debriefing) prevents or reduces the likelihood of long term consequences, i.e., post trauma stress disorder (PTSD).

e. At the very least, employees need to know:

(1) how the post trauma program works;

(2) what to expect if they are involved in a "critical incident"; and

(3) what to do if further assistance is needed.

INSTITUTION ORIENTATION PROGRAM

POST TRAUMA RESPONSE

Trainee Handouts

DEPARTMENT OF CORRECTIONS

DIVISION OF PRISONS

July 1992

POST-TRAUMA RESPONSE

The Division of Prisons recognizes that employee involvement in specific work related incidents may cause serious physical and/or emotional trauma to an employee.

The goal of this program is to minimize the effect of trauma to involved employees by providing immediate intervention so they can return to duty as soon as possible.

CRITICAL INCIDENT

Definition:

An event an individual has experienced which is outside the range of usual human experience that would be markedly distressing to almost anyone. (American Psychiatric Association)

Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later (DOP 410.170).

Certain events are almost universally traumatic. These events are called "critical incidents." There are several definitions of this term.

GENERAL EXAMPLES

1. Serious threat to one's life.
2. Physical or sexual assault.
3. Serious threat or harm to one's children, spouse or close relatives or friends.
4. Sudden destruction of one's home or community.
5. Seeing another person who is being (or has recently been) seriously injured or killed as a result of an accident or physical violence.

CORRECTIONS EXAMPLES

1. Use of force resulting in serious injury or death.
2. Witnessing or involvement in any incident where serious injury or death occurs to an employee, visitor or inmate.
3. Sexual assault.
4. Serious injury due to inmate assault.
5. Involved in a shooting incident in which it's necessary to shoot at a person.
6. Taken hostage.

EVENTS WHICH MAY CAUSE TRAUMA/STRESS

MILD TO MODERATE

* Verbal Threats
* Verbal Insults
* Racial and Ethnic Slurs
* Offensive/Profane Language
* Sacrilegious Remarks
* Bad/Disgusting Health Habits
* Discovery of Nature of Crimes
* Knowing/Anticipating that Someone is Angry with You
* Bizarre Behavior
* Thrown fluids/objects
* Staff misconduct/termination

MODERATE TO SEVERE

* Riot/Hostage Situations
* Shootings
* Serious Assaults
* Serious Injury
* Suicide/Attempt - Hangings
* Death
* Blood Spills
* Participation in Emergency Situations
    * Disaster
    * Medical
    * Fire

POST TRAUMA STRESS

A normal and likely human response when exposed to one or more critical incidents.

DOP 410.170 defines it as a "normal psychological and physiological response to perceived or actual life threatening situations."

It results in immediate and short term symptoms which may last up to three months.

CHARACTERISTICS OF CRITICAL INCIDENTS

Sudden and unexpected.

Disrupt one's sense of control.

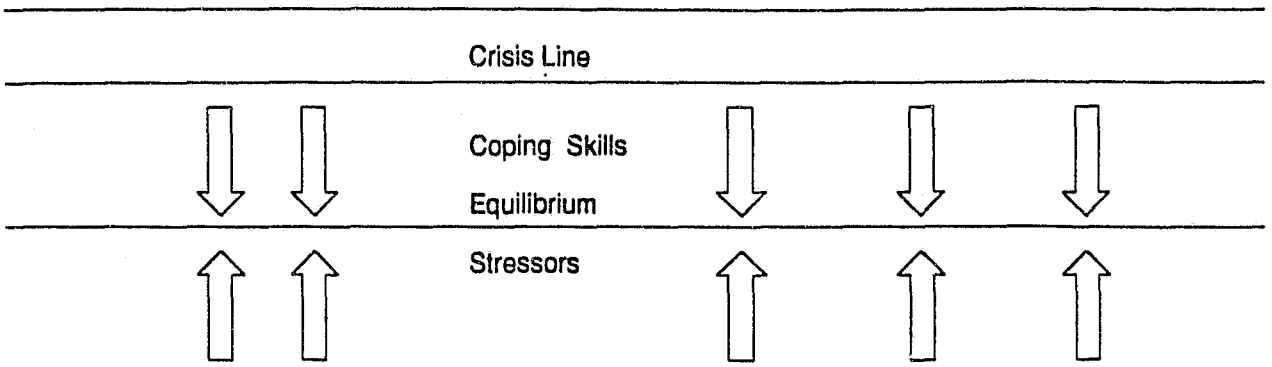
Disrupt beliefs, values and basic assumptions concerning how the world works.

Involve the perception of a life-damaging event.

May include the element of physical or emotional loss.

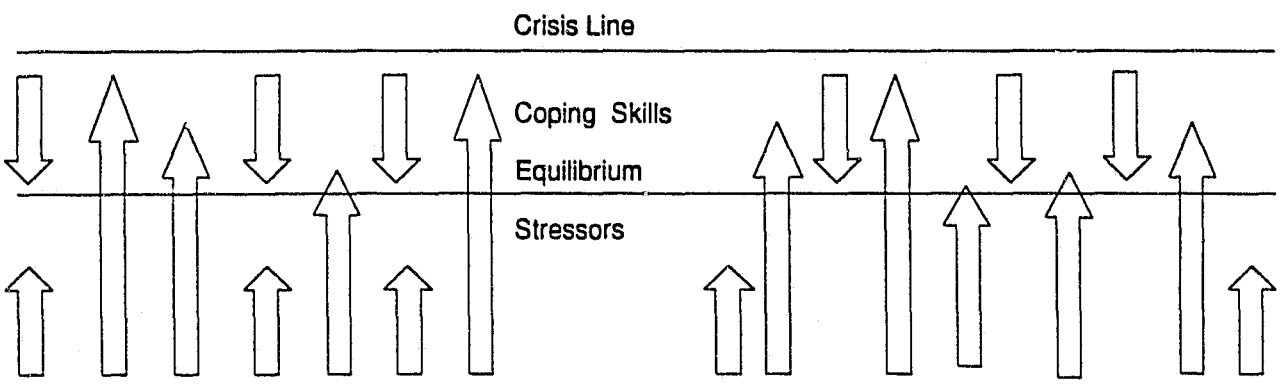
COPING WITH CRITICAL INCIDENTS

Normal State



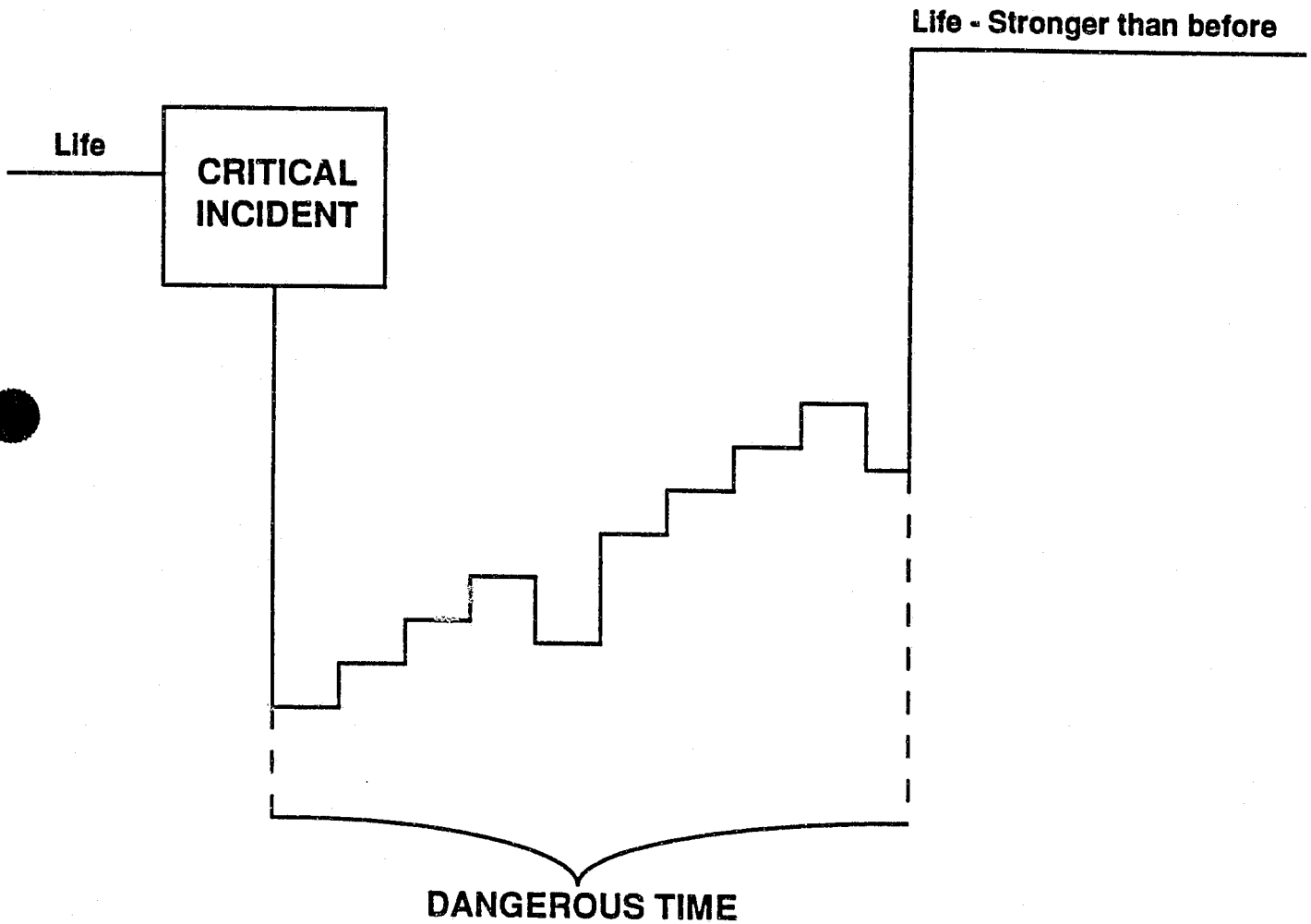
Our ability to cope or maintain our equilibrium balances out with the stress we encounter on a daily basis.

Crisis State



The amount of stress overwhelms our ability to cope, and we go out of balance for a period of time.

CRITICAL INCIDENT



RESPONDING TO CRITICAL INCIDENTS

How an individual responds to critical incidents depends on several different factors.

1. Individual coping skills.
2. Other stressors you are already dealing with.
3. The number and type of stressful events that you deal with during a critical incident.
4. What you do after the event to help your body get rid of the stress you have experienced.

POST TRAUMA STRESS SYMPTOMS

Immediate:

Psychological and emotional

* anxiety
* irritability, restlessness, hyperexcitability
* feelings of depression, moodiness, periods of crying
* anger, blaming
* feelings of apathy, diminished interest in usual activities
* feelings of isolation, detachment, estrangement
* feelings of guilt about surviving
* denial or constriction of feelings
* "flashbacks," intrusive and distressing recollections/memories of event or amnesia for the event
* recurrent distressing dreams of the event or other traumas; other sleep problems
* numbing of general responsiveness
* feelings of hopelessness/helplessness

Physical

* headaches
* feeling weakness in parts of the body
* nausea, upset stomach, other gastrointestinal problems
* soreness in muscles
* hot or cold spells, sweating or chills
* lower back pain
* faintness or dizziness
* numbness or tingling in parts of the body
* heavy feeling in arms or legs
* feeling a "lump in the throat"
* pains in chest
* increased heart rate and blood pressure
* trouble getting breath
* exaggerated startle reaction
* tremors
* fatigue/exhaustion
* increase in allergies, colds, flu
* difficulty falling or staying asleep
* appetite disturbance
* loss of coordination
* hyperactivity or underactivity

Thought

* poor concentration/distractibility
* mental confusion
* impaired thinking
* loss of objectivity
* forgetfulness
* inability to make sound judgements and decisions
* loss of ability to conceptualize alternatives or prioritize tasks
* short term memory impairment
* obsession with the incident
* distorted sense of time

Behavioral

* hyperactivity; hyperalertness
* outbursts of anger or frequent arguments
* inability to express self verbally or in writing
* withdrawal, social isolation, "distancing"
* increased use of alcohol, tobacco, other drugs; self-medication
* inappropriate use of an addictive behavior, i.e., sexual promiscuity, gambling, etc.
* avoidance of activities or places that arouse recollection of traumatic event
* family problems

Long Term

* Family problems/divorce
* Chemical dependency
* Work problems - absenteeism, disability and possible litigation
* Withdrawal from activities/people
* Burn-out
* Severe depression
* Chronic anxiety
* Domestic violence
* Difficulty with law enforcement and/or authority

THE IMPORTANCE OF A POST TRAUMA RESPONSE PROGRAM

* Employee involvement in specific, violent work related situations may cause serious physical and/or emotional trauma.

* While short-term psychological results of trauma cannot be prevented (i.e., they are normal), effective and immediate post trauma responses reduce and may prevent long-term debilitating symptoms, i.e., PTSD.

    * PTSD develops slowly and may not result in significant emotional symptoms for several months or years following the incident.

    * PTSD is difficult to treat but fairly easy to prevent through immediate and proper intervention.

* Cost effectiveness of early treatment

    * Early detection and treatment results in significant savings.

    * When detection and intervention occurs early

        * Employees return to work sooner

        * Permanent disability is uncommon

        * The potential for litigation is reduced.

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM

1. Trauma Preparation Training and Education

* Provides information on the nature and definition of duty related trauma and on the types of potentially critical incidents that may occur in corrections.
* Prepare personnel for the normal psychological consequences of exposure to traumatic incidents, i.e., post trauma stress.
* Teach basic recovery coping skills.
* Assist in creating a supportive environment throughout the organization.
* Describe the components, procedures and regulations associated with the program.
    * Orientation and in-service training
        * The purpose of training of staff is to achieve a sort of "stress inoculation"
        * Many of the psychological problems experienced following a traumatic event are the result of not being emotionally and mentally prepared for such an event.
        * Our greatest protection against the development of significant psychological problems is a knowledge of what to expect.
        * Hence, we tell employees in advance
            * How the post trauma response program works
            * What to expect if involved in a critical incident and why
            * What to do if they need assistance

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

2. Peer Support Programs

A. Purpose - to ensure each person involved in a potentially traumatic incident will receive the support and services necessary to make a successful recovery.

B. Peer supporters are not counselors. Their tasks include:

(1) Represent the post trauma program to other staff.

(2) Outreach to staff after a potentially traumatic event.

(3) Reinforcing the use of productive coping skills taught in training sessions.

(4) Assessing the need for further post trauma services and making appropriate referrals.

(5) As appropriate, assisting mental health professionals by participating in debriefings.

(6) Following up with each person through the recovery process.

C. Peer supporters are the heart of the post trauma program.

(1) They must be carefully selected and trained.

(2) Selection criteria include:

* Ability to maintain **confidentiality**
* Natural listening, rapport building and support skills
* Willingness to be involved with others in need.
* Ability to learn specific interpersonal skills.
* Patience and ability to follow through.
* Previous personal experience in a critical incident.
* Experience and training in crisis intervention.
* Knowledge of stress and its effects.
* Ability to work as a team member.
* Ability to project leadership, confidence and comfort in others.

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

3. Debriefings

A. Definition - Carefully structured meetings that occur after a critical incident.

* A debriefing is not an incident critique or fact finding.

* There is no investigation of motives and performance.

B. Designed for one to one or small groups - 20 maximum

C. Focus is on the prevention of long-term post trauma consequences and the need for additional services.

D. Should occur 1-4 days after the incident.

DOP 410.170 says "The initial session will typically occur within 24 hours of the incident, if possible."

E. Key - PTSD is difficult to treat but fairly easy to prevent through immediate and proper intervention. Without it or with improper intervention, there is a greater chance of PTSD developing.

F. Debriefings can be a timely process, i.e., 3-5 hours is not unusual.

G. The advantages of immediate intervention include:

(1) Assist the individual in coping emotionally with the traumatic event.

(2) Prevent or at least significantly reduce the potential to develop PTSD.

(3) Present an understanding of the symptoms normally present following a critical incident.

(4) Assist the individual in effectively dealing with the resulting symptoms.

(5) Identify those individuals who need additional treatment.

H. Formal debriefings should be provided to:

* Staff directly involved in the incident. For these individuals, it is mandatory.

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

* Coworkers not directly involved but who are affected by the incident.

* Spouses and family members of employees directly involved.

* Inmates directly involved in the incident.

* Inmates not directly involved but who are affected by the incident.

I. Key - Most who participate in this type of debriefing need no further services other than a routine debriefing follow-up which takes place about 4 weeks later.

J. The seven phases to a debriefing:

(1) Introductory Phase

(a) Establish ground rules.

* Not leaving during the debriefing.

* Need for confidentiality.

* Request for each person to speak freely.

(b) Purpose of debriefing explained, i.e., to assist in the emotional recovery of those involved.

(c) Description given of the debriefing process.

(2) Fact Phase

(a) Self-introduction of participants and debriefer.

(b) Participants establish the scene describing facts about themselves, the incident and their activities during the incident.

(c) Participants state where they were, what they heard, saw, smelled and did during the incident.

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

(d) Key step for several reasons:

* Retelling the story is often times the first opportunity

to do so for these individuals and most people report considerable relief after doing so.

* Provides information for a complete understanding of the event.

* Such discussion about the incident seems to decrease the memory loss that is a normal part of post trauma stress.

(3) Thought Phase

(a) Participants begin to conceptualize what they heard and saw.

(b) Participants take information shared in Fact Phase and begin to "personalize" their experience, i.e., the events are no longer a general collection of facts but become an individual recollection of how the incident was personally experienced.

(4) Reaction Phase

(a) Participants begin to share their reactions to the incident.

(b) Participants describe the worst part of the event and why it bothered them.

(c) The most commonly mentioned post trauma stress consequences are:

* Anxiety about returning to work.

* Concern that further incidents might occur.

* Sleep disorders.

* Emotional numbing.

* Withdrawal

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

(d) Involved individuals are typically relieved to discover their feelings/reactions are "normal."

5. Symptom Phase

(a) Participants share information on any physical, emotional, cognitive or behavior signs or symptoms they may be experiencing.

(b) Participants will share symptoms experienced during the event, those that appeared 3-5 days after the event and those currently being experienced.

6. Teaching Phase

(a) It is stressed that reactions and symptoms being experienced are normal.

(b) Information on managing post trauma stress and positive coping methods is shared with participants.

7. Re-Entry Phase

(a) Opportunity for participants to ask any remaining questions they may have or say anything else they wish to convey.

(b) Participants develop a plan for recovery that will assist in the management of post trauma stress and reduce the possibility of long term symptoms, i.e, PTSD.

(c) Participants are urged to support and monitor each other.

* Such support helps combat feelings of withdrawal and normalizes other post trauma stress feelings.

(d) Availability of post trauma counseling is mentioned.

(e) A follow-up session is scheduled.

* Takes place 4 weeks later.

* Purpose is to assess the level of recovery and discuss experiences since the original meeting.

COMPONENTS OF A POST TRAUMA RESPONSE PROGRAM - cont.

4. Counseling

A. Recommendations for counseling are made by the mental health professional and/or DOC post trauma providers.

B. Counseling sessions are extensions of debriefings and include continued discussion of the event, post trauma consequences and coping skills.

* As indicated in DOC 410.170 (Handout #18), the DOC will assume counseling costs for the treatment of immediate post traumatic symptoms only.

* DOC will not assume the cost of treatment for causes unrelated to work related post traumatic symptoms.

C. Most individuals needing counseling generally require 3-4 individual sessions.

D. Follow-up counseling after debriefings is usually provided by local mental health professionals.

E. All debriefing and counseling sessions are kept confidential.

(1) Any breach of confidentiality will impair the program and the recovery of those involved.

(2) Two exceptions to confidentiality.

(a) If someone is considered a risk for suicidal or homicidal behavior.

(b) If there is a genuine concern that the staff's reaction to the critical incident could substantially interfere with his/her ability to perform on the job.

* Serious impairment is a risk to other staff, inmates and the public.

COPING TECHNIQUES

Things you can do to help yourself and others who experience a tragic event in their lives.

Structure your time - keep busy

You're normal and having normal reactions - don't label yourself crazy

Diet - balanced, healthy

Exercise

Talk about the experience with others - talk is the most healing medicine

Give yourself permission to feel rotten and share your feelings with others

Spend time in activities you enjoy

Reach out

Develop a peer support group

Keep a personal journal; write your way through sleepless nights

Get plenty of rest

Keep your life as normal as possible; don't make any big life changes

Incorporate ritual and tradition

Do things for others; help your co-workers

Do things that feel good to you

Realize those around you are under stress also

The Nutrition Almanac recommends supplementing your diet with Vitamin C, Vitamin B2, Vitamin B6, calcium and magnesium

Make as many daily decisions as possible which will give you a feeling of control over your life

Get professional mental/physical help

GUIDELINES FOR OFFERING SUPPORT TO OTHERS

1. Learn about post trauma stress.
2. Be available. Initiate contact, but don't push.
3. Accept the response you get from the person. Be interested in the individual as a person.
4. Be empathic and supportive.
5. Listen.
6. Respond nonjudgementally.
7. Avoid biased questioning - your interest rather than their's.
8. Do not say, "I'll tell you what I would have done."
9. Be sensitive to changes in the person that indicate they are not coping well. Gently challenge effectiveness of maladaptive behavior.
10. You are not responsible for how they handle the situation; they are. Don't create dependency relationships; do offer support, encouragement and validation of emotions.
11. Know your limits - get professional help or guide the person to professional assistance when you feel you are over your head.

STAGES OF ADJUSTMENT/RECOVERY

The Chinese symbol for crisis is one that combines the symbols for danger and opportunity. Crisis can be dangerous for people if they are not able to understand what they are going through or become stuck in one of the phases prior to coming to terms with the event.

Working, and it does take work, through a life-threatening event can also present a tremendous opportunity for individuals to grow and learn. Just about every time you pick up the newspaper or turn on the television, there are stories about people who have overcome adversity and become better for the situation.

Each person going through a crisis of any kind progresses through stages of emotional adjustment. A victim may spend a great deal of time in one stage and only touch lightly on another, or may pass through a number of the stages over and over again, each time experiencing them with a different intensity. Furthermore, anyone close to the victim may experience these stages as well.

Stages of Adjustment

1. Shock ("I'm Numb")

   This phase may last from a few minutes to several days depending upon the severity of the event. It is characterized by:

   A. Dazed look and actions.
   B. Inattentiveness.
   C. Some memory loss.
   D. Difficulty comprehending the significance of the event.

   Few people get permanently stuck in this stage.

   Involved person likely to remember very little about what occurs during this stage; hence, offering information is not likely to be helpful during this stage.

STAGES OF ADJUSTMENT/RECOVERY - cont.

2. Denial ("This Can't Have Happened")

This phase is usually characterized by most people by:

A. Denying they need help.

B. Strongly asserting they are fine.
C. Not making needed changes in their lives to help them deal more productively with the situation.
D. Increased physical symptoms or stress.

Denial comes out strongly in corrections employees because:

A. They have difficulty saying they are hurt, afraid, etc.
B. They tend to want to prove they are tough, macho, etc.
C. They oftentimes try to dull the pain via alcohol or other drugs.

3. Anger ("What Did I Do? Why Me")

This phase is characterized by overwhelming feelings of anger. An individual in this phase may lash out at anyone or anything. It is also characterized by the need to blame someone for what has happened. The individuals in this phase will usually alternate between blaming themselves and blaming others.

Many people become stuck in this phase. Much of their anger is due to their perceived loss of strength and control over their life.

4. Bargaining ("Let's Go On As If It Didn't Happen.")

This phase is when an individual begins to come to terms with the event. The coping technique is to try and put things back the way they were. Whoever or whatever was identified as the cause usually becomes the solution during the bargain event, even if it makes no sense.

Example: If only I had been tougher on the inmates, this would not have happened. The bargain struck becomes that I will be tougher on the inmates.

5. Depression ("I Feel Worthless.")

This phase is usually characterized by feelings of sadness. If the individual is warned of this stage ahead of time, he/she may not be so thrown by it. Though painful, this stage shows the involved person has begun to face the reality of the incident.

STAGES OF ADJUSTMENT/RECOVERY - cont.

6. Acceptance ("Life Can Go On." "It's Part Of My Life.")

In acceptance, the individual learns to accept what happened, what their actions were and the circumstances. They learn that they are vulnerable but that it is okay because that is being human. They also learn vulnerable does not mean helpless or powerless but quite the opposite. They usually will go through a period of re-evaluating their values, goals and priorities in life. Most importantly, they "learn to learn" from the experience, and reaffirm their strength and worth.

POST-TRAUMA RESPONSE DIRECTIVE 410.170

DEPARTMENT OF CORRECTIONS DIVISION OF PRISONS	DIVISION DIRECTIVE	NUMBER DOP410.170	
		ISSUE DATE April 15, 1991	EFFECTIVE DATE May 15, 1991
		Page 1 of 2	

TITLE **POST-TRAUMA RESPONSE**

AUTHORITY:

DOC Policy 410.100

PURPOSE:

The Division of Prisons recognizes that employee involvement in specific work-related incidents may cause serious physical and/or emotional trauma to an employee. The goal of this program is to minimize the effect of trauma to involved employees by providing immediate intervention so they can return to duty as soon as possible.

APPLICABILITY:

This applies to all DOP facilities.

DEFINITIONS:

Critical Incident: Any situation which may cause participants to experience unusually strong emotional responses that have the potential to interfere with their ability to function, either at the scene or later.

Post-Trauma Stress: A normal psychological and physiological response that may be demonstrated by individuals exposed to perceived or actual potentially life-threatening situations. The resulting trauma can create immediate and short-term symptoms which may last for up to three months.

DIRECTIVE:

Each Superintendent shall establish a field instruction which complies with this directive.

PROCEDURE:

A. The Director of Prisons shall designate a post-trauma provider(s) for evaluation and care of any Division of Prisons employee(s) who has experienced post trauma as described in this directive. The Superintendent may request an exception to this requirement for unique situations. The exception must be approved in advance by the appropriate Deputy/Assistant Director and Director of Prisons.

B. Each Superintendent shall designate a staff person responsible for a Post-Trauma Response Program. Responsibilities include ensuring staff are trained; ensuring referral to the post-trauma provider; ensuring follow-up care is provided as recommended; and assisting the affected employee in matters of relevant concern (i.e., payroll/leave issues, L & I claim, etc.).

C. Evaluation by the designated trauma professional shall be mandatory for an employee involved in any of the following on-the-job incidents:

1. Use of force that results in serious injury/death.
2. Witnessing or involvement in any incident where serious injury or death occurs.
3. Sexual assault.
4. Serious injury due to an inmate assault.
5. Involved in a shooting incident, in which it is necessary to shoot at a person.
6. Taken hostage.
7. Other incidents that the Superintendent believes have a potential for post-trauma effects.

D. The post-trauma provider shall inform the Superintendent if the employee's functioning is impaired in such a way to make the employee a risk to himself/herself or to substantially interfere with his/her ability to perform on the job. All other information obtained in the post-trauma evaluation/care/

POST-TRAUMA RESPONSE DIRECTIVE 410.170

DEPARTMENT OF CORRECTIONS DIVISION OF PRISONS	DIVISION DIRECTIVE	NUMBER DOP410.170	
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TITLE **POST-TRAUMA RESPONSE**

treatment shall remain confidential. The employee shall be informed of the scope of this section at the time of the initial interview.

E. The initial evaluation session will typically occur within 24 hours of the incident, if possible.

F. The trauma evaluation will take priority over routine work assignments and should occur during the normal work hours of the effected staff, if possible, and will be considered work time.

G. If the post-trauma provider believes that an employee needs more in-depth or extended assistance, he/she will refer the employee to a source qualified to provide such assistance. The referral must be coordinated with the Superintendent or facility staff person responsible for the Post-Trauma treatment program. The responsibility for payment of continued treatment (i.e., institution, employee, insurance, etc.) must be clearly specified prior to the first appointment. In cases where the institution assumes the cost of further care, the provider must clearly understand the scope of services expected. In general, it is not the intent of the Department to assume the cost of ongoing mental health treatment for anything other than immediate post-traumatic symptoms.

H. All new employees will receive a briefing on the Post-Trauma Response program as a part of new employee orientation. This briefing will be documented in the employees personnel record.

REFERENCES:

SUPERSESSION:

None

Larry Kincheloe, Director
Division of Prisons
April 1991

SUMMARY

1. CRITICAL INCIDENTS DO HAPPEN.

2. IMMEDIATE AND SHORT TERM SYMPTOMS ARE A NORMAL AND LIKELY RESPONSE TO SUCH INCIDENTS.

3. IMMEDIATE AND PROPER INTERVENTION MAY PREVENT OR REDUCE THE LIKELIHOOD OF LONG TERM CONSEQUENCES.

** POST TRAUMA RESPONSE TRAINING EVALUATION **

WEDNESDAY, NOVEMBER 4

This training is the pilot project for the Division of Prisons Post Trauma Response Programs. Your evaluation/comments will help us in planning and improving the quality of this training. Please help by completing this form thoughtfully. Thank you!

	Excellent	Good	Poor
Presentation skills were:	10 9 8	7 6 5 4	3 2 1
Handout materials and visual aids were:	10 9 8	7 6 5 4	3 2 1
Speakers' responsiveness to participants:	10 9 8	7 6 5 4	3 2 1
Overall, I considered today's training:	10 9 8	7 6 5 4	3 2 1
The training facilities were:	10 9 8	7 6 5 4	3 2 1

Do you believe you will be able to apply what you have learned today in a post-trauma incident? Why? Why not?

Which information was personally most valuable?

Which information was personally least valuable?

Additional comments about the training:

** POST TRAUMA RESPONSE TRAINING EVALUATION **

THURSDAY, NOVEMBER 5

This training is the pilot project for the Division of Prisons Post Trauma Response Programs. Your evaluation/comments will help us in planning and improving the quality of this training. Please help by completing this form thoughtfully. Thank you!

	Excellent	Good	Poor
Presentation skills were:	10 9 8	7 6 5 4	3 2 1
Handout materials and visual aids were:	10 9 8	7 6 5 4	3 2 1
Speakers' responsiveness to participants:	10 9 8	7 6 5 4	3 2 1
Overall, I considered today's training:	10 9 8	7 6 5 4	3 2 1
The training facilities were:	10 9 8	7 6 5 4	3 2 1

Do you believe you will be able to apply what you have learned today in a post-trauma incident? Why? Why not?

Which information was personally most valuable?

Which information was personally least valuable?

Additional comments about the training:

** POST TRAUMA RESPONSE TRAINING EVALUATION **

FRIDAY, NOVEMBER 6

This training is the pilot project for the Division of Prisons Post Trauma Response Programs. Your evaluation/comments will help us in planning and improving the quality of this training. Please help by completing this form thoughtfully. Thank you!

	Excellent	Good	Poor
Presentation skills were:	10 9 8	7 6 5 4	3 2 1
Handout materials and visual aids were:	10 9 8	7 6 5 4	3 2 1
Speakers' responsiveness to participants:	10 9 8	7 6 5 4	3 2 1
Overall, I considered today's training:	10 9 8	7 6 5 4	3 2 1
The training facilities were:	10 9 8	7 6 5 4	3 2 1

Do you believe you will be able to apply what you have learned today in a post-trauma incident? Why? Why not?

Which information was personally most valuable?

Which information was personally least valuable?

Additional comments about the training: