



CHEVRON
PUBLISHING CORPORATION

PO Box 6274
Ellicott City, MD 21042 USA
Telephone: (410) 418-8002
Fax: (410) 418-8006
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.

© 2010

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
Laurence Miller, PhD
Boca Raton, FL

Legal Editor
Gary E. Jones, Ph.D., J.D., M.P.H.
Boca Raton, FL

Book & Media Editor
Daniel Clark, Ph.D.
Washington State Patrol

Associate Editors

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

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

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

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

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

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

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

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**, Geisinger Clinic, Danville, PA • **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 • **James L. Greenstone, PhD**, Capella and Walden Universities, Fort Worth, TX • **Christina Harnett, Ph.D.**, Psychologist/Faculty, Johns Hopkins University, Division of Public Safety Leadership, Baltimore, MD • **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 • **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.**, Friends Research Institute, Baltimore, MD • **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 • **Dennis Potter, MSW**, Kantu Consultants, Grand Rapids, MI • **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., PO Box 6274, Ellicott City, MD 21042 USA. Fourth class postage rates paid at Ellicott City, Maryland.

- **SUBSCRIPTION PRICES:** 2010 (four issues): Institutions: \$390.00 (Foreign: \$485.00); Individuals \$82.00 (Foreign: \$128.00) payable in U.S. funds through a U.S. bank. Credit card orders may be placed by calling (410) 418-8002.
- **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

The *International Journal of Emergency Mental Health* is a practice-oriented resource for active professionals in the fields of psychology, law enforcement, public safety, emergency medical services, mental health, education, criminal justice, social work, pastoral counseling, and the military. The journal publishes articles dealing with traumatic stress, crisis intervention, specialized counseling and psychotherapy, suicide intervention, crime victim trauma, hostage crises, disaster response and terrorism, bullying and school violence, workplace violence and corporate crisis management, medical disability stress, armed services trauma and military psychology, helper stress and vicarious trauma, family crisis intervention, and the education and training of emergency mental health professionals. The journal publishes several types of articles:

- **Research reports:** Empirical studies that contribute to the knowledge and understanding of traumatic disability syndromes and effective interventions.
- **Integrative reviews:** Articles that summarize and explain a topic of general or specialized interest to emergency medical, mental health, or public safety professionals.
- **Practice guides:** Reports of existing, developing, or proposed programs that provide practical guidelines, procedures, and strategies for working emergency service and mental health professionals.
- **Case studies:** Clinical or field reports of professional experiences that illustrate principles and/or practice guidelines for crisis intervention and emergency mental health.
- **Book and media reviews:** Reviews of books, films, DVDs, or electronic media of relevance to emergency response and mental health professionals.
- **First person:** Personal accounts of dealing with traumatic stress and crises, either as a victim or caregiver, that provide insight into coping and recovery.

The *International Journal of Emergency Mental Health* is *your* place to say something that can make a difference in the lives of victims and helpers and have a real-world impact on the daily practice of emergency medical, public safety, and mental health services.

Complete **Instructions for Authors** can be found on-line at:
www.chevronpublishing.com/authorinfo.pdf

Submit manuscripts electronically in Word format to:

Laurence Miller, PhD, Editor
*International Journal of
Emergency Mental Health*
Plaza Four, Suite 101
399 W. Camino Gardens Blvd.
Boca Raton, Florida 33432
docmilphd@aol.com

INTERNATIONAL JOURNAL OF
EMERGENCY MENTAL HEALTH

Volume 12 • Number 4 • Fall 2010

ORIGINAL ARTICLES

- iv Editorial
Laurence Miller
- 231 Helping Military Children Cope with Parental Deployment: Role of Attachment Theory and Recommendations for Mental Health Clinicians and Counselors
Halle B. Miller, Laurence Miller, and David Bjorklund
- 237 The Use of Psychosocial Assessment Following the Haiti Earthquake in the Development of the Three-Year Emotional Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS) Plan
Karin Jordan
- 247 The Parent-Rated Social Skills of a Sample of New York City Preschool Children 8 – 10 Months After September 11, 2001
Anastasia E. Yasik, Philip A. Saigh, Pamela Mitchell, and A. Reese Abright
- 257 Differences in Compassion Fatigue, Symptoms of Posttraumatic Stress Disorder and Relationship Satisfaction, Including Sexual Desire and Functioning, between Male and Female Detectives who Investigate Sexual Offenses against Children: A Pilot Study
Eric J. Lane, Jeffrey M. Lating, Jenny L. Lowry, and Traci P. Martino
- 267 Time of Psychiatric Patient Assaults: Twenty-Year Analysis of the Assaulted Staff Action Program (ASAP)
Raymond B. Flannery, Georgina J. Flannery, and Andrew P. Walker.
- 275 Managing Problem Employees: A Model Program and Practical Guide
Laurence Miller

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

- 287 Selected Annotated Journal Resources
Justin Chen and Rebecca Fall

BOOK AND MEDIA REVIEWS - Daniel Clark, Reviews Editor

- 297 Handbook of Adult Resilience
Edited by John W. Reich, Alex J. Zautra & John Stuart Hall
- 298 Consulting and Advising in Forensic Practice: Empirical and Practical Guidelines
Edited by Carol A. Ireland and Martin J. Fisher
- 300 Genes on the Couch: Explorations in Evolutionary Psychotherapy
Edited by Paul Gilbert
- 302 Biosocial Criminology: New Directions in Theory and Research
Edited by Anthony Walsh and Kevin M. Beaver
- 303 The criminal triad: Psychosocial development of the criminal personality type
William M. Harmening

Editorial

The scope of emergency mental health services is an extraordinarily broad and diverse one, in several ways. First, in scale, these services range from one-on-one and small group interventions for isolated crises, to megamobilizations to assist entire distressed populations. Second, in location, emergency mental health services can take place anywhere: in homes, at work, in civilian communities, or in military settings. Third, all age groups are represented, from infants and children to adults and the elderly. The articles in this issue reflect this diversity.

Interventions for and with children comprise the theme of the first four of this issue's contributions. The often-forgotten members of the armed forces community are the million-plus children of military service members who must cope with long separations from their parents due to multiple deployments. Miller and colleagues present an attachment theory-based model of deployment stress in children, and offer some practical strategies for keeping these families psychologically united while the military parent is at war. At least military children have some preparation for their ordeal; no such warning precedes a sudden cataclysm like the earthquake that ravaged Haiti in the past year. Jordan provides a protocol for narrative case-study research on the psychological effects of disaster trauma on children, adolescents, and adults. Sadly, not all disasters are acts of nature.

The terrorist attacks of September 11, 2001 continue to have reverberating effects, and the article by Yasik and colleagues describes the effects of witnessing these traumatic events on the social skills of New York City children.

Traumas that affect children also radiate outward to impact those charged with preventing their abuse and bringing the perpetrators to justice. Lane and colleagues present important information on vicarious traumatization and compassion fatigue that affect law enforcement investigators of sex crimes against children. High stress occupations also include those who work in inpatient psychiatric facilities, where staff are sometimes victims of patient assaults. It would be useful to predict when and how these assaults take place, and Flannery and colleagues provide the results of a 20-year retrospective study that highlights the time frames when staff are most at risk. Finally, doing one's job can be challenging enough, without having to worry about the misbehavior of our workmates. Miller offers a protocol for managing problem employees that can be applied to a wide range of work settings and which strives to preserve the salvageable worker, while weeding out the truly incorrigible, and thereby assuring the majority of the workforce a secure and stable environment in which to do their jobs.

Laurence Miller, PhD

Helping Military Children Cope with Parental Deployment: Role of Attachment Theory and Recommendations for Mental Health Clinicians and Counselors

Halle B. Miller

Florida Atlantic University, Boca Raton, Florida

Laurence Miller

Florida Atlantic University, Boca Raton, Florida

David Bjorklund

Florida Atlantic University, Boca Raton, Florida

***Abstract:** Military deployment of a parent carries with it a number of stresses for children, all centering around uncertainty, instability, and unpredictability. This article conceptualizes military deployment and relocation stress in the context of attachment theory, and describes the types of adverse outcomes that can occur as the result of impaired attachment. It then presents a set of practical recommendations for mental health clinicians and counselors for helping children and families cope productively and negotiate the developmental hurdles associated with maintaining healthy attachment and family stability in the face of military deployment. [International Journal of Emergency Mental Health, 2010, 12(4), pp. 231-236].*

Key words: Attachment theory, deployment stress, family counseling, military psychology, parent-child attachment.

In the United States, there are one and a half million school-aged children with parents deployed on active military duty (Mabe, 2009; Palmer, 2008). Recently, the literature on military families has cited several severe mental health risks for children with parents in the military, including increased risk with length of deployment, relocation, reenlisting, the civilian parent's responses, and the possibility of death or disablement of the parent (Barker & Berry, 2009; Figley & Nash, 2007; Hoge, 2010; Kennedy & Moore, 2006, 2010).

Halle B. Miller is a student in the Psychology Department at Florida Atlantic University. Laurence Miller is an adjunct professor in the Psychology Department at Florida Atlantic University, a clinical and forensic psychologist in independent practice, and the editor of IJEMH. David Bjorklund is professor of psychology at Florida Atlantic University. Address correspondence to Laurence Miller, PhD, Plaza IV, Suite 101, 399 Camino Gardens Blvd., Boca Raton, Florida 33432, 561-392-8881, docmilphd@aol.com.

This article describes some of the stresses on children with parents in the military and offers mental health clinicians and counselors some strategies for helping military families handle deployment stress.

Deployment Stress

Military deployment of a parent carries with it a number of stresses for children, all centering around uncertainty, instability, and unpredictability (Cohen et al., 2009; Hall, 2008; Hoge, 2010; Lincoln et al., 2008; Mabe, 2009; Reger & Moore, 2009). In the predeployment phase, the soldier first receives his/her notification for deployment, and then must wait an unspecified length of time for his/her departure. When the soldier is deployed, the family undergoes the uncertainty of his or her return, and after the soldier comes home, the family must readjust to the postdeployment fam-

ily roles, while at the same time continuing to live with the unpredictability of possible subsequent redeployment. This cycle has been accelerated in the recent Iraq and Afghanistan war theaters, leaving families even less time to fall back into familiar routines. This includes less time for the child to become accustomed to the soldier-parent's return, which can result in self-protective emotional detachment and further instability within the home. An additional feature of these wars is the large number of female service members, up to 40% of whom are mothers themselves.

Research with children of deployed parents has shown that when family members are emotionally or physically absent, these children may suffer anxiety and depression, or may rebel by acting-out. Academic performance may decline as well. Up to a third of military children with deployed parents score high on measures of risk for psychosocial problems, two-and-a-half times higher than the rate for children of civilian parents, a finding that applies across age groups. The longer the parent is deployed, the greater number and greater severity of emotional difficulties are reported (Deployment Has Psychological Toll, 2009; Fassler, 2009; Lincoln et al., 2008).

Children as young as infancy can feel the stress of their caregiver's absence. Lincoln and colleagues (2008) found that infants often show their agitation through irritability, unresponsiveness, disturbances of sleep and eating, and increased crying. The older the child, the more obvious the signs of anxiety become. In toddlers, common signs of distress include clinginess, resistance to daily activities, lack of appetite, and disruptions in sleep. As children reach the pre-school age, they will often react to parental separation by behavior regression, including aggressive and demanding behavior, reoccurrence of bedwetting, and crying for attention. This frequently creates a vicious cycle in which the parent reacts with irritation, agitation, and/or avoidance to the child's behavior, further exacerbating the child's disruptive behavior, leading to overall family dysfunction.

Relocation Stress

Aside from deployment itself, military life is a naturally unpredictable one. The average civilian child undergoes one or two moves throughout his or her life, compared with a relocation every two or three years for the typical child of a military parent. These frequent moves further disrupt the child's ability to form stable social and community attach-

ments by necessitating changes in schools, reintegration into new peer groups, forming new friendships, and adjusting to new neighborhoods. Up to one-third of military children report significant anxiety, and military children consistently point to frequent geographic relocations as the most stressful aspect of growing up in a military family. Such transitions may affect family income, childcare arrangements, school status, peer relationships, and social networks (Cohen et al., 2009; Fassler, 2009; Lincoln et al., 2008).

Attachment Theory

Attachment was first defined by Bowlby (1988, 1999) as an enduring psychological connectedness between a child and his or her parent(s), which is crucial for the child's healthy development. According to this model, attachment has four characteristics: a safe haven, a secure base, proximity maintenance, and separation distress. The *safe haven* component of attachment refers to the child's ability to be soothed by the caregiver in times of distress. A *secure base* denotes the caregiver's ability to provide a dependable psychological foundation for the child to explore the world, an interpersonal anchor that the child can mentally hold onto as he or she pursues independent action. *Proximity maintenance* refers to the child's desire to stay close to the caregiver for safety. *Separation distress* occurs when the caregiver is not physically or psychologically present.

Ainsworth (Ainsworth & Bowlby, 1965) elaborated a set of three attachment styles, based on her studies of children responding to separation: secure attachment, ambivalent-insecure attachment, and avoidant-insecure attachment. A fourth attachment style, disorganized-insecure attachment, was proposed by Main and Solomon (1986). According to this model, children with a *secure attachment style* are reported to have better conduct, a higher maturity level, to be less aggressive, and to be more empathetic than insecurely attached children. As adults, they tend to have trusting, intimate, long-term relationships, higher self-esteem, the ability to share feelings, and a willingness to reach out for support when necessary.

Children with *ambivalent-insecure attachment* are typically wary of strangers, extremely upset when the caregiver leaves, and are not comforted by the return of the caregiver. They typically reject comfort from the caregiver or display aggression toward the caregiver, alternating with clingy-dependent behavior. As adults, their relationships

are characterized by dependency, insecurity, suspicion, and fear of closeness, typically leading to depression when the relationship ends.

Children with *avoidant-insecure attachment* tend to display an attitude of indifferent avoidance of their caregiver, especially after a long period of separation, neither seeking nor overtly rejecting the caregiver's attention, and showing little preference for their caregiver over a complete stranger. As adults, they lack emotional investment in relationships, avoid intimacy, and spend little time with their partner. They are uncomfortable expressing feelings, fail to provide much emotional support for their partner, and are not particularly distressed when the relationship ends.

Children with *disorganized-insecure attachment* show a mixture of ambivalent and avoidant responses. They seem confused or agitated in the presence of the caregiver, purportedly stemming from the simultaneous feelings of comfort and fear in the presence of their caregiver, who is inconsistently present. As these children grow older, many of them assume a parentified role and become the caregiver's caregiver, a pattern that, as adults, may lead to confused and conflicted relationships with others.

Attachment, Separation, and Military Deployment

Clearly, the absence of at least one caregiver is a defining feature of military families where a parent is deployed. Additionally, the uncertainty of deployments and redeployments robs the child of any real sense of consistency in his or her physical attachment and connection to the parent. Of course, attachment refers to more than just a physical presence; indeed, it is the psychological connection between the child and caregiver that has the greatest impact on the nature of the attachment style and that influences subsequent psychosocial development.

Nevertheless, even the physical presence or absence of a caregiver may affect attachment styles in children of military families. For example, Barker and Berry (2009) surveyed 57 military families with at least one young child and one soldier-parent on active duty at two separate times, the first at three to four months into the parent's deployment and the second at four to six weeks postdeployment. They found that disturbances in the child's attachment behavior were correlated with the number of deployments in the family. The affected children displayed distress and confusion

when the deployed parent returned, accompanied by refusal to seek comfort from the returning parent and clinginess when it was time for the parent to leave, consistent with the disorganized-insecure attachment style. As expected, the child showed a strong preference for the civilian parent, who was consistently present, over the deployed parent, and these children were able to form a secure attachment with the civilian parent, indicating that the problem was not with the children, but appeared to relate to the deployed parent's inconsistent presence.

Helping Parents Help Their Kids Cope with Caregiver Deployment: Recommendations for Clinicians and Counselors

Issues involving characteristics of the returning service member-parent that relate to premorbid personality, effects of military PTSD and other traumatization, physical injury, brain injury, and marital relationship may all affect parent-child attachment and children's response to the stress of parental deployment (Cozza et al., 2010; Figley & Nash, 2007; Kennedy & Moore, 2010; Kennedy & Zillmer, 2006; Miller, 2008), all of which merit separate and individualized attention. This section will focus on how mental health clinicians and counselors can help military families maximize healthy child attachment to the deployed parent and minimize stress and adverse reactions (Cohen et al., 2009; Fassler, 2010; Hall, 2008; Hoge, 2010; Mabe, 2009; Reger & Moore, 2009).

Plan for continuity of contact.

Encourage military families to be proactive and not leave opportunities for contact to chance. Help them plan the frequency of communications and the forms that they will take. One of the present features of modern war is the unprecedented range and efficiency of communications technology, including computers and cell phones. Of course, protocols of military security and policy must be observed, but whenever possible, encourage families to plan regular, scheduled contacts to foster a sense of predictability and stability.

For those times when direct communication is impossible for security or logistical reasons, help families create multisensory reminders of the absent service member, in the form of family pictures placed throughout the house, prerecorded audio- or videorecordings of bedtime stories or other personal messages, or "talking photo albums," which record

brief audio messages of the deploying parent's voice and include corresponding photographs of the parent with the child. Even something as simple and "retro" as a handwritten letter can be a comfort to children at home. Encourage families to pre-plan family events such as birthdays, anniversaries, graduations, Mother's or Father's Day, and other holidays and family celebrations to include the deployed parent by pre-arranging cards, gifts, or flowers to be sent to and from the service member at those times.

Maintain lifestyle stability, predictability, and normalcy.

While the service member is deployed, help families maintain a regular daily and weekly routine to counteract the natural sense of insecurity felt by children during their parent's deployment. This includes helping them avoid the "waiting syndrome," i.e. putting all important family projects and life activities on hold until the service member returns. Instead, encourage nondeployed family members to enjoy fun times together, plan special events, and start new hobbies or activities, to give the sense that "life goes on." Of course, whenever possible, include the deployed parent through the use of the communication technologies mentioned above.

Normalcy also involves family discipline. Show families how to maintain rules of conduct and expectations for their children with regard to school, chores, health, and safety while the military parent is deployed. Although they may complain about it, children derive a certain comfort in knowing that the "grownups are in charge," even though one of those grownups is not physically there. Help parents to work out points of agreement and lines of communication prior to deployment, so that children will know that mom and dad are on the same page when it comes to following family rules, in order to avoid children exploiting the separation and attempting to split or triangulate the parents. Many military bases offer parent education classes that deal with these topics, but for families living in the general community, the mental health clinician or counselor may be the only resource for this information.

Keep communications open.

Encourage at-home family members to maintain good communication with one another through honest, age-appropriate discussions on a regular basis and by answering questions and being willing to listen and to express feelings. Mental health clinicians and counselors can be invaluable

here in educating parents on effective communications skills, such as reflection, active listening, and questioning about possible undisclosed concerns.

A common temptation for the at-home parent is to, consciously or unconsciously, "adultify" their children, treating and responding to them as if they were surrogates for the absent service member. Mental health clinicians should be available pre-deployment and during deployment to show these parents how to get their needs for adult contact met in a healthy way by developing and expanding friendship and extended family networks. Also important is helping at-home parents deal with their anxieties and frustrations with regard to the missing service member so that they can avoid creating a debilitatingly tense or morose atmosphere throughout the household.

Provide realistic reassurance.

As just noted, without appearing to sugar-coat the realities of war, the at-home parent should try to maintain a reasonably optimistic and upbeat attitude for their children to emulate. Both the deployed and nondeployed parent should reinforce to their children, as often as necessary, that they will always love them and that together they can get through this deployment. In some cases, mental health clinicians or counselors may be able to introduce children to other children with a deployed parent, encouraging a formal or informal support group of such children (the same can apply to their parents). Again, for families living on military bases, these services may already exist, but for community-dwelling military families, mental health clinicians may have to exercise some ingenuity in helping these families productively network, while respecting the boundaries of privacy and safety.

Facilitate family readjustment to homecoming.

The mere fact of a service member's postdeployment return to his or her family does not guarantee a seamless transition back to normal family life. Mental health clinicians and counselors should be available to assist families in coping with such issues as physical injury, psychological trauma, changed family roles, financial stresses, substance abuse, and couples issues.

Summary and Conclusions

Military parents may be deployed at just those stages in their children's lives when crucial attachments are being

formed. By being aware of the psychological dynamics of attachment and separation, and helping military families to proactively plan and maintain strategies for maximizing psychological connection to the deployed parent, mental health clinicians and counselors can have a far-reaching effect on the lives of military children and the overall mental health of their families.

REFERENCES

- Ainsworth, M. and Bowlby, J. (1965). *Child care and the growth of love*. London: Penguin Books.
- Barker, L.H. & Berry, K.D. (2009). Developmental issues impacting military families with young children during single and multiple deployments. *Military Medicine*, 174, 1033-1040.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. London: Routledge; New York: Basic Books.
- Bowlby, J. (1999). *Attachment*. (2nd ed.). New York: Basic Books.
- Cohen, J.A., Goodman, R.F., Campbell, C., Carroll, B.L. & Campagna, H. (2009). War and children coping with parental deployment. In S. Morgillo, B.A. Moore & A. Freeman (Eds.), *Living and surviving in harm's way: A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 395-416). New York: Routledge.
- Cozza, S.J., Guimond, J.M., McKibben, J.B.A., Chun, R.S., Arata-Maiers, T.L., Schnieder, B., Maiers, A., Fullerton, C.S. & Ursano R.J. (2010). Combat-injured service members and their families: the relationship of child distress and spouse-perceived family distress and disruption. *Journal of Traumatic Stress*, 23, 112-115.
- Deployment has psychological toll on children in military families. (2010). *Medical News Today*. Retrieved from <http://www.medicalnewstoday.com/printerfriendlynews.php?newsid=160421>.
- Fassler, David (2010). Children in military families: tips for parents and teachers. *Military Money.com*. Retrieved from <http://www.militarymoney.com/home/1101923157/print>.
- Figley, C.R. & Nash, W.P. (Eds.) (2007). *Combat stress injury: Theory, research, and management*. New York: Routledge.
- Hall, L.K. (2008). *Counseling military families: What mental health professionals need to know*. New York: Routledge.
- Hoge, C.W. (2010). *Once a warrior, always a warrior: Navigating the transition from combat to home, including combat stress, PTSD, and mTBI*. Washington, DC: Globe Pequot Press.
- Kennedy, C.H. & Moore, J.L. (Eds.) (2010). *Military neuropsychology*. New York: Springer.
- Kennedy, C.H. & Zillmer, E.A. (Eds.) (2006). *Military psychology: Clinical and operational applications*. New York: Guilford.
- Lincoln, A., Swift, E. & Shorteno-Fraser, M. (2008). Psychological adjustment and treatment of children and families with parents deployed in military combat. *Journal of Clinical Psychology*, 64, 984-992.
- Mabe, P.A. (2009). War and children coping with parental deployment. In S. Morgillo, B.A. Moore & A. Freeman (Eds.), *Living and surviving in harm's way: A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 349-370). New York: Routledge.
- Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/ disoriented attachment pattern: Procedures, findings and implications for the classification of behavior. In T. B. Brazelton & M. Yogman (Eds.), *Affective Development in Infancy*, 95-124. Norwood, NJ: Ablex.
- Miller, L. (2008). Military psychology and police psychology: Mutual contributions to crisis intervention and stress management. *International Journal of Emergency Mental Health*, 10, 9-26.
- Palmer, C. (2008). A theory of risk and resilience factors in military families. *Military Psychology*, 20, 205-217.
- Reger, G.M. & Moore, B.A. (2009). Challenges and threats of deployment. In S. Morgillo, B.A. Moore & A. Freeman (Eds.), *Living and surviving in harm's way: A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 51-65). New York: Routledge.

Submitted December 5, 2010

Accepted December 21, 2010

The Use of Psychosocial Assessment Following the Haiti Earthquake in the Development of the Three-Year Emotional Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS) Plan

Karin Jordan
The University of Akron

Abstract: *This article provides information about the 2010 Haiti earthquake. An assessment model used by a crisis counselor responding to the earthquake is presented, focusing on the importance of gathering pre-deployment assessment and in-country assessment. Examples of the information gathered through the in-country assessment model from children, adolescents, and adults are presented. A brief overview of Haiti's three-year Emergency Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS) is provided. Finally, how the psychosocial manual developed after assessing 200 Haitian survivors through in-country assessment, and information gathered through pre-deployment assessment became part of the EP-MMHPS is offered. [International Journal of Emergency Mental Health, 2010, 12(4), pp.237-246].*

Key words: *Haiti earthquake, psychosocial assessment, crisis counseling*

The things that you do for yourself in your life die with you. The things that you do for the world and others live forever.

– Albert Pike

On Tuesday, January 12, 2010 at 4:53 p.m., a 7.0 magnitude earthquake, the area's largest in more than 200 years, struck Haiti. The epicenter of the earthquake, which was about 10 miles west of the Haitian capital of Port-au-Prince, shattered the island nation (The Telegraph, 2010). It is believed that the earthquake occurred along a strike slip fault, in which one side of a vertical fault slipped horizontally past the other. The earthquake left massive destruction, with buildings col-

lapsing due to poor structural design and construction. Private homes, businesses, schools, hospitals, the Presidential Palace, the National Cathedral, and the Haitian Parliament building, many with people still in them collapsed with large clouds of dust. There were power outages, an overwhelmed communication system, traffic-choked streets, and bodies (dead and injured) lying in the streets.

Today it is estimated that close to 235,000 people died, some buried in mass graves, others never recovered, remaining under collapsed buildings (Delatour, 2010). Many were injured, with large numbers of Haitians dealing with amputations and other injuries. There are no final numbers of displaced orphaned children, with families moving from large camps in the city (often with thousands of inhabitants) to the country.

In the aftermath of the earthquake, Haitians in this already impoverished country sustained a drastic impact of

This article is dedicated to all those affected by the 2010 Haiti earthquake, those that survived, those that were injured, those that were killed, those that lost a loved one, those that were orphaned and those that lost everything, and all of those that are displaced in tents and makeshift shelters. Correspondence regarding this article should be directed to drkbjordan@gmail.com.

deleterious consequences to their physical and psychological well-being (USA Today, 2010). Rescue efforts quickly turned into recovery efforts, and in the initial days after the earthquake, thousands of Haitians were without food, water, and shelter. At first, much of the relief efforts focused on basic needs (water, food, shelter) as well as acute disaster injuries (first the major and then the minor). Subsequent focus was on chronic illnesses and diseases that might be bacterial, and parasitic infections from contaminated water and improperly disposed waste (UN Cluster Group, personal communication, February, 2010). There were also hidden psychosocial wounds of the earthquake that also needed attention.

Recognition of the need for psychosocial services to people affected by disaster dates back to the middle of the 20th century (Crawshaw, 1963; Mental Health Materials Center, 1955). Medical Teams International provided medical disaster response in Haiti in the first few weeks after the 2010 earthquake and determined that attention had to be given to the psychosocial needs by sending a mental health professional with the next medical team. The goal was to conduct a careful assessment of earthquake-affected Haitians so that services and resources could be tailored to Haitian culture, helping the community to heal, fostering resiliency, and avoiding making Haiti a breeding ground for Posttraumatic Stress Disorder (PTSD).

This article describes how a psychosocial assessment, conducted by a crisis counselor during the first few weeks after the Haiti earthquake, led to the development of a psychosocial training manual to be used in Haiti's three-year Emergency Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS). More specifically, this article focuses on the pre-deployment assessment/information gathering process by reviewing the literature. In addition, the contours of in-country assessment as a confluence of three factors is addressed: individual trauma experience, the workings of disaster after-effects, and displacement. Additional focus highlights how the Haiti Ministry of Health proactively addressed the chronic disaster effects of the 2010 earthquake by developing Haiti's three-year EP-MMHPS.

Multi-Level Assessment

For the purposes of this article, Barton's (1969) definition of disaster is used, which defines it as a "collective stress experience" in which a large number of persons' basic and usual needs are no longer met. Natural disasters such as

the earthquake in Haiti occur with virtually no warning or opportunity for immediate preparation, resulting in generally lessened feelings of control, and thereby do not allow survivors to make the necessary psychological adjustments that might facilitate coping. In addition, aftershocks might increase survivors' psychological stress, as there is no defined endpoint. Haiti's earthquake survivors may deal with the aftermath for months or years to come as they cope with the reminders of the destruction (e.g., aftershocks, sounds of collapsing buildings). It is therefore important that an assessment is done at multiple levels.

Conducting an assessment of a situation where the scene and scope was very large required a complex process. According to the National Institute for Mental Health (NIMH, 2002), in disaster situations it is important to do a multi-level assessment that includes individuals, groups, and the larger disaster-affected population. This can involve a multitude of assessments and should include a basic needs assessment (e.g., water food, shelter, safety) to determine whether or not the survivors' basic needs are met.

Since this disaster occurred out of country, it also requires doing an assessment of the affected culture to get some basic understanding about its history and economy (pre and post earthquake). Furthermore, the assessment process in disasters such as the Haiti earthquake should include an ongoing psychological needs assessment, including a systemic assessment of the current level of functioning and status of individuals and groups in the earthquake-affected populations.

Assessment

Sudden disasters such as the Haiti earthquake pose difficult assessment problems since they are unpredictable, and thereby preclude any systemic measures, or the application of a controlled experimental study methodology. Generally there are no pretest measures available, and control and experimental conditions cannot occur. In addition, investigative scientists may not be welcome in the midst of tragedy, and the helping role may interfere with the investigative function (Gibbs, 1989).

Therefore, this assessment began with reviewing the literature to get a basic understanding of relevant historical, socioeconomic, and environmental data, family structure and function, individual responsibilities and roles, health, education, language, and religious/spiritual practices before

the disaster. In addition to the pre-deployment literature assessment, an in-country assessment with Haitian survivors of different ages and socioeconomic status was conducted after deployment of the crisis counselor. These types of assessments, according to Gibbs (1989), create unique challenges:

The characteristics of the disaster may mean that administration of objective measures of psychopathology cannot be carried out with a representative sample.

Therefore, we determined that in-country assessments conducted shortly following a disaster such as the Haiti earthquake should be a dialog focusing on the following three factors. A focus on the actual disaster itself can provide opportunities for survivors to discuss their experiences through a range of verbal and non-verbal methods incorporating various activities, such as drawing, writing, combining drawing and writing, stories, audio and video recordings of their stories. A focus on realistic and positive methods of coping can explore and promote problem-solving skills that are culture-specific and emphasize resiliency. And, finally, there must be a focus on ongoing physical, environmental, social and psychosocial stressors (e.g., availability of food and water, shelter and relocation/displacement resulting in ecological stress, crowding, isolation and social disruption). This part of the assessment should be a dialogue with the survivors. All assessments should be done on a voluntary basis, with adequate time to attend to individual and group needs, as well as providing information about expected post-disaster reactions, helping survivors “take control of their situation by collaboratively identifying problems, resources and potential solutions” (IASC, 2007, p. 41). In addition, mechanisms need to be in place to provide crisis counseling and intervention services that promote and protect human rights and protect at-risk survivors from abuse and exploitation.

Pre-Deployment Assessment

When doing international psychosocial pre-deployment assessment, it is important that it be eco-systemically relevant. Eco-systemic thinking recognizes that individuals are part of many systems and takes into account the possible relevance of each system (such as the work system or social system, and large group factors such as gender, religion, ethnicity and culture) to another as well as to the person’s disaster experience. Therefore, crisis counselors doing this assessment should review the literature, focusing on topics such as history and socioeconomics; environment; family; health; education; language; and religion.

History and socioeconomics. Haiti, officially the Republic of Haiti, is located on the Caribbean island of Hispaniola, occupying its western third. It is the third largest country in the region, just behind Cuba and the Dominican Republic, with about 9.8 million inhabitants (United Nations Population Fund, 2006). Haiti was one of many Caribbean islands that were under colonial power (Britain and France) and became the first post-colonial black republic to gain independence in 1804 (Rotberg, 1971). Haiti’s head of the state is the President, chosen by popular election.

Today, Haiti is a politically unsettled country, dealing with repression, persecution and economic disadvantages. There are class hierarchies involving education, language, economics and culture. The population distribution is believed to be 90% Black peasants; 4% Lebanese, Syrian and European; and 5% are the elite descendants of the original French colonizers (Gopaul-McNicol, Benjamin-Dartique, & Francois, 1998).

Haiti is a very impoverished country that ranks 148th of 182 countries in the United Nations Development Index (2006). It is one of the poorest and least developed countries and, according to USA Today (2009), the 80% poverty rate has forced more than 225,000 Haitian children into slavery as unpaid household servants. Most Haitians live on \$2 a day and, prior to the earthquake, 30-40% of the national government budget was funded with foreign aid.

Environment. In 1925, Haiti was 60% forested. However, since then over 98% of the forest has been cut, resulting in the destruction of fertile farmland as well as desertification (Haggerty, 2006). Cutting the forest has resulted in large floods, such as from tropical storm Jeanne in 2004, which caused floods and mudslides, killing more than 3000 people (Bracken, 2004).

Family. Authority within the Haitian family is based on family position. Grandparents have the most authority (if they live in the same home as the family). Haitian culture is patriarchal (Weil et al., 1985). The father is the authority figure at home, followed by the mother and then the children, from the eldest to the youngest. Male children are more respected than female children. Children are expected to follow rules set by their elders. If they violate these rules, then they can be harshly disciplined. The father is generally the financial provider and the mother is responsible for taking care of the children, family and home. The elderly are taken care of by the family and are respected by adults and children.

Health. According to the World Health Organization (Park, 2010), half of the deaths in Haiti are caused by HIV/AIDS, respiratory infections, meningitis and diarrhea-related diseases (such as cholera and typhoid). In addition, 90% of Haitian children suffer from waterborne diseases and intestinal parasites (World Health Organization, 2008). Other health issues seen in Haiti are tuberculosis and malaria. According to IPS News (2008) only 40% of Haitians have access to healthcare services.

Education. In Haiti, education is the responsibility of the Minister of Education, and is based on the French education system. Only the middle class and elite can afford a high school education and, consequently, only a small percentage of Haitians can read and write (Joseph, 1984). There are more than 15,000 primary schools, 90% of which are run by Non-Government Organizations (NGO), religious organizations and communities (United States Agency for International Development, 2007). Sixty-eight percent of eligible-age children are enrolled in elementary school. The number drops severely in high school, to only 20% (Joseph, 1984). Higher education is provided by public as well as private universities.

Language. The official language used by government, businesses and the school systems is French. However, only about 20% of the Haitian population (the well-educated middle class urbanites and elite) speak that language. The majority speaks Creole, an amalgamation of French, Spanish, English and West African tribal language (Fox News, 2006). It is important to understand that in general those who speak French cannot understand Creole and those that speak Creole cannot understand French. In addition to these two official languages, there are quite a few Haitians who can also speak Spanish; however, this is not an official language.

Religion. Religion/spiritual beliefs are important to Haitians, who to a large extent are Christians. Since 1860, Roman Catholicism is practiced by about 80% of the Haitians and Protestantism by about 16% (Ferguson, 1987; Weil et al., 1985). In addition, Haitian Voodoo, a New World Afro-diaspora faith, is practiced outside of the urban areas by about half of the population (US Central Intelligence Agency, 2010). It is important to understand that Voodoo is not only associated with such things as witchcraft, but also includes a deity, angels, saints, and priests (Gopaul-McNicol, Benjamin-Dartique, & Francois, 1998). Voodooism in Haiti should be viewed as a combination of Catholicism and African (Nigeria, Congo and others) beliefs.

Gathering this eco-systemic information helped the crisis counselor gain a better understanding of the Haitian pre-earthquake situation, which might influence Haitian survivors' perspectives, functioning, and circumstances after the earthquake. This information was important for the crisis counselor to know prior to doing the in-county assessment with a broad range of survivors.

In-Country Assessment

The in-country assessment involved 200 Haitians (children, adolescents, and adults from seven different tent camps and four orphanages in Port-au-Prince and Leogane) and consisted of exploring the contours of what can be called *chronic disaster syndrome*, which refers to the "cluster of trauma and post-trauma related phenomena that are at once individual, social, and political, and that are associated with disaster as simultaneously causative and experiential of a chronic condition of distress" (Adams, Van Hattum, & English, 2009, p. 616). All participation was voluntary, and parents and/or the adults in charge in orphanages determined which children and/or adolescents would participate. The assessment process consisted of interview questions. An interview protocol was developed to obtain information about the Haitians' earthquake experience, and post-earthquake effects. The interview protocol consisted of six major questions, with follow-up probes as needed. The questions were generated from the author's disaster experience with survivors, as well as from disaster literature and discussions with mental health professionals, representatives from the NGO, and lay people in the earthquake affected areas in Haiti. The six major questions were: Describe your experience at the time of the earthquake; Describe your present (post earthquake) living situation; Describe your present food and water situation; Describe your post-earthquake family situation; How well you are sleeping at night; and Describe any fears or worries you struggle with.

The in-person interview involved either one-on-one meetings with the adults (about 25 minutes each), or one-in-a-group meetings with children and adolescents (about 50-70 minutes each). One-in-a group interviews included four to six children or adolescents. All interviews were conducted in either French or Creole, with the help of a translator. Each participant answered all questions, and a follow-up/debriefing session was made available on an as-needed basis.

Children. Children in individual meetings were asked to draw a picture of the earthquake and then were asked to

talk about their picture. They were asked the six questions identified above, with follow-up probes as appropriate. The earthquake drawings were collected and each child was asked to draw a picture of a happy memory or dream/hope for the future. They were asked to talk about these drawings as well and were encouraged to keep their second drawing. All interviews were recorded with the help of a translator. Consistent themes were identified.

The consistent overarching theme was that the earthquake was traumatic. The children described the sound of the earthquake as “thunder under the ground.” They heard people crying and calling out for Jesus. They reported feeling the ground moving, and when they tried to escape, debris falling and often hurting them, their family members, or other people. They saw people lying in the street, dead and injured, as well as injured people being transported in wheelbarrows. They saw collapsed buildings and cars, unable to stop, hitting people.

In one tent camp, children consistently reported that their schools had collapsed and that most, or all, of the other children and adults had died. There was much sadness about having lost their friends. Seventy-eight percent of the children reported having experienced a loss, which included loss of one or both parents, one or more siblings, cousins, uncles, aunts, and/or close friends. They reported being fearful, and even as we spoke, the sound of planes and helicopters scared them, reminding them of the earthquake. Initially, there were many reports of insufficient food or water. But during the visit, most children reported eating once (and a few twice) daily. The food was reported to be spaghetti, bread and coffee, or rice (plain, with beans or with vegetables). Most reported having lost their home, or that it was not safe to sleep in, because some of the walls had collapsed. Other homes had large cracks in them, leaving the children and their families sleeping on the street, in tents or makeshift huts.

As identified above, the children’s earthquake drawings and reported post-earthquake challenges had consistent themes. One example is from a 10 year-old boy, who reported:

I was at school, and we were all inside doing our lessons when the earth started shaking the floor. I got very scared and started running out of the building. I heard the school collapsing behind me. I ran as fast as I could down the stairs, outside of the building. I started falling down, and when I turned my head to look at the building, I realized that no one else made it out. Everyone died in there. I just kept on

running, I was so scared. Loud sounds still make me scared, especially at night. I miss my friends. My best friend died that day. I miss him a lot. It makes me sad that everyone is dead. When I get scared, I talk to my mom, and that helps.

An 8 year-old girl reported:

My mom and I were in the house when the earthquake happened. We both ran out. There was a boy lying next to the house. Some debris had hit him, and he was bleeding. A man started helping the boy, and some bricks fell down and killed the man. The house totally collapsed, and there were still people in it. We could hear them crying. There was a car that hit a man, and he was bleeding. There was a lot of blood. I get scared at night when it is dark. I pray with my mom when I get scared. It helps. Now we are living in a tent, as our house has collapsed. We eat one or two meals a day, generally rice and beans.

Another 8 year-old girl reported:

When the earthquake started I ran outside the house. My three sisters were killed when they tried running out. I was the first one out. Falling debris inside the house killed all three of them. I am very sad (crying), as I miss them very much. I was the youngest. My parents and I are living in a tent right there (pointing at a tent camp). We are eating once a day – rice and beans. When I get scared, I read or talk to my mom, and both help.

These are just a small sample of the experiences the assessed children reported.

Adolescents. Adolescents were given the same instructions and the six questions identified previously, with follow-up probes as needed. The adolescents could choose to draw, or write, or do a combination of both. They were asked to read what they had written, and in cases of having a drawing or combination of writing and drawing, to talk about the drawing. All of these interviews were also recorded, with the help of a translator, to identify consistent themes.

The consistent theme for adolescents was that the earthquake was traumatic and resulted in uncertainties about the future. Seventy-two percent of the adolescents reported having experienced a loss, which included loss of one or both parents, one or more siblings, cousins, uncles, aunts, and/or close friends. They also reported having seen destruction of property, crushed cars, falling debris, and people crying and calling out for Jesus. They reported generally eating only once a day, often a bowl of rice, sometimes with vegetable

and beans, but often only the rice. Water was limited, but over the weeks became more accessible. Sanitary facilities were limited or non-existent. The majority of the adolescents had been displaced, living in tents or makeshift huts, often with nothing but a mattress to sleep on.

As identified above, the adolescents' earthquake experiences and post-earthquake challenges presented in their drawings and writings had consistent themes. One example is from a 15 year-old girl's drawing:

My sister and I were upstairs in our home when the earthquake hit. I ran out as quickly as I could, but my sister got hit by some concrete as it fell on her. I went back into the house and helped free her. When we made it out of the building, it was dark outside. There were dead and injured people everywhere. We could hear lots of crying. There were people carried in wheelbarrows, as there was no other way to transport them. My parents were not home, so we prayed, hoping that they were okay. Eventually, both parents came home and were okay. I am glad that no one in my family died. My aunt got injured during the earthquake. She was in the hospital, but now she is okay.

The girl reported being afraid almost all the time, especially when it was dark. She and her family are living in a tent. Resources such as food have been very limited.

A 13 year-old boy's drawing:

During the earthquake, my aunt, uncle and three cousins and I were in the house. It started tilting to one side when the earth started moving. The top part of the house collapsed, killing almost everyone in there. My aunt and I made it out of the building, but three of my cousins and my uncle died. I get scared when I hear loud noises, such as an airplane flying over us. I sometimes pray, but it does not really help. I cannot go to my dad, and my mom is dead. She died a couple of years before the earthquake. We eat bread and coffee once a day, most days.

A 14 year-old girl's drawing:

I was at school when the earthquake hit. Everything was shaking, and we could not stand up. Everything was falling down and breaking. It was scary, as we could not get out at first. When we finally made it out, I ran home. There were collapsed and broken houses everywhere. The streets were very dusty, and there was lots of blood. There were husbands crying for their wives, wives crying for their husbands, parents crying for their children, and children crying for their

parents. Our home was totally collapsed. I thanked God that my mom and I were okay. My dad had died years back. Our neighbor's home was also badly destroyed. My best friend was injured, and she is still in the hospital. We are now living in a tent, right here (pointing at a tent camp). We are eating once a day. We had spaghetti yesterday. I was scared at first, but now I am okay.

These are just a small sample of the experiences the adolescents reported during the in-country assessment process.

Adults. The adults were interviewed focusing on the six major questions previously identified, as well as follow-up probes as needed. All interviews were recorded with the help of a translator.

Similar to the children and adolescents, the consistent theme for the adults was that the earthquake was traumatic. Seventy-one percent reported having experienced a loss, which included one or both parents, one or more children, brothers and sisters, or their spouse. More specifically, they identified having often lost more than one family member and a close friend. The loss of children was identified as especially difficult, as well as the loss of a spouse. There were repeated themes of not having been able to say good-bye to their loved ones, or not having a proper burial for them. There was uncertainty about the future, especially regarding essential needs such as water, food, and shelter. There were also worries about the sense of foreshortened future, hopelessness of what the future would hold, given the destruction, and what would happen when the NGOs leave.

As with the younger groups, the adult interviews regarding earthquake experiences and post-earthquake challenges had consistent themes. One such example is from a 24-year-old college student who reported:

Since I was young, I had a dream of going to college and made it come true. When I started going to college, I spent all my time studying, working very hard to become a great man. I did not think that things would change as I worked so hard. While I was in my class for Applied Linguistics, the earth started shaking. At that time, all the students tried to run out, but the building started to collapse. It was one of the most awful things I ever endured in my life. Many of my classmates died, and some of them suffered a lot before dying. God protected me, but my country is destroyed, my college is destroyed, and my best friend is dead. I feel very sad. Do I have to give up the fight? It is so hard, but I cannot give up, I have to follow my dream, until it comes true or until I die.

Another example is a young man, 22 years of age, who reported:

I was at home when the earthquake happened. I ran out of my home when someone told me that my sister was trapped in a building. She was crying and very upset. She wanted us to free her, but we could not reach her. She had lots of pain and suffered a lot. She did not want to die, as she had a little baby boy. She made me promise that I would watch out for him, make sure he grew up safe. She died, she did not make it. If she died, that means that I could also die at any time. How can I protect my nephew? I am not hopeful for the future, but I promised my sister. I have to tell my nephew about his mother, who had such a great sense of humor. She would always make us smile. She was a great sister. I miss her.

A woman, 26 years of age, reported:

We were all at home (mother with her two children) when the earthquake happened. We tried to run out, but debris was falling everywhere. I somehow made it out, but my children, who were right behind me when we started running, were no longer behind me. The building collapsed. I called my children's names, but there was no answer, so I started digging in the building. Some neighbors helped. We worked hard and reached my son, who was okay, but had some scrapes and a small cut on his forehead. After he was freed from all of the debris and safe, we started digging for my daughter. We could not find her at first, but when we reached her, she did not move, and I knew she was dead. (crying) That day was my son's birthday, which now also is my daughter's death day. Since the earthquake, we have been living on the street. I do not know if my husband is dead or alive, as he was not home during the earthquake. Life has been tough, with little water and most of the time little or no food. We have no tent or tarp. I miss my daughter and my husband.

In-Country Assessment Results

The events of the 2010 earthquake were harrowing. In the aftermath, 88% of the 200 interviewed Haitians (children, adolescents and adults) witnessed significant destruction of buildings and vehicles. The crisis counselor reviewed the transcripts for core themes. In addition, 84% saw people severely injured; 81% reported having lost their homes (totally destroyed, or no longer safe to live in) and, having been displaced, were living in a tent, on the street, or in an orphanage. In addition, 89% indicated eating only one meal a day and having only limited drinking water. There were

82% who reported sleeping difficulties (falling asleep and/or staying asleep, nightmares and/or night terrors), and 88% reported dealing with various difficulties, ranging from fear and worries, to concentration problems, memory problems, hyper-vigilance, depression.

Despite the need for mental health services, few residents could access them, because few were available prior to the earthquake. In addition, many mental health professionals experienced the trauma of the earthquake and were dealing with multiple losses and displacement. Health care facilities were often destroyed, leaving only a very limited number of inpatient psychiatric beds available. Some NGOs, such as Save the Children, were providing some mental health services, but generally they were short-term and often focused on crisis management rather than long-term intervention and prevention.

Emergency Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS)

Early in the wake of the earthquake, the Haitian Ministry of Health collaborated with other government and UN officials, as well as NGOs, to address the pending crisis of chronic disaster syndrome (a cluster of trauma and post-trauma related phenomena). The nomenclature used by the Haiti Ministry of Health refers not only to the stress and disruption impacting individual Haitians, but also the larger impact on the social condition, which more generally produces distress and, in nonspecific ways, impacts the larger political and economic recovery from the earthquake. Displacement of so many Haitians has itself disrupted recovery, created distress and further disruption, and prevented recovery, because displacement becomes a cause and symptom of an ongoing chronic state of "disaster" or "emergency" stress (Fassin & Vasquez, 2005). It is perpetuated by the magnitude of the destruction and losses of life. The total collapse of important structures, such as the Presidential Palace and the National Cathedral, creates what can be called a condition of "socio-cultural shock." It needs to be addressed through continuing support and assessment because it is so visible to Haitians on a daily basis. This support and assessment should be provided in a manner that avoids exacerbating the effects of the earthquake, and instead creates a remedy that builds on the Haitian's function and capacity.

The Haiti Ministry of Health, along with other government and UN officials, as well as NGOs, developed the

three-year Emergency Psycho-Medical Mental Health and Psychosocial Support (EP-MMHPS). It was developed with the recognition of the “chronicity” of earthquake trauma, which emerged as a form of ongoing displacement, the first piece of the constellation of *chronic disaster syndrome*. Several services were developed to reach large numbers of Haitians and provide psychosocial support and information to Haitians for their healing and recovery process. These included the following. Radio messages provided a way to get information about trauma recovery to large masses, since many Haitians have access to and listen to the radio. Flyers were strategically placed in tent camps, providing information about trauma recovery. Training/education of professionals interfacing with victims was provided on a regular basis. In this way information about trauma recovery was delivered to specific populations, such as teachers, physicians, nurses, physical therapists, mental health professionals, church/spiritual leaders, first responders and volunteers. It also helped them deal with their own earthquake experiences and after-effects. Several working groups were developed. There were also focus groups with church leaders (Catholic and Protestant) who developed some of the messages for radio, as well as the flyers. Another working group focused on psychosocial training for teachers. Various working groups developed the radio messages and flyers and looked at the train-the-trainer materials for professionals. The UN Mental Health Cluster Group (UN-MHCG) was regularly informed about work that the various NGOs were doing, and the location and extent of their work. Collaboration among NGOs was encouraged in order to maximize the impact, but to also provide consistent information/education. Every attempt was made to provide culturally sensitive training materials and assessment tools.

The crisis counselor who had developed a psychosocial training manual got involved in attending meetings and collaborating with representatives from the Ministry of Health who were working on “training and education of professionals interfacing with Haitians on a regular basis.” The psychosocial manual was based on the pre-assessment and the in-country assessment (conducted with children, adolescents and adults), as well as her knowledge and expertise in the area of large-scale disasters. This manual was developed for training Haitian teachers, physicians, nurses, physical therapists, mental health professionals, church/spiritual leaders, first responders and volunteers. It focused on: psychological first aid; disaster intervention skills; post-earthquake reactions and

interventions; factors to be aware of; acute stress disorder and post-traumatic stress disorder; grief and loss; things to watch out for such as safety issues and substance abuse; things you should know, such as population exposure; the personal disaster exposure of medical professionals and other first responders; and secondary traumatic stress. The manual was reviewed by officials and various Haitian mental health professionals, and later translated into French and Creole. It was presented as a resource for working collaboratively with the Haiti Ministry of Health officials to help in the long range planning for the EP-MMHPS.

The crisis counselor and a Haitian physician participated in a train-the-trainer program, the first step in the EP-MMHPS. This program includes training the key providers to deal with their own experiences and after-effects of the earthquake. They are also trained in how to provide direct services to those they serve in their professional roles, such as teachers working with children, etc. There is a focus on safety and security procedures, codes of conduct, human rights and rights-based models. In addition, attention is given to disaster affects and coping skills, psychological first aid, methods used to deal with the disaster that are culture-specific and promote dignity of the survivors. These trainers are also trained in how to train others in their area of expertise, based on “the existing capacity, context and culture of the...” disaster affected country (IASC, 2007). Part of the train-the-trainer program is instruction on giving presentations, such as being well-prepared and familiar with the materials; engaging the trainees in discussions and practice sessions; how to deal with questions; taking breaks; and scheduling a follow-up meeting for answering questions and offering additional practice sessions for trainees after they use their training. This allows the program to grow, as trainers train other Haitian professionals and volunteers to serve earthquake affected Haitians, both short and long-term.

Limitations

Our study has several limitations, such as not having pre-earthquake measures available for comparison with post-earthquake findings. In addition, the sample came from a limited number of tent camps and orphanages in Port-au-Prince and Leogane; therefore, external validating is limited. Finally, no standardized screening tool was used, as there was repeated caution raised by the UN that existing instruments from the U.S. and other countries were not culturally sensi-

tive and non-biased. Instead, six major questions, which had been identified as being important for this particular sample, were used.

Conclusion

Natural disasters such as the Haiti earthquake can be especially traumatic with long-term effects upon survivors. Careful assessment efforts (pre-deployment and in-country) should be used to identify short and long-term needs of survivors. This article focused on the importance of using an assessment model that can be used when responding to various disasters, in various countries across the globe. It is eco-systemic in nature. The assessment model presented served effectively in Haiti. The results were used to develop a psychosocial training manual that is disaster- and population-specific. The manual has been reviewed by Haitian mental health professionals, translated and used to train physicians, nurses, pastors and other church leaders, and community health workers. It is important that there is an ongoing assessment of the service delivery (training as well as direct services), to assure that Haitian survivors' needs, as they change over the months and years to come, are appropriately met.

REFERENCES

- Adams, V., Van Hattum, T., & English, D. (2009). Chronic disaster syndrome: Displacement, disaster capitalism, and the eviction of the poor from New Orleans. *American Ethnologist*, 36(4), 615-636.
- Barton, A. H. (1969). *Communities in Disaster: A Sociological Analysis of Collective Stress Situations*. New York: Doubleday.
- BBC News (2003, November 30). *Haiti's Aids and voodoo challenge*. Retrieved from <http://news.bbc.co.uk/2/hi/americas/3280749.stm>
- Bracken, A. (September 22, 2004). Deforestation exacerbates Haiti floods. *Global Exchange*. Retrieved from <http://www.globalexchange.org/countries/americas/haiti/2497.html>
- Brewin, C. R. (2003). *Posttraumatic stress disorder: Malady or myth?* New Haven, CT: Yale University Press.
- Delatour, M. L. (Producer). (2010). *35 long seconds: Palace and Haiti are changed forever*. Available from <http://haitiwired.wired.com/video/35-long-seconds-palace-and>.
- Dovell, O. (2010). Haiti overcomes by chaos of quake. *USA Today*, Jan. 13.
- Fassin, D., & Vasquez, P. (2005). Humanitarian exception as the rule: The political theology of the 1999 tragedian in Venezuela. *American Ethnologist*, 32(3), 389-405.
- Ferguson, J. (1987). *Papa Doc, Baby Doc: Haiti and the Duvalier's*. Oxford, United Kingdom: Basil Blackwell Ltd.
- Fox News (October 8, 2009). Haiti and Dominican Republic look to eradicate malaria. *FOXNews.com*. Retrieved from <http://www.foxnews.com/world/2009/10/08/haiti-dominican-republic-look-eradicate-malaria/>
- Gibbs, M. M. S. (1989). Factors in the victim that mediate between disaster and psychopathology: A review. *Journal of Traumatic Stress*, 2(4), 489-514.
- Gopaul-McNicol, S., Benjamin-Dartigue, D., & Francois, E. (1998). Working with Haitian-Canadian families. *International Journal for the Advancement of Counseling*, 20, 231-242.
- Haggerty R. A. (Ed.) (September 18, 2006). Forestry. In *Haiti: A Country Study*. Retrieved from <http://countrystudies.us/haiti/53.htm>
- Inter Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and psychosocial support in emergency settings*. Geneva: IASC.
- IPS News (2008, November 13). *Environment: Haiti can't face more defeats*. Retrieved from <http://ipsnews.net/news.asp?idnews=44683>
- Joseph, C. B. (1984). The child, the family and the school in English Haitian education. In C. R. Foster (Ed.), *Haiti Today and Tomorrow*. Lanham: University Press.
- National Institute of Mental Health (NIMH) (2002). *Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices* (NIMH Publication No. 02-5138). Washington, DC: Government Printing Office.
- Park, M. (2010, January 13). *Haiti earthquake could trigger possible medical perfect storm*. Retrieved from CNN.com.
- Revehl, R. (2010, January 19). No time to cry, 'We just keep going.' *USA Today*. Retrieved from <http://www.usatoday.com>.
- Rotberg, R. I. (1971). *Haiti: the Policies of Squalor*. Boston: Houghton Mifflin, Co.
- The Telegraph*. Major earthquake off Haiti causes hospital to collapse. (2010, January 12). Retrieved from <http://www.telegraph.co.uk/news/worldnews/centralamericaandthe>

caribbean/haiti/6977308/Major-earthquake-off-Haiti-causes-hospital-to-collapse.html.

United Nations Development Index (2006). *Statistics of the Human Development Report*. Retrieved from <http://hdr.undp.org/en/statistics/>

United Nations Population Fund (10 May 2006). New Haiti Census Shows Drastic Lack of Jobs, Education, Maternal Health Services. *UNFPA.org*. <http://www.unfpa.org/public/global/pid/227>

United States Agency for International Development (2007). *Education Overview*. Retrieved from www.usaid.gov

US Central Intelligence Agency (2010). *The world fact book - Haiti*. Retrieved from <http://www.cia.gov/library/publications/the-world-factbook/geos/ha.html>


USA Today (2009, December 22). Report: 225,000 Haitian children in slavery. Retrieved from http://www.usatoday.com/news/world/2009-12-22-haiti-slavery_N.html

Weil, T. E., Knippers-Black, J., Blutstein, H. I., Johnston, K. T., McMorris, D. S. & Munson, F. P. (1985). *Haiti: A county study*. Washington: The American University.


Submitted: May 29, 2010

Accepted: December 10, 2010

UMBC TRAINING CENTERS



1442 S. ROLLING ROAD • BALTIMORE, MD 21227-9935 • 443-543-5400
WWW.UMBCTRAININGCENTERS.COM




RESILIENCY SCIENCE INSTITUTES, INTERNATIONAL AT
UMBC TRAINING CENTERS


Is interested in recruiting
Psychologists, as well as, HR, EAP, and OD Professionals
interested in becoming Affiliate Training Faculty in
Resilient Leadership

If ever there was a time that resilient leadership was needed at all levels of society, it is now. Trainers will learn how to teach what we believe are the two “covenants” of resilient crisis leadership as well as the four essential characteristics of resilient crisis leaders. In addition, trainers will learn how to teach the evidence-based crisis and risk communications Resilient Moment Communications Model (RMC), and how to teach the fundamentals of “Psychological Body Armor” as a means of enhancing personal stress immunity and resilience.

For more information email George S. Everly, Jr., PhD, ABPP, RSI Executive Director at rsi@umbctrainingcenters.com.



Training Centers



The Parent-Rated Social Skills of a Sample of New York City Preschool Children 8 – 10 Months After September 11, 2001

Anastasia E. Yasik
Pace University

Philip A. Saigh
Columbia University Teachers College

Pamela Mitchell
Kidz Therapy Services, LLC

A. Reese Abright
Elmhurst Hospital

Abstract: *This study compared the Social Skills Rating System-Preschool Parent Version ratings of two groups of New York City preschool children 8 – 10 months after September 11, 2001. One group of children was within 1 mile (1.61 km) of the World Trade Center (WTC) during the attack and exposed to one or more traumatic events. The second group was 2.04 to 14 miles (3.28 – 22.54km) away from the WTC and not exposed to traumatic events. The social skills ratings of the comparison groups did not significantly differ. These outcomes were consistent after statistically adjusting for the potentially confounding influence of parental PTSD, anxiety, and depression symptoms. [International Journal of Emergency Mental Health, 2010, 12(4), pp. 247-256].*

Key words: *trauma, assessment, PTSD, preschool children, social skills, and resilience*

The effects of traumatic stressors have been chronicled for centuries. Reports dating from the 1666 Great Fire of London (Daily, 1981), the American Civil War (Mitchell, Morehouse & Keen, 1884), the Russo-Japanese War (Richards, 1910), World War I (Southard, 1919), and World War II (Lewis, 1942) provide vivid descriptions of the development of psychiatric morbidity after trauma exposure. Early

reports involving physically and or sexually abused children (Bender & Blau, 1937), abducted children (Terr, 1979), and child survivors of natural disasters (Bloch, Silber, & Perry, 1956) also served to highlight the emotional distress that may develop following trauma exposure.

According to the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994)*, trauma exposure is defined as experiencing, witnessing, or being confronted by an "event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 427). The DSM-IV also indicates trauma exposure may lead to the onset of posttraumatic stress disorder (PTSD). The symptoms of this disorder include unwanted recollections of the trauma, trauma-related nightmares, irritability, social withdrawal, interpersonal problems, concentration problems, and significant functional impairment (APA, 1994). The

Anastasia E. Yasik, Ph.D. is an Associate Professor of Psychology in the Psy.D. School-Clinical Child Psychology Program at Pace University. Philip A. Saigh, Ph.D. is a Professor of Psychology and Education at Teachers College, Columbia University. A. Reese Abright, M.D. is Director of Child and Adolescent Psychiatry at Mount Sinai Services Elmhurst Hospital Center in Queens, New York. Pamela Mitchell, Ph.D. is a New York State licensed psychologist employed by Kidz Therapy Services, PLLC. Correspondence regarding this article should be directed to saigh@exchange.tc.columbia.edu.

DSM-IV also indicates “the disorder can occur at any age, including childhood” (APA, 1994, p. 424).

With reference to the prevalence of PTSD among youth, Kilpatrick and colleagues (2000) studied a large American community sample aged 12 to 17 years. They reported that the current prevalence of PTSD was 8% among participants that were sexually assaulted, 17% among physically assaulted, and 39% among children who observed others being shot, stabbed, sexually assaulted, or physically assaulted. This study also determined that 8.1% of the sample had PTSD at some time during their life. Similarly, Perkonig, Kessler, Storz, and Wittchen (2000) assessed the prevalence of traumatic exposure among a representative community sample of German youth (age range 14 - 24 years). These authors reported that 21.4% of the respondents reported having had one or more traumatic incidents and 7.8% met diagnostic criteria for a current PTSD diagnosis.

After the events of September 11, 2001, several investigators estimated the probable prevalence of PTSD in New York City (NYC). [The term *probable PTSD* was used instead of PTSD as all of the post September 11, 2001 investigations that are reviewed herein did not identify PTSD cases through the use of face-to-face individually administered tests with items that correspond to all of the DSM-IV PTSD diagnostic criteria.] Examined in this context, Galea et al. (2001) employed a random-digit telephone dialing procedure 35-94 days after the attack to a sample of adults who were residing in NYC at the time of the attack. These authors reported that 7.5% of the sample evidenced probable PTSD that could be attributed to the attack. Schlenger and colleagues (2002) also employed a random-digit dialing procedure to interview adults in the NYC area and determined that the prevalence of probable PTSD that could be attributed to the attack was 11.2%. In a related effort, Bonanno, Galea, Bucciarelli, and Vlahov (2006) sampled adults in NYC and contiguous geographic areas through a random-digit dialing procedure 6 months after the attack and observed 6.0% probable PTSD. With reference to children, Hoven and colleagues (2004) administered questionnaires to randomly selected NYC public school students in grades 4 through 12 and reported that 10.6% of the sample met criteria for a probable PTSD diagnosis at 6 months after the attack.

More recently, Saigh, Yasik, Mitchell, and Abright (in press) described the psychological adjustment of two groups of NYC preschool children 8-10 months after the attack. One group was within 1 mile (1.61 km) of the World

Trade Center (WTC) during the attack and exposed to one or more traumatic events. The second group was 2.04 to 14 miles (3.28 - 22.54km) away and not exposed to traumatic events. While PTSD symptoms were evident, none of the children met criteria for a PTSD diagnosis. Moreover, estimates of childhood psychopathology as measured by the *Behavioral Assessment System for Children Parent Rating Scales Preschool Form* (Reynolds & Kamphaus, 1998) did not significantly vary between the groups.

While these investigations offer important insights about the scope and outcomes of trauma exposure after September 11, 2001, quantitative information involving the psychological functioning of traumatized preschool youth after the attack is largely limited to the findings of the Saigh and colleagues (in press) investigation. Moreover, information involving the social skills of trauma-exposed NYC preschool children after the attack has not been reported in a peer reviewed publication. In view of this and as preschool social skills are significant predictors of later mental health (Fischer, Rolf, Hasazi, & Cummings, 1984; Parker & Asher, 1987; Rubin, 1982), this study examined the social skills of the Saigh and colleagues (in press) preschool sample. In doing so, the parent-derived social skill ratings of the traumatized children who were near the WTC were compared to the ratings of the non-traumatized children who were further away. As Saigh and colleagues (in press) determined that none of the preschoolers had PTSD and as older traumatized children without PTSD did not significantly differ from non-traumatized controls on measures psychopathology and cognition (Saigh, Yasik, Oberfield, Halamandaris, & Bremner, 2006; Yasik, Saigh, Oberfield, & Halamandaris, 2007), it was hypothesized that the social skills of the trauma-exposed and not-exposed groups would not significantly vary.

METHOD

The distance from the WTC at the time of the attack and having been exposed to one or more traumatic incidents at the time were used as criteria for designating group assignments for three reasons. First, some parents with children who were within a mile of the WTC reported that they actually prevented their children from exposure to traumatic events by holding them in a way that prevented them from seeing the events at the WTC and/or deliberately distracted them by talking and/or singing about matters that were not related to the attack. Second, it was reasoned that being actually present and seeing the incidents that took place within a mile of

the WTC was consistent with the DSM-IV (1994) definition for trauma exposure (i.e., experiencing, witnessing, or being confronted by an “event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,” p. 427). Third, it was felt that comparative information regarding NYC preschoolers who did not actually see what occurred at the WTC and who were more than a mile away would offer valuable insights about their psychological well-being 8 to 10 months after the attack.

Data Collection Procedure

Six lower Manhattan preschools that were within 0.65 miles (1.05 km) of the WTC were initially selected on the basis of their proximity to the WTC. Two schools were closed and excluded from the study. Following IRB approval, administrators at the remaining schools were contacted and invited to participate. Two were able to do so and two were not. School administrators at two midtown preschools that were 2.8 to 3.0 miles (4.51 - 4.83 km) from the WTC and three uptown preschools that were 4.4 to 4.7 miles (7.08 – 7.56 km) from the WTC were also invited to participate. One of the midtown administrators and all of the uptown school administrators agreed to allow the data collection. Consent

materials were distributed to 259 parents; 72 (27.8%) of those agreed to participate.

Graduate assistants distributed research packets to the school administrators who went on to give the packets to parents that had agreed to participate. Each packet included a set of test materials, directions on how to fill out the tests, and instructions for returning the test materials in self-addressed and stamped envelopes. A licensed psychologist and a doctoral school psychology student scored the protocols according to standardized instructions.

Trauma-Exposed

As indicated by parental feedback from the *Preschool Trauma Questionnaire* (Saigh, 2001; Yasik et al., 2002), participants were assigned to this group if they were less than one mile (1.61 km) from the WTC on September 11, 2001 and reportedly experienced at least one of nine possible traumatic incidents that are consistent with the DSM-IV PTSD definition for trauma exposure (i.e., criterion A 1; APA, 1994). Of the 72 parents that agreed to participate, 31 (43.1%) of their children met criteria for inclusion in this group. Seven of the children were excluded because their parents did not complete the questionnaires and another child was excluded because he was diagnosed with autism

Preschool Trauma Questionnaire Item	N	%
Observed burning buildings	23	100.0
Observed airplane hit a building	8	34.8
Observed people jumping from building	5	21.7
Observed the building collapse	15	65.2
Exposed to the smoke cloud	18	78.3
Physically injured	0	0.0
Observed injured people	7	30.4
Saw people killed	0	0.0
Lost mother, father, or significant other due to attack	0	0.0

before the attack. Accordingly, 23 children were enrolled in this group. Table 1 lists their reported frequency and type of traumatic experiences as denoted by parental responses to the *Preschool Trauma Questionnaire*.

Not Trauma-Exposed

Child participants were assigned to this group if their parents reported that they did not experience any of the traumatic incidents that are included in the *Preschool Trauma Questionnaire* and if they were 1 to 14 miles (1.61 - 22.56 km) from the WTC when the attack on NYC occurred. Of

the 72 parents that agreed to participate, 20 (27.8%) of their children met criteria for inclusion in this group. Table 2 presents the demographic characteristics of the participants and their reported distance from the WTC at the time of the attack by group designation.

Measures

Dependent Variables

Preschool Trauma Questionnaire (Saigh, 2001; Yasik et al., 2002), a parent-rated child questionnaire, was developed because preschool children have difficulty in understanding

Table 2. Demographic Variables		
Variable	Directly Exposed (n = 23)	Not Directly Exposed (n = 20)
Age (years)		
M	4.06	4.34
SD	.51	.62
Gender	%	%
Male	65.2	50.0
Female	34.8	50.0
Hollingshead Social Class	%	%
Class I	56.5	70.0
Class II	43.5	25.0
Class III	0.0	5.0
Class IV	0.0	0.0
Class V	0.0	0.0
Race/Ethnicity	%	%
African-American	0.0	5.0
Asian	0.0	10.0
Caucasian	95.7	75.0
Hispanic	0.0	5.0
Other	4.3	5.0
Distance from WTC (miles/km)		
M	.33/.53	5.25/8.45
SD	.28/.45	2.70/4.35

and accurately responding to questions involving PTSD symptoms (Kassam-Adams & Winston, 2004; Saigh et al., 2000; Yasik et al., 2001). This instrument presents a series of questions that correspond to the DSM-IV definition of trauma exposure as well as PTSD symptoms. For the purpose of this study, only the trauma exposure items were used to identify traumatized cases (e.g., “Did your child directly observe the buildings collapse?” “Did your child directly observe people jumping from the buildings?” and “Did your child directly see people that had been killed?”). An internal consistency *alpha* coefficient of .85 was evident for the trauma exposure items. Three mental health experts who served on the DSM-IV PTSD workgroup independently evaluated the correspondence between the *Preschool Trauma Questionnaire* trauma exposure items and the DSM-IV definition of trauma exposure. Ratings were recorded on a 1-5 point Likert-type scale (e.g., 1 = Very low correspondence and 5 = Very high correspondence) and a mean rating of 4.66 was observed denoting support for the content validity of the trauma exposure items.

Dependent Measure

Social Skills Rating System-Preschool Parent Version (SSRS-PPS; Gresham & Elliott, 1990) is a nationally standardized questionnaire that measures the social behaviors of preschool children. Test items are rated on a 3-point Likert-type scale (e.g., “Never,” “Sometimes,” and “Very Often”). The instrument has two scales (e.g., Social Skills and Problem Behaviors). The Social Skills scale is composed of four subscales. These include a 10-item Cooperation subscale involving classroom rule compliance, a 10-item Assertion subscale that measures prosocial behaviors, a 10-item Self-Control subscale that assesses responses to conflict situations, and a 10-item Responsibilities subscale that measures responsible conduct. The SSRS yields an overall Social Skills score, as well as an individual score for each subscale. Gresham and Elliott (1990) reported mean *alpha* coefficients of .90, .81, .76, .83, and .75 for the overall Social Skills, Cooperation, Assertion, Self-Control, and Responsibilities scales respectively. A test-retest correlation of .87 over a 4-week interval was reported for the total Social Skills score. The Problem Behaviors scale consists of two subscales. These subscales include a 6-item Externalizing subscale denoting acting out behaviors such as temper tantrums and a 4-item Internalizing subscale reflecting symptoms of sadness and anxiety. Gresham and Elliott (1990) reported mean *alpha* coefficients of .73, .71,

and .57 for the overall Problem Behaviors, Externalizing, and the Internalizing scales, respectively. Evidence to support the criterion-related validity of the test was evidenced by moderate to high correlations with the *Child Behavior Checklist* (Achenbach, 1991) (Gresham & Elliott, 1990).

Demographic Index

Hollingshead’s *Four Factor Index of Social Adjustment* (Hollingshead, 1975) is an instrument that presents a series of questions regarding parental education, occupation, and marital status. Participants were assigned to one of five social class strata as indicated by the test scoring directions with the highest scores allocated to Class I and the lowest scores allocated to Class V. Cirino and colleagues (2002) reported moderate (.73) to high (.95) inter-rater reliability coefficients for the instrument. These authors also reported convergent validity coefficients that ranged from .42 to .92 when Hollingshead scores were correlated with Socioeconomic Index of Occupations (Nakao & Treas, 1992) scores.

Covariates

As parental psychopathology may influence the way that parents perceive and evaluate their children on standardized tests (Costello & Angold, 2006; Kinsman & Wildman, 2001), three measures of parental emotional distress were used as covariates.

Posttraumatic Stress Disorder Checklist (PCL; Weathers et al., 1993). This 17-item Likert-type scale reflects the PTSD symptoms that are listed in the DSM-IV. Blanchard, Jones-Alexander, Buckley, and Forneirs (1996) reported that the PCL has an internal consistency *alpha* coefficient of .97. Blanchard and colleagues (1993) also observed a coefficient of .93 when the PCL was correlated with scores from the *Clinician Administered PTSD Scale* (CAPS; Blake et al., 1990). Using a total PCL cut-off score of 44, Blanchard and his colleagues correctly identified 17 out of 18 cases with CAPS PTSD diagnoses (sensitivity = .94 and specificity = .86).

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). This norm-referenced test is comprised of 21 items that assess for the presence and intensity of depressive symptoms. Each item consists of four statements that reflect increasing severity about a specific symptom of depression that was evident within the past 2 weeks. Internal consistency estimates range from .92 to .93. Test-retest estimates as based

on the responses of psychiatric outpatients over a one-week interval yielded a coefficient of .93. Beck et al. (1996) reported that the BDI-II significantly discriminated between outpatients with or without mood disorders.

Beck Anxiety Inventory (BAI; Beck, 1990). This norm-referenced self-report inventory consists of 21 anxiety-related items that are rated according to a 4-point Likert-type scale. Beck and colleagues (1988) reported an internal consistency α coefficient of .92 for the instrument. These authors also reported that the BAI significantly discriminated between patients with an anxiety or mood disorder. Frydreich, Dowdall, and Chambless (1992) reported that the BAI was significantly associated with the *State-Trait Anxiety Inventory* (Spielberger, 1983) State ($r = .47$) and Trait ($r = .58$) scales.

RESULTS

Table 3 presents the parent-rated SSRS-PPS means and standard deviations for the comparison groups. Univariate analyses indicated non-significant group differences on the Total Social Skills standard score, $F(1, 41) = .35, p > .05$, and the Total Problem Behaviors standard score, $F(1, 41) = .07, p > .05$. A MANOVA, including the raw scores of the

four Social Skills subscales (i.e., Cooperation, Assertion, Responsibility, & Self-Control) did not reveal significant group differences, Wilks $\lambda, F(4, 38) = .50, p > .05$. Similarly, a MANOVA with the raw scores of the two Problem Behavior scales (i.e., Internalizing and Externalizing) did not reveal significant group differences, Wilks $\lambda, F(2, 40) = .04, p > .05$.

In order to explore the possibility that personal distress may have influenced the way that parents rated their children on the SSRS-PPS, six ANCOVAs were conducted wherein the SSRS-PPS Social Skills and Problem Behaviors Indices of the exposed and non-exposed groups were compared utilizing the PCL, BDI-II and BAI scores as covariates. An ANCOVA controlling for parental PCL scores indicated non-significant group differences on Social Skills, $F(1, 39) = .04, p > .05$, and Problem Behaviors, $F(1, 39) = .00, p > .05$. Likewise, ANCOVAs using the BAI scores as a covariate revealed non-significant group differences on the Social Skills, $F(1, 39) = .33, p > .05$, and Problem Behavior, $F(1, 39) = .01, p > .05$, indices. Non-significant group differences were also noted, after controlling for parental BDI-II scores, on the Social Skills, $F(1, 39) = .18, p > .05$, and Problem Behaviors, $F(1, 39) = .00, p > .05$.

Table 3.
Social Skills Rating Scale (SSRS) Group Means and Standard Deviations

SSRS Scale	Directly Exposed ($n = 23$)		Not Directly Exposed ($n = 20$)	
	M	SD	M	SD
Social Skills	53.96	9.75	52.75	9.16
Cooperation	12.22	2.78	11.85	2.78
Assertion	15.22	2.65	15.50	2.14
Responsibility	12.13	3.17	11.25	3.65
Self-Control	14.39	3.09	14.20	3.43
Problem Behaviors	96.26	9.81	95.35	12.70
Internalizing	.87	1.22	.80	1.44
Externalizing	4.44	2.19	4.25	2.07

Note: Reported means and standard deviations are unadjusted.

DISCUSSION

In a significant departure from earlier studies that described the psychological functioning of NYC residents after September 11, 2001, this study examined the social skills ratings of preschool children 8-10 months after the attack. Data analysis determined that the parent-completed social skill ratings of the trauma-exposed children who were within a mile of the WTC did not significantly differ from the mean ratings of children who were 2.04 to 14 miles (3.28 – 22.56 km) from the WTC and not exposed to traumatic events. These outcomes were consistent after adjusting for the potentially confounding influence of parental PTSD, anxiety, and depression symptoms.

In contrast to the outcomes of previous investigations that reported poor social skills among maltreated preschool children (Alessandri, 1991; Hasket, 1990; Levendosky, Okun, & Parker, 1995) and combat veterans (Boudewyns, Hyer, Woods, Harrison, & McCranie, 1990; Kulka et al., 1990), the social skill ratings of the trauma exposed preschoolers who were near the WTC did not significantly differ from the ratings of their non-trauma exposed peers who were further away. On the other hand, these findings are consistent with the results of investigations involving older trauma-exposed children and adolescents with or without PTSD. These studies consistently reported that traumatized children without PTSD did not differ from non-traumatized controls on measures of psychopathology and cognition (Saigh et al., 2006; Saigh et al., 2007). The current findings are also in line with the outcomes of the Saigh et al. (in press) post-September 11, 2001 study involving the preschoolers that were sampled herein as this investigation reported that the trauma-exposed and not-exposed children that were examined in this study did not evidence probable PTSD or significant differences on a norm-referenced index of behavioral problems.

Although the children who were near the WTC had experiences that are consistent with the DSM-IV definition for trauma exposure, none of the youth that were sampled were injured or had observed the death or injury of a parent. It should also be noted that these children ranged in age from 3.2 to 5.4 years. In view of this, and as children typically do not understand the meaning of death until they are 5 to 7 years old (Speece & Sandor, 1984), it is possible that the children near the WTC may not have understood the meaning of what they experienced and that this may have served to allay the development of social skill deficits.

These observations should be tempered with the understanding that a small sample was examined and that none of the children were hurt or had witnessed the death or injury of a parent. As such, the external validity of these findings may be limited to populations with similar demographic and trauma exposure histories. In addition, this study did not control for historical variables, and parent and child experiences before or after the attack on NYC may have influenced the outcomes. Clearly, the possibility that the participants may have had prior psychiatric problems such as acute stress disorder warrants consideration. This study also suffers from the limitation of all surveys that employ questionnaires in lieu of face-to-face in-depth interviews that use a variety of assessment tools to develop clinical impressions. As teachers have more opportunities to formulate comparative ratings and as parental ratings may not correspond with teacher ratings (Kamphaus & Frick, 1996; Kolko & Kazdin, 1992; Reyonlds & Kamphaus, 2006), future research may wish to examine the social skills of traumatized preschool children as denoted by teacher ratings. Future preschool trauma researchers may wish to consider the role of moderator variables such as maternal education and the quality of mother-child interactions as these variables are predictive of the social skills and adjustment of young children (Connell & Prinz, 2002; Dubow, Tisak, Causey, Hryshko & Reid, 2008). The need for longitudinal research is also apparent as early trauma exposure may lead to negative long-term psychological (McLeer et al., 1994; Sack et al., 1993; Saigh et al., 2006; Yasik et al., 2007), educational (Saigh, Mroueh, & Bremner, 1997), and biological (De Bellis et al., 1999; Stoddard et al., 2006) outcomes.

REFERENCES

- Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist: 4-18 and 1991 profile*. Burlington, VT: University of Vermont Department of Psychiatry.
- Alessandri, S. (1991). Play and social behavior among maltreated preschoolers. *Development and Psychopathology*, 13, 91-201. doi:10.1016/S0145-2134(00)00228-3.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Beck, A. T. (1990). *Beck Anxiety Inventory*. San Antonio, TX: Psychological Corporation.

- Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*, 893-897. doi:10.1037/0022-006X.56.6.893.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory – II Manual*. San Antonio, TX: Psychological Corporation.
- Bender, L., & Blau, A. (1937). The reaction of children to sexual relations with adults. *American Journal of Orthopsychiatry, 7*, 500-518. doi:10.1111/j.1939-0025.1937.tb05293.x.
- Blake, D., Weathers, F., Nagy, L., Kaloupek, G., Klauminzer, G., Charney, D., & Keane, T. (1990). *Clinician Administered PTSD Scale (CAPS)*. Boston, MA: National Center for PTSD.
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneirs, C. A. (1996). Psychometric properties of the *PTSD Checklist (PCL)*. *Behaviour Research and Therapy, 34*, 669-673. doi:10.1016/0005-7967(96)00033-2.
- Bloch, D. A., Silber, E., & Perry, S. E. (1956). Some factors in the emotional reactions of children to disaster. *American Journal of Psychiatry, 112*, 416-422. doi:10.1176/appi.ajp.113.5.416.
- Bonanno, G. A., Galea, S., Bucchiarelli, A., & Vlahov, D. (2006). Psychological resilience after disaster: New York City in the aftermath of the September 11th terrorist attack. *Psychological Science, 17*, 181-186. doi:10.1111/j.1467-9280.2006.01682.x.
- Boudewyns, P. A., Hyer, L., Woods, M., Harrison, W., & McCranie, E. (1990). PTSD among Vietnam veterans: An early look at treatment outcome using direct therapeutic exposure. *Journal of Traumatic Stress, 3*, 359-368. doi:10.1007/BF00974776.
- Cirino, P. T., Chin, C. E., Sevcik, R. A., Wolf, M., Lovett, M. W., & Morris, R. D. (2002). Measuring socioeconomic status: Reliability and preliminary validity for different approaches. *Assessment, 9*, 145-155. doi:10.1177/10791102009002005.
- Coates, S., & Schechter, S. (2004). Preschoolers' traumatic stress post-9/11: Relational and developmental perspectives. *Psychiatric Clinics of North America, 27*, 473-489. doi:10.1016/j.psc.2004.03.006.
- Connell, C., & Prinz, R. (2002). The impact of childcare and parent-child interactions on school readiness and social skills development for low-income African American children. *Journal of School Psychology, 40*, 177-193. doi:10.1016/S0022-4405(02)00090-0.
- Costello, E., & Angold, A. (2006). Developmental epidemiology. In D. Cicchetti (Ed.), *Developmental psychopathology* (2nd ed., pp. 41-75). New Jersey: John Wiley and Sons.
- Daily, R. J. (1983). Samuel Pepys and posttraumatic stress disorder. *British Journal of Psychiatry, 143*, 64-68. doi:10.1192/bjp.143.1.64.
- De Bellis, M., Baum, A., Birmaher, B., Keshavan, M., Dubner, A., & Motta, R. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67*, 367-373. doi:10.1037/0022-006X.67.3.367.
- Dubow, E., Tisak, J., Causey, D., Hryshko, A., & Reid, G. (2008). A two-year longitudinal study of stressful life events, social support, and social problem-solving skills: Contributions to children's behavioral and academic adjustment. *Child Development, 62*, 583-599. DOI: 10.1111/j.1467-8624.1991.tb01554.x.
- Eccard, C., Boring, A., Jenkins, F., & Ryan, N. (1999). Developmental traumatology part I: Biological stress systems. *Biological Psychiatry, 45*, 1259-1270. doi:10.1016/S0006-3223(99)00044-X.
- Fischer, M., Rolf, J., Hasazi, J., & Cummings, L. (1984). Follow-up of a preschool epidemiological sample: Cross-age continuities and prediction of later adjustment with internalizing and externalizing dimensions of behavior. *Child Development, 55*, 137-150. doi:10.1111/1467-8624.ep7405491.
- Frydreich, T., Dowdall, D., & Chambless, D. L. (1992). Reliability and validity of the *Beck Anxiety Inventory*. *Journal of Anxiety Disorders, 6*, 55-61. doi:10.1016/0887-6185(92)90026-4.
- Galea, S., Ahren, J., Resnick, H., Kilpatrick, D., Bucuvalias, M., Gold, J., & Vlahov, D. (2002). Psychological sequelae of the September 11 terrorist attack in New York City. *New England Journal of Medicine, 346*, 982-987. doi:10.1056/NEJMsa013404.
- Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System*. Circle Pines, MN: American Guidance Service.
- Hasket, M. (1990). Social problem-solving skills of young physically abused children. *Child Psychiatry and Human Development, 21*, 109-220. doi:10.1007/BF00706119.

- Hollingshead, A. B. (1975). *Four Factor Index of Social Adjustment*. New Haven, CT: Yale University.
- Hoven, C. W., Duarte, C., Lucas, C., Wu, P., Mandell, D., Goodwin, R., et al. (2005). Psychopathology among New York City public school children 6 months after September 11. *Archives of General Psychiatry*, *62*, 545-552. doi:10.1001/archpsyc.62.5.545.
- Kamphaus, R. W., & Frick, P. J. (1996). *Clinical assessment of child and adolescent personality and behavior*. Boston: Allyn & Bacon.
- Kassam-Adams, N., & Winston F. K. (2004). Predicting child PTSD: The relationship between acute stress disorder and PTSD in injured children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 403-411. doi:10.1097/00004583-200404000-00006.
- Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H., Best, C., & Schnurr, P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology*, *68*, 19-30. doi:10.1037/0022-006X.68.1.19.
- Kinsman, A. M., & Wildman, B. G. (2001). Mother and child perceptions of child functioning: Relationship to maternal distress. *Family Process*, *40*, 163-172. doi:10.1111/j.1545-5300.2001.4020100163.x.
- Kolko, D., & Kazdin, A. (1992). Emotional/behavioral problems in clinic and nonclinic children: Correspondence among child, parent and teacher reports. *Journal of Child Psychology and Psychiatry*, *34*, 991-1006. doi:10.1111/j.1469-7610.1993.tb01103.x.
- Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). *Trauma and the Vietnam war generation*. New York: Brunner/Mazel.
- Levendosky, A., Okun A., & Parker, J. (1995). Depression and maltreatment as predictors of social competence and social problem-solving skills in school-age children. *Child Abuse & Neglect*, *19*, 1183-1195. doi:10.1016/0145-2134(95)00086-N.
- Lewis, A. (1942). Incidence of neurosis in England under war conditions. *Lancet*, *2*, 175-183. doi:10.1016/S0140-6736%2800%2941475-3.
- McLeer, S. V., Callaghan, M., Henry, D., & Wallen, J. (1994). Psychiatric disorders in sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*, 313-319. doi:10.1097/00004583-199403000-00003.
- Mitchell, S. W., Morehouse, C. R., & Keen W. S. (1884) *Gunshot wounds and other injuries of the nerves*. Philadelphia: Lippincott.
- Nakao, K., & Treas, J. (1992). *The 1989 socioeconomic index of occupations: Construction from the 1989 occupational prestige scores* (General Social Survey Methodological Report No. 74). Chicago: University of Chicago, National Opinion Research Center.
- Parker, J., & Asher, S. (1987). Peer relations and later personal adjustment: Are low accepted children at risk? *Psychological Bulletin*, *102*, 357-389. doi:10.1037/0033-2909.102.3.357.
- Perkonig, A., Kessler, R., Storz, S., & Wittchen, H. (2000). Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica*, *101*, 46 -59 doi:10.1034/j.1600-0447.2000.101001046.x.
- Reynolds, C., & Kamphaus, R. W. (2006). *Handbook of psychological and educational assessment of children*. New York: Guilford Publications.
- Richards, P. L. (1910). Mental and nervous diseases in the Russo-Japanese War. *Military Surgeon*, *26*, 177-193.
- Rubin, K. (1982). Nonsocial play in preschoolers: Necessarily evil? *Child Development*, *53*, 651-657. <http://www.jstor.org/stable/1129376>.
- Sack, W. H., Clarke, G., Him, C., Dickason, D., Goff, B., Lanham, K., & Kinzie, J. D. (1993). A six year follow-up of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*, 431 - 437. doi:10.1097/00004583-199303000-00027.
- Saigh, P. A. (1989). The validity of the posttraumatic stress disorder classification as applied to children. *Journal of Abnormal Psychology*, *98*, 189-192. doi:10.1037/0021-843X.98.2.189.
- Saigh, P. A. (1991). On the development of posttraumatic stress disorder pursuant to different modes of traumatization. *Behaviour Research and Therapy*, *29*, 213-217. http://www.elsevier.com/wps/find/journaldescription.cws_home/265/description#.
- Saigh, P. A. (2001). *Preschool Trauma Questionnaire*. Princeton, NJ: Trauma Resources.

- Saigh, P. A. (2003). *The Children's Posttraumatic Stress Disorder Inventory test manual*. San Antonio, TX: Psychological Corporation.
- Saigh, P. A., Mroueh, M., & Bremner, D. J. (1997). Scholastic impairments among traumatized adolescents. *Behaviour Research and Therapy*, *35*, 429-436. doi:10.1016/S0005-7967(96)00111-8.
- Saigh, P. A., Sack, W., Yasik, A. & Koplewicz, H. (1999). Child-adolescent posttraumatic stress disorder: Prevalence, comorbidity, and risk factors. In P. A. Saigh, & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive textbook* (pp. 19-43). Needham Heights, MA: Allyn & Bacon.
- Saigh, P. A., Yasik, A. E., Mitchell, P., & Abright, A. R. (in press). The psychological adjustment of New York City preschool children 8-10 months after September 11, 2001. *Psychological Trauma: Theory, Research, Practice, and Policy*, *33*, 100-109. doi:1037/a0020701. <http://www.apa.org/pubs/journals/tra/>.
- Saigh, P. A., Yasik, A. E., Oberfield, R. O., Green, B., Halamandaris, P., Rubenstein, H., & McHugh, M. (2000). The *Children's PTSD Inventory*: Development and reliability. *Journal of Traumatic Stress*, *13*, 369-380. doi:10.1023/A:1007750021626.
- Saigh, P. A., Yasik, A. E., Oberfield, R. O., & Halamandaris, P. (2002). A comparative analysis of the internalizing and externalizing behaviors of traumatized urban youth with and without PTSD. *Journal of Abnormal Psychology*, *111*, 462-470. <http://www.apa.org/pubs/journals/abn/>.
- Saigh, P. A., Yasik, A. E., Oberfield, R. O., & Halamandaris, P. (2007). Self-reported anger among traumatized children and adolescents. *Journal of Psychopathology and Behavioral Assessment*, *29*, 29-37. doi:10.1007/s10862-006-9026-9.
- Saigh, P. A., Yasik, A. E., Oberfield, R. O., Halamandaris, P., & Bremner, D. J. (2006). The intellectual performance of traumatized children and adolescents with or without posttraumatic stress disorder. *Journal of Abnormal Psychology*, *115*, 332-340. doi:10.1037/0021-843X.115.2.332.
- Schlenger, W. E., Caddell, J., Ebert, L., Jordan, B., Rourke, K., Wilson, D., et al. (2002). Psychological reactions to terrorist attacks: Findings from the National Study of Americans' Reactions to September 11. *Journal of the American Medical Association*, *5*, 581-588. doi:10.1001/jama.288.5.581.
- Southard, E. E. (1919). *Shell shock and neuropsychiatric problems*. Boston: Leonard.
- Speece, M., & Sandor, B. (1984). Children's understanding of death: A review of three components of a death concept. *Child Development*, *55*, 1671-1686. doi:10.2307/1129915.
- Spielberger, C. D. (1983). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.
- Stoddard, F. J., Ronfeldt, H., Kagan J., Drake, J. E., Snidman, N., Murphy, J. M., et al. (2006). Young burned children: The course of acute stress and physiological and behavioral responses. *American Journal of Psychiatry*, *163*, 1084-1090. doi:10.1176/appi.ajp.163.6.1084.
- Terr, L. C. (1979). Children of Chowchilla: A study of psychic trauma. *Psychoanalytic Study of the Child*, *34*, 547-624.
- Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. M. (1993, October). *The PTSD Checklist: Reliability, validity, and diagnostic utility*. Paper presented at the Annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.
- Yasik, A. E., Saigh, P. A., Oberfield, R. O., Green, B., Halamandaris, P., & McHugh, M. (2001). The validity of the *Children's PTSD Inventory*. *Journal of Traumatic Stress*, *14*, 81-94. doi:10.1023/A:1007887615685.
- Yasik, A. E., Saigh, P. A., Oberfield, R. O., & Halamandaris, P. V. (2007). Posttraumatic stress disorder: Memory and learning performance in children and adolescents. *Biological Psychiatry*, *61*, 382-388. doi:10.1016/j.biopsych.2006.06.005.

Submitted September 6, 2010

Accepted December 10, 2010

Differences in Compassion Fatigue, Symptoms of Posttraumatic Stress Disorder and Relationship Satisfaction, Including Sexual Desire and Functioning, between Male and Female Detectives who Investigate Sexual Offenses against Children: A Pilot Study

Eric J. Lane, Jeffrey M. Lating, Jenny L. Lowry, and Traci P. Martino
Loyola University Maryland

Abstract: *Law enforcement detectives who work with traumatized individuals, especially children who were victims of sexual abuse or assault, are likely to experience job-related emotional distress. The purpose of this study was to examine the relations among compassion fatigue, probable PTSD symptoms, and personal relationship satisfaction, including communication and sexual satisfaction, in a sample of 47 male and female detectives. Responses to the administered questionnaires indicated a relation between compassion fatigue symptoms and probable PTSD symptoms. There also were compelling gender differences. For example, for male detectives, open communication with their spouse or significant other was negatively correlated with burnout, indicating the more open the communication, the lower the reported burnout. However, for female detectives there was a negative correlation between open communication with spouse or significant other and compassion satisfaction, suggesting that more open communication was related to lower levels of satisfaction with their ability to be a professional caregiver. Furthermore, although stepwise regression analysis indicated that years of service as a detective is independently associated with sexual desire, female detectives evidenced less sexual desire and more difficulty with sexual functioning than did male detectives. Implications of these preliminary findings are discussed and limitations addressed. [International Journal of Emergency Mental Health, 2010, 12(4), pp. 257-266].*

Key words: *detectives, child abuse, sexual satisfaction, PTSD, communication*

Police work is challenging and stressful for myriad reasons (Burke, 2006; Gershon, Barocas, Canton, Li & Vlahov, 2009; Wang et al 2010). For example, there are psychosocial stressors associated with everyday police work, such as risk of bodily harm, extended shifts, and within the past several decades, the decrease in general public's perception and appreciation of police officers (Worrall, 1999). In addition to

these recurrent stressors, there are instances where officers are involved in events that result in actual or threatened death or serious injury to colleagues, others, or themselves. At its most extreme these exposures may serve as potential precursors in officers developing signs and symptoms consistent with posttraumatic stress disorder (PTSD).

Eric J. Lane, Psy.D., PA earned his Doctorate in Clinical Psychology from Loyola College of Maryland in 2007. At this time he works as the Clinical Director for an adolescent diagnostic center and maintains a private practice in Towson, MD. He is a Clinical Member of the Association for the Treatment of Sexual Abusers, as well as the American Psychological Association and Maryland Psychological Association. Jeffrey M. Lating, Ph.D. is a Professor of Psychology at Loyola University Maryland and Director of Clinical Training of the Doctor of Psychology program. Jenny L. Lowry, Ph.D. is an Associate Professor of Psychology at Loyola University Maryland, and Associate Vice President for Academic Affairs. Traci P. Martino, M.S., is Director of Program Operations and Affiliate Instructor at Loyola University Maryland. Correspondence regarding this article should be directed to Jeffrey M. Lating, Ph.D., jlating@loyola.edu

A study of 37 police officers from the Netherlands more than 20 years ago showed that those involved in shootings may experience criteria consistent with a diagnosis of PTSD at a rate as high as 46% (Gersons, 1989). A larger study, also from the Netherlands, of 262 traumatized police officers, reported a PTSD rate of 7%, with 34% of the sample having stress symptoms consistent with a subthreshold level of PTSD (Carlier, Lamberts, & Gersons, 1997). A study of 157 Brazilian police officers resulted in estimated prevalence rates of 8.9% for “full PTSD” and 16% for “partial PTSD” (Maia et al., 2007), and another recent study of 105 police officers from the Buffalo, New York police department revealed an estimated overall PTSD rate of 28.5% for women and 31.7% for men (Andrew et al., 2008). Overall, these data support the notion that police officers are susceptible to the adverse effects of critical incident exposure, and indicate that the rates may be variable, and in some instances, quite high.

One type of exposure that has been studied minimally, but that may be particularly challenging for police officers due to the emotional expenditure required and time commitment involved, is investigative work. In particular, empirical studies have identified child sexual abuse cases as one of the most emotionally distressing investigations for law enforcement officers (LEO; Follette, Polusny, & Milbeck, 1994). From an investigative perspective, child sexual abuse cases are challenging because they likely require forensic interviews of those involved, including the alleged victim, the non-offending caregiver, and collateral sources. These interviews are likely to contain sordid and graphic details that may be extremely difficult for the interviewee to recount, and equally as overwhelming for the investigator to hear and process. Moreover, there are likely to be required investigative search and seizure operations, as well as interrogations of potential suspects (Fielding & Conroy, 1992; Underwager & Wakefield, 1990). In addition, these investigations can occur over the course of several months to several years and may partially and intermittently reinforce the discomfort in those doing the active investigations. Therefore, it is reasonable that these investigative experiences may take an aggregative negative toll on LEOs’ psychological health and other functioning.

Compassion Fatigue

Martin, McKean, and Veltkamp (1986) note that LEO often report a number of PTSD symptoms, such as recurrent and intrusive recollections and difficulty avoiding activities

that arouse these recollections, that closely resemble those identified by mental health professionals who work with child abuse cases. The literature refers to this phenomenon as *compassion fatigue*, which has been defined by Figley (2002) as the acquisition by the therapist of both physical and psychological symptoms that closely resemble the presenting symptoms of the client who has directly experienced the traumatic event. These symptoms may manifest themselves while in the presence of the client, as in the visualization of a traumatic event being described by the client, or at a later date through secondary trauma-based nightmares or avoidance behaviors (Pearlman & Saakvitne, 1995). Research suggests that working with traumatized children may leave a therapist, or other care-giving professionals, especially vulnerable to compassion fatigue (Webb, 2007). Involved professionals often report comparing the abused child to their own children or to other children with whom they have a relationship. While this comparison may be quite motivating initially in attempting to help the client, Dutton and Rubinstein (1995) suggest that, over time, it may become overwhelming and lead to compassion fatigue.

According to Figley (1995), psychological distress, changes in cognitive schema (i.e., a concept that helps organize and interpret information), and relational disturbances are indicators of compassion fatigue. Figley (1999) later identified the following three predominant factors associated with compassion fatigue in LEO: 1) possessing sufficient concern for others; 2) the presence of empathy; and 3) exposure to severely traumatized people on a continuous basis. Other variables have been associated with the development of compassion fatigue in LEO, such as abuse as a child. In fact, Follette, Polusny, and Milbeck (1994) reported that 40% of female officers and 17% of male officers reported childhood abuse histories. Moreover, in the same study these officers also acknowledged investigating more sexual abuse cases; however, only 16% reported receiving therapy to address the personal effects of working with traumatized individuals. Not surprisingly, given the nature of the work and stressors, interpersonal relationships often are affected.

Relationship Satisfaction

Several studies have noted the impact of job stress on LEO relationship satisfaction (Emmers-Sommer & Metts; 2004; Mabe, 2002; Mackay, Diemer, & O’Brien, 2004; Roberts & Levinson, 2001). However, one particular feature that may be purported to enhance and sustain relationships, and

one that most people, including LEO, are reluctant to discuss, is perceived sexual satisfaction (Acker & Davis, 1992). Byers and Demmons (1999) reported that sexual self-disclosure between partners influences overall sexual satisfaction, as well as increasing overall relationship satisfaction. Similarly, Cupach and Comstock (1990) determined that sexual communication affects overall relationship satisfaction, which in turn is related to the couple's overall sexual satisfaction.

A comprehensive review of the literature uncovered no studies examining the degree of sexual satisfaction in LEO, let alone any studies investigating relationship or sexual satisfaction in detectives who primarily investigate child sexual abuse cases. The purpose of this preliminary study was to explore the effects of compassion fatigue, probable PTSD symptoms, and relationship satisfaction variables, including communication styles, sexual desire and sexual functioning, on detectives who investigate child sexual assault and abuse cases, with an emphasis on possible differences between male and female detectives.

METHOD

Participants

Participants for the present study were 47 male and female detectives who investigate child sexual abuse and assault cases. The participants were recruited while attending the Maryland Children's Alliance, Inc. conference in Ocean City Maryland in October 2004, or interdepartmental meetings in Harford County or Frederick County, Maryland in February and April 2005. Following a break in the conference or interdepartmental meetings, one of the principal investigators introduced himself and briefly explained the purpose of the study. Details regarding informed consent, anonymity, potential risks and benefits, and available therapeutic resources were verbally provided. Participants were asked to complete the measures, seal their responses in provided envelopes, and place the envelopes in designated depository sites. Approval to perform this study using human participants was received from the Institutional Review Board (IRB) at Loyola University Maryland.

Materials and Procedure

Participants answered a demographic questionnaire developed specifically for this study that assessed characteristics such as age, gender, ethnicity, relationship status,

living arrangements, years of employment, communication style, relationship satisfaction, and whether their work was detracting from their sexual desire or interfering with their sexual functioning. Posttraumatic stress disorder symptoms were assessed using the PTSD Checklist (PCL; Weathers et al., 1993), a 17-item self-report measure. Participants responded on a 5-point Likert-type scale (1 *not at all*, through 5 *extremely*) the degree to which they had been affected by each of the PTSD symptoms during the past month. The items on the PCL reflect the three diagnostic categories of symptoms (i.e., intrusion, avoidance/numbing, and arousal) that result in a diagnosis of PTSD. The PCL can be scored continuously or categorically; however, for the purpose of this investigation it was scored continuously. When scored continuously, a cut-off total score of 50 yielded a sensitivity of 0.78 and a specificity of 0.86 when compared with a diagnosis on the Clinicians Administered PTSD Scales (Blake et al., 1990; Blanchard et al., 1996), and a sensitivity of 0.82, a specificity of 0.83, and a *Kappa* of 0.64 when compared with the Structured Clinical Interview for *DSM-III-R* (American Psychiatric Association, 1987; Spitzer, Williams, & Gibbon, 1992; Spitzer, Williams, Gibbon, & First, 1990).

Compassion fatigue symptoms were assessed using the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscale (ProQOL-RIII; Stamm, 2002), a 30-item self-report measure comprised of three subscales; Compassion Satisfaction, Burnout, and Compassion Fatigue/Secondary Trauma rated on a 6-point Likert-type scale (0 *never* to 5 *very often*). Psychometric properties of the revised, shorter version of the ProQOL are Compassion Satisfaction *Cronbach's alpha* of 0.87, 0.72 for Burnout, and 0.80 for Compassion Fatigue.

Additional quality of life and perceptions of relationship and sexual satisfaction were assessed using the Behavioral Health Measure (BHM-20; Kopta & Lowry, 1997), a 20-item self-report measure that assesses well-being, psychological symptoms, life-functioning, drug/alcohol abuse, and personal risk on a 5-point Likert-type scale (0 *poor functioning*, to 4 *excellent functioning*) over the previous two weeks. Internal consistency for this measure is high for all subscales, with reliability coefficients ranging from 0.65 to 0.72. Pearson Product-Moment correlations between the Behavioral Health Measure-20 (BHM-20) and Life Functioning scale and the Behavioral and Symptom Identification Scale - 32 (BASIS-32) Anxiety/Depression scale and Symptom Check-

list-90 (SCL-90) were all high and in the expected direction, ranging from $r = -0.65$ to $r = -0.85$ (Kopta & Lowry, 1997).

General life functioning over the previous two weeks was assessed using the Psychotherapy Outcome Assessment and Monitoring System Life Functioning Subscale (POAMS-LF; Green, Lowry, & Kopta, 2003), a self-report measure designed to assess multiple domains of life functioning (9 items). Respondents were asked to rate each question on a 5-point Likert-type scale (0 *extreme distress or dissatisfaction* to 4 *optimal functioning or satisfaction*). A score of 3 or more is indicative of healthy functioning. The POAMS Life Functioning Subscale has demonstrated good internal consistency with *Cronbach's alphas* ranging from .77 to .87.

RESULTS

As noted in Table 1, two-thirds of the participants were male, 82% who identified ethnicity were Caucasian, and more than half were in their first marriage. The average age of the sample was 37.7 years ($SD = 7.5$, range = 27 – 60 years), and there was no significant difference in age between men and women ($p = ns$). The average total number of years in law enforcement was 13.9 ($SD = 7.5$, range = 3 – 35 years), with men having more years of service than women, although this difference was not significant, $t(45) = -1.03$, $p = ns$. Moreover, the average number of years as a detective was 5.8 ($SD = 6.4$, range = .25 – 30 years), with men, on average, having two more years of service. Comparable to the total

Variables	Total			Male			Female		
	Mean	SD	n	Mean	SD	n	Mean	SD	n
Age	37.7	7.5	47	37.9	8.2	31	37.4	6.1	16
Yrs in Law Enforcement	13.9	7.5	47	14.7	8.1	31	12.3	5.9	16
Yrs as Detective	5.8	6.4	44	6.5	7.4	30	4.5	3.4	14
Ethnicity									
Caucasian			40			26			14
African-Amer			4			3			1
Hispanic			2			1			1
Other			1			1			0
Relationship Status									
Single			5			3			2
First Marriage			24			17			7
Remarried			10			7			3
Separated			2			2			0
Divorced			1			0			1
Widowed			1			1			1
Committed Partnership			4			1			3

Sample sizes may vary slightly due to missing data.

number of years, this difference did not reach significance, $t(42) = -0.93, p = ns$.

An examination of the correlations for the total sample revealed that satisfaction with quality time spent with one's spouse or significant other was related to emotional intimacy ($r = .48, p < .01$), open communication ($r = .31, p < .05$), and decreased likelihood that work would detract from the desire to be sexual with a spouse or significant other ($r = -.38, p < .01$). While quality time and open communication were not related to interference with sexual functioning, emotional intimacy was, such that the greater the emotional intimacy the less interference work had on sexual functioning as assessed by the demographic item ($r = -.37, p < .05$). The sexual functioning item on the POAMS assesses enjoyment and fulfillment, and differs from the sexual functioning item in the demographic questionnaire, which assesses more specifically whether work is interfering with sexual functioning. The POAMS sexual functioning item was related to increased satisfaction with quality time with spouse or significant other ($r = .59, p < .01$) and increased satisfaction with emotional intimacy ($r = .40, p < .01$). Of note, compassion fatigue scores and compassion satisfaction scores on the ProQOL were not related to quality time, emotional intimacy, or ability to have open communication with one's spouse or significant other; however, burnout scores were. More specifically, increased quality time ($r = -.35, p < .05$), increased emotional intimacy ($r = -.30, p < .05$), and increased open communication with one's spouse or significant other ($r = -.29, p < .05$) were all related to significantly lower burnout scores on the ProQOL.

Not surprisingly, probable PTSD symptoms, as assessed by higher total scores on the PCL, were related to both higher burnout ($r = .44, p < .01$) and fatigue scores ($r = .59, p < .01$) on the ProQOL; however, it is worth noting that only two participants scored above the suggested cut-off total score of 50 on the PCL. Other notable correlations from the total sample were that a greater Total Life Functioning score on the POAMS was associated with less detraction that work had on sexual desire ($r = .33, p < .05$) and increased sexual functioning as assessed by the item on the POAMS ($r = .60, p < .01$). The Total Life Functioning score on the POAMS was, however, not related to the sexual functioning item from demographic questionnaire.

Correlations were then examined to discern notable relations between male and female detectives on the administered measures. For both males and females, increased emotional

intimacy was related to increased open communication (for males; $r = .65, p < .001$, for females; $r = .55, p < .01$) and less interference on sexual desire with a spouse or significant other ($r = .52, p < .01$ for both men and women). There were, however, some very interesting differences that occurred between the male and female detectives. For example, increased satisfaction with quality time spent with spouse or significant other for females was highly related to increased degree of satisfaction with emotional intimacy with spouse or significant other ($r = .80, p < .01$); however, quality time had no relation with burnout, compassion fatigue or compassion satisfaction (defined as the satisfaction derived from one's ability to be a professional caregiver) scores on the ProQOL. In addition, for females, emotional intimacy had no relation with burnout, compassion fatigue, or compassion satisfaction ProQOL scores. Additionally, there was no relation between open communication and burnout or compassion fatigue ProQOL. However, there was a negative relation between open communication and compassion satisfaction ($r = -.56, p < .01$), suggesting that the more ability female detectives have to openly communicate with a spouse or significant other, the less satisfaction they derive in their role as a professional caregiver. In addition, increased open communication for female detectives was related to lower Total Well-being scores on the POAMS ($r = -.54, p < .05$), whereas quality time or emotional intimacy with spouse or significant other were not related to Total Well-being scores. There were no significant correlations between the communication variables and the demographic sexual functioning item for female detectives; however, the POAMS sexual functioning item was positively correlated with emotional intimacy with spouse or significant other ($r = .66, p < .01$).

Male detectives presented with a very different response pattern. For them, increased quality time with spouse or significant other was not related to emotional intimacy as it was for women; however, it was related to increased compassion satisfaction on the ProQOL ($r = .38, p < .05$). Moreover, increased emotional intimacy was highly related to increased compassion satisfaction ($r = .55, p < .05$), a finding also not observed in female detectives. Furthermore, unlike female detectives, increased open communication in male detectives was not related to compassion satisfaction, but it was negatively related to burnout ($r = -.57, p < .01$). In addition, for male detectives increased open communication with spouse or significant other was related to increased Total Well-being score on the POAMS ($r = .41, p < .05$), as

were increased quality time with spouse or significant other ($r = .54, p < .01$) and emotional intimacy ($r = .44, p < .05$). Also, unlike female detectives, increased scores on the sexual functioning item of the POAMS for male detectives were related to increased quality time with spouse or significant other ($r = .60, p < .01$), but not related to emotional intimacy or open communication. Similar to female detectives, the sexual functioning item from the demographic questionnaire was not related to any of the communication variables for

male detectives.

Given these relational differences between male and female detectives, and considering the study's initial query about sexual desire and sexual functioning, male and female detectives were compared directly on these and then other assessment measures. As seen in Table 2, male and female detectives did not differ from each other with regard to probable PTSD symptoms (PCL Total), compassion satisfaction, burnout, fatigue, overall life functioning, symptoms related to

Table 2.
Differences between Male and Female Detectives on Assessment Measures

Measure	Total			Male			Female			t-value
	Mean	SD	n	Mean	SD	n	Mean	SD	n	
PCL Total	26.88	8.55	47	27.20	9.90	31	26.30	5.30	16	-.36
ProQOL										
Compassion Satisfaction	37.66	8.75	47	39.20	4.94	31	36.90	13.50	16	.86
Burnout	20.53	5.23	47	19.65	5.62	31	22.25	3.97	16	1.65
Compassion Fatigue	13.89	7.82	47	12.87	7.87	31	15.88	7.57	16	1.27
POAMS										
Well-being	2.52	.79	47	2.70	.79	31	2.17	.70	16	-2.27*
Symptoms	3.39	.77	47	3.48	.55	31	3.20	.47	16	-1.18
Life-functioning	2.90	.53	47	2.97	.55	31	2.77	.47	16	-1.22
Global Mental Health	3.19	.57	47	3.29	.55	31	2.99	.57	16	-1.73
Sexual Life Functioning Item	2.82	1.03	45	3.03	.99	30	2.40	1.00	15	-2.01*
Demographic Questionnaire										
Sexual Desire	2.00	1.05	46	1.71	.90	31	2.60	1.12	15	2.90**
Quality Time	3.35	.99	46	3.55	.99	31	2.93	.88	15	-2.04*
Sexual Functioning	1.48	.86	46	1.16	.45	30	2.13	1.13	15	4.19**

Note. *indicates gender differences at $p < .05$, **indicates gender differences at $p < .01$.

life functioning, or global mental health. They did, however, differ on the POAMS Well-being scale, such that female detectives reported less overall well-being than male detectives, $t(45) = -2.27, p < .05$. Female detectives also endorsed significantly less quality time with their spouse or significant other than did male detectives, $t(45) = -2.27, p < .05$. On the demographic item assessing sexual desire (in which higher scores are indicative of work detracting more from desire), female detectives reported significantly more detraction than did male detectives, $t(44) = 2.90, p < .01$. Similarly, on the demographic item assessing the impact of work on sexual functioning, female detectives reported significantly more interference than male detectives, $t(44) = 4.19, p < .01$. On the sexual functioning item from the POAMS, in which lower scores are indicative of more impaired functioning, female detectives acknowledged significantly more problems than did male detectives, $t(43) = -2.01, p < .05$.

To assess whether number of years of service as a detective, age, or gender may contribute to the experience of sexual desire and sexual functioning, three exploratory stepwise multiple regression analyses were conducted with $PIN = .05$ and $POUT = .10$, using sexual desire and the two sexual functioning items as criterion variables. When sexual desire was used as the criterion variable, the stepwise multiple regression revealed that two predictor variables entered the model. First, "years as a detective" entered, with a standardized β of $-.39, t = -2.67, p < .02$. A second variable entered the model at step two; gender. The final model contained years as a detective ($\beta = -.35, t = -2.55, p < .02$) and gender ($\beta = -.34, t = -2.43, p < .02$), and accounted for 26% of the variance, $F(2, 41) = 6.96, p < .003$.

Using the demographic sexual functioning item as the criterion variable, the stepwise multiple regression revealed that gender was the only variable that entered the model, $b = -.53, t = -3.98, p < .001$. The final model accounted for 28% of the variance, $F(1, 41) = 15.84, p < .001$. When the sexual functioning item for the POAMS was used as the criterion variable in the stepwise multiple regression, no variables entered the model, although there was a significant correlation between gender and sexual functioning, $r = .29, p < .05$.

DISCUSSION

The exposure of detectives to victims of sexual abuse or assault, especially children, should make them particularly susceptible to adverse effects, such as compassion fatigue,

burnout, and mitigated compassion satisfaction. However, there are very few studies of these constructs in this population, and a comprehensive review of the literature found no studies exploring the effects of sexual desire or functioning with detectives who investigate childhood sexual assault or abuse cases. Therefore, the results of the current study, while preliminary, provide compelling initial data regarding factors related to compassion, communication and intimacy of significant relationships, and probable PTSD symptoms within a unique population of detectives.

The association between compassion fatigue symptoms and probable PTSD symptoms is notable; however, this outcome is somewhat tempered by the overall asymptomatic scores on the PCL. More specifically, the mean score on the PCL for this sample was 25.1 and only two participants scored above the accepted cutoff of 50 (Schlenger et al., 2002). Although one may suggest that these lower scores may be related to a law enforcement culture that is reluctant to endorse items related to PTSD symptoms, because this type of self-disclosure and endorsement of psychological symptoms may be perceived as character weakness, other studies have found a relation between the PTSD and compassion fatigue in LEO (Martin, McKean, & Veltkamp, 1986). Therefore, it may be suggested that since most of these data were gathered at a conference that was held at an ocean resort, away from daily occupational stressors, that this may have tempered the detectives' responses. Regardless, future studies should explore this relation.

Some of the more compelling findings from this study were the relational differences that occurred between male and female detectives. More specifically, for male detectives, quality time and emotional intimacy with their spouse or significant others increased compassion satisfaction, or their ability to be effective caregivers at work. Moreover, for men, open communication with their spouses or significant others led to decreased chances of emotional burnout. These data are consistent with literature suggesting the protective value of a strong support system (Delp, Wallace, Geiger-Brown, & Muntaner, 2010; Gray-Stanley et al., 2010; Maslanka, 1996; Wade, Cooley, & Savicki, 1986).

For female detectives, however, neither quality time nor emotional intimacy with their spouse was related to compassion fatigue, burnout, or compassion satisfaction on the ProQOL; however, ability to openly communicate with their spouse or significant other was negatively correlated with compassion satisfaction. This finding is unexpected since

open communication is typically associated with improved coping, better mental health functioning, and less ambiguity in relationships (Esmail & Huang, 2010; Mallinger, Griggs, & Shields, 2006; Muehlenhard, Andrews, & Beal, 1995). Thus, these results suggest that female detectives' ability to have an open communication style outside of work with their spouse or significant other may adversely impact or take an emotional toll on their ability to be effective caregivers at work. This finding could be explained in part as a compensatory choice made by the female detectives, such that the development of an open communication style with a spouse or significant other may be seen as compromising or possibly detrimental to them when investigating sexual abuse cases of children that typically involve male perpetrators. Whereas quality time or emotional intimacy are thought to be reserved for someone special such as a spouse or significant other and are more clearly delineated, open communication may be considered more of a general style that for women may be seen as detrimental if transferred and then blurred when doing challenging investigative work. Clearly this interesting finding needs to be replicated with a larger, diverse sample of female detectives, and women in other care giving occupations.

The difference between male and female detectives on well being as assessed by the POAMS is noteworthy given that the female detectives' mean score of 2.17 is consistent with impairment (Green, Lowry, & Kopta, 2003). Moreover, female detectives' acknowledgement of work interfering with sexual desire and finding significantly less sexual enjoyment and fulfillment than male detectives is noteworthy. Given that it was not part of the study's initial hypotheses, personal sexual abuse history was not assessed. Therefore, it is uncertain what the impact of previous sexual abuse may have had on the current outcome (Follette et al., 1994) or whether these results are due to, or consistent with, inherent differences in sexual interest between the genders (Baldwin & Baldwin, 1997). Regardless, to find significance with a relatively small sample of women suggests the possibility that their maternal instincts, or possibly having children of their own, may leave them particularly vulnerable to the effects of doing these types of investigations. It is notable, however, that the female detectives endorsed fewer difficulties on the demographic item related to work interfering with sexual functioning, suggesting that there may be other reasons why, compared to their male counterparts, they are experiencing less sexual fulfillment. Clearly, additional investigations with larger samples of women detectives, and investigating

additional variables, including abuse history and whether they have children, are warranted. If future empirical studies support these current findings, then it may be worthwhile to consider the benefits of doing pre-incident preparation training in the general domain of relationship satisfaction for female detectives before they begin doing child abuse investigations.

A last finding worth noting from this pilot investigation was that years of service as a detective was associated with work detracting from sexual desire, such that detectives with fewer years on the job acknowledged more distraction. While this result may be attributed to the toll that the initial years on the job takes on those investigating sexual offenses against children, it is also possible that a number of variables, including the demands of raising a young family, finances, and lack of job security may be involved.

Overall, there is clearly a need for future research in this area. This current study is limited by its sample size, and future research would benefit from expanding questions to assess further variables related to time on the job, types of victims and specific crimes investigated, and factors related to resiliency. Additional information in these areas may result in police agencies better screening detective applicants, providing more specific training in factors related to compassion effects, and assisting male and female detectives in fostering and maintain satisfying relationships with their spouses and significant others.

REFERENCES

- Acker, M., & Davis, M. H. (1992). Intimacy, passion and commitment in adult romantic relationships: A test of the triangular theory of love. *Journal of Social & Personal Relationships, 9*, 21-50. Doi:10.1177/0265407592091002
- Andrew, M. E., McCanlies, E. C., Burchfiel, C. M., Charles, L., Hartley, T. A., Fekedulegn, D., & Violanti, J. M. (2008). Hardiness and psychological distress in a cohort of police officers. *International Journal of Emergency Mental Health, 10*(2), 137-148.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders 4th Ed. Text Revision. DSM-IV-TR*. Washington, DC: Author
- Baldwin, J. D., & Baldwin, J. L. (1997). Gender differences in sexual interest. *Archives of Sexual Behavior, 26*, 181-210.
- Blake D. D., Weathers F. W., Nagy L. M., Kaloupek D. G., Klauminzer G., Charney D., & Keane T. M. (1990). A

- clinician rating scale for assessing current and Lifetime PTSD: The CAPS-1. *Behavior Therapist*, 13, 187-188.
- Blanchard E. B., Jones-Alexander J., Buckley T. C., & Forneris C. A. (1996). Psychometric properties of PTSD checklist as a measure of symptomatic change in combat-related PTSD. *Behaviour Research and Therapy*, 34, 669-673.
- Burke, R. J. (2006). Work-family stress, conflict, coping, and burnout in police officers. *Stress Medicine*, 9(3), 171-180. doi:10.1002/smi.2460090308
- Byers, E. S., & Demmons, S. (1999). Sexual satisfaction and sexual self-disclosure within dating relationships. *Journal of Sex Research*, 36, 180-189. doi:10.1080/00224499909551983
- Carlier, I. V. E., Lamberts, R. D., & Gersons, B. P. R. (1997). Risk factors for posttraumatic stress symptomatology in police officers: A prospective analysis. *Journal of Nervous and Mental Disease*, 185(8), 498-506.
- Cupach. W. R., & Comstock, J. (1990). Satisfaction with sexual communication in marriage: Links to sexual satisfaction and dyadic adjustment. *Journal of Social and Personal Relationships*, 7, 179 -186. doi:10.1177/0265407590072002
- Delp, L., Wallace, S. P., Geiger-Brown, J., & Muntaner, C. (2010). Job stress and job satisfaction: Home care workers in a consumer-directed model of care. *Health Services Research*, 45(4), 922-940. doi:10.1111/j.1475-6773.2010.01112.x
- Dutton, M. A., & Rubinstein, F. L. (1995). Working with people with PTSD: Research implications. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. (pp. 82-100). Florence, KY: Brunner/Mazel.
- Emmers-Sommer, T. M., & Metts, S. (2004). The effect of communication quality and quantity indicators on intimacy and relational satisfaction. *Journal of Social & Personal Relationships*, 21, 399-411. doi:10.1177/0265407504042839
- Esmail, S., & Huang, J. (2010). Couple's experiences when men are diagnosed with multiple sclerosis in the context of their sexual relationships. *Sexuality and Disability*, 28(1), 15-27. doi:10.1007/s11195-009-9144-x
- Fielding, N.G., & Conroy, S. (1992). Interviewing child victim: Police and social work investigations of child sexual abuse. *Sociology*, 26(1), 103-124. doi:10.1177/0038038592023001007
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Psychotherapy in Practice*, 58, 1433-1441. doi:10.1002/jclp.10090
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. (pp. 1-20). Florence, KY: Brunner/Mazel.
- Figley, C. R. (1999). Police Compassion Fatigue: Theory, research, assessment, treatment, and prevention. In P. Volanti (Ed.), *Police Trauma: Psychological Aftermath of Civilian Combat*. (pp. 37 -53). Charles C Thomas Publisher, LTD. Springfield, IL.
- Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, 25, 275-282. doi:10.1037//0735-7028.25.3.275
- Gersons, B. P. (1989). Patterns of PTSD among police officers following shooting incidents: A two-dimensional model and treatment implications. *Journal of Traumatic Stress*, 2(3), 247-257. doi:10.1002/jts.2490020302
- Gershon, R. R. M., Barocas, B., Canton, A.N., Li, X., & Vlahov, D. (2009). Mental, physical, and behavioral outcomes associated with perceived work stress in police officers. *Criminal Justice and Behavior*, 36(3), 275-289. doi:10.1177/0093854808330015
- Green, J. L., Lowry, J. L., & Kopta, S. M. (2003). College students versus counseling center clients: What are the differences? *Journal of College Student Psychotherapy*, 17, 25-37.
- Gray-Stanley, J. A., Muramatsu, N., Heller, T., Hughes, S., Johnson, T. P., & Ramirez-Valles, J. (2010). Work stress and depression among direct support professionals: The role of work support and locus of control. *Journal of Intellectual Disability Research*, 54(8), 749-761. doi:10.1111/j.1365-2788.2010.01303.x
- Kopta, S. M., & Lowry, J. L. (1997). *Psychotherapy Outcome and Assessment Monitoring System*. Copyrighted questionnaire, available from the authors.
- Mabe, L. W. (2002). An exploratory study of self-disclosure and marital adjustment in law enforcement officers. *Dis-*

sertations Abstracts International Section A: Humanities & Social Sciences, 63, 98.

- Mackay, R. A., Diemer, M. A., & O'Brien, B. A. (2004). Relational factors in understanding satisfaction in the lasting relationships of same-sex and heterosexual couples. *Journal of Homosexuality*, 47(1), 111-136. doi:10.1300/J082v47n01_07
- Maia, D. B., Marmar, C. R., Metzler, T., Nobrega, A., Berger, W., Mendlowicz, M. V., Coutinho, E. S. F., & Figueira, I. (2007). Post-traumatic stress symptoms in an elite unit of Brazilian police officers: Prevalence and impact on psychosocial functioning and on physical and mental health. *Journal of Affective Disorders*, 97, 241-245.
- Mallinger, J. B., Griggs, J. J., & Shields, C. G. (2006). Family communication and mental health after breast cancer. *European Journal of Cancer Care*, 15, 355-361. doi:10.1111/j.1365-2354.2006.00666.x
- Martin, C., McKean, H., & Veltkamp, L. (1986). PTSD in police and working with victims: A pilot study. *Journal of Police Science and Administration*, 14, 98-101.
- Maslanka, H. (1996). Burnout, social support and AIDS volunteers. *AIDS Care*, 8(2), 195-206
- Muehlenhard, C. L., Andrews, S. L., & Beal, G. K. (1995). Beyond 'just saying no': Dealing with men's unwanted sexual advances in heterosexual dating contexts. *Journal of Psychology & Human Sexuality*, 8(1-2), 141-168.
- Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). Florence, KY: Brunner/Mazel.
- Roberts, N.A., & Levenson, R.W. (2001). The remains of the workday: Impact of job stress and exhaustion on marital interaction in police couples. *Journal of Marriage & the Family*, 63, 1052-1067. doi:10.1111/j.1741-3737.2001.01052.x
- Schlenger, W. E., Caddel, J. M., Ebert, L., Jordan, K. B., Rourke, K. M., Wilson, D., et al. (2002). Psychological reactions to terrorist attacks: Findings from the national study of Americans' reactions to September 11. *Journal of the American Medical Association*, 288, 581-588.
- Spitzer, R. L., Williams, J. B. W., & Gibbon, M. (1992). The Structured Clinical Interview for DSM-III-R (SCID): History, rationale and description. *Archives of General Psychiatry*, 49, 624-629.
- Spitzer, R. L., Williams, J. B. W., Gibbon, M., & First, M. B. (1990). *Structured clinical interview for DSM-III-R*. Washington, DC: American Psychiatric Association.
- Stamm, B. H., 2002. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-III (ProQOL)*. <http://www.isu.edu/~bhstamm>.
- Underwager, R. & Wakefield, H. (1990). *Real world of child interrogations*. Springfield, IL.: Charles C. Thomas Publisher, LTD.
- Wade, D. C., Cooley, E., & Savicki, V. (1986). A longitudinal study of burnout. *Children and Youth Services Review*, 8(2), 161-173. doi:10.1016/0190-7409(86)90016-2
- Wang, Z., Inslicht, S.S., Metzler, T.J., Henn-Haase, C., McCaslin, S.E., Tong, H., Neylan, T.C., & Marmar, C.R. (2010). A prospective study of predictors of depression symptoms in police. *Psychiatry Research*, 175(3), 211-216. doi:10.1016/j.psychres.2008.11.010
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., Keane, T. M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. *Paper presented at: Annual Conference of the International Society for Traumatic Stress Studies*; San Antonio, Texas.
- Webb, N. B. (2007). *Play therapy with children in crisis: Individual, group, and family treatment* (3rd ed.). New York: Guilford.
- Worrall, J. L. (1999). Public perceptions of police efficacy and image: The "fuzziness" of support for the police. *American Journal of Criminal Justice*, 24(1), 47-66. doi:10.1007/BF02887617.

Submitted October 24,, 2010

Accepted November 14, 2010

Time of Psychiatric Patient Assaults: Twenty-Year Analysis of the Assaulted Staff Action Program (ASAP)

Raymond B. Flannery, Jr, Ph.D.
Massachusetts Department of Mental Health
Harvard Medical School

Georgina J. Flannery, M.S.
Newton, MA

Andrew P. Walker, B.A.
Massachusetts Department of Mental Health

Abstract: *Apparent random acts of violence viewed in the aggregate appear to occur in fairly exacting temporal patterns. This is true of rape, street assaults, and domestic violence, among other acts of violence. Patient assaults on staff as acts of violence should also follow a temporal pattern. This twenty-year retrospective study of assaultive psychiatric patients in one public sector examined the temporal pattern of such assaults. Inpatient assaults were more likely to occur in the summer, in the middle ten days of the month, during the first shift at mealtimes. In community settings, assaults were more likely in winter during the first ten days of the month, and on the first shift at noon time. The possible reasons for these time patterns, their possible biological roots, and their implications for emergency services personnel and health care providers were discussed. [International Journal of Emergency Mental Health, 2010, 12(4), pp. 267-274].*

Key words: *Assaulted Staff Action Program (ASAP), assaults, psychiatric patients, time, Emergency Services*

Paramedics, police, firefighters, other emergency service (EMS) personnel, as well as health care and social service providers, are subject to assaults and other types of violence from the very patients/suspects for whom they are in the process of providing care (American Psychiatric Association,

1992; Cheney, Gossett, Fullerton-Gleason, Ernst, & Sklar, 2006; Daffern & Howell, 2002). While these individual acts of violence may appear to be random events, research has documented that, in the aggregate, different types of human-perpetrated violence appear to follow specific temporal patterns (Flannery, 2009; Flannery, White, Flannery, & Walker, 2007b). For example, rapes often occur between 8:00 PM - 4 AM on Sunday evenings (Manser, 1992). Street assaults appear to occur between 8:00 PM - 4 AM (Wright & Kaiya, 1997), while domestic violence assaults most frequently occur between 8:00 - 11 PM on weekends in the kitchen (Flannery, 2004). These temporal patterns for violent acts suggest that EMS and health care providers are not at equal risk for assault and violence during every working hour and that a knowledge of the types and timing of violent acts for a particular profession or facility could lead to the development of helpful risk management strategies. These risk manage-

Raymond B. Flannery, Jr, Ph.D., is Director of The Assaulted Staff Action Program (ASAP) and was Senior Psychologist, Worcester State Hospital, Massachusetts department of Mental Health. Dr. Flannery is on the faculties of Harvard Medical School and the University of Massachusetts Medical School. He is now at the Cambridge Health Alliance. Georgina J. Flannery, MS, is Reference Librarian, Newton Free Library, Newton, MA, and Research Associate and Information Specialist for the ASAP program. Andrew P. Walker, B.A., is an Automated Information Technologist, the Executive Decision Support Team, Massachusetts Department of Mental Health, and the ASAP program statistician. Correspondence regarding this article may be directed to raymond_flannery@hms.harvard.edu.

ment strategies would enhance the safety of both patients/suspects and attending staff personnel.

Similar to the acts of violence noted above, assaults on health care providers also appear to follow a temporal pattern. (Davis, 1991; Hansen, 1996; Mellesdal, 2003). Previous ten- and fifteen-year studies from the present database (Flannery, Corrigan, Tierney, & Walker, 2000; Flannery et al., 2007b) have documented temporal patterns in such assaults. In hospital settings, these assaults occurred most frequently in the middle of the week between 7:00 - 9:00 AM, when ward activity was greatest, and at 10:00 PM in community residences, when group home activity was most active. Patient assaults on paramedics and other EMS personnel appear to occur most frequently during nighttime hours and often on weekends (Cheney et al., 2006; Gershon, Vlahov, Kelen, Conrad, & Murphy, 1995; Mechem, Dickinson, Sholer, & Jaslow, 2002; Murphy, Winters, O'Farrell, Fals-Steward, & Murphy, 2005).

One limitation of these temporal studies for studying aggregate data has been their short duration, ranging from a few months to a few years. The purpose of the present retrospective study is to continue the inquiry into the temporal patterns of psychiatric patient assaults on staff in one public sector mental health care system during a twenty-year period. Based on past research (Davis, 1991; Flannery et al., 2000; Flannery et al., 2007b; Hansen, 1996; Mellesdal, 2003), it was hypothesized that there would be a temporal pattern to psychiatric patient assaults.

METHOD

Subjects

The subjects were 1,417 male (49%) and 1,410 female (49%) assaultive psychiatric patients of the Massachusetts Department of Mental Health (DMH). During this twenty-year period, they received treatment services in 7 DMH state hospitals and 9 DMH state or DMH-vendored community programs. There were 1,163 (50%) male and 1,108 (48%) female assaultive inpatients and 254 (45%) male and 302 (53%) female assaultive patients in community settings. The sample was drawn from a population of 21,000 Department of Mental Health (DMH) child (15%) and adult (85%) patients.

In 2008, there were 2,197 unduplicated adult inpatients. There were 1,357 male (62%) and 840 female (38%) patients with an average age of 41.89 years (± 13.70). The estimated

main diagnostic categories were schizophrenia (56%), major affective disorders (26%), and primary personality disorders (3%). There were 1,411 Caucasian (64%), 378 Black (17%), 211 Hispanic (10%), 52 Asian (2%), and 145 (7%) other racial groups. This data is similar to the 15-year findings (Flannery et al., 2007b) and there appeared to be no statistically significant changes in adult inpatient settings with regard to gender ratio, racial composition, or diagnostic categories during the 20 years of this study.

In 2008, there were 33 male (58%) and 24 female (42%) child/adolescent unduplicated inpatients under age 18. There were 28 Caucasian (49%), 10 Black (18%), 12 Hispanic (21%), 1 Asian (2%), and 6 other racial groups (10%). Their average age was 16.96 years (± 1.24) and the main diagnostic categories were schizophrenia (21%), major affective disorders (44%), and anxiety/posttraumatic stress disorders (7%). There appeared to be no statistically significant changes in child gender ratio, racial composition, or diagnostic categories during the years of this study.

In 2008, there were 7,516 adults in DMH state or vendor-operated community residences. There were 4,505 male (60%) and 3,011 female (40%) adult patients. Their average age was 45.99 years (± 12.89). There were 5,412 Caucasians (72%), 1,065 Black (14%), 315 Hispanic (4%), 161 Asian (2%), and 563 other racial groups (8%); the main diagnostic categories were schizophrenia (45%), major affective disorders (16%), and personality disorders (12%). Again, there appeared to be no statistically significant differences in adult community programs in gender ratio, racial composition, or diagnostic categories during the twenty years of this study. There were no ASAP teams in child/adolescent programs in the community and, thus, there are no reports of child/adolescent community assaults.

Measures of Assault

The four types of assaults included in this study remained the same as they have been since the program was fielded in 1990. Physical assaults were defined as unwanted contact with another person with intent to harm, including punching, kicking, slapping, biting, spitting, and throwing objects directly at staff. Sexual assaults were unwanted sexual contacts and included rape, attempted rape, fondling, forced kissing, and exposing. Nonverbal intimidation referred to actions intended to threaten and/or frighten staff, such as pounding on the staff office door, random throwing

of objects, and destruction of property. Verbal threats were statements meant to frighten or threaten staff, and included threats against life and property as well as racial slurs and other derogatory comments.

Procedure

The information on the characteristics of patient assailants and time of assaults was gathered from the medical chart and incident report records and was recorded on Assaulted Staff Action Program (ASAP) report forms, after ASAP services had been provided (Flannery, 1998; Flannery, Farley, Rego & Walker, 2007a). ASAP is a voluntary, system-wide, peer-help, crisis intervention program to assist staff victims to cope with the psychological sequelae of patient assaults. In addition to individual crisis counseling, ASAP also utilizes its own group crisis intervention procedures, staff victims' support groups, staff-victim family outreach, and private referrals to trauma specialists as indicated. About 95% of ASAP services are individual crisis interventions. ASAP provides needed support to staff victims and is also associated in some facilities with sharp reductions in assaults facility-wide (Flannery, 1998; Flannery et al., 2007a). During the past twenty years, ASAP has grown to include 38 teams in 7 states with more than 1,650 ASAP-trained responders. Since various state laws preclude the transmission of patient information across state lines, each state's ASAP programs keep their own state data. Thus, this study reports only on data from the 16 Massachusetts teams that were fielded during this 20 year period. No MA team was online for the full 20- year period.

ASAP team members practiced completing ASAP report forms until acceptable levels of skill and reliability were obtained. To guard against underreporting (Lion, Snyder & Merrill, 1981), the inpatient charge nurse or the community residential house director were required to call the ASAP person on-call, to complete a DMH incident report, and to orally review the incident at daily staff meetings. This analysis assumes that all staff were at equal risk for the full period, except for some brief hospitalizations during which community patients were absent from residential placements. At times, total numbers do not equal 100% because of occasional missing data. All data are reported as assault incidents.

RESULTS

From 1990 to 2010, the MA ASAP teams responded to 2,891 patient assaults on staff. ASAP services were accepted

in 2,520 incidents (87%) and declined in 371 others (13%).

Months/Quarters

As can be seen in Table 1, in inpatient settings the most assaults occurred in March (226; 10%) and the fewest in December (167; 7%). Similarly in community settings, the most assaults occurred in March (62; 11%) and the fewest in September (37; 7%). Assault data by quarters can be inferred from Table 1 also. In inpatient settings most assaults occurred during the third quarter, summer (628; 27%) and the fewest during the first quarter, winter (571; 25%). In community settings, there were 154 (27%) community assaults in the first quarter and 132 (23%) assaults in the third quarter. This seasonal difference was not statistically significant ($\chi^2 = 0.515$; $df = 3$).

Days of Month/Week

Although the 5th day of the month in inpatient settings and the 6th day of the month in community settings were the days with the highest frequency of assaults, an analysis of the data by ten-day increments permits a more clear understanding of trends. The most significant increments were seen in

Table 1.
Total Inpatient and Community Assaults
by Month

Month	Inpatient	Community
January	177	52
February	168	40
March	226	62
April	192	47
May	215	44
June	168	43
July	202	52
August	217	43
September	209	37
October	194	40
November	188	45
December	167	59

807 assaults (35%) committed during days 11-20 in inpatient settings and 261 assaults (46%) committed in community settings during days 1-10. This finding was statistically significant at the .01 level ($\chi^2 = 79.29$; $df = 2$). Wednesday was the day with the highest risk for assault in inpatient settings (402; 17%) and Sunday presented the highest risk in community settings (90; 16%).

Shift/Meal Times

The hours of 10:00 AM and 11:00 AM in both inpatient settings and community settings were the hours of most frequent assaults. However, an analysis of time across shifts and meal periods permits a more robust examination of possible additional trends. In both inpatient (1,280; 55%) and community settings (306; 54%), the greatest risk for assault occurred during the first shift. The breakfast meal time (7:00 – 9:00 AM) presented the greatest risk for assault in inpatient settings (424; 18%) and the noon meal time (11:00 AM - 1:00 PM) for community settings (85; 15%). The findings for shifts were statistically significant at the .05 level ($\chi^2 = 8.61$; $df = 2$). A summary of the time variables may be found in Table 2.

DISCUSSION

The temporal findings from the present study, which appears to be the longest such study in the published health care literature, support its hypothesis and are consistent with previously studies of community violence (Daffern & Howell, 2002; Flannery, 2004, 2009; Manser, 1992; Wright

& Kariya, 1997), with previous studies of various healthcare systems (Davis, 1991; Hanson, 1996; Mellesdal, 2003), with previous studies of EMS (Cheney et al., 2006; Gershon et al., 1995; Murphy et al., 2005), and with the two earlier studies from this data base (Flannery et al., 2000; Flannery et al., 2007b). Taken collectively, these findings are robust in their support of specific temporal dimensions in acts of violence. What appear to be random incidents do not appear to be random when viewed in the aggregate.

In this study, patient assaults followed specific, if differing, patterns in inpatient and community settings. As in the earlier studies (Flannery et al., 2000; Flannery et al., 2007b), in inpatient settings patient assaults were more likely to occur in the summer months when staff and students may be terminating, staff may be on vacation, patients may have more freedom on the grounds, and the ambient air temperature may be high. Inpatients appear more likely to be assaultive during the middle ten days of the month. While the etiology of pattern needs further research, this time pattern may reflect the additions and deletions to the patients' medications at the beginning of the month. Some of these medication changes may not be fully reflected until two weeks later.

Inpatients whose brain functioning may be compromised by psychosis and/or a variety of organic components at times feel overwhelmed by excess sensory stimulation (Flannery et al., 2000b). This excess stimulation appears to be one of the components in assaults on Wednesdays, first shifts, and meal times. These are when hospital activities are highest and/or sustained for protracted periods of time. For example, during the first shift from 7:00-9:00 AM, patients are shower-

Table 2.
High risk for Assaults by Time Variables

Time Variable	Inpatient	Community
Season	Summer	Winter
Month	August	March
Days of Month	Days 11-20	Days 1-10
Days of Week	Wednesday	Sunday
Shift	First	First
Meal Times	7 AM - 9 AM	11 AM - 1 PM
Other Risk Hours	Hour 10 AM	Hour 10 AM

ing, getting dressed, talking medications, having breakfast, and preparing for the day's activities. Staff are changing shift and clinicians come to the ward. The general level of required patient interactions is substantially increased and some may become overwhelmed and assaultive.

The seasonal pattern for patients in community settings appear to be the reverse of the inpatient findings. In the community, New England winters appear to result in more patient assaults. Long winter nights, the need for heavy coats and boots in snow and ice, more difficulty in commuting to day programs, and generally less freedom to come and go easily appear to contribute to increased assaults. Unlike inpatient settings, most community assaults occur in the first ten days of the month. This is most likely accounted for by the patients receiving their financial benefits. Disagreements with staff about budgeting monies and drinking nights on the town may result in increased frustration and anger. However, similar to the inpatient findings, the excess stimulation of community residential activity, especially at noon time, appears to result in the increased probability of assault. The compromised brain functioning of many of the patient residents appears to be involved in these assaults, as it is in the inpatient settings.

Finally, attention should be drawn to these remarkably stable and invariant findings over a twenty-year period in one health care system. One might argue that these are the same patients in the same system but that is not an accurate assumption. That many patients enter and leave the system is easily understood. That the health care system itself is vastly different may not appear so obvious at first either. During the past twenty-years, this public health care system has seen several downsizings and closures of both inpatient and community settings; the privatization of several services; several and repeated reductions in force; increased patient assessments by means of patient-at-risk, forensic, medication, and behavioral consultations; new system-wide policy initiatives, such as restraint-free approaches, managed care initiatives, and updated approaches to safe non-violent self-defense initiatives; and resource scarcity due to the impact of the 2008-2009 global economic downturn. In the face of all of these changes, the timing of patient assaults has remained essentially invariant.

In Medicine, the presence of an epidemiological invariant often suggests a biological marker. While there appear to be clear environmental precipitants associated with patient assaults (e.g. ward activity, substance use, unstructured time), the present findings also suggest that there may be biological

markers in the specific temporal patterns of patient assaults. Excess stimulation of persons with impaired brain functioning may be one of possibly several, as yet unknown, other biological markers. The same may be true for other types of human-perpetrated violence and suggests the need for further empirical research to reduce the human suffering associated with patient assaults on staff.

Risk Management Implications

The continuing accumulation of data denoting the importance of timing in violent incidents strongly suggests the importance of organizations that deal with potentially violent persons to develop some database to determine the time patterns in the work involved. Such data bases may be easily constructed.

For EMS, the call log becomes the basic timing safety tool; for health care providers, the admitting chart or medical record on the ward. To determine when staff may be at risk and when staffing may need to be increased, the log or admitting chart needs to include all relevant information on the identified patient/suspect, the characteristics of the responding agency staff, the environmental context, the time of the event, and any other variables thought to be salient to a specific agency's mission. Whatever report forms are utilized in the field should be clear, concise, and brief to ensure compliance. The report form should be easily modifiable to capture any additional information and a computer data base that captures all of the relevant information on the paper report from needs to be created. In some circumstances, for example, police in squad cars and health care providers on patient-care sites may have immediate access to computers. In these cases, an electronic report form can be completed in the field and be sent directly to the central computerized data base.

The data gathered about the timing of particular types of violent acts is an important tool in reducing risk and thereby enhancing safety. This first important step can then be coupled with additional risk management strategies, such as awareness of the types of medical and psychiatric illnesses associated with potential violence; knowledge of the early warning signs of loss of control; training in surveying the scene for risk; and awareness of old brain stem functioning in highly agitated individuals, where more common rational thinking has been greatly compromised. [See Flannery (2009) for a more detailed analysis of these issues.] Two risk man-

agement strategies readily suggest themselves. The first is to increase staffing during high risk periods. The second is to reduce the level of activity to small manageable steps, if the situation permits. As has been commonly stated, safety is no accident and EMS and health care providers can do much to decrease their risk of harm by following these basic safety guidelines.

Methodological Issues

While operational definitions of specific times of incidents are consistent across studies, other variables may not be. For example, in health care research, there remains the need for consistent operational definitions of patient assaults, a standardized rating scale of the severity of such incidents, and a standardized reporting system that captures all of the incidents that are to be included. This standardized reporting system also needs to replace the current mix of observations, self-reports, chart reviews, and other non-standardized data reporting systems. As stated earlier, the standardized format would need to be clear, concise, short in length, and readily available to staff to enhance compliance. All staff should be mandated to report and record all incidents, even those deemed less serious by attending staff.

Depending upon the mission of the organization that is gathering the temporal data, additional specific components of the incidents may prove of assistance in enhancing staff safety and should be captured. For example in health care settings, it is helpful to know the precipitants to patient assaults as well as the basic demographics of staff victims. This data, in addition to timing, is helpful in determining what circumstances increase the risk of assault and who is most likely to be victimized.

As with much of behavioral science research, there remains the need for prospective, longitudinal research, preferably in the form of randomized controlled studies. The various methodological refinements noted above should greatly enhance generalizability across studies and strengthen our understanding of the person x event x environment configurations that result in violence.

REFERENCES

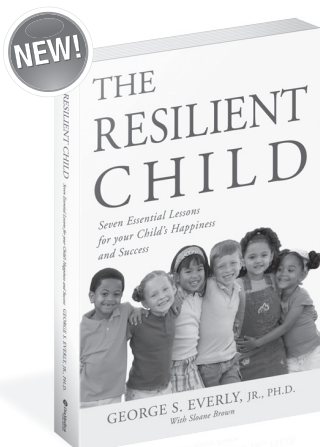
- American Psychiatric Association (1992). *Clinical Safety Task Force Report #33*. Washington, DC: American Psychiatric Press.
- Cheney, R.R., Gossett, L., Fullerton-Gleason, L., Weiss, S.J., Ernst, A.A., & Sklar, D. (2006). Relationship of restraint use, patient injury, and assaults on EMS personnel. *Pre-hospital Emergency Care, 10*, 207-212.
- Daffern, M., & Howells, K. (2002). Psychiatric inpatient aggression: A review of structural and functional assessment approaches. *Aggression and Violent Behavior, 7*, 477-497.
- Davis, S. (1991). Violence in psychiatric patients: A review. *Hospital and Community Psychiatry, 42*, 585-590.
- Flannery, R.B., Jr. (1998). *The Assaulted Staff Action Program (ASAP): Coping with the psychological aftermath of violence*. Ellicott City MD: Chevron Publishing Corporation.
- Flannery, R.B., Jr. (2004). *Posttraumatic Stress Disorder (PTSD): The victim's guide to healing and recovery*. Second Edition. Ellicott City, MD: Chevron Publishing Corporation.
- Flannery, R.B., Jr. (2009). *The violent person: Professional risk management strategies for safety and care*. New York, NY: American Mental Health Foundation.
- Flannery, R.B., Jr., Corrigan, M., Tierney, T., & Walker, A.P. (2000). Time and risk of psychiatric patient assault: Ten year analysis of the Assaulted Staff Action Program (ASAP). *Journal of Healthcare Safety, Compliance, and Infection Control, 5*, 31-35.
- Flannery, R.B., Jr., Farley, E.M., Rego, S., & Walker, A.P. (2007a). Characteristics of staff victims of psychiatric patient assaults: Fifteen-year analysis of the Assaulted Staff Action Program (ASAP). *Psychiatric Quarterly, 78*, 25-37.
- Flannery, R.B., Jr., White, D.L., Flannery, G.J., & Walker, A.P. (2007b). Time of psychiatric patient assaults: Fifteen-year analysis of the Assaulted Staff Action Program (ASAP). *International Journal of Emergency Mental Health, 9*, 89-96.
- Gershon, R.R., Vlahov, D., Kelen, G., Conrad, B., & Murphy, L. (1995). Review of accidents/injuries among emergency medical services workers in Baltimore, Maryland. *Prehospital Disaster Medicine, 10*, 14-18.

- Hansen, W. (1996). Workplace violence in the hospital psychiatric setting: An occupational health perspective. *American Association of Hospital Nurses Journal*, 44, 575-590.
- Lion, J.R., Snyder, W., & Merrill, G.C. (1981). Underreporting of assaults on staff in a state hospital. *Hospital and Community Psychiatry*, 32, 497-498.
- 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.
- Mellesdal, L. (2003) Aggression on a psychiatric acute ward: A three-year prospective study. *Psychological Reports*, 92, 1229-1248.
- Murphy, C., Winters, J., O'Farrell, T. J., Fals-Steward, W., & Murphy, M. (2005). Alcohol consumption and intimate partner violence by alcoholic men: Comparing violent and nonviolent conflicts. *Psychology of Addictive Behaviors*, 19, 35-42.
- Wright, J., & Kariya, A. (1997). Assault patients attending a Scottish accident and emergency department. *Journal of the Royal Society of Medicine*, 90, 322-326.

Submitted September 10, 2010

Accepted October 13, 2010

Seven Essential Steps To Preparing Children for Tomorrow's Challenges



ISBN: 978-0-9793564-5-2
Softcover • 160 pages • \$14.95

All DiaMedica publications are available at online bookstores, including Amazon.com and Barnesandnoble.com, as well as in your local bookstores. You can also visit our website at www.diamedicapub.com, or e-mail us at marketing@diamedicapub.com.

The Resilient Child

Seven Essential Lessons for Your Child's Happiness and Success

George S. Everly, Jr., Ph.D.

"...This delightful and informative book is designed to help busy caregivers and parents guide their children to view their lives as 'half full' even in the face of adversity and the bumps along life's journey." — Alan M. Langlieb, MD, MPH, MBA, The Johns Hopkins Hospital

"...All parents who struggle to prepare our children to make the most of their lives and to be good world citizens will find something helpful in this book."

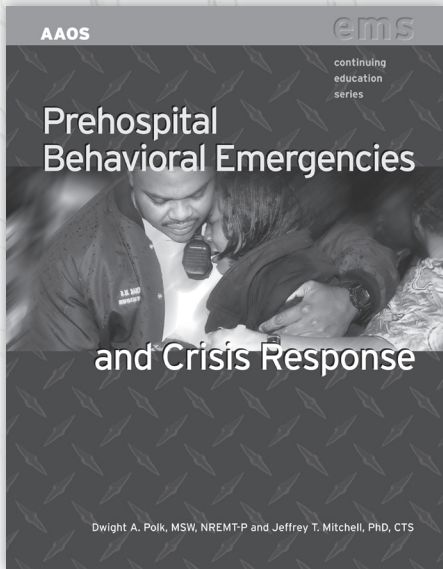
—Rear Admiral Brian W. Flynn, EdD, Assistant Surgeon General (USPHS, Ret.)

The Resilient Child teaches parents the key responses that all children need to learn in order to effectively cope with life's adversities. Dr. Everly teaches readers how to live a stress-resilient life that will lead to happiness and success. These skills are presented as seven essential lessons:

- Develop strong relationships with friends and mentors.
- Learn to think on the bright side and harness the power of the self-fulfilling prophecy.
- Learn to make difficult decisions.
- Believe in something greater than you are.
- Learn to take responsibility for your own your actions.
- Learn that the best way to help others, and yourself, is to stay healthy.
- Learn to follow a moral compass: Integrity

George S. Everly, Jr., PhD is one of the "founding fathers" of modern resiliency and stress management. He is on the faculties of The Johns Hopkins University School of Medicine and The Johns Hopkins University Bloomberg School of Public Health.

A Resource for All Health Care Providers Responding to Mental Health Emergencies



Prehospital Behavioral Emergencies and Crisis Response

American Academy of Orthopaedic Surgeons,
Dwight A. Polk, and Jeffrey T. Mitchell

ISBN-13: 978-0-7637-5120-3

\$41.95 • Paperback • 300 Pages • © 2009

Chevron Publishing is pleased to distribute the newest addition to the American Academy of Orthopaedic Surgeons (AAOS) Continuing Education Series: *Prehospital Behavioral Emergencies and Crisis Response*. Like all titles in this series, an Instructor's ToolKit CD-ROM including PowerPoint presentations and Lecture Outlines, is available to support this program.

Prehospital Behavioral Emergencies and Crisis Response educates providers on crisis and behavioral health issues demonstrated by patients in the prehospital environment. Separated into three parts, coverage includes:

- (1) The acute behavioral crisis
- (2) Chronic mental health issues
- (3) Prehospital response

This resource simplifies various types of diagnosed mental disorders such as mood, personality, eating, and sleeping, as well as schizophrenia and psychosis.

To learn more about this exciting new title, or to place your order, visit Chevron Publishing online at www.ChevronPublishing.com, or call 1-410-418-8002 today.

Table of Contents

- | | |
|---|---|
| 1. The Importance of Crisis and Behavioral Emergencies Training | 10. Disorders of Infancy, Childhood, or Adolescence |
| 2. Crisis Intervention Principles for Prehospital Personnel | 11. Delirium, Dementia, and Amnesic Disorders |
| 3. Assessment in the Prehospital Environment | 12. Substance Related Disorders |
| 4. Responding to the Emotional Crisis | 13. Schizophrenia and Psychotic Disorders |
| 5. Assisting Large Groups Through Crisis | 14. Mood Disorders |
| 6. Emergency Response to Violence | 15. Anxiety Disorders |
| 7. Suicide: An Extraordinary Case of Violence | 16. Dissociative Disorders |
| 8. Supporting Victims of Death Related Crises | 17. Eating Disorders |
| 9. Crisis Intervention in Disasters and Other Large-Scale Incidents | 18. Sleep Disorders |
| | 19. Personality Disorders |
| | 20. Sustaining Staff |

About the Authors

Dwight A. Polk, MSW, NREMT-P—Paramedic Program Director, University of Maryland Baltimore County

Involved in EMS since 1975, and a paramedic since 1982, Dwight Polk has held the position of Paramedic Program Director at the University of Maryland Baltimore County (UMBC) since 1990. Prior to arriving at UMBC, Mr. Polk was a field paramedic and Education Coordinator at Acadian Ambulance Service in Lafayette, Louisiana.

Jeffrey T. Mitchell, Ph.D., CTS—Clinical Professor of Emergency Health Services at the University of Maryland and President Emeritus of the International Critical Incident Stress Foundation.

After serving as a firefighter /paramedic, Dr. Mitchell developed a comprehensive, systematic, integrated and multi-component crisis intervention program called "Critical Incident Stress Management." He has authored over 250 articles and 10 books in the stress and crisis intervention fields. He serves as an adjunct faculty member of the Emergency Management Institute of the Federal Emergency Management Agency.



**JONES AND BARTLETT
PUBLISHERS**
BOSTON TORONTO LONDON SINGAPORE

Place Your Order Today!

Call: 1-410-418-8002 • Visit: www.ChevronPublishing.com

Managing Problem Employees: A Model Program and Practical Guide

Laurence Miller
Independent Practice, Boca Raton, Florida

Abstract: *This article presents a model program for managing problem employees that includes a description of the basic types of problem employees and employee problems, as well as practical recommendations for: (1) selection and screening, (2) education and training, (3) coaching and counseling, (4) discipline, (5) psychological fitness-for-duty evaluations, (6) mental health services, (7) termination, and (8) leadership and administrative strategies. Throughout, the emphasis is on balancing the need for order and productivity in the workplace with fairness and concern for employee health and well-being. [International Journal of Emergency Mental Health, 2010, 12(4), pp. 275-286].*

Key words: *Employee coaching, fitness-for-duty, management psychology, problem employees, workplace discipline*

If there really is such a thing as an 80/20 rule, then it certainly applies to the work of most managers in virtually any kind of organization: 80 percent of a manager's time is spent supervising the 20 percent of employees who present a problem of one kind or another. While they might differ on the actual percentages, most managers would agree with the concept.

This article presents a practical program for managing problem employees that grew out of my experience working with law enforcement and public safety agencies (Miller, 2006b) where "employee misconduct" can have local, regional, and national repercussions in terms of expensive legal action, civil unrest, and loss of public confidence. Ac-

cordingly, these organizations tend to have a zero-tolerance policy toward such misconduct that may be even stricter than that which most managers are willing to abide in their workplaces. Accordingly, as my own work has expanded to encompass public and private organizations of many types (Miller, 2008), managers may feel free to pick and choose from the following recommendations to custom design a problem-management program that works best for their particular organization or department.

Types of Problem Employees and Employee Problems

The term *problem employee* encompasses an enormously wide range of behavior, from tardiness and failure to complete paperwork to bullying, harassment, and workplace violence (Anderson & Pearson, 1999; Blythe, 2002; Casciaro & Lobo, 2005; Einarsen, 1999; Flannery, 1995; Friedman et al, 2000; Johnson & Indvik, 2000; Kidwell & Martin, 2005; Kinney, 1995; Labig, 1995; Lowman, 1993; Miller, 1999, 2002, 2003, 2008; Namie & Namie, 2000; Roberts & Hogan, 2001;

Laurence Miller is an adjunct professor in the Psychology Department at Florida Atlantic University, a clinical and forensic psychologist in independent practice, and the editor of IJEMH. Address correspondence to Laurence Miller, PhD, Plaza IV, Suite 101, 399 Camino Gardens Blvd., Boca Raton, Florida 33432, 561-392-8881, docmilphd@aol.com.

Sperry, 1996). While some extreme forms of behavior automatically preclude retaining an employee and may well incur criminal charges, many kinds of less serious and far more common infractions or patterns of substandard performance are amenable to change with the proper approach, informed by principles of practical psychology. Accordingly, this section outlines some common forms of employee problems.

Workplace aggression is defined as any act or threat of violence, including assault, harassment, vandalism, or other acts of harm or intimidation. It is important to note that overt aggression is often the end-point of a downward behavioral spiral that begins with other problem behaviors at work.

Workplace misconduct typically involves violation of rules regarding time schedules, conduct, workplace relationships, dishonest and corrupt behavior, and other nonviolent infractions. Note, however, that the dividing line between this category and the previous one can be quite fluid; for example, is “creating a hostile environment” by a male employee’s wordlessly salacious leering at a female coworker a form of misconduct, harassment, or other category of problem behavior? Is threatening one’s assistant with onerous duty to muzzle him regarding the supervisor’s bill-skimming scheme a form of bullying, harassment, intimidation, or theft – or all of the above? In general, the sooner such problems are addressed and corrected, the less chance they have of mushrooming out of control.

Marginal performance generally refers to “sins of omission,” and includes such infractions as tardiness and absences, failure to complete work assignments, misuse of company equipment and property, insubordination and problems with chain of command, passive violation of company rules and safety guidelines, poor customer relations, unprofessional behavior, and special infractions related to an individual job.

We might also take a moment to consider what makes a *good* employee (Blustein, 2006; Buckingham, 2005; Casciaro & Lobo, 2005; Collins, 2001; Ferris et al, 2000; Flin, 1996; Lax & Sebenius, 1986; Lerbinger, 1997; Lowman, 1993; Miller, 2003, 2008; O’Reilly & Pfeffer, 2000; Roberts & Hogan, 2001; Sewell, 1992; Sperry, 1996; Stone, 2007; Yandrick, 1996). For virtually all jobs, and especially for occupations that involve any kind of independent judgment or decision-making, there is a need for employees and supervisors who possess good overall intelligence, especially abstract reasoning, mental flexibility, interpersonal creativity, and problem-solving skills. Other related positive traits and

qualities include psychological maturity, common sense, reliability, conscientiousness, and the ability to apply discretion in an ethical and equitable manner. Leaders, supervisors, and higher-ranking managers should be mature, seasoned individuals with a well-developed sense of integrity and professionalism. The challenge for all organizations and industries is to find or develop selection and training protocols that can accurately identify, predict, and develop these positive traits.

Bad Employee to Good Employee: Practical Solutions and Strategies

There are a number of points along the process of hiring, training, and retaining employees that solutions to workplace misconduct can be applied. Indeed, for most workplaces, it is far easier and more economical to salvage a basically good employee with a few correctible faults than to jettison him or her and then recruit and train a replacement. The key is to separate out the more common not-so-bad employee from the minority who are truly irredeemable.

Different employees are dysfunctional for different reasons, and organizations therefore need to develop an integrated system of interventions to target different groups of employees at different phases of their careers. Importantly, interventions must address not just personality characteristics and individual behavior, but the organizational practices of the companies in which the employees work. Management can hardly model unfair or corrupt behavior and then expect their workers to behave honorably. Executives and managers must provide the example they want their employees to emulate.

The following is a step-by-step model of employee selection, training, coaching, counseling, and managing that I have developed for public safety agencies and that can be adapted for organizations of all types, including public companies, government agencies, private corporations, healthcare facilities, and small-to-medium businesses (Miller, 1999, 2001a, 2001b, 2003, 2005, 2006a, 2006b, 2008). The different stages should be thought of less as linear rungs on a ladder than an array of cyclic flywheels, each phase shading into the next and drawing from the ones that precede it.

Selection and Screening

The best way to prevent employee misconduct is not to hire misconduct-prone applicants in the first place. If only

it were that simple. It's surprising how few organizations outside law enforcement, public safety, and some government agencies, employ any kind of formal psychological or informal behavioral screening measures of their respective employees. Other companies contract with self-styled selection service providers who employ questionably valid screening measures and procedures. However, any hiring manager can use his or her brain and a few psychologically-informed principles of common sense to weed out job candidates that have "TROUBLE" scrawled across their foreheads.

Basic *screening-out* red flags include drug or alcohol abuse, a serious or extensive criminal history, evidence of past repeated conflicts with authority, misconduct or poor performance in former jobs, chronic financial problems, or a spotty and inconsistent work record. A particularly important feature of the evaluation is the candidate's style of handling anger and frustration, both in the past and presently.

Screening-in protocols should assess not just behavioral styles and character traits, but the potential for learning from both formal training and on-the-job experience. As noted earlier, traits to look for include good overall intelligence and problem-solving ability, emotional maturity, good communication skills, reliability, conscientiousness, and the ability to use discretion and independent thinking in a fair and ethical manner. Many of these traits, or their absence, will have emerged during a careful pre-employment interview.

Yet even the best screening protocols and interviews are really only behavioral snapshots of the employee's psychological qualifications at the beginning of his or her career with the company. Even the best pre-employment screening protocol cannot necessarily anticipate emotional and psychological problems that may develop during an employee's tenure with that company. Ideally, then, periodic evaluations and reassessments should be a regular component of an employee's progress. Such reassessments should be balanced with fair and effective monitoring, training, and supervision throughout the employee's span of employment (Buckingham, 2005; Garner, 1995).

Education and Training

This includes not just training for the specific job description (bookkeeper, machine operator, stock manager, salesperson, medical technician), but training in the necessary "people skills" that make a workplace congenial or distressing to work in. Certain interpersonal skills and qualities are

largely innate: you either have them or you don't. Many skills, however, can be taught, albeit to varying degrees that depend on the potential and willingness of the individual. Given the impact that interpersonal behavior has on employee satisfaction and productivity, it is surprising how many companies leave this dimension to chance. Notable exceptions include service industries, such as hospitality or sales, where acting cordially is part of the uniform because it directly affects customer satisfaction and the bottom line. But why not apply these principles to all companies to make them more pleasant places to work?

Skeptical managers should note that this type of interpersonal skills training need not be complicated or expensive. The general models employed by most trainers who consult to service-industry businesses and organizations are based on principles of adult learning that involve a combination of didactic instruction, behavioral participation, simulated scenarios, and role playing. The emphasis is on developing a range of psychosocial and communication skills that assume frequent – and potentially unpleasant – interactions between customers and employees. Such exercises focus on anticipating problems before they arise and utilizing a range of flexible problem-solving conflict-resolution strategies to defuse problems before they explode into crises.

But formal training goes only so far. Much teaching, experience, and socialization of new employees occurs on the job under the guidance and influence of immediate supervisors who transmit and model the *corporate culture* of that organization (Collins, 2001; O'Reilly & Pfeffer, 2000; Pfeffer & Sutton, 2006). Training thus has an important attitudinal component: it socializes employees into their respective organizations and inculcates organizational philosophies, values, and expectations. These seeming "intangibles" have great impact on employees' behavior, something managers should always be mindful of as they interact with their staff on a daily basis.

Coaching and Counseling

Coaching and counseling may be considered more focused and individualized applications of education and training that directly address a particular employee's problematic behavior in the context of a supervisory session. Coaching and counseling both require constructive confrontation of the problem employee's behavior, but it is important to realize that such confrontation need not – indeed, should

not – ever be gratuitously hostile, offensive, or demeaning. Professionalism and respect can characterize the interaction of a superior with a subordinate in any supervisory setting, including coaching, counseling, discipline, or even termination. The focus is on correcting the problem behavior, not bashing the employee. Supervisors should be firm but civil, preserving the dignity of all involved.

Coaching

The difference between coaching and counseling lies in their focus and emphasis. *Coaching* deals directly with identifying and correcting problematic behaviors. It is concerned with the operational reasons those behaviors occur and with developing specific task-related strategies for improving performance in those areas. Most of the direction and guidance in coaching comes from the supervisor, and the main task of the supervisee is to understand and carry out the prescribed corrective actions. For example, a quality assurance inspector who fails to complete reports on time is given specific deadlines for such paperwork as well as guidance on how to word reports so that they don't become too overwhelming. A restaurant waiter who behaves discourteously with customers is provided with specific scenarios to role-play in order to develop a repertoire of responses for maintaining his or her dignity without offending the eatery's patrons.

One useful model of coaching is adapted from the no-nonsense world of law enforcement and public safety (Engel, 2002; Garner, 1995; Miller, 2006b; Peak et al, 2004; Robinette, 1987; Sewell, 1992; Thibault et al, 2004), where breaches of communication and conduct can have serious and far-reaching consequences for both the department and the community; similar models have been developed specifically for the corporate world (Stone, 2007). Productively applied to the broad universe of organizational supervision, this protocol can be divided into five basic stages:

Identify and define the problem. This assures that the manager and the employee are on the same page and prevents any misunderstanding from the outset:

“There have been four customer complaints filed against you for discourteous behavior in the past six months.”

State the effect of the problem. This objectifies the situation, providing the employee with a general rule of behavior that applies to everyone. That way, the employee can't accuse the manager of singling him or her out for personal reasons.

“When customers experience our staff as unpleasant to work with, they'll want to take their business elsewhere. In addition, they tell other people, which hurts our business still further. Lost business means fewer raises and bonuses and possibly staff cuts. It also makes the atmosphere generally less pleasant to work in. As you recall from our new-hire orientation, courteous speech and behavior are part of the 'uniform' we all wear when we're at work.”

Describe the desired action. The manager should be crystal clear about what he or she expects the employee to do. The instruction should be repeated as many times and in as many ways as necessary to be sure the employee understands it. It's amazing how people hear what they want to hear, so the manager's directive should leave as little room for ambiguity as possible:

“There seem to be some common threads in these complaints. Let's review some of these situations and see if we can come up with better responses. You can utilize the suggestions we discuss here or feel free to come up with ideas of your own, but the bottom line is, your style of interaction with customers has to change.” [Supervisor and employee review specific scenarios and discuss alternative responses, using discussion and role-play as needed.]

Make it attractive: motivate the employee. Although it may sound like a cliché, the manager should try to make the coaching session seem more like an opportunity and less like a punishment. Employees will take correction and stick to the program to the extent that they feel they have something to gain from doing so – i.e. managers should try to inculcate employee *buy-in*.

“We appreciate your efforts to be an aggressive, meticulous, high-producing sales rep and we know that better customer relations means more business, which is better for everyone. People like doing business with reps who make them feel comfortable and welcome. These ways we've discussed of interacting with customers should help you shoot your numbers even higher.”

Document and summarize. Again, nothing should be left to chance. If a repeat coaching session is necessary, it

will be essential to have written confirmation of what the manager and the employee already discussed and agreed on.

“Okay, I’m writing down here that we reviewed this and that we both agree that you’re going to make these changes.”

Counseling

Counseling differs from coaching in two main ways. First, it is less task-focused and more supportive, empathic, non-directive, and non-evaluative; it seeks to understand the broader reasons underlying the problematic behavior. This is especially appropriate when the difficulty lies less in a specific action or infraction and more in the area of attitudes and style of relating, where there may be a general factor accounting for a range of specific problem behaviors. Second, counseling is less top-down directive than coaching, and puts more of the burden of change on the supervisee, encouraging the employee to creatively develop his or her own solutions to the problem. In the counseling approach, much of the feedback to the supervisee may occur in the form of *reflective statements*, so that a kind of Socratic dialogue emerges, moving the supervisee increasingly in the direction of constructive problem solving:

Manager: Do you know why I asked to speak with you today?

Employee: Well, I guess there have been some complaints about me.

[Discussion continues about the nature of the complaints and their consequences]

Manager: I see you’ve been here three years with a pretty good record. What’s been going on lately?

Employee: I dunno, maybe the job’s getting to me. Ever since the 2005 downsizing and last February’s robbery, it’s like everything seems to drag. And the customers seem more of a pain in the butt than ever. There are fewer big deals these days and more of them seem to be these nickel-and-dime small business operations. Every little thing seems to tick me off. Oh yeah, and things at home haven’t been going that great, either.

[Some further discussion ensues about job and personal problems]

Manager: Well, I’m glad you told me that, and I understand things have been rough the past couple of months, but I’m sure you understand that we need to maintain a certain standard of professionalism. I’m going to refer you to our EAP for some counseling to help you get your bearings. In the meantime, I’d like you to take the next few days to think of some ways you can improve how you’re interacting with the customers. Jot them down, in fact, and we’ll meet next time to discuss this further. You do your part, and we’ll help you get through this, agreed?

Employee: Okay, I’ll try.

Manager: Well, I need you to do more than try, because the situation does have to change. So get back to me with some specifics next week and we’ll take it from there, okay?

Employee: Okay.

Discipline

If educative, coaching, and counseling measures have been ineffective, some form of disciplinary action, ranging from an official reprimand, to suspension, to termination may be indicated. Good discipline begins with proactive assessment and monitoring of the employee’s behavior to detect precursors and patterns of misconduct, so that interventions can be applied as early as possible. Many companies are too lax in this regard, not realizing that disregarding seemingly minor misbehaviors is a perfect way of abetting and encouraging larger transgressions down the road.

The opposite problem in many organizations is an overly heavy-handed approach to discipline in an attempt to enforce zero-tolerance policies. But zero-tolerance for bad behavior doesn’t mean zero-humanity in dealing with the employee. Discipline should be consistent, impartial, immediate, and definitive – but not cruel or vindictive. Ideally, the goal should be to stop the misbehavior, while salvaging an otherwise effective employee. To this end, interventions should be step-wise and targeted to the specific problem.

Practical Discipline

Again, like all categories, the boundaries between coaching, counseling, and discipline are elastic and interac-

tive (Grote, 1995; Serpas et al, 2003; Stone, 2007; Weitzel, 2004). One disciplinary protocol, adapted to the corporate world from the domain of law enforcement and public safety (Garner, 1995), specifies the following set of five basic principles of corrective action that should undergird any effective disciplinary interview.

Have the required administrative support before taking corrective action. For discipline to be effective, the manager must be able to back it up. To begin with, he or she should be working from a standard Policies and Procedures manual that specifies fair and equal rules for all employees. The manager should also have the backing of his or her supervisors to use appropriate managerial discretion and authority in handling the matter.

Have as much background information as possible and know the full story. Few things so erode the effectiveness of workplace discipline as being uninformed and unprepared. You may never be able to know everything, but whatever you can find out about the incident or pattern in question will bolster the manager's authority and leave the employee little wiggle room to manipulate the situation. It also shows that the manager is doing everything possible to be thorough and fair because this is important enough for him or her to have taken the time to thoroughly investigate the matter.

Know the employee as well as possible. This is a corollary to the above principle, but a little broader. A good manager should always strive to know the people he or she works with – not just to analyze or “psyche them out,” but to know them as *people*, because then it's much easier to tailor an approach to them as individuals when coaching, counseling, or disciplining them is necessary (Miller, 2003, 2008).

Frame constructive criticism in a supportive context. It's important to raise some good points, not just the bad (Weisinger, 2000). One suggestion is to sandwich any criticism between two slices of praise:

“I know you're trying to keep your orders moving and we appreciate that, but some of our customers are feeling like you're rushing them through their meals, so we have to work on lightening up the intensity. And most of the customers appreciate your not making them have to keep asking for their drink refills.”

Try to obtain agreement, commitment, and buy-in from the employee – but don't be afraid to pull rank when you have

to. In the best case, the employee will feel like the final solution is his or her decision, as well as the manager's. That's why it's important for the manager to first ask if the employee has any ideas of their own about correcting the problem. Then they can work on them together to come up with the best solution. In some cases, however, the employee will just stare blankly or actively protest the manager's suggestions; then he or she has to make it clear that, ultimately, the manager has the last say and it's up to the employee to comply.

Psychological Fitness-For-Duty Evaluations

Where it is suspected that personal traits, disorders, or stress reactions are causing or contributing to an employee's problem behavior, a formal *psychological fitness for duty* (FFD) evaluation may be ordered to (1) determine if the employee is psychologically capable of continuing to fulfill his or her job requirements; (2) if not, then what measures, if any, are recommended to make him or her more effective and able to function up to the standards of the organization; and (3) what kinds of reasonable accommodations, if any, must be in place to permit the employee to work in spite of the residual disabilities. The FFD evaluation thus combines elements of risk management, mental health intervention, labor law, and departmental discipline (Stone, 2000).

For example, under the Americans with Disabilities Act (ADA), for positions that involve public safety workers, such as police, firefighters, and emergency medical personnel, courts have generally tended to afford greater discretion to employers seeking to require a psychological FFD evaluation if there is a potential for that worker's impaired mental state to put the public at risk. This applies as well to medical personnel, transportation workers, security personnel, and those who work with children. One primary factor in such FFD assessments is concern for liability, such as claims of negligent hiring, negligent retention, negligent supervision, and so on; these issues are endemic in the public and private employee sector. However, for most other jobs that don't involve critical safety issues, managers should consult with their business attorneys before ordering any kind of formal psychological examination.

The following will summarize the main points necessary for managers to understand about the basic components of a psychological FFD evaluation (Rostow & Davis, 2004; Stone, 2000).

Identifying data. The employee's name, identifying demographics, departmental referral information, name of the evaluator, and dates of the evaluation.

Reason for evaluation. The main incidents, issues, and referral question(s) that have led the employee to the examining psychologist's office. The focus of the evaluation itself should be specific to the work-related question at hand.

Background information. The information in this section can be narrow or broad but, again, the scope and range of such background data should be defined by their relevance to the referral question(s). For example, conflicts with previous employers may be relevant; history of marital infidelity may not.

Clinical interview and behavioral observations. As with all clinical evaluations, much useful information can be gleaned about a subject from a good clinical interview. How the subject answers questions and how he or she generally behaves is just as important as what he or she says.

Review of records. Depending on the individual case, the volume of pertinent records can range from a few sheets to literally cartons of documents. The psychologist's challenge is to distill this raw data in order to summarize the main points necessary to form a conclusion.

Psychological test findings. Not all FFD evaluations will include psychometric tests but, where they do, the measures administered should be relevant to the job-related question being asked. Usually, the basic areas covered include: general intelligence; cognitive functioning (attention, concentration, memory, reasoning); personality functioning; assessment of mood; and screening for psychotic symptoms.

Conclusions and discussion. This section should be a succinct summary of the main points relevant to the FFD question(s), with documentation of the psychologist's reasoning on each point. For example:

“Psychological test findings are essentially within normal limits, with the exception of a tendency to disregard rules and conventions and to responding impulsively under stress. This is supported by the employee's statement that ‘If I know the policy is wrong, it's my responsibility to do it the right way.’ This is further corroborated by records indicating three prior disciplinary actions in his present

department, and at least one prior suspension in his previous job.

“Overall findings are consistent with an employee of average intelligence, no major mental disorder, high ability and skill in certain job-related areas (financial figures and spread sheets), but with a long-standing tendency to disobey authority and respond impulsively, but not violently, under conditions of stress.”

Recommendations. This is perhaps the most challenging section of the report, because here the psychologist has to boil the findings down to specific recommendations that the manager can understand and utilize and that may affect this employee's entire career. There are several possible outcomes to an FFD evaluation (Rostow & Davis, 2004; Stone, 2000):

Unfit for duty. The employee is unfit for duty and is not likely to become fit in the foreseeable future, with or without psychological treatment. Examples include the effects of a traumatic brain injury, a longstanding severe personality disorder, or a substance abuse problem that continues to get worse.

Unfit but treatable. The employee is currently unfit, but the problems appear to be amenable to treatment that will restore him or her to fitness in a reasonable amount of time. For example, a depressed, alcoholic employee agrees to enter a 12-step abstinence program, attend psychotherapy sessions, and take prescribed antidepressant medication as needed. Following the recommended course of treatment, the employee will usually be referred for a *post-treatment evaluation* to assess if he or she is now fit to resume his or her duties.

No psychological diagnosis. There is nothing in the results of the psychological FFD evaluation to suggest that the employee's unfitness for duty is related to a psychological disorder or mental health diagnosis per se. In such cases, the employee will usually be referred back for administrative coaching or counseling, further education and training, or disciplinary action.

Invalid evaluation. The employee has failed to cooperate with the evaluation, has not been truthful, and/or has shown malingering or other response manipulation on interview or psychological tests. Again, he or she will usually be referred back to management for further administrative action.

Mental Health Services

One of the purposes of an FFD evaluation is to make recommendations for education, retraining, counseling, or treatment. Unfortunately, referral of employees for mental health services when their job performance has begun to deteriorate is often viewed as punishment within a disciplinary context, rather than as a proactive human resource intervention that might forestall further problems and help contribute to that employee's better job performance and overall health. This is especially likely if the referral for counseling follows a particularly unpleasant and contentious psychological FFD evaluation.

Ideally, the goal of company-referred psychological treatment should be to use the minimum depth and intensity of intervention necessary to restore the employee to her adequate baseline functioning or to modify a pre-existing pattern of problem behavior that interferes with her work role. In some cases, when a certain level of clinical trust and comfort has been established, employees may later opt for further, more extensive individual or family therapy to work on personal issues of special concern to them, once the original departmentally-referred issue has been resolved (Lowman, 1993; Miller, 2008; Quick et al, 1997; Sperry, 1996).

The best use of psychological services is to recommend counseling to troubled employees well before the situation rises to the level of a disciplinary action. Many employees are actually glad to be afforded this option once they have been given the endorsement by a manager to see the psychologist without stigma, especially if they trust that this supervisor has their best interests at heart. As with most recommendations, the more buy-in obtained from the employee, the more likely the process is to be successful.

Termination

Unfortunately, not every problem employee can be salvaged. Despite all reasonable efforts at training, coach-

ing, counseling, psychological services, and constructive discipline, employees who are persistently and uncorrectibly underperforming or misbehaving must be terminated. In some cases, such as theft, vandalism, or violence, formal legal charges may have to be brought. If things have progressed to this point, discipline should be consistent, impartial, immediate, and definitive. The weeding out of the few truly bad employees is a fundamental prerequisite for the ability of the many good employees to serve their companies and the public with skill and dedication (Albrecht, 1996; Friedman et al, 2000; Johnson & Indvik, 2000; Mitroff, 2001; Namie & Namie, 2000). If it comes to that, there are some basic recommendations (Grote, 1995; Labich, 1996; Miller, 1999, 2008, Lerbinger, 1997; Mitroff, 2001; Weitzel, 2004; Yandrick, 1996) that can facilitate the process.

Some authorities believe that the best person to terminate an employee is the manager or supervisor who has had the best overall relationship with the worker. Others recommend that the actual firing be done by a more objective and interpersonally removed higher-up, while the trusted supervisor remains a source of support to ease the transition. However it's done, a termination should always include a systematic process of documentation. The key to effective termination, in both the psychological and legal senses, is to make it as clear as possible to the employee that this action is for a specific reason, rather than for general attitude problems or personal beefs. This should be clearly reviewed and documented in writing.

In an uncomplicated, or "cool" termination, your company's own policies may dictate a variety of actions, including the opportunity for the employee to complete certain work projects, receive severance pay, or get insurance benefit protection for a specified time period. In an adversarial, or "hot" termination, the disturbed or disgruntled employee may have to be asked to leave immediately. He or she may have to be escorted off the premises by company security or police. Managers should not give the terminated worker time to stew, either by delaying the inevitable or allowing him or her to hang around and poison the workplace atmosphere with negative talk or dangerous behavior.

Termination should be done at the beginning or end of the shift. Most companies have a policy of not allowing terminated employees access to the premises without escort. Companies should have a strict ID policy in place and be prepared to enforce it. Even in this post-September 11 world, it is surprising how lax some organizations are with regard to

security, especially with people they've known in the past. Again, the employee should be treated to reasonable privacy and respect, but should understand in no uncertain terms – by the presence of security or police if necessary – that the termination action is final and will be backed up. He or she should also be informed of any counseling or other services offered by the company for the transition period. Providing continued medical and mental health benefits to help the fired employee over the hump is not just the humane thing to do, but may be an important measure in quelling revenge fantasies that could potentially lead to a violent confrontation.

In general, the least adversarial, embarrassing, and disruptive method for terminating the employee should be used. Law enforcement officers trained in verbal negotiation and conflict resolution strategies understand how much cooperation can be elicited from a seemingly hostile subject just by treating him or her in the proper manner: firm but fair, no abuse but no nonsense – the difference between *authoritative* and *authoritarian*, i.e. Sheriff Andy Taylor versus Deputy Barney Fife (Miller, 2006). If cops can do it, so can managers. It's distressing to observe how a clumsy, heavy-handed, gratuitously nasty, and unnecessarily humiliating approach can turn an otherwise malleable situation into a violent explosion – or ruinous lawsuit.

After a termination, the remaining employees will usually want to know what happened. On an individual basis, company representatives should make themselves available to anyone who would like to sit down and discuss in general terms why the terminated employee is no longer with the company. In particularly controversial or high-profile cases, management should issue a company-wide memo explaining the gist of what happened and why the actions were taken. It's not management's obligation to offer rationalizations or justifications as to why a problem employee was terminated, and the purpose of this informational briefing is certainly not to violate basic privacy or to gossip about the terminated employee, but to use the opportunity as an educative experience to inculcate company policies and procedures. Company spokespersons should address comments to the concerns voiced by the remaining staff about their own roles and responsibilities, and lay the groundwork for more effective communication in the future:

“You've all been oriented to our policy on workplace harassment and violence. When an employee consistently violates those policies

and has not been responsive to our efforts to correct it, we have no choice but to let him or her go.”

Managers will want to consult with their legal departments about how much information they can provide, but it is important that management control wild rumors and let the remaining personnel know that, if they have a problem with another employee or supervisor, they can bring it up without fear of recrimination from their bosses.

Conclusions: The Role of Administration, Management, and Leadership

Most employees know when they are being treated fairly and when they are not. As noted earlier, to fully address the problem of employee misconduct and poor performance, it must be treated as a system-wide problem that includes departmental administrative policies as well as individual elements of the human resource system described in this paper, namely, selection, training, supervision, coaching, counseling, discipline, and access to mental health services when needed. These elements should ideally be integrated into a structure that maximizes their impact on the individual employee and on the organization overall.

Consistent with the leadership literature from management psychology (Buckingham, 2005; Collins, 2001; Flin, 1996; Le Storti, 2003; Miller, 2006a, 2008; Sewell, 1992), integrity begins at the top. In this view, the most important factor for prevention of misconduct in an organization is a leader who is mature, seasoned, stable, utilizes cognitively flexible thinking, and has personal integrity and a strong personal ethic. Company leaders who set a strong, positive tone for their agencies and back it up with firm and fair action, should be able to expect an organization they can be proud of.

REFERENCES

- Albrecht, S. (1996). *Crisis management for corporate self-defense*. New York: Amacom.
- Anderson, L.M. & Pearson, C.M. (1999). Tit for tat: The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24, 452-471.
- Blustein, D.L. (2006). *The psychology of working: A new perspective for career development, counseling, and public policy*. Mahwah, NJ: Erlbaum.

- Blythe, B.T. (2002). *Blindsided: A manager's guide to catastrophic incidents in the workplace*. New York: Portfolio.
- Buckingham, M. (2005). What great managers do. *Harvard Business Review*, March, 70-79.
- Casciaro, T & Lobo, M.S. (2005). Competent jerks, lovable fools, and the formation of social networks. *Harvard Business Review*, June, 92-99.
- Collins, J. (2001). *Good to great: Why some companies make the leap...and others don't*. New York: Harper Business.
- Einarsen, S. (1999). The nature and causes of bullying at work. *International Journal of Manpower*, 20, 16-27.
- Engel, R.S. (2002). Patrol officer supervision in the community policing era. *Journal of Criminal Justice*, 30, 51-64.
- Ferris, G.R., Perrewe, P.L., Anthony, W.P. & Gilmore, D.C. (2000). Political skill at work. *Organizational Dynamics*, 28, 25-37.
- Flannery, R.B. (1995). *Violence in the workplace*. New York: Crossroad.
- Flin, R. (1996). *Sitting in the hot seat: Leaders and teams for critical incident management*. New York: Wiley.
- Friedman, R.A., Tidd, S.T., Currall, S.C. & Tsai, J.T. (2000). What goes around comes around: The impact of personal conflict style on work conflict and stress. *International Journal of Conflict Management*, 11, 32-55.
- Garner, G.W. (1995). *Common sense police supervision: A how-to manual for the first-line responder* (2nd ed). Springfield, IL: Charles C Thomas.
- Grote, D. (1995). *Discipline without punishment: The proven strategy that turns problem employees into superior performers*. New York: Amacom.
- Johnson, P.R. & Indvik, J. (2000). Rebels, criticizers, backstabbers, and busybodies: Anger and aggression at work. *Public Personnel Management*, 29, 165-173.
- Kidwell, R.E. & Martin, C.L. (Eds.) (2005). *Managing organizational deviance*. Thousand Oaks, CA: Sage.
- Kinney, J.A. (1995). *Violence at work: How to make your company safer for employees and customers*. Englewood Cliffs, NJ: Prentice Hall.
- Labich, K. (1996). How to fire people and still sleep at night. *Fortune*, June, 65-72.
- Labig, C.E. (1995). *Preventing violence in the workplace*. New York: Amacom.
- Lax, D.A. & Sebenius, J.K. (1986). *The manager as negotiator*. New York: Free Press.
- Lerbinger, O. (1997). *The crisis manager: Facing risk and responsibility*. Mahwah, NJ: Erlbaum.
- Le Storti, A.J. (2003). *When you're asked to do the impossible: Principles of business teamwork and leadership from the U.S. Army's elite Rangers*. Guilford: Lyons Press.
- Lowman, R.L. (1993). *Counseling and psychotherapy of work dysfunctions*. Washington DC: American Psychological Association.
- Miller, L. (1999). Workplace violence: Prevention, response, and recovery. *Psychotherapy*, 36, 160-169.
- Miller, L. (2001a). Workplace violence and psychological trauma: Clinical disability, legal liability, and corporate policy. Part I. *NeuroLaw Letter*, 11, 1-5.
- Miller, L. (2001b). Workplace violence and psychological trauma: Clinical disability, legal liability, and corporate policy. Part II. *NeuroLaw Letter*, 11, 7-13.
- Miller, L. (2002). How safe is your job? The threat of workplace violence. *USA Today Magazine*, March, 52-54.
- Miller, L. (2003). Personalities at work: Understanding and managing human nature on the job. *Public Personnel Management*, 32, 419-433.
- Miller, L. (2005). Command leadership under fire. *Law and Order*, June, 26.
- Miller, L. (2006a). Psychological principles and practices for superior law enforcement leadership. *The Police Chief*, October, 160-168.
- Miller, L. (2006b). *Practical police psychology: Stress management and crisis intervention for law enforcement*. Springfield, IL: Charles C Thomas.
- Miller, L. (2008). *From difficult to disturbed: Understanding and managing dysfunctional employees*. New York: Amacom.
- Mitroff, I.I. (2001). *Managing crises before they happen: What every executive manager needs to know about crisis management*. New York: Amacom.
- Namie, G. & Namie, R. (2000). *The bully at work: What you can do to stop the hurt and reclaim your dignity on the job*. Naperville, IL: Sourcebooks.
- O'Reilly, C.A. & Pfeffer, J. (2000). *Hidden value: How great companies achieve extraordinary results with ordinary people*. Boston: Harvard Business School Press.

- Peak, K.J., Gaines, L.K. & Glensor, R.W. (2004). *Police supervision and management in the era of community policing* (2nd ed.). Upper Saddle River: Prentice-Hall.
- Perrewe, P.L., Ferris, G.R., Frink, D.D. & Anthony, W.P. (2000). Political skill: An antidote for workplace stressors. *Academy of Management Executive*, 14, 115-123.
- Pfeffer, J. & Sutton, R.I. (2006). *Hard facts, dangerous half-truths, and total nonsense: Profiting from evidence-based management*. Boston: Harvard Business School Press.
- Quick, J.C., Quick, J.D., Nelson, D.L. & Hurrell, J.J. (1997). *Preventive stress management in organizations*. Washington DC: American Psychological Association.
- Roberts, B.W. & Hogan, R. (Eds.) (2001). *Personality psychology in the workplace*. Washington DC: American Psychological Association.
- Robinette, H.M. (1987). *Burnout in blue: Managing the police marginal performer*. New York: Praeger.
- Rostow, C.D. & Davis, R.D. (2004). *A handbook for psychological fitness-for-duty evaluations in law enforcement*. New York: Haworth.
- Serpas, R.W., Olson, J.W. & Jones, B.D. (2003). An employee disciplinary system that makes sense. *The Police Chief*, September, 22-28.
- Sewell, J.D. (1992). The law enforcement executive: A formula for success. *FBI Law Enforcement Bulletin*, April, 22-26.
- Sperry, L. (1996). *Corporate therapy and consulting*. New York: Brunner/Mazel.
- Stone, A.V. (2000). *Fitness for duty: Principles, methods, and legal issues*. Boca Raton: CRC Press.
- Stone, F.M. (2007). *Coaching, counseling, and mentoring: How to choose and use the right technique to boost employee performance* (rev. ed.). New York: Amacom.
- Thibault, E.A., Lynch, L.M., McBride, R.B. & McBride, B.R. (2004). *Proactive police management*. Upper Saddle River: Prentice-Hall.
- Weisinger, H. (2000). *The power of positive criticism*. New York: Amacom.
- Weitzel, T.Q. (2004). Managing the problem employee: A road map for success. *FBI Law Enforcement Bulletin*, November, 25-32.
- Yandrick, R.M. (1996). *Behavioral risk management: How to avoid preventable losses from mental health problems in the workplace*. San Francisco, CA: Jossey-Bass.

Submitted December 12, 2010

Accepted December 17, 2010

Elearn1 productions and Dr. Jeff Mitchell have developed a variety of new video based training programs on critical incident stress management. Go to www.DrJeffMitchell.com to view DVD samples and purchase online.

FEATURED DVD:

Critical Incident Stress Management Strategic Planning On the Street!

An intense training program featuring Dr. Jeff Mitchell discussing why good CISM is based on a strategic plan, and how to create that plan.

Three scenarios are accompanied by questions for discussion.

The program opens with suggestions on training applications for team leaders.



ALSO AVAILABLE:

Crisis Management Briefing

Dr. Jeff Mitchell offers information about the nature and uses of a CMB, and then conducts a demonstration with a group of traumatized employees in a business setting.

Debriefing

Dr. Mitchell explains the rationale for using a CISD and describes, in detail, the seven steps in the process. Following a Crisis Management Briefing demonstration, he leads a traumatized group of business executives through a CISD.

Lessons From Experience

In this series, CISM professionals share their experiences and lessons with Dr. Jeff Mitchell. Program One concentrates on working with schools and working in circumstances where the event is separated from the intervention.

Defusing

Dr. Jeff Mitchell describes the defusing process and its benefits. Following a crisis management briefing, he conducts a demonstration of a defusing with a small group of business executives.

Each program includes study questions that can be used for discussions among CISM team members.

Selected Annotated Journal Resources

Justin Chen, M.S. and Rebecca Fall, M.S.

Maguen, S., Vogt, D. S., King, D. W., Litz, B. T., Knight, S. J., & Marmar, C. R. (2010). The impact of killing on mental health symptoms in gulf war veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. Doi: 10.1037/a0019897

TYPE OF ARTICLE

- Original empirical investigation

OBJECTIVE/PURPOSE OF THE STUDY

- To examine the relations among killing and post-deployment mental health issues, such as posttraumatic stress disorder symptoms, alcohol use, and depression in Gulf War veterans, after controlling for perceived danger, exposure to death and dying, and witnessed killing.

METHODS

Participants

- The total sample consisted of 495 veterans identified from the Defense Manpower Data Center and a national registry of Gulf War veterans.
- Of the sample, 317 veterans met the inclusion criteria, which were that the participants had to be Gulf War veterans who responded to a question about killing in the war zone.
- These 317 participants were assessed for posttraumatic stress symptoms.
- Additionally, 158 participants were randomly selected and asked to also complete depression and alcohol questionnaires.

Materials

- A self-report demographic questionnaire was used to collect information on age, gender, race, education status, and marital status.
- There were four screening questions, which each pertained to a particular component of the war zone experience: a) perceived danger b) exposure to death and dying, witnessing the killing of a fellow soldier and d) killing. Exposure to death and dying, witnessing the killing of a fellow soldier, and killing were all assessed by dichotomous items, while perceived danger was evaluated using a five-point Likert-type scale.
- Posttraumatic Stress Symptoms (PTSS) were assessed using the PTSD Checklist, Military Version.
- Depression symptoms were assessed using an adapted version of the Beck Depression Inventory-Primary Care (BDI-PC). Unlike the original BDI, the adapted version used for this study employed a five-point Likert-type..
- Alcohol use was assessed using two separate measures: a) the CAGE questionnaire and b) an index of frequency and quantity of alcohol use. The index of frequency and quantity of alcohol use consisted of two questions: a) “In the past three months how often have you had a drink containing alcohol?” with responses rated on a five-point scale ranging from never to four or more times a week and b) “In the past three months, how many drinks containing alcohol have you had on a typical day when you were drinking?” with responses rated on a five-point scale ranging from none to seven or more.

Procedure

- Veterans who were identified from the Defense Manpower Data center and a national registry of Gulf War

veterans were asked to complete a survey package containing a collection of stressor and health outcome measures.

- Participants who completed the surveys and questionnaires, particularly an item regarding killing in a war zone, were included in the study.
- Depression and alcohol questionnaires were randomly distributed to half of the participants “to reduce [the] time burden on participants while still retaining a broad array of measures.
- Participants who achieved a score of 50 or greater on the PTSD Checklist, Military Version were considered a positive screen for PTSD.
- Participants who achieved a score of four or greater on the BDI-PC were considered a positive screen for depression.
- The product of participants’ responses to the index of alcohol frequency and quantity were used in a multiple regression equation indexing alcohol use.
- Participants who responded positively to at least one question on the CAGE were considered a positive screen for problematic alcohol use, given that there is a precedent for using lower thresholds on military populations.

RESULTS

- Of the sample, 46% reported perceiving danger during their deployment, 42% reported exposure to death and dying, 19% reported witnessing killing of a fellow soldier, and 11% reported killing in combat.
- Of the participants, 20% met the threshold screening criteria for PTSS, 45% met the threshold screening criteria for depression, and 6% met the screening criteria for current problem alcohol use.
- The predictive factors of PTSS were found to be older age, ethnic minority status, lower education, perceived danger, exposure to death and dying, and reported killing, which remained significant even after controlling for perceived danger, exposure to death, and witnessing killing.
- The predictive factors of depression symptoms were found to be perceived danger, being single, and exposure to death and dying. Reported killing was not found to be a significant predictor of depression symptoms.
- After controlling for prior problem drinking, reported killing was found to be the only predictor of current problematic alcohol use.

CONCLUSIONS/SUMMARY

- Results indicate that killing in combat was a significant predictor of PTSS and problematic alcohol use in Gulf War veterans.
- Furthermore, the study reports that of the variables examined, killing in a war zone is the only significant predictor for alcohol use.
- The study suggests that a feeling of invincibility as a result of killing could lead to increased high risk behaviors, including increased alcohol use.
- One limitation of this study is that it was retrospective; thus a recall bias could have occurred.
- A second limitation is that the study was conducted on American Gulf War veterans, so its external validity is limited.
- A third limitation is that the sample was not necessarily a representative population of Gulf War veterans.
- A fourth limitation is that the measures employed in this study were self-report and used for screening rather than as diagnostic instruments.

CONTRIBUTIONS/IMPLICATIONS

- A comprehensive evaluation of veterans returning from combat should include an assessment of killing experiences as well as reactions to killing, precursors to killing, and perceived dangers, as these were all found to be risk factors for the development of PTSS and other mental health problems.

Wilcox, S. (2010). Social relationships and PTSD symptomatology in combat veterans. *Psychological Trauma: Theory, Research, Practice, and Policy* 2(3), 175-182.

TYPE OF ARTICLE

- Original Empirical Investigation.

OBJECTIVE/PURPOSE OF THE ARTICLE

- To contribute to the understanding of the underlying mechanisms of social support.
- To provide insight into how social support operates for combat veterans who exhibit some degree of PTSD symptomatology.

METHODS

Participants

- The participants were 83 married male Army combat veterans stationed at mid-Atlantic military bases.
- Female combat veterans were not excluded from the study, but rather elected not to participate.
- Of the 83 participants, 86.75% were White, 10.84% were Black, and 2.41% were of other racial background.
- The participants ages ranged from 19-38 years and all had served in a war for the United States in the past seven years.
- All participants were married during the time of participation and marriage length ranged from 3 – 84 months.
- Although combat veterans without PTSD symptoms were not excluded from the study, all participants exhibited some degree of PTSD symptomatology.

Materials

- Multidimensional Scale of Perceived Social Support (MSPSS) was used to assess the perceived social support of the participants from family, friends, and significant others. The measure was modified to also include a fourth dimension: perceived social support from military peers.
- The PTSD Checklist, Military Version (PCL-M) was used to assess the participants' PTSD symptomatology.

Procedure

- Participants were recruited from communities near military bases through flyers and referral by other research participants.
- Of the 112 individuals who expressed interest in the study, 83 individuals responded with complete data.
- Participants who scored at least 50 on the PCL-M and were classified to the “high PTSD” symptomatology group, while participants who achieved a score below 50 on the PCL-M were placed in the “low PTSD” symptomatology group.
- Principal-axis factor analysis was performed to analyze the factors derived from the collected data.
- The eigenvalue-one procedure was performed to determine the number of factors that should be retained, and suggested that four factors should be extracted.

- An equamax rotation with four factors was performed to determine the weight of the four factors.
- One-way analysis of variance (ANOVA) was conducted on each of the four factors to differentiate among sub-groups of social support.
- ANOVA was performed on the combined factors to determine the ability of the Global Score to differentiate among diagnostic groups.

RESULTS

- Thirty-five participants reported high levels of PTSD symptomatology and classified in the “high PTSD” group, while the remaining forty-eight participants were classified in the “low PTSD” group.
- All participants exhibited some degree of PTSD symptomatology, as indicated by a score above 17 on the PCL-M.

CONCLUSIONS/SUMMARY

- The results from the analyses suggested that combat veterans differentiate between distinct sources of social support from family, friends, significant other, and military peers, rather than one all-inclusive global construct of social support.
- The study also suggested the possibility that among the four types of social support, support from friends produced less of an impact on combat veterans' PTSD symptomatology than the other factors. However, since all the participants were married, it is possible that they spend more time with their families and hold their families' support in higher esteem than their friends. The study also did not differentiate between military friends and non-military friends, which should be explored further in subsequent studies.
- One possible limitation of the study was its relatively small sample size.

CONTRIBUTIONS/IMPLICATIONS

- Latent factors within the veteran's social supports, including friends, significant others, and military peers, seem to buffer against PTSD symptomatology.
- Future research could focus on social support for combat veterans in the prevention and treatment of PTSD symptomatology.

Meis, L. A., Barry, R. A., Kehle, S. M., Erbes, C. R., & Polusny, M. A. (2010). Relationship adjustment, PTSD symptoms, and treatment utilization among coupled National Guard soldiers deployed in Iraq. *Journal of Family Psychology, 24(5), 560-567.*

TYPE OF ARTICLE

- Original Empirical Investigation.

OBJECTIVE/PURPOSE OF THE STUDY

- To examine the role of PTSD symptoms, relationship adjustment, and their interplay in predicting mental health service use among returning veterans.

METHODS

Participants

- A sample of 223 Minnesota National Guard soldiers was drawn from a larger longitudinal project examining risk and resilience.
- Inclusion criteria for this study were that the soldiers had to be married or involved in a romantic relationship for more than six months at the outset of the study (Time 1), had to have returned from serving in Operation Iraqi Freedom within the past two to three months, and had to have completed the Time 1 and Time 2 surveys.
- The average age of the participants was 33.74 years ($SD = 8.66$), 89.7% were male, 93.7% were Caucasian, 88.1% had greater than a high school education, 83.4% were enlisted, 90% reporting engagement in combat patrol/missions, and 93.2% noted receiving hostile incoming fire.

Materials

- Participants completed self-report demographics surveys regarding their age, sex, employment status, education level, relationship status, living situation, and enlistment status
- The Abbreviated Dyadic Adjustment Scale (ADAS), the Navy Quality of Life Survey Marriage/Intimate Relationship Satisfaction scale (NQOLS-MIRS), and the Navy Quality of Life Survey Relationship Satisfaction Survey (NQOLS-SAT) were used to measure relationship adjustment.
- The PTSD Checklist (PCL) was used to measure PTSD symptoms among participants.

- Mental health service utilization was measured using items adapted from earlier work with Operation Enduring Freedom and Operation Iraqi Freedom veterans. Participants were asked about the utilization of various types of mental health services within the past year, such as medications, individual counseling, group counseling, marriage or family counseling, and chemical dependency treatment.

Procedure

- Approximately two to three months after the participants returned from deployment (Time 1), they were mailed self-report surveys using multiple mailings and a \$50 incentive.
- Twelve months later (Time 2) the same self-report surveys were mailed to the participants using multiple mailings and a \$50 incentive.
- In order to prevent bias toward participants who remained in relationships at Time 2, all participants who filled out the Time 2 survey were included in the study regardless of their relationship status at Time 2.
- The researchers averaged the participants' standardized scores on the ADAS, NQOLS-MIRS, and NQOLS-SAT in order to reduce the number of comparisons and create a more reliable index of relationship adjustment indices.
- Two hierarchical and logistic regression analyses were then performed to examine how symptoms of PTSD and relationship adjustment assessed at Time 1 independently and jointly predicted individual-orientated mental health treatment utilization or use of any couple/family services as assessed at Time 2.
- Logistic regressions were performed to test interactions such as 1) the relation between PTSD symptoms and individual-oriented treatment use at low, medium, and high levels of relationship adjustment and 2) the relation between relationship adjustment and use of any couple/family services at low, medium and high levels of PTSD symptom severity. The low, medium, and high values were calculated by adding or subtracting one standard deviation from the centered variable.

RESULTS

- Of the sample, 64.1% reported use of an individual-oriented mental health service, while 28.7% reported utilizing couple or family therapy.
- Participants with lower relationship adjustment and

greater PTSD symptom severity were associated with greater utilization of individual-oriented mental health services.

- Participants with poorer relationship adjustment were significantly associated with the seeking of couples/family-oriented mental health services.
- The severity of PTSD symptoms was not significantly correlated with family-oriented mental health service utilization. However, severity of PTSD symptoms was significantly associated with greater odds of individual-oriented mental health service utilization.
- The odds of using individual-oriented treatment increased with greater relationship adjustment.
- A significant association between poorer relationship adjustment and utilization of family/couples treatments was found only when low severity PTSD symptoms were reported.

CONCLUSIONS/SUMMARY

- Among National Guard soldiers deployed to Operation Iraqi Freedom, PTSD symptom severity uniquely predicted greater odds of obtaining individual-oriented services, above and beyond the status of their relationship adjustment, which the authors noted is consistent with previous research
- A significant interaction was found where as relationship adjustment improved, the association between PTSD symptom severity and the odds of obtaining individual-oriented mental health services increased. This interaction was in direct contrast to the expectations of the study, but consistent with the idea that highly supportive intimate relationships are more likely to encourage the use of mental health services when they are necessary.
- Neither PTSD symptom severity nor relationship distress predicted couple/family-oriented services; however, when considered together, a strong association was found between poorer relationship adjustment and the seeking of couples/family-oriented therapy at low levels of PTSD symptomatology. These associations were not found at higher levels of PTSD, leading the authors to postulate that PTSD symptomatology impedes receipt of family-oriented care.
- One limitation to the study is that the sample was mostly White, male, National Guard soldiers from the Midwest, which limits the generalizability of the findings across other populations.

- A second limitation is that this study relied on self-report surveys, and did not assess (Justin, is this correct?) the significant others' perception of the relationship adjustment.
- A third limitation of the study is that there were a number of demographic differences between responders and non-responders to the Time 1 mailings, which may have influenced the results..
- A fourth limitation to the study is that it relies on soldiers reports of obtaining mental health services and did not assess whether a failure to utilize services was due to disinterest or inability to access them.

CONTRIBUTIONS/IMPLICATIONS

- For returning veterans, involving partners and families in veterans' care for PTSD symptoms seems vital to promoting a more comprehensive care system that will not end once the veterans leave treatment.

Marshall, A. D., Martin, E. K., Warfield, G. A., Doron-Lamarca, S., Niles, B.L., & Taft, C. T. (2010). The impact of antisocial personality characteristics on anger management treatment for veterans with PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy*, 2(3), 224-231.

TYPE OF ARTICLE

- Original empirical investigation.

OBJECTIVE/PURPOSE OF THE STUDY

- To examine the impact of antisocial personality characteristics on effectiveness of cognitive-behavioral anger management group treatment (AMGT).

METHODS

Participants

- Participants were 86 male veterans obtained through the Behavioral Science Division of the National Center for PTSD, VA Boston Healthcare System, or the affiliated VA outpatient clinic.
- All participants were diagnosed with PTSD using the Clinician Administered PTSD Scale and supporting evidence was gathered through self-report measures of PTSD, including the PTSD Checklist.

- The majority of participants were Caucasian (83%); however, the sample included African American (15%), and “other” (2%).
- The participants’ average age was 55 years (range 22–76 years) and the majority of the sample was married (49%) or divorced (27%).
- Data were collected from 1997 to 2006, with most participants who served during the Vietnam era (76%), the Korean War (7%), World War II (7%), Operation Desert Storm (3%), and other conflicts (7%).

Materials

- The screening included the State-Trait Anger Expression Inventory (STAXI), which measures the primary components of anger.
- The Conflict Tactics Scale (CTS) was used in a modified format to assess physically aggressive behaviors against any person.
- The Minnesota Multiphasic Inventory II, Antisocial Practices Scale (MMPI-II ASP) was used to assess antisocial personality characteristics.

Procedure

- Participants first completed a comprehensive assessment.
- Following the assessment, participants enrolled in a series of group interventions prior to enrolling in a manualized cognitive-behavioral anger management group treatment (AMGT).
- Some participants engaged in individual psychotherapy or psychopharmacological treatment concurrent with AMGT.
- Treatment groups met for 90 minutes once per week for 12 weeks.
- Participants completed self-report measures of anger and aggression during the first and last sessions of AMGT.

RESULTS

- Nearly all subscales of the STAXI (i.e., State Anger, Trait Anger, and Anger Expression) were significantly intercorrelated within and across pre- and posttreatment assessments.
- The only exception on the STAXI pattern was that post-treatment state anger did not correlate significantly with pretreatment trait anger and pretreatment anger expression.

- The MMPI-II ASP content scale did not correlate significantly with trait anger at pre- or posttreatment, but did correlate significantly with trait anger and anger expression at both pre- and posttreatment.
- Correlations between the MMPI-II ASP content scale and physical aggression pre- and posttreatment approached statistical significance.
- Participants reported a significant decrease in physical aggression, with a medium effect size, representing an average of 1.24 fewer types of physically aggressive acts perpetrated during the 3 months of treatment.
- Antisocial personality characteristics were significantly associated with smaller decreases in trait anger and physical aggression during treatment.
- Antisocial personality characteristics were significantly associated with smaller decreases in anger expression, but this association was represented by a medium effect size.

CONCLUSIONS/SUMMARY

- Over the 12-session cognitive-behavioral AMGT, the sample of veterans reported small to medium reductions in state and trait anger, and small (but statistically nonsignificant) reductions in anger expression.
- The results cautiously suggest cognitive-behavioral AMGT may be effective in the reduction of physical aggression.
- It is possible that the observed decreases in anger and aggression will serve to preserve social supports that can provide additional therapeutic benefits over time.
- Higher levels of antisocial personality characteristics were related to less reduction in trait anger and physical aggression during AMGT.

CONTRIBUTIONS/IMPLICATIONS

- This study is unique in looking at antisocial personality characteristics as a potential predictor of treatment resistance.
- The association between antisocial personality characteristics and greater decrease in state anger during AMGT represents diminished engagement in the therapy process among those high in antisocial personality characteristics.
- The findings raise a need for further evaluation of the role of anger during therapy with PTSD patients and questions research and theory suggestions that anger is

used by individuals with PTSD to avoid the anxiety and fear that arises during treatment.

- Anger and PTSD have been found to lead to diminished social support over time; therefore it is proposed that the use of physical aggression may mediate the relation, especially because the deterioration of social support has reciprocal consequences for PTSD symptoms.
- An alternative interpretation to the study's findings may be that the observed decreases in anger and aggression are due to regression to the mean effects.
- A second alternative interpretation is that the observed decreases in anger and aggression may be due to participant demand characteristics. More specifically, a veteran high in antisocial personality characteristics may be less motivated to report changes in anger and aggression due to lower levels of social desirability, etc.
- Another limitation of the study may be its internal validity. In particular, since some participants completed individual psychotherapy or psychotropic medication management concurrent with AMGT this may have influenced the study results.

Brenner, L. A., Terrio, H., Homaifar, B. Y., Gutierrez, P. M., Staves, P. M., Harwood, J., E. F., Reeves, D., Adler, L. E., Ivins, B. J., Helmick, K., & Warden, D. (2010). Neuropsychological test performance in soldiers with blast-related mild TBI. *Neuropsychology*, 24(2), 160-167. doi:10.1037/a0017966.

TYPE OF ARTICLE

- Original Empirical Investigation.

OBJECTIVE/PURPOSE OF THE ARTICLE

- To increase understanding of neuropsychological test performance in those with blast-related mild traumatic brain injury (mTBI).
- To assess the impact of mTBI symptoms and history of posttraumatic stress disorder (PTSD) on test performance.

METHODS

Participants

- A sample of 45 soldiers were used, all of whom had a history of blast exposure with alteration of or loss of consciousness (LOC).

- Of the participants, 40.75% with mTBI symptoms and 77.78% without mTBI symptoms had a history of one blast-related TBI.
- Of the sample, 20% of participants had a history of two or more blast-related TBIs.
- The median age range is 24 years of age, 98% were male, 73% identified as white; 27% identified as other.
- PTSD was present in 38% of participants.

Materials

- Soldiers completed the Warrior Administered Retrospective Casualty Assessment Tool (WARCAT), a questionnaire based on the Brief Trauma Brain Injury Screen (BTBIS) which assesses injuries, mental status, or symptoms associated with TBI.
- To assess cognitive domains, a wide range of measures used in clinical practice were administered and the scores were corrected using the following norms: PASAT and Trails A and B; Rey Auditory Verbal Learning Test (RAVLT); Stroop Color and Word Test; Wisconsin Card Sorting Test Computerized Version 4 (WCST 4).
- Participants also completed the Symbol Digit Modalities Test (SDMT).
- Additionally, participants completed the Neurobehavioral Evaluation System 3 (NES 3) and the Palm Handheld Personal Digital Assistant-administered version of the Automated Neuropsychological Assessment Metrics (ANAM), BrainCheckers Combat Stress Assessment (CSA).
- The ANAM-CSA contained an emotional Stroop test, where participants were asked to react to emotionally laden words that were expected to elicit a response secondary to Operation Iraqi Freedom (OIF) deployment experiences (e.g., kill).
- The MINI-International Neuropsychiatric Interview, a structured diagnostic interview used to assess 17 Axis-I disorders using the DSM-IV and ICD-10 criteria, was also used.

Procedure

- Returning military personnel completed questionnaires during the postdeployment health assessment (PDHA) and postdeployment health reassessment (PDHRA) processes to gather information about present health status and deployment-related exposure to numerous

illness-producing risk factors, such as combat stress and environmental hazards.

- Prior to the neuropsychological measures being administered, the Computerized Assessment of Response Bias (CARB) was given to ensure that participants were putting forth good effort. Participants then completed the WARCAT.
- Collateral information from “battle buddies” was obtained when possible.
- Exclusion criteria were assessed.
- All tests were completed in one day.
- Individuals who administered the protocol were members of a civilian research team with graduate degrees in psychology or psychiatric nursing, and received supervision from the first author.

RESULTS

- Performance on accurate and complex computerized tests (i.e., NES 3, ANAM-CSA) did not differ between those with and without mTBI symptoms.
- In the sample, 22% of soldiers who endorsed TBI sequelae did not meet criteria for a current mental health diagnosis or PTSD.
- Roughly 60% of participants with a history of mTBI symptoms, versus roughly 20% of those without symptoms, reported multiple-blast-related mTBI exposures.
- Findings suggest differences in mTBI symptom reporting based on military rank, such that fewer higher enlisted individuals reported sequelae.
- There are significant differences in years of education between participants with mTBI and PTSD and those with mTBI and no PTSD.

CONCLUSIONS/SUMMARY

- Neither history of mTBI symptoms nor PTSD impacted test performance.
- Results from the standard neuropsychological tests were not particularly informative in terms of increasing understanding regarding mTBI symptoms or PTSD history.
- Results support the assertion that for some, mTBI symptoms may have no association with a psychiatric diagnosis.
- Results suggest a potential relationship between a history of multiple-blast-related mTBIs and symptom endorsement.

CONTRIBUTIONS/IMPLICATIONS

- Although adjusted p values did not necessarily support previous findings regarding PTSD and neuropsychological functioning in this population with co-occurring mTBI, large effect sizes suggest that further study in this area is indicated.
- Increased understanding regarding cognitive functioning in Operation Enduring Freedom (OEF)/OIF veterans may support interventions aimed at facilitating short- and long-term recovery.
- Future research should be aimed at exploring dynamic performance in OEF/OIF veterans with mTBI and with and without PTSD.
- Further research regarding the natural history of mTBI symptoms and co-occurring psychiatric disorders should be conducted.
- Differences in participants’ level of education and PTSD highlight the potential impact of preexisting individual differences in the development of PTSD.
- One limitation of this study is its exploratory nature; therefore, measures with a greater degree of sensitivity to assess for history of PTSD may be warranted.
- Additionally, a replication of this study with a larger sample and the inclusion of additional groups (PTSD only, non-TBI and non-PTSD controls) is recommended.
- Further study is needed to assess potential impairments in those with blast-related mTBI symptoms, with the aim of increasing functional outcomes.

Garcia-Rea, E. A., LePage, J. P. (2010). Effects of Childhood Abuse on Relapse in a Recently Homeless Substance-Dependent Veteran Population. *Psychological Trauma: Theory, Research, and Policy*, 2(3), 201-205.

TYPE OF ARTICLE

- Original Empirical Investigation.

OBJECTIVE/PURPOSE OF THE STUDY

- To evaluate the association between abuse and failure to complete treatment due to substance relapse in a substance-dependent homeless male veteran population.

METHODS

Participants

- A sample of 70 substance-dependent homeless male veterans recruited from the Dallas Domiciliary Residential Rehabilitation and Treatment Program (DRRTP).
- The average age was 48 years.
- The majority of the participants were African American (60.0%); however, the sample included White/Caucasian (35.7%), and other minority groups (4.3%).
- Participants were single (23%), married (6%), separated (23%), divorced (47%), and widowed (1%).
- The majority of the sample had been diagnosed with a mental health diagnosis (67%) other than substance dependence—psychotic disorder (3%), Bipolar I (10%), depression (44%), and PTSD (10%).

Materials

- The comprehensive assessment was administered to collect information on abuse history, including the Addiction Severity Index used to assess aspects of life that may contribute to substance abuse problems.
- The categorization of participants who experienced childhood abuse was based on self-report only due to limited family involvement to corroborate reports.

Procedure

- Veterans were interviewed for childhood histories of sexual and physical abuse upon admission to the Life-styles Study.
- Abuse history was collected using the Addiction Severity Index and review of their medical records.
- Throughout the study, veterans were given random and scheduled urine drug tests and alcohol panels.
- Discharge conditions were reviewed when participants left and were divided into two categories: substance-related discharges and nonsubstance-related discharges.

RESULTS

- Of the sample, 29% reported a history of childhood sexual abuse, and 33% reported a history of childhood physical abuse.
- Of the sample, there was an overlap in the type of abuse, as 19% reported a history of combined physical and sexual abuse, 7% reported sexual abuse only, and 14% reported physical abuse only.

- Of the sample, those with sexual abuse histories also had higher rates of comorbid mental health diagnoses (85%).
- Of the sample, 87% of participants with a history of physical abuse also had a comorbid diagnosis, compared to 51% without physical abuse histories.

CONCLUSIONS/SUMMARY

- Findings suggest that a childhood history of physical abuse, not sexual abuse, is associated with relapse in a homeless psychosocial rehabilitation program.

CONTRIBUTIONS/IMPLICATIONS

- The study suggests that while sexual abuse may account for more long-term problems, these problems may not generalize to unsuccessful completion of rehabilitation or substance recovery programs.
- A potential limitation for this study is the differences in duration, intensity, and frequency of abuse, which was not assessed and may account for the discrepancy between physical and sexual abuse.
- Individual differences of the perpetrator may also contribute to differences in interpretations of the traumatic experience.
- Another limitation of this study is that while the sample is representation of other homeless populations, selection biases for admissions to the studied program may limit generalizability.
- Another limitation of the study is that veterans in the sample may have underreported or overreported levels of abuse; however, according to the authors, levels reported did not significantly differ from previous published studies.
- Lastly, it is not certain that abuse causes in-program relapses because there may be other aspects that both those with a tendency to relapse and those with abuse may share.
- Based on the findings programs should implement services for those with histories of childhood abuse to reduce relapse rates and increase successful completion of treatment programs.
- Programs may benefit from an integrated format, rather than compartmentalizing trauma and substance abuse treatment.
- Programs serving homeless and substance-abusing veteran populations should consider incorporating psy-

choeducation classes that focus on the cycle of violence, victimization, safety issues, and healthy relationships, and should possibly include group or individual therapy focusing on processing the traumatic experiences and normalizing consequences.



Bring ICISF training to your area

*The latest training and education on
Comprehensive Crisis Intervention Systems*

Speakers Bureau Program

- Dynamic speakers
- Avoid travel costs - train your staff at your site
- Highest quality professional programs
- Wide variety of stress, crisis intervention and disaster psychology courses
- Specialized topics to suit your needs
- Keynotes, General Sessions and Breakouts

Host a 2011 Regional Conference

- Earn Scholarships to attend classes
- Choose classes to suit your training needs
- Earn a portion of the conference net profit
- Network with other CISM Practitioners from around the World
- Discuss issues facing you or your team with ICISF faculty & staff

www.ICISF.org or call Terri (410) 750-9600

Handbook of Adult Resilience

Edited by John W. Reich, Alex J. Zautra & John Stuart Hall

New York: Guilford Press, 2010

Reviewed by Laurence Miller, PhD

As researchers and practitioners in the field of emergency mental health, readers of this journal are immersed in the world of stress, and we regularly observe, study, intervene, and treat a variety of stress disorders in our daily practices. However, we can't fail to notice that some individuals seem to be able to push back healthfully against life's adversities, while others fold under far less pressure – that is, people seem to vary widely with regard to the trait of stress resilience. Is this quality a natural gift? Something that can be learned? If so, when and how early should such training begin?

The large size and scope of this *Handbook of Adult Resilience* is justified by its being a one-stop-shopping resource for both researchers and clinicians in the field of stress and stress management. The book begins by emphasizing that resilience is not just a quality that inheres in individual personalities, but that interacts with biological predispositions, ethnic and cultural factors, and relationships to the community. Early chapters discuss the biological foundations of resilience and its opposite – stress vulnerability – and then go on to consider cognitive, emotional, temperamental, and spiritual dimensions of resilience and their role in shaping personality and psychopathology in the context of ethnicity, culture, and community norms.

But does a person who is resilient at one age retain that quality over time? The book goes on to consider resilience across the lifespan, including the role of early childhood and later adult experiences, as well as the broader social environment in shaping resilience to different kinds of adversity. The emerging lesson seems to be that, like intelligence, resilience is not a static, monolithic characteristic. Just as some individuals can be more or less skilled and clever in

math or reading or art, so there may be many different kinds of resilience that are applicable to a variety of challenges, and at different points across the lifespan. The resilience that gets you through the death of a loved one may not be nearly as effective for buffering your reaction to rejection at work, and so on.

For me, the measure of a book like this is the “So-what” factor: How is all this empirical research, theoretical scholarship, and clinical wisdom going to help the boots-on-the-ground practitioner deal with the practical challenges of managing stress in the real world. Happily, the final chapters tackle this subject, describing a variety of formal programs for inculcating, shaping, and reinforcing stress resilience on the individual, group, and community levels. I would have liked to see a chapter on resilience-based individual psychotherapy modalities and perhaps another chapter devoted to critical incident stress. Also, there is a whiff of trendiness detectable in the frequent evocation of the new darlings of stress research: mindfulness, happiness, and transcendent coping. One problem with studying stress in university clinics is that we academic types often assume self-actualization as an entitlement, and are therefore often opaque to the sheer grubbiness of lives eked out around us every day, wherein happiness and transcendence are dreams deferred for basic survival and sustenance.

Overall, *Handbook of Adult Resilience* is a solid work that makes a substantial contribution to the field of stress, coping and resilience. The many references in each chapter will whet the reader's appetite to learn more about how some people do manage to rise above their adversities, and how we can help others aspire to do the same.

Consulting and Advising in Forensic Practice: Empirical and Practical Guidelines

Edited by Carol A. Ireland and Martin J. Fisher
BPS Blackwell and John Wiley & Sons Ltd, 2010, 273 pages

Mental health researchers and practitioners are being utilized in increasing numbers as consultants, advisors and employees of organizations—public and private—that provide forensic services ranging from courtroom to law enforcement, to custodial institutions. *Consultancy and Advising in Forensic Practice: Empirical and Practical Guidelines* edited by Carol Ireland and Martin Fisher addresses the issue of how mental health professionals can best assist these forensic settings. This well conceived book of readings is not for the timid, nor for those consultants—forensic or otherwise—who rely on the latest fads, canned programs or passing banners to substitute for the careful thinking and content knowledge necessary to effective consultation. Ireland and Fisher orchestrate a systematic, conceptually comprehensive, and practical guide for serious practice—one which warrants comment on each chapter.

The book addresses two main themes through 13 chapters. Part I deals with consultancy and advising from a theoretical perspective. Chapter 1 by Carol Ireland presents psychological consultancy as an emerging presence in forensic settings, both in the sense of expanding numbers and also in the sense of diversity of roles. More important is her discussion of the changing and fluid nature of the consultancy as a product of the consultant's sensitivity to organizational needs combined with the increasing trust and perception of the usefulness of the individual consultant in the eyes of the organization. This discussion is expanded by Ireland in her Chapter 2 where she provides a good discussion of the key stages and complex issues of stakeholders, organizational boundaries and culture. She provides a nice balance between conceptual organizers and concrete suggestions for working with real organizations. This discussion points out the dynamics of consultation and honors the changing and evolving relationship between consultant and client over time.

Of particular interest to this reviewer is David Vickers, Eliza Morgan and Alice Moore's Chapter 3 discussion relating Theoretically Driven Training and Consultancy, later elaborated in Chapter 11. As a consultant who provides considerable training (as well as being a researcher and educator), I was delighted to find these chapters nudging into the very relevant and usually neglected interface between

learning theory and training practice in consulting work. A consultant is at heart an educator, and as such issues of learning and assessment figure high on the list of required competencies for consultation.

Decisions made regarding assessment carry definite ethical consequences. In Chapter 4 Susan Cooper and Martin Fisher rightly elaborate ethical considerations when choosing appropriate testing and assessment instruments, and contextual issues that need to be included when reporting findings. Also of note is their straightforward discussion of the ethical demands of testimony. Professional ethical standards exist to clarify the professional's role in various contexts and courtrooms are the arenas for intersecting interests. This chapter is helpful in its succinct outlining of various responsibilities. For example, their advice regarding disclosing testing conditions: "it is important for psychologists to make legal authorities aware of the sources of conflict between professional standards and legal issues" is well taken. As is their presentation of conflict of interest considerations from the courts point of view—how confusion over the role of the witness dilutes the usefulness of testimony. Perceived bias taints testimony by a "hired gun."

Part II explores a variety of practical considerations. As a therapist and a qualitative researcher who uses interview data, this reviewer found Andy Griffith and Becky Milne's Chapter 5 discussion of investigation interview considerations fascinating. The enhanced cognitive interview process—documented to result in more comprehensive and more accurate recall—holds promise beyond the context of forensic interviews. Sometimes more in-depth accounting of personal experience may be useful in those qualitative research interviewing contexts in which rich data is preferred over summative accounts. Also intriguing are the studies cited by Griffith and Milne pointing out that UK laws have recently allowed greater transparency in witness interviewing, and that this allows researchers greater access to study interview methods in relation to corroborated recall. This is the stuff of which qualitative validity is made.

And as an occasional crisis management consultant I was particularly keen on Fisher and Ireland's Chapter 6 on Acting as a Consultant/advisor in Crisis Situations. Very

useful information and perspectives are offered, although the chapter is a bit ambitious: incidents range from hostage situations to prison riots to airline hijacking and the Belsan school attack. Key discussion points include consulting context and skills, crisis negotiation models, and ethical considerations. The chapter focuses mainly upon the provision of advice regarding negotiation and problem resolution; for a different approach and broader consideration of consulting roles within different kinds of crisis including disasters and system failure, see chapter 13.

In Chapter 7 Ireland contextualizes her discussion of report writing and court testimony with a brief but helpful history of cases in which court witnesses presented seriously flawed and damaging evidence. Ireland's discussion of report writing is brief but succinct, outlining elements in a complete report, discussing the nature of facts and their presentation, and pointing out various traps and pitfalls to which the unwary are prone. Ireland does an enlightening job of explaining both the hidden purpose of these potential traps and practical strategies to take in responding to them professionally and effectively.

Chapter 8 authors Simon Keslake and Ian Pendlington present an engaging case study utilizing an organization-specific approach to implementing behavior change within a law enforcement organization. The past several decades have shown a dismal succession of attempts to apply popular organizational development approaches that were born in the business sector to the less trendy and more task focused and tradition based public service organizations such as emergency services. Such programs generally meet resistance and are often considered organizational underbrush to the employees who are already too busy doing the agency's work. Given the diversity of theoretical approaches and ambiguity of current literature, Keslake and Pendlington's behavior change framework appears well grounded and practical. Most importantly, the approach begins with listening at all levels and sufficient design rigor is brought to bear on the change process as to give legs to what often amounts to empty flag waving to be endured by already burdened staff. Further, the model incorporates both group level and individualized intrinsic motivation for participant buy-in.

Chapter 9 continues the discussion of employee engagement within the context of the H.M. Prison Service. Suzi Dale examines the links between staff perception and performance in the pressure cooker context of a large established agency dealing with rising public expectations and

declining resources, a situation not uncommon elsewhere but critical—given the potential consequences of a doubled prison population within a 15 year period. Through discrepancies in her data regarding performance and attitudes, she demonstrates the need for the Prison Service to embellish its success by including performance metrics based around employee engagement.

While the subject of inspecting prisons initially appeared dreary, this reviewer came away impressed with Chapter 10, wherein Louise Felshaw describes the methodology applied in the inspection of secure institutions in the private sector using the Prisons Inspectorate, providing independent qualitative assessment of the outcomes for those in custody, utilizing multiple methods of evidence. The chapter is well constructed, providing enough contextual background for the reader to understand the Inspectorates function as well as methods. The Inspectorate of Prisons focuses on the human rights of those detained and has developed a methodology underpinned by human rights principles and adopts an outcome-focused approach assessing qualitative outcomes (i.e., what those in custody are actually experiencing). This continued focus of the Inspectorate of Prisons contributes to the Optional Protocol to the U.N. Convention Against Torture (adopted in 2002) that mandates a system of regular site visits to prisons in order to prevent torture and other degrading treatment. This chapter details an altogether impressive system of on-going evaluation of an enormous and complex system with the well being of many at stake. Would that all countries follow this high road . . .

Chapter 11 by Morgan, Vickers and Moore provides a succinct, a theoretical introduction to the world of training, including a nifty comparison chart of different training methods described with comparison of the various benefits and issues of each. With the exception of a concluding case study, however, the chapter does little to point out training concerns unique to forensic situations. Also missing are some of the gritty nuts and bolts about how to graciously handle potentially sticky situations such as uncooperative participants who were mandated to come, substandard, incompatible or malfunctioning audiovisual material, panicked organizational managers who intrude in the presentation "to help out," groups or managers with hidden agendas they don't mention, or client organizations who take you aside after the presentation to explain that due to a competing scheduled event they were unable to attract enough attendance to be able to pay you the full fee. There's more, but I'm sure you've

been there . . . What this report does highlight is how the development of relationship between consultant and client, punctuated by refining the agreements at each stage of the cycle, can effectively minimize many of the sticky situations mentioned above.

If our human tendency to err is the norm, our propensity to make it worse is legendary—the dark humor of the squad room comes about rightly and has its origin within the organization as well as the street. In an appropriately pithy footnote to Chapter 12 on Systemic Failure and Human Error, Adrian Needs points out that analysis and action must go beyond scapegoats and platitudes” (p. 219). This chapter is one of the gems of this collection. Along these lines, in his analysis of sources of incident mismanagement, Needs cites Boin & McConnell’s (2007) attribution of the response to Hurricane Katrina in 2005 as exhibiting “a number of ‘psychological pathologies’ such as overconfidence, wishful thinking, insensitivity, bureaucratic complexity and conflict in the system . . . in part due to a preoccupation with civil emergencies due to terrorism in the wake of 9/11.” In this regard, he points out that keeping crises from bad endings (his definition of disaster) requires a crucial move from executing highly structured responses to ill-structured situations, to more comprehensive assessment and more flexible response taking into account multiple models of the situation and challenges to the dominant view. I found Need’s discussion important, as fully half of the on-scene CISM Class I & II Incident Command consultation I have provided has to do with difficult situations whose severity have been compounded by actions taken in attempts to contain it, where those actions were themselves driven by latent systemic failures similar to those Boin & McConnell point out.

Genes on the Couch: Explorations in Evolutionary Psychotherapy

Edited by Paul Gilbert. New York: Routledge, 2000.

Reviewed by Karin Machluf and Virginia A. Periss

Since the times of antiquity, persistent abnormalities in behavior have been viewed as a type of illness within the body and/or mind. Treatments for these pathologies, as a result, focused on trying to rid the individual of their ailments, such as the dated practice of draining the body of toxic fluids (i.e., bleeding, dehydration). Although the practice of treating mental illness has come a long way since the advent of

In the final chapter Roisin Hall and Donald Darroch introduce Project Management as a systematic way of ensuring the implementation of discrete pieces of work with defined product or deliverable that creates a change (e.g., introduction of a new program, provision of a training exercise or research project, setting up a multi-disciplinary information sharing group). The design and management of such project within forensic contexts sometimes befall psychologists directly or indirectly, and the Project Management model defines three stages with intermittent steps at each stage. Creating a clear framework and due consideration of the process at each stage and each step helps avoid the wasted effort and cost, loss of moral, recriminations and poor outcomes of such efforts. Their discussion of the various stages and steps of project management is detailed and provides an operational sense of application.

In all, this is a remarkable book about a complex subject. Mental health professionals consulting in forensic contexts have much to learn from Ireland and Fisher about theoretical, professional, and practical concerns. But it isn’t simply a book for consultants. Managers and specialists within the forensic community would do well to seek out the perspectives and parameters presented to enhance their utilization of mental health resources toward their organizational ends.

REFERENCES

Boin, A. & McConnell, A. (2007). Preparing for critical infrastructure breakdowns: The limits of crisis management and the need for resilience. *Journal of Contingencies and Crisis Management*. 15 (1), 50-59.

modern medicine the majority of psychologists nevertheless still view certain types of persistent abnormalities in behavior as reflecting an illness that must be “cured.”

Genes on the Couch provides an insightful alternative perspective on mental illness that incorporates an evolutionary theoretical framework. With the growth in popularity of

evolutionary psychology, and added explanatory ability in application to various perspectives throughout the field, it is no small surprise that a clinical application is forthcoming. Evolutionary psychology is responsible for many explanatory tools such as Parental Investment theory (Trivers, 1974), Mate selection (Buss, 1994), Reciprocal Altruism (Trivers, 1971), and theories on social exchanges (Cosmides & Tooby, 1992) that help understand people's behaviors from a new viewpoint. This book uses an evolutionary approach to help answer questions regarding origins of different psychopathologies, as well as provide direct application to the therapeutic process.

The book is split into three parts. The first part of the book, Theory and Principles, begins with an introductory chapter presented by Gilbert, Bailey, and McGuire who provide a complete, but not exhaustive overview into the emerging field of evolutionary psychotherapy. They supply the reader with the basic principles of evolutionary theory, inclusive fitness, selection pressures, and genetics, with the purpose of providing readers with the required background information needed to better treat mental illness and detail how evolutionary history helps us understand how and why we feel the way we do. "Clues as to why we relate to others in the way we do, why we feel certain emotions, in certain situations and why we are prone to neurosis, personality disorders and other pathologies, can be found in our evolutionary history" (p. 4). While the authors do provide a detailed and somewhat accurate view of the various selection pressures that our ancestors experienced in relation to these challenges, the authors fail to mention other subdisciplines within the field of evolutionary psychology that may provide an even greater insight into the origins of mental illness. In particular, evolutionary developmental psychology could explore these attributes as they relate occur across development rather than just during adulthood. Furthermore, little discussion is given as to the role of environment in the expression of genes. For example, Gilbert and colleagues state, "In sum, then, genes are the fundamental building blocks of life, and further, that they shape & distally predispose an organism to *do* certain things" (pg. 8). No doubt, a better understanding of the relationship between specific genes and mental illness is a critical step in understanding pathological behaviors, such as manic depression or schizophrenia. Another important aspect of this process, however, that has seemingly been overlooked in this chapter was a discussion of the role of individual expressions of these genes associated with mental illness in relation to the environment in which they are expressed and their developmental progression.

The authors, overall, provide readers with a detailed explanation into the nature of psychopathologies as resulting from adaptive processes rather than from maladaptive processes. An individual, as a result, expressing depression may be more likely to interpret a hostile or negative signal as a personal insult to that person's reputation or standings within the group. In that sense, depression is no longer maladaptive but rather a tool that a person can use to recognize that a change needs to be made. In cases in which the individual is unable to change this state of being is no longer adaptive but rather becomes an obstacle that person must overcome.

The second part of the book, Evolutionary Psychotherapies, introduces the different ways a therapist can apply evolutionary views to help understand how to be the most helpful therapeutic agent for their patient. For example, Kriegman points out how evolutionary biology and Triver's (1974) Parental investment theory can help understand conflicts of interests between caregivers and a patient, and a therapist and their patient. The section then shifts its focus on bridging together traditional Jungian and Freudian approaches coupled with evolutionary theoretical framework to create a more robust enriched approach to psychotherapy.

This section is then followed by a discussion from Gilbert on the emergence of internal conflicts stemming from dissonance in the use of various types of evolved strategies that at times may come in conflict with one another. Mothers, for example, have evolved mechanisms for nurturing that may come into conflict with her current availability of resources that in turn led to conditions such as postpartum depression and in more extreme cases filicide (Weekes-Shackelford & Shackelford, 2004). One key factor in Gilbert's discussion centers on the concept of social signals that trigger psychological response patterns that in turn influence not only one's actions but also one's internalized model of themselves. Individuals suffering from depression, for example, are prone to interpret the world around them in terms of social status or their place within the social hierarchy. A depressed person, therefore, may be more sensitive to interpreting possible hostile signals from others as a direct reflection of their social status rather than in the context of the situation itself.

In relation to this, Allen and Gibert explore the implications for having an evolved cheater detection system that when hyperactive results in an evolved heuristic strategy to always assume the worst-case scenario. This strategy, while being functional in some cases, will inevitably lead to false positives in many others. Assuming others in your social

environment will reject you or try to take resources from you even when their intentions are not such will lead to social isolation. On the other hand, during development, a child that has a degrading overbearing parent may, in turn, internalize these negative attributes to be true and begin to blame itself. This section, in sum, provides a wonderful framework for smoothly combining theoretical perspectives that focus on the “relationship between individual experience, social influences, and the phylogenetic propensities which guide and inform all human development” (pg. 113). The final section of the book, Special Topics, focuses on a variety of particular issues including incest avoidance, disorganized

attachment styles, rejection sensitivity, shame, and effective strategies for applying an evolutionary model to individual patient’s needs.

Genes on the Couch, only briefly reviewed here, clearly articulates the benefits of using an evolutionary psychotherapy approach. The cohesive chapters successfully present evidence that viewing a behavior from the perspective that it is adaptive, rather than abnormal, and has now become maladaptive, may help psychotherapists gain greater understanding over psychopathologies, as well as produce more successful methods of treatment.

Biosocial Criminology: New Directions in Theory and Research

Eds. Anthony Walsh and Kevin M. Beaver

New York, NY: Routledge, 2009

Soft Cover: \$47.95

Reviewed by Patrick Douglas Sellers II, Florida Atlantic University

Editors Dr. Anthony Walsh and Dr. Kevin Beaver challenge criminologists to take notice of extant research demonstrating the explanatory power of biological sciences or risk quickly becoming artifacts of an archaic age of behavioral science and criminology. Given that “most criminologists were (and are) sociologically trained” they tend to be “poorly trained in biology” resulting in a glaring absence of biologically inclusive work in the criminology literature and a hesitant attitude toward integration (p.7). Through a combination of the traditional fields of criminology (e.g. sociology and psychology) with the relatively novel fields of biology, neuroscience and evolution, *Biosocial Criminology* provides a theoretical framework with the potential to restructure established theory and research while opening new doors for future work and application.

Authors first address the lack of biological and neuroscience knowledge among most criminologists by providing an introduction to fundamental principles of heritability, molecular genetics, the brain, and evolutionary theory. Those of us not trained in the “hard sciences” will appreciate the direct and informative manner in which complex biological and genetic processes are broken down into digestible pieces and the presentation of research relating these pieces to criminal behavior. However, the presentation is not simple

to a fault. Authors provide enough detail to allow readers an understanding of advanced phenomena such as epigenetics, gene-environment interaction, and brain imaging.

Focus then shifts to re-evaluating traditional theoretical accounts of major correlates of crime with the inclusion of biological research. As the backbone upon which modern criminological work is built, these correlates require a reinterpretation under a biosocial theoretical framework if criminology is to move forward in an integrated fashion. Gender, age, race, hormones, and substance abuse are all covered in detail despite the potential for, and unfortunately all too common occurrence of, tip-toeing around sensitive or politically correct issues in scientific evaluation. Authors break down the walls of potential prejudice and present scientific findings that provide new insights and explanations for differences in criminal behavior between groups.

The final section reinterprets research on the “relatively small percentage of all offenders [who] account for more than half of all offenses,” career criminals (p. 205). Genetic, biological, and evolutionary determinates of personality traits and psychopathologic conditions associated with criminology, and subsequent gene-environment interactions, provide an interactive framework within which to search for dynamic determinates of criminal behavior. This framework

culminates in Integrated Systems Theory, a biosocial theory that bridges the gaps between apparently disparate levels of analysis. The inclusion of multiple levels of analysis allows for incredible explanatory power by encompassing the bi-directional influence of numerous systems (Cell, Organ, Organism, Group, Community, and Society) and additional interaction effects. Augmenting Integrating Systems Theory with a developmental framework is particularly influential, as it allows researchers to fine tune this model even further, and provides a timeline for the influence of accumulating multi-level risk-factors across the lifespan.

Throughout the book, authors successfully combat philosophical arguments against the inclusion of reductionist biological sciences and evolutionary theory by illustrating how: 1. these arguments are often counter to the endeavors of science in general, 2. founded in misconceptions, and 3. independent analysis of any particular level fails to integrate adequate scientific knowledge to sufficiently explain criminal behavior. *Biosocial Criminology* officially ushers in a new, biologically inclusive age of criminology. Authors provide unequivocal evidence, from varied fields of expertise, for the necessary addition of biological research in the investigation of criminology.

The criminal triad: Psychosocial development of the criminal personality type

William M. Harmening (2010)

Springfield, IL: Charles C. Thomas.

David F. Bjorklund, Department of Psychology, Florida Atlantic University

Developmental psychologists have come to realize that a multitude of interacting factors are responsible for the life trajectory of any individual and that to truly understand adult behavior requires tackling the complex interactions among multiple levels of organization and how they change over time. William Harmening, a career law enforcement officer and an Adjunct Professor of Psychology, takes such a view in his book, *The Criminal Triad*, as he explains how the criminal personality develops. The triad in the title of his book refers to three core aspects of personality, each focused on a particular time in development, although each also having its impact on personality formation throughout life: attachment during infancy, morality during childhood, and identity during adolescence.

Harmening begins the book with a brief history of crime and how criminals have been perceived, from the time of Hammurabi through the emergence of science to modern times. He then introduces *Criminal Triad Theory*, stating that his goal is “not to create a new theory of criminality, but rather to provide a new way of synthesizing into one model existing theories that have over the decades contributed to a fuller understanding of deviant behavior” (p. 12). The next three chapters are a tour of major theories of development over the 20th century. Chapter 2 focuses on the psychoanalytic theories of Sigmund Freud and Erik Erikson, which served

as the foundation for subsequent theories of personality and its development. Erikson’s ideas prove especially important for Harmening’s later account of problems of identity formation in the development of the criminal personality. Learning theories are the focus of Chapter 3, notably the ideas of John B. Watson, B. F. Skinner, and the social learning/social cognitive theory of Albert Bandura. Bandura’s account serves as the connection between the behavioral theories that dominated psychology in the earlier part of the last century to the cognitive theories that followed. It is hard to minimize the importance of social learning for the development of criminal behavior (or for any complex behavior, for that matter), and Harmening’s emphasis on social learning is in line with contemporary research on the centrality of social cognition in human development and the transmission of knowledge from one generation to the next. Chapter 4 concludes the history section with a review of Jean Piaget’s highly influential theory of cognitive development.

Chapter 5 introduces us to ways in which major 20th century theorists, including Samuel Yochelson and Stanton Samenow, Hans Eysenck, and the formulators of the DSM-IV, have conceived the criminal personality and concludes with a description of how Criminal Triad Theory characterizes personality. Basically, the theory proposes three internal-deterrence mechanisms: the *self-deterrence mechanism*,

which compels the individual to avoid deviance for fear of failing oneself; *the moral-deterrence mechanism*, a person's empathic awareness of another's pain and suffering; and the *social-deterrence mechanism*, equivalent to Freud's super-ego, that attempts to live up to the expectations of others. According to the model, the criminal personality is defined as anyone who has deficits in at least two of these three internal-deterrence mechanisms.

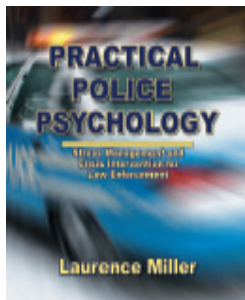
The next series of chapters outlines research and theory on the three components of the criminal triad: attachment in infancy as well as research on different styles of parenting (authoritative, authoritarian, permissive, neglectful) in Chapter 7; moral development as described by major psychoanalytic and cognitive theorists in Chapter 8 and its relation to the criminal triad in Chapter 9; and identity formation in Chapters 9 and 10.

Chapter 11 takes the foundation built in the previous chapters and examines the different types of young criminals (*opportunistic offenders, ego-directed offenders, and symbolic defenders*), their developmental origins, and how they might be identified. Chapter 12 looks at how, once we understand the origins of the criminal personality, we might intervene to the betterment of high-risk children and society

at large. Harmening points out the success of preschool intervention programs at reducing criminality and promoting economic and academic achievement and the important role that mentors can play in the lives of youth at risk for criminal behavior. He is well aware that American society typically focuses less on prevention and more on punishment when it comes to youth crime and recognizes the difficulties that teachers and other public servants face when trying to intervene. Yet, given what we know about the importance of secure attachment, the ability to empathize with the suffering of others, and the importance of establishing a positive sense of identity, we have the tools to minimize juvenile crime and prevent many wayward youth from becoming career criminals.

Harmening delivered what he promised. At the beginning of his book, he stated that *Criminal Triad Theory* was not so much a new way to view criminality but a synthesis of what we know about development and how children and adolescents can sometimes go astray due to deficits in attachment, morality, or identity. His integration of theory and research as it relates to the development of the criminal personality (and to the noncriminal personality as well) serves as a useful guide for anyone trying to understand why some children turn to crime and others don't and what can be done about it.

From Laurence Miller, PhD



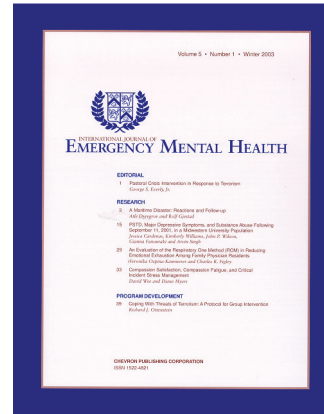
Practical Police Psychology: Stress Management and Crisis Intervention for Law Enforcement

Patrol tactics, police-citizen interactions, crime victim intervention, officer-involved shooting, line-of-duty death, hostage crises, suicide-by-cop, officer suicide, undercover investigation, testifying in court, officer misconduct and discipline, critical incidents and job stress, police families, law enforcement leadership, community policing.

Thomas, 2006, ISBN: 0398076367, \$72.95 (hardcover), ISBN: 0398076375, \$48.95 (softcover). Order from ccthomas.com or amazon.com.

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 \$ 82.00 / year
- International \$128.00 / year

Institutional Subscription (Four issues)

- USA Only \$390.00 / year
- International \$485.00 / year

Subscribe by returning this form with your payment to Chevron Publishing, PO Box 6274, 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: _____

INTERNATIONAL JOURNAL OF
EMERGENCY MENTAL HEALTH

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 should be sent as an attachment to Laurence Miller, PhD at:

docmilphd@aol.com
- The email should be clearly labeled with the author(s)' name, manuscript title, and date.