



CHEVRON  
PUBLISHING CORPORATION

5018 Dorsey Hall Drive, Suite 104  
Ellicott City, MD 21042 USA  
Telephone: (410) 740-0065  
Fax: (410) 740-9213  
office@chevronpublishing.com

### Purpose and Scope

The **International Journal of Emergency Mental Health** provides a peer-reviewed forum for researchers, scholars, clinicians, and administrators to report, disseminate, and discuss information with the goal of improving practice and research in the field of emergency mental health.

The **International Journal of Emergency Mental Health** is a multidisciplinary quarterly designed to be the premier international forum and authority for the discussion of all aspects of emergency mental health.

The **Journal** publishes manuscripts (APA style) on relevant topics including psychological trauma, disaster psychology, traumatic stress, crisis intervention, emergency services, Critical Incident Stress Management, war, occupational stress and crisis, employee assistance programs, violence, terrorism, emergency medicine and surgery, emergency nursing, suicidology, burnout, and compassion fatigue. The **Journal** publishes original research, case studies, innovations in program development, scholarly reviews, theoretical discourse, and book reviews.

Additionally, the **Journal** encourages the submission of philosophical reflections, responsible speculations, and commentary. As special features, the **Journal** provides an ongoing continuing education series providing topical reviews and updates relevant to emergency mental health as well as an ongoing annotated research updates of relevant papers published elsewhere, thus making the **Journal** a unique and even more valuable reference resource.

© 2007

Chevron Publishing Corporation

In accordance with the American National Standard/National Information Standards Organization (ANSI/NISO), this journal is printed on acid-free paper.

# INTERNATIONAL JOURNAL OF EMERGENCY MENTAL HEALTH

**Founding Editor**  
George S. Everly, Jr., Ph.D.

**Editor**  
Richard L. Levenson, Jr., Psy.D.  
New York, NY

**Legal Editor**  
Gary E. Jones, Ph.D., J.D., M.P.H.  
University of San Diego

**Media Review Editor**  
Daniel Clark, Ph.D.  
Washington State Patrol

### Associate Editors

**Bertram S. Brown, M.D.**  
Former Director  
National Institute of Mental Health

**Raymond B. Flannery, Jr., Ph.D.**  
Harvard Medical School  
Boston, Massachusetts

**Jeffrey M. Lating, Ph.D.**  
Loyola College in Maryland  
Baltimore, MD

**Charles R. Figley, Ph.D.**  
Florida State University  
Tallahassee, Florida

**Paul J. Rosch, M.D.**  
President, American Institute of Stress  
Yonkers, New York

**Raymond H. Rosenman, M.D.**  
Mount Zion Hospital and Medical Center  
San Francisco, California

### Editorial Board

**David Alexander, Ph.D.**, University of Aberdeen, Aberdeen, Scotland • **Fahad Al-Naser, Ph.D.**, Director General, Social Development Office, Amiri Diwan, State of Kuwait • **Joseph A. Boscarino, Ph.D., MPH**, The New York Academy of Medicine, New York, NY • **Gilbert Burnham, M.D., Ph.D.**, Johns Hopkins School of Hygiene and Public Health, Baltimore, MD • **Atle Dyregrov, Ph.D.**, Director, Center for Crisis Psychology, Solheimsvik, Norway • **Murray N. Firth**, Canadian Critical Incident Stress Foundation, Creemore, Ontario, Canada • **Michael G. Gelles, Psy.D.**, U.S. Naval Criminal Investigative Service, Washington, DC • **Mark Goodman, Ph.D.**, University of Medicine and Dentistry of New Jersey, S.O.M., West Orange, NJ • **Melvin Gravitz, Ph.D.**, George Washington University School of Medicine, Washington, DC • **Russell J. Hibler, Ph.D.**, Union Memorial Hospital, Baltimore, MD • **A. MacNeill Horton, Jr., Ed.D.**, Psych. Associates, Towson, MD • **Jodi M. Jacobson, Ph.D.**, LCSW, Towson University, Towson, MD • **Col. Richard L. Jaehne**, University of Illinois Fire Service Institute, Champaign, IL • **Kendall Johnson, Ph.D.**, San Antonio High School, Claremont, CA • **Terence M. Keane, Ph.D.**, National Center for PTSD and Boston University School of Medicine, Boston, MA • **Gerry Larsson, Ph.D.**, Swedish Defense College, Karlstad, Sweden • **Jörg Leonhardt, M.S.W., Dipl.**, German Air Traffic Control, Langen, Germany • **Jen Lowry, Ph.D.**, Loyola College in Maryland, Baltimore, MD • **O. Lee McCabe, Ph.D.**, Johns Hopkins Medical Institution, Baltimore, MD • **Margaret McEntee, R.N., Ph.D.**, University of Maryland School of Nursing, Baltimore, MD • **Laurence Miller, Ph.D.**, Boca Raton, FL • **Theodore Millon, Ph.D., D.Sc.**, Harvard Medical School & University of Miami, Miami, FL • **Jeffrey T. Mitchell, Ph.D.**, University of Maryland, Baltimore, MD • **Shannon Gwin Mitchell, Ph.D.**, Thomson Medstat, Washington, DC • **Robert W. Motta, Ph.D.**, Department of Psychology, Hofstra University, Hempstead, NY • **Ralph Piedmont, Ph.D.**, Loyola College in Maryland, Columbia, MD • **Stanley Platman, M.D.**, University of Maryland Medical School and Helix Health System, Baltimore, MD • **Albert R. Roberts, Ph.D.**, Rutgers University, Piscataway, NJ • **Robyn Robinson, Ph.D.**, Director, Trauma Support Consultants, North Carlton, NSW, Australia • **Glenn R. Schiraldi, Ph.D.**, University of Maryland, College Park, MD • **SSA Donald Sheehan**, Federal Bureau of Investigation, (Retired) • **Martin Sherman, Ph.D.**, Loyola College in Maryland, Baltimore, MD • **Beth Hudnall Stamm, Ph.D.**, Dartmouth Medical School, Hanover, NH • **Susan Villani, M.D.**, Kennedy Krieger Institute, Baltimore, MD • **Victor Welzant, Psy.D.**, International Critical Incident Stress Foundation, Ellicott City, MD • **Mary Beth Williams, Ph.D.**, LCSW, Warrenton, VA

**International Journal of Emergency Mental Health** (ISSN 1522-4821) is published quarterly by Chevron Publishing Corporation, Inc., 5018 Dorsey Hall Drive, Suite 104, Ellicott City, MD 21042 USA. Fourth class postage rates paid at Ellicott City, Maryland.

- **SUBSCRIPTION PRICES: 2007** (four issues): Institutions: \$385.00 (Foreign: \$465.00); Individuals \$77.00 (Foreign: \$108.00) payable in U.S. funds through a U.S. bank. Credit card orders may be placed by calling (410) 740-0065.
- **SINGLE ISSUES:** Available from the publisher for \$25.00 per issue.
- **CHANGE OF ADDRESS:** Please inform the publisher at least six weeks prior to any change. If possible, include old mailing label.



## *Call for Papers*

# INTERNATIONAL JOURNAL OF EMERGENCY MENTAL HEALTH

Invitation for submission of case studies, literature reviews, anecdotal and field reports, and empirical studies on posttraumatic stress disorder, emergency mental health, crisis intervention, Critical Incident Stress Management, burnout, compassion fatigue, and other relevant topics for publication in the International Journal of Emergency Mental Health for 2007 - 2008.

Submit manuscripts in triplicate as well as an electronic version in Word format to:

**Richard L. Levenson, Jr., Psy.D., CTS**  
135 East 50th St., Suite 110 • New York, NY 10022  
[drlevenson@att.net](mailto:drlevenson@att.net)

Instructions for authors can be found on-line at:  
[www.chevronpublishing.com/authorinfo.pdf](http://www.chevronpublishing.com/authorinfo.pdf)

---

INTERNATIONAL JOURNAL OF  
**EMERGENCY MENTAL HEALTH**

Volume 9 • Number 1 • Winter 2007

**ORIGINAL ARTICLES**

- 5 Precipitants to Psychiatric Patient Assaults: Review of Findings, 2004-2006, with Implications for EMS and Other Health Care Providers  
*Raymond B. Flannery, Jr.*
- 13 Line-of-Duty Death: Psychological Treatment of Traumatic Bereavement in Law Enforcement  
*Laurence Miller*
- 25 Associations Between Major Life Events, Traumatic Incidents, and Depression Among Buffalo Police Officers  
*Tara A. Hartley, John M. Violanti, Desta Fekedulegn, & Michael E. Andrew*
- 37 Psychological Debriefing in Cross-Cultural Contexts: Ten Implications for Practice  
*Stephen Regel, Stephen Joseph, & Atle Dyregrov*

**BOOK EXCERPT**

- 47 World War II Survivors: Lessons in Resilience  
*Glenn R. Schiraldi*

**SELECTED ABSTRACTS FROM THE 9<sup>TH</sup> WORLD CONGRESS ON STRESS,  
TRAUMA & COPING**

- 55 *Richard L. Levenson, Jr., Jeffrey M. Lating, Martin F. Sherman, George S. Everly, Jr., Traci P. Martino, Victor Welzant, Amie C. Kolos, David F. Wee, Debra A Pender, Karen K. Prichard, Danny W. Pender, Leslee Sandberg, Kathryn Goddard, Kelly Jones, Kathryn Lee, Sidney Lutz, Shirley Pike, and Nancy Veldhuizen, Charles P. Dunn, Edward Dale, Suzanne B. Phillips, Dianne Kane, Heather Ziemba, Jacqueline Jennett, Dwight A. Polk, Ray L. Sheets, Jr., Andrew T. Young, Thomas E. Webb, Amie C. Kolos, Abigail S. Malcolm, Sheila Gillespie Roth, Peggy Kearney, & Robert Reed.*

---

**EMERGENCY MENTAL HEALTH UPDATES - Jeffrey M. Lating, Associate Editor**

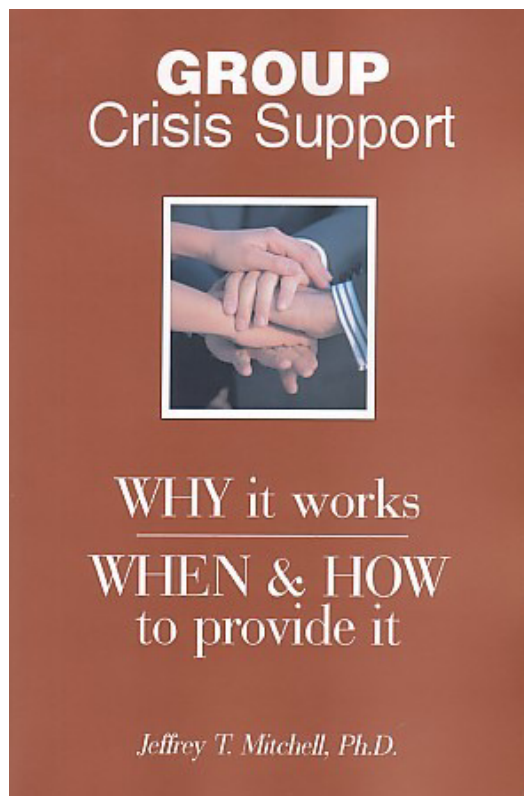
- 72 Selected Annotated Journal Resources  
*Rebekah L. Horst and Karina E. Chapman*
- 

**MEDIA REVIEWS - Daniel Clark, Media Review Editor**

- 82 War and the Soul: Healing Our Veterans from Post-traumatic Stress Disorder  
*By Edward Tick*
- 83 Resiliency After Violent Death: Lessons for Caregivers  
*From: Gift From Within*

# NEW for 2007 • Exclusively from Chevron!

## *A New Book and DVD by Jeffrey T. Mitchell*




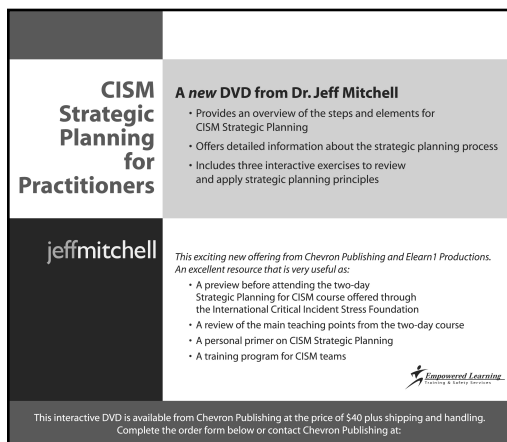
**Catalog #MIT5**  
**Paperback 186pp (2007)**  
**ISBN 13:978-1-883581-24-4**

**\$30.00**

### **Group Crisis Support** **Why it works** **When & How to provide it**

Jeffrey T. Mitchell, PhD

*Group Crisis Support* is a straightforward, practical guidebook for anyone providing either crucial information or crisis support services to distressed groups. More than a hundred years of sound crisis intervention theory and positive-outcome research back up the guidelines in the book. *Group Crisis Support* provides valuable information for those recently trained as well as the more experienced peer support personnel and crisis intervention professionals. It contains thoughtful crisis management strategies and well-referenced crisis intervention procedures for both large and small groups that will undoubtedly enhance the group management skills of trained crisis support personnel. *Group Crisis Support* is an invaluable tool for crisis response teams in schools, businesses, church groups, emergency medical services, fire services, law enforcement organizations, and the military. 



**Catalog #DVDSP**  
**(DVD)**

**\$40.00**

### **CISM Strategic Planning** **for Practitioners**

Provides an overview of the steps and elements for CISM Strategic Planning — offers detailed information about the strategic planning process and includes three interactive exercises to review and apply strategic planning principles.

**Order by phone, Monday-Friday, 9-5 EST, (410) 740-0065**

**— or —**

**Order online 24/7 at [www.chevronpublishing.com](http://www.chevronpublishing.com)**

## Precipitants to Psychiatric Patient Assaults: Review of Findings, 2004-2006, with Implications for EMS and Other Health Care Providers

Raymond B. Flannery, Jr.  
The Massachusetts Department of Mental Health  
and  
Harvard Medical School

*Abstract: Violent psychiatric patients present a safety risk for Emergency Medical Services (EMS) personnel and other health care providers. Although there have been numerous studies of the demographic and clinical characteristics of assaultive patients, these studies have yielded limited information in predicting violence. Recent research has begun to examine possible specific precipitants to patient assaults. This paper reviews the published studies from 2004 to 2006. Psychosis, organic impairment, staff interactions, and limit setting were cited as frequently occurring precipitants. The implications of these findings and specific strategies to reduce these precipitant risks for EMS and other health care providers are presented. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 5-11].*

**Key words:** Emergency Medical Services, EMS, health care safety, patient assaults, precipitants

The violent psychiatric patient presents a safety risk for staff providing care (Occupational Safety and Health Administration, 1996). This is true for prehospital Emergency Medical Services (EMS) personnel (Grange & Corbett, 2002; Mechem, Dickinson, Shofer, & Jaslow, 2002) as well as hospital inpatient and community health care providers (Davis, 1991; Busch & Shore, 2000; Flannery, Juliano, Cronin, & Walker, 2006a). These assaults may result in death, permanent disability, medical injury, psychological trauma, medi-

cal and legal expense, sick leave utilization, industrial accident claims, and lost productivity (Davis, 1991).

Extensive research on the demographic and clinical variables of assaultive patients has revealed the most likely assailants to be either older male patients with a diagnosis of schizophrenia and with histories of violence toward others and substance use disorder or younger, male or female patients with a diagnosis of personality disorder and histories of violence toward others, personal victimization, and substance use disorder (Davis, 1991; Busch & Shore, 2000; Flannery et al., 2006a). Although past violence toward others, personal victimization, and substance use disorders (Flannery, Hanson, Corrigan, & Walker, 2006b) have been associated with subsequent violence, in general the patient characteristic studies have yielded limited information of predictive value (Daffern & Howells, 2002; Flannery et al., 2006a). This has led researchers to begin to examine specific precipi-

---

**Raymond B. Flannery, Jr., PhD**, is Director of The Assaulted Staff Action Program (ASAP) and Senior Psychologist, Worcester State Hospital, Massachusetts Department of Mental Health. Dr. Flannery is on the faculties of Harvard and the University of Massachusetts Medical Schools. Correspondence regarding this article should be directed to: Raymond.Flannery@dmh.state.ma.us.

tants for assault in specific incidents in an effort to better predict possible instances of patient assault.

The first review of the precipitant literature (Flannery, 2005) surveyed the period from 1990 through 2003. There appeared to be only six peer-reviewed, empirical studies. Common precipitants in these studies from different nations included psychosis, excess sensory stimulation, staff restrictions of patient behaviors, denial of services, and provocation by others. These initial studies have led to a sharp increase in subsequent precipitant research.

The purpose of this paper is to continue to review of the burgeoning empirical literature on precipitants to psychiatric patient assaults since the first review (Flannery, 2005). This study examined the research from 2004 through 2006 to ascertain if there were any commonalities of precipitants across studies and, if so, to present initial risk management strategies for EMS and other health care providers to address these common precipitants.

## METHOD

A detailed abstracts search of the literature was conducted utilizing the National Archives of Medicine (Pub Med) abstracts and the American Psychological Association's Psychological Abstracts. Since there is currently no common agreement on a keyword for "precipitant," the following key words were abstracted to ensure thoroughness: *client characteristics, patient assailant characteristics, precipitants, predictors, risk factors, and staff/victim characteristics*. The search covered the years June, 2003 through June, 2006, as some of the 2003 articles did not actually appear in print nor in the abstracts until 2004. Reprints of all citations were obtained and common information across studies was recorded.

### The Empirical Findings

Table 1 presents a chronological summary of the fifteen, peer-reviewed, empirical studies that were published during this time period (Crownier, Peric, Stepic, & Lee, 2005; Daffern & Howells, 2002; Delaney & Fogg, 2005; Duxbury & Whittington, 2005; Fagan-Pryor, Haber, Dunlap, Stanley, & Wolpert, 2003; Flannery, Peterson & Walter, 2005; Flannery, Laudani, Levitre, & Walker, 2006c; Ilkiw-Lavalle & Greneyer, 2003; Meehan, McIntosh, & Bergen, 2006; Mellesdal, 2003;

Troisi, Kustermann, DiGenio, & Siracusano, 2003; Nolan et al., 2003; Secker, Benson, Balfe, Lipsedge, Robinson, & Walker, 2004; Waldheter, Jones, Johnson, & Penn, 2005; Winstanley & Whittington, 2004). There were a total of 2,372 assault incidents reported in these studies from Australia, Italy, Norway, the United Kingdom, and the United States. The assailants in these studies were primarily public-sector, adult inpatients. There were two studies of forensic patients and one study of child patients. Research assessment methodologies varied widely and included interviews, test batteries, record reviews, or combinations of these assessment approaches.

There was remarkable uniformity of precipitants across nations. The most common precipitants included patient precipitants of psychosis (especially with hostility), organic impairment, excess sensory stimulation, and boundary violations (threats, assaults by others on patient), and staff precipitants of denying services, setting limits, and being perceived by patients as uninvolved.

## DISCUSSION

This study's findings are consistent with findings in the six studies in the previous review (Flannery, 2005). There appear to be common precipitants across differing patient populations and across nations for a fifteen-year period in both cross-sectional and longitudinal studies. Common patient precipitants included psychosis, organic impairment, excess sensory stimulation and boundary violations. Common staff precipitants included denial of services, setting limits or restrictions, and being perceived by patients as uninvolved. This consistency of content over a long period of time in various parts of the world suggests the possibility of identifying potential precipitants before they emerge and/or developing risk management strategies to address their presence in preventing or mitigating subsequent patient assault.

This study's findings also reflect a 150% increase in the research effort focused on precipitants. These early, consistent, and common worldwide findings point to the importance of this area of experimental inquiry. The field will need to develop common operational definitions of the various precipitants as well as to develop a common assessment procedure to enhance the generalizability of findings across studies. Other populations need to be studied, including patients in the private sector inpatient facilities, patients in public and

private community-based facilities, and children and adolescents in public and private facilities. This research should include age, social class, ethnic or racial factors, and other fundamental variables that may need to be included. The full range of psychiatric diagnoses should be included in each study as well. Over time, these studies should result in a better understanding of the various precipitants and improved risk management studies to further enhance patient and care provider safety.

## Risk Management Implications

This review's findings suggest the need for risk management strategies in addressing the more frequently occurring precipitants. These strategies are meant to be helpful suggestions to be considered in providing care to specific patients. These strategies are not exhaustive, will likely not work in all circumstances, and are not meant to replace effective strategies that the care provider currently utilizes.

*Psychosis/Excess Sensory Stimulation.* Patients with psychosis are experiencing problems with the neurotransmitters in the brain, problems that may result in unusual cognition, intense feelings, and strange behaviors. Very often these patients can communicate in simple ways with care providers, even when these patients are in a psychotic state. These patients are sensitive to being rejected or ridiculed and are very alert to stigmatizing comments or behaviors.

As would be the case with most humans, having one's brain capacity fail and having an awareness of that failure can be frightening, anxiety-provoking, terrifying, and, in some cases, literally traumatizing. These patients correctly perceive themselves to be out of control of their brain functioning. It is reasonable to assume that as many as 80% of these patients have a prior history of psychological trauma in some form of personal victimization, so there often may be a basic and general distrust of others that arises from the present psychotic state as well as the previous victimizations.

One helpful approach to these patients is to address them as Mr., Mrs., or Ms., leave a wide margin of personal space, state clearly who you are and why you are there, and tell the patient where he or she is, and what care interventions are being considered and why. Be empathic and help the patient identify and express his or her painful feeling states. State that you are a care provider, not a police officer. Make a therapeutic alliance with the patient and ask the patient to participate in developing his or her treatment plan

with you (e.g. permitting the patient to walk to the ambulance rather than be taken in restraints).

Special care and time is needed with those who are guarded or paranoid or with patients who are psychotic, hearing command hallucinations to harm others when you ask them about this, and who have been self-medicating their emotional distress with drugs or alcohol. Service should be provided calmly in a reassuring manner and with minimal stimulation, as the brains of these patients may be easily overwhelmed by excess sensory stimulation. These patients may become assaultive when they are having command hallucinations to harm others, when they feel out-of-control, when they do not want to go to a hospital, and when they are denied services.

Psychotic patients with the above characteristics, along with histories of violence toward others, personal victimization, and substance use disorder, further present an increased risk of assault. If the patient is behaviorally out-of-control and alternatives to restraint and seclusion, such as talking, the passage of time, or the provision of social support, are not helpful, implement restraint procedures as quickly as possible. Have at least four persons involved in the restraint, and use restraint only for safety reasons. Restraint is not for punishment or some form of extended behavioral control. It is utilized only for the safety of the patient and/or others.

*Organic Impairment/Excess Sensory Stimulation.* Patients with impairment have structural damage to the brain in some form. They present a risk of assault because they have trouble understanding and responding to what is happening around them and to them. This absence of information and misunderstanding of common interpersonal cues may result in these patients feeling frightened, anxious, terrified, and out-of-control. They strike out as a form of self-defense at persons and situations that they perceive as posing imminent harm. Sudden changes to the environment can become very confusing and again frightening. Moves from home to ambulance and from the ambulance to the hospital can be fully disorienting. Sadly, striking out in these circumstances may represent a survival strategy.

Patients with these impairments are greatly assisted by calm tones of voice, caring support, a clear description of what is or is about to happen, clear and simple directions of what is expected, providing personal control and involvement for the patient to the extent possible, and repeating these pieces of information on an ongoing basis. Asking the

Table 1  
Empirical Studies of Patient Precipitants:

Study	Assault Incidents	Setting	Country	Duration of Study	Main Assessments	Main Findings
Fagan-Pryor et al., 2003	52	VAMC Inpatient	USA	3 Months	Interviews	Internal Stressors Cognitions, Symptoms, Outpatient Feelings, Interpersonal Stressors Personality Conflicts, Abrasive Words, Money, Family Issues Personal Space, Staff Uninvolvement
Ilkiw-Lavalle 2003	47	Public Sector Inpatient	Australia	4 Months	Semi-structured Interviews	Patients' Illnesses Poor Communication Limit Setting
Mellesdal, 2003	981	Private Sector Inpatient	Norway	36 Months	Incident Report Forms	Limit Setting Problems in Communication Physical Contact
Nolan et al., 2003	70	Private Sector Inpatient	USA	22 Months	Interviews and Videotaping	Positive Psychotic Symptoms Psychotic Confusion
Troisi et al., 2003	80	Public Sector Inpatient	Italy	6 Months	Brief Psychiatric Rating Scale	Hostility
Secker et al., 2004	11	Public Sector Inpatient	UK	2 Months	Interviews	Lack of Staff Engagement



Table 1 (continued)

Study	Assault Incidents	Setting	Country	Duration of Study	Main Assessments	Main Findings
Winstanley & Whittington 2004	69	Public Sector Inpatient	UK	8 months	Interviews	Patient Cognitive Processing, Misunderstanding
Crowner et al., 1994	55	Public Sector Inpatient	USA	24 Months	Videotaping	Threatening Behaviors Intrusive Behaviors
Daffern et al., 2005	110	Public Sector Inpatient (Forensic)	Australia	12 Months	Battery of Tests	Psychosis
Delaney & Fogg, 2005	69	Private Sector Inpatient (Child)	USA	2 Months	Record Review	Agitation, Paranoia, Threats Assaults by Others
Duxbury & Whittington, 2005	162	Public Sector Inpatient	UK	1 Month	Management of Aggression and Violence Attitude Scale, Semi-Structured Interview	Mental Illnesses Poor Communication
Flannery, et al., 2005	20	Public Sector Inpatient	USA	18 Months	Record Review and Interview	Denial of Services Acute Psychosis
Waldheter, et al., 2005	29	Private Sector Inpatient	USA	2 Months	Battery of Tests	Hostile Attribution, Personalizing Basis
Flannery, et al., 2006c	590	Public Sector Inpatient and Community	USA	36 Months	Record Review and Interview	Denial of Services Acute Psychosis Excess Sensory Stimulation
Meehan et al., 2006	27	Public Sector Inpatient (Forensic)	Australia	2 Months	Group Interviews	Psychosis Organic Impairment Impulsiveness

patient his or her understanding of what is to happen and asking if this is permissible with him or her, where possible, will permit the care provider to gauge the patient's understanding with any cognitive limitations and will develop a caring therapeutic alliance that will make providing services an easier and more efficacious process.

*Boundary Violations.* Since so many psychotic patients have been victims of psychological trauma, assume that the patient that you are providing care for may be a victim as well. Stay a reasonable distance away from your patient. State clearly who you are and why you are there. Ask if you may be of help and ask what is the best way to do this. Actively involve the patient in the process so that he or she does not feel out of control, as he or she did during the victimization episode. Ask permission to approach closer, repeat again who you are and why you are there. This is especially important to patients who are presently immobilized by medical illness or serious accident. Ask the patient to give you ongoing feedback about the care that you are providing and ask if anything that you are doing is bringing back intrusive memories of their current or prior victimization. A trauma victim may strike out if he or she feels under attack again.

*Care Provider Precipitants.* The staff precipitants of denial of services, restrictions on behaviors, and staff uninvolvement may have common themes for the patient of being rejected, treated unfairly, or treated perfunctorily. Assaults are sometime a common response. All care provider staff can be overwhelmed, overextended, or worn out at times, and routine medical care may become automatic. However, for psychiatric patients who have a lifetime of rejection and stigmatization, automatic care may be perceived as being shunted quickly aside and may be complicated by the patient's misunderstanding of the procedure because of the nature of his or her illness. For example, a routine flu injection may be perceived as a lethal dose of poison by a patient with paranoia. Direct eye contact, providing emotional support, and answering any questions is often all that is needed for the quiet provision of care.

Limiting and/or denying services may again make the patient feel rejected and angry. Sometimes it is helpful to tell the patient that you are doing this because you care about them, that the denial is due to their illness and not due to them personally, and that you will assist them in providing some ways to cope with the denial or limitations. Help them to remain in control. Always offer hope that things can change in the future and provide a reasonable time line, if

that is possible.

Risk management interventions such as these by EMS personnel in prehospital care and other health care providers in hospital and community health care settings should result in fewer assaults, greater patient and care provider safety, and enhanced service delivery and care.

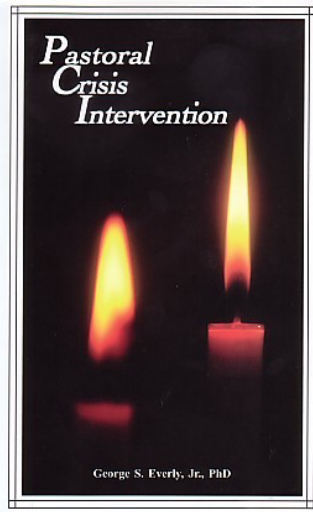
## REFERENCES

- Busch, A.B., & Shore, M.F. (2000). Seclusion and restraint: A review of the literature. *Harvard Review of Psychiatry*, 8, 261-270.
- Crowner, M.L., Peric, G., Stepic, F., & Lee, S. (2005). Assailant and victim behaviors immediately preceding inpatient assault on EMS *Psychiatric Quarterly*, 76, 243-256.
- Daffern, J., & Howells, K. (2002). Psychiatric inpatient aggression: A review of structural and functional assessment approaches. *Aggression and Violent Behavior*, 7, 477-497.
- Daffern, J., Howells, K., Ogloff, J., & Lee, J. (2002). Individual characteristics predisposing patients to aggression in forensic psychiatric hospital. *Journal of Forensic Psychiatry and Psychology*, 16, 729-746.
- Davis S. (1991) Violence in psychiatric patients: A review. *Hospital and Community Psychiatry* 42, 585-590.
- Delaney, K.R., & Fogg, L. (2005). Patient characteristics and setting variable related to use of restraint on four inpatient psychiatric units for youths. *Psychiatric Services*, 56, 186-192.
- Duxbury, J., & Whittington, R. (2005). Cause and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing*, 50, 469-478.
- Fagan-Pryor, E.C., Haber, L.C., Dunlap, D., Nall, J.L., Stanley, G., & Wolpert, R. (2003). Patients' views of causes of aggression by patients and effective interventions. *Psychiatric Services*, 54, 549-553.
- Flannery, R.B., Jr. (2005). Precipitants to psychiatric patient assaults on staff: Review of empirical findings, 1990-2003, and risk management implications. *Psychiatric Quarterly*, 76, 371-327.
- Flannery, R.B., Jr., Juliano, J., Cronin, S., & Walker, A. P. (2006a). Characteristics of assaultive psychiatric patients: Fifteen-year analysis of the Assaulted Staff Action Program (ASAP). *Psychiatric Quarterly*, in press.

- Flannery, R.B., Jr., Hanson, M.A., Corrigan, M., & Walker, A.P. (2006b). Past violence, substance use, and precipitants to psychiatric patient assaults: Eleven-year analysis of the Assaulted Staff Action Program (ASAP). *International Journal of Emergency Mental Health*, 8, 157-163
- Flannery, R.B., Jr., Laudani, L., Levitre, V., & Walker, A. P (2006c). Precipitants of psychiatric patient assaults on staff: Three-year empirical inquiry of the Assaulted Staff Action Program (ASAP). *International Journal of Emergency Mental Health*, 8, 15-22.
- Flannery, R.B., Jr., Peterson, B., & Walker, A.P. (2005). Precipitants of elderly psychiatric patient assaults on staff: Preliminary empirical inquiry. *Psychiatric Quarterly* 76, 167-175.
- Grange, J.T., & Corbett, S.W. (2002). Violence against emergency medical services personnel. *Prehospital Emergency Care*, 6, 186-190.
- Ilkiw-Lavalle, O., & Grenyer, B.F. (2003). Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services*, 54, 389-393.
- Mechem, C.C., Dickinson, E.T. Shofer, F.S. & Jaslow, D. (2002). Injuries from assaults on paramedics and firefighters in an urban emergency medical services system. *Prehospital Emergency Care*, 6, 396-401.
- Meehan, T., McIntosh, W., & Bergen, H. (2006). Aggressive behaviour in the high-secure forensic setting : The perceptions of patients. *Journal of Psychiatric and Mental Health Nursing*, 13, 19-25.
- Mellesdal, L. (2003). Aggression on a psychiatric acute ward: A three-year prospective study. *Psychological Reports*, 92, 1229-1248.
- Nolan, K.A. Czobor, P., Roy, B.B., Platt, M.M., Shope, C.B., Citrome, L.L., & Volavka, J. (2003). Characteristics of assaultive behavior among psychiatric inpatients. *Psychiatric Services*, 54, 1012-1016.
- Occupational Safety and Health Administration (1996). *Guidelines for preventing workplace violence in health care and social service workers*. Publication #3148. Washington, DC: United States Department of Health and Human Services.
- Troisi, A., Kustermann, S., DiGenio, M., & Siracusano, A. (2003). Hostility during admission interview as a short-term predictor of aggression in acute psychiatric male inpatients. *Journal of Clinical Psychiatry*, 64, 1460-1464.
- Secker, J., Benson, A., Balfe, E., Lipsedge, M., Robinson, S., & Walker, J. (2004). Understanding the social context of violent and aggressive incidents on an inpatient unit. *Journal of Psychiatric and Mental Health Nursing*, 11, 172-178.
- Waldheter, E.J., Jones, N., Johnson, E.R., Penn, D.L. (2005). Utility of social cognition and insight in the prediction of inpatient violence among individuals with severe mental illness. *Journal of Nervous and Mental Disease*, 193, 609-618.
- Winstanley, S., & Whittington, R., (2004). Aggressive encounters between patients and general hospital staff : Staff perceptions of the context and assailants' levels of cognitive processing. *Aggressive Behavior*, 30, 534-543.

# NEW for 2007 • Exclusively from Chevron!

## *New Books by George S. Everly, Jr.. . .*



**Catalog #EVE10**  
**Paperback 100pp (2007)**  
**ISBN 978-1-88351-1-18-3**  
**\$25.00**

### **Pastoral Crisis Intervention**

George S. Everly, Jr., PhD

*Pastoral Crisis Intervention* is one of those rare, truly groundbreaking books! Dr George S. Everly, Jr., who first coined the term “pastoral crisis intervention” and initially defined the field, now offers to define the practice. In this volume, Dr Everly, a true pioneer in the field of stress management, provides a useful guide to the rationale, theory, and practice of pastoral crisis intervention. He argues that the pastoral community is an essential resource in the effort to rebuild lives and communities in the wake of trauma and disaster, but that this resource is often under-prepared and often overlooked. This book dares to change that. *Pastoral Crisis Intervention* is essential reading for clergy, pastoral counselors, and laity alike. It should be mandatory reading for all students in formal religious education. ☺

## *... and George S. Everly, Jr., and James T. Reese*

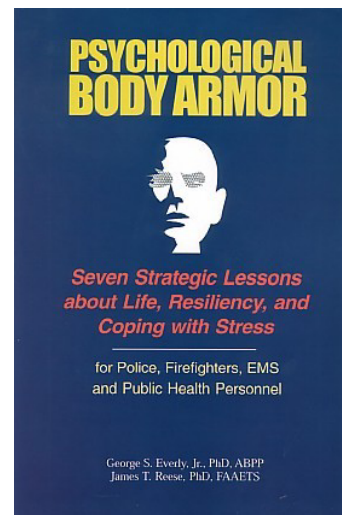
**Catalog #EVE9**  
**Paperback 100pp (2007)**  
**ISBN 13: 978-1-88358-17-6**

**\$25.00**

### **Psychological Body Armor**

George S. Everly, Jr., PhD and James T. Reese, PhD

*PSYCHOLOGICAL BODY ARMOR* is the first book written on strategic stress management, the most recent and advanced concept in the field of managing stress. This book goes beyond techniques and addresses the core values that set the stage for stress vulnerability as well as stress resistance and resiliency. The book will be of value to law enforcement, fire suppression, disaster response, nursing, emergency medical, as well as public health personnel...anyone who may be a “first responder.” The book will also be of assistance to those who work with these personnel such as counselors, chaplains, and family support personnel. Doctors Everly and Reese directly address key issues that are seldom, if ever, discussed in the context of emergency response. This book should be considered essential reading.



**Order by phone, Monday-Friday, 9-5 EST, (410) 740-0065**

**— or —**

**Order online 24/7 at [www.chevronpublishing.com](http://www.chevronpublishing.com)**

## Line-of-Duty Death: Psychological Treatment of Traumatic Bereavement in Law Enforcement

Laurence Miller

Independent Practice, Boca Raton, Florida

**Abstract:** *A line-of-duty death (LODD) strikingly brings home the risk and vulnerability of all law enforcement officers and affects the officer's peers, the entire department, the wider police community, and the officer's family. This article will place LODD in the context of general bereavement psychology, as well as describe some of its unique features. A variety of supportive and psychotherapeutic measures will be offered for helping peer and family survivors cope with this type of tragedy. This is one important area where police psychologists and community mental health clinicians can be of tremendous service in applying their specialized training in trauma therapy and grief counseling to the special needs of law enforcement and emergency services. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 13-23].*

**Key words:** *line-of-duty death, traumatic bereavement, critical incident stress, law enforcement psychology, police psychology*

In the world of law enforcement critical incidents, there are few events more traumatic to officers than the death of a comrade, or *line-of-duty death* (LODD; Blum, 2000; Henry, 2004). In addition to the normal grief and loss reactions that officers feel at the death of someone they worked with and knew, the death of an officer, even in a different department, even in a different city, reverberates with all officers because of the powerful identification factor: "It could happen to any of us." In addition, such deaths are traumatic for the families of deceased officers who have suddenly and often brutally

been deprived of a loved one in what is usually the prime of his or her life. This article will describe some of the unique features of LODD bereavement, as well as attempt to understand it within the context of general bereavement psychology. A variety of supportive and psychotherapeutic measures will be offered for helping peer and family survivors cope with this type of tragedy.

### Line-of-Duty Deaths: Facts and Stats

When people think of mass casualties involving police officers and other emergency service workers, they tend to evoke the September 11, 2001 terrorist attacks on the World Trade Center in New York. This was, indeed, the single dead-

---

Correspondence regarding this article should be directed to: Laurence Miller, PhD, Plaza Four, Suite 101, 399 W. Camino Gardens Blvd., Boca Raton, Florida 33432. (561) 392-8881. docmilphd@aol.com

liest day in the history of U.S. law enforcement, with 72 police officers killed in a single incident. But almost as many law enforcement personnel were slain by ordinary criminals around the country in 2001, representing a four-year high in murders of police officers. Every year at least 52 police officers are killed in the line of duty, and 26,000 others are injured in service-related assaults. Overall, since 1960, 2,219 police officers have been killed in the line of duty, and 328,000 more have been injured in assaults. Law enforcement's unpleasant little secret is that a high proportion of officers (43% in one study) are accidentally killed or nonfatally shot by their own gun or a fellow officer's weapon. A smaller proportion die by their own hand. Nevertheless, fewer officers are dying in the line of duty today than were back in the 1970s; this is largely attributable to better officer training, more cops on the street, better use of protective gear, and improved firepower of officers relative to the criminals they confront.

Police are most likely to be slain with a handgun and two-thirds of assailants have prior criminal records. Most police homicides occur at night, with Friday being the most dangerous day, and Sunday the least violent. Most officer deaths occur in the course of making an arrest; the next highest category is during workplace or domestic disturbance calls. The South is the most dangerous part of the US for police officers, with more than twice the number of LODDs occurring there as in any other region. A sizable number of officers also die in job-related accidents, which is a line-of-duty death that does not often get the same attention as deaths at the hands of criminals. Most of these involve car and motorcycle accidents (Anderson, 2002; Blau, 1994; Cummings, 1996; Geller, 1993; Haddix, 1999; Miller, 2005, 2006-b, 2006-c; Smith & Rodriguez, 2006; US Department of Justice, 2003; Violanti, 1999).

## Reactions of Fellow Officers to a Line-of-Duty Death

Few events are more psychologically destabilizing to a police agency than the death of one of their own in the line of duty. Blum (2000) describes several stages of the grief reaction to a fellow officer's LODD. In my experience, these do not necessarily occur in chronological "stages" per se, but I have observed these reactions in some form or another in most officers following a LODD within a department (Miller, 2006). Similar reactions have been described by Henry (2004).

*Shock and disbelief* are often the first reactions to a comrade's LODD. Officers may feel numbed and disoriented and "just go through the motions" of their jobs while trying to grapple with the enormity of what has just happened. Many report that they expect to see the slain officer at his desk or in his patrol car. A few will even reluctantly admit to quasi-hallucinations of the dead compatriot ("I saw Smitty standing in the hall, like he was really there"), which under these extreme circumstances is not necessarily a psychopathological reaction, but a form of sensory-perceptual wish fulfillment.

*Telling stories about the deceased* is a form of self-prescribed narrative therapy, wherein the officers share reminiscences and experiences involving their deceased colleague. Often, much of this takes place at the local bar. This is not necessarily a bad thing, as long as the alcohol is used moderately and constructively to oil the mechanism of self-expression in a supportive atmosphere, not self-destructively to drown feelings by getting smashed beyond reason and/or drinking alone.

Aside from states of intoxication, another place where officers should feel free to show tears is at the slain officer's funeral. It is here that the proper example of *grief leadership* by upper management can have a powerful healing effect. These tough guys need to see that normal expressions of grief do not make someone a weak person and that showing one's honest feelings in a dignified way is actually a sign of respect for the deceased (Miller, 1995, 1998b, 2000, 2003c, in press).

As time since the funeral passes, many surviving officers continue to experience a feeling of profound *sadness*. Officers may experience a sense of overwhelming fatigue, of feeling "drained" most of the time, of dragging themselves through their shifts. Appetite and sleep may be affected and there may be dreams of the slain officer. It is probably incorrect to label this as depression per se, because this is usually an expectable part of the grief process; however, some officers may actually become clinically depressed if they had a special relationship to the slain officer or if they have had a history of mood disorders or other problems in the past (Miller, 1999c, 2003b).

Sadness may be tinged with *anger*, which may be directed at several shifting targets. Anger at the perpetrator of the officer's death – whether a cold-blooded shooter in a gunshot death or a stupidly careless motorist in a traffic fa-

tality – is common, often fueled by what cops see as the inadequacies of the criminal justice system in redressing this outrage against one of their own. Anger may also be directed toward members of the perpetrator’s broader group, such as all lawbreakers or all traffic violators. This may lead to overzealous enforcement efforts on the surviving officers’ parts, which in some cases may escalate to abuse-of-authority complaints (Miller, 2004). Even if not leading to work problems per se, a general smoldering resentment may adhere to friends, family members, and the general civilian population who “just don’t get it” about the dangerous work police officers do, and who are regarded as spoiled, ungrateful recipients of society’s protections that these officers risk their necks to provide.

Some of this anger may be stoked by *survivor guilt*, especially where the LODD incident involved a number of officers on the scene: “There but for the grace of God could’ve gone I.” More rarely, grief over the comrade’s death may be admixed with anger at the slain officer himself, where it is believed that he somehow contributed to his own death by impulsivity, negligence, or frankly illicit behavior – especially if his actions also put other cops in danger and/or may now result in more work and stress for the surviving officers: “Dammit, we told Manny to wait for back-up, but he always had to be Mr. First-In;” “What the hell was Jonesy doing in a high-speed chase during a damn thunderstorm? We all could’ve been killed in that pile-up, and now we’re all gonna be investigated;” “I didn’t want to believe J.D. was involved in that drug deal, but it looks like the bangers greased him, and now we gotta run this down and fix it.”

In still other cases, there may be anger at command staff who assigned the patrol or operation, or more generally at the department or city government for cutting manpower and equipment that might have prevented the death, or for administratively hamstringing the cops’ ability to adequately control the scene through the imposition of naively soft policies for dealing with dangerous suspects.

Although most officers in most departments are able to resolve their grief and get on with their life and work, a few are unable to let go of the LODD and may experience a *permanently altered world view* about policing, society, or life in general. A small percentage of these individuals may leave the police profession, but most hang on, although with a radically changed perspective of their job and their role in society. Still other officers work out their distress by becoming disciplinary problems – although, in my experience, it is

rare for this to happen in officers who have never had these problems before. In such cases, it is important to determine if the LODD or other traumatic critical incident is the main contributor to the problem behavior, or if it represents the continuation or accentuation of a previously existing and long-standing problem (Miller, 2003b, 2004). In the best cases, surviving officers continue to do their good work as a way of honoring their fallen comrade.

## Family Survivors of a Line-of-Duty Death

The untimely death of a loved one under any circumstances is a wrenching experience, and family members of a slain law enforcement officer must undergo the further trauma of investigations, court proceedings, and media exposure, during which they will be forced to relive the tragedy again and again.

To add further stress, not all family survivors of slain officers are treated equally, and the difference typically depends on the cause of death, with families of officers slain by criminal assailants tending to receive preferential treatment over those killed in accidents (Haddix, 1999) or judged to be suicides (Miller, 2005). Perhaps this relates to the warriormentality notion that the death of a cop while facing down a formidable adversary is somehow more noble than that caused by a glitch of fate or a personal check-out. Whatever the case, law enforcement agencies must assure that all families get the care and consideration they deserve.

### *Common Family Reactions to an Officer’s LODD*

Family members, especially spouses, of slain officers typically show a number of physical and psychological reactions in the aftermath of their loved one’s death (Danto, 1975; Niederhoffer & Niederhoffer, 1978; Rynearson & McCreery, 1993; Sawyer, 1988; Sheehan, 1991; Sprang & McNeil, 1995; Spungen, 1998; Stillman, 1987; Violanti & Aron, 1994). Many of these are similar to the symptoms of traumatic bereavement experienced by the slain officer’s colleagues, but are usually more long-lasting. That’s because the other officers have their own intact families to provide support and, when necessary, they can mentally distance themselves from their preoccupation with their comrade’s death by immersing themselves in work and their own family activities. No such respite is afforded family members of the deceased officer, who must live with the tragedy 24/7 and will experience the practi-

cal and emotional effects of the loss for years to come.

For many family survivors, the first news of the LODD strikes a *mortal blow to the self*, evoking their own sense of personal loss. Family members are often preoccupied with the nature of the injuries inflicted on the officer, the brutality of the killing, the types of weapons used, and whether and how much the officer suffered. Families may clamor for information about the identity of the murderer and the circumstances under which the killing occurred. Unlike accidental death, murder always involves a human perpetrator, and the greater the perceived intentionality and malevolence of the killing, the greater the distress of the survivors (Carson & MacLeod, 1997; MacLeod, 1999; Miller, 1998c; Spungen, 1998). Indeed, the psychological distress of family members bereaved by any kind of homicide can persist with undiminished intensity for as long as five years following the murder (Kaltman & Bonanno, 2003).

Family survivors may be seized with an *impulse to action*, an urge to “do something.” A deep and justifiable *anger* toward the murderer alternately smolders and flares as the investigation and trial meander along. Even after sentencing of the perpetrator, the anger may persist for years. A common coping dynamic consists of ruminating on fantasies of revenge. Actual vengeful attacks by family members on perpetrators are extremely rare, probably due in large part to the sheer impracticability of getting at the murderer as well as to the basic moral values and common decency of most families, who are not looking to correct one atrocity with another. Some of the anger may be projected onto the department: “You gave him this dangerous assignment. You took him away from me.” Most families eventually direct their energies toward efforts to aid in the apprehension and prosecution of the killer, which can be seen as either a help or hinderance by investigators and prosecutors.

Even more common than anger, a pervasive *free-floating anxiety*, or “fear of everything,” begins to loom in the survivors’ consciousness, beginning with their first news of the slaying and persisting for several years or more. Survivors’ heightened sense of their own vulnerability may spur them to change daily routines, install house and car alarms, carry weapons, or refuse to go to out after dark or to visit certain locales. There may be phobic avoidance of anything related to the trauma, including people, places, certain foods, music, and so on. Due to a combination of aversion and anger, family members may shun even well-meaning approaches by departmental representatives, other officers and

their families, or anyone associated with law enforcement. They may have an ambivalent relationship with their slain spouse’s police artifacts: some spouses may sleep in their deceased loved one’s uniform, others may burn it.

Family survivors may experience psychophysiological *hyperstartle responses* to such ordinarily nonthreatening stimuli as TV crime shows or news stories of any tragedy, including noncriminal deaths such as traffic fatalities or fatal illnesses. The survivors’ usual range of territorial and affiliative activity becomes constricted as the home is turned into a protective fortress, strangers are avoided, and unfamiliar surroundings are circumvented. All family members may be outfitted with pagers and cell phones, and may have to submit daily schedules of activity, as there develops a compulsive need for family members to be close at hand or reachable at a moment’s notice. Older children and adolescents may resent this “babying” restriction of their autonomy and independence.

While some family members come to develop a feeling of support and kinship with fellow bereaved victims and co-victims of tragedy, others experience a profound sense of *isolation and alienation*, feeling like lepers or pariahs, cast out of a pre-trauma state of normal existential comfort that the majority of civilians take for granted to assuage their sense of vulnerability, but which no longer is a coping option for the family survivors of a LODD: “We know better – the world is a cruel and ugly place.” Survivors may have frequent *disturbing dreams* of the imagined death of the officer, or wish-fulfillment dreams of protecting or rescuing him. This may be compounded by *irrational guilt* if they somehow feel, however illogically, that they should have “done more” to keep their loved one safe: “He had the flu that day, but he said ‘no big deal,’ he needed the overtime to cover the trip he planned for us for our twentieth anniversary and was glad to go in. I should never have let him go to work sick for a goddamn stupid vacation – I’ll never take a vacation again!”

Everybody’s health suffers. Common *psychophysiological disorders* include appetite and sleep disturbances, gastrointestinal and cardiovascular symptoms, decreased resistance to infections, and increased anxiety and depression. A few family members may show classic signs of PTSD.

### *Aggravating Factors in Family Reactions to a LODD*

Certain factors exacerbate the stressful challenges of



families trying to cope with an officer's LODD. "Cop-killed-in-the-line-of-duty" stories are second only to "cop-gone-bad" stories in terms of being media favorites. Indeed, where the media can connect these two themes, the prurient interest level of the story rises exponentially. The elevated visibility and scrutiny of such *high-profile cases* virtually assures that family members will be assailed by the media, using every available channel – phone calls, home visits, mobbing on the courthouse steps, and so on. Even if the family could, for a few blessed moments, forget the tragedy they are going through, there will always be the TV, radio, internet chatter, and so on, to remind them. Alternatively, in low-profile cases, some families may feel that the plight of their loved one and themselves is being totally ignored: "Doesn't anyone even care what happened?"

LODD-bereaved police family members form a small subfraternity within the larger police extended family system (Miller, 2006-c, 2007-a, in press). This may lead to a *contagion effect*, with other spouses and families knowingly or unconsciously avoiding the LODD survivors, fearing the reminder of their own loved one's vulnerability. As noted above, families of LODDs involving accidents may not be afforded the same respect and consideration as those slain by criminal assailants; still less support and greater avoidance may be shown to families of officers known or suspected to have died by their own hand (Cummings, 1996, Miller, 2005).

On the other side, officer LODD survivors may not be fully able to bond with other types of non-police bereaved family members whose loved ones died of illness or other causes. Families of these civilian murder victims may have difficulty relating to the unique stresses that families of law enforcement LODD experience. In some cases, civilian family survivors of homicide may actually resent the LODD families because of the preferential treatment they believe a slain officer's case gets over those of mere citizens. All this serves to heighten the LODD police family's sense of isolation and alienation from any kind of community support.

### *Family Coping Strategies in a LODD*

*Grief work* is the term often used for the psychological process that moves the survivor from being preoccupied with thoughts of the murdered victim, through painful recollections and resolutions of the loss experience, to the stage, where possible, of integrating the experience into one's world-meaning system (Parkes, 1975; Parkes & Brown, 1972). Those who appear to adapt best to painful and traumatic experi-

ences generally seem to possess a range of available coping strategies and resources that permit them greater flexibility in dealing with the particular demands of the traumatic event (Aldwin, 1994; Bowman, 1997; Calhoun & Tedeschi, 1999; Miller, 1998a; Silver & Wortman, 1980). In fact, psychotherapists may capitalize on the individual's and family's natural coping processes to aid them in their grief work and eventual resolution of the trauma.

Following a LODD, police families may employ a range of coping strategies to help themselves make it through the aftermath of the death (Sheehan, 1991; Violanti, 1999). Some try to *mentally distance themselves* from the experience, at least for brief periods of time, by immersing themselves in work or family responsibilities. The myriad and picayune details surrounding the arrangements for funerals and financial matters in the wake of the death can abet a temporarily adaptive intellectualization process that protects the survivor against being emotionally overwhelmed.

To this end, many families who describe feeling drained and beaten by their own emotional storms make a *conscious effort to exert self-control* whenever they can, keeping their feelings to themselves, especially in front of outsiders. Paradoxically, this may cause well-meaning others to urge them not to "hold back" and to "let it all out," when that's exactly what the family members may have been doing for the past 48 hours, and now crave some composure so they can feel normal even for a brief time.

Many families *seek social support* and are able to accept sympathy, understanding, and advice from friends and family members. On the other hand, some withdraw from people and *isolate themselves*. Others become irritable and snappish, and eventually alienate potential sources of support. Children may complain that their surviving parent is "taking it all out on us." Many survivors are so cracked and scarred emotionally that they fear any kind of human contact will cause them to lose what little emotional control they have and "split wide open." Others are still dealing with rage and resentment at how "other people just get to go along with their damn lives because their spouse wasn't a cop."

### **Psychological Interventions for Family Survivors of a Line-of-Duty Death**

The principles of psychological intervention with family survivors of a LODD represent applications of generally validated principles of critical incident debriefing, grief counsel-

ing, and bereavement therapy to the special population of law enforcement families (Green, 1993; Kirschman, 1997; Lindy, Grace, & Green, 1981; Miller, 1995, 1998b, 2006-a, 2006-c, 2007-a, in press; Mitchell & Everly, 1996, 2003; Rynearson, 1994, 1996; Sprang & McNeil, 1995; Spungen, 1998; Violanti, 1996, 1999; Worden, 1991).

### *Line-of-Duty Death Debriefing*

Mitchell & Levenson (2006) have recently elaborated a specialized law enforcement debriefing model for officers coping with a LODD. They point out that on the day of the LODD, a full seven-phase critical incident stress debriefing, or CISD (Mitchell & Everly, 1996, 2003), is probably far too emotionally overwhelming for most personnel who have just endured the death of a colleague and friend. Accordingly, this more extensive intervention is postponed for three to seven days following the slain officer's funeral.

In the interim, the immediate post-LODD debriefing is modified into a streamlined, five-phase protocol that is conducted on the day of the death and usually lasts between 30 and 45 minutes. Its objectives are to disseminate accurate information about the incident and its aftermath and to prepare the personnel to face the turmoil of the next few days, as they go through the funeral and mourning process. Additionally, it is helpful in guiding people in self-care and "buddy support" as they deal with the loss of a colleague. The phases of the modified LODD debriefing are:

*Introduction.* This is kept as brief as possible. In general, for intradepartmental debriefings, everybody pretty much knows everybody already.

*Fact phase.* Missing or ambiguous information is almost always more stressful than the "grim facts," no matter how unpleasant those may be. Officers who were present during the LODD are asked to briefly describe what happened so that others can obtain at least the most basic and pertinent facts of the situation.

*Reaction phase.* The participants are asked, "What are you having the most difficulty with right now?" The rationale is that the overall "worst part" of the situation (as is asked in the traditional debriefing model) typically cannot yet be solicited because, at this early point, most of the officers are still emotionally raw and/or numb and haven't had time to come to grips with what the overall worst part may be. For many, the worst part will occur during or after the funeral.

*Teaching phase.* The teaching phase is used to prepare officers for the funeral and to encourage them to do things that will help them to take care of themselves as they cope with this loss.

*Reentry phase.* For the most part, this is a question, answer, and summarization process to help officers move into the next phase of the tragedy.

### *Psychotherapy for Bereavement: Support and Control*

Spungen (1998) cites Getzel and Masters' (1984) delineation of the basic tasks of family bereavement therapy after death by homicide: (1) helping the family understand and put into perspective the rage and guilt they feel about their loved one's murder; (2) helping survivors examine their grief reactions and other people's availability to them so that they regain their confidence in the social order; (3) helping the family accept the death of their relative as something irrevocable yet bearable; and (4) assisting members of the immediate and extended kinship system in establishing a new family structure that permits individual members to grow in a more healthy and fulfilling manner.

One basic element of all effective psychotherapy is to provide *support*. In cases of LODD bereavement, this encompasses emotional, educative, and material support. In addition to regularly scheduled sessions, psychotherapists should be *available* by phone or beeper for family members who just need to reach out for a few words during periods of crisis. Mental health clinicians should *educate* family members on the nature of the grief process and identify and normalize the sometimes baffling and frightening symptoms and reactions that family members may experience. Therapists should offer *realistic reassurance* that families can live through this, but stay away from comments that suggest that the experience will be "resolved" or that families will "get over" the loss any time soon. At this early stage of the traumatic bereavement, there is no way families will believe this, and they may resent what they perceive as a trivializing of their pain by suggestions that it is something that can be "gotten over with."

Trying to help families achieve some measure of control in the midst of such an emotional maelstrom may seem like an impossibly daunting task, but sometimes the place to start is with *physical control*. Most survivors will be on high physiological alert, experiencing anxiety, panic, dizziness, head-

aches, stomach distress, sleep disturbances, ruminating thoughts, impaired memory and concentration, and other signs and symptoms. Training family members in relaxation, biofeedback, meditation, or other self-regulation exercises that reduce arousal can show them that they can control at least something – their own bodies. This may give them the confidence to try to gain increasing degrees of control over other chaotic aspects of their now-upside down lives (Miller, 2007-b).

Some survivors cope by maintaining a *steely reserve*, an unnatural calmness of mood, speech, and behavior that may well reflect an innate stoicism of character, but may also be a typical posttraumatic sign of emotional numbing. In the early stages, this should be accepted, since this rigid emotional splint may literally be the only thing that is holding the person together. As time goes on, therapists should gently guide the explorative process to gradually unbind the emotionally constricted survivor, but always in the context of respecting the individual's ability to handle the emotions, and always with the ultimate goal of increasing, not diminishing, the person's sense of control (Miller, 2007-b).

Other survivors may want to vent and, indeed, the therapist's office may be the only place where they feel safe enough to do so. With such individuals, therapists need to remember the difference between *venting* and *spewing*. The former is a cathartic, albeit sometimes painful, expression of suppressed emotions that leads to a feeling of relief and possibly greater insight and control. The latter is an unproductive emotional regurgitation that often heightens distress, clouds understanding, and leaves the person feeling even more out of control. Therapists have to monitor and guide the expressive process so that it heals, not hurts (Miller, 2006-c, 2007-b).

### *Psychotherapy for Bereavement: Guilt and Anger*

Two especially important issues that are often intertwined in the coping process after a LODD are *guilt* and *anger*. In an attempt to make some existential sense out of their loved one's death, family members may blame themselves for their officer's fate. As unfair to oneself as some of these self-reproachful rationales may seem to others ("If we didn't have a fight the night before, he wouldn't have left work so early the next morning, and then he wouldn't have been the one to make that fatal traffic stop"), families may cling to these pseudoexplanations to provide at least some kind, any kind,

of meaning. Being angry at oneself is one way to seize a form of psychological control of the situation, and some of this internalized anger may be projected outward onto the police department, the criminal justice system, or society in general.

Or vice-versa. Sometimes there is a legitimate basis for the family's anger that is partly expressed outward, and partly internalized. Maybe the criminal really was let out of jail too early. Maybe the city really should have authorized funds for body armor for law enforcement personnel instead of spending all that money on a damn stadium. Maybe the media really are acting like slime in calling the house every five minutes and ambushing the family outside their home or business. Maybe those blissfully stupid and uncaring civilians really do have absolutely no clue and don't care about the sacrifices made every day on behalf of their safety by police officers and their families.

Therapeutically, even legitimate, righteous anger must be handled carefully, allowed to come out at a controlled pace in the venting-not-spewing format noted above. Guilt feelings should also be acknowledged, and it is usually a vain exercise to try to stir someone out of the self-reproachful viscosity that is temporarily allowing their psyche to stay glued together. Having the individual explore the reasons for his or her feelings can often delicately guide them into a more realistic view of causation and responsibility. Equally important is helping the family – when they are ready – to channel guilt and anger feelings into productive activities that may actually make a difference in how the system works and may serve to memorialize the slain officer.

One way to do this is to help the family members *reconfigure their respective family roles* in the absence of the missing loved one. Aside from all the other stresses associated with the traumatic LODD, different family members will have to pick up new and different responsibilities, from paying the bills, to preparing meals, to mowing the lawn, to helping with homework, to participating in social functions. The stresses associated with these role shifts should be expressed and acknowledged, and the therapist should support and assist family members in making these transitions.

Related to this are *grief and closure exercises* that enable the family to master and integrate the traumatic bereavement, partly through *memorialization activities* that allow planning for the future while honoring the past. For example, pictures and other mementos of the deceased officer can

serve as comforting images, reviewed in the therapy session to summon nurturant, positive imagery that may counterbalance the grotesque recollections of the bereavement by homicide. Similar memorializing activities include writing about the deceased, drawing pictures, or creating a scrapbook. Again, none of this should become an unending, unhealthy, all-consuming preoccupation, although in the early stages, some leeway should be afforded to allow the memorializers to “get it out of their systems.” If possible, family members should collaborate in these personalized memorial rituals and projects as a way of forging a renewed sense of meaning and commitment within the family structure.

Finally, although some families do manage to forge a *posttraumatic growth experience* out of the LODD of their loved one (Bear & Barnes, 2005; Calhoun & Tedeschi, 1999), psychotherapists should be cautious not to turn this into an expectation, which can risk further demoralizing an already-reeling family by giving them one more thing to feel bad about – that they weren’t able to extract a “growth experience” from their tragedy. However, when family members indicate an ability and willingness to take this existential step, therapists must be willing able to guide them along this path (Miller, 1998b).

## Children and Line-of-Duty Death

The death of a parent or other close relative from any cause has a special impact on children, and this applies poignantly to children of officers killed in the line of duty (Williams, 1999). As with all untimely deaths, children must cope with the loss of the parent and the disruptions in family routines, living standards, and family roles that this entails. At too early an age, children are faced with the existential reality of life’s fragility and impermanence and the fact that bad things can happen to good people unexpectedly at any time.

### *Effects of LODD on Children*

Unlike the anticipated death of a loved one from a long illness, death that is sudden and unexpected leaves no chance to say goodbye or to take care of *unfinished business*. Death that additionally is violent and traumatic can leave bereaved children with mixed feelings of shame and horror.

The palpable distress of the surviving parent, as well as

his or her distraction by numerous activities and responsibilities following the officer’s death, may cause children to *fear that they will be abandoned*, either because the parent has “better things to do,” or because their last remaining caretaker will die too.

Compounding the distress, the high media attention afforded a law enforcement LODD virtually assures that families, including children, will be subjected to *endless replays and retellings* of the event that keep the traumatic memories stinging fresh in everyone’s mind long after bereaved families of more “ordinary” deaths have had a chance to apply the balm of time and regain their bearings.

### *Psychotherapy with Child Survivors of LODD*

Williams (1994a, 1994b, 1999) has outlined a set of psychological principles for dealing with children of LODD officers that are similar to those that have been found effective more generally in treating traumatically bereaved children and families (Crenshaw, 2005; James, 1989; Johnson, 1989; Miller, 1998b, 1999a, 1999b, 2003a, in press). First, *accurate information*, at a level and in a tone that is appropriate for the child in question, should be provided. Contrary to popular belief, children are hardly ever reassured by dismissive “there-there, it’s nothing for you to bother about, everything will be alright”-type answers to their questions about the most jarring traumatic event in their lives (Yalom, 1980). On the contrary, such ambiguity only adds to their anxieties and amplifies their fearful fantasies about what may have happened to the deceased parent.

As much as possible, the surviving parent and other family members should strive to create as much of a *semblance of normalcy* as possible, so that the child does not feel that his or her whole world has been completely tossed on its head. At the same time, as noted above, adults should not go too far in the opposite direction of pretending that “nothing’s wrong,” because, clearly, the child will be aware of the overall atmosphere of grief and stress hanging over the family. Such mixed messages can only further confuse and frighten children.

A much healthier response is to *model mature strength under pressure*: adults should strive to let their children know that it is okay to grieve and that the adults are hurting too, but that they will not break under the pressure, and that, above all, they will be there to protect and take care of their children as needed. This is, in fact, the family version of *grief*

*leadership* shown by supervisors in law enforcement agencies where a fellow officer has been slain.

As discussed earlier, children can be encouraged to participate productively in *memorialization activities* by helping with funeral and other memorial arrangements – at an age-appropriate level, and only if the child wants to – as well as writing stories, drawing pictures, making a photo scrapbook, and other activities to remember the slain parent.

Finally, the help of the *child's school* should be enlisted by informing teachers and school officials about the bereavement, providing classmates with age-appropriate information, helping the other kids know how to make the returning child feel safe and welcomed, and by trying to make the classroom an oasis of stability and normalcy, a haven apart from the turmoil that may be going on at home in the first few months and years following the traumatic bereavement.

### **Administrative Policies and Actions for Family Survivors of a Line-of-Duty Death**

Police agencies have been criticized for neglecting or abandoning the bereaved spouse and family after a line-of-duty death by failing to provide adequate follow-up support services (Sawyer, 1988; Stillman, 1987). Surviving officers and their wives may dislike interacting with the widow of a slain officer because it reminds them of their own and their loved one's vulnerability and mortality, the *contagion effect* noted previously. Both police administrators and mental health clinicians can encourage the sharing of grief responses with others who have walked in the same shoes as an adjunct to more formal psychotherapeutic grief work (Blau, 1994; Regehr & Bober, 2005; Miller, 2006; Sprang & McNeil, 1995; Spungen, 1998). Recently, a number of law enforcement family self-help support groups, such as *Concerns of Police Survivors (COPS)* and others, have begun to respond to the challenge; survivors should be urged to consult local directories and websites (Kirschman, 1997). A cop's life encompasses all those around him or her in police family and home family alike. Each deserves proper consideration, support, and respect.

### **Conclusions**

A line-of-duty death slams home the risk and vulnerability of all law enforcement officers and therefore may be re-

acted to by a paradoxical combination of morbid fascination and numbed avoidance by members of the immediate and extended police family. Police psychologists and community mental health clinicians can be of tremendous service to surviving officers and their families by applying the principles of trauma therapy and grief counseling to the special needs of the law enforcement community.

## **REFERENCES**

- Aldwin, C.M. (1994). *Stress, coping, and development*. New York: Guilford.
- Anderson, C. (2002). Report: Police slayings increase. *South Florida Sun-Sentinel*, December 3, p. 3A.
- Bear, T.M. & Barnes, L.L.B. (2005). Posttraumatic growth in survivors of law enforcement officers killed in the line of duty. *Study conducted with the membership of Concerns of Police Survivors (COPS)*.
- Blau, T.H. (1994). *Psychological services for law enforcement*. New York: Wiley.
- Blum, L.N. (2000). *Force under pressure: How cops live and why they die*. New York: Lantern Books.
- Bowman, M. (1997). *Individual differences In posttraumatic response: Problems with the adversity-distress connection*. Mahwah: Erlbaum.
- Calhoun, L.G. & Tedeschi, R.G. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah: Erlbaum.
- Carson, L. & MacLeod, M.D. (1997). Explanations about crime and psychological distress in ethnic minority and white victims of crime: A qualitative explanation. *Journal of Community and Applied Social Psychology*, 7, 361-375.
- Crenshaw, D.A. (2005). Clinical tools to facilitate treatment of childhood traumatic grief. *Omega*, 51, 239-255.
- Cummings, J.P. (1996). Police stress and the suicide link. *The Police Chief*, October, pp. 85-96.
- Danto, B.L. (1975). Bereavement and the widows of slain police officers. In E. Schoenberg (Ed.), *Bereavement: Its psychological aspects* (pp. 150-163). New York: Columbia University Press.
- Geller, W.A. (1993). Put friendly-fire shooting in perspective. *Law Enforcement News*, 18, 9.

- Green, B.L. (1993). Identifying survivors at risk. In J.P. Wilson & H. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 135-144). New York: Plenum.
- Haddix, R.C. (1999). Responding to line-of-duty deaths. In L. Territo & J.D. Sewell (Eds.), *Stress management in law enforcement* (pp. 287-296). Durham: Carolina Academic Press.
- Henry, V.E. (2004). *Death work: Police, trauma, and the psychology of survival*. New York: Oxford University Press.
- James, B. (1989). *Treating traumatized children: New insights and creative interventions*. New York: Free Press.
- Johnson, K. (1989). *Trauma in the lives of children*. Alameda: Hunter House.
- Kaltman, S. & Bonanno, G.A. (2003). Trauma and bereavement: Examining the impact of sudden and violent deaths. *Journal of Anxiety Disorders, 17*, 131-147.
- Kirschman, E.F. (1997). *I love a cop: What police families need to know*. New York: Guilford.
- Lindy, J.D., Grace, M.C. & Green, B.L. (1981). Survivors: Outreach to a recalcitrant population. *American Journal of Orthopsychiatry, 51*, 468-479.
- MacLeod, M.D. (1999). Why did it happen to me? Social cognition processes in adjustment and recovery from criminal victimization and illness. *Current Psychology, 18*, 18-31.
- Miller, L. (1995). Tough guys: Psychotherapeutic strategies with law enforcement and emergency services personnel. *Psychotherapy, 32*, 592-600.
- Miller, L. (1998a). Ego autonomy and the healthy personality: Psychodynamics, cognitive style, and clinical applications. *Psychoanalytic Review, 85*, 423-448.
- Miller, L. (1998b). *Shocks to the system: Psychotherapy of traumatic disability syndromes*. New York: Norton.
- Miller, L. (1998c). Psychotherapy of crime victims: Treating the aftermath of interpersonal violence. *Psychotherapy, 35*, 336-345.
- Miller, L. (1999a). Treating posttraumatic stress disorder in children and families: Basic principles and clinical applications. *American Journal of Family Therapy, 27*, 21-34.
- Miller, L. (1999b). Posttraumatic stress disorder in child victims of violent crime: Making the case for psychological injury. *Victim Advocate, 1*(1), 6-10.
- Miller, L. (1999c). Psychotherapeutic intervention strategies with law enforcement and emergency services personnel. In L. Territo & J.D. Sewell (Eds.), *Stress management in law enforcement* (pp. 317-332). Durham: Carolina Academic Press.
- Miller, L. (2000). Law enforcement traumatic stress: Clinical syndromes and intervention strategies. *Trauma Response, 6*(1), 15-20.
- Miller, L. (2003a). Family therapy of terroristic trauma: Psychological syndromes and treatment strategies. *American Journal of Family Therapy, 31*, 257-280.
- Miller, L. (2003b). Police personalities: Understanding and managing the problem officer. *The Police Chief, May*, pp. 53-60.
- Miller, L. (2003c). Law enforcement responses to violence against youth: Psychological dynamics and intervention strategies. In R.S. Moser & C.E. Franz (Ed.), *Shocking violence II: Violent disaster, war, and terrorism affecting our youth* (pp. 165-195). New York: Charles C. Thomas.
- Miller, L. (2004). Good cop – bad cop: Problem officers, law enforcement culture, and strategies for success. *Journal of Police and Criminal Psychology, 19*, 30-48.
- Miller, L. (2005). Police officer suicide: Causes, prevention, and practical intervention strategies. *International Journal of Emergency Mental Health, 7*, 23-36.
- Miller, L. (2006-a). Critical incident stress debriefing for law enforcement: Practical models and special applications. *International Journal of Emergency Mental Health, 8*, 189-201.
- Miller, L. (2006-b). Officer-involved shooting: Reaction patterns, response protocols, and psychological intervention strategies. *International Journal of Emergency Mental Health, 8*, 239-254.
- Miller, L. (2006-c). *Practical police psychology: Stress management and crisis intervention for law enforcement*. Springfield: Charles C Thomas.
- Miller, L. (2007-a). Police families: Stresses, syndromes, and solutions. *American Journal of Family Therapy, 35*, 1-20.
- Miller, L. (2007-b). *METTLE: Mental Toughness training for law enforcement*. Flushing, NY: Looseleaf Law Press.
- Miller, L. (in press). Stress management and crisis intervention for law enforcement and mental health professionals.

- In F.M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (3<sup>rd</sup> ed.). New York: Guilford.
- Mitchell, J.T. & Everly, G.S. (1996). *Critical incident stress debriefing: Operations manual*. (rev. ed.). Ellicott City: Chevron.
- Mitchell, J.T. & Everly, G.S. (2003). *Critical incident stress management (CISM): Basic group crisis intervention* (3<sup>rd</sup> ed.). Ellicott City: ICISF.
- Mitchell, J. & Levenson, R.L., Jr. (2006). Some thoughts on providing effective mental health critical care for police departments after line-of-duty deaths. *International Journal of Emergency Mental Health*, 8, 1-4.
- Niederhoffer, A. & Niederhoffer, E. (1978). *The police family: From station house to ranch house*. Lexington: Heath.
- Parkes, C.M. (1975). Determinants of outcome following bereavements. *Omega*, 6, 303-323.
- Parkes, C.M. & Brown, R. (1972). Health after bereavement: A controlled study of young Boston widows and widowers. *Psychosomatic Medicine*, 34, 449-461.
- Regehr, C. & Bober, T. (2005). *In the line of fire: Trauma in the emergency services*. New York: Oxford University Press.
- Rynearson, E.K. (1988). The homicide of a child. In F.M. Ochberg (Ed.), *Posttraumatic therapy and victims of violence* (pp. 213-224). New York: Brunner/Mazel.
- Rynearson, E.K. (1994). Psychotherapy of bereavement after homicide. *Journal of Psychotherapy Practice and Research*, 3, 341-347.
- Rynearson, E.K. (1996). Psychotherapy of bereavement after homicide: Be offensive. *In Session: Psychotherapy in Practice*, 2, 47-57.
- Rynearson, E.K. & McCreery, J.M. (1993). Bereavement after homicide: A synergism of trauma and loss. *American Journal of Psychiatry*, 150, 258-261.
- Sawyer, S. (1988). *Support services to surviving families of line-of-duty death*. Maryland: COPS, Inc.
- Sheehan, P.L. (1991). Critical incident trauma and intimacy. In J.T. Reese, J.M. Horn & C. Dunning (Eds.), *Critical incidents in policing* (pp. 331-334). Washington DC: Federal Bureau of Investigation.
- Silver, R. & Wortman, C. (1980). Coping with undesirable life events. In J. Garber & M. Seligman (Eds.), *Human helplessness* (pp. 279-340). New York: Academic Press.
- Smith, K. & Rodriguez, I. (2006). A tragedy in a split second: Broward law officer struck, killed by car. *South Florida Sun-Sentinel*, February 17, p. 4B.
- Sprang, G. & McNeil, J. (1995). *The many faces of bereavement: The nature and treatment of natural, traumatic, and stigmatized grief*. New York: Brunner/Mazel.
- Spungen, D. (1998). *Homicide: The hidden victims. A guide for professionals*. Thousand Oaks: Sage.
- Stillman, F.A. (1987). *Line-of-duty deaths: Survivor and departmental responses*. Washington DC: National Institute of Justice.
- United States Department of Justice, Federal Bureau of Investigation (2003). *Uniform crime report: Law enforcement officers killed and assaulted, 1990-1993*. Washington DC: U.S. Government Printing Office.
- Violanti, J.M. (1996). The impact of cohesive groups in the trauma recovery context: Police spouse survivors and duty-related death. *Journal of Traumatic Stress*, 9, 379-386.
- Violanti, J.M. (1999). Death on duty: Police survivor trauma. In J.M. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 139-158). Springfield: Charles C Thomas.
- Violanti, J.M. & Aron, F. (1994). Ranking police stressors. *Psychological Reports*, 75, 824-826.
- Williams. M.B. (1994a). Intervention with child victims of trauma in the school setting. In M.B. Williams & J.F. Sommer (Eds.), *Handbook of posttraumatic therapy* (pp. 203-220). Westport: Greenwood Press.
- Williams. M.B. (1994b). Impact of duty-related death on officers' children: Concepts of death, trauma reactions, and treatment. In J.T. Reese & E. Scrivner (Eds.), *Law enforcement families: Issues and answers* (pp. 111-119). Washington DC: U.S. Printing Office.
- Williams. M.B. (1999). Impact of duty-related death on officers' children: Concepts of death, trauma reactions, and treatment. In J.M. Violanti & D. Paton (Eds.), *Police trauma: Psychological aftermath of civilian combat* (pp. 159-174). Springfield: Charles C Thomas.
- Worden, J.W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. New York: Springer.
- Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.



## CRISIS OPTIONS

**Consulting  
Speaking  
Training**

*Jeanne Meyer Caverly, M.Ed., CII*

*Jim Caverly, M.Ed., CEAP, FBI-Retired*

### Contact CRISIS OPTIONS for:

- Security Surveys
  - ICISF CISM Courses: Group, Individual, School
  - Hostage Crisis Negotiations
  - Stress Management Using FFT & Hypnosis
  - Compassionate Death Notification
  - Preventing Workplace Violence
  - Strengthening Marriage After Traumatic Loss
- ...and more!

[www.CrisisOptions.com](http://www.CrisisOptions.com)

[CrisisOptions@mac.com](mailto:CrisisOptions@mac.com)

518-399-1727



**Catalog #QUICK  
(Set of four cards)**

**\$7.50 Chevron Publishing**

## Quick Cards

This set of four pocket-sized, color-coded plastic cards is a great quick reference. The crisis intervention card outlines the major steps in the intervention process and on the reverse side displays the SAFE-R model, a great peer support reference. The second card (defusing) defines and outlines the defusing process. Card three deals with crisis management briefing and demobilization. The fourth card (debriefing) outlines the essential topics of each of the seven phases of the debriefing process.

Cards also display contact information for the International Critical Incident Stress Foundation, including emergency contact numbers.

**Order By Phone - M-F, 9-5 EST - (410) 740-0065**

**Order Online 24/7 - [www.chevronpublishing.com](http://www.chevronpublishing.com)**

# Training Programs from Sidran Institute

**For more  
information:**

[www.sidran.org](http://www.sidran.org)

410-825-8888

[training@sidran.org](mailto:training@sidran.org)



Sidran Institute offers training programs that equip staff to deal confidently and compassionately with traumatized, abused, or troubled clients.

### We Train Service Providers in:

- Family and Children's Services
- Sexual Assault Recovery Centers
- Psychiatric Hospitals
- Police/Emergency Services
- The Clergy

Training sessions can be tailored to meet the needs of individual agencies. Some of our most popular topics include:

- **Fostering Trauma-Informed Multidisciplinary Teamwork**
- **Self-Awareness and Self-Care for Crisis Intervention Personnel**
- **Partnering with Clergy to Respond to the Spiritual Needs of Victims**

Sidran is a national nonprofit organization dedicated to supporting people with traumatic stress conditions; providing education, training, and consulting; providing trauma-related advocacy; and publishing and distributing books and other materials on trauma.



## Associations Between Major Life Events, Traumatic Incidents, and Depression Among Buffalo Police Officers

Tara A. Hartley

National Institute for Occupational Safety and Health

John M. Violanti

State University of New York at Buffalo

Desta Fekedulegn

National Institute for Occupational Safety and Health

Michael E. Andrew

National Institute for Occupational Safety and Health

Cecil M. Burchfiel

National Institute for Occupational Safety and Health

**Abstract:** *Police officers are considered to be a highly stressed population due to the nature of the work they perform. Repeated exposures to work stress and stressful life events can affect one's psychological and physiological well-being. The objective of this study was to determine whether negative life events and traumatic police incidents are associated with depression in police officers. One hundred randomly selected urban officers completed a series of self-report measures as part of a cross-sectional pilot study. Using four negative life event categories (none, low, medium, and high) a J-shaped pattern was observed with mean depression scores ( $\pm$ SD) of 9.26 ( $\pm$ 7.41), 6.21 ( $\pm$ 5.94), 8.17 ( $\pm$ 7.42), and 14.64 ( $\pm$ 8.04), respectively (test for linear trend  $p = 0.0186$ ). Adjustment for age ( $p = 0.0209$ ), then age, gender, and ethnicity together ( $p = 0.0184$ ) did not alter this pattern appreciably. No association between traumatic police incidents and depression was observed. Results indicate that exposure to multiple negative life events is significantly associated with elevated depression scores among this sample. Police agencies should consider developing psychological assistance efforts to help affected officers cope with these events and deal with depression. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 25-35].*

**Key words:** *police officers, depression, life events, traumatic incidents*

Stressors, either acute events or ongoing situations, invoke a strong emotional reaction (Brown & Harris, 1978; Wheaton, 1994). Stressors have been classified as life events, chronic stressors, or work-related stressors (Orpana &

Lemyre, 2004). The present study focused on two types of stress: exposure to negative life events and traumatic work stress.

---

**Tara A. Hartley, M.P.A., M.P.H.**, Health Effects Laboratory Division, National Institute for Occupational Safety and Health, Morgantown, WV; **John M. Violanti, Ph.D.**, School of Public Health and Health Professions, Department of Social and Preventive Medicine, State University of New York at Buffalo, Buffalo, NY; **Desta Fekedulegn, Ph.D., Michael E. Andrew, Ph.D., and Cecil M. Burchfiel, Ph.D., M.P.H.**, Health Effects Laboratory Division, National Institute for Occupational Safety and Health, Morgantown, WV. This work was supported by the National Institute for Occupational Safety and Health (NIOSH), contract no. HELD01B0088. The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the National Institute for Occupational Safety and Health. Address correspondence and requests for reprints to: Tara A. Hartley, Health Effects Laboratory Division, National Institute for Occupational Safety and Health, 1095 Willowdale Road, MS 4050, Morgantown, WV, 26505. Telephone: 304-285-6222. Email: THartley@cdc.gov

---

## *Life Events*

According to the American Psychological Association, two-thirds of Americans have reported experiencing at least one stressful life event, such as the death of a family member, divorce, or the birth of a child, in the last two years. As these events accumulate, stress levels increase: 17% of those with two life events and 20% with three or more events reported concern over the level of stress in their lives. Additionally, of those experiencing three or more stressful life events, one-third rated their physical health and 20% rated their psychological health as fair or poor (American Psychological Association, 2006). Significant associations between depression and multiple negative life events, such as a loss or separation, have been found in children (Goodyer, 1995). The risk for depressive episodes has been shown to be five-fold greater for individuals experiencing a single negative event and nearly eight-fold higher for those experiencing multiple events compared to individuals having no negative events (Patton, Coffey, Posterino, Carlin, & Bowes, 2003).

The psychological effects of experiencing life events have been well studied. Life events often precede depressive episodes and psychiatric disorders such as anxiety states, alcoholism, bulimia, and schizophrenia (Kendler, Karkowski, & Prescott, 1998; Kendler, Kessler, Neale, Heath, & Eaves, 1993), contribute to depression, and are associated with greater risk of illnesses (Brown & Harris, 1989).

In recent years, researchers have established a biological link between life events and the development of depression. Among individuals reporting multiple stressful life events over a five year period, Caspi and colleagues (2003) identified a gene variant between those who developed depression and those who did not. Forty-three percent of those with a “short” or stress-sensitive version of the serotonin transporter gene developed depression compared to only 17% with the “long” protective version of the gene, suggesting that the short variant leaves an individual vulnerable to stress (Caspi et al.).

Alzheimer caregivers experiencing more life events in addition to the chronic stress of caregiving had higher plasma norepinephrine levels than those caregivers experiencing fewer life events (Mills et al., 1997). The physical effects from the combination of chronic and acute stress may result in an increased risk of coronary artery disease (von Kanel, Dimsdale, Patterson, & Grant, 2003). Additionally, caregivers experiencing four or more life events had higher D-dimer lev-

els, indicative of a hypercoagulable state, than those experiencing less than four events (von Kanel et al.).

## *Work Stress*

Sixty-two percent of Americans say work has a significant impact on their stress levels, and more than half are concerned that stress will lead to future health problems (American Psychological Association, 2006). Work stress has been significantly associated with a number of unhealthy outcomes, including chronic back pain, alcohol abuse, and depression (Chen et al., 2006). Police officers, because of the nature of their occupation, are known to experience high levels of workplace stress. Police stress has been defined as any condition that negatively affects an officer’s well-being (Crank & Caldero, 1991). Police officers contend with chronic stressors, such as organizational issues, large amounts of paperwork, and court appearances, and are faced with handling traumatic incidents involving shootings and witnessing violent acts. The chronic stress associated with frequent exposure to occupational stress may compound the symptoms police officers experience following traumatic incidents (Lieberman, Fagan, Weiss, & Marmar, 2002; Patterson, 2001a). Police stress has been linked to physical conditions, such as hypertension, ulcers, and cardiovascular disease, and emotional disturbances, such as alcoholism, divorce, and suicide (Ayres & Flanagan, 1992; Reiser & Dash, 1978). Patterson (2001a) described five types of police officer stress: external stressful events, work-related events outside of the law enforcement organization; internal stressful events, dealing with internal policies and procedures; task-related stressful events, performing law enforcement tasks; individual stressful events or life events; and traumatic incidents in law enforcement.

Traumatic incidents can be a significant source of work stress for police officers. Most incidents involve intentional, human-made disasters, such as rape, abuse, and shootings (Patterson, 2001a). While police officers may adapt to the negative effects of chronic stress, acute traumatic incidents necessitate specialized mental health treatment for police officers (Patterson, 2001a). Two studies utilizing the 60-item Spielberger Police Stress Survey asked police officers to rate the amount of stress associated with each item. Violanti and Aron (1994) observed that police officers perceived task-related events such as “killing someone in the line of duty,” a “fellow officer being killed,” and “physical attack” to be the highest work stressors. Spielberger and colleagues (1981) observed similar results with police officers ranking “fellow

officer killed in the line of duty,” “killing someone in the line of duty,” and “exposure to battered or dead children” as the most stressful.

Several demographic factors may contribute to the type and number of traumatic incidents experienced. Female officers have reported exposure to more traumatic incidents, such as natural disasters, suicide, and child and spousal abuse, than male officers reported (Martin, McKean, & Veltkamp, 1986). Patterson (2001b) found that officers who were female, older, non-white, assigned to specialty units, had no prior military experience, and had more years of police experience reported fewer traumatic incidents than male officers, younger officers, white officers, officers assigned to patrol units, officers with prior military experience, and officers with fewer years of police experience. Older police officers may be more experienced, more likely to be promoted in rank and transferred to units where they may be exposed to fewer criminal acts, while younger officers have less experience and are likely to be assigned to units where more criminal acts occur. Additionally, previous research has found that younger officers are more aggressive and make more arrests than older officers (Patterson, 2001b).

### *Stress and Depression*

Repeated exposures to acute work stressors (e.g., violent criminal acts, sad and disturbing situations, and physically demanding responses), in addition to contending with negative life events (e.g., divorce, serious family or personal illness, and financial difficulties), can affect both the psychological and physiological well-being of this population. Therefore, when evaluating the stress level and its relationship to the police officers' overall health, the influence of traumatic events, including those related to work and personal life, is important to consider. The objective of this study was to determine to what extent negative life events and traumatic police incidents are associated with depression in police officers. Our hypotheses were that: (1) police officers who experienced more negative life events would have higher depression scores than officers who experienced fewer negative life events, and (2) police officers who experienced more traumatic police incidents would have higher depression scores than officers who experienced fewer traumatic police incidents.

## **METHODS**

### **Study Population**

The Buffalo, New York, Police Department, with a police force of 934 officers in 2001, was the selected site. A random sample ( $N = 100$ ) was generated from all police officers in the department using a computer-generated random number table. Female officers were over-sampled (42 females, 58 males). No specific inclusion criteria were used for the study, other than the participant had to be a sworn police officer and willing to participate in the study.

The Center for Preventive Medicine, University of New York at Buffalo, School of Public Health and Health Professions, Buffalo, New York served as the data collection site. Details of the study design and population have been described elsewhere (Violanti et al., 2006). The study protocol was approved by the State University of New York at Buffalo Internal Review Board.

This cross-sectional study involved a series of self-report measures, including the Center for Epidemiologic Studies-Depression (CES-D) scale, a modified version of Paykel's Life Events Scale, and a measure of traumatic police incidents based on a summarized categorization of all traumatic events listed by police officers and used in a recent paper by Violanti and Gehrke (2004). Complete data were available for 99 out of 100 police officers.

### **Study Measures**

#### *Life Events*

Participants were asked to complete a 41-item life events scale assessing type of stressful events encountered during the previous year, including events related to work, home, and family, using a *yes* and *no* response format. This scale was slightly modified from the 1971 version of Paykel's Life Events Scale (Paykel, Prusoff, & Uhlenhuth, 1971).

Each life event was categorized as positive (e.g., marriage) or negative (e.g., death of a close relative). A total life event score was calculated by summing the 41 events. Separate scores for positive events and negative events were also computed using the same approach. Negative life events were divided into four ordinal categories: none ( $n = 23$ ), low 1 – 2 events ( $n = 33$ ), medium 3 – 4 events ( $n = 29$ ), and high  $\geq 5$  events ( $n = 14$ ).

## Traumatic Police Incidents

The traumatic police incidents scale asks the participant to indicate occurrence (*yes/no*) of traumatic events experienced during the past year. Items include witnessing the shooting of another police officer, being involved in a shooting incident, seeing abused children, seeing victims of a serious traffic accident, seeing someone die, seeing dead bodies, seeing severely assaulted victims, and seeing victims of a homicide. A total traumatic police incident score was calculated by summing the *yes* (affirmative) responses to the nine questions (range = 0 – 9). Traumatic police incidents were divided into four ordinal categories: none ( $n = 11$ ), low 1 – 3 incidents ( $n = 30$ ), medium 4 – 6 incidents ( $n = 39$ ), and high  $\geq 7$  events ( $n = 19$ ).

## Depression

The CES-D scale is a 20-item test measuring symptoms of depression (e.g., restlessness, sadness, poor appetite). Respondents rate items on a 4-point scale according to how often the symptom occurred in the past seven days: 0 (rarely or none of the time, less than 1 day), 1 (some or little of the time, 1 - 2 days), 2 (occasionally or a moderate amount of the time, 3 - 4 days), and 3 (most of all of the time, 5 - 7 days). Scores are calculated by summing the 20 items and can range from 0 to 60. The CES-D has been widely used in identifying symptoms of depression. Respondents with scores of 0 – 15 are unlikely to be clinically depressed, scores of 16 – 21 indicate mild to moderate depression, and scores of 22 or greater are associated with major depression (Radloff, 1977). A score of  $\geq 16$  has been reported as an indicator of clinical depression (McDowell & Newell, 1996). The CES-D score ranged from 0 to 34 for our sample. The scale has a correlation of 0.56 with a clinical rating of depression severity (McDowell & Newell).

## Statistical Methods

Descriptive statistics for gender, age, ethnicity, education, marital status, years of police service, and police rank were computed. The means and standard deviations for life events, negative life events, traumatic police incidents, and CES-D scores were also computed. One female police officer was omitted from this analysis because questionnaire data were incomplete. Analysis of variance (ANOVA) was used to test for differences in total life events, negative life events, traumatic police incidents, and CES-D scores by age cate-

ries ( $< 40$ ,  $40 - 49$ , and  $\geq 50$  years), gender, and ethnicity. Unadjusted, age-adjusted and multivariable-adjusted associations between depression and negative life events or traumatic police incidents were examined using analysis of covariance (ANCOVA). Negative life event and traumatic police incident scores were classified into four ordinal categories and the trend in mean depression scores across these categories was assessed using orthogonal polynomial coefficients. An alternative statistical method, the Poisson regression model, was also used to relate mean depression score to negative life events and confirm the results obtained thorough ANOVA. All analyses were completed utilizing SAS software version 9.1<sup>®</sup> (SAS Institute, Cary, NC). All hypotheses were performed at the 0.05 significance level. Categorical variables were dummy coded. Checks for normality and homogeneity of variance were performed.

## RESULTS

### Demographics

The study population included 58 male and 41 female police officers (Table I). Nearly one half of the officers were between 40 and 49 years of age. Sixty-three percent of the female officers were 40 – 49 years of age, while male officers were evenly distributed between the three age categories. Three-quarters of the sample were Caucasian and over half had earned a college degree. A larger percentage of male officers were married (74.1%) than female officers (51.2%) and correspondingly, more female officers were divorced (24.4%) than male officers (8.6%). Two-thirds of the sample had 11 or more years of police experience. A larger percentage of male officers had 20 or more years of experience than female officers and males held higher police ranks than female officers.

### Life Events

Officers had experienced an average of 2.78 (SD  $\pm$  2.64) life events during the previous year. The most frequently reported life events were negative: 1) experiencing a major argument with boss or coworker (28.3%); 2) decrease in income (27.3%); 3) death of a close relative (20.2%); 4) serious argument with spouse or partner (19.2%); 5) major damage to home or property (15.2%); and 6) death of a close friend (15.2%). Life events did not differ by age, gender, or ethnicity (Table II).

**Table I**  
**Demographic characteristics of BCOPS**  
**Pilot Study Police Officers.**

Characteristics	Male N=58	Female N=41	Total N=99
<b>Age</b>			
Less than 40	34.5*	22.0	29.0
40 – 49	32.8	63.4	45.0
50 or older	32.8	14.6	26.0
<b>Ethnicity</b>			
Caucasian	75.9	75.6	76.0
African American	15.5	24.4	19.0
Hispanic American	8.6	0.0	5.0
<b>Education</b>			
≤ High Sch/GED	15.5	17.1	16.0
College < 4 years	29.3	26.8	29.0
College ≥ 4 years	55.2	56.1	55.0
<b>Marital Status</b>			
Single	17.2	24.4	20.0
Married	74.1	51.2	65.0
Divorced	8.6	24.4	15.0
<b>Years of Police Svc.</b>			
1 – 5 years	19.0	19.5	19.0
6 – 10 years	10.3	14.6	12.0
11 – 15 years	20.7	26.8	23.0
16 – 20 years	19.0	26.8	23.0
20 + years	31.0	12.2	23.0
<b>Police Rank</b>			
Patrol Officer	46.6	56.1	51.0
Sgt/Lieutenant	15.5	14.6	15.0
Captain	10.3	4.9	8.0
Detective	19.0	9.8	15.0
Other	8.6	14.6	11.0

\* Data are percentages.

## Negative Life Events

Our hypothesis focused on the exposure to negative life events, a subset comprised of 34 questions from the total life events scale. Officers in this sample had experienced an average of 2.45 (SD ± 2.41) negative life events during the previous year. The number of negative life events did not differ by age or gender; however, African Americans had experienced a significantly higher number of negative life events than Caucasians (Table II). The prevalence of experiencing a positive life event across the four negative life event categories (none, low, medium, and high) was 13.0%, 18.2%, 24.1% and 42.9%, respectively, and was significant (linear trend  $p = 0.0385$ ).

## Traumatic Police Incidents

Police officers had experienced an average of 4.16 (SD ± 2.48) traumatic police incidents during the previous year. The most frequently occurring incidents reported were: 1) seeing dead bodies (73.7%); 2) seeing severely assaulted victims (69.7%); and 3) seeing abused children (60.6%). The number of traumatic police incidents did not differ by age or ethnicity; however, male officers experienced a significantly higher number of incidents than female officers (Table II).

## Depression Scores

The mean depression score for this sample of police officers was 8.69 (SD ± 7.60). The mean depression score was higher among officers aged 40 and older than among younger officers. Female officers had higher scores than male officers, and Hispanic officers had higher scores than either Caucasian or African American officers. However, these differences were not statistically significant (Table II).

## Negative Life Events and Depression

Analysis of variance and covariance were used to examine the association between negative life events and depression. A J-shaped pattern was observed with mean depression scores (± SD) across the four negative life event categories (none =  $9.3 \pm 7.4$ , low =  $6.2 \pm 5.9$ , medium =  $8.2 \pm 7.4$ , high =  $14.6 \pm 9.0$ ; test for linear trend  $p = 0.0186$ ). In addition to the significant linear trend, the test for quadratic trend was also significant ( $p = 0.0024$ ). Adjustment for age ( $p = 0.0209$ ) and for age, gender, and ethnicity ( $p = 0.0184$ ) did not alter the pattern of mean depression scores appreciably (Figure I). An increasing stepwise trend was observed for officers experiencing one and progressively more negative life events (Figure I).

Results from Poisson regression analyses indicated that a one unit increase in negative life event was associated with a 7 % increase in the estimated mean depression score ( $p = 0.0127$ ). Adjustment for age ( $p = 0.0254$ ) and age, gender, and ethnicity ( $p = 0.0227$ ) did not affect the result.

When the three lowest negative life events categories were collapsed and compared to the highest category (none, low, and medium: 0–4 versus high: ≥ 5), the mean depression score was nearly twice as high in the group with ≥ 5 negative

Table II  
Life events, traumatic police incidents and depression scores by selected demographic characteristics.

Characteristics	Total Life Events Mean ± SD	Negative Life Events Mean ± SD	Traumatic Police Incidents Mean ± SD	CES-D* Mean ± SD
<b>Age</b>				
Less than 40	2.45 ± 1.86	2.03 ± 1.64	4.62 ± 2.47	6.90 ± 4.10
40 – 49	3.00 ± 3.01	2.78 ± 2.74	4.11 ± 2.46	9.22 ± 8.51
50 or older	2.76 ± 2.76	2.36 ± 2.55	3.72 ± 2.53	9.80 ± 8.81
<i>p-value**</i>	0.668	0.623	0.186	0.164
<b>Gender</b>				
Female	2.95 ± 2.77	2.54 ± 2.41	3.44 ± 2.46	9.76 ± 8.84
Male	2.66 ± 2.57	2.40 ± 2.43	4.67 ± 2.38	7.93 ± 6.56
<i>p-value***</i>	0.585	0.778	0.014	0.241
<b>Ethnicity</b>				
Caucasian	2.45 ± 2.19	2.12 ± 1.88	4.40 ± 2.45	8.56 ± 7.70
African American	3.79 ± 3.22	3.53 ± 3.20	3.68 ± 2.40	8.11 ± 7.21
Hispanic American	3.80 ± 5.22	3.40 ± 4.72	2.40 ± 2.70	12.80 ± 7.82
<i>p-value***</i>	0.096	0.049	0.140	0.454

\* CES-D, Center for Epidemiologic Studies Depression scale

\*\* *p-values test for linear trend*

\*\*\* *p-values test any differences among the means*

life events compared with those experiencing four or fewer events ( $14.6 \pm 9.0$  and  $7.7 \pm 6.9$ , respectively,  $p = 0.0013$ ; Figure II).

### Traumatic Police Incidents and Depression

Analyses of variance and covariance were used to examine the association between traumatic police incidents and depression. A V-shaped pattern was observed for mean depression scores ( $\pm$  SD) across the four traumatic police incident categories (none =  $12.0 \pm 9.5$ , low =  $7.1 \pm 6.9$ , medium =  $8.4 \pm 7.2$ , high =  $10.0 \pm 8.0$ ; test for linear trend  $p = 0.5930$ , test for quadratic trend  $p = 0.0560$ ). Adjustment for age ( $p = 0.7901$ ) and for age, gender, and ethnicity ( $p = 0.8231$ ) did not alter this pattern (Figure III). An increasing stepwise trend was observed among officers experiencing one and progressively more traumatic police incidents (Figure III).

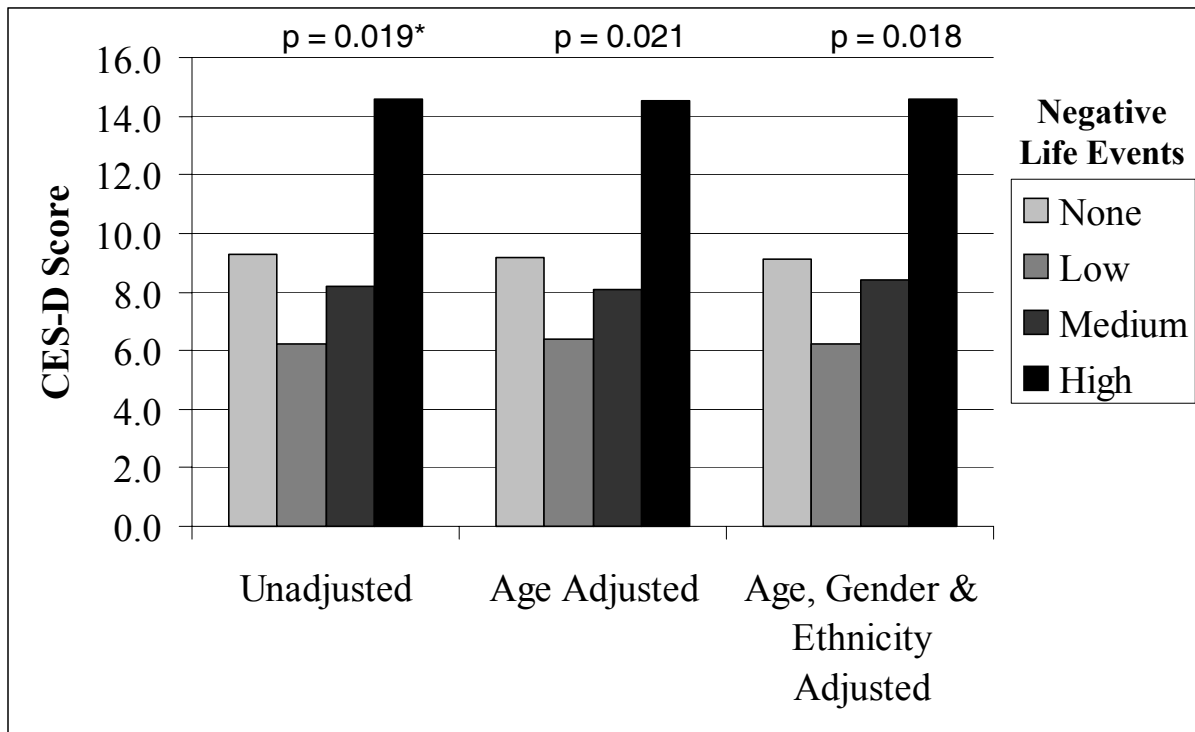
In addition, a two-way ANOVA model relating depression to the four negative life event categories, four traumatic police incident categories and their interaction showed no evidence of interaction between traumatic police incidents and exposure to negative life events in relation to depression

(interaction  $p = 0.4725$ ). A more general multiple regression analysis using negative life events, traumatic police incidents, age, gender, and ethnicity as independent variables and depression score as the dependent variable showed negative life events as the only predictor with significant association to depression ( $p = 0.0479$ ).

### Higher Depression Scores for Zero Event Categories

Police officers who experienced either zero negative life events or zero traumatic police incidents in the past year appeared to have higher depression scores than those experiencing at least one negative life event ( $9.26$  vs.  $8.51$ ,  $p = 0.6814$ ) or traumatic police incident ( $12.00$  vs.  $8.27$ ,  $p = 0.1256$ ). We explored a number of potential explanations for this occurrence. In comparisons of officers reporting zero negative life events and officers reporting one or more negative life events, there were no differences for the following characteristics: age, marital status, police rank (patrol officer or sergeant, lieutenant or captain, detective or ‘other’), number of positive life events reported in the past year, or number of traumatic police incidents encountered in the past year.

Figure 1 Association between negative life events and depression.



\* *p-values test for linear trend*

We also explored the possibility that those officers experiencing one or more negative life events were harder than officers who experienced zero negative life events and thus, experiencing these negative events would not be associated with higher depression scores. Hardiness is defined as one's control, commitment, and challenge or opportunity in response to stressful events (Bartone, 1991). Additionally, were officers who experienced zero negative life events avoiding activities reminiscent of a past event? The avoidance construct is a subscale of the Impact of Event scale developed by Horowitz and colleagues (Horowitz, Wilner, & Alvarez, 1979). However, no differences were found between the two groups in terms of hardiness or avoidance.

The two groups did differ in the number of years of police service. Police officers reporting zero negative life events averaged  $18.74 \pm 8.9$  ( $\pm$  SD) years of service, while those reporting one or more negative life events averaged  $13.72 \pm 8.9$  years of service ( $p = 0.021$ ).

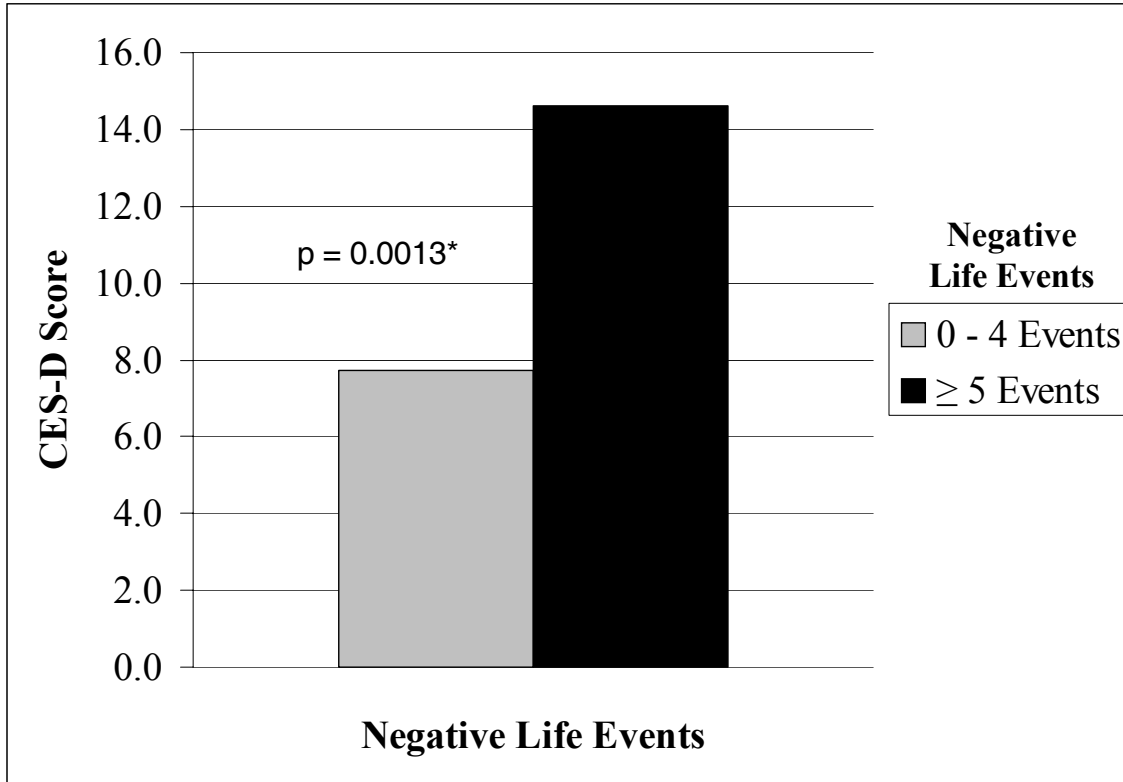
A comparable approach was taken for traumatic police incidents. Eleven officers reported experiencing zero incidents in the previous year. We compared this group to officers experiencing one or more incidents. The groups did not differ

for the following variables: marital status, police rank (patrol officer or sergeant, lieutenant or captain, detective or 'other'), number of negative life events reported in the past year, hardiness (Bartone, 1991), and avoidance (Horowitz et al., 1979). The two groups did differ in age and the number of years of police service. Police officers reporting zero traumatic police incidents were older than officers experiencing at least one incident ( $48.3 \pm 8.8$  years versus  $43.4 \pm 7.3$ ,  $p = 0.0415$ ) and had more years of police service ( $20.2 \pm 7.8$  versus  $14.2 \pm 9.1$ ,  $p = 0.0415$ ).

## DISCUSSION

It has been well documented in the literature that exposure to stressful life events increases the risk of depression (Brown & Harris, 1989; Caspi et al, 2003; Kendler et al, 1998; Kessler, 1997). It has also been established that police officers experience a great deal of chronic work-related stress, such as paperwork and shift work, as well as acute work stress, threats to personal safety and exposure to injury and death (Collins & Gibbs, 2003; Violanti & Gehrke, 2004). Additionally, police officers are also challenged with negative life events, such as family illnesses, financial difficulties, and

Figure II. Differences in depression scores between 0 – 4 negative life events and 5 or more events.



\* *p-value test for difference*

divorce. This study examined two sources of stress – negative life events not specifically related to police work (off duty) and traumatic police incidents, and their association with depression among a random sample of 100 Buffalo, New York police officers.

### Life Events and Depression

This sample of police officers averaged nearly three life events during the previous year. Among the most reported life events were: the death of a close relative or friend, decrease in income, and serious arguments with spouse, boss, or coworkers. Therefore, our analyses focused on exposure to negative life events, a subset of the life events scale, with our sample experiencing 2.5 negative events during the previous year. Results reveal associations between exposure to negative life events and depression. Depression scores for this sample increased as the number of negative life events increased. Age, gender, and ethnicity did not alter the association. An increasing stepwise trend in depression scores was observed between officers experiencing a low, medium, and high number of negative life events, a finding consistent

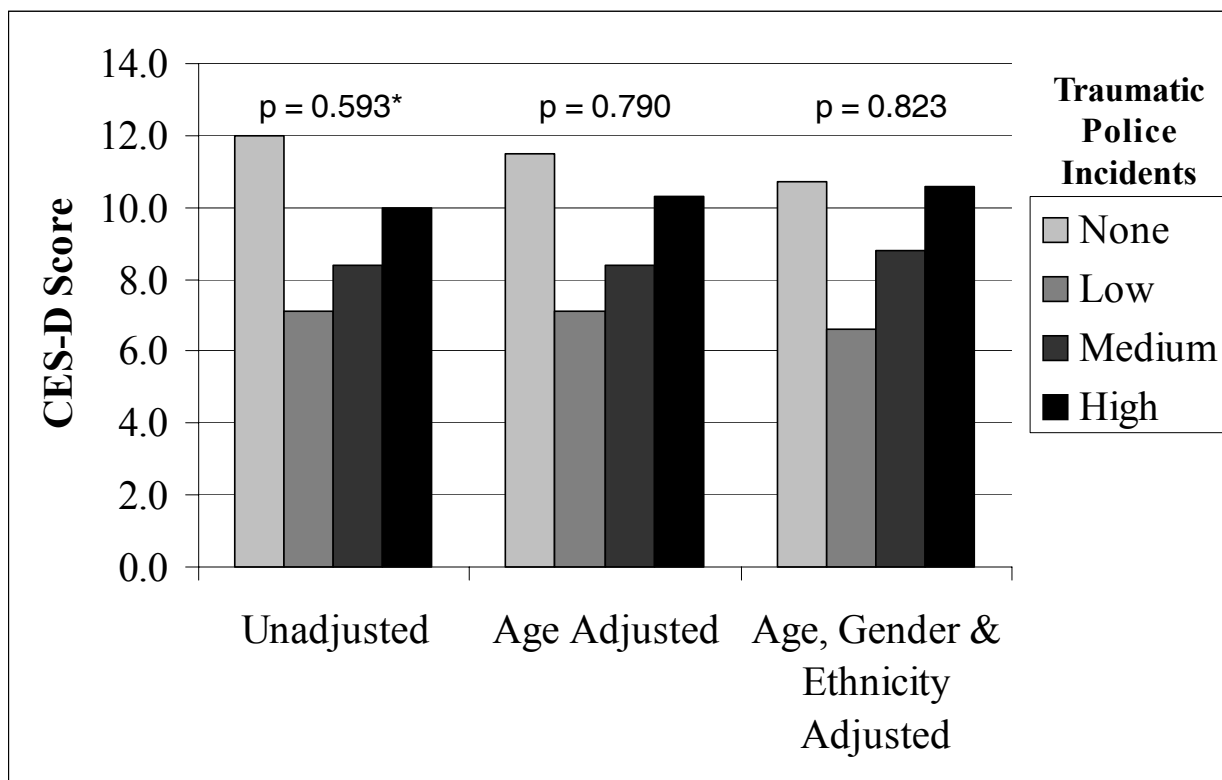
with work by Patton and colleagues (2003).

Further analyses revealed that experiencing a high number of negative life events ( $\geq 5$ ) over the past year compared to four or fewer events nearly doubled depression scores in this sample of police officers. Kendler and colleagues (1998) have proposed a positive interactive model where a coping threshold is reached, such that an individual's coping ability withstands one event but becomes overwhelmed by exposure to multiple events. Perhaps this sample of police officers possesses a higher coping threshold or the ability to withstand more events than other populations.

Officers reporting zero negative life events had higher depression scores than officers who experienced up to four negative life events. Further examination of this group indicated that officers experiencing zero negative life events had significantly more years of service than officers experiencing at least one negative life event, but the groups did not differ in age, marital status, or police rank. This was an unusual result, as previous work has demonstrated associations between life events and depression (Brown & Harris, 1989; Caspi et al, 2003; Kendler et al, 1998; Kessler, 1997). There are sev-



Figure III. Association between traumatic police incidents and depression



\*p-values test for linear trend

eral possible explanations for the present result. First, there were a small number of police officers who fell into this zero negative life event category ( $n = 11$ ); therefore, results may not be consistent with reported and validated larger national samples where associations between depression and life events have been found (Kessler, 1997). Secondly, reporting bias may be possible among police officers, and questions concerning life events or depression may have been answered conservatively or not at all due to guardedness. Third, officers reporting one or more negative life events may have had significantly better sources of social support and, therefore, were better able to cope with the life events they did experience. Future work in this area should include measures of instrumental and perceived social support.

### Traumatic Police Incidents and Depression

Our sample averaged over four traumatic police incidents during the previous year. Among the most frequently reported were exposure to dead bodies, abused children, and victims of assault. Male officers experienced a significantly higher number of incidents than female officers. This finding is con-

sistent with previous work where female officers reported fewer traumatic incidents than male officers (Patterson, 2001b).

There were no associations between the number of traumatic police incidents and depression scores. However, a stepwise trend was observed among police officers experiencing one or more traumatic incidents; depression scores increased as the number of incidents experienced increased.

Police officers who reported zero traumatic police incidents were significantly older and had more years of police service than officers experiencing at least one incident, a finding consistent with other studies (Patterson, 2001b). This finding may imply that the duties of the younger, less experienced police officers differ from those of the older, more experienced officers. Older, more experienced officers may be assigned to areas where fewer criminal acts occur, either by choice or seniority. Younger, less experienced officers may be in position to respond more quickly to dispatch calls, and previous research has found that younger officers are more aggressive and make more arrests than older officers (Patterson, 2001b).

## Limitations

This study was based on cross-sectional data and, therefore, causal relations cannot be determined. Kessler (1997) cautioned against making associations between life events and depression because depression can itself lead to some events and individuals with a history of depression have been shown to have more events than those without episodes of depression. The number of participants was somewhat limited for some of the comparisons. Additionally, some level of recall bias may be introduced as the survey measures asked participants to recall events and experiences that occurred over the course of the previous year.

## Strengths

Strengths of this study include the use of a standardized protocol, high response rates, and cooperation by the police officers. Police officers are a unique occupational group, given their frequent exposure to various forms of acute and chronic stress. Efforts to understand these sources of stress and associated physical and psychological outcomes could be beneficial in developing strategies for stress prevention and reduction.

## Next Steps

These results warrant further investigation into the effects of negative life events and traumatic police incidents on this population, both psychologically and physically. A multi-year prospective study would be beneficial in determining both when the event or incident occurred and when depression occurred, and thus, clarifying the temporal relationship and providing a stronger basis for causality.

The type of negative life event experienced may be a better predictor of depression than the frequency, as past research has shown that severe events are more strongly associated with depression than non-severe events (Kessler, 1997). A global occupational stress score, including both routine organizational and traumatic police incidents, would yield a clearer, more informative assessment of the effects of work-related stress on this population. Additionally, including a measurement of lifetime depression would offer a better estimate of when depressive symptoms first occurred and length of occurrence instead of a snapshot of symptoms experienced over the previous seven days.

## REFERENCES

- American Psychological Association. (2006, February 23). *Stress and Mind/Body Health*. Retrieved July 7, 2006, from <http://apahelpcenter.mediaroom.com/file.php/87/Exec+Summary+Stress+Survey.doc>.
- Ayres, R. M., & Flanagan, G. S. (1992). *Preventing law enforcement stress: The organization's role*. Washington, DC: U.S. Department of Justice Bureau of Justice Assistance.
- Bartone, P. T. (1991, June). *Development and validation of a short hardiness measure*. Paper presented at the Third Annual Convention of the American Psychological Society, Washington, DC.
- Brown, G. W., & Harris, T. O. (1978). *The social origins of depression*. London: Tavistock.
- Brown, G. W., & Harris, T. O. (1989). *Life events and illness*. New York: Guilford.
- Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., et al. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, *301*, 386-389.
- Chen, H., Chou, F. H., Chen, M. C., Su, S., Wang, S., Feng, W., et al. (2006). A survey of quality of life and depression for police officers in Kaohsiung, Taiwan. *Quality of Life Research*, *15*, 925-932.
- Collins, P. A., & Gibbs, A. C. C. (2003). Stress in police officers: a study of the origins, prevalence and severity of stress-related symptoms within a county police force. *Occupational Medicine*, *53*, 256-264.
- Crank, J. P., & Caldero, M. (1991). The production of occupational stress in medium-sized police agencies: A survey of line officers in eight municipal departments. *Journal of Criminal Justice*, *19*, 339-349.
- Goodyer, I. M. (1995). Life events and difficulties: Their nature and effects. In I. M. Goodyer (Ed.), *The depressed child and adolescent: Developmental and clinical perspectives* (pp. 171-193). Cambridge: Cambridge University Press.
- Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of event scale: a measure of subjective stress. *Psychosomatic Medicine*, *41*, 209-218.
- Kendler, K. S., Karkowski, L. M., & Prescott, C. A. (1998). Stressful life events and major depression: Risk period,

- long-term contextual threat, and diagnostic specificity. *Journal of Nervous and Mental Disease*, 186, 661-669.
- Kendler, K. S., Kessler, R. C., Neale, M. C., Heath, A. C., & Eaves, L. J. (1993). The prediction of major depression in women: Toward an integrated etiologic model. *American Journal of Psychiatry*, 150, 1139-1148.
- Kessler, R. C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology*, 48, 191-214.
- Martin, C. A., McKean, H. E., & Veltkamp, L. J. (1986). Post-traumatic stress disorder in police working with victims: A pilot study. *Journal of Police Science and Administration*, 14, 98-101.
- McDowell, I. & Newell, C. (1996). *Measuring health: A guide to rating scales and questionnaires*. (2<sup>nd</sup> ed.) New York: Oxford Press.
- Mills, P. J., Ziegler, M. G., Patterson, T., Dimsdale, J. E., Haugher, R., Irwin, M., et al. (1997). Plasma catecholamine and lymphocyte beta2-adrenergic receptor alterations in elderly Alzheimer caregivers under stress. *Psychosomatic Medicine*, 59, 251-256.
- Orpana, H. M., & Lemyre, L. (2004). Explaining the social gradient in health in Canada: Using the National Population Health Survey to examine the role of stressors. *International Journal of Behavioral Medicine*, 3, 143-151.
- Patterson, G. T. (2001a). Reconceptualizing traumatic incidents experienced by law enforcement personnel. *The Australian Journal of Disaster and Trauma Studies*, 2.
- Patterson, G. T. (2001b). The relationship between demographic variables and exposure to traumatic incidents among police officers. *The Australian Journal of Disaster and Trauma Studies*, 2.
- Patton, G. C., Coffey, C., Posterino, M., Carlin, J. B., & Bowes, G. (2003). Life events and early onset depression: Cause or consequence? *Psychological Medicine*, 33, 1203-1210.
- Paykel, E. S., Prusoff, B. A., Uhlenhuth, E. H. (1971). Scaling of life events. *Archives of General Psychiatry*, 25, 340-347.
- Radloff, L. S. (1977). The CES-D Scale. A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Reiser, M., & Dash, J. (1978). Suicide among police in urban law enforcement agencies. *Journal of Police Science and Administration*, 6, 18-21.
- Spielberger, C. D., Westberry, L. G., Grier, K. S., & Greenfield, G. (1981). *The Police Stress Survey: Sources of stress in law enforcement*. Human Resources Institute, Tampa FL.
- Violanti, J. M. & Aron, F. (1994). Ranking police stressors. *Psychological Reports*, 75, 824-826.
- Violanti, J. M., Burchfiel, C. M., Miller, D. B., Andrew, M. E., Dorn, J., Wactawski-Wende, J., et al. (2006). The Buffalo Cardio-Metabolic Occupational Police Stress (BCOPS) Pilot Study: Methods and participant characteristics. *Annals of Epidemiology*, 16, 148-156.
- Violanti, J. M., & Gehrke, A. (2004). Police trauma encounters: Precursors of compassion fatigue. *International Journal of Emergency Mental Health*, 6, 75-80.
- von Kanel, R., Dimsdale, J. E., Patterson, T. L., & Grant, I. (2003). Association of negative life event stress with coagulation activity in elderly Alzheimer caregivers. *Psychosomatic Medicine*, 65, 145-150.
- Wheaton, B. (1994). Sampling the stress universe. In W. R. Avison, & I. H. Gotlib (Eds.), *Stress and mental health: Contemporary issues and prospects for the future* (pp. 77-114). New York: Plenum.



# International Critical Incident Stress Foundation, Inc.

The Source for Information and Training  
in Comprehensive Crisis Intervention Systems

## Regional Conference Calendar

**June 4-7, 2007**

❖ **New York City, NY**

Disaster Chaplaincy Services

**August 9-12, 2007**

❖ **Denver, CO**

Mayflower Crisis Support Team

**June 21-24, 2007**

❖ **Naples, FL**

Collier County CISM Team

**Other 2007 upcoming locations:**

❖ **Boston, MA**

❖ **Chicago, IL**

❖ **Nashville, TN**

❖ **Myrtle Beach, SC**

❖ **San Diego, CA**

(dates to be determined)

**June 21-24, 2007**

❖ **San Francisco, CA**

San Mateo County CISM Team

**July 17-22, 2007**

❖ **Columbia, MD**

ICISF

### More ICISF Training Opportunities:

Host an ICISF Regional Conference  
to Earn Scholarships for your Team-  
Now scheduling dates in 2008

Contact [Terrip@icisf.org](mailto:Terrip@icisf.org)  
for more information

3290 Pine Orchard Lane, Suite 106 ❖ Ellicott City, MD 21042

Phone: (410) 750-9600 ❖ Fax: (410) 750-9601 ❖ Web: [www.icisf.org](http://www.icisf.org)

For more details, call (410) 750-9600 or visit our Web site at [www.icisf.org](http://www.icisf.org)

## Psychological Debriefing in Cross-Cultural Contexts: Ten Implications for Practice

Stephen Regel

Centre for Trauma, Resilience, and Growth,  
Nottinghamshire Healthcare NHS Trust

Stephen Joseph

Centre for Trauma, Resilience and Growth  
University of Nottingham

Atle Dyregrov

Center for Crisis Psychology

**Abstract:** *Crisis interventions following exposure to traumatic events have become common in most western and in some non-western countries. The literature regarding early interventions, specifically the use of Psychological Debriefing (PD), is grounded in a western context. Little has been written of its use in different cultural settings. This article focuses on the use of PD in different cultural settings, as well as some of the conceptual issues related to cross-cultural trauma research and practice, which inevitably have implications for the use of early intervention. Ten key implications for practice are suggested. [International Journal of Emergency Mental Health, 2007, 9(1), pp. 37-45].*

**Key words:** *early intervention; Critical Incident Stress Management, psychological debriefing; posttraumatic stress; culture; cultural contexts; practice*

The use of psychosocial interventions has become a standard part of disaster interventions across cultures. For example, the International Federation of Red Cross and Red Crescent Societies (IFRC) has over the past decade developed a range of programs through the IFRC Reference Centre for Psychosocial Support, hosted by the Danish Red

Cross, which coordinate resources, assessments, training, and evaluation of psychosocial programs following complex emergencies. Further evidence has recently emerged from research conducted following the Tsunami about the mental health impact of major disasters in different cultural contexts (Yule, 2006). However, the implementation of psychosocial support programs has become controversial in recent years because some researchers have argued against the use of early interventions, such as Psychological Debriefing (PD), following traumatic events (Rose & Bisson, 1998). In this article we will (1) address some of the issues and confusion concerning early interventions, specifically PD; (2) discuss extant evidence and use of early interventions cross-culturally and (3) outline ten implications for the use of early intervention across different cultures.

---

Stephen Regel, M.A., Centre for Trauma, Resilience and Growth, Nottinghamshire Healthcare NHS Trust, Westminster House, 598 The Wells Road Nottingham, NG7 6JJ, England, UK e-mail: stephen.regel@nottshc.nhs.uk Atle Dyregrov, Ph.D., Center for Crisis Psychology, Fabrikkgaten 5, 5059 Bergen, Norway Stephen Joseph, Ph.D., Centre for Trauma, Resilience and Growth, School of Sociology and Social Policy, University of Nottingham. Correspondence concerning this article to Stephen Regel, M.A. at: stephen.regel@nottshc.nhs.uk

## Early Intervention

In order to discuss the role of early interventions it is first necessary to clarify what we mean by early interventions post-trauma. The umbrella term ‘early interventions’ has been used to refer to a variety of different types of intervention. However, it is generally accepted that this would encompass a range of interventions which would come under the construct of Critical Incident Stress Management (CISM).

### *Critical Incident Stress Management (CISM)*

CISM has been clearly articulated in a comprehensive review by Everly and Mitchell (2000). CISM refers to a comprehensive, systematic, and integrated multi-component crisis intervention package that enables individuals and groups to receive assessment of need, practical support, and follow-up services following exposure to traumatic events in the workplace. In addition, it facilitates the early detection and treatment of post-trauma reactions and other psychological sequelae (Mitchell, 1983; 1988). One of the components of CISM is Critical Incident Stress Debriefing (CISD). However, for the purposes of this article, we will use the term Psychological Debriefing (PD). Dyregrov (1989) coined the term *Psychological Debriefing* (PD). Dyregrov has always maintained that PD is about the same as CISD and, especially in Europe, CISD and PD have become interchangeable; they essentially *do* mean the same thing. The main difference (apart from the names of some of the phases) is that Dyregrov (1997) places more emphasis on group process than does the ICISF model. The former has been developed within a European context and may therefore reflect a different tradition for groups and structure than in the US. The other difference is the use of the word *psychological*, which may in some organizational and cultural contexts have negative connotations. PD, like CISD, was also originally developed within the field of crisis intervention and is a structured intervention facilitated through a series of stages. What is also important to note is that CISM is neither counselling nor psychotherapy and was never intended as a ‘psychological treatment.’ This is important because confusion can arise when the terms are used interchangeably, as has occurred throughout the literature.

### *The Cochrane Report*

Despite the widespread use of CISM, it has become controversial in recent years due, in part, to the publication of

The Cochrane Report (1998; 2000). The Cochrane Report (1998; 2000) has been interpreted as providing evidence against early intervention. Thus, before we consider different cultural contexts, it is important to briefly review the main conclusions of the Cochrane Report.

The Cochrane Report on PD (Wessley, Rose, & Bisson, 1998) provided evidence that PD might have negative effects on participants. As a result, many organizations and professionals stopped utilizing PD as a crisis intervention technique. There are, however, reasons why this conclusion should be approached cautiously. First, the studies reviewed by Wessley, Rose, and Bisson (1998) consisted of randomized controlled trials (RCTs) of single sessions with individuals who were primary victims of trauma (e.g., exposed to burn trauma and motor vehicle accidents). CISM approaches are not usually intended as single sessions but involve follow-up and are chiefly designed for use with secondary victims. Second, there were also a number of methodological shortcomings in the studies of the Cochrane Report. In a number of the studies reviewed, there was a lack of or inappropriate training for those providing PD as it is defined above. Third, the techniques employed by the intervention in the studies was not always as articulated above by either Mitchell and Everly (1999) or Dyregrov (1990). For example, in one study it is stated that “debriefing involves the use of intense imaginal exposure” (Bisson, Jenkins, & Alexander, 1997). PD, as described above, does not entail imaginal exposure. Fourth, not all of the studies were interviewer-blind. In their 1996 study of MVA victims, Hobbs and colleagues merged assessment with the interventions and follow-up, perhaps compromising “interviewer blindness.”

For these reasons, the conclusion to the Cochrane report should be approached cautiously, as many of the studies included in the review were not concerned with CISM or PD procedures as they are generally accepted by workers in the field. In addition, what has been termed PD in the Cochrane report has often been viewed as a form of psychotherapy or counselling (Davidson, 2004; Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Summerfield, 1995). Previous articles have made a clear distinction of the difference in terminology. However, in the field, practitioners who are not adequately trained may use the terms interchangeably and thus inaccurately, with the potential to cause confusion in recipients. PD as reviewed by Rose and Bisson (1998) has been viewed as a form of counselling or psychotherapy and, although it is a form of psychological help, it is

psychoeducational rather than concerned with the reconfiguration of personality or altering personal defenses as is the case with counselling and psychotherapy.

We concur with the Cochrane Report that organizations that seek to help disaster stricken populations or to serve their own personnel should refrain from single-session debriefings, but we also argue that it would be going beyond the evidence to over-generalize the findings of the Cochrane Report to a) all early interventions b) counselling and psychotherapy or c) the plethora of research pertaining to the successful use of PD in a variety of contexts, but simply not considered for inclusion in the Review because they were not randomized control trials. Our response to the Cochrane Report is to call for a broader range of follow-up services as part of comprehensive, multi-component early intervention strategies (e.g., Everly & Langlieb, 2003; Flannery, Everly, & Eyler, 2000; Rauch, Hembree, & Foa, 2001; Litz, Gray, Bryant, & Adler, 2002). There is also a need for further research on early intervention procedures more widely defined. Work published subsequent to the Cochrane Report appears to have provided 'evidence' that PD may be harmful, but there is also evidence that early intervention utilizing PD can be beneficial. Adequate early intervention procedures in the workplace, following disasters and in other contexts have been shown to have beneficial effects across a spectrum of outcomes (Boscarino, Adams & Figley, 2005; Deahl, Srinivasan, & Jones, 2000; Richards 2001; Dyregrov & Gjestad, 2003). Solomon, Shklar, and Mikulincer (2005) evaluated front-line treatment based on the principles of proximity, immediacy, and expectancy used in early intervention and showed that even after twenty years the use of these principles was associated with improved outcomes.

### **The Use of Psychological Debriefing in a Cross-Cultural Context**

Considering early interventions in different cultural contexts, it seems prudent to be even more cautious about generalizing the findings of the Cochrane Report to non-Western cultures. First, it is important to recognize that our conceptions of suffering are cultural specific. People differ in what they believe and understand about life and death, what they feel, what elicits those feelings, the perceived implications of those feelings, their expression and appropriateness of certain feelings, and strategies for dealing with feelings (see, Rosenblatt, 1993). A cross-cultural perspective demonstrates the variety, for example, in people's responses to death and

dying and the process of mourning. Rather than being process-orientated, mourning is seen as an adaptive response to specific task demands arising from loss that must be dealt with regardless of individual, culture, or historical era (Hagman, 1995). Stroebe (1992-1993) challenges the belief in the importance of 'grief work' for adjustment to bereavement. Stroebe examined claims made in theoretical formulations and principles of grief counselling and therapy concerning the necessity of working through loss. Several authors have shown how grief reactions are patterned by the culture, formed by one's society's belief systems, expectations, values and norms for relationships, and bonds (Eisenbruch, 1991; Stroebe & Schut, 1998; Wikan 1990). This will influence both expression and duration of grief reactions across different cultural settings. In essence, sensitivity to the culturally appropriate needs for ritual in responding to grief and providing for privacy and personal needs are paramount. Evidence for the role of early intervention must be evaluated within its cultural context.

Green and Honwana (1999) and Summerfield (1999) have been critical of debriefing, arguing that many of the major aid organizations, such as UNICEF, USAID, Save the Children, and the Christian Children's Fund, should exercise caution when developing psychosocial programs to assist war affected children. Similar concerns were expressed by the Overseas Development Institute (ODI) report regarding the Disaster Emergency Committee (DEC) Kosovo Appeal Funds (ODI, 1999/2000) psychosocial interventions and the plethora of counselling and therapy programs in the region. However, the ODI report also advocated for early interventions for staff workers to help with the stressful nature of humanitarian work (ODI, 1999/2000, p.124). Again, here are examples of confusion in the terminology combined with misconceptions about PD and what constitutes psychosocial interventions, counselling, and therapy. Dyregrov and colleagues (2002) argue that it is possible to be culturally sensitive in such cases by working closely with local agencies to ensure the culturally appropriate application of methods and the integration of the host culture's natural healing systems and processes. Evidence is limited, not surprisingly, and randomized controlled research is not available; but other research and experience suggests ways in which this might be implemented. One example is the South Africa's Kwa Zulu Natal Program for Survivors of Violence.

The Kwa Zulu Natal Program for Survivors of Violence (KZNSV) provides an insightful case study of the use of

early intervention in a different cultural context. A non-profit NGO, it aims to rebuild the social fabric of communities most severely affected by violence in Kwa Zulu Natal province. It offers holistic community-based interventions through community development. It provides a range of interventions, ranging from personal development work, education, and training to trauma counselling, conflict resolution, and debriefing. Early intervention in this context is utilized very much along the lines of the crisis intervention model outlined previously, offering small groups the opportunity to discuss various issues affecting their communities following exposure to traumatic events (e.g. witnessing or being subject to political and criminal violence, rape, sexual assault, and domestic violence). The sessions are often held in the community, perhaps in one of the community leaders' homes. There may be more than one session, and follow-up sessions are included. Therefore 'debriefing' in this example is adapted to suit the needs of the community and would appear to be informal and semi-structured, utilizing narrative and storytelling (Zandile Nhlenghwa, KZNSV Coastal Co-ordinator, personal correspondence).

Similarly, in South Africa, many trauma service providers have been gradually shifting from their traditional roles of dealing with survivors of torture in a post-apartheid society. Some are being utilized by numerous organizations for the provision of post-trauma related support where indicated, providing a broad range of interventions for dealing with trauma survivors. Psychological debriefing and other forms of early interventions for groups and individuals, clearly viewed as different from "counselling" and therapeutic interventions, are provided. In the cultural context of a multi-ethnic country, such as South Africa, the need for flexibility, adaptability, and the ability to be responsive to the needs of various ethnic groups was an important consideration. Additionally, in dealing with complex communities where political violence and high crime rates are a major consideration, early interventions are seen as pragmatic and practical responses in dealing with survivors.

Mercer, Ager, and Ruwanpura (2005), in their article on Tibetan exiles, illustrate how traditional non-western coping strategies and cultural practices can be supplemented by western interventions following conflict and forced migration. They also suggest that the facility may accommodate explanatory models as a key factor in the acceptability of the project, as well as accommodating the views and priorities of local stakeholders. Likewise Straker and Moosa (1994) present

a case and discuss the use of western inspired early interventions (telling their story several times), along with the use of African rituals and healing practices; they attribute the successful outcome to the integration of these methods.

### *Asylum seekers and refugees in the United Kingdom*

What we know about early intervention does not necessarily apply in other cultures, and this is of course also true when we work with asylum seekers in the U.K. The use of debriefing with asylum seekers in the U.K. in assessment centres has also been reported (Izycki, 2001), although little detail is provided other than to indicate that the model used is the Three Stage Model. This model essentially adapts Mitchell's 7-stage model into three phases: facts, feelings, and future (Letts & Tait, 1995). It is suggested that the PD techniques mentioned previously be used alongside elements of crisis intervention, indicating that it is possibly being used for a different purpose. The rationale for utilizing a debriefing intervention is not provided and no indication is given as to evaluation or intended outcomes, which begs the question of the appropriateness or utility of such an intervention in such instances.

Early interventions following conflict and disasters are often used at a time when there is a breakdown in traditional systems of care, (i.e., when there is a cultural trauma; Stamm, Stamm, Hudnall, & Higson-Smith, 2004). It is important that the use of early interventions does not accelerate cultural disintegration, but works to nurture and supplement healing elements within the indigenous culture. This is especially true for asylum seekers who are already displaced from their own culture. Thus, culturally appropriate early interventions should stimulate a sense of identity, support self-efficacy, and work to re-establish structure and meaning on both an individual and collective level. However, we would also caution that respect for cultural traditions should not prevent us from confronting traditional practises that may further complicate the situation for those affected by a trauma (Dyregrov, Gupta, & Raundalen, 2002).

### *The use of early intervention within humanitarian aid organizations*

As part of preparation for a recent chapter in the British Psychological Society's (BPS) Professional Practice Board Working Party Report on Psychological Debriefing (BPS,



2002), one of the authors (SR) contacted a number of humanitarian aid organizations to elicit current practice, training, use of protocols and procedures, supervision, follow-up, and evaluation. Among the agencies that responded, it was clear that their welfare departments supply support, advice, and early intervention to providers in the field or upon their return from a mission. There are clear protocols in place for the delivery of the interventions, and supervision guidelines are provided. Members of the debriefing teams also have refresher training and updating.

In 2000, the United Nations High Commissioner for Refugees (UNHCR), during the Kosovo operations, utilized CISM and peer debriefing training in the field for UNHCR staff, (conducted by SR). This training was evaluated by all participants with quantitative and qualitative feedback and was conducted in conjunction with the welfare department, both in Geneva and in the field. Follow-up arrangements were organized with UN Counsellors in the field to provide the overall structure for those personnel identified as requiring further support.

Many organizations have a proactive policy and model to support their emergency workers when they are exposed to a critical incident. Some have adapted a debriefing model to suit their needs and have identified three areas: Ongoing (or cumulative) critical incident stress; group versus individual procedures; and field versus post-mission procedures. Protocols have been developed for ongoing stress, for a three-phase group, and for complementary individual sessions (Cohen de Lara-Kroon & van den Berkof, 2001). It is known that many of the other aid organizations are providing PD and other CISM support, though it is unclear which particular models have been selected and used.

The International Federation of Red Cross and Red Crescent Societies (IFRC/RC) Reference Centre for Psychosocial Support, hosted by the Danish Red Cross, was established in 1993. The Reference Centre has been instrumental and innovative in the development of a community-based Psychological Support Program (PSP). This is a short, modular training program intended as an adjunct to basic Red Cross work and aimed at addressing the psychological support needs of both volunteers and the public in case of a major disaster. The program now has a roster of mental health professionals who are able to provide assessment and training to other Red Cross National Societies in the PSP program. In June 2001, the IFRC used the WHO theme of mental health

to launch a document entitled *Psychological Support: Best Practices from Red Cross and Red Crescent Programs* (IFRC/RC, 2001). The document highlighted best practice as demonstrated by fifteen programs throughout the world that had developed PSP programs following disasters or civil conflict.

In this program early interventions are addressed from a supportive community-based perspective. The guidelines for the implementation of a psychological support program in emergencies have not endorsed PD as a routine model, because of the “scientific disagreement about the effectiveness of the approach...” (IFRC, 2001, p.8), or “because of possible negative effects” (World Health Organization, 2003). A major factor for the inclusion of such statements has been the impact of the Cochrane Review on practice, yet the Cochrane Review also stated that “we are unable to comment on the use of group debriefing, nor the use of debriefing after mass traumas” (Wessley, Rose, and Bisson, 1998, p.10).

A survey of 24 Red Cross National Societies who said they used PD as part of their range of interventions following disasters or critical incidents was undertaken to assess the current use of PD as an early intervention strategy. This was also an opportunity to gauge the use of PD across different cultures. What is clear is that some form of early crisis intervention, in the form of different group formats, is in place in many instances, though there are wide variations in training, supervision, and evaluation (Regel and Courtney-Bennett, 2002). Some NSs have adopted their own model or adhered to a culturally specific model, as in the case of the French Red Cross (Lebigot, 2001). It is also clear that the controversy did not deter many Red Cross and Red Crescent National Societies from continuing what they perceived as “a necessary practice.” This view is supported by the results of a meta-analysis of studies of psychological debriefing with vicarious trauma in emergency care providers (Everly, Boyle, & Lating, 1999)

### **Undertaking Psychological Debriefing in Different Cultural Settings – Ten Implications for Practice**

This literature review examined the impact of the cultural context following traumatic events and has highlighted the following ten issues and implications for the use in the practice of early intervention. It must be noted that these implications are derived from, but not necessarily based on, the current literature review and that empirical support is necessary to test their efficacy.

1. Different ethno-cultural groups have differential responses to traumatic events that will become apparent in the context of a group session. In addition, building trust and establishing a safe environment for such meetings may be especially difficult when the facilitator is from a different cultural or racial background than the participants.
2. Many non-Western ethnic groups present symptoms somatically rather than psychologically or existentially; this has implications for the development of a cohesive narrative and the interpretation, contextualization and normalization of traumatic responses
3. There is a need for more research among ethno-cultural minority populations to identify the sources of strength and resiliency that mediate the onset, course, and outcome of Posttraumatic Stress Disorder (PTSD). This would impact on the educational and support elements of the intervention process. For example, there would be less need to emphasize the role of community support as that is often a given in different cultures, a view supported by those attending psychosocial training programs in Somalia, Korea, and Japan, where there was a universal recognition among participants (all drawn from local communities) that the community would gather resources and support as necessary in the event of a disaster or crisis.
4. Some researchers have suggested that, whereas intrusive thoughts and memories of a traumatic event may transcend cultural experiences, the avoidance/numbing and hyper-arousal symptoms may be highly determined by ethno-cultural affiliation. This has implications for the application of more sophisticated interventions and explanations in the psycho-educational phases of the intervention process.
5. The need to use interpreters will influence interactions and compound difficulties mentioned above. Therefore, careful discussion of the process in psychological debriefing will be essential. In addition, this will also affect the time frame of the intervention, posing possible constraints on participation and attendance.
6. Culturally based willingness to accept different “therapeutic” formats (e.g., individual vs. group interventions) may have an impact on the intervention. In many cultures, story telling and discussion in a group context and setting is often common, thus making the idea of discussing difficult experiences more acceptable.
7. A consideration of indigenous expressions of disorder, idioms of distress, formats, language, and concepts is vital in order to contextualize attribution and meaning arising out of a crisis.
8. Early intervention in a cross-cultural setting must be offered within a broader context and framework, integrating ethno-cultural factors, rituals, problems of meaning and language, metaphors, cultural symbolism, and awareness of adaptational/acculturation pressures.
9. Early intervention conducted in a cross-cultural setting should also be carried out within a structured framework, ensuring follow-up arrangements for ongoing support. This is especially important in the context of humanitarian aid organizations where delegates are exposed to critical incidents and stressors in the field.
10. Finally, the cultural sensitivity and sophistication of the facilitator is paramount when discussing pertinent aspects of the trauma, such as those related to sexual matters or to death.

The above points are not intended as a comprehensive checklist, but merely offered as factors that should be considered if early intervention, such as PD, is applied in different cultural settings. The challenge remains of how best to approach interventions with these populations in a culturally relevant framework. More research is now needed on the precise nature of interventions across cultures, organizations working with diverse cultures and populations affected by extreme traumatic events. Due to the paucity of literature in the field, longitudinal prospective studies are needed to examine the effects of cumulative stressors in humanitarian aid workers. There are also a number of implications for practice, especially with regard to the practice of early interventions in different cultural settings and contexts. The ability to be flexible and adapt robust crisis intervention strategies and techniques is essential, as is the ability to distinguish between therapy and sound psycho-educational interventions for individuals and groups following exposure to traumatic events (Marsella, Friedman, & Gerrity, 1996).

## CONCLUSION

This article has addressed a range of issues that impact on the use of early intervention in different cultural contexts. Our review suggests that many organizations use early intervention, including various forms of PD, despite the criticism of such approaches and the pressure to cease the practice. There is reason to believe that early interventions are often helpful. We now need further evaluations that are able to address the various criticisms of the Cochrane Report. In many other cultures the notion of psychological or psychosocial support following traumatic or extremely stressful events is viewed as common sense and a humanitarian act, whether this is in the form of low key support or more professionally driven psychological interventions. There are clear examples of good practice among some of the key humanitarian aid organizations with clear protocols and practice frameworks in place. The relatively widespread use of early intervention in culturally diverse settings, such as the International Federation of Red Cross and Red Crescent Societies (IFRC), is an indication that the need for support mechanisms of some kind for volunteers, aid workers, and survivors of disasters or critical incidents are deemed to be essential. Finally, we have outlined ten issues for consideration that we think should inform future practice and research in understanding effective early interventions.

## REFERENCES

- Bisson J.I., Jenkins P.L., & Alexander, J. (1997) Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, 171, 78-81
- Boscarino, J.A., Adams, R.E., & Figley, C.R. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Mental Health*, 7, 9-22.
- British Psychological Society (2002) *Psychological Debriefing -Report of the Professional Practice Board Working Party*. British Psychological Society, Leicester, UK
- Cohen de Lara-Kroon, N., & van den Berkof, R. (2001). Debriefing Procedures for Humanitarian Aid Workers. Workshop presented at ESTSS Seventh European Conference on Traumatic Stress, 26-29<sup>th</sup> May, Edinburgh, Scotland.
- Davidson, J.R.T. (2004) Long-term treatment and prevention of Posttraumatic Stress Disorder. *Journal of Clinical Psychiatry*, 65 [Supplement 1], 44 – 48.
- Deahl, M., Srinivasan, M., Jones, N. (2000). Preventing psychological trauma in soldiers: The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology*, 73, 77-85.
- Dyregrov, A. (1989) Caring for helpers in disaster situations: Psychological debriefing. *Disaster Management*, 2(1), 25-30
- Dyregrov, A. (1997) The process in psychological debriefings. *Journal of Traumatic Stress* 10(4), 589-605.
- Dyregrov, A., & Gjestad, R. (2003). A meritime disaster: Reactions and follow-up. *International Journal of Emergency Mental Health*, 5 (1), 3-14.
- Dyregrov, A., Gupta, L., Raundalen, M (2002). Is the culture always right? *Traumatology*, 8(3).
- Dyregrov, A., Gjestad, R, Raundalen, M. (2002). Children exposed to warfare: A longitudinal study. *Journal of Traumatic Stress Vol. 15* (1), 59-68.
- Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees, *Social Science & Medicine*, 33, 673-680.
- Emmerik, A.P., Kamphuis, J.H., Hulsbosch, A.M., & Emmelkamp, P.M. (2002). Single session debriefing after psychological trauma: A meta-analysis. *Lancet*, 360, 766-771.
- Everly, G.S., Jr., Boyle, S.H., & Lating, J.M (1999) The Effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine*, 15, 229-233.
- Everly G.S., Jr., & Mitchell, J.T. (2000). The debriefing “controversy” and crisis intervention: A review of lexical and substantive issues. *International Journal of Emergency Mental Health*, 2 (4), 211-225
- Everly, G.S., Jr., & Langlieb, A. (2003). The evolving nature of disaster mental health services. *International Journal of Emergency Mental Health*, 5(3), 113–119.
- Flannery, R.B., Jr., Everly, G.S., Jr., & Eyler, V. (2000). The assaulted staff action program (ASAP) and declines in assault: A meta-analysis. *International Journal of Emergency Mental Health*, 2(3), 143–148.
- Green, E.C., & Honwana, A. (1999). Indigenous healing of war – affected children in Africa. *Indigenous Knowledge (IK) Notes, No.10, July*, Africa Region’s Knowledge and Learning Centre & World Bank Publications.
- Hagman, G. (1995). Mourning: A review and reconsideration. *International Journal of Psychoanalysis*, 76, 909 – 925.

- Hobbs, M., Mayou, R., Harrison, B. (1996). A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *British Medical Journal*, 313, 1438-1439
- International Federation of Red Cross and Red Crescent Societies (2001) *Guidelines for the Implementation of a Psychological Support Program in Emergencies*. International Federation of Red Cross and Red Crescent Societies: Geneva.
- Izzychi, K. (2001). A safe haven for asylum seekers. *Mental Health Practice*, 4(6) 12-15.
- Lebigot, F. (2001). Le debriefing collectif. *Stress et Trauma*, 1(3), 137–141.
- Letts, C., Tait, A. (1995). Post-raid de-briefing. *Occupational Health Vol. 47*(12), 418-421.
- Litz, B.T., Gray, M.J., Bryant, R.A., & Adler, A.B. (2002). Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice*, 9, 112-134.
- Marsella, A.J., Friedman, M.J., Gerrity, E.T. (1996) (Eds.) *Ethnocultural aspects of PTSD: An overview of issues research and clinical applications*. American Psychiatric Press: Washington, D.C.
- Mercer, S. W., Ager, A., & Ruwanpura, E. (2005). Psychosocial distress of Tibetans in exile: Integrating Western interventions with traditional beliefs and practices. *Social Science & Medicine*, 60, 179–189.
- Mitchell, J.T. (1983). When disaster strikes - The critical incident stress debriefing process. *Journal of emergency Medical Services, need volume #*, 36-39.
- Mitchell, J.T. (1988). Development and functions of a critical incident stress debriefing team. *Journal of emergency Medical Services, need volume #*, 43-46.
- Mitchell, J.T., & Everly, G.S., Jr. (1999). Critical incident stress management: A new era in crisis intervention. *ESTSS Bulletin*, 6(2), 3-7.
- Overseas Development Institute (1999-2000). Independent Evaluation of Expenditure of DEC Kosovo Appeal Funds, Phase I & II. ODI: London.
- Raunch, S., Hembree, E., & Foa, E. (2001). Acute psychosocial preventive interventions for posttraumatic stress disorder. *Advances in Mind-Body Medicine*, 17, 160–196.
- Regel, S., & Courtney-Bennett, H. (2002). Cultural factors with an impact on psychological debriefing. In *Psychological debriefing: Report by British Psychological Society Professional Practice Board Working Party*, Chapter 9, pp. 64 - 73- British Psychological Society: London.
- Richards, D. (2001). A field study of critical incident stress debriefing versus critical incident stress management. *Journal of Mental Health*, 10, 351-362.
- Rose, S., & Bisson, J. (1998). Brief early psychological intervention following trauma: A systematic review of the literature. *Journal of Traumatic Stress*, 11, 697–710.
- Rosenblatt, (1993). Cross cultural variation in the experience, expression and understanding of grief. In: Irish, D.P., and Lundquist, K.F (Eds.) *Ethnic variations in dying, death and grief: Diversity in universality*. Taylor and Francis: Washington D.C.
- Solomon, Z., Shklar, R., & Mikulincer, M. (2005). Frontline treatment of combat stress reaction: A 20-year longitudinal evaluation study. *American Journal of Psychiatry*, 162, 2309–2314.
- Stamm, B., Stamm IV, H.E., Hudnall, A.C., & Higson-Smith, C. (2004). Considering a theory of cultural trauma and loss. *Journal of Loss and Trauma*, 9, 89–111.
- Stroebe, M.S. (1992-1993). Coping with bereavement: A review of the grief work hypothesis. *Omega: Journal of Death and Dying*, 26, 19-42.
- Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care*, 17, 7–11.
- Straker, G., & Moosa, F. (1994). Interacting with trauma survivors in contexts of continuing trauma. *Journal of Traumatic Stress*, 7 (3), 457-465.
- Summerfield, D. (1995). Debriefing after psychological trauma: Inappropriate exporting of Western culture may cause additional harm. *British Medical Journal*, 311, 7003, 509
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programs in war affected areas. *Social Science and Medicine*, 48, 1449 – 1462.
- Wessely S., Rose, S., Bisson, J. (1998). A systematic review of brief psychological interventions (“debriefing”) for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder. *The Cochrane Library*, 1998(4).

Wikan, U. (1990). *Managing turbulent hearts*. The University of Chicago Press: Chicago.

World Health Organization (2003) *Mental health in emergencies*. Department of Mental Health and Substance Dependence: Geneva.

Yule, W. (2006). Theory, training and timing: Psychosocial interventions in complex emergencies. *International Review of Psychiatry*, 18 (3), 259-264.

## International Critical Incident Stress Foundation, Inc.

The Source for Information and Training in Comprehensive Crisis Intervention Systems

### Contact ICISF today for...

- ❖ Regional Conferences on crisis intervention—  
Visit the ICISF website for the range of topics available
- ❖ World Congress on Stress, Trauma & Coping (bi-annual)
- ❖ Membership in an international multi-disciplinary organization devoted to crisis intervention education
- ❖ Quarterly member newsletter
- ❖ Quarterly journal (with certain membership options)
- ❖ Certificates of Specialized Training in five specialty tracks
- ❖ Assistance in formation of CISM Teams
- ❖ International Database & Registry of CISM Teams
- ❖ Consultation in crisis & disaster response



### ICISF, Inc.

3290 Pine Orchard Lane, Suite 106  
Ellicott City, MD 21042  
Telephone: (410) 750-9600  
Fax: (410) 750-9601  
Email: [icisf@icisf.org](mailto:icisf@icisf.org)  
Website: [www.icisf.org](http://www.icisf.org)

The Association of Traumatic Stress Specialists is an international multidisciplinary organization founded to educate and professionally certify qualified individuals actively engaged in crisis intervention, trauma services and response, and the treatment and healing of those affected by traumatic stress. The Certification Board represents individuals who have practical experience in providing direct support to trauma victims and survivors.

**MEMBERSHIP BENEFITS**

- Three Membership Options: Agency/Team, Student/Retiree, and Individual
- Reduced Certification and Re-Certification Fees
- International Board Certifications Options for Eligible Application and Recognition as a Certified Trauma Responder (CTR), Certified Trauma Specialist (CTS), and Certified Trauma Services Specialist (CTSS)
- Comprehensive ATSS Membership Directory and Code of Ethics
- Trauma Lines Quarterly ATSS Newsletter
- Conference and Training Discounts
- Continuing Education Recognition from Professional Associations for ATSS-Sponsored Training and Education Events
- Affiliation with an International Professional Network of Skilled Trauma Specialists
- One Vote in ATSS Organizational Elections
- Opportunities to Network with Other Specialists
- Reduced Subscription Rates to the Quarterly *International Journal of Emergency Mental Health*
- Web Site Links to the Information You Need

**Agency, Organization, or Team Membership Benefits**

- All of the Above-Listed Individual Member Benefits Apply
- Conference and Training Discounts for Five Individuals
- Reduced Certification Fees for Staff and Volunteer Agency Representatives

**MEMBERSHIP APPLICATION**

- \$ 70.00\* **Individual Membership** Dues For One Year
- \$ 35.00\* **Student/Retiree Membership** Dues For One Year  
Please provide proof of student status
- \$175.00\* **Agency Membership** Dues For One Year  
*International Journal of Emergency Mental Health* (optional)
- \$ 54.00\* **Domestic Subscription**
- \$ 77.00\* **International Subscription**
- \$ \_\_\_\_\_ **Donation** Contributions or gifts to ATSS may be deductible as charitable contributions for income tax purposes. All dues are deductible by members as an ordinary and necessary business expense.
- \$ \_\_\_\_\_ **TOTAL** \*PAYABLE IN U.S. FUNDS ONLY

Agency/Organization Applicant \_\_\_\_\_

Agency Contact \_\_\_\_\_

Individual Applicant \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

I am interested in (please check all that apply):

- CTR (Trauma Responder)    CTS (Trauma Treatment)    CTSS (Trauma Services)

**METHOD OF PAYMENT**

Check, PO or Money Order Enclosed (Payable to: ATSS). Check or PO # \_\_\_\_\_

Credit Card:    MasterCard    Visa    Discover    AMEX

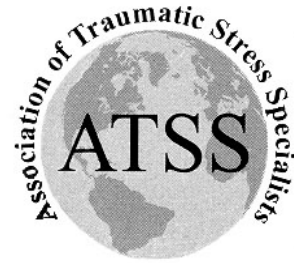
Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Signature \_\_\_\_\_

I authorize ATSS to charge my card for the amount shown above.

Return this application with fee to: **ATSS, P.O. Box 246, Phillips, ME 04966 USA**

If paying by credit card, this form may be faxed to: **207-639-2434**



**Association of  
Traumatic  
Stress Specialists**

*An International Organization  
Recognizing Standards of Excellence  
In Response, Treatment & Services*

**P.O. Box 246  
Phillips, ME 04966  
Phone: 207-639-2433  
Fax: 207-639-2434  
E-mail: Admin@ATSS.info  
Web Site: www.atss.info**

For information on certification,  
membership, affiliations,  
or upcoming conferences,  
please contact:

**David Sanders  
Office Manager  
207-639-2433  
Admin@ATSS.info**

or

Visit our Web site:

**www.ATSS.info**

*ATSS Members  
Make A Difference!*

## *Book Excerpt*

### **World War II Survivors: Lessons in Resilience**

by  
Glenn R. Schiraldi, Ph.D.

Resilience is, perhaps, needed more now than ever before. Symptoms in high-risk first responders (firefighters, police, military, and so forth) reflect the difficulty in coping with increasingly inhospitable environments. These symptoms include alcoholism, depression, anxiety, post-traumatic stress disorder (PTSD), domestic violence, divorce, and a host of stress-related medical illnesses. *WWII Survivors: Lessons in Resilience* is a book that explores lessons learned from the WWII generation about resilience.

Over a five-year period, Dr. Schiraldi traveled the country to interview more than forty people who survived combat with reasonably good mental adjustment and who had also survived an average of eighty years of life with all of its challenges. Each person told his or her story, and then discussed the strengths of mind and character that comprise resilience—strengths that helped them to cope under pressure, fend off PTSD and related disorders, and return to live fruitful lives.

The book contains histories of people who experienced nearly every aspect of WWII, from Hitler's invasion of Poland to Pearl Harbor, the Bataan Death March, the Burma-Thailand Death Railway, D-Day, Bastogne, Iwo Jima, and prisoner of war camps. Interviewees represented Tuskegee Airmen, Navajo Code Talkers, Infantrymen, Airmen, Sailors, Marines, and resistance fighters.

After they told their stories, each person was asked whether or not they were troubled by PTSD symptoms as a barometer of their post-war adjustment. They were then asked to provide their perspectives on the strengths that got them through the war in relatively good mental health, as well as on the fourteen specific strengths that have been associated with resilience. Together, the interviews provide a rich portrait of resilience, one which can help today's generations better understand what it takes to survive conditions of extreme distress.

What follows is one interview from *WWII Survivors*. Dr. Schiraldi relates, "Unlike many of the resilient survivors in this book, Mr. Dunham did not come from a secure and happy home. He was the only member of his family who did not become an alcoholic, although he had ample reasons to do so. Understandably, he took awhile to get his bearings in life, and his post-war transition was not without some challenges. Yet his story is about one who overcame enormous odds, and it offers great insights into resilience."

#### **CHAPTER 15 RUSSELL DUNHAM MEDAL OF HONOR**

I was born February 23, 1920, in East Carondelet, Illinois, in a converted boxcar on the Mississippi River. Dad worked then for a barge line. I was the sixth of eight children—three girls and five boys. When I was three, we moved because of my mother's health.

---

**Glenn R. Schiraldi, PhD**, has served on the stress management faculties at the Pentagon, The International Critical Incident Stress Foundation and the University of Maryland. Correspondence regarding this article should be directed to Dr. Schiraldi at: glenn@umd.edu. *World War II Survivors: Lessons in Resilience* is available from Chevron Publishing Corporation at [www.chevronpublishing.com](http://www.chevronpublishing.com).

We moved quite a bit. Mother was sick with tuberculosis most of my life. She died when I was seven. I don't remember her walking. At one point the family moved to Springfield, in southern Missouri, where my mother had a sister and the weather was warmer. We traveled the distance of 400 miles in a covered wagon.

The whole family had to work real hard, all the time. My dad was a gardener all his life and my first Christmas present was a hoe. As everyone said, my dad was a good boss. Dad rented farms. He moved around when the rent came due. I had an older sister who took pretty good care of us.

After my mother died in 1927, we had a number of housekeepers before Dad remarried. The older children left as soon

as they were able. Dad remarried in 1932. My stepmother had three children of her own, and together they had three more.

During the Depression, we oftentimes didn't know where our next meal was coming from. Everybody was expected to do their part from the time they were able to do anything at all. Dad checked on us as we worked. He was busy selling produce, mainly butterbeans, to the produce market in St. Louis. Dad was strict, no doubt about it. Nowadays, welfare probably wouldn't have put up with the way he handled us kids. He was mean to us. My stepmother was worse than he was. I didn't go to high school. He needed us to work at home.

I left home at 16 or 17, when he broke my plate and said get out. It was my stepmother's idea that I leave home. I went to stay with my older brother in St. Louis, peddling hot tamales at night, and brooms and mops by day from carts. I also distributed advertising circulars for stores door to door at thirty-five cents an hour. Overtime was fifty cents an hour.

My dad coaxed me into going into the Civilian Conservation Corps in 1938. I always tried to help him. CCC paid \$30 per month, \$25 of which was to be sent home. He said he would give me back some of the money I sent home, but he never did. I worked on farms, setting out trees, building dams, placing tiles to drain farm fields, clearing out farm fields. After my six months were up, my buddy and I took a freight train to California to pick cotton. Business wasn't good, so I came back to St. Louis to sell hot tamales, brooms, and mops until spring.

My buddy and I decided to go back to California. We got to Tulsa, Oklahoma, and joined a carnival. I traveled over the country until the fall of 1939. Then it was back to selling tamales, brooms, and mops in St. Louis.

In August of 1940, my brother Ralph, a buddy, and I went to Peoria, Illinois, to look for a job. Finding none, we joined the Army. We knew that eventually war was on the way. I was so dumb I didn't know any better than to join the infantry (*chuckling*).

We went to Fort Ord, California, to the old 7<sup>th</sup> Infantry Division under General Stillwell.

In March of 1941, they transferred all three-year men to the 3<sup>rd</sup> Infantry Division. I was in "I" Company, 3<sup>rd</sup> Battalion, 30<sup>th</sup> Infantry Regiment, and stayed with that unit throughout the war.

My brother was with me all the time. When we transferred to the 3<sup>rd</sup>, my brother stayed with the 7<sup>th</sup> Division because he was on the boxing team. Meanwhile, we went to Ft. Lewis, Washington, for maneuvers. When the war broke he joined us at Ft. Lewis.

In December of 1941 we traveled up and down the West coast on guard duty, watching bridges. We had a grand ol' time. Because we'd trained so much, we always said, "Let the Japs come, we're not afraid of them." We also trained in amphibious operations with the Marine Corps. Then we took the train to Camp Pickett, Virginia, a staging area to go overseas. We shipped out to North Africa in October 1942, getting there in November 8, 1942. We saw our first combat there under General Patton. We fought against the French three days before they surrendered. We were shelled when we landed; we scurried. This was the first time we were shot at. After things settled down, Patton paid us a visit. He learned that some of our guys were in the stockade for drinking. He said, "Whoever heard of locking up a GI for drinking? Release them." By 1943 the Germans had given up.

July 10, 1943 was our first fighting in Sicily. We walked across Sicily under Patton for 38 days. We lost a lot of men to the Germans. There were also lots of casualties from malaria and trench foot. Patton was a slave driver. That's where he slapped that boy and was relieved. We used to get mad at the Italians because they wouldn't fight.

We fought up the boot of Italy in General Clark's 5<sup>th</sup> Army. We were in the bloody battle for the monastery at Cassino. Only a few of us—32 of the 800 men in the battalion—walked away from Mount Rotundo. Ralph landed in the hospital with trench feet. Anzio was a real blood bath. We went in with 202 men and the next day we were only 22. By mid-March of 1944 the division had lost 6000 men, killed, wounded, or missing. I got hit on the 28<sup>th</sup> of January, 1944. I was in the hospital for 30 days from shrapnel wounds in the leg, mouth, and chin from white phosphorous. I rejoined the unit and the fighting was still going on hot and heavy.

In June, my company commander assigned me to lead a patrol of six into the town of Labico. We surprised a group of about fifty Germans preparing for a meeting in a building. Just as we'd disarmed them, a German tank approached. Leaving a man to guard the prisoners, the rest of us hid in the shadows of the building. When the tank came, two of my men jumped on the tank and surprised the crew. Now we'd



captured a tank. Then an ambulance with a high-ranking German doctor came down the road and we captured that. We were the center of attention when my little patrol returned with a column of sixty Germans, a tank, and an ambulance.

We made the famous breakthrough to Rome. We were there only a few days, when the Normandy invasion took place. When people ask where I was during D-Day, I say we were over there waiting. We had already been there over 1½ years before they came over.

We landed in southern France on August 15, 1944, joining up with the D-Day invaders under Patton, who had been forgiven and now had the Third Army. Thousands of Germans were trapped, along with horses, vehicles, and giant railroad guns, in southern France.

In September we got into the Vosges Mountains, with rain and snow coming in, fighting determined Germans for each position. We finally broke out of there in November and went into Strasbourg.

From there we were attached to the French 1st Army. A key target in the “Colmar Pocket” (a bulge west of the Rhine River) was Kaisersberg. Near there I received the Medal of Honor for action on January 8, 1945. After a quick prayer (“God, give me this day.”), I led my platoon in the attack on Hill #616. We were pinned down by machine-gun fire in the snow on the hillside. Our own artillery was also landing near us. There were three enemy machine gun nests. I crawled in the snow, about seventy-five yards, toward the first one. I got close enough to heave a hand grenade, which killed two German soldiers. I reached into the nest and yanked the survivor out and threw him down the hill (our mission was to take prisoners for interrogation). As I moved toward the second nest, I felt a stinging sensation across my back as I was hit. I rolled down the hill. When I stopped rolling I went up the hill again toward the second nest. I tossed a grenade and killed the crew. I crawled uphill toward the third gun emplacement and cleared that out with a hand grenade. Back in town, someone asked what all the shooting was about. Someone said, “The Dunham brothers were on the loose again.” Later, as I lay on a bunk at the battalion medics, I realized that my earlier prayer had been answered. *[The citation credits Dunham with killing nine Germans, wounding seven and capturing two. In addition to neutralizing the machine-gun emplacements, he also fired his carbine and a rifle (from a wounded GI) and threw grenades into supporting foxholes, dispatching and dispersing the enemy riflemen. Through-*

*out this attack, Dunham was under intense enemy machine-gun, automatic rifle, and mortar fire. At one point he kicked aside a German egg grenade that landed at his feet. His white camouflage robe, turned red from the blood from a 10-inch gash in his back, made him a conspicuous target against the white background. In the episode Dunham expended 11 grenades and 175 rounds of carbine ammunition.]*

I was captured on January 22, 1945, in the fatal attack on the little town of Holtzwihr.

We didn’t know the tanks weren’t behind us. They caved in on the bridge behind us. German tanks came in and captured many from our company. I had flown through an open window and hid in a sauerkraut barrel by a barn all night. This was possible because my weight had dropped from the usual 150 to 117 pounds. When I got out and stopped to relieve myself, I was captured. They searched me and took my grenades, but missed my concealed shoulder pistol. They got into a fight over my candy bars and cigarettes. Two guards placed me in the back seat of a jeep headed to Germany. When we stopped, one guard went into a building. I shot the other. I traveled through the woods at night heading toward the sound of our guns. During the three days coming back I almost froze to death. I went back to the hospital. My feet froze up and I had a piece of shrapnel in my foot. It was operated on. I rejoined the company in Germany, but I never did go back to combat again.

After the war, I got out and felt lost. I went from job to job and couldn’t find one I liked. Finally, President Truman said that all Medal of Honor recipients could work for the Veterans Administration. I took him up on his offer and did this from 1946 to 1975. As a VA representative, I advised veterans of their rights and benefits. I mostly lived near St. Louis, where the main office was, and also worked in Vietnam, Germany, and Korea.

I met Wilda in 1955. She was a city clerk in Alton, my home. We moved here to Jerseyville in 1985. We built a house on property we’d owned for several years. Our grandchildren still live in my place in Alton.

## PTSD SYMPTOMS?

In the service, I saw guys foam at the mouth and curl up. One sergeant at Anzio came to me and said he was not going to fight and ran away from the front. My ability to function

was never impaired in the military or after. I got credit for 407 days in combat. After the war, I had an anxiety condition off and on, and always tried to hide it and fight it. I'm often anxious and in a hurry. But I find it sometimes relieves me to talk about it. You don't want to keep it cooped up in you. You have to let it out.

I never did have too many dreams. I have no trouble sleeping. I never shut down from people and wasn't bothered by memory problems. Watching the movie *Saving Private Ryan* didn't bother me. Maybe I'm short tempered at times, but I always was. I think I got that from my dad. I still have pain in the leg. I didn't use drugs. I saw my brother drink himself out. It killed him, so I shut drinking off altogether.

### WHAT HELPED YOU COPE?

My childhood strengthened me. I always had it rough. The two-mile walks to school and handling the animals and the chores strengthened my body. Many a night we went to sleep without anything to eat. I learned to fend for myself and to defend myself against my older siblings. My sister, bless her heart, even said that it would be best if Ralph and I got killed. We had nothing left to come home to, so we might as well get killed and let some of the other guys live. It makes you stubborn and stronger in some ways. My dad, bless his heart, had four or five women and they all wanted to whip me 'cause I was little and ugly and mean. I didn't have a bath or a change of clothes. Every Thursday night we got a whipping whether we needed it or not. Other families had it as rough. My dad never accepted welfare. That was out. When I graduated from 8<sup>th</sup> grade, I had no shoes to wear to the graduation. My stepmother ordered them through welfare. Oh, boy, dad really ranted and raved. In St. Louis, you couldn't get a social security number until you were eighteen, and so it was hard to find jobs. But some people liked me and hired me anyway.

We used to walk night and day hunting. We were strong. If we got tired we just figured we had to put up with it. I knew what it meant to persist. In the Army, I didn't want to get court-martialed for goldbricking. I was downtrodden and had no help from Congressmen or relatives, so I knew I'd better perform. Our company commander said, "I didn't train you guys to get hit." He would court martial you or not promote you if you couldn't prove the wound was legitimate. But he liked me for some reason.

### CALM UNDER PRESSURE

It was just pride that kept me functional. I didn't want anybody thinking that I couldn't do it, just like a pitcher in a ballgame. Then, too, if you have men under you that you are responsible for, if you have something to do for them, it helps. I didn't only have myself to worry about. I was in the same platoon all the way through, from the time I was transferred to the 3<sup>rd</sup> Division. I ran the whole platoon for a long time.

A lot of people think that heroic acts are done in a blind rage, where you forget what you are doing. During the incident on Hill #616, where I earned the Medal of Honor, that wasn't the case. I was very aware and thinking about what I had to do at each point. If you forget what you're doing, you're lost and can get killed in action.

I admired the Germans, really, because of their stamina and fighting ability. I felt no bitterness. The first thing we did was give them a cigarette. Most German front line troops in Africa and Europe treated us pretty well if captured. When I was captured in France, I was treated alright.

### RATIONAL THOUGHT PROCESSES

There were a number of times when I thought I might break. But I summoned my reserve strength and pushed that thought aside, knowing I had to carry on as part of the team. After seeing so many friends wounded and killed, I couldn't dwell too long on this for my own sanity. I'd think of happier times and think that I had to press on for awhile.

When someone made a mistake, I was a good actor. I could make out like I was mad as hell, but at the same time I was laughing way down deep. I never actually got mad at them. I still hear from a couple of the guys who are still alive. I didn't promote one to PFC because of sand in his rifle. He still throws it at me. He says I'm the only sergeant who told him why he didn't get promoted. When you have eleven openings for twelve guys what are you going to do? Of course, a week or so later I promoted him. I bawled out another for dragging his rifle in the dirt. I would correct people but I wasn't mean. My sister wrote and said I probably give people hell now that I'm a sergeant. I just thought, "You don't know the conditions that we're in here." As a leader, and in my own life, I always felt that no matter how low you go, you can usually come back. I always saw some good in any misfit. That's probably why I could relate to my men, and why later, working in the VA, I could talk to the soldiers.

Sometimes you really felt bad if you messed up, or sent someone in there when you knew you shouldn't have, and someone got wounded or killed. That hurt. In time it wears off, or you find out you were actually right, or that maybe someone else upstairs gave an order that made it bad. Now in this one attack, when Sergeant Palmer with 25 years of service was killed, the Germans had captured a recon car with two .50 caliber machine guns. The company commander wanted us to attack it point blank. I told the captain if he'd let me sneak around, rather than head on, I could take it. I lost 28 men in about 15 minutes. I never did get over that. There was nothing I could have done. The captain would have relieved me if I'd disobeyed. So I didn't feel guilt but sorrow for the guys lost.

## **SOCIAL SUPPORT**

I never did hear from my dad. My sister wrote letters every two weeks. If I didn't respond, she wrote my company commander and, boy, did I catch it. A girl in California wrote all the time and sent me cookies. After you're on the line, letters became oh, so dear. In the bitter fighting in the mountains of Italy, I read and re-read one letter from home several times.

We really had a lot of good friends in the unit. I'd take guys to the tavern to get to know them. There was constant turnover. Ralph was the only one who went all the way through with me. My brother was braver than I was. I saw him do things I couldn't have done. He had a fist fight with a German in the combat when Sergeant Palmer got killed.

Some guys would die for me. One guy from North Dakota would come to me every time we were in a tight spot. We were together all the time.

Men call me today. It really does you good. It helps your morale a lot when friends say a lot of us wouldn't be alive today if it hadn't been for Dunham.

## **COMFORTABLE WITH EMOTIONS**

The killing bothered me—especially when people were killed because of leaders' mistakes and when I lost friends. Tears ran down my cheeks when I had to identify the bodies of friends killed on Mount Rotundo and had to carry their bodies down the hillside. I didn't like the hardness that war caused.

I could acknowledge fears. You had to have a certain amount of fear to protect yourself or you wouldn't live to tell about it. As a private, we used to talk about how scared we were. I had some friends I could really open up with. I had one buddy, especially, that used to tell me about eating apple pie in Alabama. We went on a patrol with a lieutenant in Italy, 20 miles behind the German lines. I don't think he was afraid of anything. We sat there in an olive grove and watched him shave and sing and mark targets on his map. My buddy and I were really afraid. We said, "Don't let us get on a patrol again with this stupid dude," because he was too brave. He got killed not too long after that. Another I knew, that didn't seem to be afraid, got killed. Sometimes I wasn't afraid. Sometimes I *was*, but maybe not as much as the next guy. Back at the tavern, we'd talk about it.

Once you're in the thick of it, you lose all fears. You don't have time to be scared. But it gets you when you are waiting to move out. I didn't like it when we were sitting off the coast of Africa in a ship. Confidence and eagerness to get into battle were mixed with reluctance because of what might happen. Approaching the shore, shells were landing all around and you couldn't do anything about it. As experience and confidence grew, fear tended to subside somewhat. There was still strong fear, but it seemed that the more intense the fight, the more the survival instinct took over and the calmer I became.

When I was a sergeant, I kept fears under my hat because I had to. If the men asked me what I thought I'd say, "We'll be there alright. We'll be drinking wine in Rome in a couple more days." I took pride in not showing fear. They all thought that I was not afraid. When people asked me why I wasn't afraid, I was. I just said, "You gotta do what you gotta do."

I can understand people who need to talk about their fears, and even those who crack under the pressure.

## **SELF-ESTEEM**

I thought I was a good leader most of the time. I was pretty confident because of the other men. They thought I was better than any officer, and they actually helped me believe it. When I asked for volunteers to go on a patrol with me, they'd be willing to go. Other guys had to appoint people.

I knew I was worthwhile. That was acquired. I knew it to be true because everybody depended on me. That makes

you feel good. They'd go AWOL from their own outfit and want to be with me under the same circumstances.

## **ACTIVE, ADAPTIVE COPING**

I didn't want to die, and fighting like mad was the only way to keep from dying. You had to go forward, otherwise our own artillery would get you, as we learned in Anzio. In rolling artillery barrages, the first barrage lands in front of you, and the next barrage advances. Then they'd fire behind you to protect you from flank attacks.

I wanted to pull my load. I didn't want to be a burden on someone if I got wounded. I figured, if they get me, let them get me good. There are worse things than dying. In fact, I didn't even want to be in the hospital. I got mad when an officer in the hospital interviewed me to see if I was goldbricking. I told him that I was put in for the Medal of Honor, I was there legitimately, and I didn't want to be there.

Sometimes I thought I wasn't going to get out of this world alive anyway, so take it as it comes, one day at a time. I always had hope it would end. Every time you broke through the lines you thought, "We gotta keep it going." When you had them on the run you had to keep them on the run. Having had so much training in the year before the war is the only thing that saved me.

When captured, I knew I was going to escape. All I was waiting for was the chance to do it. I wasn't going to stay captured. I would have died getting away. It was humiliating to be captured.

Even on the line, we'd talk about creative ways to go AWOL—never to avoid fighting when we were needed, but for brief respites and fun. There were some times between fights when I would drink to try to block out the memories. I found that this didn't really help much because the hangover only added to my other woes that hadn't changed. Now I find when I get anxious, it helps if I find something to do that tires me out in a comfortable way.

## **SPIRITUAL AND PHILOSOPHICAL STRENGTHS**

### **God**

You always had a prayer on your lips. That was natural. At times I could almost feel God's presence, as if He were

sitting beside me. I was a believer in someone greater than us and felt that I knew God in my own way. Even today I believe, although on Anzio I thought that God went on a coffee break. When I was a child, we went to church and Sunday school, but not too much. We said the Lord's prayer every morning before school started. I always believed in God. It gives you comfort. When it's over, you thank God that you made it. The war actually strengthened my belief. I say my prayers still.

### **Meaning & Purpose**

We knew we had to win. We knew enough about what was going on in Germany. The Jews were dead meat, and we knew that the colored were next. The Germans would then dispose of everybody if they could, even Hitler's own people that he didn't like. I went through some of the prison camps around Munich. You didn't have to be a Jew to be gassed. You saw thousands stacked in the boxcars. Some of them weren't even dead yet.

I wrote my autobiography in hopes that people will consider the mindless and wasteful suffering of war and perhaps eliminate wars in the future. Greatness is achieved over the conference table, not in war. I agree with the saying, "Only God and a GI know the misery of war."

### **Morality**

We always felt sorry for people and didn't kill them needlessly—prisoners and civilians. It was important not to harm them. But, you couldn't even trust some people to take prisoners back. I got on several people for shooting Germans with their hands up. In Africa, I stopped a French guard from beating two Arabs.

As a platoon sergeant, I was always truthful with my men. I never did like a lie and never was much on that. I had to report a soldier next to me for a self-inflicted wound. But I told the company commander that I wouldn't lie by saying that he did it on purpose, because I hadn't seen him do it.

A thief in our company didn't live long if he were caught.

Ralph wasn't getting promoted in the heavy weapons platoon, because his platoon wasn't having the casualties like the other platoons. At Anzio, the company commander asked if I could be impartial if he came into my platoon. I told him that I figured everyone in the outfit was my brother. So I became his boss. When my brother was complaining, I real-

ized that I had been picking on him so as not to appear to be favoring him. I was trying to be fair.

I worry about killing people. You know down deep that mistakes were made. A lieutenant was on the verge of a nervous breakdown. He was sending one man at a time into a clearing to make an attack. Three guys got killed before I got to him. I said, "You aren't going to send my men to get killed." I went back and told the company commander and I never did see that lieutenant again. Instead we flanked and attacked all together and lost no more men.

## **Love**

You can't explain the bond that forms between comrades in arms. I had a lot of respect for my men. I cared for my men. As a private, I was inseparable from my friends. Returning to my unit after being wounded was like returning home—the only one I had at the time. I had tears in my eyes when I said goodbye to them at the end of the war. You needed your friends before, during, and after the battle. I'm sure the friends that I made in the hospital helped in my rehabilitation.

## **Optimism**

I was optimistic to a certain extent. There were times I thought that we couldn't go further, but we knew we'd win eventually.

## **Humor**

We had a lot of humor in our outfit. You had to think of something funny to say. We'd laugh at letters we'd get. One guy sent his girlfriend a Purple Heart. She wrote back and told him to get one for her mother. One guy's brother worked in the shipyards. He said he wished the war would last long enough for him to pay for an automobile. We had a Jewish lieutenant in our outfit, a good guy. We'd ask him who held the world speed record—a Jew going through Berlin on a bicycle.

## **Long View of Suffering**

In my early years in the Army, I'd been a screw-up, a yardbird. I didn't want the responsibility of leadership. But in Italy, we had so many casualties that I had to take over. In

fact, I was threatened with a court martial for shirking from duty if I didn't. I'm grateful for the opportunity that I had to become a leader. I determined to become a good one and gained an appreciation for good leadership. I knew I was a good soldier, and wanted to be a good man. I came to treasure my stripes and felt that I had earned them.

The fact is that combat helped me with my VA work, to realize what the soldiers were up against. I saw some of my best friends succumb to battle fatigue, and understood that it could happen to anybody. I could tell if a man was a gold-brick or genuinely stressed. I got in trouble for helping them. I don't think a man should stay on the line more than a year.

My Congressional medal also shaped my life. It gave me a sense acceptance and recognition for being the fighting man I had tried to be, and helped me to feel a greater sense of value inwardly.

## **MAINTAINING BALANCED LIVING**

For exercise, I like hunting, fishing, and gardening. On my 40 acres, you name it and I grow it. I walk and mow the lawn. I get seven or eight hours of sleep regularly, from 10:00 p.m. to 5:00 or 6:00 a.m. I eat regular meals. I don't believe in junk food. I never smoked. I gave up alcohol years ago.

For recreation, I enjoy lots of cards, parties, hunting in the winter, and fishing in a nearby lake. I lecture at schools. I used to go to Disabled Veterans meetings, but that has tapered off since my wife got sick.

## **ADVICE TO YOUNGER GENERATIONS**

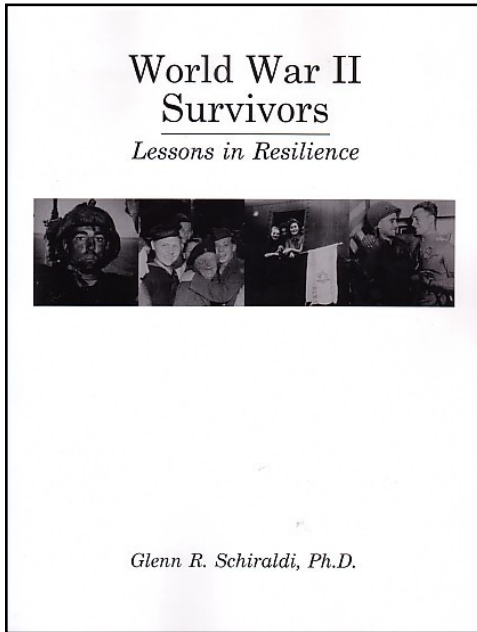
Take care of your body and lead a good clean life. Stay away from drugs and smoking. Don't overdo anything.

Don't hold yourself above others. Don't think you're better than people who had less opportunity. See yourselves as equals. I saw a number of leaders who didn't understand this, who created resentment.

No matter how low you get, you can usually come out of it.

# NEW for 2007 • Exclusively from Chevron!

## A New Book by Glenn R. Schiraldi



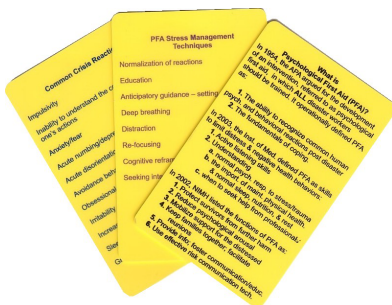
**Catalog #SCH11**  
**Paperback 350pp (2007)**  
**ISBN 978-1883581-23-7**

**\$39.00**  
**World War II Survivors**  
*Lessons in Resilience*  
 Glenn R. Schiraldi, PhD

What keeps people functioning and sane under conditions of extreme duress? Look into the hearts and minds of forty-one remarkable individuals who survived the combat of WWII and emerged well-adjusted. Explore the inspiring, powerful stories and timeless lessons that demystify resilience and remind us that it is achievable by all.

Replete with vintage WWII photographs which accompany each survivors' personal and moving account of their war and post-war experiences, this book is as suitable for gift-giving and display as it is for referencing both Resilience and WWII. 🇺🇸

## Two New Sets of Handy Reference Cards!



**Catalog #PFA**  
**Set of 3 Cards**  
**\$6.50**  
 Psychological First Aid Cards



**Catalog #SCR**  
**Set of 5 Cards**  
**\$8.50**  
 School Crisis Response Notes

**Order by phone, Monday-Friday, 9-5 EST, (410) 740-0065**

— or —

**Order online 24/7 at [www.chevronpublishing.com](http://www.chevronpublishing.com)**

## Abstracts from the 9<sup>th</sup> World Congress on Stress, Trauma, and Coping

Richard L. Levenson, Jr.  
Independent Practice and  
Ulster County Sheriff's Office

Many important and technically innovative presentations were made recently at the 9<sup>th</sup> *World Congress on Stress, Trauma, and Coping* held in Baltimore, February 15 through 18, 2007, under the auspices of the International Critical Incident Stress Foundation, Inc. (ICISF). With attendance of approximately 1,000 people from throughout the world, the latest research, applied crisis intervention strategies, and their applications to the field of Critical Incident Stress Management were discussed in relation to the airline and business industries, emergency services, schools, and the clergy, as well as many other disciplines.

The following pages contain Abstracts of those presentations that are thought to highlight the ongoing, important work of researchers, planners, and practitioners working to develop techniques and improve applied mental health criti-

cal care for those who have need for its application – in short, all of us! We present these Abstracts here, within the *International Journal of Emergency Mental Health*, for those who were not in attendance and, as with past ICISF World Congresses, hope you will glean much from the content and correspond with those authors whose work stimulates your interest to know more.

My sincere thanks to Mr. Donald Howell, Executive Director, International Critical Incident Stress Foundation, and Mr. C. Kenneth Bohn, Jr., ICISF Director of Operations, for their help in coordinating presenters for this issue. In addition, grateful appreciation is expressed to Victor Welzant, Psy.D., ICISF Director of Training, for his cooperation and support of this effort on behalf of the *International Journal of Emergency Mental Health*.

---

Richard L. Levenson, Jr., Psy.D., F.A.A.E.T.S., CTS, is Editor of the *International Journal of Emergency Mental Health*. Email to: drlevenson@att.net.

# The Potential Impact of Different Symptoms in the Course of Posttraumatic Psychological Distress

Jeffrey M. Lating  
Loyola College in Maryland

Martin F. Sherman  
Loyola College in Maryland

George S. Everly, Jr.  
Loyola College in Maryland and  
Johns Hopkins University, Bloomberg  
School of Public Health

Traci P. Martino  
Loyola College in Maryland

The DSM-IV (APA, 1994) diagnostic category of PTSD includes three clusters: reexperiencing, avoidance, and arousal with 17 criteria symptoms (5 symptoms representing reexperiencing, e.g., intrusive recollections; 7 symptoms representing avoidance or numbing; and 5 symptoms representing hyperarousal). Soon after DSM-IV's introduction, debate began regarding whether or not these symptom clusters accurately represent the fundamental dimensions and criteria of PTSD (Foa, Riggs, & Gershuny, 1995; Schell, Marshall, & Jaycox, 2004).

There is theoretical and empirical support, mostly in the form of exploratory and confirmatory factor analytic studies, suggesting that avoidance and numbing should be considered as separate factors (Buckley, Blanchard, & Hickling, 1998; Feuer, Nishith, & Resick, 2005; King, Leskin, King, & Weathers, 1998; Taylor, Koch, Kuch, Crockett, & Passey, 1998). While these studies have facilitated an improved understanding of the phenomenology and structure of PTSD, it is notable that the results occurred from analyses of samples that included treatment-seeking individuals both with and without probable PTSD. Moreover, these previous factor-analytic studies on the structure of PTSD did not directly assess the possible clinical implications of their findings.

The purpose of this study was to perform an exploratory factor analysis on a unique and fairly large sample of American Airlines (AA) flight attendants, all of whom had probable PTSD ( $N=370$ ) in the wake of the September 11, 2001 attacks (in which AA flight 11 crashed into the North World Trade Center Tower and AA flight 77 crashed into the Pentagon), the tragic loss on November 12, 2001 of AA flight 587, and the December 21, 2001 incident on AA flight 63 involving the shoe bomber. The results of this study supported a four factor model of PTSD with items related to 1) intrusion, 2) numbing/depression, 3) hyperarousal, and 4) avoidance. Of note, only the items from numbing/depression factor were related to well being and life functioning. These results have implications for assessment and treatment of those exposed to traumatic events.

## REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Washington, DC: Author.
- Buckley, T. C., Blanchard, E. B., & Hickling, E. J. (1998). A confirmatory factor analysis of posttraumatic stress symptoms. *Behavior Research and Therapy*, *36*, 1091-1099.
- Foa, E. B., Riggs, D. S., & Gershuny, B. (1995). Arousal, numbing, and intrusion: Symptom structure of PTSD following assault. *American Journal of Psychiatry*, *152*, 116-120.
- Feuer, C. A., Nishith, P., & Resick, P. (2005). Prediction of numbing and effortful avoidance in female rape survivors with chronic PTSD. *Journal of Traumatic Stress*, *18*, 165-170.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Jeffrey Lating, Ph.D.; Martin F. Sherman, Ph.D.; George S. Everly, Jr., Ph.D.; Traci F. Martino, M.S. E-mail: jlating@loyola.edu.



King, D. W., Leskin, G. A., King, L. A., & Weathers, F. W. (1998). Confirmatory factor analysis of the Clinician-Administered PTSD Scale: Evidence for dimensionality of posttraumatic stress disorder. *Psychological Assessment, 10*, 90-96.

Schell, T. L., Marshall, G. N., & Jaycox, L. H. (2004). All symptoms are not created equal: The prominent role of

hyperarousal in the natural course of posttraumatic psychological distress. *Journal of Abnormal Psychology, 113*, 189-197.

Taylor, S., Koch, W. J., Kuch, K., Crockett, D. J., & Passey, G. (1998). The structure of posttraumatic stress symptoms. *Journal of Abnormal Psychology, 107*, 154-160.

## Incorporating Risk Communication Principles into Comprehensive Crisis Intervention

Victor Welzant

International Critical Incident Stress Foundation

Amie C. Kolos

The Johns Hopkins University

Principles of Risk Communication are used by public health personnel to facilitate public education about health risk, encourage health related actions, and to prevent unnecessary anxiety in the face of a public health threat. Despite a wealth of literature that has evolved, crisis intervention practitioners often have minimal exposure to the basic principles of Risk Communication. This workshop presented an overview of risk communication concepts and principles for crisis intervention teams. The presenters reviewed ways crisis teams can enhance their practice by incorporating risk communication into the overall intervention plan.

Crisis Intervention teams are increasingly utilizing informational briefing models, such as the Crisis Management Briefing, to address groups in crisis. While an effective model of conducting these briefings has evolved, little attention has been directed toward the specific principles of

communicating risk information effectively. The presenters reviewed principles of risk communication as outlined by the Centers for Disease Control and Prevention. Illustrations of effective and ineffective communication styles were presented to allow for concrete application of the risk communication concepts. Key concepts such as verification of information prior to release, acknowledging uncertainty, honesty, and establishing an empathic connection early in the communication were emphasized. Factors that influence risk perception were also identified, as well as strategies for bringing perceived risk into closer alignment with actual risk.

Another aspect of the workshop was to identify key reasons that crisis communication fails to address the recipient group needs. The importance of pre-briefing assessment to identify themes and concerns was reviewed. Examples of effective and ineffective messaging from public events were utilized to highlight these points. Participants were given two crisis scenarios and asked to construct the fact phase of a Crisis Management Briefing using principles reviewed in the training. Future directions for team training were recommended, and the role of Public Health personnel in collaborating with Crisis Intervention Teams was discussed.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Victor Welzant, Psy.D.; Amie C. Kolos. E-mail: [welzant@icisf.org](mailto:welzant@icisf.org).

# Cultural Competence in Critical Incident Stress Management

David F. Wee

The challenge for practitioners of Critical Incident Stress Management is to transform their experience, knowledge, and skills with work cultures and to broaden their experience, knowledge, and skills to include diverse cultures and the promises of increased effectiveness. Critical Incident Stress Management has a solid foundation of core elements that address cultural competence. Culture can be broadly described as group and individual identity based on work, beliefs, values, symbols, boundaries, norms, lifestyles, physical and mental disabilities, ethnicity, gender, sexual orientation, social, economic status, and other communities. Culture groups also have historical, current community, and individual experiences of trauma, discrimination, oppression, and privilege that contribute to the group and individual identity and experience.

Historically, CISM has been based on work cultures and work culture competence and diversity in the emergency services and has expanded to other groups who are at risk of experiencing critical incident stress. While many CISM practitioners identify as members of a work culture, many are work multi-cultural. Similarly, many of the practitioners and the people who receive CISM services are multi-cultural and are members of multiple work cultures, professions, languages, cultures, ethnicities and races, gender, regions, organizations, classes, political groups, migration, immigration and citizenship status, and groups who experience oppression. Effectively serving multi-cultural persons, within multi-cultural groups requires the CISM practitioners to be knowledgeable, skilled, and competent in understanding the unique aspects of the cultures in relation to history, language, world view, and psychological hypersensitivity.

Critical incidents that affect groups, nations, and the world are seen as cultural traumas that impact large numbers

of people and leave a lasting mark on the groups and change individual and group identity. Examples of critical incidents that have emerged as cultural trauma are the September 11, 2001 Terrorist Attacks on the World Trade Center in New York City and the Indian Ocean Tsunami. Cultural trauma serves the function of reinforcing the lessons and pain of past events, attempting to avoid the reoccurrence of these events in the future. This is the basis for hope and for resilience so necessary for human survival. There are cultural groups which have experienced horrendous cultural trauma that continues as a stress reaction that can be described using a *Cultural Posttraumatic Stress Model*. The Cultural Posttraumatic Stress Model includes the concept of historical trauma and current community trauma that is experienced vicariously by people along with the individual traumatic experiences people experience in their lifetimes.

The culturally proficient Critical Incident Stress Management practitioner is culturally aware, has cultural knowledge, cultural skills, and cultural sensitivity, and engages in cultural encounters with humility, curiosity, and enthusiasm. The field of crisis intervention in general, and Critical Incident Stress Management in particular, has grown because of increasing diversity in work cultures in the organization. The diversity of work cultures has added tremendously to the practice and theory of Critical Incident Stress Management as well as to the people who conduct or participate in Critical Incident Stress Management. Increasing cultural competence in Critical Incident Stress Management will continue this growth and development. Developing cultural competence requires commitment. Critical Incident Stress Management competence plus work and cultural competence, plus cultural experience, knowledge, and skill equals cultural competence. Cultural competence includes moving from what we know to what we need to know in order to effectively serve the people we serve. Cultural competence is a transformational process for the individual, CISM Team, and organization.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. David F. Wee, MSSW; Diane Myers. E-mail: david.wee@sbcglobal.net.

# Answering the Call for Critical Incident Stress Management Research: Examining Effectiveness of the Group Process

Debra A Pender, Karen K. Prichard, Danny W. Pender

Critical Incident Stress Debriefing is a psychoeducational group sometimes offered to emergency service responders after exposure to potentially traumatizing events. This inquiry embraced the complexity of the factors that shape Critical Incident Stress Debriefing intervention outcomes; addressed the context of traumatic events, individual risk factors, diversity and gender differences, work-place ecology, group quality and trauma resolution indicators; and employed multi-site, multi-incident data collection techniques. The findings enhance the field's understanding of how (establishing the utility of treatment) and for whom (identifying subgroups) debriefing interventions are beneficial or harmful.

This mixed model inquiry utilized web-based data collection of a structured interview with a purposive sample of emergency service personnel and Critical Incident Stress Management mental health and peer providers to assess the group process factors and contextual factors in Critical Incident Stress Debriefing interventions. The study utilized critical incident questionnaire methodology (Kivlighan & Goldfine, 1991) and consensual qualitative analysis (Hill, Knox & Thompson, et al 2005) to gain understanding about the effectiveness of Critical Incident Stress Debriefing group process variables. Process reports from thirty-eight informants (i.e., emergency responders, Critical Incident Stress Management peers and mental health providers) were analyzed. A team consisting of the principal investigator, two coders and an auditor identified the textual data that yielded an understanding of both effective and not recommended group practices, the role of the incident, importance of therapeutic factors, the role of peer co-facilitators, and differences in the responses on the "distressful moment" question. The research team selected consensus themes that included the understanding of confidentiality and CISD purpose, leader effectiveness, helpful impacts, damaging aspects, and indicators of trauma resolution.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Debra Pender, Ph.D.; Karen K. Prichard, Ph.D.; Dan Pender, EMTP/Firefighter II. E-mail: dpender@niu.edu.

Findings support evidence of effective and ethical group work included elements of group planning, performing and processing. Attention to pre-Critical Incident Stress Debriefing preparation, Critical Incident Stress Debriefing participant composition, establishing ground rules and bounds for confidentiality, managing disclosure and member pacing were important group leadership aspects. Therapeutic factors suggest the Critical Incident Stress Debriefing process is largely support group work and focuses on the event, not individual issues or growth. Further, evidence of therapeutic factors support the conclusion that the Critical Incident Stress Debriefing interventions reported here shared common ground with the literature on affective and cognitive support groups and with the literature on crisis intervention. Themes of resolution include connection to peers and family members, recognition of good enough effort, and acceptance of human limitations. Analysis of informants' assumptive beliefs supported adaptive shifts in the acceptance of life's injustice with the belief that life is good and manageable.

Effectiveness of the Critical Incident Stress Debriefing process may be better understood in terms of the mechanisms of change that occur, or do not occur, as mediated through the perceptions of those that provide and those that receive the intervention than in trying to prove or disprove overall efficacy. Themes from the narratives reported here confirmed that the Critical Incident Stress Debriefing does reduce social isolation and promote adaptation to the demands of emergency service responder work.

## REFERENCES

- Kivlighan, D. M., & Goldfine, D. C. (1991). Endorsement of therapeutic factors as a function of stage of group development and participant interpersonal attitudes. *Journal of Counseling Psychology, 38*, 150-158.
- Hill, C., Knox, S., Thompson, B., Williams, E., Hess, S., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205.

# Creating and Maintaining a Multi-School-Based Critical Incident Stress Management Team from the Ground Up: “How To” Ideas

Leslee Sandberg, Kathryn Goddard, Kelly Jones, Kathryn Lee,  
Sidney Lutz, Shirley Pike, and Nancy Veldhuizen  
Grant Wood Area Education Agency Critical Incident Stress Management Team

When schools are impacted by a critical incident, it is common for counseling intervention to be offered to students and staff. The efficacy of services provided depends on the expertise of those who intervene. The presenters of this workshop assert that a highly trained, well organized Critical Incident Stress Management team can help schools prepare for and respond to critical incidents in ways that support personal recovery and restoration of the learning environment.

**Team Development:** Grant Wood Area Education Agency (GWAEA), an intermediate educational service agency, serves 33 public school districts and several non-public schools in eastern Iowa, USA. GWAEA staff members, including school social workers and school psychologists, formed a team to work in a coordinated effort to respond to critical incidents in schools. The team developed a mission, vision, and guiding principals and chose the International Critical Incident Stress Foundation (ICISF) model for responding to critical incidents. School staff and members of the faith community were recruited to join the team. Team members were required to have training in the ICISF model. GWAEA became recognized by ICISF as a registered Critical Incident Stress Management team. The team has grown to over 80 members and has responded to critical incidents involving student and staff deaths due to motor vehicle accidents, explosions, drowning, suicide, and homicide.

**Team Maintenance:** The GWAEA Critical Incident Stress Management team meets several times per year to reflect on

lessons learned from previous incidents. Member skills are maintained and increased over time through table top and role play scenarios. Self assessment of the team’s strengths, weaknesses, opportunities, and threats help direct the team toward continual growth and improvement. The team has developed a “tool kit” to assist responses to crises in schools. The tool kit contains printed materials and templates for use in communicating with parents, students, staff and the community. Forms and checklists have been developed to assist the team with organizing the crisis response. The GWAEA Critical Incident Stress Management team tool kit can be accessed on the internet at <http://www.aea10.k12.ia.us/schcomplan/cism.html>.

**Team Sustainability:** The GWAEA Critical Incident Stress Management Team, in conjunction with a local community college, applied for and was awarded a Federal Emergency Response Crisis Management Grant for pre-incident planning and post-incident recovery. The grant provided the opportunity for eight members of the team to become certified trainers of two courses developed by the International Critical Incident Stress Foundation. Local training was offered, at no cost, to area school staff and faith-based practitioners. Upon completion of the training, many course participants joined the team.

**Funerals in Schools:** The GWAEA CISM Team provides support to school administrators in the event that a request is made for a funeral to be held in a school building. Although uncommon, funerals in schools are increasing as they appear to meet the combined needs of school staff, the family, and their community. Helping school staff explore the variety of activities involved and how to coordinate with the family and their funeral service provider is also based on shared “lessons learned” from other school districts in the area.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Leslee Sandberg, Ph.D.; Kathryn Goddard, MSW, LISW, ACSW; Kelly Jones, MSW, LISW; Kathryn Kramer Lee, MSW, LISW; Sidney Lutz, MSW, LISW, ACSW; Shirley Pike, MA, NCSP; Nancy Veldhuizen, MSW, LISW. E-mail: [Lsandberg@aea10.k12.ia.us](mailto:Lsandberg@aea10.k12.ia.us).

# CISM in a War Zone

Charles P. Dunn and Edward Dale  
Kellogg, Brown, & Root, Inc.

In response to the current war on terrorism, contractors work with the military to accomplish the mission. The purpose of this presentation was to identify the stressors experienced by the battlefield contractors working in a war zone. Strategies utilized to mitigate this stress were discussed. It examined the use of the Critical Incident Stress Management model in response to a variety of critical incidents. The scope of this presentation was on work in Iraq.

There are many stressors associated with working alongside military personnel in the current global war on terrorism. The focus was on stress reactions to critical incidents. Iraq critical incidents normally involved the loss of life associated with enemy hostile activity. However, in some cases it might be related to an accidental death. Although there are many different contractors in Iraq, most of the contract work is currently provided by Kellogg, Brown & Root (KBR). KBR provided an Employee Assistance Program to those employees deployed in Iraq. It was the EAP Counselors' duty to respond to critical incidents. A modification of the ICISF Model of Critical Incident Stress Management was used to provide this service.

This presentation reviewed how the ICISF Model was utilized in response to the unique problems associated with working in Iraq. It provided an overview of the modified seven stages used in our critical incident response strategy. To illustrate and explain, it described the stages as implemented in the suicide bombing incident in Mosul, Iraq, December 21, 2004.

The modified ICISF Model approach maintained the seven original ICISF stages, but the language and procedures were adapted to the war zone for ease of training and implementation. The First stage was pre-crisis preparation. This step involved counselor readiness, base planning and overall preparation. Immediately after the incident, we transitioned to stage Two, the M-CON stage, which focused on mobilization and consultation, often resulting in traveling to the site via military aircraft. Stage Three, the base pre-stabilization phase involved defusings, management consultations, and site visits to the affected work groups. Stage Four, the three R stage, was designated as a time for the counselor(s) to withdraw and regroup, as they made plans for the next couple of days. The Fifth stage consisted of conducting Critical Incident Stress Debriefings. Stage Six, base stabilization, involved individual counseling, continued management consultation, and coordination with "need to know" staff. Stage Seven, identified as follow-up, involved making referrals for further care, documentation of services provided and "debriefing the debriefers."

Overall, the approach served as a useful model in handling difficult and painful life experiences. It provided needed structure in what was a chaotic situation, full of emotions, uncertainty, and fear for all concerned, giving management a tool to effectively deal with the crisis situation. It provided an opportunity to begin the healing process, normalizing responses, while helping individuals to cope with emotions and thoughts. Finally, it helped to identify individuals whose needs warranted a more intensive intervention.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Chuck Dunn; Edward Dale, Psy.D. E-mail: charles.dunn@militaryonesource.com.

# The Use of Psychological First Aid and Group Psychological First Aid

Suzanne B. Phillips

American Group Psychotherapy Association

Dianne Kane

Counseling Unit, Fire Department, City of New York  
and Hunter College School of Social Work, New York City

This workshop will familiarize disaster workers with Psychological First Aid and Group Psychological First Aid as viable responses in the acute stage of a disaster. Psychological First Aid has been broadly endorsed as a safe, supportive response suited for children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism (International Society for Traumatic Stress Study, 2005; National Child Traumatic Stress Network and National Center for PTSD, 2005; Schnurr & Cozza, 2004)

Psychological First Aid offers a supportive and compassionate presence to reduce initial distress, facilitate continued and additional support if needed, and ultimately foster short and long term adaptive functioning (National Child Traumatic Stress Network and National Center for PTSD, 2005; Everly & Flynn 2005). The core actions of Psychological First Aid include:

- Establish a non-intrusive, compassionate human connection
- Enhance immediate, ongoing safety; physical and emotional comfort
- Help survivors articulate immediate needs and concerns
- Offer practical assistance and information
- Connect survivors to social support networks: family members, friends, community resources
- Support and acknowledge positive coping efforts and strengths
- Provide psycho-education to normalize responses to trauma

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Dr. Suzanne B. Phillips and Diane Kane, DSW. Email: suephil@optonline.net.

- Refer to higher levels of care

(National Child Traumatic Network and National Center for PTSD, 2005.)

In the *Introduction to and Overview of Group Psychological First Aid*, Everly, Phillips, Kane, and Feldman (2006) expanded the principles of Psychological First Aid to the group setting. Recognizing the unique advantages that group interventions offer to traumatized individuals (Herman, 1996; Klein and Shermer, 2000; Ullman, 2004), Everly et al (2006) considered that “in situations where groups of individuals were exposed to the same amplitude and chronicity of traumatic exposure, there may be a strong rationale for implementing psychological first aid practices in that natural homogeneous cohort” (p.131). This factor is particularly relevant for uniformed service personnel (i.e., fire-rescue, police, emergency medical and military) who have a sense of cohesion and a “band of brothers” mentality. Group Psychological First Aid is also applicable for school, hospital, or corporate groups facing unexpected violence, trauma, and disaster in that it supports existing group strengths and resiliencies. Group Psychological First Aid involves a group process that may be conceptualized in terms of Pre-Group Activities, 6-Group Intervention Activities, and Post-Group Activities:

Pre-Group Activities:

- Assess homogeneity, suitability, and functionality for group intervention
- Identify medical and physical needs
- Reduce situational stressors
- Refer to higher levels of care

6- Group Intervention Activities:

- Introduce leaders, group purpose, duration, and ground rules.
- Review incident facts to control escalation of rumors and establish safety.

- Invite clarification, or correction of the facts with members participating as desired.
- Normalize, i.e. psycho-education about responses to trauma, basic coping and stress management.
- Support the natural cohesion and resiliency of the group.
- Facilitate connection to formal and informal support systems.
- Invite Self-Care and Buddy Care.
- Refer for continued and follow-up services.

Post-Group Activities are directed to the leader(s):

- Continued availability
- Leader debriefing
- Countertransference issues.
- Self-Care
- Evaluation of the efficacy of Group Psychological First Aid.

At a time when early group intervention in the aftermath of trauma has been open to question, Group Psychological First Aid, appropriately applied to intact groups, offers a safe, compassionate alternative to previously described interventions.

## REFERENCES

- Everly, G.S., Jr. & Flynn, B.W. (2005). Principles and practice of acute psychological first aid after disasters. In G. S. Everly, Jr. & C. L. Parker (Eds.). *Mental Health Aspects of Disasters: Public Health Preparedness and Response, Revised* (pp. 79-89). Baltimore: Johns Hopkins Center for Public Health Preparedness.
- Everly, G., Phillips, S., Kane, D., Feldman, D. (2006) Introduction to and overview of group Psychological First Aid, *Brief Treatment. and Crisis Intervention*, 6(2) May 2006, Oxford University Press.
- Klein, R. H. & Schermer, V.L. (Eds.). (2000). *Group psychotherapy for psychological trauma*. New York: the Guilford Press.
- National Child Traumatic Stress Network and National Center for PTSD, (2005). *Psychological First Aid: Field Operations Guide*, September, 2005.
- Schnurr, P.P., and S.J. Cozza (Eds.). (2004). *Iraq war clinician guide* (Second Edition). Department of Veterans Affairs, National Center for PTSD.
- Ulman, K.H. (2004). Group interventions for treatment of trauma in adults. In B. J. Buchele & H. I. Spitz (Eds.). *Group Interventions for Treatment of Psychological Trauma*. NY: AGPA.

## Stress Management in Corrections

Heather Ziemba and Jacqueline Jennett  
Connecticut State Department of Correction

Those involved in law enforcement and other first emergency personnel have a unique set of stressors that they encounter while doing their jobs. These professions include but are not limited to police officers, firefighters, military per-

sonnel, Emergency Medical Technicians, parole and probation officers, and correction officers. Although these professions have many common stressors due to their experiences, the Correctional Professional has these as well as additional and unusual stressors they must contend with due to their work environment; anticipation stress, confinement stress, threat of communicable diseases, the responsibility for inmate safety, negative culture constraints, and cross-gender

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Captain Heather Ziemba; Counselor Supervisor Jacqueline Jennett. E-mail: Ziembafarm@aol.com.

supervision, to name a few. This presentation identified the stress commonalities among law enforcement and first responding personnel and then further identified the unique stressors that correctional professionals face and why. One of the stressors in the correctional environment is overcoming the cultural limitations in a quasi-military civil service position, a critical one being receptivity to the idea that staff need stress relief care. This presentation identified how to help the administration see the benefit of Critical Incident Stress Management Response Teams. It identified a step-by-step account of how to get the buy-in of the stakeholders and how to recruit support and team members, as well as giving examples of the Connecticut Department of Corrections' operations and guidelines manual with maintenance procedures and training lesson plans. The presentation also included identifying the obstacles, such as funding, the blue-

culture, old attitudes, the barrier of the "suck-it-up" mentality, and the idea that the program is a feel-good program not for the men's environment. It also explained how the participant can develop a Critical Incident Stress Management Response Team in a correctional setting using the Connecticut "T DOC" model, and identified viable options to combat the aforementioned obstacles. The final piece of the training identified types of interventions, tweaked for correctional staff, and the way that each intervention assists in dealing with correctional-unique stress. Some of these interventions include the ICISF model, grief support and maintenance model (developed by our Connecticut Training Department of Correction Critical Incident Stress Management Response Team), relaxation techniques, education, one-to-one follow-up programming, and a family intervention program.

## Complicated CISM in a Police Department after Two Line-of-Duty Deaths

By Andrew T. Young  
Lubbock Christian University

This presentation detailed the mental health services provided to the members of a police department after the occurrence of two line-of duty deaths over the course of a week. One motorcycle officer was killed while escorting a funeral procession; the other was killed during a SWAT operation. The fallout from these incidents was varied and traumatic, and included the firing of the police chief, a demotion, and chronic Posttraumatic Stress Disorder among a number of officers.

A discussion of the lessons learned by the Critical Incident Stress Management (CISM) team was provided and implications for effective practice were discussed. One of the lessons learned from these incidents is that a CISM team must be prepared, well established, and its members must be known and trusted by those it will assist in order to be effective. In order to be prepared for an incident like this one, CISM teams must train many officers from many divisions

within a police department. Even when this is accomplished, mutual-aid agreements with other police-oriented CISM teams must be established, and training with these teams must occur prior to their utilization.

The proper application of the CISM model during this incident was complicated at best. A discussion of the rationale for the decisions that were made was included and a critique followed. The timing of funerals, the changing facts surrounding the second line-of-duty death (what was first believed to be a death at the hands of a criminal turned into a death by friendly fire), and the extensive media coverage all served to complicate our CISM interventions.

The notion that CISM can save lives was explored within the context of these two incidents. An officer who was a close friend of the first officer who died was also a participant in the incident involving the second line-of-duty death. It is my contention that if this officer had participated in CISM and/or the CISM team had been consulted about the impact of the first death on this officer, the second death might have been prevented.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Dr. Andrew Young Associate Professor in Behavioral Sciences Lubbock Christian University andy.young@lcu.edu



# Mobile Crisis Teams and the Role of Critical Incident Stress Management

Dwight A. Polk, MSW, NREMT-P and Ray L. Sheets, Jr., MA  
Grassroots Crisis Center, Inc.

Mobile Crisis Teams have been in existence for approximately 25 years and have served to increase access to treatment, de-escalate and stabilize crises, and have reduced both unnecessary hospitalizations and intervention by law enforcement professionals. Mobile Crisis Teams are used by both community and police organizations to respond to a variety of crises such as psychiatric, family, behavioral, school

crises, adolescent runaways, homelessness, and death interventions. The use of various Critical Incident Stress Management models, especially peer and group intervention, are paramount to the success of Mobile Crisis Teams. A review of the literature notes that little research has been conducted regarding the efficacy of Mobile Crisis Teams, but the studies that have been conducted indicate that Mobile Crisis Teams showed statistically significant differences in the reduction of hospitalizations (and more importantly, involuntary hospitalizations) when compared to regular police models.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Dwight A. Polk, MSW, NREMT-P; Ray L. Sheets, Jr., MA. E-mail: dpolk@comcast.net.

## Assessing and Responding To Spiritual Symptoms Of Traumatic Stress

Thomas E. Webb  
Webb & Associates Chaplaincy Consulting

Like behavioral symptoms of traumatic stress exhibited in the context of relationships with family, friends, and co-workers, spiritual symptoms arise after time has passed for one to encounter and notice impairment in their relationship with God. Spiritual symptoms of traumatic stress often evoke intense reactions of uncertainty within Critical Incident Stress Management responders as what to say or do. For example, a husband, who is well known in the community for his stalwart spiritual faith, tragically loses his wife and two children in a car accident. After a few days have passed, despondent and dejected, the husband cries out, "Why has God for-

saken me?" Great is the potential angst of the interventionist who hears his cry. An interventionist's initial reaction often is to respond in a manner most familiar with respect to their primary professional role. Thus, pastors and chaplains are tempted to preach, counselors to counsel, and therapists to "therapize" as opposed to making a strategic spiritual (pastoral) crisis intervention.

Spiritual symptoms of traumatic stress often evoke intense reactions of uncertainty within Critical Incident Stress Management responders (i.e., chaplains as well as peers) as to what to say or do. The purpose of this presentation was to elucidate assessment criteria of and effective intervention strategies for those making a spiritual cry of distress or experiencing a crisis of faith.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Chaplain Thomas E. Webb, Th.M. E-mail: prayerboss@earthlink.net.

# Effectiveness of Critical Incident Stress Debriefing in the Reduction of Post Traumatic Stress Disorder

Jason P. Maffia

New York City REMSCO Critical Incident Response Team

Anthony J. Maffia

The Jamaica Hospital Medical Center, Department of  
Psychiatry

How do you move forward after a disaster? What is the healthy response? The emotional aspects of traumatic events are often ignored. It is essential that we are prepared physically and emotionally for traumatic situations. There is a growing body of theoretical and empirical literature that recognizes that engaging in work with trauma survivors can and does impact the professional involved. According to the National Center for Posttraumatic Stress Disorder, nearly 8% of individuals who work with traumatized individuals will experience PTSD at one point in their lives.

Widespread acknowledgment within several professions regarding the risk of exposure to traumatic events has stimulated the development of interventions designed to

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Jason P. Maffia, M.A.; Anthony J. Maffia, LCSW. E-mail: [jmaff72653@aol.com](mailto:jmaff72653@aol.com)

assist the recovery of those affected. Psychological debriefing is the most commonly provided resource in this context (Raphael, Meldrum & McFarlane, 1995). Support for the effectiveness of debriefings has been cited in several studies (Busuttil, et al. 1995). One of the most often cited studies evaluating the perceived helpfulness of debriefings described the opinions of 172 emergency service, welfare, and hospital personnel in Australia (Robinson & Mitchell, 1993). Subjects reported that the debriefings were of considerable to great value to themselves and their peers. The greater the impact the event had on subjects, the more likely they were to value the debriefings. Seventy-seven to 96 percent of the subjects reported that the debriefing had contributed to a reduction in their stress symptoms. The effectiveness of the debriefing seemed to derive primarily from affording subjects an opportunity to talk about the incident and to develop an increased "understanding of one's self." (Robinson & Mitchell, 1993).

## Roles in Respite Centers: Peers, Chaplains, and Mental Health

Rev. Julie Taylor and Diane M. Ryan

Respite Centers are opened during prolonged emergency operations in order to provide first responders and rescue and/or recovery workers with a secure place for brief periods of rest, nourishment, and support during breaks and shift changes. A Respite Center is a place for workers to decompress and relax out of public view. It is not open to outsiders, trauma tourists, media, or unauthorized civilians. Security is

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Rev. Julie Taylor, CTR; Diane Ryan, LCSW. E-mail: [jtaylor@dcs-ny.org](mailto:jtaylor@dcs-ny.org)

a requirement. Respite Centers often create settings that foster natural recovery mechanisms and, because they are considered to be safe places, workers may be more open to the administration of mental health critical care or psychological first aid. Respite Centers are the natural congregating place for workers during emergency operations. Therefore, Respite Centers are an ideal location for early psychological interventions by peers, chaplains, and mental health workers. Peers, chaplains, and mental health workers should advocate for a recognized role during pre-incident planning stages.

Peers, chaplains, and mental health workers come together to provide a unique service in a Respite Center. Because they are not assigned a primary function (e.g., feeding, logistics), they are able to scan the room, triage, assess needs, look for ways to support personnel, provide helpful information, and introduce self-care techniques. Each of these functions brings different points of reference to the Respite Center. The value of peer support to the responder population has long been recognized. Peers speak the same language as responders and have an inherent understanding of how they think, what coping mechanisms are helpful, and best ways to support them. Peers also provide validation of mental health support. Chaplains provide a spiritual presence, a wider perspective to the meaning of an event, and often a connection to hope. Mental Health workers assess any emotional concerns that go beyond what is to be expected from a disaster response. It is essential for chaplains and mental health workers to leave behind traditional roles and methodologies.

The core of the work of these three groups in the Respite Centers is the provision of crisis intervention, advocacy, and

psychological first aid. The most helpful mechanism to administer these techniques is compassionate presence. Compassionate presence is being with another in a particular moment and space while bearing witness. Compassionate presence is demonstrated in a variety of verbal and non-verbal ways, for the purpose of communicating to another that he/she is not alone in their journey.

Peers, chaplains, and mental health workers have a special role in advocating for and advising in the development of closing rituals. The ceremonial removal and collecting of mementos, photographs, posters, letters, shrines, etc., provides meaning for workers as they prepare to end their assignment. It is essential to develop a good self-care plan for before, during, and after deployment. A pre-deployment checklist for considering both concrete and emotional/spiritual needs is quite helpful. Collegial support during an assignment is valuable in maintaining endurance. Post-disaster, workers should be prepared for a readjustment period and possible reactions such as mood swings, changes in relationships with others, and mixed emotions such as relief, sadness, and guilt.

## **What's this Tapping Stuff? Thought Field Therapy and Energy Psychology in the Big Picture**

Robert L. Bray

Fifty citations are now listed by PILOTS database for Thought Field Therapy alone. Some of these are duplicated in the 27 citations resulting from a search of Energy Psychology. As the information about these approaches and the discussion about these techniques expand in the Critical Incident Stress Management field, clear definitions and standards are needed. The emphasis of this workshop was to assist the participants in answering questions such as: When is it safe and appropriate to use these new techniques; who should use them and to what ends; what will they not

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Robert L. Bray, Ph.D., LCSW, C.T.S. E-mail: [www.rlbray.com](mailto:www.rlbray.com)

help to change; and what are the theoretical underpinnings of these techniques? Callahan Techniques© Thought Field Therapy (CT-TFT) provides a foundation in gaining a working knowledge and understanding of the development, applications, and theory of the new energy psychologies.

In applying any new techniques, proceed within the limits of your training and expertise and always keep the welfare of your client foremost in your mind. There are no reports of Callahan Techniques© Thought Field Therapy causing harm. In general, the criticisms of TFT are that the claims for its effectiveness and its theoretical formulations are without support in traditional research and clinical paradigms. CT-TFT protocols are clear; that if there is no immediate

improvement, more advanced protocols are to be applied. Once the practitioners have exhausted their skills in TFT without the predicated results, they should stop TFT and use any other helping skills they have and refer to more advanced practitioners as needed. The moment-to-moment self-reports used in CT-TFT will show whether or not the technique is working; there is no waiting to see what happens after longer periods of time. Professionals from many fields and various clinical approaches learn how to integrate their approaches with TFT in Callahan Techniques© Thought Field Therapy workshops and books.

The differences between “energy psychology” and other “tapping” techniques are apparent as the history, development, techniques, and theories are examined. In a structured discussion of threshold standards and questions to determine appropriate applications of these approaches, participants considered continued research and development.

Training and certification for these new approaches were discussed.

Participants were able to test for themselves the validity and power of CT-TFT in the workshop. The process is safe with no negative side effects. Either the TFT works or it does not work. TFT will not cause harm. TFT does not require disclosure or the retelling of the events; just think of the event for an instant and then proceed. TFT does not require a belief in its efficacy to work. To investigate for yourself, all that is needed is a curious mind and an honest evaluation. The simplest treatment protocol demonstrated is only one of the many TFT treatment components and focuses on traumatic stress responses; other protocols and elements of TFT are used to relieve other conditions. TFT is neither culture nor language specific. It works with all people, all ages, all cultures, and all languages. Written instructions for using a CT-TFT protocol and references were provided.

## **Integrating Awareness of Posttraumatic Cognitions into Critical Incident Stress Management**

Amie C. Kolos

The Johns Hopkins University

Victor Welzant

International Critical Incident Stress Foundation

Posttraumatic cognitions are increasingly becoming the focus of many studies and interventions for Posttraumatic Stress Disorder. These cognitions can generally be grouped into three categories: negative cognitions about the self, negative cognitions about the world, and cognitions involving self-blame. Data collected from 111 trauma survivors was analyzed to determine if these cognitions intercede the well-established relationship between trauma type and Posttraumatic Stress Disorder. Results revealed, in fact, that cognitions mediate this relationship and may actually be more predictive of Posttraumatic Stress Disorder than trauma type alone.

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Amie C. Kolos; Victor Welzant, Psy.D. E-mail: akolos1@jhmi.edu

This finding supports the idea that those who negatively appraise the trauma and their responses to the trauma have a higher likelihood of developing Posttraumatic Stress Disorder than those who accept the illogicality of the trauma and normalize their responses after the event. Relating to trauma type, research suggests that interpersonal traumas result in more negative posttraumatic cognitions than non-interpersonal traumas. There is a need to integrate this new evidence into methods for recognizing and treating negative appraisals early before they transform into Posttraumatic Stress Disorder.

One way to recognize negative responses to trauma immediately after the trauma occurs is through various types of crisis intervention. The evidence-based significance of posttraumatic cognitions has applicability to Critical Incident Stress Management, and the goal of this workshop

centered on educating peer support team members about ways to recognize common posttraumatic symptoms such as nightmares and irritability in the wake of a trauma or crisis. This information acted as a supplement to the information already provided in Critical Incident Stress Management courses offered to educate team members on recognizing and responding to negative appraisals. Although mental health professionals on Critical Incident Stress Management teams are often aware of the presence of posttraumatic cognitions, other team members are not generally trained to implement awareness of these cognitions into debriefing sessions. One goal of this workshop was to alert non-mental health team members about posttraumatic cognitions and their roles in posttrauma adjustment. In addition to posttraumatic cognitions, attendees learned the differences between interpersonal and non-interpersonal trauma and which cognitions a team member may expect a trauma survivor to experience following each type.

The remainder of the workshop focused on assisting team members in incorporating this new information into early intervention principles and practices. Team members were familiarized with appropriate and inappropriate responses to traumatic cognitions by watching video segments of simulated debriefings. The issue of determining when a commonly experienced cognition becomes grounds for a referral was discussed, as well as real-life accounts from attendees who had heard posttraumatic cognitions in past crisis situations where they volunteered. Finally, attendees were provided with an evidence-based strategy for team clinicians to use when educating teams about early intervention following trauma. It is hoped that those who attended this workshop left better equipped to handle the difficult thoughts that often emerge without warning in the wake of a traumatic event.

## **Law Enforcement Officer Stress Survey (LEOSS): The Research and the Reality**

Abigail S. Malcolm

Eastern Shores Psychological Services  
Salisbury, Maryland

Stress in police officers has become a growing concern for law enforcement agencies and the community. The Law Enforcement Officer Stress Survey (LEOSS) evolved as a joint project between the FBI Academy Law Enforcement Communications Unit and Nova Southeastern University Center for Psychological Studies. The LEOSS was designed using the behavioral analytic model of test construction which incorporated police officers input in constructing the 25-item device (LEOSS; Van Hasselt et al., 2003). Specifically, this model involved asking officers themselves to identify significant stressful situations in their work. Based on their responses, the situations were formulated into brief

scenarios (e.g., "You are called to a burglary in progress and the assailant may be armed"). Another group of officers rated these situations on "likelihood of occurrence" and "difficulty." Items rated highest on these test dimensions were retained for the final form of the LEOSS (Sheehan & Van Hasselt, 2003; Van Hasselt et al., 2003). The researchers recently completed a study proposed to ascertain the test-retest reliability and validity of the LEOSS and are currently writing up this phase of the project. As the LEOSS project prepares for the next step in test construction (i.e., obtaining descriptive statistics from clinical law enforcement sample in order to develop a scoring system designed to detect stress) the origination of the LEOSS serves to help the researchers renew their focus. The long-term goal of this project is to pro-

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Abigail S. Malcolm, Psy.D. E-mail: malcolma@nova.edu.

vide law enforcement professionals with a simple, brief, and psychometrically sound screening tool that can be employed to identify police officers at-risk for stress-related problems and disorders. However, another proposed use for the LEOSS has emerged; the LEOSS as a prescriptive training model. Incorporating preparation and training into the LEOSS project has aligned the tool with current Best Practices for emergency mental health early intervention services (Sheehan, Everly, & Langlieb, 2004). As the LEOSS project continues to develop, the researchers maintain focus on the realistic applications for the LEOSS and welcome diverse and critical feedback from both the law enforcement community and emergency mental health professionals.

## REFERENCES

- Sheehan, D.C., Everly Jr., G.S., Langlieb, A. (2004). *FBI Law Enforcement Bulletin*, 3, 9.
- Sheehan, D.C., & Van Hasselt, V.B. (2003). Identifying law enforcement stress reactions early. *FBI Law Enforcement Bulletin*, 72, 12-17.
- Van Hasselt, V.B., Sheehan, D.C., Sellers, A.H., Baker, M.T., & Feiner, C. (2003). A behavioral-analytic model for assessing stress in police officers: Phase I. Development of the law enforcement officer stress survey (LEOSS). *International Journal of Emergency Mental Health*, 5, 77-84.

## The Public Safety Family: Do They Have Stress?

Sheila Gillespie Roth, Peggy Kearney, Robert Reed

Careers in public safety can be rewarding and stressful; as a result the potential for a stressful lifestyle is high. Family members of public safety providers are not immune to this stress. This presentation provided valuable information about strengths and needs identified by public safety families. It was in part based upon a research project conducted by two of the authors during the spring of 2004, which looked at EMS providers and family life. This presentation provided an understanding of the types of stressors facing public safety families. Data was organized by areas of concern: physical threats, health risks, coping techniques, sources of stress, and family issues.

Being a family member of a public safety provider creates a different lifestyle from most people in society. It is a challenge to keep a public safety family functioning in a 9 to 5 world, due to unpredictable work conditions, unexpected call-outs, and shift work. Stress caused by critical incidents affects the provider and the family. Families see the news and hear rumors about the incident like the rest of the community,

---

Abstract of a presentation at the ICISF 9th World Congress, Baltimore, MD, February 14 - 18, 2007. Sheila Gillespie Roth, Ph.D.; Peggy Kearney, LCSW, QCSW; Robert A. Reed, Psy.D. E-mail: rothsg@carlow.edu

but their loved ones were present at the incident. This can cause worry and concern for families. Some may even urge the public safety providers to quit their job.

Providers and families can help one another during stressful times by doing the following. Do not force one's own coping style onto a partner or family member. Coping strategies that work for one person may not help another person. One useful question could be: "What can I do that would be helpful to you right now?" Then follow through with that request, if it is reasonable. Keep in mind that men and women sometimes express distress and grief differently. Men often choose to work through their stress/grief (i.e., work overtime, work at a hobby to keep busy). They might not choose to talk about their feelings. Women often state that they feel better after expressing their feelings or concerns. It may be helpful for some to tell their story. One way of coping is not better than the other, they are just different. Another suggestion is to acknowledge that a stressor has occurred, and to try to normalize life at home following a stressful shift. Daily routines within the family are important (i.e., rituals with kids, family time). Make home a happy place to be and reassure your partner or family member that he or she is loved and cared about. Families and providers should

expect an adjustment period following an event. Always be certain to take care of yourself. If you are a family member you will need to remember that you were not at the event and the provider may not choose to talk with you about it (for good reasons). The provider may choose to talk with a peer or co-worker. This can cause some family members to feel frustrated or insulted. The provider may need to tell the family member that his or her support is still very important. If the

family member finds it necessary to vent frustration about this difficult role, he or she should find a trusted person to talk to. A good listener is often the best help. If needed, seek out a support group or a licensed mental health professional (familiar with public safety lifestyles or CISM) to assist you. Finally, remember that flexibility, trust, commitment, and communication are all important characteristics of healthy relationships.

## Selected Annotated Journal Resources

Rebekah L. Horst, M.S. and Karina E. Chapman, M.A.

---

**Startup, M., Makgekenene, L., & Webster, R. (2007). The role of self-blame for trauma as assessed by the Post-traumatic Cognitions Inventory (PTCI): A self-protective cognition? *Behaviour Research and Therapy*, 45, 395-403.**

---

### TYPE OF ARTICLE

- Original empirical investigation

### OBJECTIVE/PURPOSE OF THE ARTICLE

- The authors of this study sought to examine the ability of the Post-traumatic Cognitions Inventory (PTCI) subscales to differentiate between traumatized individuals with and without PTSD and to predict PTSD symptom severity.

### METHOD

#### Participants

- Participants included 63 individuals who had experienced and were currently distressed by a traumatic event such as a serious accident, natural disaster, non-sexual assault, sexual assault, military combat, imprisonment, torture, or life-threatening illness.
- Participants were recruited through advertisements in local newspapers, a university newsletter, and radio stations.

#### Measures

- The PTCI contains 33 items scored on a seven-point Likert-type scale. These items form three subscales in addition to the total score: Negative Cognitions about Self, Negative Cognitions about the World, and Self-blame.

- The Beck Depression Inventory was used to measure depressive symptomatology.
- The Post-traumatic Stress Diagnostic Scale (PDS), a 49-item self-report questionnaire, was used to assess the presence or absence of DSM-IV criteria for PTSD.

### Procedure

- Following a brief screening telephone interview, the surveys were distributed to potential participants who then returned them.

### RESULTS

- Thirty-seven participants met criteria for a diagnosis of PTSD (PTSD group), as assessed by the PDS. Twenty-six of the participants did not meet criteria for a diagnosis of PTSD (non-PTSD group).
- Participants in the PTSD group had significantly more depressive symptoms and post-traumatic symptoms than did those in the non-PTSD group.
- Those in the PTSD group scored significantly higher on two of the subscales of the PTCI: Negative Cognitions about Self and Negative Cognitions about the World.
- No differences were found between the two groups on the Self-blame scale of the PTCI.
- The type of trauma (accidents/disasters; non-sexual assaults; sexual assaults; life-threatening illness; bereavement) was not related to the mean severity of post-traumatic symptoms; however, it was related to the scores on all three subscales of the PTCI.
- The authors found an accuracy of .65 and sensitivity of .70 when using the three subscales of the PTCI to discriminate between the PTSD group and the non-PTSD group.



- Higher self-blame scores were associated with less risk of a diagnosis of PTSD and lower post-traumatic symptomatology.

## CONCLUSIONS/SUMMARY

- The subscales of the PTCI were found to be effective in differentiating between individuals who did and did not meet criteria for PTSD and in predicting PTSD symptom severity.
- However, higher scales on the Self-blame subscale were associated with less risk of a diagnosis of PTSD and lower post-traumatic symptomatology.

## CONTRIBUTIONS/IMPLICATIONS

- The authors suggested that for some individuals, behavioral self-blame (measured by the Self-blame scale) could be a protective factor against PTSD while characterological self-blame (measured by the Negative Cognitions about Self scale) could be more problematic and thus more highly correlated with the development of PTSD.

---

**Ehring, T., Ehlers, A., & Glucksman, E. (2006). Contribution of cognitive factors to the prediction of post-traumatic stress disorder, phobia, and depression after motor vehicle accidents. *Behaviour Research and Therapy*, 44, 1699-1716.**

---

## TYPE OF ARTICLE

- Original empirical investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- The authors of this study investigated the extent to which theoretically-derived cognitive variables can predict PTSD, phobias, and depression in individuals who have survived motor vehicle accidents (MVA). These cognitive predictors were then compared to a set of established non-cognitive predictors.
- Cognitive predictors of PTSD included cognitive processing during the MVA, memory disorganization, negative appraisals of the trauma and the events that followed, safety behaviors, rumination about the trauma and its

consequences, thought suppression, and ongoing dissociation.

- Cognitive predictors of travel phobia included fear during the MVA, negative beliefs related to travel, safety behaviors regarding travel.
- Cognitive predictors of depression included self-devaluation, depressive rumination, social support, severity of ongoing physical problems related to the MVA, and the number of stressful life events.
- Non-cognitive predictors included the number of past traumas, past emotional problems, perceived life threat during the MVA, negative emotions regarding the MVA, dissociation during the MVA, social support after the MVA, and years of education.

## METHOD

### Participants

- Participants included 101 individuals who had been patients at an Accident and Emergency Department at a hospital in London.
- The participants were between the ages of 18 and 65 years and included 57 males and 44 females. All participants had been involved in a motor vehicle accident as a driver, passenger, motorcyclist, or cyclist.

### Measures

- The Structured Clinical Interview for the DSM-IV (SCID) was used to assess for the presence of PTSD, travel phobia, and major depressive disorder.
- Self-report measures were used to assess the severity of symptoms of PTSD, travel phobia and major depressive disorder. The Post-traumatic Diagnostic Scale (PDS), the Travel Phobia Questionnaire (TPQ) and the Beck Depression Inventory were used.
- The participants were administered the Trauma History Interview to assess their previous experiences with trauma.
- The SCID was used to assess for past emotional problems, which included past major depression, past PTSD, and past travel phobia. The participants also completed a self-report questionnaire that asked if they had been in mental health treatment for emotional problems or substance abuse.
- Perceived life threat during the MVA was assessed by asking the participants to rate, on a five-point Likert-

type scale, how much they thought they were going to die during the MVA.

- The Peritraumatic Emotions Questionnaire was used to assess negative emotions during the MVA as well as fear during the accident.
- The State Dissociation Questionnaire was used to assess dissociation during the MVA.
- A modified version of the Crisis Support Scale was used to assess social support after the MVA. One item was omitted from the scale and two items regarding informational support and companionship support were added.
- The Processing Questionnaire was used to assess cognitive processing during the MVA, namely, data-driven processing, lack of self-referential processing, and dissociation.
- The Disorganization subscale of the Trauma Memory Questionnaire was used to assess memory disorganization.
- The Negative Thoughts about the Self subscale of the Post-traumatic Cognitions Inventory was used to measure negative appraisals of the trauma and its sequelae.
- The Safety Behaviors Questionnaire was used to measure safety behaviors, including both generalized safety behaviors and precautions specifically related to travel.
- The Responses to Intrusions Questionnaire was used to assess rumination about the trauma and its consequences as well as thought suppression.
- The Current Dissociation subscale of the State Dissociation Questionnaire was used to assess ongoing dissociation.
- The Travel Phobia Beliefs Questionnaire, developed for this study, was used to assess negative beliefs related to travel.
- The Depressed States Checklist was used to assess self-devaluation.
- The short version of the Response Style Questionnaire was used to measure depressive rumination.
- Participants were asked to rate the severity of ongoing physical problems related to the MVA on an 11-point Likert-type scale.
- The Stressful Life Events Interview, developed for this study, was used to assess stressful life events that were experienced by the participants in the past 12 months in

domains such as family, friends, social life, work, health, legal problems, and finances.

- Participants completed a self-report questionnaire which included demographic items.
- Injury severity was assessed using the triage categories established and provided by the Accident and Emergency Department.

### **Procedure**

- Participants completed a packet of self-report questionnaires the day before meeting with the first author for an interview.
- The first author conducted the SCID assessment as well as some remaining questionnaires.
- Participants were compensated 30 pounds as a reimbursement for their time.

### **RESULTS**

- Using the SCID to determine diagnoses, 22 participants met criteria for PTSD following the MVA, 31 participants met criteria for a specific phobia for travel with onset following the accident, and 11 participants met criteria for a current major depressive episode which started or worsened following the accident. In total, 37 participants met criteria for one or more of these disorders and 62 participants did not meet criteria for any of these disorders.
- Injury severity was not significantly correlated with any of the symptom severity scales.
- Time following the accident was negatively correlated with PTSD symptom severity but not with symptom levels of depression or phobia.
- All of the cognitive variables correlated moderately to highly with the respective outcome variables (PTSD severity, phobia severity, depression severity). In each case, the cognitive variables accounted for more of the variance in symptom severity than did the established predictors (PTSD severity 76% vs. 45%; phobia severity 66% vs. 40%; depression severity 72% vs. 46%).
- Additionally, the cognitive variables derived from the disorder-specific models for PTSD, phobia, and depression a higher percentage of the variance for each respective disorder than did the variables included in the models of other disorders.

## CONCLUSIONS/SUMMARY

- The cognitive variables derived from disorder-specific models of PTSD, phobia, and depression accounted for a larger proportion of symptom severity than did the established variables.
- These cognitive variables for each disorder accounted for a higher proportion of the variance for the severity of that disorder than did the variables included in the models of other disorders.

## CONTRIBUTIONS/IMPLICATIONS

- The authors noted that most of the research on MVAs focuses solely on the development of PTSD; however, this study also included phobia and depression, as these are also relatively common among survivors of MVAs.
- This study suggests that disorder-specific cognitive variables may be able to be used to differentially predict psychological outcomes such as PTSD, phobia, and depression. Previously established predictors, such as years of education and negative emotions regarding the MVA did not differentially predict psychological outcomes.

---

**Jones, C., Harvey, A. G., & Brewin, C. R. (2007). The organization and content of trauma memories in survivors of road traffic accidents. *Behaviour Research and Therapy*, 45, 151-162.**

---

## TYPE OF ARTICLE

- Original empirical investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- The authors examined whether certain characteristics of trauma narratives of road traffic accident survivors were related to the presence of ASD or PTSD.
- Specifically, the authors examined the potential development of trauma narratives from the first week post-trauma until three months post-trauma.
- The authors also examined whether Traumatic Brain Injury (TBI) can have the same effects on trauma narratives, such as narrative disorganization, as ASD and PTSD symptomatology do.

- The authors also investigated the sensory and emotional content of the trauma narratives.

## METHOD

### Participants

- Participants included 131 individuals who had been patients at the Accident and Emergency Department in a hospital in the United Kingdom who had been involved in a road traffic accident.
- Participants ranged in age from 18 to 65 and included 52 males and 79 females.
- Participants included 71 car drivers, 26 motorcyclists, 13 cyclists, 12 passengers, and 9 pedestrians.

### Measures

- The Acute Stress Disorder Interview (ASDI), a 19-item dichotomously scored measure, was used to assess the presence of ASD. Item 5B, which measures dissociative amnesia, was excluded due to the possible overlap between this construct and post-traumatic amnesia (PTA) due to TBI.
- The PTSD Symptom Scale (PSS) was used to assess for the presence of PTSD. This measure includes 17 Likert-type items that correspond to the reexperiencing, avoidance, and arousal symptoms that comprise PTSD.
- The extent of TBI was assessed by asking participants questions to determine the duration of PTA. Specifically, they were asked “What is the first thing you remember after the accident?” and then “And what happened then?” Participants who sustained PTA of greater than 24 hours were excluded from the study.
- The authors then attempted to elicit a narrative memory of the trauma by asking the participants to recall and relate everything about the trauma as they could remember, including the accident, the events that occurred before and after the accident, and their experience in the hospital. These memories were audiotaped and transcribed, and they were later broken up into utterance units.
- The narrative memories were then rated for a series of specific constructs designed to determine the extent of disorganization and dissociation. The constructs comprising disorganization included repetition, confusion, and non-consecutive chunks (utterance units being out

of order). A global coherence rating, using an 11-point Likert-type scale, was assigned to each narrative. Additionally, dissociation was rated as being present when an utterance unit reflected any of the symptoms of dissociation of ASD.

- To assess the sensory and emotional content of the trauma narratives, Linguistic Inquiry and Word Count (LIWC), a software package, was used. LIWC is designed to assess the percentage of a text that is congruent with specific dimensions of language. The authors used LIWC to determine the percentage of sensory words and negative emotion words used in the trauma narratives.

### Procedure

- Participants were assessed and interviewed at three time points. The time points included as soon as possible after admission, approximately six weeks post-trauma, and approximately three months post-trauma.
- At the first interview, the ASDI was administered and all participants were assessed for TBI. At the second and third interviews, the PSS was administered. At all three interviews, participants provided a narrative memory of the trauma.
- All interviews were conducted by a masters' level clinician in the home of the participants, except for the first interviews, which were sometimes conducted in the hospital, depending on the length of the participant's hospital stay.

### RESULTS

- At both one week and six weeks, participants with ASD or PTSD produced narratives that were less coherent and included more dissociation.
- At three months, participants with PTSD produced narratives that included more repetition, more non-consecutive chunks, and more sensory words.
- TBI was associated with the construct of confusion at one week, six weeks, and three months.
- After controlling for initial symptoms of ASD/PTSD, three aspects of narrative organization at one week (repetition, non-consecutive chunks, and coherence) predicted PTSD severity at three months.

### CONCLUSIONS/SUMMARY

- The authors found a relation between narrative disorganization and ASD/PTSD symptomatology.
- The authors also found a relation between TBI and narrative disorganization; however, TBI was related to a different construct (confusion) than the aspects of narrative disorganization that were related to ASD/PTSD symptomatology (repetition, non-consecutive words).
- Participants with PTSD also had narratives that included more sensory words than participants without PTSD.

### CONTRIBUTIONS/IMPLICATIONS

- The authors note that the results of this study support both a concurrent and predictive relationship between narrative disorganization (repetition, non-consecutive chunks, and coherence) and ASD/PTSD in survivors of road traffic accidents. However, they also note that as individuals recover from ASD/PTSD, their narratives do not necessarily become better organized.

---

**Fikretoglu, D., Brunet, A., Best, S. R., Metzler, T. J., Delucchi, K., Weiss, D. S., Fagan, J., Liberman, A., & Marmar, C. R. (2007). Peritraumatic Fear, Helplessness, and Horror and Peritraumatic Dissociation: Do Physical and Cognitive Symptoms of Panic Mediate the Relationship Between the Two? *Behavior and Research Therapy, 45*, 39-47.**

---

### TYPE OF ARTICLE

- Original Empirical Investigation

### OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine whether panic mediates the relationship between fear, helplessness, and horror and dissociation at the time of trauma in a civilian and non-civilian sample.

### METHODS

#### Participants

- Participating police officers were part of a larger study on risk and resilience factors for PTSD, and were recruited from police departments in New York, NY, and

Oakland and San Jose, CA. Civilian participants were nominated by participating officers based on age- and gender- match.

- The final sample included 709 police officers and 317 civilians that had experienced a critical incident, for a total of 1026 participants.
- The average ages of police officers and civilians were 36.9 and 36.8 years respectively, and the majority of participants were men (77% and 60.6%, respectively).

### Materials

- Exposure to critical incidents in police and civilians was assessed with the Critical Incident History Questionnaire (34 items) and the Trauma History Questionnaire (24 items). Participants selected the one incident that was the most troublesome, disturbing, or distressing, and completed all incident-specific questionnaires based on the single event. Critical incidents were classified according to type and severity.
- Peritraumatic fear, helplessness, and horror and peritraumatic panic were assessed using 11 items taken from a pool of 13 items from the Peritraumatic Distress Inventory (internal consistency  $\alpha = .75$  and  $.76$  for police and civilians). Participants selected the statement that best described their experience on a Likert-type rating scale that ranged from 0 (not at all) to 4 (extremely true).
- Peritraumatic dissociation was assessed by the Peritraumatic Dissociative Experiences Questionnaire—Self-Report Version (PDEQ). Participants rated on a 10 item Likert scale that ranged from 1 (not at all) to 5 (extremely true) the extent of their dissociative experiences at the time of the critical incident ( $\alpha = .79$ ).

### Procedure

- Potential officer participants ( $N = 747$ ) were identified through computerized personnel records. Those agreeing to participate completed the self-report questionnaire and were asked to nominate age- and gender-matched civilian peers. The nominated men and women were invited to participate and comprised the 338 participants in the civilian group.
- Participants filled out measures of critical incident exposure, revealing that only 709 police officers and only 317 civilians had experienced a critical incident. Thus, the final sample included 1026 individuals.

- All participants were compensated \$100.

### RESULTS

- Among police officers, 46% personally experienced a critical incident, 43.9% witnessed a critical incident, and 10.2% heard of a close friend or relative being exposed to a critical incident. Police officers having experienced a critical incident were mostly likely to report witnessing a significant injury/illness or death, followed by physical assault, and harassment/threats.
- Among civilians, 62.5% personally experienced a critical incident, 15.5% witnessed a critical incident, and 22.1% heard of a close friend or relative being exposed to a critical incident. Civilians most commonly reported significant injury/illness or death, physical assault, and harassment/threats.
- The average time elapsed since the time of the traumatic event was 6.48 years ( $SD = 5.40$ ) for police and 8.82 years ( $SD = 7.49$ ) for civilians.
- Police were more likely to have witnessed a critical incident whereas civilians were more likely to have directly experienced or heard about a critical incident.
- Police officers were more likely to have experienced physical assault and significant injury/illness or death, whereas civilians were more likely to have experienced harassment, sexual assault, and other types of potentially traumatic events.
- Results of the first linear regression demonstrated a significant relationship between peritraumatic fear, helplessness, and horror and dissociation (small to moderate effect size)
- Results of a second linear regression revealed a moderate-sized relationship between fear, helplessness, and horror and physical and cognitive symptoms of panic.
- Panic reactions partially mediated the relationship between fear, helplessness, and horror and peritraumatic dissociation in police and completely mediated that relationship in civilians.

### CONCLUSIONS/SUMMARY

- Combined physical and cognitive symptoms of panic mediate the relationship between fear, helplessness, and horror and dissociation at the time of trauma in both civilians and non-civilians.

- The partial mediation of panic for police officers compared to the complete mediational role of panic reactions for civilians may indicate further moderation by additional variables that distinguish these two traumatized populations.
- The results of the current study are consistent with past research demonstrating that peritraumatic dissociation occurs in the context of significant traumatic distress (i.e., fear, helplessness, horror), and that extreme levels of fear, helplessness, and horror may give rise to panic in vulnerable individuals.
- The relationship between physical and cognitive symptoms of panic and dissociation replicates and extends earlier findings of a significant relationship between cognitive symptoms of panic and dissociation at the time of trauma.
- One limitation of the study is the disparate recruitment of the civilian and non-civilian samples. Also, the cross-sectional design of the study required reporting of peritraumatic reactions retrospectively, thus the accuracy of these reports can be affected by forgetting, attributional biases, and malingering, and precludes conclusions regarding the causality of the significant relationships. The cross-sectional design poses a greater limitation the mediational models tested because it is more likely to produce biased estimates. The exclusive measurement of symptoms of panic without assessing the psychological processes or traits potentially underlying the mediational role of panic posed an additional limitation. Finally, severity of response to trauma was not measured, preventing testing alternative explanations for some of the findings.

### CONTRIBUTIONS/IMPLICATIONS

- This appears to be the first study to assess whether physical and cognitive symptoms of panic mediate the relationship between fear, helplessness, and horror and dissociation at the time of trauma in a civilian and non-civilian sample.
- Future studies should identify the psychological processes that may underlie panic; prospective longitudinal studies would be particularly useful in linking the demonstrated mediational model to current theories of panic. Further examination of the mediational role of panic should also assess and control for overall severity of response to trauma.

---

**Ickovics, J. R., Meade, C. S., Kershaw, T. S., Milan, S., Lewis, J. B., & Ethier, K. A. (2006). Urban Teens: Trauma, Posttraumatic Growth, and Emotional Distress among Female Adolescents. *Journal of Consulting and Clinical Psychology, 74(5), 841-850.***

---

### TYPE OF ARTICLE

- Original Empirical Investigation

### OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine traumatic events, posttraumatic growth, and emotional distress over the course of 18 months in a sample of urban adolescent girls.
- Determine how type and timing of events related to profiles of posttraumatic growth.
- Prospectively examine effects of event type and post-traumatic growth on short- and long-term emotional distress with controls for pre-event distress.

### METHODS

#### Participants

- Participants were adolescent girls participating in a longitudinal prospective study on HIV/STD risk behavior.
- Adolescents were recruited from 10 hospital clinics, community health care centers, and high school clinics in New Haven, Bridgeport, and Hartford, Connecticut.
- Participants were between 14 and 19 years of age ( $M = 17.2$ ,  $SD = 1.5$ ), had a history of sexual activity, but no previous children at the time of the study. Most participants were ethnic minorities (43% African American, 35% Hispanic/Latina, 10% Caucasian, and 2% mixed/other).
- 328 out of the 411 adolescents who agreed to participate (80%) were included in the current study by completing both the baseline and the 12-month follow-up interviews. Among these participants, 307 (95%) also completed the 18-month interview.

#### Materials

- Participants indicated the “hardest thing that they ever had to deal with” at the 12-month follow up interview, and indicated whether the event took place: within the past year, 1-2 years ago, 3-5 years ago, or more than 5 years ago. Open-ended responses were coded into cat-

egories by two research assistants reach a high level of agreement ( $k = .90, p < .001$ ).

- The degree to which a person's life changed as a result of a significant event was measured by a version of the Posttraumatic Growth Inventory (PTGI) modified to be more comprehensive to an urban adolescent population and to be more easily administered in a structured interview by changing the original 6-point scale to a 3-point scale indicating the amount of change as a function of the traumatic event (0 = no change; 1 = a little change; 2 = a lot of change). Subscales included were the four factors confirmed in pilot testing: Appreciation of Life, Relating to Others, Personal Strength, and New Possibilities ( $\alpha$  range = .72 - .80, overall  $\alpha = .90$ ).
- Emotional distress was assessed at each time point using the Brief Symptom Inventory (BSI), a self-report measure designed to assess psychological symptom patterns in psychiatric medial, and community populations.

### Procedure

- Adolescents were recruited for the study between June 1998 and March 2000 from clinics providing gynecological and obstetrical services in low-income predominantly minority communities by referral from a health care provider, contact with an interviewer at participating clinics, or advertising materials.
- Of the 534 eligible girls, 411 agreed to participate (77%): 203 were pregnant at the time of entering the study and 211 were not.
- Participants completed four 90-minute face-to-face interviews semiannually over the course of 18 months. Traumatic events and posttraumatic growth were assessed only at the 12-month follow-up interviews.
- Longitudinal data were collected allowing for prospective evaluation of changes from pre-event distress (baseline interview) to short- and long-term distress following the traumatic events (measured at the 12- and 18-month follow-up interviews).
- Participants were compensated \$25 for each interview.

### RESULTS

- Almost all of the teens reported some traumatic event (97%). More than half of the teens reported having experienced a difficult event in the past year. The two most common events reported were death of a loved one (23% in the past year, 50% more than 1 year ago) and

pregnancy and motherhood (29% in the past year, 11% more than 1 year ago). Also reported somewhat less frequently were interpersonal problems, vicarious experience of another's problems, sexual abuse or harassment, physical threats, basic socioeconomic needs, and crime.

- Participants who had experienced a trauma in the past year tended to be slightly younger and reported greater emotional distress at the 12-month follow-up interview.
- Participants who reported "interpersonal problems" had lower levels of growth on multiple PTGI subscales.
- Time since the event was not associated with posttraumatic growth.
- The type of traumatic event did not directly or indirectly predict subsequent emotional distress after accounting for other factors.
- Posttraumatic growth was associated with subsequent short- and long-term emotional distress.
- Adolescents who reported higher posttraumatic growth had less emotional distress up to 12 and 18 months post-event.
- When emotional distress finally declined up to 18 months post-event, distress was still higher among teens with low posttraumatic growth than among teens with high posttraumatic growth.

### CONCLUSIONS/SUMMARY

- The type of traumatic event was associated with different profiles of posttraumatic growth.
- The interaction between posttraumatic growth and time indicates that pre-event emotional distress was higher among those with low posttraumatic growth and then remained elevated up to 12 months post-event.
- Those with low posttraumatic growth appear to be more vulnerable to emotional distress, especially in response to trauma.
- The sample consisted of sexually active teens, half of whom were pregnant at baseline. Thus, although the results may reflect other urban clinical populations, the sample cannot be assumed to be representative of all adolescents. Additional limitations of the study include the relative absence of other potential confounding factors that could affect emotional distress among adolescents and the lack of data on severity, controllability, predictability, or chronicity of events.

## CONTRIBUTIONS/IMPLICATIONS

- Studies conceptualizing, measuring, and theorizing the role of posttraumatic growth in an adolescent sample are limited, and the current study offers a parsimonious approach to documenting the associations between the effects of posttraumatic growth and short- and long-term emotional distress.
- The greater vulnerability of those with low posttraumatic growth supports the possible utility of interventions to promote posttraumatic growth in therapeutic or community service settings.
- Greater integration of the posttraumatic growth and developmental course would allow researchers and clinicians to set normative expectations, generate more precise predictions about successful adaptation, and design and deliver interventions to facilitate growth for adolescents at various stages of development.
- Future research should address how traumatic events and posttraumatic growth can affect adolescent growth and development, as well as its influence on other psychological and behavioral outcomes, such as quality of life, relationship quality, educational attainment, and engagement in health-promoting versus health damaging behaviors.

---

**Cortina, L. M. & Kubiak, S. P. (2006). Gender and Posttraumatic Stress: Sexual Violence as an Explanation for Women's Increased Risk. *Journal of Abnormal Psychology, 115*(4), 753-759.**

---

## TYPE OF ARTICLE

- Original Empirical Investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- To evaluate two alternative explanations of gender differences in PTSD, one positing inherent vulnerability and the other emphasizing experiences of sexual violence across the life span.
- To test these competing theories by analyzing data from the Violence Against Women Survey data.

## METHODS

### Participants

- The study consisted of a subsample of 591 adults (194 men and 397 women) who completed the larger National Violence Against Women (NVAW) survey (N = 16,000 adults) and who met partner-victimization criteria and received the PTSD assessment.
- The mean age of the sample was 39.80 years ( $SD = 13.40$ ) and the majority of participants had completed high school.

### Materials

- Participants were initially screened for exposure to physical victimization using the 12 item dichotomous (yes/no) Conflict Tactics Scale. Additionally, 8 dichotomous items were included to assess participants' encounters with stalking victimization.
- PTSD symptom severity was measured using the mean of 21 items from the Impact of Event Scale—Revised ( $\alpha = .95$ ). The items fall into three PTSD clusters including intrusion items, avoidance items, and hyperarousal items. To meet DSM—IV symptoms criteria for PTSD, a person must experience at least one intrusion, symptoms, at least three avoidance symptoms, and at least two hyperarousal symptoms.
- The survey defined sexual violence as “any unwanted sexual experience you may have had as an adult or child.” Four items assessed experiences of completed oral rape with penis, completed anal or vaginal rape with finger or object, and attempted rape of any kind. Women's surveys included an additional item pertaining to completed penile-vaginal rape. Each item had a dichotomous (yes/no) response option. Items collectively yielded a measure of lifetime exposure to sexual violence, including adult and childhood experiences ( $\alpha = .84$ ).

### Procedure

- Data came from the National Violence Against Women (NVAW) Survey, headed by Patrician Tjaden and Nancy Thoennes. All sampling and interviewing was conducted by a survey research firm.
- A national random sample was obtained by using random-digit dialing to reach households with a telephone,



identifying all eligible household members, and selecting the adult with the most recent birthday to participate.

- The study was introduced as a study of “personal safety”. Between November 1995 and May 1996, a total of 8,000 men and 8,000 women completed the telephone interview.
- Respondents were first screened for exposure to sexual, physical, and stalking victimization. Participants acknowledging any history of victimization were asked to indicate who had perpetrated the abuse.
- If a current spouse or cohabiting partner had ever been a perpetrator, the respondent was considered to have been a victim of current-partner aggression. Interviewers then assessed for PTSD symptoms related to this aggression.

## RESULTS

- Simple linear regression revealed that gender predicted exposure to sexual violence across the life span such that women’s average exposure was significantly higher than men’s.
- There was also a small but significant effect for gender and PTSD symptom severity such that women reported somewhat more severe symptoms than did men.
- The relationship between gender and symptom severity was mediated by sexual victimization; gender lost its predictive power when simultaneously included in the hierarchical regression.
- Additional analysis revealed that significantly more women (39%) than men (24%) had feared serious injury or death during at least one of their victimizing experiences. More women than men were also likely to sustain physical injury during this violence (38% vs. 25%).
- The pattern of results between sexual victimization and symptom severity remained unchanged and gender remained insignificant when these two violence assessments were added to the third step of a regression. Physical injury and life threat accounted for additional unique variance in PTSD symptom severity.

## CONCLUSIONS/SUMMARY

- In explaining the higher prevalence of PTSD among women than men, the results challenge the theory that women are inherently more vulnerable to trauma-related

disorders and instead support that posttraumatic stress is more directly attributable to violent situations.

- Consistent with past research on gender and sexual trauma, the current study found that women were four times more likely to face some form of sexual violence in the course of their lives.
- The study assessed symptoms of partner-aggression-related PTSD independent of the exposure to sexual violence across the lifespan. Even though sexual violence frequently occurred outside of the index event (e.g., current partner was not the perpetrator), lifetime sexual violence still increased risk for posttraumatic stress stemming from intimate partner aggression.
- Limitations include the cross-sectional correlational design of the study, which precludes conclusions regarding causality. Related to measurement of PTSD, the assessment focused only on current PTSD symptoms and did not address lifetime PTSD. Therefore, it cannot be determined whether the results represented gender differences in PTSD onset or PTSD course.

## CONTRIBUTIONS/IMPLICATIONS

- The present research identified an alternative explanation for the apparent gender differences in PTSD symptoms and established sexual victimization history as a significant risk factor for a specific victim population.
- These findings suggest that in past studies reporting gender differences in trauma-related disorders, gender may have served as a proxy for lifetime sexual victimization.
- The current study also highlights the importance of considering traumatic events across the life course when investigating and treating PTSD.
- Future research should pursue features of traumatic situations that increase PTSD risk and gender differences in processes that maintain PTSD (i.e., maladaptive coping, rumination, and memory).
- Although it seems likely that the identified relationships between gender, lifetime sexual violence, and PTSD symptoms would generalize to other trauma populations rather than being unique to victims of partner-aggression, further research is necessary to support this generalization. Additionally, future studies can build on this work by focusing on other demographic variables that correlate with violence exposure and outcomes.

## **War and the Soul: Healing Our Veterans from Post-traumatic Stress Disorder**

By Edward Tick, Ph.D.

Quest Books, 2005, Softcover, \$19.95

“The mortars have stopped falling. The tracers have stopped screaming...But years later, veterans still have nightmares and flashbacks...Though hostilities cease and live moves on, and though loved ones yearn for their healing, veterans often remain drenched in the imagery and emotion of war for decades and sometimes for their entire lives (p. 1).”

Dr. Edward Tick has worked with veterans for over 25 years. In “War and the Soul,” he blends insights from warrior cultures ranging from the ancient Greeks to Native Americans to assist veterans in healing their hearts, minds, and souls following the trauma of war.

The book is organized into three sections. Part I examines war from historical, mythological, and religious/spiritual traditions. Part II explores Post-traumatic Stress Disorder (PTSD) in terms of identity issues. Part III focuses on healing practices from shamanic, ancient Greek, Native American, Vietnamese, and other traditions.

One of the keys to healing veterans, Dr. Tick asserts, is in how we understand PTSD. Dr. Tick redefines PTSD as an identity disorder rather than an anxiety disorder because an anxiety disorder assumes a pathological distortion that can be treated and returned to normal. Viewing PTSD as an identity disorder focuses on one of the most difficult questions veterans must answer: “Who am I now?”

Veterans know that war has changed them, even though society expects veterans to return unchanged, to put the war behind them, and to move on with their lives. He quotes veteran Robert Reiter as answering the question, when did you leave Viet Nam, with “Last night. It will be that way till my soul leaves this old body (p. 99).”

He describes PTSD as “a constellation of fixated experience, delayed growth, devastated character, interrupted initiation, and unsupported recovery (p. 107),” supporting his assertion of PTSD as an identity disorder or a soul wound. He states that veterans cannot figure out who they have become nor can they shape this new self into an identity that helps them find peace.

Some of the war-caused changes he discusses include the challenge to soldier’s belief that they are the ‘good guys, the “cavalry led by John Wayne.” Belief systems are often shattered in wartime. Behaviors that are unacceptable in peacetime become acceptable in wartime. However, when veterans return to civilian life, “what was normal during warfare becomes criminal or dysfunctional in peacetime.”

Veterans and survivors are often saturated with death. They may have killed, including “innocents.” Veterans may feel as if “there is a cemetery inside them; they feel an overwhelming responsibility to honor and not forget their lost dead (p. 179).” Faces and body parts may haunt them, both waking and sleeping. Dr Tick describes veterans as coming “home stumbling out of hell.”

Building on his reorientation of PTSD as an identity disorder, and drawing on different warrior cultures, he recommends viewing healing as a journey with four steps. The first step is purification and cleansing. The second step is telling their story, and feeling that their story was “heard.” Many veterans are reluctant to tell their stories because they fear their stories will not be well received or even understood by non-veterans. Veterans often struggle with the contrast between the truth of war as they know it and the illusions society often holds about war.

The third step is restitution in the family and the nation. He explains that for veterans to heal, our society and our leaders must accept responsibility for the war the veterans waged in their name. He asserts that the “severity, incidence, and aftermath of PTSD increase or decrease according to the surrounding social context (p. 266).”

The final step of the veteran’s healing journey is their initiation as a warrior. He explains that a “veteran becomes a warrior when he learns to carry his war skills and his vision in mature ways (p. 251).” A warrior serves in peace as well as war, disciplines the violence within himself, and serves spiritual and moral principles. He points to the Japanese samurai or the Native American Plains societies as examples.

I recommend this important, healing, and well-written book to veterans and those who work with veterans. It is

clearly and directly written, without psychobabble or esoteric theories. It will challenge readers to reassess their beliefs regarding war, veterans, and PTSD.

*Dr. Tick is a nationally recognized expert on the psychological, spiritual, historical and cultural aspects of war, the Vietnam Era, and Post-traumatic Stress Disorder. He began treating Vietnam veterans in 1979 before PTSD was a diagnostic category. Since that time, he has treated veterans and survivors of WWII, the Holocaust, Korea, the Gulf War, Central American conflicts, Lebanon, the Balkan wars, the Irish civil and religious wars, the Greek Civil War, the Middle East conflicts, and the Iraq War, among others. He is the director and senior psychotherapist of Sanctuary: A Center for Mentoring the Soul ([www.mentorthesoul.com](http://www.mentorthesoul.com)).*

## **“Resiliency After Violent Death: Lessons for Caregivers.”**

Gift From Within, 2006, Ordering information: [www.giftfromwithin.org](http://www.giftfromwithin.org)  
Two hours. \$75.00 VHS & DVD

*Resiliency After Violent Death: Lessons for Caregivers* effectively offers helpful strategies for supporting families dealing with the emotional distress of a violent death. Dr. Ted Rynearson, a prominent psychiatrist, opens the video by recommending clinicians, clergy, and caregivers shift their focus from the death itself to the longer term needs of loved ones dealing with the tragedy of losing a loved one to violent death.

The video is organized around two clinical cases: Ms. Walker, who lost three children to violent death, and Mr. and Mrs. Yarborough, whose 17 year old daughter was murdered. Each interview lasts approximately 30 minutes, and is followed by a 45 minute discussion by a panel of experts, including Charles Figley, PhD, Alison Salloum, PhD, Janice Harris Lord, ACSW, and Ted Rynearson, MD, all noted clinicians.

The panel discussion addresses three psychological responses. The first is intense separation and trauma distress, which is the immediate challenge for families. The experts in

this section recommend that families be given the facts of their loved ones death, when they feel ready for that information. Lacking such factual information, many family members, including children, create vivid fantasies about the death, which can be more harmful than the facts themselves.

The second response is reframing dying. Dr. Rynearson recommends asking patients about their concept of death – what do they think occurs? Spiritual beliefs may play an important role, both explanatory and comforting. Also important is listening to survivors tell their story. The experts remind the helpers that they should listen to the family members without imposing their own beliefs.

The third response is meaningful reengagement. The panel highlights the importance of supportive family and friends, the importance of “just being there,” and the importance of letting the process develop over time without trying to rush it. Both sets of surviving parents in their clinical interviews, and the panel, discuss the importance and meaningfulness of reaching out to others, after time.

The video effectively uses the DVD format, opening with a menu of topics. From the menu, viewers can choose the introduction, either one of the clinical interviews, the panel discussion, or the conclusion. The panel discussion is edited into chapters reflecting the three common psychological detailed above. This format allows viewers to reference their topic of interest directly and easily.

*Resiliency After Violent Death: Lessons for Caregivers* is an informative, professional quality video which many clinicians, chaplains, caregivers and instructors/students will find useful. This is certainly another video produced by Gift from Within which is worthy of adding to your audio-visual library.

**Subscribe Now!**

**INTERNATIONAL JOURNAL OF  
EMERGENCY  
MENTAL HEALTH**



A peer-reviewed forum for researchers, scholars, clinicians, and administrators to report, disseminate, and discuss information with the goal of improving practice and research in the field of emergency mental health. Published quarterly, topics include: psychological trauma, disaster psychology, traumatic stress, crisis intervention, emergency services, critical incident stress management, war, occupational stress and crisis, employee assistance programs, violence, terrorism, emergency medicine and surgery, emergency nursing, suicidology, burnout and compassion fatigue.

Check one only:

**Individual Subscription (Four Issues)**

- USA Only ..... \$ 77.00 / year
- International ..... \$108.00 / year

**Institutional Subscription (Four issues)**

- USA Only ..... \$385.00 / year
- International ..... \$465.00 / year

Subscribe by returning this form with your payment to Chevron Publishing, 5018 Dorsey Hall Drive, Suite 104, Ellicott City, MD 21042; fax this form with a purchase order to [410.740.9213] or order on-line from our Web site with a credit card. No company or institution checks can be accepted for individual subscriptions.

A limited number of back issues are also available for \$15.00 each. Visit our Web site for a complete table of contents for each issue or email [office@chevronpublishing.com] for more information.

**Subscription For**

(Please Print Clearly):

Name/Institution \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip/Country \_\_\_\_\_

E-Mail (for confirmation) \_\_\_\_\_

**Method of Payment**

- Check or Money Order (in U.S. funds)  
(Payable to Chevron Publishing Corp.)
- MasterCard       VISA       AMEX

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

Name on Card: \_\_\_\_\_

Card No.: \_\_\_\_\_

Signature: \_\_\_\_\_

**Instructions For Contributing Authors**

1. The *International Journal of Emergency Mental Health* provides a peer-reviewed forum for researchers, scholars, practitioners, and administrators to report, disseminate, and discuss information relevant to the goal of improving practice and research within the field of emergency mental health. Editorials, special articles or invited papers may not be peer-reviewed.
  2. The *Journal* publishes manuscripts on topics relevant to emergency mental health including psychological trauma, disaster psychology, traumatic stress, crisis intervention, rescue services, Critical Incident Stress Management (CISM), war, terrorism, emergency medicine and surgery emergency nursing, burnout and compassion fatigue, occupational stress and crisis, employee assistance programs, suicidology and violence.
  3. The *Journal* publishes manuscripts which fall into eight major categories:
    - original research
    - book reviews
    - case studies
    - empirical reviews
    - commentaries
    - theoretical reviews
    - continuing education updates/reviews
    - program development
  4. The *Journal* will not consider manuscripts which are under concurrent review for publication elsewhere, or manuscripts which have been previously published.
  5. For purposes of author-editor communication, a phone number, fax number, e-mail address, and a postal address should be included with the manuscript. Manuscripts without this contact information may not be accepted for review.
  6. **The following guidelines must be followed for manuscript preparation:**
    - **Manuscripts must be double spaced and prepared in accordance with the most current *Publication Manual of the American Psychological Association*.**
    - **Manuscripts must include a 100 to 200 word abstract and a suggested running headline.**
    - **A list of three to seven key words or phrases must be provided for indexing purposes.**
    - **The corresponding author must be clearly indicated with the street address, telephone number, fax number, and email address.**
    - **Camera-ready figures and illustrations must be provided separate from the text.**
    - **Generic or chemical names should be used when indicating specific medications.**
7. Authors are responsible for all statements made within the manuscript. They are responsible for the accuracy of their work and for obtaining any necessary permissions prior acceptance.
  8. Upon acceptance, all authors must assign the copyright for the manuscript to the publisher.
  9. Blind review for manuscripts is available upon the specific request of the author.
  10. Upon acceptance, all manuscripts will be retained by the publisher.
  11. Authors will receive page proofs for review prior to publication. For timely publication, page proofs must be returned within three days.
  12. There are no page publication charges.
  13. Reprints may be ordered directly from the publisher. A reprint order form will be included with the page proofs.
  14. Manuscripts should be submitted in electronic version in Word format and sent as an attachment to Richard L. Levenson, Jr., Psy.D., C.T.S.:  

drlevenson@att.net
- The email should be clearly labeled with the author(s)' name, manuscript title, and date.





