U.S. Department of Justice
Office of Justice Programs
Office for Victims of Crime

DEATH NOTIFICATION

MADD
Mothers Against Drunk Driving

Breaking the Bad News with Concern for the Professional and Compassion for the Survivor

A Seminar for Medical Professionals

Office for Victims of Crime
OVC
Adocating for the Fair Treatment of Crime Victims

DEATH NOTIFICATION

A Seminar for Medical Professionals
(Revised 1996)

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This project was supported by Grant Number 95-MU-GX-K007 awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The Assistant Attorney General, Office of Justice Programs coordinates the activities of the following programs and offices: Bureau of Justice Assistance, Bureau of Justice Statistics, National Institute of Justice, Office of Juvenile Justice and Prevention, and Office for Victims of Crime. Points of view in this document are those of Mothers Against Drunk Driving and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Cover: Photography by Dorothy L. Carter

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PLANNING YOUR DEATH NOTIFICATION SEMINAR FOR MEDICAL PROFESSONALS

1. Contact victims who have been notified of the sudden death of their loved one by a physician, the medical examiner, or EMT and ask if they felt it had been handled with dignity an respect for their needs. Also contact physicians, particularly emergency physicians, and ask what training they have had in delivering death notifications. Talk with nurses, hospital social workers and chaplains to see if they feel they have been adequately trained in death notification. If you sense a need for the training after these interviews, move forward with planning your seminar.

   If you conclude that the seminar is not needed, don't plan one! Offering a seminar which is not needed is not good for your agency's image, so do your homework!

2. If the training is needed, try to obtain the support of local chiefs of police and key medical and EMT staff in your community. Include the signatures of all agency heads and yours on a cover letter to be mailed with seminar registration brochures.

3. Arrange accreditation of the program through the Continuing Education Program of a local university or other accrediting agency that oversees medical professionals. This will greatly enhance attendance. If you cannot get the seminar accredited, it may not be worthwhile to offer the training.

4. Arrange for two or three victims to share their personal experiences of being notified of the death of their loved one. It is best if at least one felt it had been done poorly and at least one felt it had been done appropriately. Be sure the panel is diversified in terms of race, gender and relationship to the person who was killed. The Victim Impact Panel is a very important part of the seminar.

5. Invite someone respected from the medical profession to give introductory remarks at the beginning of the seminar.

6. The seminar may be conducted from two hours, perhaps as an in-service opportunity, to about four hours. Medical professionals have limited time for continuing education, so the shorter the better. Serving lunch after a morning seminar or before an afternoon seminar is recommended because it gives attendees the opportunity to discuss the topic informally and also helps get them there. If the seminar is offered in the morning, serve coffee and rolls, even if you choose not to serve lunch.

7. Make basic plans for the seminar at least three months before the event. Mail the letters and flyers out at least one month before the event. One week before the event, call each group which has not yet registered to remind them of the seminar. If participants register by mail, be sure to send a confirmation card or letter.

8. Work with co-sponsoring agencies' public relations departments to send out news releases and media alerts if you wish media coverage. Some professional groups do not want the media at their seminars, but the media usually is intrigued by the topic and can give your organization some credibility. If media covers the event, they will probably want to interview the victims who speak on the victim panel. Be sure that the victims are willing before allowing this. Because of the devastating nature of a death notification, some victims have difficulty talking about it, especially with the media.

9. The training curriculum is flexible and can be altered to fit the needs of any audience.

10. Develop an evaluation sheet or use the sample form in this publication.

COMMENTS OF ATTENDEES

(May be used for flyers or brochures)

"As a result of the training received this weekend, I am confident that members of the Police Department's Command Staff and other officers in attendance are much more aware of the importance of providing support to victims as their first responder."

James N. Robey
Chief of Police
Howard County, Maryland

"My wife is a paramedic and on the Sunday after the seminar she was able to put to use some of the things she had learned. She and another paramedic who (also) attended the seminar said that everything they had learned was worthwhile and really helped."

George Smith
Billings, Montana

"The effort that you put into the planning and execution of the program was obvious from the extremely professional manner in which the program was conducted. I found it both intellectually and emotionally moving."

Joseph Murtha
Assistant State's Attorney
Howard County, Maryland

"As president of the Association for Death Education and Counseling, an international association of more than 1700 members, I know this is a subject of great urgency. Not only must we always be willing to update ourselves to better assist others, but we must also learn how to take care of ourselves. Through programs such as this, we do just that!"

Ben Wolfe, M.Ed.
Duluth, Minnesota

"Although more than seventy years of police experience was represented in our officers who attended the seminar, we all gained new insights, information, and appreciation for the victims."

_____
Samuel E. Corbin
Prince George's County, Maryland

"Having seen you in action, I can say that the service you provide through the training is truly beneficial, not only to the law enforcement community, but to those individuals who find themselves on the receiving end of a death notification. This training has the potential to positively impact thousands of lives, and should be continued and expanded.

Marc W. Harlow
Michigan Sheriff's Association

"The evaluation comments of our officers were highly favorable to the content and information. Often expressed were statements wishing the class could have been longer. Many others noted they had no idea how much information was available and worth considering."

Captain K. S. Gilbraith
Wyoming Highway Patrol

"We need more of this training. The reaction from those who have attended is overwhelming. Recently, a victim who came because she was to speak on the panel told me she had spent several years in therapy, but the information she received at the seminar helped her significantly. She said she gained a clearer perspective of why she reacted the way she did, but it also helped her understand why the officers reacted as they did."

Wayne Smith
Chief of Police
Clataskanie, Oregon

"This program is long over-due. We have found that law enforcement personnel receive little or no training in this sensitive issue during their training at the police academy. We also find that the chaplains don't rate high in delivering death notifications because too often they bring in the religious aspects of the death rather than allowing the survivors to openly express their response to the devastating news."

Susie Sawyer
Concerns of Police Survivors

"After reviewing this curriculum, I found myself looking back at my 23 years in law enforcement. Little or no thought was ever given to this topic when I began my career. I remember carrying the emotional consequences back home with me as I had no other outlet. With this thought in mind, I highly recommend that this material be incorporated into basic training at the academy."

Anthony A. Munoz
Police Lieutenant
Waterford, Connecticut

TIPS FOR TRAINING ADULTS

HOW TO SUCCEED IN REACHING ADULT AUDIENCES

(OH 1,2)

1. Explain how it will benefit them (What's in it for me?)

2. Relate the learning to their past experiences.

3. Encourage participation and interaction.

4. Listen and respect opinions (Make me feel good about myself.)

5. Encourage audience to be resources to you and to each other.

6. Always treat like adults.

MAXIMUM EFFICIENCY IN LEARNING

(OH 3,4)

Least Effective:

Verbal Symbols
Alone

Visual Symbols Alone

Verbal Symbols Combined with
Visual Symbols

Most Effective:

Verbal, Visual Hands-On Experience

FLIP CHART TIPS

1. Make letters at least 1 1/2 inches high.
2. Before presentation, go to back of room to assess how large you will need to print.
3. Leave 2" or more between lines.
4. Use the top 2/3 of the pad only.
5. Use as few words as possible.
6. Highlight key points by using
   - color
   - shapes
   - graphics
   - boxing
   - underlining
   - pictures
7. Alternate colors when listing ideas from the audience.
8. If comparing or contrasting data, use two flip charts.
9. If material needs to be retained, tape pages on the wall.
10. Write presentation notes in pencil on margins of flip chart.
11. Tab pre-prepared charts to eliminate searching for them.
12. Cover errors with white labels, then write over them rather than begin a new page.

TRANSPARENCY TIPS

1. Use as few words as possible.

2. No more than six words per line.

3. No more than six lines per page unless you reveal lines one at a time by using paper as a mask.

4. Address only one major idea with up to three subpoints on each transparency unless revealing item by item.

5. Use various colors of tinted plastic to reduce glare and add interest.

6. Illustrate as much as possible with pictures, shapes, and graphs.

7. Use up to three colors if possible.

8. Keep lines straight.

9. Turn transparency projector off between transparencies unless using in rapid succession. They detract from what is being said if left up too long.

10. If using several times, mount in plastic or cardboard frames.

11. Pencil presentation notes on frames of transparencies.

12. Place masking tape around edges of projector glass to keep out light and to keep transparencies from slipping and becoming crooked.

CURRICULUM

The following curriculum includes materials on crisis responder stress, post traumatic stress disorder, and secondary traumatization which may be useful for law enforcement professionals. However, if time is limited, some of these topics may be eliminated. If shorter trainings are preferred, the most important sections are Sections VI through IX.

I. Introduction

A. Welcome by Local Host; Introduction of Guest Trainers

B. **(OH 5)** Goals and Objectives of the Seminar

Goals: The goals of this seminar are to enhance awareness of the emotional hazards of the work you do as EMT, physicians, nurses, medical examiners, and other health professionals; and to learn strategies for compassionate and thorough death notifications.

Objectives: The objectives are to accomplish this include learning about the homicide survivor's family experience through the first few weeks, listening to some victims share about their notifications, and working through some protocols developed after meeting with thousands of family members of someone killed.

C. Introduce Agenda.

- Selection of the Notifier
- Homicide Survivor Reactions
- Homicide Survivor Panel
- Protocol for Death Notification

D. Define Audience (EMT's other medical professionals, counselors, victim advocates, clergy, other).

E. Explain contents of training packets.

F. Explain accreditation and CEU procedures.

G. Address practical concerns: restrooms, meals, parking, etc.

II. Overview (Preferably taught by an EMT or other medical professional)

A. Dealing with sudden, violent death is a very big problem in this country. It touches many professionals on a daily basis: law enforcement officers, emergency medical personnel, funeral directors, clergy, mental health counselors, and victim advocates.

B. **(Following are national statistics. Trainer may prefer to use local or state statistics.)**

- About 470 people in the U.S. are murdered each week **(Department of Justice, 1995).**
- The number of youth under 18 arrested for murder rose from 23 per week in 1985 to 57 per week in 1994 **(FBI, 1995).**
- About 780 people in the U.S. are killed in vehicular crashes each week. **(National Center for Statistics & Analysis, June, 1995).**
- Crashes are the number one killer of Americans aged 1-34 **(National Center for Statistics & Analysis, June, 1995).**
- More than 320 of the 780 weekly vehicular crash victims die in crashes that are alcohol and other drug related **(National Center for Statistics & Analysis, June 1995).**
- The Oklahoma City bombing killed nearly 300 people, and that terrorist attack was unquestionably a national crisis. Yet, drunk drivers kill more than that every single week in this country.
- All of these victims leave behind hundreds of thousands of parents, children, spouses, brothers, sisters, and friends whose lives are forever changed.

C. Looking at it from this broader perspective, we are a country of the walking wounded.

The **Amick-McMullan and Kilpatrick et al. research (1989a)** involved random phone calling of 12,500 people and found that nearly four percent of U.S. population -- an estimated 6.7 million people -- have had a loved one murdered or killed by a drunk driver. Their study also revealed that more than five percent of them are currently suffering from post-traumatic stress syndrome related to homicide. Twenty-three percent have had PTSD sometime since their trauma **(Amick-McMullan, et. al., 1989b).**

D. **Most families in which someone was killed say that the most traumatic moment of their life was the notification of the death of their loved one. Most recall vivid tunnel-vision for a portion of it. Likewise, most people who are required to deliver death notifications say it is the most difficult part of their jobs.**

Spencer Eth, Chief of Clinical Services at the VA Medical Center Mental Health Clinic in Los Angeles studied a large group of detectives and found that 67% admitted that death notifications were "very or extremely stressful."

(OH 6) Their apprehensions stemmed from (1) feeling untrained and unprepared, (2) over-identifying with the victim families because they genuinely cared about their reactions, (3) personal vulnerability: fear of verbal or physical aggression; and (4) fear of being labeled ["If you can't stand the heat, get out of the kitchen" attitude] **(Chard, 1987).**

E. Our desire to help can be a two-edged sword. As long as we genuinely want to help, we will be vulnerable to pain. Unfortunately, too much focus is placed on shutting down feelings in our professions. No, we must not let our feelings get in the way of rational thinking and appropriate professional behavior, but staying totally in the cognitive realm may be more harmful than helpful. Feelings motivate us to be even sharper in our thinking and behaving. The worst consequence repressing feelings is that we can't turn them back on when we get home.

F. Did you ever think of yourself as a victim even though you may never have been raped, assaulted, or had a loved one killed?

Did you ever look through the list of symptoms of post traumatic stress in terms of yourself?

Difficulty sleeping, night mares, intrusive thoughts about crimes you are aware of, feelings of numbness as you hear someone's story, exaggerated startle response, hyper-vigilance.

III. Selection of the Notifier

A. (OH 7) Selection of the notifier is as crucial as the procedure itself.

A stressed notifier will not be a good deliverer of death notification because he or she will be focused on self, experiencing the task as one more layer of stress. The best attitude for delivering a death notification is a positive one, believing that it is an opportunity to do a good job with an extremely difficult task.

B. Post-Traumatic Stress Disorder, a common result of trauma work, can significantly interfere with one's ability to deliver an effective death notification.

1. Post-Traumatic Stress Disorder is now a common diagnosis for direct victims of war and crime, but it is also referred to as Secondary Post-Traumatic Stress Disorder among those who experience the symptoms because of over-exposure to the traumas of others.

2. Recent large scale studies **(quoted in Pitman and Orr, 1993)** are indicating that:

1% to 9% of the general US population suffers PTSD.
34% to 78% of rape victims suffer PTSD.
3% to 37% of assault victims suffer PTSD.
15% to 35% of Vietnam Veterans suffer PTSD **(Card, 1987; Kulka, 1990).**
2% to 7% of family and friends of someone murdered or killed in a drunk driving crash suffer PTSD.

Some have said about 1/3 of the population has PTSD **(Figley, 1995)**

This is not to mention the large numbers who suffer some of the symptoms, but not enough of them to warrant the full diagnosis.

3. PTSD has been in existence a long time, but by different names:

WWI:	Shell Shock Traumatic Neurosis
WWII:	Combat Exhaustion A-Bomb Disease Survivor Syndrome
Vietnam War:	Post-Traumatic Stress Disorder

(This audience will be familiar with the DSM IV criteria for PTSD, but may not have considered post-traumatic decline as a possible diagnoses for themselves. **Post-Traumatic decline refers to chronic symptoms not related to one specific trauma, but to having witnessed or experienced a number of traumas.**

4. Consider the following symptoms of PTSD **(Refer to handouts, page 24).**

Post-traumatic Stress Disorder Criteria: Diagnostic and Statistical Manual IV **(American Psychiatric Association)**

a. The person has been exposed to a traumatic event in which **both** of the following were present:

---

(1) The person experienced, witnessed, or was confronted with an event or events that involved **actual or threatened death or serious injury**, or a threat to the physical integrity of self or others.

(2) The person's response involved **intense fear, helplessness, or horror**. NOTE: In children, this may be expressed instead by disorganized or agitated behavior.

b. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions. NOTE: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. NOTE: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). NOTE: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external causes that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

c. Persistent avoidance of stimuli associated with the trauma and numbing general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings or conversations associated with the trauma.

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) Inability to recall an important aspect of the trauma (psychogenic amnesia).

(4) Markedly diminished interest or participation in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills).

(5) Feeling of detachment or estrangement from others.

(6) Restricted range of affect (e.g., unable to have loving feelings).

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

d. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep.

(2) Irritability or outbursts of anger.

(3) Difficulty concentrating.

(4) Hyper-vigilance.

(5) Exaggerated startle response.

e. Duration of the disturbance (symptoms in B, C, and D) is **more than one month.**

f. The disturbance causes **clinically significant distress or impairment** in social, occupational, or other important areas of functioning.

Specify if:

Acute: If duration of symptoms is less than three months.

Chronic: If duration of symptoms is three months or more.

Delayed Onset: If onset of symptoms is at least six months after the stressor.

g. Yale studies

Research at Yale **(Goldman, 1990)** has found that victims of PTSD may have had chemical changes take place in their brains which are irreversible. Changes include:

(1) Time Expansion:

During the trauma a victim may have felt time was passing very slowly. After that, victims may have difficulty with time perception, assessing how long things take, and may have to continually watch the clock.

(2) Tunnel Vision:

During the trauma, a victim may have focused on only one specific part of what happened which he or she remembers vividly. Other parts, however, are not clear at all. Such victims may later have difficulty "seeing the whole picture" of issues, solving problems, etc. Recovery of the full memory may or may not occur, and the capacity for full and abstract thinking may be limited.

(3) Ability to Dissociate:

If a victim became so distressed that he could not handle the physical/emotional pain, he may have "left his body", so to speak. Once accomplished, dissociation is fairly easy to repeat.

(4) Startle Reflex:

Victims may over-react to sudden loud sounds.

C. Stress Studies

1. Research about work-related stress is showing that the most deadly combination is low control and high demand. Low control means you have very little latitude -- very little opportunity for independence -- in how you perform your job. High demand means too much to do in too little time. Robert Karosek, professor of work environment at the University of Massachusetts at Lowell, has found that, based on that criteria, 20% of American men have "bad jobs."

Dr. Peter Schnoll, a cardiologist at New York Hospital in Manhattan, revealed that those who complained of job strain were more likely to have high blood pressure, and sonograms showed that the walls of their hearts were thicker **(Ubell).**

2. Post-Trauma Recovery of Public Safety Workers in Delta 191 Crash **(Lanning, 1987)**

   a. The Delta 191 crash in August, 1985 in Dallas resulted in 136 deaths. There were 27 survivors.

   b. Joan Lanning studied 77 police, fire fighters, and paramedics 20 months after the crash.

   c. The crisis workers had an average of 14 years of experience.

   d. Findings which have implications for the development of stress management plans:

      (1) Being able to treat the bodies with respect, especially prior to death, helped in adjustment. Those who stepped on bodies or had to put body parts in bags had the most difficult recovery.

      Another study **(Green et. al., 1989)** found that exposure to the grotesque, especially dismembered body parts, specifically predicted PTSD.

      (2) After 20 months, 16% of the crisis workers were still having "intrusive recollections" (pictures, sounds and smells popping into mind) of the crash numerous times during the week, for many of them, daily. Police had the most intrusive recollections, then paramedics (very close), with fire fighters significantly lower. Beginning to talk about the memories helped reduce unwanted intrusions.

      (3) Regarding overall stress scores, paramedics scored the highest, followed by police, with the fire fighters having the lowest scores. Paramedics had to make life and death decisions, dealing intimately with bodies. They expressed a great sense of loss of control over the situation. The fire fighters were believed to have lower scores because they had more time to debrief informally.

(4) Thirty percent were still experiencing symptoms of PTSD at the time of the study -- 20 months after the crash. About half were still experiencing numbing symptoms, (lack of feelings, positive or negative) and about half were having intrusive symptoms.

5. The Fort Worth Star Telegram interviewed a number of the Delta 191 survivors and crisis workers in July, 1995, for a ten-year anniversary series. Dallas/ Fort Worth fire fighter Paul Reese, now 38, was one of the first rescue workers at the crash site. He says he still remembers much of it in vivid detail -- "as if it happened yesterday."

"It was just unbelievable. I wasn't ready for what I saw -- so many dead bodies and body parts. You couldn't see anything until you got right to it because it was raining so hard. I really didn't think I could make it into the plane without stepping on a person or parts of a person. I finally was able to pull some victims out. There was a lady on the concrete, incoherent. I could hear another one calling for help. I had to move one dead body out of the way to cut another man out of his seat belt. When I got to him I could see that his leg was cut off and he was burned over 100% of his body. I saw three sets of legs -- a man, a woman, and a child. When I turned their seats over, there was nothing there but legs. It was hard, putting bodies in body bags, knowing how many more there were to do."

"Afterward I developed a twitch in my left leg that came every time I went out on an alarm. It took a long time to stop. I still don't like to be out in the truck with low planes flying over me. I still wonder if any of those I pulled out survived. I wish there was some way to know who made it and who didn't." **(Reese, 1995)**

3. An editorial in JAMA (Journal of the American Medical Association) responded to a previous article in which a physician wrote about the impact of his colleague's suicide, lamenting that he had not taken time to hear about the problems he was facing, even though they had been friends since medical school **(Sweet, 1991).** The responding doctor says:

Unfortunately, physicians whose major skill was once to be good listeners, seem to be losing this very important talent. I, myself, have been very seriously ill, totally bed-ridden and in excruciating pain for the last five years....I have reached the point where I do not want to go on living....Despite my condition, I am unable to discuss it with my medical

colleagues. It is a very sad state of affairs that the people on whom I thought I was able to rely on the most are the very people who do not wish to hear how very serious things have become for me. I have come to believe that physicians suffer from "compassion fatigue" much more readily than lay people. Are we living in very cynical times? Have other physicians in distress found their colleagues hesitant to express sympathy toward them? Is it not possible that one of the major reasons for the very high suicide rate among physicians is that they feel afraid to share their distress with colleagues? **(Booth, 1991).**

4. Caregiver Burnout

(OH 8) Dr. Alan Wolfelt, a well-known thanatologist, has identified symptoms of "caregiver burnout" **(1989, 1990, 1992).**

a. Exhaustion and lack of energy

b. Irritability

c. Cynicism and detachment

d. Physical complaints

e Disorientation and confusion

f. Omnipotence and feeling indispensable

g. Minimization and denial of feelings

Discussion Question: How might any of the problems we have just discussed interfere with one's ability to deliver a compassionate and thorough death notification?

IV. Crime Victims and Medical Professionals

A. **(OH 9)** Research has taught us what victims want:

- To be able to tell their story again and again
- To have all their feelings accepted and to be believed
- To be with others who have been through it

(Wortman, 1985; Pennebaker & O'Heeron, 1984; Weinberg, 1985; Weiss, 1988).

B. (OH 10) Likewise, we know what victims don't want:

- Encouragement to take medicine.
- Being told not to think about it.
- Being referred to support groups prematurely (If they selected you as their confidante, they want you to listen.). **(Wortman, 1985; Weinberg, 1985, Weiss, 1989).**

C. **(OH 11) Are our needs as medical professionals much different?**

Medical professionals can tend to put a protective barrier around ourselves to cope with the suffering we face every day--a way of staying "on top of it."

Also because of the medical profession's emphasis on confidentiality, we not accustomed to going home and talking with spouses or friends about our work.

Law enforcement officers don't either, not because of confidentiality concerns, but because they tend to put a protective barrier around themselves to cope with the trauma they face every day and feel that they must remain "tough" in order to adequately perform their jobs. That may be true to some extent, but it does have its repercussions.

Listen to what happened to a law enforcement investigator who cared a lot, but didn't receive adequate support. Have things like this happened to any of us?

State Trooper Sonny Cease put in 2000 hours of work as the lead investigator in the 1988 school bus crash in Kentucky in which 24 children and 3 adults burned to death. He did not talk about what was going on because he had to protect the case. Thirteen months later, after the trial was over, he suddenly woke up at 3 a.m. one morning, thinking he was having a heart attack. He was off work and sick for four months with severe sick headaches, chronic fatigue, and rapid heartbeat. Ten doctors and a trip to Mayo Clinic later, he was diagnosed with delayed post-traumatic stress disorder. He is now back at work, but still has trouble. He couldn't sleep after seeing the Waco cult compound burning on TV **(Estep, 1993)**.

V. Strategies for Staying Emotionally Healthy as a Crisis Professional

A. **(OH 12)** Key factors in recovery: Delta 191 Study **(Lanning, 1987)**
These findings may be useful for you personally or as you plan debriefings for other trauma workers.

1. Expression of appreciation for what they had done. The ones with the greatest problems after 20 months had received no expression of appreciation from anyone -- media, agencies, or families.

2. **(OH 13)** Meaningful debriefings

   a. Supervisors should explain to workers that they are being asked to attend the debriefing because they are concerned with their emotional well-being. (In this study, police officers, fire fighters and paramedics were being debriefed. Clergy nearly always have to seek out their own debriefings, usually informally or with a counselor.)

   b. The initial debriefing should be mandatory with one-on-one follow-up appointments available for a year.

   c. Debriefings should be held on the work premises if possible. This links the debriefing to the trauma and symbolically expresses the support of the agency.

   d. Information about post-traumatic stress disorder should be given to normalize symptoms and let the workers know they are not "going crazy."

   e. Small, informal, confidential groups should follow the informational component to allow for sharing experiences and reactions honestly.

      Dr. Earl Grollman, who lectures extensively on male grief, says that only one of every 15 men has even one person he can honestly share personal reactions with. Most men admit that they would rather talk with women because women are more comfortable with feelings.

   f. Facilitators should be professionals from outside the agency to assure confidentiality.

   g. Supervisors should have separate debriefings so all in each group are of the same rank.

   h. Spouses and other family members should have their own debriefings.

      Those who work in positions with the opportunity to accomplish these debriefing components regularly and informally will probably handle stress more effectively than those who work in isolation.

Several De-briefing models have been developed **(See Bell, 1995; Mitchell, 1988; Mitchell & Bray, 1990; Armstrong et. al, 1991; Raphael, 1986; Bergman & Queen, 1986; Young, 1991).**

3. **(OH 14)** Personal characteristics were identified in the study that decreased the risk for PTSD:

   a. Easy-going personality / sense of humor

   b. Training

   c. Religious beliefs

   d. Opportunity to do training or public speaking

   e. Positive relationship with father

   f. Desire to help people

   How does that list work for you? What would you add to it?
   State Trooper Sonny Cease put in 2000 hours of work as the lead investigator in the 1988 school bus crash in Kentucky in which 24 children and 3 adults burned to death. He did not talk about what was going on because he had to protect the case. Thirteen months later, after the trial was over, he suddenly woke up at 3 a.m. one morning, thinking he was having a heart attack. He was off work and sick for four months with severe headaches, chronic fatigue, and rapid heartbeat. Ten doctors and a trip to Mayo Clinic later, he was diagnosed with delayed post-traumatic stress disorder. He is now back to work, but still has trouble. He couldn't sleep after seeing the Waco cult compound burning on TV **(Estep, 1993).**

Discussion Question: What would you add regarding (1) staying generally emotionally healthy, and (2) being prepared to deliver compassionate and thorough death notifications?

VI. Homicide Survivor Reactions (This section is preferably taught by a mental health professional or seasoned advocate.)

A. We now shift our attention from the stresses faced in our own professions to what it is like to be on the family member end when a loved one has been killed or murdered. Historically, the victims' movement was synonymous with the women's movement. Primary concern was with battered women and children and rape victims. Only within the last few years have family members of those killed been considered "victims of crime."

1. Dorthea Morefield, whose son was murdered: *"I can accept a great deal of ignorance and a great lack of awareness. But to be told that I am not a real victim when I have lost something more precious to me than my own life, I will not tolerate. If you feel you are not dealing with a real victim when you deal with homicide survivors, just call me."*

2. Professionals who work with families in the aftermath of a sudden, violent death need to understand something of the homicide survivor experience for the first few weeks.

B. (OH 15) Death Models

1. Death models have been around for 15-20 years, but have never been proven valid. Kubler-Ross studied dying children and their families and noted the following stages: Denial, anger, bargaining, depression and acceptance. Terese Rando is probably the finest contemporary researcher on death and dying and she describes stages as follows: Avoidance, Confrontation, and Re-establishment. Most models neglect the totality and complexity of life and death. Each day is different. Each hour is different. The problem comes when stages become prescriptive (you are in this stage now, and later you will move into that stage) rather than descriptive or situational.

2. (OH 16) Rather than stages, **Charles Corr (1991)** suggests that, regardless of where a mourner is, we should consider his or her physical, psychological, social and spiritual needs.

3. Grief, in itself, is not bad. It is a natural, spontaneous emotional healing process. But it is much more complex after a homicide.

   Rynearson studied 18 young adults whose loved one had been murdered a mean of 2.5 years ago. Seventeen of the 18 were still experiencing intense, terrifying intrusive images of the fantasies they had developed about the murder from bits and pieces of facts they had gathered. The researcher concluded that grief work could not be done until the trauma was dealt with first. Thus anti-anxiety medication and classical conditioning techniques were used to calm the patients, help them sleep and reduce the intrusive imagery. Rynearson concludes that the combination of grief (pining, longing, guilt, idealized attachment to the victim) coupled with intense traumatic imagery should alert clinicians that significant treatment is warranted **(Rynearson, 1993).**

4. Grief and Mourning are not the same thing. Grief is the pain. Mourning is how we express it. It includes redefining self and roles. In our society we grieve, but we do not mourn without being labeled or scorned.

   Society, on the one hand, insists that people mourn, and labels them as "in denial" if they are not doing so. However, if someone mourns outwardly, they refer them to counseling or support groups as if mourning is an illness to be avoided or overcome.

C. **(OH 17)** The homicide survivor's experience differs from that of grief following an anticipated death in the following ways: **(Lord, 1986)**

1. Unanticipated, Sudden:

   No Time to Prepare -- to say "I Love you, I'm Sorry, Good-bye."... Or for the dying victim to say, "Thank you. I'll be okay."

   Death of child feels "generationally wrong."

   One study found that parents who lost adult children in vehicular crashes suffered more over-all psychiatric distress, expression of guilt, and health complaints than parents whose children died of cancer **(Schanfield, et. al., 1987).**

2. Violent:

   The feeling of helplessness from knowing that a loved one suffered physically is insurmountable. We are intimately attached to the bodies of our loved ones, and no matter how assured our faith makes us that their souls are in Heaven, we still grieve what has happened to the bodies and that we were powerless to stop the pain.

3. Senseless:

   Homicides are somebody's fault; they are not an accident

4. Legal Frustrations, both criminal and civil:

   Survivors are thrown into a system they do not understand. This component may be more difficult for advocates who are victims themselves than advocates who are not They may have had a negative experience in their own situation so it still feels like "their" system.

5. Financial Stress:

   Insurance assesses value of life from practical economic usefulness, so a "child" who doesn't produce income but spends income isn't worth much.

   Dr. Dorothy Mercer's (1993) research of 286 victim advocates, 64% of which were family members of someone killed, shows that 1/6 lost their jobs. 40% noted financial changes -- 13% of those said positive (insurance?) The remainder said financial changes were negative.

(Trainer should point out significance of Crime Victims Compensation programs and explain if audience is not familiar. See compensation information on page 30 in the Handouts)

6. Faith/Philosophy of Life Challenges:

Some have never ever thought about God, but they do in the aftermath of trauma. Others feel they have God in their pocket.

A plus in this area is mystical experiences. Over 50% have visual, auditory, or olfactory experiences of the one killed.

Example: A daughter may appear to her mother after the crash letting her know she is alright and happy.

D. **(OH 18)** The Aftermath of Homicide:

1. Grief lasts longer than that following anticipated death.

   a. **Lehman and Wortman (1987)** studied 39 people whose spouse was killed and 54 whose child was killed in a vehicular crash. They found that it takes at least one year to rebuild a "pattern of daily life" -- may be less for death of a child and more for death of a spouse.

      Emotional recovery can take four to seven years after the crash; and, in fact, is never complete. Most people at year seven are much like they were at year four. This may mean that people are usually as recovered as they are going to get after four years.

   b. **Dr. Mercer's study (1993)** of 1447 bereaved and injured victims of drunk driving crashes showed the greatest time of unmet support needs was one year after the death. After 5 years they were still significantly more stressed than non-victims on measures of well-being, somatization, obsessive-compulsion, depression, anxiety, hostility, self esteem and PTSD. They also reported poorer health, particularly high blood pressure. They were more likely than non-victims to take sleep medication or anti-anxiety drugs. Other research shows that six months is much harder than two months after and one year is worse than six months.

Some say year two is worse because they don't expect it to be so bad, but it is **(Rinear, 1988).**

c. Parkes found that bereaved people visit their physicians more frequently and are admitted to the hospital more often than the non-bereaved. His research found them suffering more depressive illnesses, anxiety states, personality disorders, rheumatic and arthritic conditions, disturbances of autonomic functions, and ulcerative colitis. Finally, he found that the bereaved die more often than the non-bereaved from coronary thrombosis and arteriosclerotic heart disease **(Parkes, 1981).**

d. **Florence Ditchick's study (1990)** of 110 couples whose child had been killed (most subjects were from MADD) found that second year was easier but third year worse. Increases in years three, five and seven, then steady decrease.

e. Quote of a woman whose husband was killed: *"It took me a long time to work through the trauma of my husband's crash. I don't think I really knew how draining it was for probably one or two years. It took that long to get used to the fact that life was never going to be the same. Then, even after accepting the realities, it probably took me two or three more years to cope with the tragic components of what happened to his body and how unnecessary it all was. The healing process is physical, but it's not just physical. It goes on in your mind too. The mental healing takes much longer than most people realize."*

f. The point is that grief following a sudden, violent death lasts for a lifetime. There is wisdom in the 23rd Psalm which states that we "walk -- not run -- through the valley of the shadow of death."

2. A wider and more intense emotional range of emotions than anything most people have experienced follows this kind of death.

a. People get upset when you move outside the range of emotional acceptability in the culture.

b. PTSD among homicide survivors is high.

(1) Amick-McMullen and colleagues found in their study of family members of someone murdered and someone killed by drunk driver that the aftermath was very similar for both groups. 23.4% had suffered PTSD since the homicide and 5.1% still had it.

(2) In both the **Amick-McMullen and Rynearson** studies, a history of psychiatric disorder heightens the risk of PTSD. Rynearson's further study (1994) of this sample and others revealed a high correlation between early child abuse and serious PTSD following the homicide of a family member.

(3) Traumatic death in the family is especially hurtful to children and youth. **Bradach (1995)** studied 181 young people aged 17 to 28 and found that those who had experienced a traumatic loss reported more depression, more global psychological stress, higher levels of fusion with parents, and lower individuation from the family than those experiencing normal losses. They also reported more difficulty forming intimate relationships.

(4) Differences between men and women are narrowing, especially among the middle to well-educated. More women are employed and more men are helping at home. Men are getting more comfortable with feelings.

(a) The issue of dependence may be more a factor than gender when grieving. The more dependent the relationship, the more difficult it is for the surviving individual to experience their grief in a healthy fashion. If "I" only exist when I am in relationship, then "I" die when the relationship is gone. In support groups, dependent people are uncomfortable talking about self image because they don't have one.

(b) Other factors correlating with complicated mourning include (1) an ambivalent relationship, (2) previous unresolved losses, (3) weakness in character, and (4) lack of a promising future **(Weiss, 1986, 1988).**

(c) **Steele (1992)** studied 60 widows and widowers in their 60's and found age to be the most significant predictor of high stress. The very young (25-30) and the elderly (66-85) experienced the most stress.

(d) One study compared 30 widowers and 30 widows with 60 married people and found those with weak internal locus of control (feeling they have little control over what happens to them) who experienced

their spouse's death unexpectedly to have significantly more depression and somatic (physical) complaints. Of the group, 42% were clinically depressed at six months and 27% were still clinically depressed after two years **(Stroebe & Domittner, 1988).**

(e) Another large study compared physical illnesses among those whose spouse had died, those who had divorced, and those who were married. The younger people developed more stress-related illnesses after loss than the older people, possibly due to single-parenting, because more young deaths are traumatic, and because young people are less psychologically prepared **(Williams & Siegel, 1989).**

E. **(OH 19)** Denial/Shock

The moment of notification of the death is, for most people, the most traumatic moment of their lifetime and can be the focus of PTSD symptoms that develop later.

1. The trauma can be made worse by what happens immediately after they are notified or during early investigations. From a mental health perspective, survivors must never be blamed for what happened. They may be suspect by the law enforcement agency, and, if so, will need more support than ever from counselors and advocates.

2. Many family members remember, a very narrow focus (words, sight, smell) of the notification.

   a. Example: The doctor who told Anne Forgey that her son was critical said, "*Your son is going to die.*" Ann went into shock and begged him to do brain surgery. The doctor responded, *"Ma'am. if we open up his head, his brain will squish out like toothpaste out of a tube!"*

   b. Example: Rick Uhey, whose daughter was killed (and another daughter injured) in the Kentucky school bus crash, remembers every detail of the late night call he received telling him about the crash, getting in his car, and frantically driving from hospital to hospital to find his children. *"I can tell you everything just as vividly as if it were yesterday and I'll be able to do that in ten years."*

3. Shortly after the notification, the confusion and lack of ability to concentrate sets in. Some have said it is like being told, "Tomorrow has been canceled."

a. They will have difficulty remembering things. Investigating officers must accept this and not consider it a form of non-cooperation.

b. Example: Diane Holmes recalls, *"My husband and I came upon the crash scene on the morning of February 5 as we were looking for Sean. The image that will live with me for the rest of my life is that of the yellow plastic covering over Sean's body and our being restrained from going to him. I still do not remember driving home."*

c. Many react with a basic Fight, Freeze, or Flight Response which is their way of saying, "Oh No - this isn't real; I don't believe it." Fighters may assault; Flighters might run or faint.

(1) Because of chemicals being released in the brain due to the shock, many seem to almost freeze after a few moments. Some remain very calm, but it doesn't take long to realize they are not reacting. One woman said, *"Well, my heart goes out to you. You have a very difficult job, coming to tell people that their loved one is dead."*

(2) Physical Symptoms of Shock:

Rush of oxygen to the blood
Raising or lowering of blood pressure
Cold, clammy skin, increased heartbeat
Increased respiratory rate
Amplified muscular tension
Sweating
Bowel and bladder relaxation
A sense of overwhelming anxiety **(Chard, 1987)**

The survivor may need to lie down and be kept warm.

3. Some describe the numbness as existing robot-like, seemingly out of body.

(a) Example: Betty Jane Spencer, whose four sons were killed, writes about her experience when she got to the hospital, *"Oh no, it can't be. Nurses were staring at me. What had happened? I was having trouble making sense of it all. I didn't want to think of the boys and what had happened to them. I was alive, so I reasoned they were too, even though I had seen them*

killed. Words hung in the air while I tried to make sense of them. Words like "dead" and "autopsy" floated through. Maybe I could do something to stop the words. I didn't want to hear them. But all I could say out loud was, "Please don't tell me how many of them are dead."

(b) The numbness serves as a general anesthetic to prevent experiencing the full psychological pain. Very rarely are tranquilizers necessary. Most who are given them regret it. Medical professionals should ask before administering them.

(c) The shock within their own bodies renders them literally too weak to undertake grieving, so the body shuts down, becoming something like a protective cocoon for the soul. **Jacob Lindy (1985)** refers to this as "trauma membrane" and points out that it should only be burst when the victim is ready.

(d) The first one in the family to return to a functioning state usually plans the funeral, greets the guests, identifies the body, etc.

(e) Numbness can last a long time.

1. Example: Barbara Kaplan (who was shot and two of her colleagues killed by a former client) *"For the first few months I was in a daze. I was plagued by flashbacks, but I only half believed it had been real...Friends commented on how brave and calm and strong I was. What they did not know was that I had not yet fully comprehended the enormity of what had happened."*

2. In a study of 250 parents of children who had been killed, 72.6% reported feeling numb for up to six months. **(Rinear, 1988)**

F. **(OH 20)** Fear and Powerlessness

1. In our hearts, we believe that "good things happen to good people and bad things happen to bad people." Before victimization, people feel uniquely invulnerable. After victimization, they feel not only universally vulnerable, but uniquely vulnerable -- now ready for more bad things to happen **(Lerner, 1980).**

   a. This sense of being out of control is referred to by some as "existential grief." The definitive question is, "What kind of world is this?"

   b. This can become a tremendous issue with adolescents who are trying to find out what life is about - let alone death.
   Many youth who act out are found to have experienced a major loss within previous six months. They often turn to friends rather than family because they feel they lose their family, too. They are so fearful and feel so abandoned that they go for stability anywhere they can find it.

2. Another quote from Barbara Kaplan: *"The fact that I could also be killed hit me with full force. I felt powerless and off-balance. Would I feel frightened of everyone I didn't know? I saw each stranger as a potential killer. I envied those who could walk trusting others, and I worried because I was becoming weak and fearful."*

3. Another example: *"If you think about it, everything we do in life depends on other people acting in a rational and predictable way. When you get in a car and drive it away, you're investing a lot of trust in every other driver on the road. So what happens when that trust is gone? Try driving down a two-lane highway with cars passing you just a few feet over in the oncoming lane. Your guts will be in knots if you can handle it at all. When you start to see every faceless stranger as a potential madman or thug, you're not only scared but depressed. You really feel betrayed."* (Even though her trauma had nothing to do with vehicular crashes, her anxiety was generalized to all areas of her life.)

4. The powerlessness is compounded by frustrations with law enforcement, the prosecutor, insurance adjustors, clergy who proclaim it's "God's Will." **Dr. Mercer's study (1993)** found that of those who sought clergy counseling, only 1/3 found it helpful while of those who sought support from MADD, 3/4 found it helpful.

5. In the **Amick-Kilpatrick study (1989)**, 49% of family members whose loved one was killed by a drunk driver and 36% of family members of someone murdered said they were now much more careful about personal safety: started wearing seat belts, obeyed traffic laws, drove defensively, kept doors and windows locked. One percent started carrying a gun.

   The same study noted that the most difficult part of the criminal justice system for victims was lack of understanding and information.

6. How to Help:

   a. The need to know is paramount. Knowledge impacts powerlessness. Therefore, if they want them, assist family members in obtaining:

      (1) the crime report
      (2) the autopsy report
      (3) photos

   b. Obtain a copy of your state's Victims Bill of Rights and support family members in attending the trial and preparing a victim impact statement.

G. Viewing the Body

1. After being notified of the death, many family members desperately want to go to the body of their loved one whether at the scene or in the hospital. Some family members will want to view the body at the medical examiner's rather than wait for the cosmetic work of the funeral home. This is understandable because of not being able to say goodbye.

2. It is now generally acknowledged that survivors who can view the bodies do better than those who are not able to do so (such as following military deaths). Hospitals have learned this and are giving family members as much time they want with loved ones who have died.

   Fantasies may be worse than reality.

3. Sometimes families want to see the body, even though the body is mutilated. It has been our experience that family members know what they can handle -- and they are already numbed by their own body chemistry. Sheila Awooner-Renner writes of her experience when she was finally able to be with her 17-year-old son who had been killed in a car crash **(Awooner-Renner, 1993; Osmont, 1993).**

Permission was finally granted for me to see Timothy on the condition that I "didn't do anything silly." As they watched, I presumed that meant I was not to touch him or disturb anyone....Timothy was my child; he had not ceased to be my child. I desperately needed to hold him, to look at him, to see his wounds. These instincts don't die when the child dies. I needed to comfort and cuddle him, to examine and inspect him, to try to understand, and most of all, to hold him. But I had been told "not to do anything silly." So I betrayed my instincts and my son by standing there and "not doing anything silly." If I did, I feared my watchers would rush in, constrain me, and lead me away. Our society has lost touch with our most basic instincts -- the instincts we share with other mammals. We marvel at a mother cat washing and caring for her kittens. We admire the protection an elephant gives her sick calk, and we are tearful and sympathetic when an animal refuses to leave its offspring when it dies, nuzzling him and willing him to live again. That is exactly what a mother's human instinct tells her to do. If a mother is not able to examine, hold, and nuzzle her child, she is being denied motherhood in its extreme.

4. Don't under-estimate a family member's ability to understand why they may not be able to go be near the body for awhile, such as maintaining the crime scene, taking photos, etc. They can understand and accept that if explained. The problem comes when family members are restrained without explanation.

   One funeral director believes that families should have the choice of viewing their loved one no matter how bad they look -- even if bones and skin is all that remains. He says that no matter how gruesome the loved one looks, the families have always been grateful that they were given the choice. He believes his success rate is so high because he informs them -- and they maintain control over their decisions -- each step of the way.

5. The issue is informed choice. We strongly believe that if a family member is told about the condition of the body, he or she will know whether or not they can handle it. Some will want to see and others will change their mind. Even being allowed to touch a hand is helpful if the entire body cannot be viewed.

   a. Example: A woman's son was killed in car crash. He ran head-on into telephone pole and his head was split in two. She wanted to go to medical examiner's office to see him. She was told no initially, but she insisted. After more persistence, she was allowed to see her son's body, but his head was covered. She mourned appropriately. She then said she wanted to see his head. Again, she was told no at first, but she insisted. So they removed the towel from his head. She looked just a couple of seconds, then looked away. The mother displayed no traumatic outcry or loss of control.

b. Example: A baby's neck was broken in car crash and baby died quickly. Mother desperately wanted to hold child. Police officer said no, but later gave in. She held the child about five minutes, crying and rocking, then willingly handed the baby back to the officer.

c. If a suicide, allow the family to be with the body privately after the crime scene is maintained. Don't deny access to a suicide note unless it must be kept as evidence. It is the only link they have with their loved one. If they need to talk, allow them to ask questions about the "how." Don't try push them on "why" questions.

6. The tendency of clergy, funeral directors, police, and others is to over-protect. This refusal only enhances the fear and powerlessness already beginning to overwhelm the family. They need to be given as many choices as possible.

H. Viewing Photos

1. The same philosophy holds true for later wishing to view photos. Informed choice is the issue. People know what they can handle **(Awooner-Renner, 1993; Osmont, 1993).**

2. Parents of Murdered Children has developed a procedure for viewing photos which seems quite useful:

a. The person wishing to view photos selects a trusted support person, perhaps counselor, advocate, clergy, or friend to accompany them.

b. Agency places each photo in a large envelope, or separates each with a piece of paper, arranging them such that least offensive picture is on top and the most offensive photo is on bottom.

c. The support person views the first photo. The survivor has two pieces of information to consider: (1) the affect of the support person as he/she viewed the photo, and (2) the support person's detailed description of what is in the photo.

d. Based on this information, the survivor decides whether to look at the photo or not.

e. Repeat the procedure for each photo.

3. It is also sometimes useful to give the survivor a set of the photos if they request it, even though they may not be ready to view them. Simply having them in one's possession -- perhaps in the bottom of a dresser drawer -- helps the survivor feel in control.

4. Depending on state law, some funeral homes take photographs of the deceased in the casket. Survivors can check with the funeral home to see if such pictures are available.

5. **Kelly Osmont (1993)**, a bereavement counselor for several funeral homes, shares her experiences of three women whose loved ones had died tragically. None of the women had been allowed to view their family members. Two had lost a husband and one had lost a child.

   a. All three gave the therapist permission to locate photos, which she did through the police department -- after meeting a great deal of resistance. She was able to get one set only after a family member who was a physician accompanied her.

   b. Since all three women had been members of a support group, they decided to look at the pictures during a support group session. The therapist sat beside each woman, offered the least offensive photo first and described it before showing it. As each woman was ready to look, the therapist held the photo 2-3 feet in front of her. She could choose whether or not to take the photo from the therapist for viewing.

   c. Each women exhibited intense grief reactions which resolved in 20 - 30 minutes. The mother whose son had drowned instinctively cupped her arms as if she were holding him and began to rock back and forth. The therapist placed a pillow in her arms and she continued rocking, moaning, and sobbing as she held the pillow to her bosom.

   d. The three women were mailed questionnaires some time later, and all expressed gratitude. The mother said, *After the initial shock and pain, it was better. Before seeing the photos, my imagination had been painting horror pictures. I was relieved to see him, I think, to hold him in my mind, and to know that he really was gone so I could go on with my grief.*

One of the widows had not been able to have one happy memory of her husband since he had died. Two days after viewing the pictures she began to remember several events with her husband which had been fun and loving times.

The other widow, who had remained adamant that her husband had been murdered and not committed suicide, was able to realize, after seeing the photos, that he had been depressed enough to commit suicide.

Viewing bodies or photos is not for everyone, and no one should be forced to do it. On the other hand, we need to support the desires of those who need to and want to.

VII. Homicide Survivor Panel

Ask your local MADD chapter or Homicide Survivors Support Group to provide a panel. See criteria for selecting panelists on page 37. Try to obtain two or three panelists to speak about ten minutes each -- about their notification and what EMT's or physicians did that helped or hurt.

VICTIM IMPACT PANEL QUESTIONNAIRE

Please read the following questions and circle the answers that best describes your experience.

1. **How frequently in the last seven (7) days did you try not to get emotional when you thought about or were reminded of your victimization?**

   (1) Not at all; (2) Once or twice; (3) Once every day or two; (4) Once or twice a day; (5) A few times a day; (6) Several times a day; (7) Much of each day.

2. **How angry are you at the person who committed the crime?**

   (1) Never was angry; (2) No longer angry; (3) Mildly angry; (4) Moderately angry; (5) Still very angry; (6) Permanently angry.

3. **How frequently in the last seven (7) days did you have bad dreams related to your victimization?**

   (1) Not at all; (2) Once or twice; (3) Once every day or two; (4) Once or twice a day; (5) A few times a day; (6)Several times a day; (7) Much of each day.

4. **Not counting medication to help you sleep, how many days out of the past thirty (30) did you take prescription or non-prescription medication to make you feel more calm or relaxed?**

   (1) None; (2) ____ Days.

5. **How much discomfort have you experienced during the last seven (7) days due to thoughts of ending your life?**

   (1) None; (2) A little; (3) A moderate amount; (4) Quite a bit; (5) An extreme amount.

6. **Taking all things together, how happy would you say you are these days?**

   (1) Very happy; (2) Pretty happy; (3) Not very happy; (4) Very unhappy

7. **How often during the last seven (7) days were you distressed about blaming yourself for things in general?**

   (1) Not at all; (2) Once or twice; (3) Once every day or two; (4) Once or twice a day; (5) A few times a day; (6) Several times a day; (7) Much of each day.

VIII. **(OH 21)** Death Notification Procedure

(This protocol is presented as a step-by-step procedure, but it's more like a tool box. The tool or tools you use will depend on the circumstances. Each death notification is different.)

A. Be absolutely certain of identity of deceased.

Work with the police to assure that you know who you have. Use more than one source of ID: witnesses, photo, identifying marks, etc.

B. Get medical information about the family if possible.

1. The family physician may be identified through RX bottles, business cards, or other documents in purse or billfold of the victim.

2. If able to get any of this data, call the physician to ask for information if he or she will meet the family when they get to the hospital (or come to the scene if the immediate family is there.)

(C - F are only for physicians, medical examiners and other medical professionals who do not have immediate access to the family)

C. Don't call.

1. Ask the police or sheriff's department to notify the family in person and transport them to the hospital or medical examiner's office. If they unable or unwilling, use hospital volunteers or auxiliary police.

2. If a phone call is the only alternative, remember that the person to be notified may go into shock without support. The call should be made by an experienced doctor or nurse who will arrange for someone to transport them to the hospital. If volunteers are not available, call a cab for them. It is much too dangerous to drive in the high anxiety state of families after receiving this kind of call.

D. Determine which staff members will greet the family.

1. The family should be met by a physician, nurse, social worker, or chaplain who is current on the physical condition of the patient or on the cause of death. It is best if two people greet the family: the attending physician because he or she knows the facts about the patient and a second person who can remain with the family if the physician needs to return to other duties.

2. At least one of the greeters should be experienced in dealing with shock and/or trained in CPR/medical emergency.

3. If the attending physician greets the family, he or she should be in a clean uniform to project assurance and authority. Never speak with the family with the patient's blood on your uniform.

4. It may be helpful if one of the team is a female because some people are more comfortable ventilating reactions with women than with men.

5. If a large group comes to the hospital and the patient has died, several staff members may be needed to attend to the needs of various family members. Children may need someone trained in dealing with traumatized children to attend to them

6. If there are multiple victims, try to arrange for all families to be notified at about the same time. It is ideal if each family is assigned a social worker, chaplain, or nurse to inform them about their family member.

7. Determine who the liaison staff member for the family will be for each shift.

E. Those who will interact with the family should talk about their reactions to what has happened before the family arrives.

Don't repress your reactions, but try to be honest about them, so your focus can be totally on the family when they arrive.

F. Greet the family and take them to a private, comfortable furnished waiting area if possible.

The ideal room is fairly spacious, has windows, has coffee of other soft drinks available, and has a phone.

G. If the patient is critical, plan to inform the family as soon as it is known.

H. Sit down. Ask them to sit down, and be sure you have the nearest next of kin.

1. Use the victim's name, i.e., "Are you the parents of____?

2. Never notify a child unless he or she is with a parent when the adult is notified.

a. They become traumatized with no support.

b. This gives them the burden of telling parents or other adults.

c. Never use a child as a translator if the family doesn't speak English. The child is traumatized by what he is hearing and is then being asked to burden adult family members with the bad news. This is too much for a child to handle.

d. If children have come to the hospital, after getting seated, ask the parents if you could speak with them privately while someone else attends to the children.

3 Never notify older siblings before notifying parents or spouse.

4. Children should not be excluded from family crises; on the other hand, if a parent emotionally or physically loses control, it can be very frightening to the child. Children should rejoin the family as soon as the parent or other trusted adult has regained some control. Crying with a child is fine.

I. Allow family members who choose to, to be with the patient if at all possible.

This is a very strong need of many parents and spouses, and it may do the patient good as well. If it is impossible at the time the family is notified, tell the nearest next of kin when he or she might be able to see the patient. Being told they cannot without reason is extremely frustrating.

J. If the patient has died, inform simply and directly with warmth and compassion.

1. Don't beat around the bush with expressions like "expired", "passed away", or "we've lost...."

2. Say: "I'm afraid I have some very bad news for you. (Pause just a moment...you are "preparing and predicting") Name has been involved in a serious vehicular crash/shooting, etc., and (s)he has died. (Pause again.) I'm so sorry."

a. The "I'm sorry" is very important because it expresses feelings rather than facts, and invites them to ventilate their reactions.

b. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body", or "the deceased."

K. Don't discount feelings, theirs or yours.

1. Hospitals tend to reinforce emotional constraint, but being notified of a death naturally causes intense emotional reactions. Outbursts, though uncomfortable for staff, are a natural component of shock and mourning and should be affirmed. Tranquilizers should not be given.

2. Expect fight, flight, freeze, or other forms of regression.

   a. Understand that all of these reactions are acceptable, and only physically harmful behaviors to self or another is to be checked.

   b. Understand tears as a "tender tribute to mourning." People cry only because they need to cry.

3. Long silences are OK. They are indications that mourners are regaining control on their own rather than being forced to get control before they are ready.

L. Join the survivors in their grief without being overwhelmed by it.

1. (OH 22) What Not to Say

   a. Discounters:

   - I know how you feel. (You don't.)
   - Time heals all wounds. (It doesn't.)
   - You'll get over this someday. (They will get better, but they will never "get over it.")
   - You must go on with your life. (They will, the best way they can, and they don't need to be told.)
   - He didn't know what hit him. (Unless you're sure.)
   - You can always find someone worse off than yourself. (Not at the moment)
   - You must focus on your precious memories (Not now)
   - It's better to have loved and lost, then never to have loved at all. (How do you know?)

All of these discounters say, "I am not comfortable with you like you are. I need to make it better so I will feel better."

2. **(OH 23)** Disempowering statements:

- You don't need to know that.
- What you don't know won't hurt you.
- I can't tell you that. (If you can't, go on to explain why, and when they can expect to have the answer.)

3. **(OH 24)** God cliches:

- It must have been his/her time.
- Someday you'll understand why.
- It was actually a blessing because_____
- God must have needed her more than you did.
- God never gives us more than we can handle.
- Only the good die young.

If survivors use their own faith beliefs to comfort themselves, that's fine. But we should not burden them with these statements/ platidues/whatever!

4. **(OH25)** Unhealthy Expectations:

- You must be strong for your children/wife/parents. (Not true)
- You've got to get hold of yourself. (No reason)

5. **(OH 26)** What to Say

- I'm so sorry. (simple, direct, validating)
- It's harder than most people think. (validates, normalizes, encourages them to seek support)
- Most people who have gone through this react similarly to you. (validates and normalizes)
- If I were in your situation, I'd feel very _____ too. (validates, normalizes, assures)
- (When ready to leave) I'll check back with you tomorrow, see how you're doing, and if there's anything else I can do for you. (Be sure you do.) (validates significance of loss, expresses concern, introduces an element of control)

M. **(OH27)** Answer all questions honestly.

1. Don't give more detail than is asked for, but be honest in your answers.

2. Don't volunteer that the victim appeared to be intoxicated, but if they ask, be honest about odor of alcohol and blood alcohol content. Families feel very betrayed if they don't learn that the victim was intoxicated until the trial.

3. Explain the actual cause of death is simple language.

N. Offer to make calls, arrange for child care, call pastor, relatives, employer.

1. If the family wishes for you to make these calls, write them down and the time of day you called, as they will have difficulty remembering who they asked you to call.

2. If they request further personal notifications, try to accommodate by working with the police, victim advocates, or other volunteers.

O. Talk to media only after discussion with the family about the statement.

1. Ideally, media is only spoken to with family's permission unless public's "need to know" is paramount. It is generally best to refer all media to the investigating law enforcement agency.

2. Families feel very betrayed to learn new things on the media they have not been told. Warn them that television coverage will likely be highly dramatic and may be replayed for some time.

P. Don't leave survivors alone.

Social workers, chaplains, victim advocates, or nurses may arrange for others to come, and should wait with the family until they do.

Q. Depending on the emotional state of primary survivor, give written information such as where the body will be autopsied and how to obtain the autopsy report.

***(See handout)**. It is usually better if the law enforcement officer takes this information to the family the next day.

R. If identification of the body is necessary, tell the person who will identify exactly what to expect.

1. Explain where the room is and what it looks like. Describe the condition of the body and what it will look like. They need to know that the skin will be pale since blood settles to point of lowest gravity.

2. If law enforcement officers have brought a family member to identify the body and then left, be sure to have a social worker, victim advocate or chaplain arrange transportation back home.

S. Next day, call.

1. Call and re-express willingness to answer all questions. The family will probably have many more today than yesterday.

2. Ask the family if they are ready to receive the victim's clothing, jewelry, etc. Honor their wishes.

   a. Clothing should be folded nicely and placed in a box, not a trash bag.

   b. Dry clothing thoroughly to decrease bad odor.

   c. When the family is ready to receive these things, a victim advocate, social worker or chaplain should explain what is in the box and the condition of the items so they will know what to expect when they decide to open them.

3. If there is anything positive to say about the last moments (no pain, peaceful look, reaching out visions, etc., share them now. Give assurances such as, "Most people severely injured do not remember the direct assault and do not feel pain for some time." "Death occurs very quickly after the rupture of the aorta." However, never say "He never knew what hit him," unless you are absolutely sure.

T. LET THE SURVIVORS KNOW YOU CARE.

1. The most loved physicians, EMTs and other first responders are those who are willing to share the pain of the loss.

2. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.

IX. Ask seminar attendees to complete evaluation.

ANNOTATED LITERATURE REVIEW

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Amick-McMullan, A., Kilpatrick, D., Veronen, L., and Smith, S. (1989a). Family survivors of homicide victims: Theoretical perspectives and an exploratory study. Journal of Traumatic Stress, 2(1), 21-35.

This study is based on a National Institute of Justice funded survey in 1987 which assessed the indirect effects of criminal homicide in the U.S. Key finding was 1.58% of the sample, or an estimated 2.8 million adults, had lost an immediate family member to criminal homicide defined as murder or drunk driving. Another 1.48% of the sample, or an estimated 2.6 million adults Americans, had lost a relative to criminal homicide. An additional .75% of the sample, or an estimated 1.3 million adult Americans, had lost a close friend to criminal homicide. An estimated 3.82% of the sample, or an estimated 6.7 million adult Americans, had suffered a homicide death of someone close to them.

Amick-McMullan, A., Kilpatrick, D., and Veronen, L. (1989b). Family survivors of homicide victims: A behavioral analysis. The Behavior Therapist, 12(4), 75-79.

Based on the above survey, the researchers found that very similar percentages of family members of someone murdered and someone killed by a drunk driver developed Post-Traumatic Stress Disorder -- 23.4% had suffered PTSD at some time since the death and 5.1% which met full diagnostic criteria for currently having PTSD. Therefore, more than one million Americans have suffered homicide-related PTSD at some time in their lives.

Amick-McMullan, A., Kilpatrick, D., & Resick, H. (1991, October). Homicide as a risk factor for PTSD among surviving family members. Behavior Modification, 545-559.

Based on their 1987 survey, the researchers found that 1/4 of those whose family member had been killed within the past two years were likely to have PTSD. Other characteristics that correlated with a high risk profile included: degree of relationship with the victim (parents, spouses and siblings were at highest risk); elevated fear of crime and automobile crashes; serious thoughts about taking revenge against the defendant; attributional search for some reason, meaning, or other way to make sense of the homicide; history of suicidal ideation, suicide attempts; having sought therapy; and presence of diffuse symptoms of psychological distress.

Armstrong, K., et al. (1995). Multiple stressor debriefing and the America Red Cross: The East Bay Hills fire experience. Social Work, 40(1), 83-90.

Following response to a severe fire in the San Francisco Bay area, American Red Cross personnel debriefed crisis workers with the Multiple Stressor Debriefing (MSD) model. The authors discuss the four-phase model and offer guidelines to enhance [debriefing] leader effectiveness and improve delivery of services.

Armstrong, K., et al. (1991). Debriefing Red Cross disaster personnel: The multiple stressor debriefing model. Journal of Traumatic Stress, 4(4), 581-593.

The article examines the effects of utilizing Mitchell's Critical Incidence Stress Debriefing model for American Red Cross volunteers and staff following a severe earthquake. Although the staff and volunteers did not participate in direct rescue efforts, exposure to traumatized people, especially those urban poor who were also experiencing multiple psychosocial problems, placed them as risk for Post Traumatic Stress Disorder. Various forms of debriefing were provided for the staff and volunteers. Evaluation of the process supported its value although certain adaptations are suggested by the authors.

Awooner-Renner, S. (1993). I desperately needed to see my son. British Medical Journal, International Edition, 32, 356.

In the Personal View column, the author describes wanting to see her 17-year-old son following his automobile death. The hospital was unprepared and unsupportive in her desire to view his body. She describes her unmet needs as the hospital tried to protect her from the reality of his death.

Babin, M. (1983). Notifying the next of kin: Helping the bereaved survivors at the moment of shock. R.C.M.P. Gazette, 46(2), 2-5.

The author discusses grief reactions following death by accident or criminal victimization and suicide. He discusses the difficulties police officers face when making death notifications; provides suggestions for notifications of next of kin and tips for evaluating the mental/emotional/physical state of the bereaved.

Bell, J. (1995). Traumatic event debriefing: Service delivery designs and the role of social work. Social Work, 40(1), 36-43.

This article hypothesizes that social workers have a unique combination of skills that lend themselves to facilitating Traumatic Event Debriefings. The article provides an overview of Post Traumatic Stress Disorder, noting that human-induced trauma may be more devastating than natural disasters. The author draws on the Mitchell model and provides a step-by-step debriefing guide. The author also discusses three additional team designs which may be utilized depending on the nature of the trauma, the needs of the target population, and the availability of debriefers. Finally, the article reviews social worker qualifications which lend themselves to social work being the "profession of choice to develop and facilitate debriefing teams."

Bergman, L. H. & Queen, T. R. (1986). Critical incident stress: Parts I & II, Fire Command, 18-20, 52-56.

Bergman and Queen's continuum of care model includes the following debriefing components: setting the stage, ground rules, and telling the story (description of experiences and consequences). The debriefers then attempt to help the attendees understand their consequences through normalization

and teaching coping skills. The final portion includes contracting for recovery -- development of plans to prevent long-term stress consequences. The authors also emphasize the significance of duty-related trauma training, peer support and post-trauma counseling.

Booth, E. (1991). Compassion fatigue. Journal of the American Medical Association, 266(3), 362.

A follow-up Letter to the Editor (see Sweet) expresses support of the author and the personal experience as a seriously ill physician unable to get support from colleagues.

Bradach, K. & Jordan, J. (1995). Long-term effects of a family history of traumatic death on adolescent individuation. Death Studies 19, 315-326.

This study of 181 young people aged 17 to 28 found that having experienced a traumatic loss was related to more reported depression, more global psychological distress, higher levels of reported fusion with parents and lower overall individuation from the family than those experiencing normative losses (no unexpected or traumatic loss) or transgenerational loss (traumatic death in the family prior to the birth of the subject). They also reported less peer intimacy than the transgenerational loss group or the normative loss group.

Brooks, N. & McKinlay, W. (1992). Mental health consequences of the Lockerbie disaster. Journal of Traumatic Stress, 5(4), 527-543.

Coordinated by a group of plaintiff attorneys, the authors became part of a group of examiners charged with measuring the psychological damage of more than 800 claimants following the Lockerbie, Scotland airline disaster. The article reports on the mental health consequences of 66 adult claimants who were citizens of Lockerbie at the time of the bombing. Although unable to determine unequivocal predictors of the presence or severity of Post Traumatic Stress Disorder, the examiners found a substantial number of claimants with one or more diagnoses. The authors discuss potential predictors within the literature, comparing and contrasting their own findings.

Burke, T. (1993a, February). The correlation between dispatcher stress, burnout and occupational dissatisfaction. First in a Series. APCO Bulletin.

The author highlights results of a survey conducted of civilian police dispatchers from southern New Jersey. Occupational dissatisfaction was defined as the totality of a dispatcher's feelings about various aspects of her or his occupation. Those dispatchers who perceived the greatest amount of occupational stress and job burnout reported that they were dissatisfied with their job. Dispatchers cited conflicting role demands and a lack of loyalty in the work setting as a major cause of occupational stress. Co-workers played a vital role in the reduction of dispatcher stress and burnout. In particular, dispatchers reported less psychological stress when they perceived that they had the support of fellow dispatchers.

Burke, T. (1993b, March). The correlation between dispatcher stress, burnout and occupational dissatisfaction. Second in a Series. APCO Bulletin.

This continuation of the series focused on social support for dispatchers or its lack. The role of the dispatcher was compared with the stress experienced by air traffic controllers. Those dispatchers who perceived a lack of social support from colleagues and supervisors reported occupational stress/burnout. Additionally, those dispatchers who lacked intimate contacts with close friends outside the work settings and could not count upon family members for support, also reported job stress/burnout.

Burke, T. (1993c, April). The correlation between dispatcher stress, burnout and occupational dissatisfaction. Last in a Series. APCO Bulletin.

This final article offers some recommendations/suggestions for dispatchers. It was reported that the lack of control noted by dispatchers contributed to impersonal and uncaring attitudes toward the citizens they serve. They indicated that their training, education, skills and experience were inappropriate for the demands of the job. In other words, lack of control affected the way in which the dispatcher perceived his or her role. Several recommendations are made for police administrators. Managers should (1) allow police dispatchers greater input into decision-making, (2) encourage dispatchers to attend training seminars, particularly in areas of stress management, and (3) fully support and appropriately compensate dispatchers financially for successful work.

Card, J. (1987). Epidemiology of PTSD in a national cohort of Vietnam veterans. Journal of Clinical Psychology, 43, 6-17.

The author quotes several large scale studies of PTSD among Vietnam veterans. The findings of the studies suggest that 15% to 35% of Vietnam veterans suffer from PTSD.

Chard, P. (1987). Grief: Handling theirs and yours. Emergency Medical Services, 16(1), 36-41.

EMT's should expect aggression upon death notification (fight or flight response). They should also expect shock -- increased heart rate, hyperventilation, amplified muscular tension, sweating, bowel and bladder relaxation. They should also learn to accept rather than judge denial. If the grieving person did not need to deny the reality of the death, he or she would not be using it as a defense. A sidebar article quotes Spencer Eth, Chief of Clinical Services at the VA Medical Center Mental Health Clinic in Los Angeles, who found that 67% of detectives say death notification is "moderately, very, or extremely stressful." Their apprehensions stemmed from feeling unprepared and from over-identifying with the victim family because they were genuinely concerned about their reactions.

One officer described his approach as "brutally honest." He left a note on the front door, "Your son hanged himself in jail. For more information, call ___." Perhaps Eth's most notable finding was that the more notifications detectives performed, the more insensitive they became.

Chard adds to Eth's concerns that of personal vulnerability to verbal or physical aggression and fear of criticism of colleagues if they have difficulty with notifications.

Corr, Charles (1991). Presentation at annual conference of Association of Death Education and Counseling, Duluth, Minnesota.

Dr. Corr highlights the inappropriateness of stage theory in working with families following a death. He states that such theories are problematic when they become prescriptive rather than descriptive. He suggests, instead, that helpers focus on the physical, mental, emotional, and spiritual realms of grief depending on the primary concerns of the survivor at the moment.

Criminal Victimization 1993. (May, 1995). Washington D. C.: US Department of Justice Office of Justice Programs, p. 3.

This report of the National Crime Victimization Survey for 1993 provides statistics for the categories of victims of crime evaluated by the Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

Death Notification. Police Chief Training Key #358, pp. 127-132.

This International Association of Chiefs of Police death notification process is structured into four interrelated elements, the first being information gathering to put collect necessary data and information. Secondly, the notification should be organized to add structure, stability and support to the survivor. Next, a thorough assessment of the situation allows the notifier to determine the stability of the survivor and the direction that further actions should take. Providing referrals is the final step in a notification. It serves to identify immediate survivor needs, provide added information and contact with other helping persons or agencies.

Death Notification. Field Training Manual. 105th Academy, New Hampshire Police.

The New Hampshire Field Training Manual includes a section entitled Victim/Witness Relations-Death Notification. This section covers the impact of crime on victims, services available to victims; victim rights legislation; the scope of victimization; the crisis reaction; the grieving process; long term crisis reaction; and delivering death notifications.

Diagnostic and Statistical Manual of Mental Disorders, 4th edition. (1994). Washington, D.C.: American Psychiatric Association.

Criteria for Post-Traumatic Stress Disorder, used in the Death Notification curricula, is outlined in this manual, the diagnostic tool used by mental health practitioners.

Ditchick, F. (1990). The reactions of husbands and wives to the death of their child and its effect on their marital relationship. Adephui University: Unpublished dissertation.

Ditchick studied parents of a child killed, accessing nine variables: depression, anxiety, anger, powerlessness, somatization, despair, withdrawal, disassociation, and death anxiety. She found that the mothers scored higher than the fathers on all nine variables. The parents were able to correctly identify the symptoms that bothered them the most and the symptoms that bothered their spouses the most. However, they had limited understanding of how their own symptoms affected their spouses. The fathers were most troubled by their wives' anger and somatization. The mothers were most troubled by their husbands' despair.

Figley, C. (1993, February). Compassion stress: Toward its measurement and management. Family Therapy News, 3-4.

The author introduces the notion of Compassion Stress/Compassion Fatigue, defining it as the tension or demand associated with feeling compassion or sympathy. Compassion Stress is contrasted with burnout and depression, suggesting that family therapists may be especially vulnerable. A self test designed to measure the potential for Compassion Stress is included in the article.

Figley, C. (1995a). Compassion fatigue. Paper presented at the International Association of Trauma Counselors, Annual Conference, Austin, TX.

The paper includes a workshop outline and handouts from the Compassion Fatigue workshop presented by the author at the annual conference of the International Association of Trauma Counselors. Several charts and a bibliography are included.

Figley, C. (1995b). Compassion Fatigue. New York: Brunner/Mazel.

Figley, as editor, brings together several authors writing on burnout, secondary post-traumatic stress disorder, vicarious traumatization and compassion fatigue. It is a well-documented book, citing numerous current studies on caregiver stress.

Gersons, B. (1989). Patterns of PTSD among police officers following shooting incidents: A two-dimensional model and treatment implications. Journal of Traumatic Stress, 2(3), 247-257.

When a shooting incident occurs, the psychological impact for the officers involved may take the form of severe PTSD symptomatology. Of 37 police officers who had been involved in serious shooting incidents between 1977-1984, the researchers found 46% fulfilled DSM-III criteria for PTSD. The researchers presented a two-dimensional model which seems to fit the PTSD pattern in police officers reacting to trauma. Police officers involved in these incidents sought refuge in denial or re-experiencing behaviors. The two dimensional model better represents the psychological symptom pattern of police officers after shooting incidents than the traditional DSM-III criteria. The model of

re-experiencing and denial more adequately describes the psychological post-traumatic sequelae reported. The model is used in treatment, beginning with guided reexperiencing of the event in a very clear and precise way, as a cathartic experience for the suppressed emotions and fears. Post traumatic decline can be a long term effect of chronic PTSD and burn out after too many traumatic events. Prevention of post traumatic decline is possible through screening and follow up to police officers who have been subject to serious shooting incidents in the course of duty.

Goldman, D. (1980, June 12). Key to post-traumatic stress lies in brain chemistry. New York Times.

This newspaper article reports on Yale studies of PTSD indicating that at least three physiological symptoms may be related to changes in brain chemistry and, therefore, may be irreversible: tunnel vision, time perception, and the ability to disassociate

Hayes, J. A., Gelso, C. J., Van Wagoner, S. L., & Diemer, R. A. (1991). Managing counter-transference: What the experts think. Psychological Reports, 69, 138-148.

Hayes and his colleagues studied 33 expert therapists to identify traits or skills that caused them to be resilient to counter-transference, burnout, and compassion fatigue. The top five were (1) self-integration, (2) self-insight, (3) empathic ability, (4) skill conceptualization, and (5) anxiety management.

Herrera, C. G. (1994, November 28). In the line of duty. The Fort Worth Star Telegram, p. 1.

The newspaper article highlights several police officers who were killed in the line of duty. In this aftermath, the spouses got together and formed the Metroplex chapter of Concerns of Police Survivors. The article outlined the agenda developed by the Metroplex chapter of C.O.P.S.

Hyland, L. & Morse, J. (September-October, 1995). Orchestrating comfort: The role of funeral directors. Death Studies, 19 (5), 453-474.

The authors describe in detail the role of funeral directors in comforting mourners. Comforting strategies include mechanistic comfort (separating the ceremonial aspects of the funeral from the technical aspects of embalming by demarcating "front stage" from "back stage" work areas; controlling the "front stage" area with an aura of dignity and respect; personal comfort (vigilant observation of mourners and provision of support and control without intruding into the family group); and technical comfort (embalming and restorative work on the deceased that enables the family to view death as a peaceful state. The authors conclude that funeral directors fill an extraordinary role in society as professional comforters of the bereaved. Since frequently there is no previous relationship between the client and the professional, this is a unique, short-term, professional, caring relationship the occurs between strangers.

Kroshus, J. (1993, November/December). Critical incident stress among funeral directors: Dramatic impact-dramatic outcome. The Forum, pp. 11-13.

This article presents findings of a study designed to gather statistical data on critical incident stress among funeral directors. Utilizing a questionnaire, respondents were asked to indicate the number of times they had been involved in a specific critical incident and the frequency and type of symptom they may have experienced as a result of exposure to the critical incident. 762 useable surveys were returned. Among those who had been in the funeral business less than twenty years, irritability and frustration were most commonly associated with critical incidents. Those with more than twenty years experience reported significantly higher levels of fear of abandonment, feelings of isolation and excessive concern for their physical well-being. Women scored significantly higher in the area of apathy than did men. The authors suggest including funeral directors as members of emergency response teams, developing community education to de-mystify the funeral profession, enhancing support among funeral directors, encouraging counseling within the profession, and developing prevention curriculum to be taught in mortuary science schools, as possible ways to reduce the levels of stress faced by funeral directors.

Kulka, R., Schlenger, W., Fairbank, R., Hough, B., Jordon, C., Marmar, C., & Weiss, D. (1990) Trauma and the Vietnam War generation: Report of the national Vietnam veterans readjustment study. New York: Brunner/Mazel.

Kulka and his colleagues found that 25% to 30% of Vietnam veterans have PTSD. They also found that African American and Hispanic veterans experienced higher rates of PTSD than Caucasians.

Lanning, J. (1987). Post-trauma recovery of public safety workers for the Delta191 crash: debriefing, personal characteristics, and social systems. Copyrighted, unpublished manuscript.

This study evaluated Dallas/Fort Worth Airport public safety workers (police, fire-fighters, and EMT's) 20 months after the Delta 191 crash in which 136 people were killed. 16% were still experiencing high stress at the time of the study. Both avoidance and intrusion PTSD sub-scales were high with visual intrusion slightly more common than avoidance behavior. As they spoke about the memories more and more, responders were less bothered by intrusions. Paramedics had the highest scores, but police had the highest mean scores. Those first on the scene were most troubled because of the vastness of the trauma coupled with severe storm conditions. Paramedics had to make numerous moral decisions about who to treat and not to treat. Those who felt they had lost control of the situation fared poorly as did those who stayed at the scene for a lengthy period of time. Those who continued to suffer PTSD symptoms did not perceive their recovery environment as personal and positive. One person -- the most highly stressed -- received no support at all, felt he lost control, and then developed severe identity problems. Much anger was directed toward airport management for their indifference and lack of support.

The study identified components of a meaningful debriefing:

a. Management must explain reasons for attending (concern for employee's well-being);

b. Initial debriefing should be mandatory, with one-on-one follow-up appointment available and periodic follow-ups at one month, three months, six months, and twelve months;

c. Debriefing should be held in work premises in a familiar environment;

d. Debriefing must be facilitated by experienced professionals from outside, with management willing to consider recommendations;

e. Debriefing should begin with education about PTSD symptoms followed by small discussion groups;

f. Supervisors (all of the same rank) should be debriefed separately;

g. Separate debriefings should also be held for spouses and family members.

Lehman, D., and Wortman, C. (1987). Long-term effects of losing a spouse or child in a motor vehicle crash. Journal of Personality and Social Psychology, 52(1), 218-231.

This study measured the long-term effects of the sudden, unexpected loss of a spouse or a child four to seven years ago in motor vehicle crash. Thirty-nine individuals who had lost a spouse were compared with 39 controls. Forty-one parents who had lost a child were compared with 41 controls. Significant differences between bereaved spouses and controls were revealed on depression, social functioning, psychological well-being, reactivity to good events, and future worries and concerns. In fact, respondents scored similarly to psychiatric outpatients. Parents scored higher than spouses on depression but lower on other variables. From 30% to 85% (depending on the question) continued to ruminate about the crash and what might have been done to prevent it. They appeared unable to accept, resolve, or find any meaning in what happened. Those who lost a spouse or child six to seven years ago did not function differently from those whose crash was four to five years ago. Their bereavement was also associated with increased mortality rate, drop in financial status, and divorce (parents only). The clear finding is that grief following sudden and violent loss is not easily or quickly resolved.

Lerner, M. J. (1980). The belief in a just world: A fundamental delusion. New York: Plenum.

Lerner advances the "just world" theory that most people adhere to, even though it is not rational: that good things happen to good people and bad things happen to bad people. Before experiencing something "bad," most people feel invulnerable. After experiencing something "bad," people not only feel universally vulnerable, but uniquely and personally vulnerable. Lerner suggests that in order to

reduce the stress from exposure to others who are suffering from a life crisis, we look for weaknesses in the victims behavior to explain the incident. Was she driving too fast, wearing a seat belt, etc. Alternatively, we attempt to identify weaknesses in the person's character to explain the crisis.

Lindy, J. (1985). The trauma membrane and other clinical concepts derived from psychotherapeutic work with survivors of natural disasters. Psychiatric Annals, 15(3), 153-160.

Lindy introduces the term "trauma membrane" to describe the psychic protective shield traumatized people put up to defend themselves from more emotional stress than they can handle. It is an extensive denial strategy that serves the trauma victim well until they are strong enough to face reality. It must be burst from the inside, only when the victim is ready -- not by an outsider (therapist, for example).

Looney, H. & Winson, J. (1982). Death notification: Some recommendations. Reproduced from Police Chief Magazine.

The authors provide sixteen suggestions they believe are helpful in accomplishing the task of death notifications. They stress that the subject of death notification needs to be included in Academy training and re-visited at in-service workshops.

Lord, J. (1986). No time for goodbyes. Ventura, CA: Pathfinder Publishing.

Based on interviews with hundreds of family members of someone murdered or killed in drunk driving crashes, the author identifies their specific concerns including the fact that the trauma was sudden and unexpected, violent, senseless, and brings with it significant justice concerns, financial stress, and faith and philosophy of life concerns.

Lord, J. (1987). Survivor grief following a drunk driving crash. Death Studies, 11, 413-435.

Lord cites findings of her survey of more than 400 family members of those killed in drunk driving crashes, noting what their reactions were and what helped or hurt them during the first few days, a week after, a month after, six months after, a year after, and at the time the survey was completed.

Martin, C., McKean, H., & Veltkamp, L. (1986). PTSD in police and working with victims: A pilot study. Journal of Police Science and Administration, 14, 98-101.

This group studied 53 police officers and found that 1/4 of them had PTSD. The data suggested that the stress was linked to cases in which they identified with the victim (similar to self, spouse or child).

Martin, R. S. (1994). Counseling unit helps officers handle grief. The Fort Worth Star-Telegram, 18.

The article discusses the stress and violent scenes police officers encounter. Experts say if police don't talk things out and get in touch with their feelings, severe emotional problems can arise. The unusually high suicide rate for the New York City police officers was cited. No definitive explanation was given. One study suggests that New York City officers are prone to being "too macho to seek help when needed."

McCammon, S. & Schmuckler, E. (1993, October). A descriptive study of stress-related symptoms of public safety dispatchers. Unpublished paper based on thesis by Patricia M. Grand-Holsten, presented at International Society for Traumatic Stress Studies, San Antonio, TX.

The purpose of the study was to examine and describe work-related stress among a population of dispatchers. Eighty four subjects attending a training program for communication officers completed four questionnaires: A background and work-related information questionnaire, the Symptom Checklist-90, the Cincinnati Stress Response Scale, and a Life Events Questionnaire. Results showed that dispatchers reported significant psychological distress when compared to the normative sample group. Women showed higher scores in depression, phobic anxiety and the positive symptom distress index; men reported higher incidences of increased blood pressure. City workers reported higher scores on several dimension of the SCL as compared to county workers or workers in 911 centers. It appears life events correlated significantly with several of the SCL dimensions as well as physical symptoms.

McCann, L. & Pearlman, L.A. (1990a) Psychological Trauma and Adult Survivor: Theory, Therapy, and Transformation. New York: Brunner/Mazel.

The authors point out that a major risk of working with traumatized patients is "infection of the soul." It is impossible to do this kind of work alone. In order to understand the victim's internal situation, the therapist must be a willing participant in the drama, a situation that of necessity causes a loss of objectivity. Therapists must rely on colleagues to provide the same zone of safety that the therapist is providing for the patient.

McCann, L. & Pearlman, L. A. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal Traumatic Stress, 3(1), 131-137.

Noting that working with traumatized clients can be traumatizing for the mental health professional, the authors propose a new concept for understanding the stress -- vicarious traumatization. Based on their observations, the authors contrast vicarious traumatization from burnout and counter-transference. They suggest that the trauma comes from the disruption of the mental health professional's schemas -- life rules that are important to the professional. Working with clients whose

trauma is such that it violates the helper's schemas will be more traumatic than exposure to traumatic situations that do not violate the schemas or do not violate them to a significant degree. Schemas can be identified under six major categories: trust, safety, power, esteem, autonomy, and intimacy. In addition to identifying one's most important schemas, other self-help techniques such as balance, humor, and processing personal issues are addressed.

McFarlane, A. C. (1986). Long-term psychiatric morbidity after a natural disaster: Implications for disaster planners and emergency services. Medical Journal of Australia, 145, 561-563.

The prevalence and longitudinal course of PTSD were studied in a group of 459 fire-fighters who were exposed to the Ash Wednesday brush fires in South Australia. The main finding, that the level of symptoms four months after the disaster remained almost unchanged at 29 months, suggested the long-term nature of PTSD. Twenty-nine months after the fire, 21% of the fire-fighters were continuing to experience imagery of the disaster, in a way that interfered with their lives. The failure of present disaster management plans to recognize the psychological impact of natural disasters and the long term nature of PTSD is emphasized, and the need for preventative mental health programs to minimize symptoms in the future is discussed.

McFarlane, A.C. (1988). The aetiology of PTSD following a natural disaster. British Journal of Psychiatry, 152, 116-121.

McFarlane continued his study of the Ash Wednesday fire fighters and found that an additional 20% had experienced "delayed onset" PTSD -- commencing more than 11 months after the fire. He also found that those suffering the most PTSD symptoms had previous psychiatric care prior to the fire.

McLauchlan, C. Handling distressed relatives and breaking bad news (clipping of unknown origin)

This article makes the following recommendations for death notifications in the hospital: (1) Law enforcement should notify the family personally and transport them to the hospital. (2) If the family must be notified by phone, it should be given by an experienced doctor or nurse who offers to arrange for someone to drive them to the hospital. (3) The family should be met by a nurse, social worker, chaplain or victim advocate who is informed about the status of the patient. This person should remain the contact person for the family. (4) The family should have a private, comfortably furnished waiting area. (5) The family should be told the patient is critical as soon as it is known. (6) When the doctor is ready to talk with the family, he or she should be introduced by the designated liaison professional. The doctor should be in clean clothing and be calm. (7) The doctor should identify the nearest next of kin and sit down in front of or beside that person. If death is probable, the doctor should say so. Likewise, if death has occurred, it should be stated clearly as soon as possible. Do not exclude children from the room. (8) Follow the pronouncement with silence until more questions are asked. Be accepting of all responses. (9) Give basic medical information in language the family can understand. (10) It is OK for the physician's feelings to show but it is not OK to use platitudes.

Use the word "dead" and "died" several times. (11) Allow family members who want to, to spend time with their loved one -- dead or alive -- if at all possible. (12) If the patient dies, the liaison person may ask the family if they would like a lock of hair. (13) The liaison asks the family if they would like anyone called. (14) Avoid sedation. (15) Before the family leaves, give written information.

Mercer, D. (1993, October). Drunk driving victimization or non-victimization effects on volunteer victim advocates. Paper presented at the International Society for Traumatic Stress Studies, San Antonio, TX.

The author studied 1,447 bereaved and injured victims of drunk driving crashes. She found that victims showed poorer adjustment on measures of well-being, somatization, obsessive-compulsion, depression, anxiety, hostility, Post Traumatic Stress Disorder, and self esteem than non-victims. Victims also reported poorer health, particularly hypertension, and more limitations on activity due to health problems. They were more likely than non-victims to take sleep medication or anti-anxiety drugs. While finances improved over the years for non-victims, they worsened for victims. The mean time between the crash and the interview was five years.

Mitchell, J. T. (1988). Stress: The history, status and future of critical incident stress debriefings. Journal of Emergency Medical Services, 13 (11), 46-47, 49-52.

Mitchell's Critical Incident Stress Debriefing (CISD) model includes introductions and explanation of ground rules, fact phase (participants describe their job and the facts of what happened), thought phase (participants describe what they were thinking as they completed their tasks), reaction phase (participants describe how they felt as they were performing their tasks), symptom phase (participants discuss symptoms they are currently experiencing, and re-entry phase (participants make contracts or plans for the future). Mitchell's model also includes peer support as the first step with carefully selected peers determining if debriefings are needed.

Mitchell, J. T. & Bray, G. (1990). Emergency services stress: Guidelines for preserving the health and careers of emergency services personnel. Englewood Cliffs, N.J.: Prentice Hall.

Mitchell and Bray have developed a shorter (30 - 45 minute) less formal and less structured version of the CISD model that is to be conducted within a few hours of the critical incident. It allows for some ventilation and information on stress which may prevent the need for a full debriefing.

Mitchell, M. (1990, July). Lockerbie air disaster. Reviewed in STSS StressPoints, 4(3),5.

In December, 1988 all 259 passengers and crew and 11 people on the ground were killed when a bomb on board a Pan Am airliner exploded over Lockerbie, Scotland. A study of 190 police officers who worked the scene of the disaster found that absenteeism and sick leave in 1989 rose 70% from

1988. Mitchell believes the stress of dealing with "quite unimaginable injuries" explained the phenomenon. It was clear that officers who worked in the mortuary appeared to be the most traumatized. Dr. Mitchell concluded that the officers who had discussed their reactions with colleagues reported fewest stress-related symptoms. Increased absenteeism among the workers was consistent with other research showing that depression, anxiety and reduced job satisfaction complicated recovery.

National Victim Center. (1990). Developing and implementing a death notification program. Strategies in Action, Fort Worth, TX: Author.

The section provides an overview and curriculum for death notification training. The outline provides a guideline for victim advocates to review before implementing a training. It goes on to cover the purpose of the training, characteristics of death notification professional and volunteers; recommended procedures; death notification in the work place; and debriefing techniques. Much of this publication draws from the work of Mothers Against Drunk Driving.

Norris, F. & Thompson, M. (1993). The victim in the system: The influence of police responsiveness on victim alienation. Journal of Traumatic Stress, 6(4), 515-532.

This study addresses how the negative consequences of victimization can be counter-acted (or augmented) through satisfactory (or unsatisfactory) experiences with the justice process. The sample consisted of 220 adults who had experienced a crime within the past six months, had reported the crime to the police, and were willing to participate in a telephone interview. The data was analyzed using the Linear Structural Relations Program as the statistical technique. Nine variables were observed. Results showed that an arrest was beneficial but not essential for victims' faith in the world to be restored. Crime severity was generally associated with greater alienation, but was partially counteracted when victims believed the system was being responsive to their plight. The most discouraging finding was that very few victims actually had satisfactory experiences.

Osmont, K. (1993, November/December). The value of viewing in grief work reconciliation: A psychotherapist's perspective. The Forum Newsletter, pp. 1, 19.

From the perspective of a psychotherapist in private practice, the author presents support and methods for viewing the body following tragic death. The article presents clinical observations and the results of a questionnaire used with three female clients whose loved ones had died tragic deaths but who had not been given an opportunity to view the bodies of their loved one. Testing the theory, "better late then never," the author obtained photographs of the deceased which were shared with the members of their bereavement support group. The survivors believed that seeing the photos helped them view the deaths more realistically and helped them focus on their loved one's life rather than just the death. The survivors also believed that seeing the pictures was not as difficult as they had anticipated, and it had helped them get in touch with some feelings they had been avoiding. The author encourages the education of police, funeral directors, and mental health professionals relative to the value of viewing the body.

Parkes, C. (1981). Emotional involvement of the family during the period preceding death. In Acute grief (Eds.) Margolis, O., Raether, H., Kutscher, A., Power, B., Seeland, I., DeBellis, R., and Cheno, D. New York: Columbia Press.

Bereaved people visit their physicians more frequently, are admitted more often to the hospital, and undergo more surgical operations than non-bereaved people. They also suffer more depressive illnesses, anxiety states, personality disorders, rheumatic and arthritic conditions, disturbances of autonomic functions, and ulcerative colitis. Finally, the bereaved die more often than the non-bereaved from coronary thrombosis and arteriosclerotic heart disease.

Pearlman, L. A., & Mc Ian, P. S. Vicarious traumatization among trauma therapists: Empirical findings on self-care. In ISSTS Stresspoints, 7, (3) (Summer, 1993).

The researchers asked subjects which of 22 activities they engaged in to balance their trauma work, and whether they found them useful. Activities noted to be helpful, from most to least commonly reported were (1) discussing trauma cases with colleagues - 85%, (2) attending workshops - 76%, (3) spending time with family and friends - 70%, (4)travel, vacations, hobbies, movies - 69%, (5) talking with colleagues between sessions - 69%, (6) exercising - 62%, (7) limiting one's caseload - 56%, (8) developing a spiritual or religious life - 44%, (9) receiving general supervision -44%, and (10) receiving trauma-related supervision - 43%. Only 38% of males and 74% of females received any kind of supervision.

Pennebaker, J. W. & O'Heeron, R. C. (1984). Confiding in others and illness rate among spouses of suicide and accidental-death victims. Journal of Abnormal Psychology, 93, 473-476.

The authors studied health and coping strategies in 19 spouses of suicide and accidental death victims approximately one year after their spouses' deaths. The number of health problems correlated positively with internal rumination about the deaths and negatively with their amount of confiding in others.

Pfost, K. & Stevens, M. (1989). Relationship of purpose in life to grief experiences in response to the death of a significant other. Death Studies, 13, 371-378.

This study assessed anger among those grieving the death of a significant other. Findings were that those with low purpose in life before the death experienced significantly more anger than those with high purpose in life before the death. This might imply that low purpose results in meshing with others to establish identity, so that when the significant other dies, the person is left feeling fragmented and is angry about it.

Pickett, G., et al. (1994, November). Methods of coping used by police officers following traumatic events. Paper presented at the International Society for Traumatic Stress Studies, Chicago, IL.

This study focuses on the development of Post Traumatic Stress Disorder in officers not involved in fatal shootings. The authors believe that personal coping mechanisms used by officers mediate the effects of trauma, thus influencing their level of distress. The paper examines the relationship between traumatic experiences, coping styles and the development of PTSD symptoms in police officers.

Five hundred police officers in seven suburban St. Louis areas were contacted. Data provided by 80 officers was available for analysis. Five different questionnaires were used, including the Police Experience Checklist (PEC). All of the events on the PEC meet the requirements for DSM-III-R Criterion A. Results of this study indicate that the length of time an individual has served as an officer is not related to the level of PTSD symptoms or distress. Also, the amount of time since the traumatic event is not able to predict distress. Individual coping styles were more predictive of PTSD symptoms and distress. Coping styles can be identified in individual officers. It may be possible therefore, to target and provide interventions early to those officers who might be at greater risk for developing PTSD.

Pitman, R. & Orr, S. (1993). Psychophysiologic testing for post-traumatic stress disorder: Forensic Selection of the notifier is as crucial as the procedure itself. Forensic psychiatric application. Bulletin of Academy of Psychiatry and the Law, 21(1), 37-52.

This article reviews the literature on psychophysiological assessment of PTSD as background for discussing the use of psychophysiological reactivity as relevant information in a court of law. The authors describe how data from research studies can be used to evaluate a single case and review relevant case law involving PTSD.

Proactive Security. (1993, June). Sudden violent death: Effects of line of duty death and responsibilities of law enforcement agencies. Paper presented at the Florida Police Chiefs Association 39th Annual Training Conference, Pensacola, FL.

This presentation covers delivery of death notifications; assisting survivors at the hospital; inter-departmental issues; support for the survivors during the visitation and funeral; providing information and assistance to the family concerning benefits; providing support during legal proceedings; and on-going support for survivors. The packet also includes a referral list and contact information.

Raphael, B (1986). When disaster strikes: How individuals and communities cope with catastrophe. New York: Basic Books.

Raphael's debriefing model asks participants to share their role in the critical incident and their feelings as they carried it out. Psychological perceptions and reactions, both positive and negative, are explored in depth. Relationships with family and co-workers are discussed, and participants are asked to plan how they will relinquish the disaster role.

Reynolds, J. (1995, May/June). Disenfranchised expertise: The funeral director as helping professional. The Forum, 3, 13-14.

Starting from the hypothesis that death industry professionals are not highly valued within American culture, the author discusses historical and contemporary views of the profession. Two significant issues contribute to the problem, (1) an overriding cultural anxiety about death which makes death a taboo subject, and (2) myths, stereotypes and misconceptions about the death industry and death industry professionals. The author argues that the solution lies within the profession and should include self-credentialling, public education, and professional education beginning in mortuary school. Finally, the author connects the profession's disenfranchised status with the lack of self-care opportunities afforded to death industry professionals.

Rinear, E. E. (1988). Psychosocial aspects of parental response patterns to the death of a child by homicide. Journal of Traumatic Stress, 1(3), 305-322.

In a study of 250 parents whose children had been killed, 72.6% reported still feeling numb for six months.

Roberts, A. & Camasso, M. (1994). Staff turnover at crisis intervention units and centers: A national survey. Crisis Intervention, 1(1), 1-9.

A study of 107 crisis intervention units projected an annual national number of callers in acute crisis at 4.3 million. This averages more than 100 crisis contacts per unit per week. Masters degree social workers had the highest rate of turnover in these programs, and the turnover was linked to problems of child abuse, sexual abuse, alcohol abuse and marital adjustment. Social workers had been adequately trained to deal with trauma. Also, crisis counseling is usually perceived as an entry-level position, requiring night and weekend work. The positions pay poorly (while most social workers are paying off their student loans).

Rynearson, E. K. & McCreery, J.M. (1993). Bereavement after homicide: A synergism of trauma and loss. American Journal of Psychiatry, 150(2), 258-261.

This study evaluated 18 adults (mean age, 39) whose loved one had been murdered. All were referred to the study (and treatment) because of treatment failure of previous therapists or support groups. Twelve had a history of psychiatric disorder before their loved one was killed. A mean interval of 2.5 years had passed since the murder, but 17 of the 18 were still experiencing intense, terrifying intrusive images of the fantasies they had developed about the murder from the bits and pieces of facts they had gathered. The authors concluded that the grief work could not be done until the trauma was dealt with first. Thus, anti-anxiety medications and classical conditioning techniques were used to calm the patients, help them sleep, and reduce intrusive imagery. The researchers conclude that the combination of grief, (pining, longing, guilt, idealized attachment to the victim) coupled with intense traumatic imagery should alert clinicians that significant treatment is warranted.

Rynearson, E. K., Parrington, J., Sinnema, C., & Olson, D. (1994, Spring). Support project for bereavement after homicide. Virginia Mason Clinic Bulletin, 48, pp. 33-41.

This article builds on the previous one with a treatment group of 32 and a control group of 20, 2.5 years after of a homicide death in the family. The control group felt no need for treatment. Those who sought treatment showed significantly increased frequency of childhood abuse and significantly high measures of grief, trauma, and disorganizing flashbacks of reenactment imagery. The authors conclude that early childhood trauma results in diminished resiliency to subsequent trauma. They also conclude that restorative recovery for homicide survivors is rare.

Sanders, K. & Stavish, M. (September 1, 1995). Flaming wreck brings double sorrow to family. Fort Worth Star Telegram, p.1.

This newspaper article explains the details of a double tragedy when a man burned to death in his wrecked car, and his elderly father died of a heart attach when an investigator from the medical examiner's office told him about the wreck on the phone in requesting dental records.

Sawyer, S. (1993). Support services to surviving families of line-of-duty death. A public safety handbook. Grant Numbers 89-PS-CX-001 and 93-PS-DX-001 awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.

This booklet was written by the Concerns of Police Survivors for surviving families of fallen public safety officers. It addresses not only the tangible procedural issues but intangibles such as emotional support and counseling. In summary, Concerns of Police Survivors, Inc., believes that it is the responsibility of every emergency response agency to provide liaison assistance to the immediate survivors of any officer who dies in the line of duty, whether feloniously or accidentally. This active member of the department is to offer the family a comprehensive explanation of survivor benefits and to provide tangible and intangible emotional support during this traumatic period of re-adjustment for the surviving family.

Schanfield, S., Swain,B., & Benjamin, G. (1987). Parents' responses to the death of adult children from accidents and cancer: A comparison. Omega, 17, 289-297.

This study found that parents who lost adult children in vehicular crashes suffered more over-all psychiatric distress, expression of guilt, and health complaints than parents whose children died of cancer.

Shelby, J. & Tredinnick, M. (1995). Crisis intervention with survivors of natural disaster: Lessons from hurricane Andrew. Journal of Counseling and Development, 73, 491-497.

As volunteers with the Disaster Mental Health Services team through the American Red Cross, the authors responded to a community affected by Hurricane Andrew. They note several significant differences between traditional counseling and the crisis intervention they were limited to due to the nature of the emergency. The authors make several suggestions on ways to adapt to less formal and

non-clinical settings including taking a more proactive role, increased touching, and focusing on pre-existing skills. Rather than disempowering the counselor, it was noted that the frantic pace and limited resources typical of a crisis response actually left clients more receptive to new options and new skills. Results were often immediate and significant which contrasted with more traditional counseling expectations. The article discusses traumatized children and offers suggestions for responding therapeutically to children, particularly children from cultures that don't traditionally value counseling. Finally, the authors offer suggestions for responding effectively to culturally diverse populations as a whole.

Skill Building Handout. (1984, April). Arizona Law Enforcement Training Academy Manual.

The Arizona Law Enforcement Training Academy Manual provides a section on Death Notification Protocol. Three basic stages are covered. Stage 1: Pre-notification debriefing (the information gathering state of the notification process); Stage 2: Actual notification to family (the delivery stage of the notification process); and Stage 3: Post-notification (the wrap-up portion of the notification process).

Skogan, W.; Davis, R., & Lurgio, A. (1990). Victim needs and services. Final report to the National Institute of Justice, Chicago, IL: Northwestern University Center for Urban Affairs and Policy Research, 50-53.

This study found that the greatest need of crime victims is to be able to tell the story time and time again and to have personal safety needs met.

Sly, R. (1992, May). I'm sorry to inform you... Law and Order, pp. 26-29.

The author is the chaplain coordinator for the Riley County Police Department in Manhattan, Kansas. He offers ten action points to maximize the ability of a department to carry out the task of notification effectively and efficiently. He urges the use of police chaplains or volunteer clergy to assist the officer with notifications.

Smith, T. & Walz, B. (1995). Death education in paramedic program: A nationwide assessment. Death Studies, 19, 257-267.

This article reports on an exploratory study of death education taught in paramedic programs. Noting that paramedics are frequently present at the moment of death, training within the profession should include death education covering legal, technological and psychosocial content areas. Findings include that the vast majority of programs surveyed do offer death and dying education utilizing lecture and discussion formats. The article includes observations about paramedic training and recommendations for incorporating death education into primary and continuing education courses.

Soderfelt, M., Soderfelt, B., & Wang, Lars-Erik. (1995). Burnout in social work. Social Work 40(5), 638-647.

The authors reviewed the literature on burnout, discovering a multitude of definitions and also finding that social workers do not experience significant burnout regardless of the definition. Burnout became popular in the mid-70's as a characterization of adverse reactions to work, primarily in human services settings. The authors believe that its popularity stems from the fact that it carries low stigma. It is somewhat noble to say one has "burned out" -- unlike acknowledging that one is incompetent or inept. Numerous burnout scales have been developed, but the Maslach Burnout Inventory (MBI) (Malasch & Jackson, 1981) may be the most popular. The following suggestions from the literature review are given to prevent burnout: improve staff communications, define work objectives clearly, rotate work assignments, create low work pressure allowing for independence, give adequate training, and compensate fairly.

Solomon, R. (1987). Coping with vulnerability. Copyrighted manuscript.

Every emergency worker has to learn to cope with fear and vulnerability. The author breaks down a critical situation into four phases. 1. Here Comes Trouble, 2. Oh Shit!, 3. Survival, and 4. Response. The author emphasizes that we are not helpless and can control our responses to a situation with our ability and capability of responding fueled by the resource frame of mind.

Staff. (1992). "In person, in time"; Recommended procedures for death notification. Crime Victim Assistance Division, Iowa Department of Justice.

The booklet offers procedures for death notifications. The topics covered include; basic death notification procedures; death notification procedures in the work place; death notification in a hospital setting; debriefing for death notification volunteers and professionals; and how survivors respond to death notification (general information). This publication was based on the death notification program of Mothers Against Drunk Driving.

Staff. (1992). Program of Instruction for Death Notification. Georgia Peace Officer Reference Text.

Sections of the Georgia Peace Officer Reference text discuss tips for officers delivering death notifications. The tips include: be professional; keep your cool; be sensitive; look to the person's physical needs and try to meet them; and provide follow up with the family. The booklet offers a list of resource materials available.

Steele, L. (1992). Risk factor profile for bereaved spouses. Death studies, 16,387-400.2.

High risk variables among 60 bereaved spouses included age (younger and older were more unhappy than middle-aged), sex (widows were more unhappy than widowers), socio-economic status (as financial stress increased, so did unhappiness), and quality of relationship (those very close to their deceased spouse had more guilt and developed more somatic complaints). Age was the most significant variable with the 25-35 year old and 66-85 year old at greatest risk.

Stroebe, W. and M. & Domittner, G. (1988). Individual and situational differences in recovery from bereavement: A risk group identified. Journal of Social Issues, 44(3), 143-158.

This study compared 30 widows and 30 widowers with 60 married persons in their 50's in Germany. Unexpected loss resulted in high depression and somatic complaints for those with low inner focus of control. This group with low levels of inner control improved very little over the two-year period of the study. The depression scores were so high that, had these individuals not been bereaved, 42% would have been diagnosed as clinically depressed at 6 months. After two years, 27% were still that depressed.

Sweet, J. (1991). Farewell. Journal of the American Medical Association, 265(12), 1518.

A physician reflects in an editorial the circumstances which may have led to a physician friend's suicide. The stressors faced by the author's colleague/friend included the death of a child, a divorce, and financial difficulties.

Talbot, A. (1990). The importance of parallel processing in debriefing crisis counselors. Journal of Traumatic Stress, 3(2).

Talbot uses the notion of parallel processing to describe how traumatized clients will set up a reenactment scenario in whatever group setting affords the opportunity to recreate the original drama. This behavior is unconscious, often highly symbolized, but an established pattern of a lifetime.

(1995, June). Traffic Safety Facts. Washington D. C.: National Center for Statistics & Analysis.

This document records annual statistics for numerous components of highway safety.

Ubell, E. Is your job good for you? (Citation unknown)

The combination of low control and high demand are the marks of a "bad job." Low control means your boss tells you what to do and how to do it. High psychological demand means too much work in too little time. Social support is also a necessary element of a positive work environment. Robert Karosek, professor of work environment at the University of Massachusetts at Lowell, began researching job strain and heart disease in 1980 and says that about 20% of American men, based on the above criteria, have "bad jobs." The stress culprits, Karosek says, are bosses and supervisors who, in the name of short-term efficiency and profits, dehumanize work.

A study of 215 men by Dr. Peter L. Schnoll, a cardiologist at New York Hospital in Manhattan, revealed that those who complained of job strain were more likely to have high blood pressure, and sonograms showed that the walls of their hearts were thicker.

Valencia, R. (1994, June). Death notifications. Paper presented at the First Annual Governor's Training Conference on Crime Victim Assistance, FL.

This death notification outline covers traditional grief responses; coping styles; criteria for persons making notifications; death notification preparation and process; what to say/not say; and follow up.

Valteirra, J. & Valteirra, E., (1992, February 16). Please be sensitive to family feelings in times of sorrow. Fort Worth Star-Telegram.

This guest editorial is written by bereaved parents who were abruptly notified of their son's death by telephone. The caller was a paramedic at the hospital where the victim was taken following an automobile crash. The authors describe the experience and maintain that the mode and manner in which the notification was made caused them unnecessary emotional trauma. They make several suggestions, including in-person notifications, to improve death notification procedures.

Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. Psychotherapy: Theory, research and practice, 28, 411-421.

Van Wagoner and colleagues studied 93 expert therapists and found them, in contrast with general therapists, as (1) having more insight into and explanations for their feelings, (2) having greater capacity for empathy, (3) being more able to differentiate between the needs of the client and their own needs, (4) being less anxious with clients, and (5) being more adept at conceptualizing dynamics in the clients' present and past.

Weatherhead, L. (1972). The will of God. Nashville: Abingdon Press.

Weatherhead offers a more differentiating model of "God's will" than the simplistic catch-all, "It must have been his/her time." He suggests that God's intentional will is that all should have long and abundant lives. However, God gave human beings great latitude in free will which is called circumstantial will. Bad choices will always be made which result in pain. God's ultimate will is that out of everything, no matter how awful, some good can come.

Weinberg, N. (1985). The health care social worker's role in facilitating grief work: An empirical study. Social work in health care 10(3), 107-117.

Weinberg studied 155 Illinois college students who had experienced the death of someone significant to them. On a scale of one to five, they rated the severity of their loss at a mean of 4.164. When asked what helped, they rated the following behaviors in this order: (1) allowing them to talk about what happened including their feelings; (2) normalizing their feelings and talking about ways of coping and (3) offering "quiet" support such as praying with them and touching them. Those experiencing the most severe pain found sharing their loss significantly more helpful than people with lesser pain. Behaviors not helpful included, in this order: (1) encouraging them to take medication, (2) encouraging them not to think about it, (3) informing them about support groups or other resources (they wanted to tell their story to that person), (4) sitting with them but not talking, and (5) talking about the future.

The article points out that hospitals tend to reinforce emotional constraint. Visitors are urged to speak quietly and to be calm. Emotional outbursts are treated with tranquilizers. Patients who are rational, calm and agreeable are congratulated. Outbursts, though uncomfortable for staff, are a natural component of shock and mourning and should be affirmed.

Weiss, R. (1988). Loss and recovery. The Society for the Psychological Study of Social Issues.(Paper presentation)

Weiss acknowledges that "adaptation" and "accommodation" are more appropriate than "acceptance" in many cases. However, he uses "recovery" to describe a return to ordinary functioning. Following are five signs of recovery: (1) ability to give energy to daily life, (2) psychological comfort as demonstrated by freedom from pain and distress, (3) ability to experience gratification -- to feel pleasure when desirable, hoped-for, or enriching events occur, (4) hopefulness about the future; being able to plan and care about plans, (5) ability to function with reasonable adequacy in social roles as a spouse, parent, and member of the community. Failure to recover is marked by (1) chronicity -- unmoving persistence in protesting (not accepting reality), (2) depressed withdrawal, and (3) compartmentalization -- refusal to think or feel about it. Failure to recover may be linked to (1) lack of meaning surrounding the death, (2) ambivalence toward the one who died, (3) low self esteem, (4) dependence on the deceased, and (5) feelings of responsibility or guilt.

Weiss, R., et al. (1986). Widowers as a contrasting group. The First Year of Bereavement.

Weiss compares widows and widowers two to four years after the death of their spouse, finding significant differences. Men tended to define their loss as dismemberment while women defined theirs as abandonment. Men tried to avoid crying; women did not. Women appreciated encouragement to express emotion; men appreciated encouragement to move toward greater control. Men and women both expressed anger, but men were much more quickly able to manage it. Men felt more guilt early on ("I should have recognized how sick she was") but were able to be rationale much more quickly than women. Widows felt more guilty as time went on. Men were more apt to look at photos and read old letters than women. Almost half of the men reported involuntary visualizations of their wives. About 1/4 of each reported "sensing the presence" of their spouse by the third week. At one year, the women were still talking about it; the men were not. During the first few weeks, the men received support as replacement of their wive's functioning, i.e., cooking, cleaning, children, but received little emotional support. The opposite was true with wives. The men refused help much sooner than the women. By the end of the second month, nearly half the widows (44%) were anxious and fearful of nervous breakdown. Very few men had this experience. Men moved much more quickly toward re-marriage. By the end of the first year, 50% of the men had remarried, only 18% of the women had remarried. Men were much less tolerant of loneliness and saw remarriage as the way to resume normal functioning. Women felt they should finish grieving their dead spouse before entering a new relationship. Men felt the new spouse should assist them in their continued grieving. Relative to unexpected death, every widower whose wife died suddenly was unable to establish a new relationship and every widower who had forewarning remarried.

Weiss, R. (1988). Recovery from bereavement: Findings and issues in preventing mental disorders. Washington, DC: National Institute of Mental Health, 108-121.

Weiss says we should not expect people who have suffered a severe loss to go back to being the people they were before. "You don't get over it. You get used to it." Tasks in recovery (being able to function in life again) include: (1) Development of "an account," or explanation of how the traumatic loss came to be; and (2) slow, steady letting go of some of the images and memories and moving on to more positive ones. Factors leading to difficult recovery include: (1) unexpected death, (2) ambivalent relationship, (3) dependent relationship, (4) previous unresolved losses, (5) character structure too weak to support the pain of grief and mourning, (6) lack of a promising future. Three forms of failure to recovery include: (1) chronic grief (stuck on a particular memory or image and can't move to others, (2) unwillingness or inability to grasp the reality of the loss, and (3) development of other methods to cope; i.e. alcoholism, workaholism, etc.

Wells, P. J. (1993). Preparing for sudden death: Social work in the emergency room. Social work, 38(3), 339-343.

The author suggests that one social worker serve as a liaison between medical staff and the patient's family, keeping them constantly informed of the patient's condition. The worker should use understandable terminology at all times. If the patient dies, the family should be taken to a private area and told simply and directly.

White, P. and Brown, L. (April, 1995). Compassion fatigue as it impacts the caregiver. Paper presented at Two Days in May, Columbus, Ohio.

This paper includes an overview and handouts from a workshop on the subject of Compassion Fatigue. The presenters pull from Charles Figley's work including his definition of Compassion Fatigue and Compassion Stress.

Williams, J. & Siegel, J. (1989) Marital disruption and physical illness: The impact of divorce and spouse death on illness. Journal of Traumatic Stress, 2(4), 555-562.

This study compared physical illnesses among 152 people whose spouse had died within the last five years, 263 who had divorced within the last five years, and 1741 who had married or remained married during the last five years. Findings were that younger people develop more illnesses following both death and divorce than older people, possibly because of the added stress of single-parenting, because more young deaths are traumatic, and because younger people may be less psychologically prepared. Women had a slightly healthier adjustment to divorce than men, but not to death. Divorced subjects with the highest level of education had the highest rate of illness.

Williams, T. (1993). Trauma in the workplace. In J. Wilson & B. Raphael; (Eds.), International Handbook of Traumatic Stress Syndromes, pp. 925-933.

The author of this chapter identifies common emotional responses to traumatic events in the workplace, offers a prevention model, and a company training program. Employee safety suggests that trauma reduction should begin with preventing the traumatic event from occurring. However,

secondary prevention measures, such as debriefings, can be incorporated after a traumatic event but before symptoms occur. Lastly, therapeutic resources may be employed for individuals experiencing stress symptoms. The author notes that some occupations have a higher risk level than others for traumatic events. Employers within these occupations have an obligation to provide crisis services. The article includes a sample training program and a sample handout that may be utilized within the workplace.

Wolfelt, A. (1988, Winter). Bereavement caregiver burn-out: Signs and symptoms. Thanatos, 6-8.

This article reviews symptoms of bereavement caregiver burn-out and emphasizes the need to combat it with knowledgeable self focus.

Wolfelt, A. (1989, Spring). Caring for oneself as a caregiver. Thanatos, 16-18.

A follow-up to a previous article, Bereavement Caregiver Burn-Out: Signs and Symptoms, the article discusses general indicators of Bereavement Care Burnout. The author includes a ten-question survey, but acknowledges that there is little documented research comparing levels of stress among different professions. Emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment may indicate burnout. Self-care guidelines to reduce or avoid burnout symptoms include: awareness of risk, periods of rest and renewal, self-compassion, setting limits, effective time-management, support systems, personal expression, understanding personal motivation, and healthy eating, sleeping and exercise patterns.

Wolfelt, A. (1990). Toward an understanding of the co-dependent bereavement caregiver. Thanatos, 20-22.

The first of two-part series defines the co-dependent bereavement caregiver: a person who continually puts the needs of the bereaved before their own, ultimately to their own detriment. The author presents a model of co-dependent behavior and identifies signs and symptoms of bereavement caregiver co-dependence.

Wolfelt, A. (1992). Understanding grief: Helping yourself heal. Muncie, IN: Accelerated Development Publishers.

This book offers a multitude of practical suggestions for helping oneself move through the pilgrimage of grief and mourning toward healing. The author is a well-known thanatologist who has worked with thousands of bereaved individuals in developing his concepts and models.

Wolterstorff, N. (1987). Lament for a son. Grand Rapids, MI: Eerdmans Press.

This small but very engaging book follows the spiritual pilgrimage of the author after his son fell off a mountain in Europe and was killed. The father, a Lutheran theologian, addresses his difficulty in assimilating what happened into his former belief system and slowly rebuilding a new theology.

Wortman, C. (1985). Reactions to victims of life crises: support attempts that fail. In I. G. Sarason and B. R. Sarason (Eds.), Social support theory, research, and application. Dordreeht, The Netherlands: Marinus Nijhoff.

This paper focuses on three reasons why people may respond to victims of life crises in ways that are unsupportive: (1) Contact makes people feel threatened and vulnerable with anxiety increasing the more unfortunate the victim's plight i.e., those in greatest need are last likely to get it. (2) People are uncertain about what to say or do. (3) People are misinformed about how others "should" respond to life crises. These problems result in victims feeling isolated and alone because they feel they cannot share their experiences, they dismiss the victim's feelings as insignificant or unimportant, and they imply that victims should not feel as bad as they do. They are particularly harmful among those closest to the victim who are looked to for support. The authors interviewed 100 people whose loved one had been killed in a vehicular crash. Supports the survivors found most helpful were (1) being able to talk about the deceased, (2) ventilation or and acceptance of feelings, and (3) being with others who have experienced the same thing.

Wortman, C. & Silver, R. (1989). The myths of coping with loss. Journal of Counseling and Clinical Psychology, 57(3), 349-357.

This article supports the position that there is no prescription for how to grieve properly and no research-validated guideposts for what is normal vs. deviant mourning. Society, on the one hand, insists that people mourn -- and labels them if they do not. On the other hand, it labels someone outwardly mourning as a person in need of therapy. Therefore, bereaved people, in order to maintain harmonious social relationships, may hide both their distress and their cheerfulness.

Yassen, J. Prevention of secondary traumatic stress in individuals. In Figley, C., Ed. (Spring, 1994).Secondary Traumatic Stress Disorder: Trauma and Its Wake III. Bruner/Mazel.

Yassen outlines a strategy for self care for therapists who work with traumatized patients. I. Individual. A. Personal - physical health, social supports, life balance, spiritual connections, creative expression, self awareness, plans for getting help, community activism, relaxation, and humor. B. Professional - boundaries/limit-setting, plans for emergency coping, variety of tasks, adequate training, replenishment. II. Environmental. A. Social - assessment and education of social supports. B. Societal - educational strategies, coalition building, legislative reform, social action. C. Work setting - physical setting, articulated value system, clear job tasks and personnel guidelines, supervisory/management support, collegiality. Yassen says that attention to each of these supports is especially crucial for caregivers who are also survivors.

Young, M. (1991). Community crisis response team training manual. Washington, D.C.: National Organization for Victim Assistance.

Young's model is developed for primary victims rather than crisis responders. Debriefing is done by a pair of debriefers -- a leader and a scribe who validates feelings by writing them on a flip chart. The leader normalizes the feelings, predicts reactions the attendees may experience in the future, and identifies positive coping techniques. Participants are given handouts to take home, and the flip chart is destroyed.

Young, M. (1993). Victim assistance: Frontiers and fundamentals. Dubuque: Kendall/Hunt.

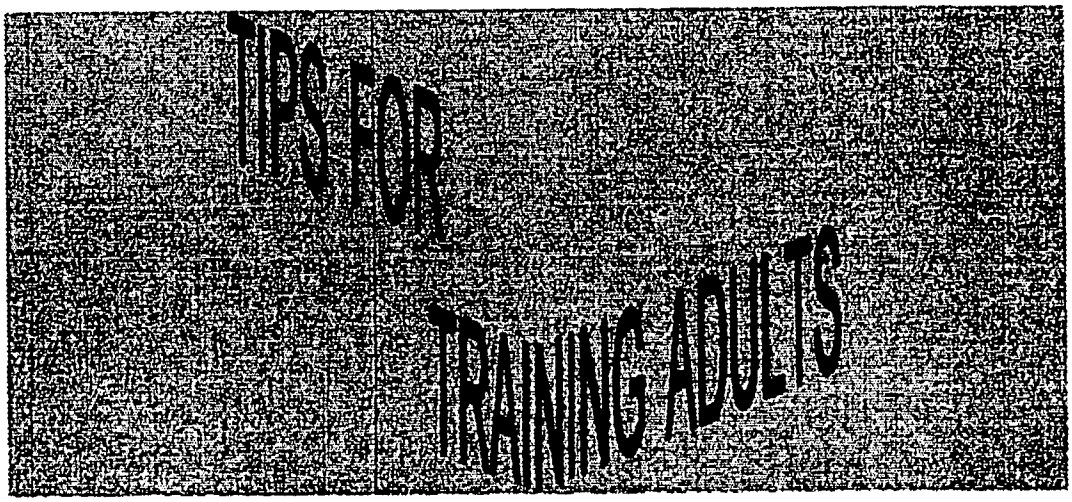
This booklet highlights 24 specific areas of victim assistance. The booklet ranges in topic including the psychological trauma of crime victimization, people management in victim assistance programs, victim services as a profession, and an overview of the victim movement.

Young, M. & Stein, J. Eds. (1994). 2001: The next generation in victim assistance. Dubuque: Kendall/Hunt.

Megatrends in the Victims' Movement: A National Conference took place in 1992. This book is the proceedings of that conference. Speeches and discussions were edited for print, workshops were expanded upon, and new ideas were formulated into chapters. The book covers a wide spectrum of victimization topics including Ethics and the Media, Spirituality and Trauma; Victim Justice: A New Bill of Rights; A Global Response to Crisis; and the Future of Victim Assistance in the Federal Government.

OVERHEADS

HOW TO SUCCEED IN REACHING ADULT AUDIENCES



1. **EXPLAIN HOW IT WILL BENEFIT THEM (What's in it for me?)**

2. **RELATE THE LEARNING TO THEIR PAST EXPERIENCES.**

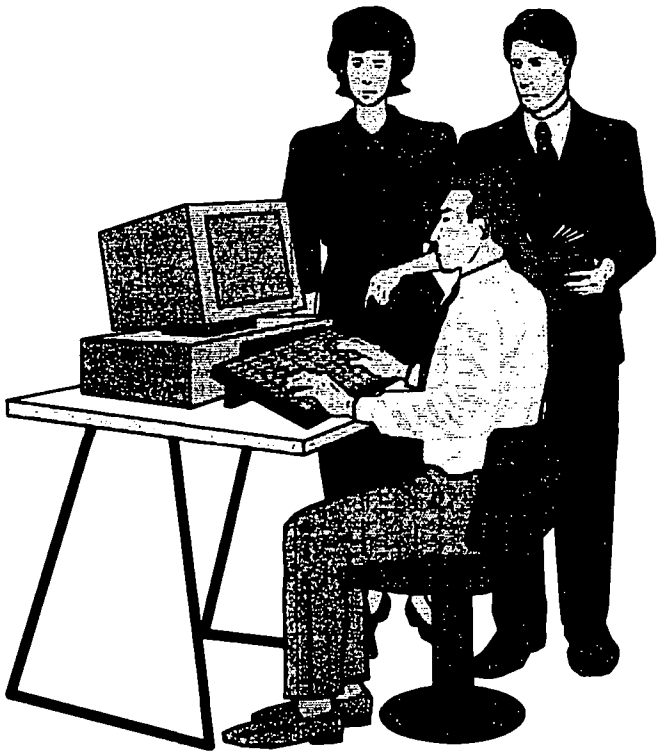
3. **ENCOURAGE PARTICIPATION AND INTERACTION.**

4. **LISTEN AND RESPECT THEIR OPINIONS (Make me feel good about myself).**

5. **ENCOURAGE THEM TO BE RESOURCES TO YOU AND TO EACH OTHER.**

6. **ALWAYS TREAT THEM LIKE ADULTS.**

MAXIMUM EFFICIENCY IN LEARNING

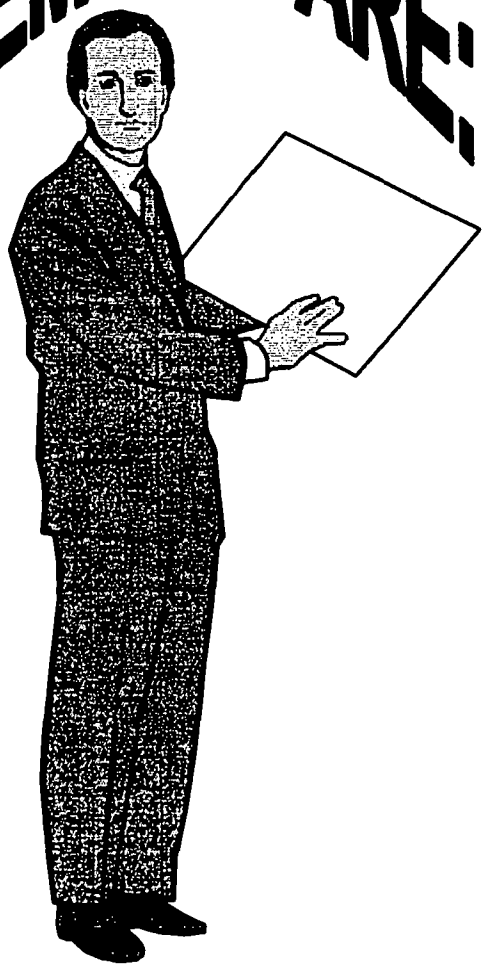


VERBAL AND VISUAL SYMBOLS COMBINED WITH HANDS-ON EXPERIENCE

MINIMUM TO MAXIMUM LEARNING

- **<u>LEAST EFFECTIVE</u>: VERBAL SYMBOLS ALONE (LISTENING)**
- **VISUAL SYMBOLS ALONE (READING)**
- **VERBAL AND VISUAL SYMBOLS COMBINED (LISTENING AND OVERHEADS)**

THE GOALS OF THIS SEMINAR ARE:



- **TO ENHANCE AWARENESS OF THE EMOTIONAL HAZARDS OF CRISIS WORK.**

- **TO TEACH STRATEGIES FOR COMPASSIONATE AND THOROUGH DEATH NOTIFICATION.**

APPREHENSIONS ABOUT DEATH NOTIFICATIONS

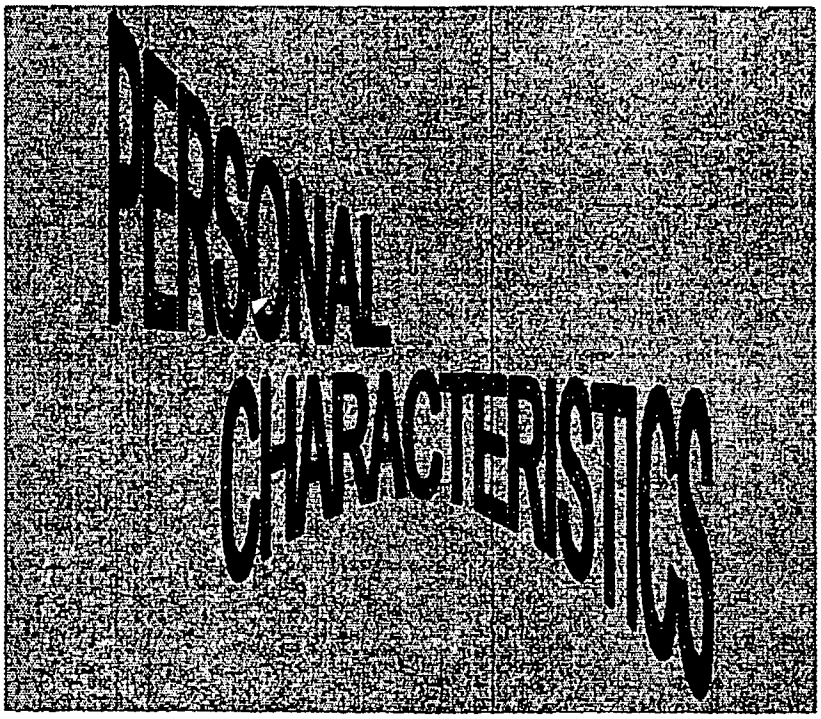
1. **FEELING UNTRAINED OR UNPREPARED.**

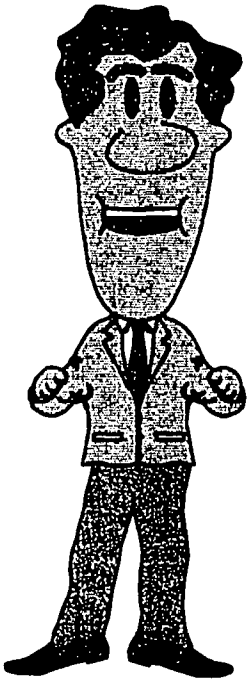
2. **OVER-IDENTIFICATION WITH THE VICTIM'S FAMILY.**

3. **PERSONAL VULNERABILITY.**

4. **FEAR OF BEING LABELED BY COLLEAGUES.**

SELECTION OF THE NOTIFIER IS AS CRUCIAL AS THE PROCEDURE ITSELF





EASY GOING PERSONALITY/SENSE OF HUMOR

TRAINING

RELIGIOUS BELIEFS

OPPORTUNITY TO TRAIN OTHERS OR SPEAK PUBLICLY

POSITIVE RELATIONSHIP WITH FATHER

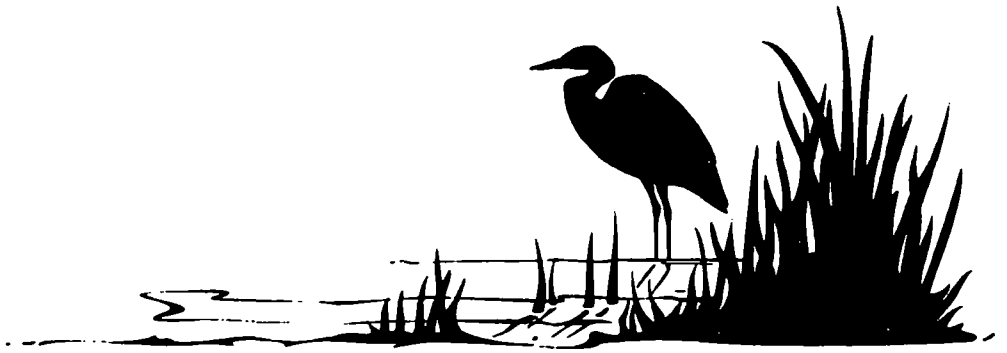
DESIRE TO HELP PEOPLE

VICTIMS WANT:

TO TELL THEIR STORY AGAIN AND AGAIN

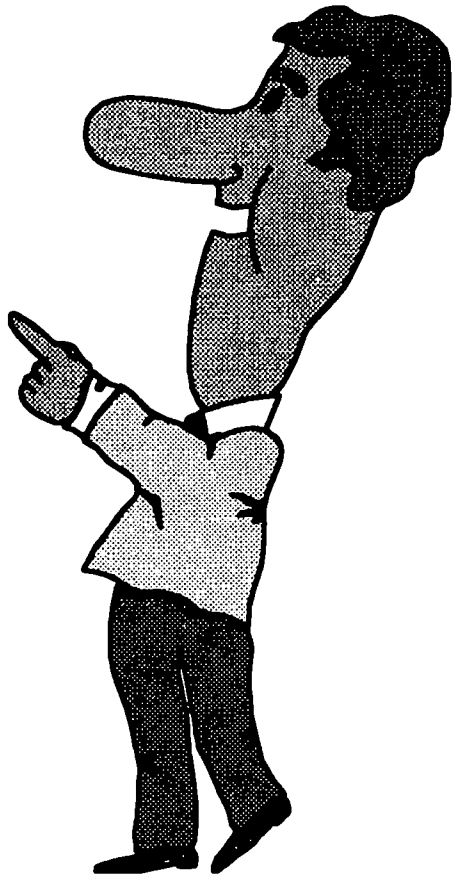
TO HAVE ALL FEELINGS ACCEPTED AND BELIEVED

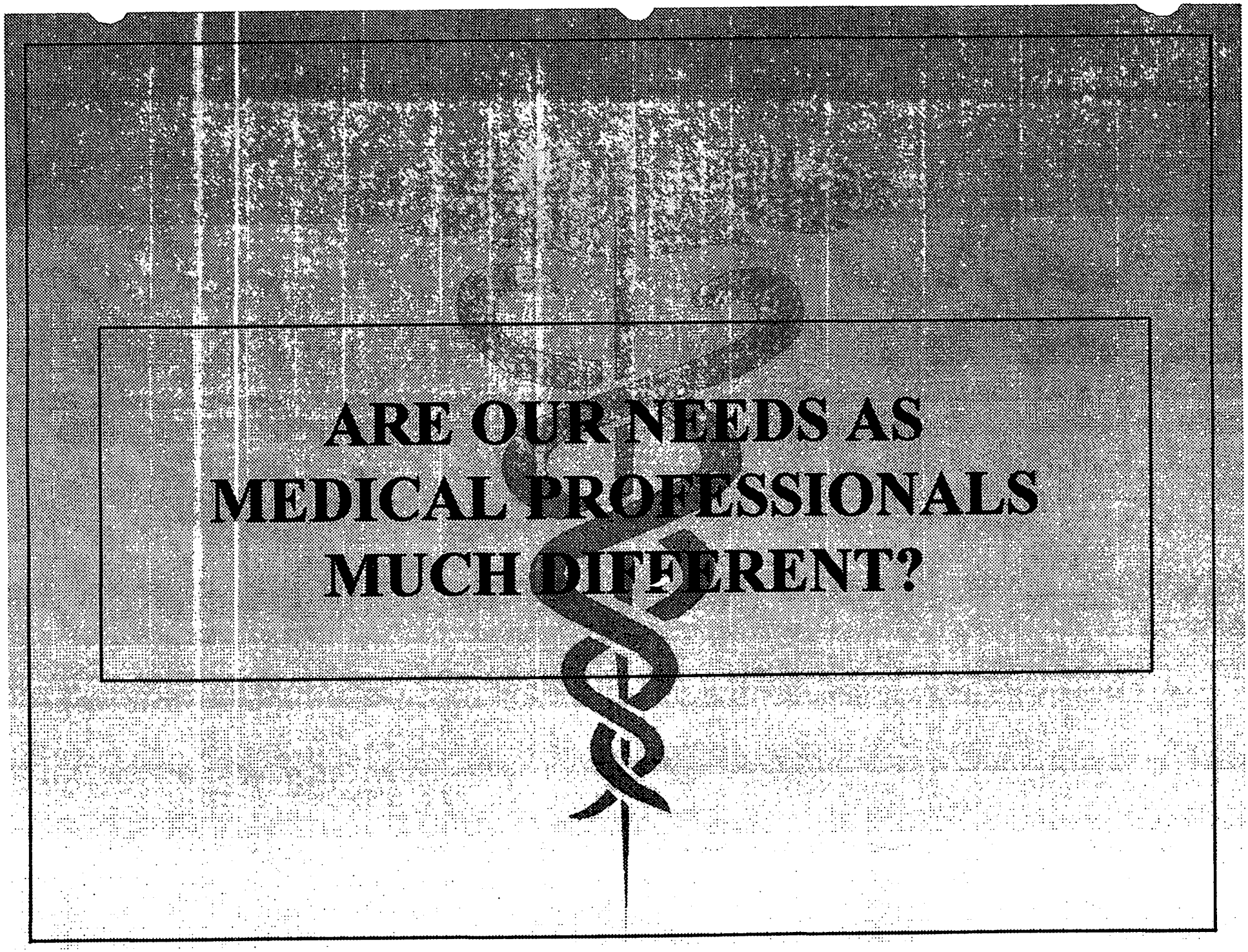
TO BE WITH OTHERS WHO HAVE BEEN THROUGH IT



VICTIMS DON'T WANT:

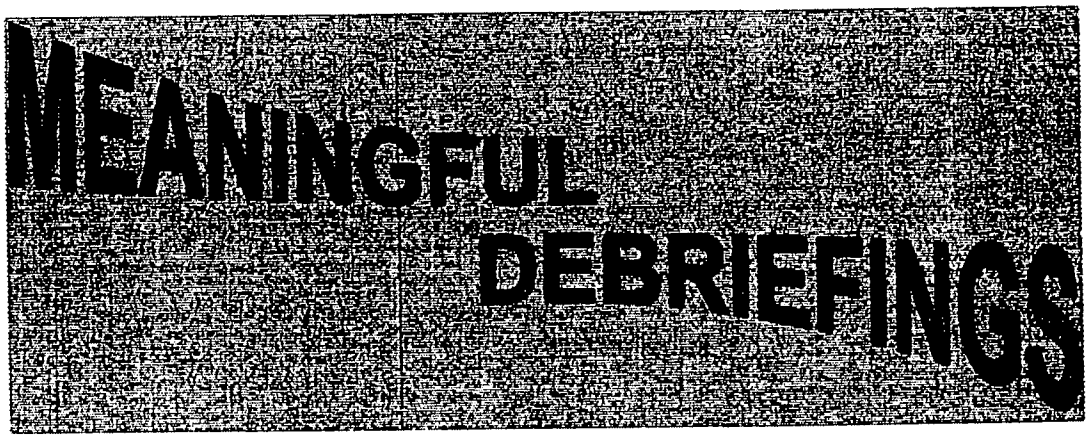
- **ENCOURAGEMENT TO TAKE MEDICINE**
- **BEING TOLD NOT TO THINK ABOUT IT**
- **BEING PREMATURELY REFERRED TO SUPPORT GROUPS**




ARE OUR NEEDS AS
MEDICAL PROFESSIONALS
MUCH DIFFERENT?

KEY FACTORS IN RECOVERY (LANNING, 1987)

- EXPRESSION OF APPRECIATION
- MEANINGFUL GREETINGS
- CERTAIN PERSONAL CHARACTERISTICS



EXPLAIN REASON FOR DEBRIEFING

INITIAL DEBRIEFING MANDATORY

HELD ON WORK PREMISES

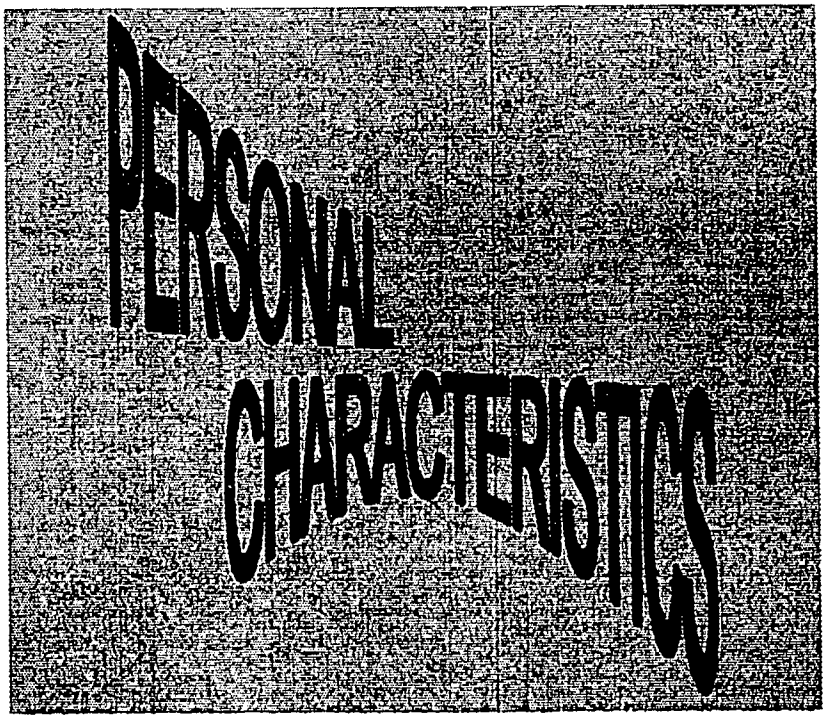
INFORMATION ABOUT PTSD

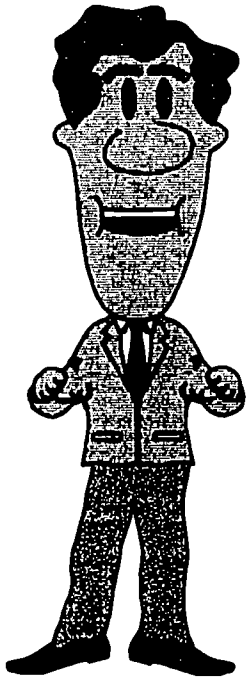
SMALL, INFORMAL, CONFIDENTIAL GROUPS

PROFESSIONAL FACILITATORS FROM OUTSIDE

SEPARATE DEBRIEFINGS FOR SUPERVISORS

SEPARATE DEBRIEFINGS FOR SPOUSES





EASY GOING PERSONALITY/SENSE OF HUMOR

TRAINING

RELIGIOUS BELIEFS

OPPORTUNITY TO TRAIN OTHERS OR SPEAK PUBLICLY

POSITIVE RELATIONSHIP WITH FATHER

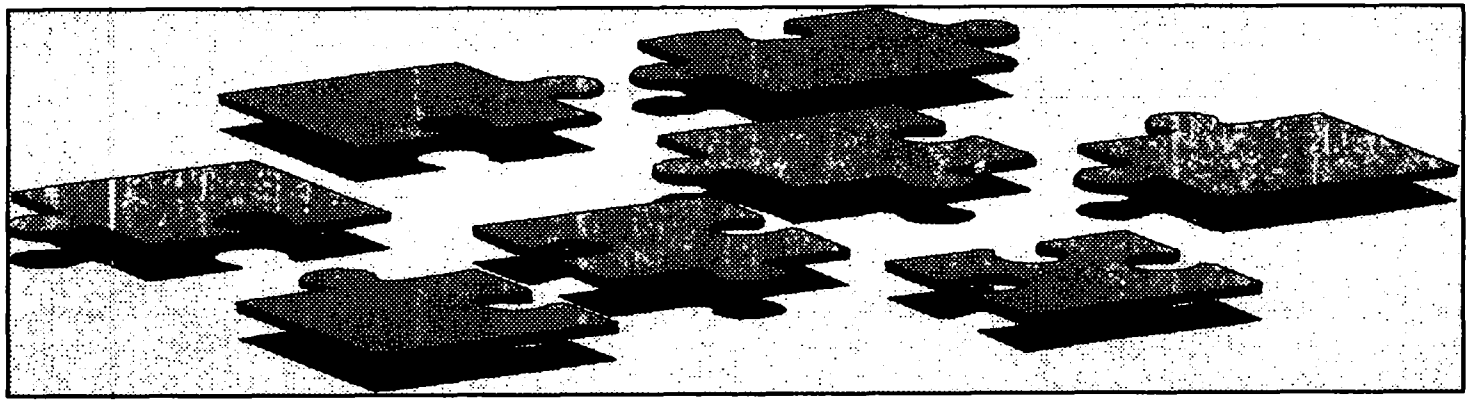
DESIRE TO HELP PEOPLE

DEATH MODELS

KUBLER-ROSS	TERESE RANDO
DENIAL	AVOIDENCE
ANGER	
BARGAINING	CONFRONTATION
DEPRESSION	
ACCEPTANCE	RE-ESTABLISHMENT

PHYSICAL EMOTIONAL MENTAL SPIRITUAL

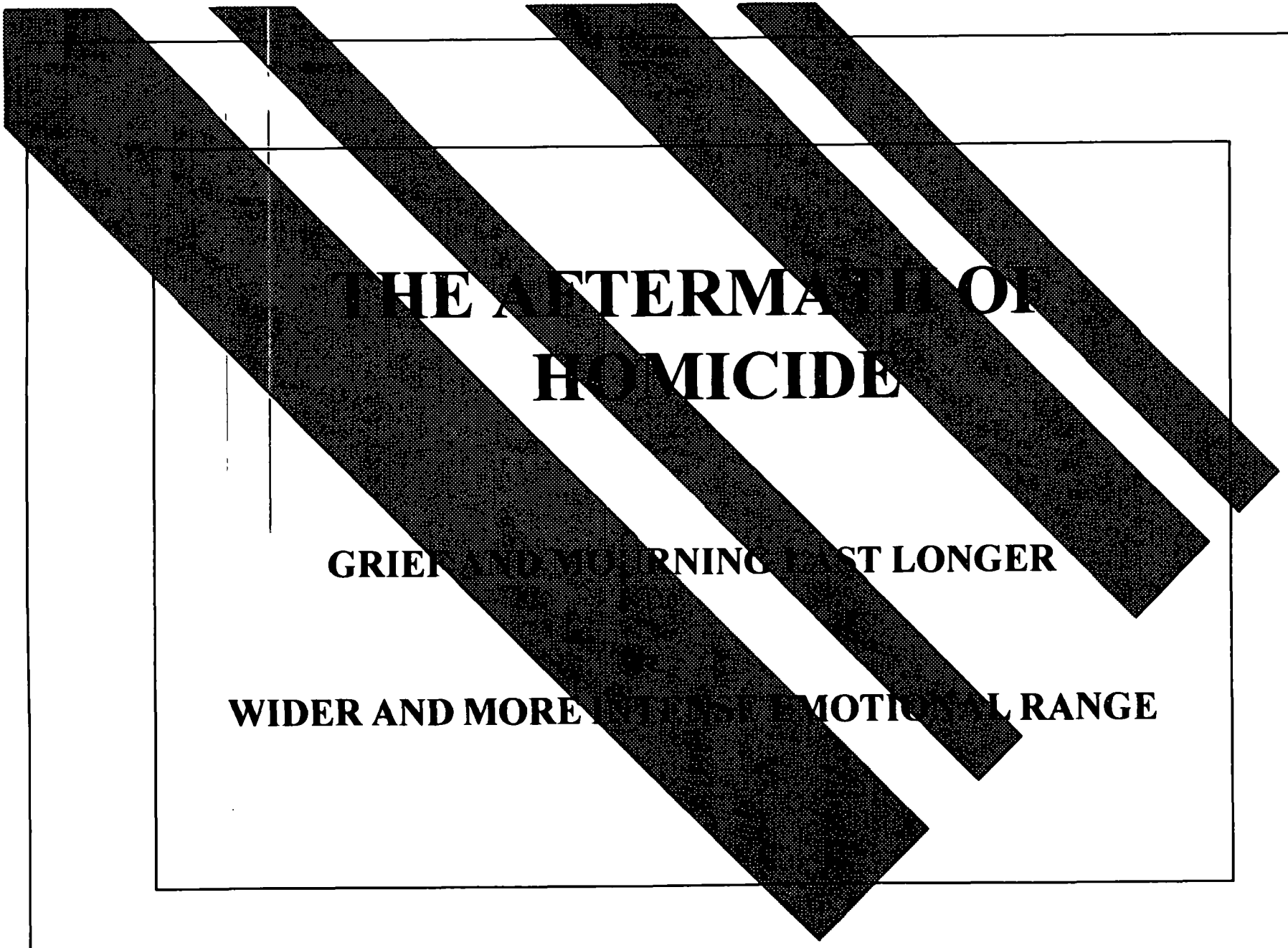
Charles Corr



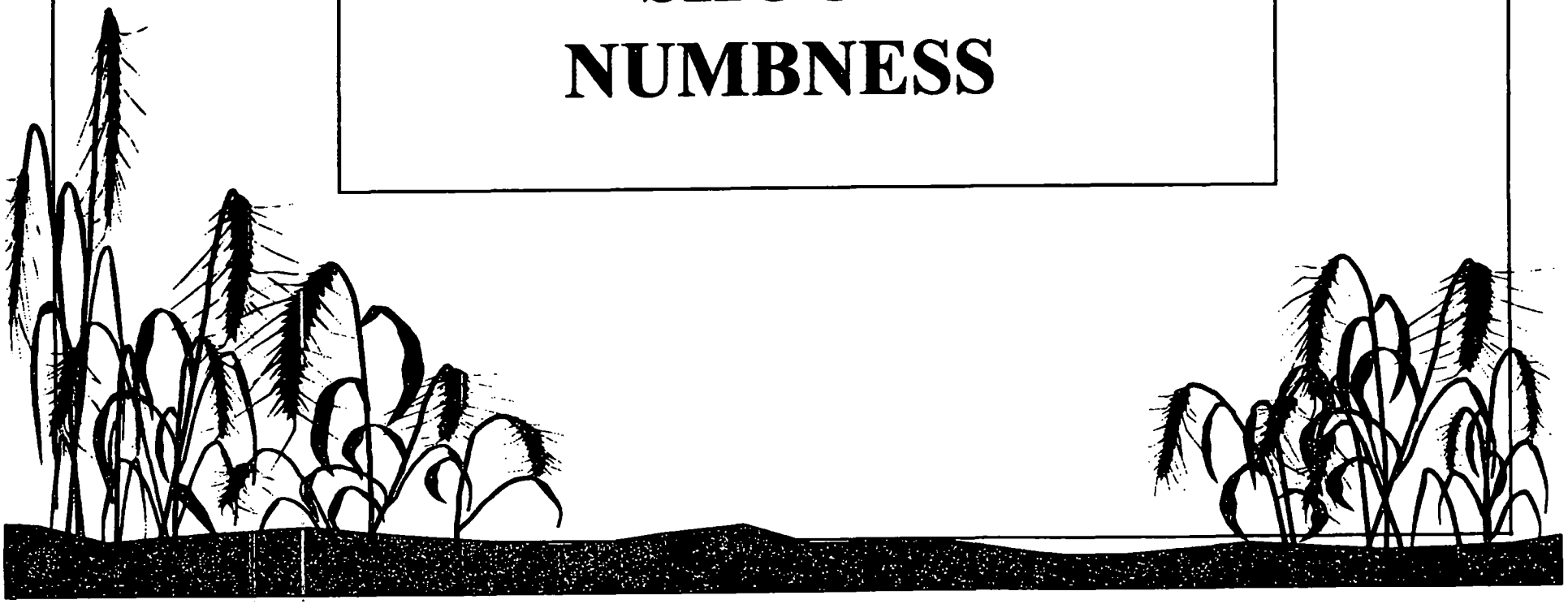
UNIQUE FEATURES OF HOMICIDE

- UNANTICIPATED
- VIOLENT
- SENSELESS

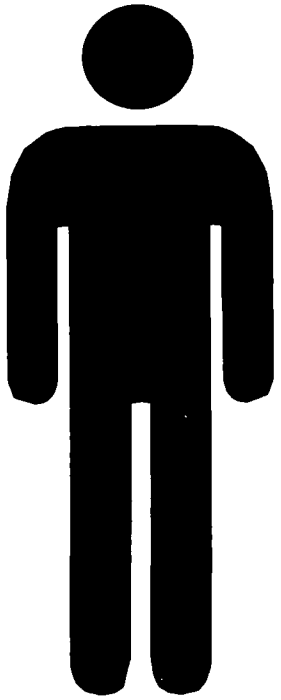
- LEGAL FRUSTRATIONS
- FINANCIAL STRESS
- FAITH/ PHILOSOPHY OF LIFE

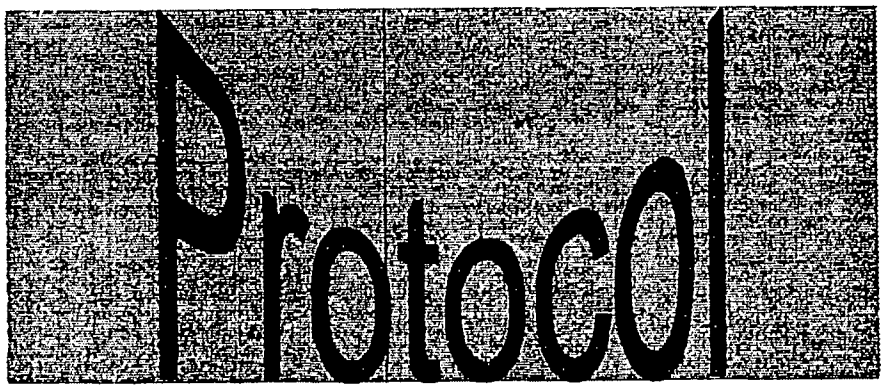

THE AFTERMATH OF
HOMICIDE
GRIEF AND MOURNING LAST LONGER
WIDER AND MORE INTENSE EMOTIONAL RANGE

DENIAL
SHOCK
NUMBNESS



FEAR AND POWERLESSNESS





1. **BE ABSOLUTELY CERTAIN OF IDENTIFY OF DECEASED.**

2. **GET AS MUCH MEDICAL INFORMATION AS POSSIBLE ABOUT FAMILY TO BE NOTIFIED.**

3. **GO. DON'T CALL.**

4. **TAKE SOMEONE WITH YOU.**

5. **TALK ABOUT YOUR REACTION ON THE WAY.**

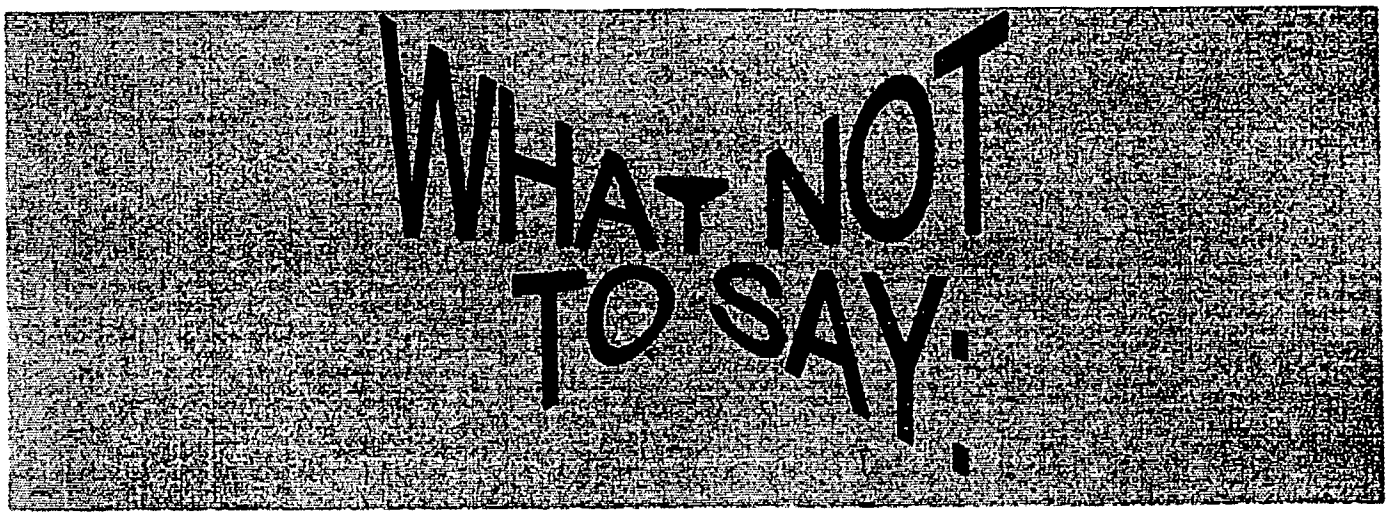
6. **PRESENT CREDENTIALS. ASK TO COME INSIDE.**

7. **SIT DOWN. ASK THEM TO SIT DOWN; BE SURE YOU HAVE NEAREST NEXT OF KIN.**

8. **INFORM SIMPLY AND DIRECTLY - - WITH COMPASSION.**

9. **DON'T DISCOUNT FEELINGS, THEIRS OR YOURS.**

10. **JOIN THE SURVIVORS IN THEIR GRIEF WITHOUT BEING OVERWHELMED BY IT.**



DISCOUNTING STATEMENTS

I KNOW HOW YOU FEEL.

TIME HEALS ALL WOUNDS.

YOU'LL GET OVER THIS.

YOU MUST GO ON WITH YOUR LIFE.

HE DIDN'T KNOW WHAT HIT HIM.

YOU CAN ALWAYS FIND SOMEONE WORSE OFF THAN YOURSELF.

YOU MUST FOCUS ON YOUR PRECIOUS MEMORIES.

IT'S BETTER TO HAVE LOVED AND LOST THAN NEVER TO HAVE LOVED AT ALL.

DISEMPOWERING STATEMENTS:

YOU DON'T NEED TO KNOW THAT.

WHAT YOU DON'T KNOW WON'T HURT YOU.

I CAN'T TELL YOU THAT.

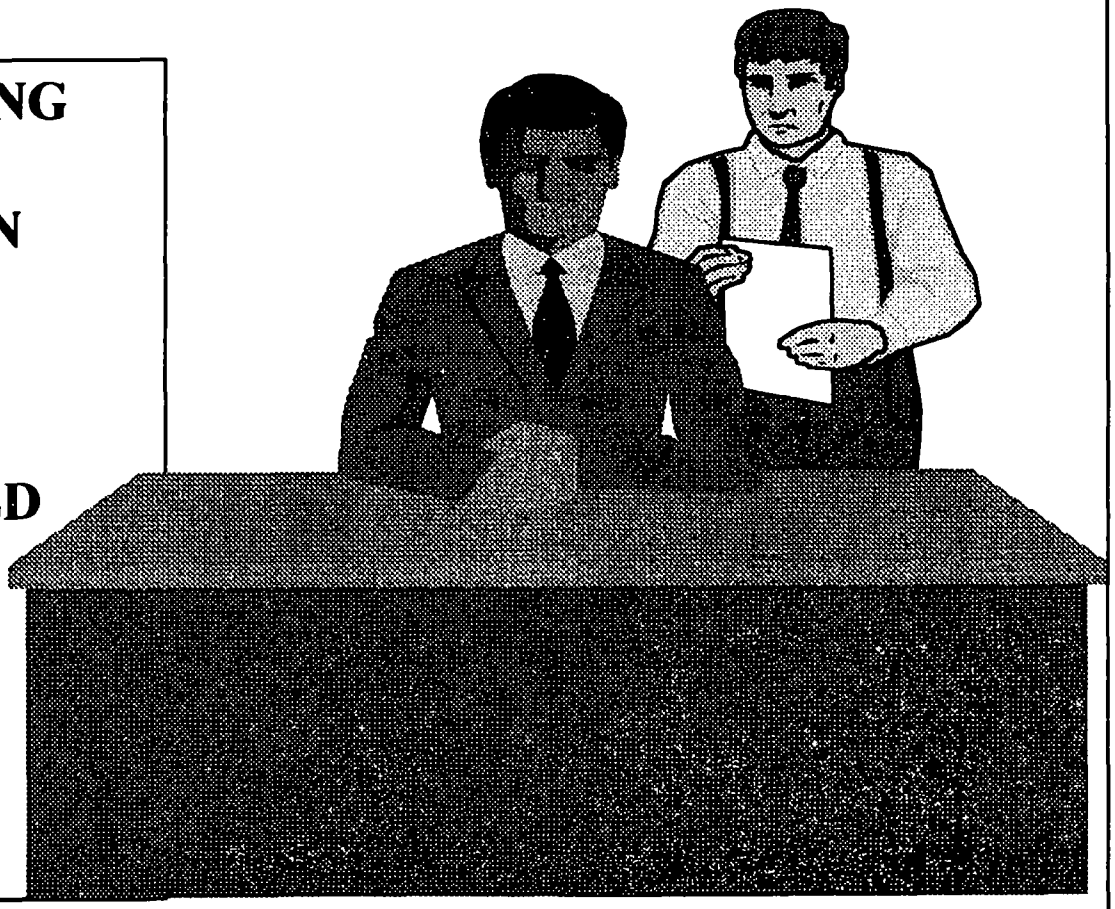
GOD CLICHES

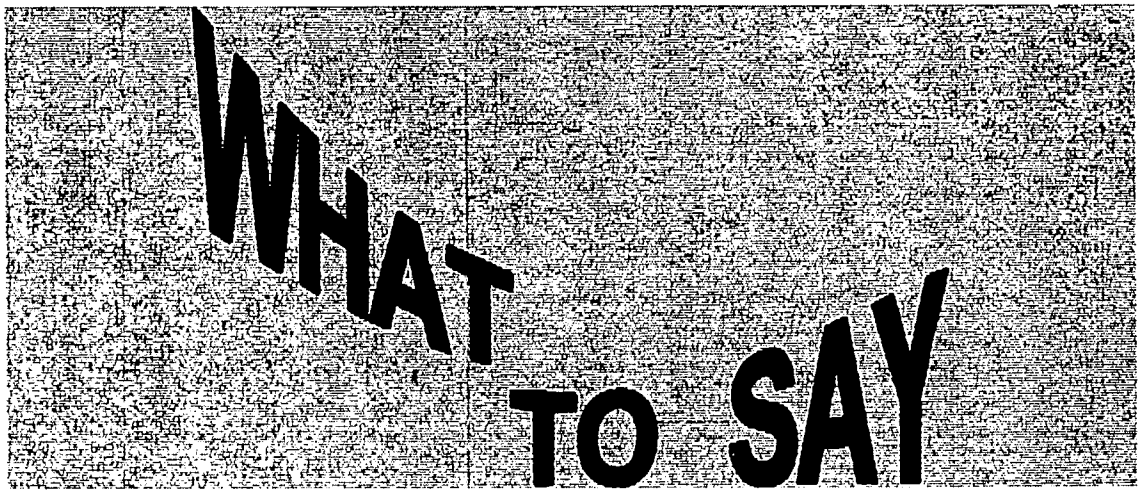
- **IT MUST HAVE BEEN HIS/HER TIME.**
- **SOMEDAY YOU'LL UNDERSTAND WHY.**
- **IT WAS ACTUALLY A BLESSING BECAUSE__.**
- **GOD MUST HAVE NEEDED HER MORE THAN YOU DID.**
- **GOD NEVER GIVES US MORE THAN WE CAN HANDLE.**
- **ONLY THE GOOD DIE YOUNG.**

UNHEALTHY EXPECTATIONS

- **YOU MUST BE STRONG FOR YOUR WIFE/CHILDREN PARENTS.**

- **YOU MUST GET HOLD OF YOURSELF.**





I'M SO SORRY.

IT'S HARDER THAN MOST PEOPLE THINK.

MOST PEOPLE WHO HAVE GONE THROUGH THIS REACT SIMILARY TO WHAT YOU ARE EXPERIENCING.

IF I WERE IN YOUR SITUATION, I'D FEEL VERY _____ TOO.

I'LL CHECK BACK WITH YOU TOMORROW, SEE HOW YOU'RE DOING AND IF THERE'S ANYTHING MORE I CAN DO FOR YOU.

HANDOUTS

SEMINAR AGENDA

SPEAKER BIOS

OUTLINE

I. Introduction

II. Overview

III. Selection of the Notifier

A.

B. Post-Traumatic Stress Disorder (See Page 24)

C. Stress Studies

1. Work-Related Stress **(Karosek; Ubell)**

2. Delta 191 **(Lanning, 1987)**

3. JAMA article **(Sweet, 1991)**

4. Caregiver Burnout **(Wolfelt)**

   a.

   b.

   c.

   d.

   e.

   f.

   g.

IV. Crime Victims and Medical Professionals

A. Victims Want:

1.

2.

3.

B. Victims Don't Want:

1.

2.

3.

C.

V. Strategies for Staying Emotionally Healthy as a Crisis Professional

A. Key Factors in Recovery: Delta 191 Study

1. Appreciation

2. Meaningful Debriefings

a.

b.

c.

d.

e.

f.

g.

h.

3. Personal Characteristics

a.

b.

c.

d.

e.

f.

VI. Homicide Survivor Reactions

A. History

B. Death Models

C. Unique Components of Homicide:

1.

2.

3.

4.

5.

6.

D. The Aftermath of Homicide

1.

2.

E. Denial/Shock

F. Fear/Powerlessness

G. Viewing the Body

H. Viewing Photographs

VII. Death Notification Impact Panel

VIII. Death Notification Protocol

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

WHAT NOT TO SAY

Discounting Statements:

I know how you feel.

Time heals all wounds.

You'll get over this.

You must go on with your life.

He didn't know what hit him.

You can always find someone worse off than yourself.

You must focus on your precious memories

It's better to have loved and lost than never to have loved at all.

Disempowering Statements:

You don't need to know that.

What you don't know won't hurt you.

I can't tell you that.

God Clichés:

It must have been his/her time.

Someday you'll understand why.

It was actually a blessing because _____.

God must have needed her more than you did.

God never gives us more than we can handle.

Only the good die young.

Unhealthy Expectations:

You must be strong for your wife/ children/ parents.

You must get hold of yourself.

WHAT TO SAY

I'm so sorry.

It's harder than most people think.

Most people who have gone through this react similarly to what you are experiencing.

If I were in your situation, I'd feel very ___ too.

I'll check back with you tomorrow, see how you're doing and if there's anything more I can do for you.

11.

12.

13.

14.

15.

16.

17.

18.

19.

20.

IX. Evaluation

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Post-Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

2. The person's response involved intense fear, helplessness, or horror. NOTE: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions. NOTE: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. NOTE: In children, there may be frightening dreams without recognizable content.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). NOTE: In young children, trauma-specific re-enactment may occur.

4. Intense psychological distress at exposure to internal or external causes that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. **Inability to recall an important aspect of the trauma (psychogenic amnesia).**

4. **Markedly diminished interest or participation in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills).**

5. **Feeling of detachment or estrangement from others.**

6. **Restricted range of affect (e.g., unable to have loving feelings).**

7. **Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).**

D. **Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:**

1. **Difficulty falling or staying asleep.**

2. **Irritability or outbursts of anger.**

3. **Difficulty concentrating.**

4. **Hyper-vigilance.**

5. **Exaggerated startle response.**

E. **Duration of the disturbance (symptoms in B, C, and D) is more than one month.**

F. **The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

Specify if:

Acute: **If duration of symptoms is less than three months**

Chronic: **If duration of symptoms is three months or more**

Delayed Onset: **If onset of symptoms is at least six months after the stressor. (America Psychiatric Assn., 1994)**

People can also experience "Post-traumatic Decline" -- chronic symptoms which relate not to a specific trauma, but to having witnessed or experienced a number of traumas.

ARTICLES

ARTICLES

ARTICLES

ARTICLES

CRIME VICTIMS COMPENSATION INFORMATION

SAMPLE HAND-OUT FOR FAMILY OF HOMICIDE VICTIMS

The following information is provided to assist you in making arrangements. The exact order of events may vary.

AUTOPSY

1. **Your loved one has been taken to the County Medical Examiner's Office in _____(City)_____ _____(State)_____ for examination. This is required by law in cases of unexpected death.**

2. **Call the funeral home of your choice to inform them of the death and your desire to use their services.**

3. **Call the Medical Examiner's Office, ___ (number)___, to inform them of the funeral home you have chosen. The Medical Examiner may need further information from you.**

4. **The Medical Examiner's Office is open ____(time)____ until ____(time)____, Monday through Friday. Although the office is closed on Saturday, an attendant is normally on duty from ____(time)____ until ____(time)____.**

5. **The Medical Examiner will normally keep your loved one's body from 12 to 24 hours. (Optional) Under some circumstances, the Medical Examiner will allow the family to view the body before it is taken to the funeral home. If you desire to do this, call ____(number)____. Ask the condition of the body, which will help you decide if you wish to view it in this state.**

6. **The Medical Examiner will call your funeral home to transport the body when the examination has been completed.**

7. **Your funeral home will make an appointment with you to come into their office to make funeral arrangements.**

CRASH REPORT

1. **The investigating officer at the crash, ____(Name)____, ____(Phone)____, is preparing the crime report. If you wish, you may phone him/her with questions about the crime. You may obtain a copy of the report in 3 to 5 days at ____(Address)____.**

2. **Fee for the report is _____.**

3. **If we can be of further service to you, please call the Police Department at ____(Phone)____.**

FURTHER INFORMATION

1. **If you are interested, you may obtain a copy of the offenders driving record by writing ____(Address)____. Submit the offender's name, license number and date of birth (from the crime report) and enclose a fee of _____.**

2. **If you would like to contact a victim program, call:Victim Assistance_____**
   MADD_____
   _____
   _____

INFORMATION ABOUT STATE VICTIMS' COALITIONS, LIST OF MADD CHAPTERS AND PARENTS OF MURDERED CHILDREN'S GROUPS, LOCAL TRAUMA COUNSELORS, AND OTHER LOCAL RESOURCES

SAMPLE EVALUATION

Thank you for completing this evaluation. Your responses will be taken into consideration for future seminars. Please circle the appropriate response number for each statement. Feel free to offer additional suggestions and comments on the back of this sheet.

The goals of this seminar were to enhance awareness of the emotional hazards of crisis responders and to provide strategies for compassionate and thorough death notifications as one means of reducing stress in a very difficult task.

We attempted to achieve these goals through presentations, group discussion, audio-visual aids, a Victim Impact Panel, and written materials.

		Yes				No	
1.	Were the stated goals achieved?	5	4	3	2	1	NA
2.	Was the content well-presented?	5	4	3	2	1	NA
3.	Was the group interaction and discussion helpful?	5	4	3	2	1	NA
4.	Did you become more aware of the victim perspective in death notifications?	5	4	3	2	1	NA
5.	Do you feel more prepared than before to deliver compassionate death notifications?	5	4	3	2	1	NA
6.	Were the overhead transparencies helpful?	5	4	3	2	1	NA
7.	Was the training room satisfactory?	5	4	3	2	1	NA
8.	Was food service satisfactory?	5	4	3	2	1	NA
9.	(Trainers) I plan to offer this training in my department/agency.	5	4	3	2	1	NA

10. I would like more information about:_____

11. Please list additional comments:_____