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Innovative, Precise, and Descriptive Terms for Group Crisis Support Services: A United Nations Initiative

Jeffrey T. Mitchell

Department of Emergency Health Services
University of Maryland, Baltimore County

Abstract: Terminology borrowed from other disciplines for use in crisis intervention is inadvertently open to misinterpretation and misrepresentation. Misconceptions about terminology are most common when terms are transmitted across social, cultural, national, language, and attitudinal boundaries. Critical Incident Stress Management, which is a subset of crisis intervention, encountered that exact problem with three of its terms: demobilization, defusing, and Critical Incident Stress Debriefing. Several flawed studies based on misinterpretations of the meaning of these terms have appeared in the literature. The studies may have stimulated some practitioners of crisis intervention to incorrectly conclude that those interventions were ineffective. Professionals within the Critical Incident Stress Management Unit of the Department of Safety and Security of the United Nations suggested alternative and augmented terminology to reduce the potential for further misinterpretations of Critical Incident Stress Management procedures. [International Journal of Emergency Mental Health, 2007, 9(4), pp. 247-252].

Key words: crisis intervention, Critical Incident Stress Management, demobilization, defusing, Critical Incident Stress Debriefing, crisis terms, Critical Incident Stress Management Unit, United Nations.

Words change over time. Their meaning may decay or be convoluted with imprecise utilization, with translation between languages, or when they are borrowed from one discipline and then used in a new context. For example, in 1965, the word *mouse* was defined as "...any of numerous small rodents ... with pointed snout, rather small ears, elongated body and slender tail..." (Merriam Company, 1965, p. 554). Today, most people use a mouse while working at a

computer. But the mouse they use in their offices does not have a pointed snout, rather small ears, or a slender tail; and it is certainly not a rodent. The term *mouse* was borrowed from zoology and is now used in computer science with a very different meaning.

Some words are derived from combinations of several words, which, when combined, provide a different meaning than when they are used separately. For instance, the English word *sincere* comes from two Latin words – *sine* and *cerō*. *Sine* means "without" and *cerō* is a word that means "to smear or coat with wax." In ancient Rome, some unscrupulous sculptors and stone craftsmen would use wax when repairing public buildings and monuments. Typically, after they were paid, the hot sun would eventually melt the wax

Jeffrey T. Mitchell, PhD is President Emeritus of the International Critical Incident Stress Foundation and is a Clinical Associate Professor of Emergency Health Services at the University of Maryland, Baltimore County. Correspondence regarding this article should be directed to jmitch@umbc.edu.

and the building or monument would, in a short time, return to a state of disrepair. Legitimate craftsmen, under the threat of grave penalties, were therefore required to certify that their work was “sine cero” or “without coating with wax.” The word *sincere* eventually evolved from “sine cero” to mean honest, without deceit, or genuine.

The examples in the paragraphs above set the stage for what has occurred in the field of crisis intervention. Today, crisis intervention terminology is plagued by imprecise utilizations of terms, borrowed words, combined terms, and misinterpretations or misrepresentations of the meanings of original terminology. Critical Incident Stress Management (CISM), as a subset of the general field of crisis intervention, certainly has suffered from some of the very same problems in its own terminology. As a result, progress in applying crisis intervention principles and practices and in learning and transmitting valuable lessons has been seriously impeded (Mitchell, 2003; Everly & Mitchell, 2008).

The Development of CISM Terminology

Crisis Intervention had its origins in the late 1800s and the early 1900s (Janet, 1889; Charcot 1890; Stierlin, 1909; Myers 1915, 1916, 1940; Lindemann, 1944). The model for trained non-professionals to provide “psychological first aid” was established well before the evolution of the CISM field in the mid 1970s. Gerald Caplan, for instance, who was one of crisis intervention’s most prestigious theorists and practitioners, frequently stated that excellent help can be provided by friends, family members, and colleagues (Caplan, 1961, 1964, 1969). Peer support personnel from emergency services and the military were a vital part of crisis intervention services from the inception of CISM (Mitchell & Everly, 2001; Mitchell & Mitchell, 2006; Mitchell, 2007). The use of para-professionals was more recently reconfirmed and endorsed by the National Institutes of Mental Health (NIMH) in 2002.

Since all CISM tactics are really crisis intervention or, more specifically, *supportive procedures*, and **not** psychotherapies or any type of a substitute for psychotherapy, the original labels for CISM tactics were chosen deliberately to avoid clinical or psychosocial-sounding vocabulary. Trained peer support personnel, who have provided the bulk of crisis intervention services within not only the emergency services professions but also in numerous other professions since the inception of CISM services in the 1970s, are not mental health professionals. They require simple, concise, and prac-

tical terms to enable them to work efficiently in the field of crisis intervention. CISM labels and terms were originally selected because they were uncomplicated and non-clinical.

In some cases, the original names for CISM procedures were actually borrowed from other professions such as the military, emergency medical services or law enforcement (e.g., demobilization, critical incident, and defusing). Some CISM terms consist of a combination of labels that had their source within the military, physics, and even the space program (e.g., stress, briefing, debriefing, and the term *re-entry* phase in the CISD process). Unfortunately, borrowed terminology comes with its own set of drawbacks and shortcomings. For example, almost from its inception, the use of the term *demobilization* was unacceptable to the military because they use that same term to mean something very different from its meaning for CISM teams.

The borrowed or combined terminology opened some CISM interventions to serious misinterpretations and misapplications of the procedures. As a result, horribly flawed studies were produced on the weakest of all foundations, that is, on the basis of misconceptions. Those faulty studies were then used to criticize certain CISM tactics and, at times, even the entire field.

Distortions in CISM Terminology

When new psychosocial programs, such as CISM, grow rapidly and are used in a wide range of professions, such as the emergency services, hospitals, the military, schools, businesses, churches, and communities, unexpected misinterpretations of the basic terminology are quite possible. Matters are made worse when terms migrate across national boundaries and must be translated into different languages. Distortions of original intentions in the terminology are likely. In addition, cultural issues, inadequate training, preconceived notions, language barriers, traditions, and flawed research methodologies often form obstructions to the proper dissemination and utilization of these programs. To some degree, all of these factors have been the source of inaccuracies, misinterpretations, and misapplications of the CISM program (Dyregrov, 1997, 1998, 2003; Mitchell, 2003; Leonhardt & Vogt, 2007).

Over the years, there have been occasional criticisms of the field of CISM. These attacks are typically based on misinterpretations and misrepresentations of the terminology. One technique in particular, the Critical Incident Stress

Debriefing (CISD) process, has been singled out from among the many techniques within the CISM field; it has been the focus of several attacks. A careful review of the studies that criticize this small-group crisis intervention process reveals the following.

- The field of Critical Incident Stress Management was *not* evaluated in the negative outcome studies.;
- The term “debriefing” was often used, but the actual CISD process was *not* actually evaluated.
- The studies examined some form of an individual psychotherapy technique and then evaluated that technique as if it were a suitable psychotherapy process for primary injured victims. The studies did not, however, evaluate CISD, which is not a psychotherapy, but a support service with a prevention-oriented focus that was specifically designed for homogeneous groups of operations personnel.
- The research was done out of context (e.g., no use of peers, not within an organizational setting, violating the basic protocols and procedures of CISM, etc.; Mitchell & Mitchell, 2006; Mitchell, 2007; Everly & Mitchell, 2008).

It is clear from the researchers’ own statements within their papers that, even when they claimed to evaluate the CISD process, they made seriously flawed alterations to the process before they misapplied it to injured individuals. The fatal flaw in those studies, in each case, is that the researchers removed the group CISD process from its context within the field of Critical Incident Stress Management. They substantially altered the process and then misapplied it as an individual, single session, psychotherapy process for wounded individuals. In none of the negative outcome studies was the process applied for its intended purpose as a group support process for homogeneous groups. Furthermore, under the misleading name of “debriefing,” they used their alterations for unintended populations such as serious burn victims (Bisson, Jenkins, Alexander & Bannister, 1997), injured road traffic accident victims (Conlon, Fahy & Conroy, 1999; Hobbs, Mayou, Harrison, & Warlock, 1996; Mayou, Ehlers, & Hobbs, 2000), sexual assault victims (Rose, Berwin, Andrews, & Kirk, 1999), women suffering the loss of a baby due to a miscarriage (Lee, Slade, & Lygo, 1996), and to reduce maternal depression for post-operative childbirth (Small, Lumley, Donohue, Potter, & Waldenstrom, 2000). These stud-

ies form the core of the Cochrane Review which is often cited, although incorrectly, as evidence that the CISD should be abandoned (Wessely, Rose, & Bisson, 1998; Rose, Bisson, & Wessely, 2002). The problem, in essence, is one of misinterpretation of the core CISM terminology and its written procedures.

Sometimes the meaning behind certain words has become so distorted that people inexplicably and irrationally cling to misinterpretations of the terminology even when they become fully aware of the facts to the contrary. For example, in 2003, two Australian authors (Deville & Cotton) claimed that CISM was a substitute term for CISD. That error of mixing up a tactic (CISD) with a program (CISM) was strongly and clearly corrected in the following issue of the same psychological journal (Mitchell, 2004). Yet, in a staggering disregard for accurate information, the researchers went on to repeat the very same mistakes in their next article in the same journal (Deville & Cotton, 2004).

Imprecise or misinterpreted terminology can sometimes poison (to borrow a term from medicine) or skew a population’s view of a specific procedure or even an entire program. People may, therefore, refuse to explore or use what could possibly be helpful techniques because their view of those interventions has been clouded by the distortions. When the United Nations (UN) began to explore the world’s most frequently used crisis intervention and staff support programs, with a view to developing their own staff support program, there were some who presented distorted information regarding CISM to the UN’s professional staff.

To their great credit, Moussa Ba, a psychiatrist and head of Psychological Services for the Department of Safety and Security, and Ruth Sembajwe, Director of the Staff Counselors office at UN headquarters in New York, were not swayed by the mere presentation of negative arguments. Instead, they set out to carefully and systematically explore all aspects of the crisis intervention field. They collected and read the actual positive and negative studies and interviewed key people who provided crisis intervention services in many nations around the world. In all, Ba and Sembajwe spent three years both carefully exploring the literature and reviewing the entire range of crisis intervention practices (UN, 2007a). They ultimately concluded that the negative literature represented significant distortions of CISM programs and procedures.

The Development of Alternative and Augmented CISM Terminology

Ba and Sembajwe concluded that there were three crisis intervention systems in place in the world and that the best elements of each would form the UN staff support program. The three crisis intervention programs that were selected were

- the Early Medical-Psychological Intervention program developed by Dr. Louis Crocq at the French Institute for Research and Education in Trauma and Stress in Paris, France;
- the Acute Trauma Management program of the American Academy of Experts in Traumatic Stress; and
- the Critical Incident Stress Management program of the International Critical Incident Stress Foundation.

UN professionals moved ahead to incorporate these three programs into the fabric of the UN staff support program. The official name of the UN staff support system is the *Critical Incident Stress Management Unit (CISM-U)* of the United Nations Department of Safety and Security (DSS). The DSS is housed within the Secretariat Branch of the United Nations and reports directly to the UN Secretary General (UN, 2007b).

Despite the fact that the concept of CISM was accepted by the UN, the terms, *demobilization*, *defusing*, and *Critical Incident Stress Debriefing (CISD)* were still tainted by the flawed studies described in the preceding section of this paper. In order to eliminate confusion and lower the chance for further misinterpretation of those terms, Dr. Ba suggested that it would be helpful to the UN if an alternative set of terms could be developed for the three currently in use. He felt that the chance of misunderstanding would be substantially reduced if the alternative terms were descriptive in nature (Ba, 2007).

Alternatives for the three CISM terms, *demobilization*, *defusing*, and *Critical Incident Stress Debriefing* were developed. The alternative terms were approved by the United Nations, the International Critical Incident Stress Foundation, the American Academy of Experts in Traumatic Stress, and the French Institute for Research and Education in Trauma

and Stress. The alternate terms were presented to United Nations personnel during two extensive training programs in March and June of 2007. They are now being used by the Critical Incident Stress Management Unit of the Department of Safety and Security of the United Nations (UN, 2007c).

Subsequently, the alternative terms were presented at several instructor Train-the-Trainer programs for the International Critical Incident Stress Foundation. Feedback from the courses' participants was extremely positive. As a result, ICISF decided that either the original CISM terminology or the alternative terminology would be acceptable both in the CISM literature and in actual practice (Howell, 2007).

Please note that each of the alternative labels or terms (below) is a *descriptive* term. Descriptive terms explain more accurately the nature of a specific process. They also portray what actually happens when a particular CISM tactic is applied. In the case of CISM, the essential processes remain the same; only the titles or labels have been changed.

The side-by-side presentation of both the traditional and the alternative CISM terms below should be helpful in clarifying the use of the alternative CISM terminology.

Alternate Descriptive Terms for CISM group interventions

<i>Traditional term</i>	<i>Alternative term adopted by UN</i>
Demobilization	Rest, Information, and Transition (RIT)
Defusing	Immediate Small Group Support (ISGS)
Critical Incident Stress Debriefing (CISD)	Powerful Event Group Support (PEGS)

In addition to the alternative terminology for the three CISM terms above, alternate terminology has also been developed for each phase of the CISD process. These terms serve to *clarify and describe accurately* the functions of each specific phase of the small-group crisis intervention process.

<i>CISD Phases</i>	<i>PEGS Phases</i>
Introduction	Introduction
Fact	Brief Situation Review
Thought	First impressions
Reaction	Aspect that caused greatest personal impact
Symptoms	Signals of distress
Teaching	Stress management information and recovery guidelines
Re-entry	Summary

The side-by-side presentation of the traditional terminology for the CISD process along with the alternative descriptive terminology for the PEGS process indicates that the process remains the same even though the labels are altered.

Concluding Comments

Hopefully, this explanation will allay some of the fears and concerns that a few rumors have generated within the CISM field. The alternate terms should allow CISM teams to continue to do good work and reduce the level and number of misconceptions in the field. Either the traditional terminology (CISD) or the alternative terminology (PEGS) is endorsed and accepted within the CISM field internationally. Both sets of terms are simply different labels for the same processes.

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Impact of Homeland Security Alert Level on Calls to a Law Enforcement Peer Support Hotline

Saad B. Omer

The Johns Hopkins Bloomberg School of Public Health

Daniel J. Barnett

The Johns Hopkins Center for Public Health Preparedness
The Johns Hopkins Bloomberg School of Public Health

Cherie Castellano

University of Medicine and Dentistry of New Jersey
University Behavioral HealthCare

Rachel K. Wierzba

Uniformed Services University of the Health Sciences

Girish S. Hiremath

The Johns Hopkins Bloomberg School of Public Health

Ran D. Balicer

Ben-Gurion University of the Negev

George S. Everly, Jr.

The Johns Hopkins Center for Public Health Preparedness
The Johns Hopkins Bloomberg School of Public Health
The Johns Hopkins School of Medicine; and Loyola College in Maryland

Abstract: *The Homeland Security Advisory System (HSAS) was established by the Department of Homeland Security to communicate the risk of a terrorist event. In order to explore the potential psychological impacts of HSAS we analyzed the effects of terror alerts on the law enforcement community. We used data from the New Jersey Cop 2 Cop crisis intervention hotline. Incidence Rate Ratios – interpreted as average relative increases in the daily number of calls to the Cop 2 Cop hotline during an increased alert period – were computed from Poisson models. The hotline received a total of 4,145 initial calls during the study period. The mean daily number of calls was higher during alert level elevation compared to prior 7 days (7.68 vs. 8.00). In the Poisson regression analysis, the Incidence Rate Ratios of number of calls received during elevated alert levels compared to the reference period of seven days preceding each change in alert were close to 1, with confidence intervals crossing 1 (i.e. not statistically significant) for all lag periods evaluated. This investigation, in the context of New Jersey law enforcement personnel, does not support the concern that elevating the alert status places undue stress upon alert recipients. [International Journal of Emergency Mental Health, 2007, 9(4), pp. 253-258].*

Key words: *Homeland Security, alerts, terror threat alert, hotline, law enforcement, peer support, cop 2 cop, law enforcement stress*

Saad B. Omer, MBBS, MPH, Ph.D., Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; Daniel J. Barnett, MD, MPH, Johns Hopkins Center for Public Health Preparedness, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; Cherie Castellano, MA, LPC, University of Medicine & Dentistry of New Jersey- University Behavioral HealthCare, Piscataway, NJ; Rachel K. Wierzba, MD, MPH, Uniformed Services University of the Health Sciences, Bethesda, MD; Girish S. Hiremath, MBBS, MPH, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; Johns Hopkins School of Medicine, Baltimore, MD; Ran D. Balicer, MD, MPH, Epidemiology Department, Faculty of Health Sciences, Ben-Gurion University of the Negev, Israel; and George S. Everly, Jr., Ph.D., Johns Hopkins Center for Public Health Preparedness, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; Johns Hopkins School of Medicine, Baltimore, MD; and Loyola College in Maryland, Baltimore, MD. Address correspondence concerning this article to: Daniel J. Barnett, MD, MPH, Johns Hopkins Center for Public Health Preparedness, Johns Hopkins Bloomberg School of Public Health, 615 North Wolfe Street, Room E2148, Baltimore, MD 21205; email: dbarnett@jhsph.edu .

Members of the law enforcement community often represent the difference between chaos and order in the wake of disaster. In the case of terrorism, not only do they respond to terrorist events but they play a significant role in preventing subsequent events. Their physical and mental well-being is therefore critical. Post-9/11, disaster mental health research has yielded some important insights into the impacts of terror on law enforcement personnel. A review of a 2002-2003 New York City Police Department (NYPD) screening program suggests that the mental health of law enforcement officers was adversely affected by the September 11, 2001 World Trade Center attacks. In their review, Dowling, Moynihan, Genet, and Lewis (2006) found that 34% of NYPD officers had at least one behavioral symptom related to the attacks, more than 50% had a related emotional symptom, and 24% reported a cognitive symptom.

As such, terrorism represents a significant public health challenge that demands attention, not just in response, but in pre-event preparation. Indeed, effective response is believed to be predicated upon effective planning (Butler, Panzer, & Goldfrank, 2003). One tool for tactical preparation that has been used within recent years is the threat alert warning system. Alert warning systems may be considered a plausible frontline public health strategy in a variety of settings, such as the context of pandemic influenza mitigation (U.S. Department of Health and Human Services, 2007).

The Homeland Security Advisory System (HSAS) was established by the U.S. Department of Homeland Security (DHS) in 2002 to communicate the risk of a terrorist event to federal, state, and local agencies as well as to the public and private sectors (The White House, 2002). The HSAS includes five *threat conditions*, each identified by a corresponding color and description. From lowest to highest, the levels and colors are: Low (Green); Guarded (Blue); Elevated (Yellow); High (Orange); Severe (Red). According to this scale, a higher *threat condition* refers to a greater risk of a terrorist attack. This risk scale reflects “both the probability of an attack occurring and its potential gravity.” Threat conditions can either be assigned for the entire nation, or targeted toward a particular geographic area or industrial sector (The White House, 2002).

On a nationwide level, the threat level has remained at Yellow (Elevated) for most of its existence; this national level has been raised to Orange (High) five times between September 10, 2002 and January 9, 2004 (Homeland Security Advi-

sory System, 2007). However, threat alerts since 9/11 have received some criticism, suggesting that they needlessly alarm the population that they are intended to serve and thus may have a negative public health outcome (Lichtblau & Drew, 2004). Moreover, the law enforcement community is at the forefront of response mechanism to the elevated security levels, and thus might be at risk of being disproportionately affected by any anxiety caused by elevation in the alert level.

In order to explore the potential psychological impacts of the HSAS, we analyzed the effects of terror alerts on a select subgroup that plays an essential role in this nation’s response to terrorism, the law enforcement community.

METHODS

We used data from the New Jersey Cop 2 Cop crisis intervention hotline. The Cop 2 Cop program was established in 1999 by University Behavioral HealthCare, University of Medicine and Dentistry of New Jersey, in partnership with the New Jersey Department of Personnel, to assist law enforcement personnel in seeking peer counseling. This population was selected because of the unique saliency that any elevation in alert status might have due to their close physical and psychological proximity to the terrorist attacks of 9/11.

The call data from September 9, 2002 – January 30, 2004 were used. This time period covers all of the national alert-level changes thus far. All callers were assigned a unique ID on the first call. For analysis, a call was defined as sequential interaction with the staff with the same call ID number. Personal identifiers were stripped for analysis. Alert dates were obtained from web-based search of news reports, reflecting elevations of Homeland Security alert levels from Yellow (Elevated) to Orange (High).

Raw time series data were plotted for visual representation. Call data were modeled as count per day. A time-dependent indicator variable was generated with a value of zero for seven days prior to the first days of the increase in alert level. For the primary analysis, the indicator variable was coded as 1 for all days during which the alert level was Orange (High), starting from the day after the announcement. We did not code the day of the announcement because the changes in the alert level were announced at various times of the day. In order to explore the effect of a lag of up to five days in change in call frequency, the secondary analyses included coding

the indicator variable as 1 starting from 2, 3, 4, 5, and 6 days after the increase in the alert level. We used Poisson regression to model the association of daily counts and whether a day was included in the increased alert period – without (primary analysis) or with (secondary analysis) a lag. Incidence Rate Ratios were computed from Poisson models.

Incidence Rate Ratios were interpreted as average relative increases in the daily number of calls to the Cop 2 Cop hotline during an increased alert period. For example, an Incidence Rate Ratio of 1.05 would have meant that the daily count of the calls was, on an average, five percent higher during the alert period compared to the reference period (i.e. 7 days prior to the increase in the alert level). However, associations were considered statistically significant if the confidence interval of Incidence Rate Ratios did not contain 1.

A Poisson regression of a dependent variable of counts on normally distributed independent variable using a sample of 1,062 observations achieved >80% power at a 0.05 significance level to detect a response rate ratio of at least 1.04 due to a one-unit change in the independent variable.

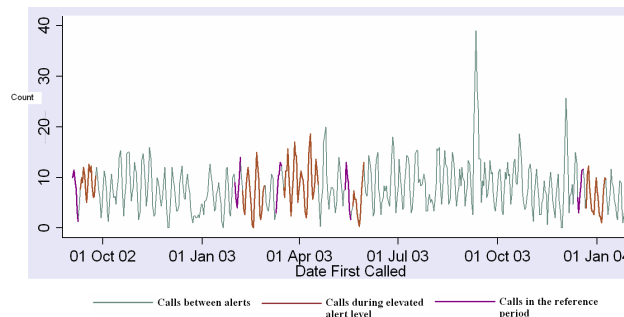
The study was approved by the institutional review boards of the Johns Hopkins Bloomberg School of Public Health and the University of Medicine and Dentistry of New Jersey.

RESULTS

The HSAS national alert level was raised from Yellow to Orange five times: 9/10/02 - 9/24/02 (15 days), 2/07/03 - 2/27/03 (21 days), 3/17/03 - 4/18/03 (33 days), 5/20/03 - 5/30/03 (11 days), and 12/21/03 - 1/09/04 (20 days). We excluded the last level elevation (end-of-December 2003 – early January 2004) from our analysis because in each of the four years prior to the alert in question, there was a clear trend of lower number of calls during the holiday season (data available upon request). The hotline received a total of 4,145 initial calls during the study period. Of these, 1,062 initial calls occurred in the exposure period (i.e. either up to 7 days before the study or during the period of elevation).

The smoothed plot of daily number of calls showed a substantial increase in the number of calls to the Cop 2 Cop hotline near the second anniversary of 9/11 (Figure 1). However, there was no perceptible pattern corresponding to the increase in alert level.

Figure 1



Although the mean daily number of calls was higher during alert level elevation compared to the reference period (1 day lag: 7.68 vs. 8.00), in the Poisson regression analysis the Incidence Rate Ratios of number of calls during elevated alert levels compared to the reference period of seven days preceding each change in alert were close to 1 with confidence intervals crossing 1 (i.e. not statistically significant) for all lag periods (see Table 1). These results should be interpreted as showing no statistically significant difference between the mean number of daily calls in the alert period compared to the reference period (7 days prior to the alert) for all lag periods (i.e., not counting calls made within 5 days after an alert was announced).

DISCUSSION

Our results suggest that elevations in the HSAS national alert level are not associated with a perceptible increase in short term psychological distress in law enforcement personnel as measured by calls to a peer counseling hotline.

Past studies have suggested that national warning systems have little mental health impact on the general public. Sorensen (2000) found that the public rarely panics in response to warnings of impending natural disaster. A retrospective review of the psychological impact of air raids in the UK during World War II found no evidence of an increase in mental illness (Jones, Woolven, Durodie, & Wessley, 2007).

However, while these studies have examined the population at large, the specific mental health effect of national alerts on frontline responder populations has received scant attention. Kramer, Brown, Spielman, Giosan, and Rothrock (2003) evaluated the psychological reactions of post-9/11 New York City disaster-relief workers to changes in the HSAS alert level, but their results were inconclusive. To our knowl-

edge there has been no other assessment of the psychological impact of the HSAS, and we believe that ours is the first to examine these HSAS alert impacts on a population of law enforcement responders.

The results of this investigation would appear to be in concert with the aforementioned conclusions as extended to the law enforcement community; threat alert elevations did not appear to engender sufficient distress as to warrant utilization of the Cop 2 Cop hotline. It is important to note, however, that the Cop 2 Cop hotline is seen as a viable mechanism for expressing such discord when experienced by a law enforcement population. Statistics from the Cop 2 Cop hotline program indicate that approximately 1700 calls were received within a one year period prior to 9/11/01, while 1 year following 9/11, call volume increased to approximately 4500 (Castellano, 2003).

These data would suggest that law enforcement personnel are not immune to the adverse psychological consequences of disasters, but would also suggest that the process of elevating the threat alert status does not have the effect of

increasing perceived stress levels to the point that a previously highly-utilized method of outreach is necessary.

CONCLUSION

It has been suggested that emergency response and law enforcement personnel are more resilient to the effects of critical incidents and trauma than are those in non-emergency-oriented professions, though not immune (Mitchell & Bray, 1990; Sheehan, Everly, & Langlieb, 2004). These postulations have to some degree been supported by North's observation of the relative prevalence of posttraumatic stress disorder in emergency personnel compared to civilians exposed to the Oklahoma City bombing (North et al., 2002). The results of the present investigation would tend to support and extend these findings. More specifically, concern has been expressed in the civilian mass media that elevating the alert status places undue stress upon alert recipients and should therefore be discontinued. This investigation does not support that conclusion as it pertains to law enforcement personnel in New Jersey.

Table 1: Incidence Rate Ratios of calls during HSAS alert level elevations by lag days.

Lag	Calls in Reference Period*		Calls in Exposure Period†		Incidence Rate Ratio‡ (95% CI)	p value
	n	Mean/day (95% CI)	N	Mean/day (95% CI)		
1 Day**	269	7.68 (5.86-9.51)	760	8.00 (6.64-9.36)	1.04 (0.91-1.20)	0.57
2 Day	269	7.68 (5.86-9.51)	723	8.03 (6.60-9.47)	1.04 (0.91-1.20)	0.54
3 Day	269	7.68 (5.86-9.51)	668	7.86 (6.40-9.31)	1.02 (0.89-1.18)	0.76
4 Day	269	7.68 (5.86-9.51)	615	7.68 (6.18-9.19)	1.00 (0.87-1.15)	0.99
5 Day	269	7.68 (5.86-9.51)	582	7.76 (6.21-9.31)	1.00 (0.87-1.17)	0.90

*Reference Period: Seven days prior to each change in alert level. Mean counts/day are computed by dividing the total number of calls in the reference period by the total number of days in the reference period.

†Exposure Period: Period of increased alert level minus the lag days. Mean counts/day are computed by dividing the total number of calls in the exposure period by the total number of days in the exposure period.

‡Reference for the Poisson Regression Model: Daily counts of calls in seven days prior to each change in alert level

**Day 1: The day after the elevation in alert level

The Cop 2 Cop hotline, as noted earlier, has shown sensitivity in reflecting psychological discord within the law enforcement population in response to environmental stressors. Nevertheless, no extraordinary utilization of the Cop 2 Cop hotline was in evidence to a series of elevated terrorist alerts. At worst, the elevations in alert status may be seen as inert. More positively, these alerts may be postulated as providing useful information to a population that tends to rely heavily upon information as a means of coping with stressful situations and enhancing self-efficacy (Sheehan, Everly, & Langlieb, 2004).

It is important to note that our results only shed light on the initial/short term response within this population. It is known that psychosomatic/behavioral outcomes may present in later stages, especially around anniversaries as our data suggests. Nevertheless, we see no evidence that the elevation in terrorism alert status places any undue stress upon law enforcement personnel in New Jersey.

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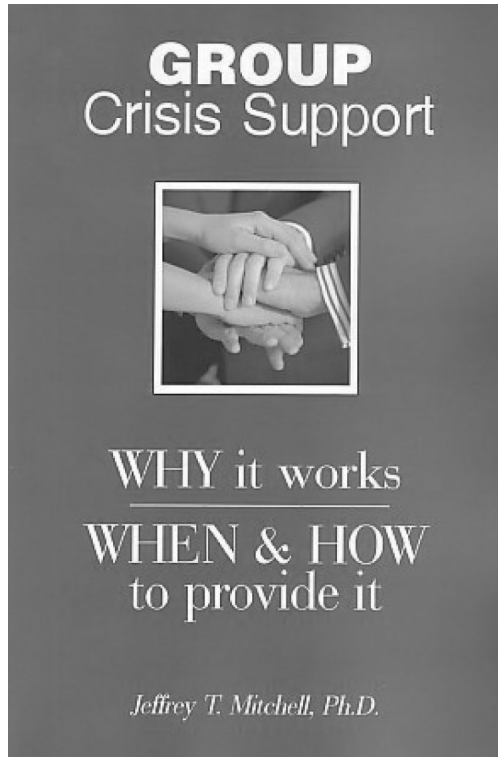
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Workplace Violence: Practical Policies and Strategies for Prevention, Response, and Recovery

Laurence Miller
Independent Practice
Boca Raton, Florida

Abstract: *The design and maintenance of behaviorally safe workplaces represents a vital collaboration between industry and the mental health professions. Employers must take all threats to worker safety seriously and take appropriate action to deal with those threats. They must have measures in place to handle disciplinary matters, safe hiring and firing, escalating crises, ongoing emergencies, and aftermath effects. This article describes the essentials of research and practice in the field of workplace violence and provides guidelines for crisis counselors, trauma therapists, and emergency mental health clinicians who consult with organizations and who provide direct clinical services to victims of violence. Finally, workplace violence prevention and response comprise one facet of the comprehensive management consultation role in which increasing numbers of behavioral and mental health specialists will find themselves at the start of our new century.[International Journal of Emergency Mental Health, 2007, 9(4), pp. 259-280].*

Key words: *workplace violence, workplace safety, corporate crisis intervention, emergency mental health, business psychology, industrial/organizational psychology*

“A disgruntled [pick one: postal worker, law client, insurance claimant, store customer, hospital patient, factory worker] stormed into his place of business yesterday, killing three people and wounding several more, before turning the gun on himself. Film at 11:00.”

You’ve heard this one before. Often the lead story is followed by interviews with coworkers or associates whose comments almost invariably follow one of two main themes:

“He was always a little strange, you know, quiet.

Kept to himself a lot, didn’t get along with too many people, but came in, did his job, and never caused any real trouble. But nobody ever figured him for a stone killer. Man, we didn’t see this one coming.”

Or:

“Dammit, I knew it was just a matter of time till something like this happened. This guy was bad news, a ticking bomb, and we all knew it. But there were no precautions or any real kind of discipline at all. We tried to tell management, but they just got annoyed, said there was nothing they could do, and told us not to stir up trouble. When he finally snapped, we were sitting ducks.”

Correspondence regarding this article should be addressed to: Laurence Miller, PhD, Plaza Four, Suite 101, 399 W. Camino Gardens Blvd., Boca Raton, FL 33432. E-mail: docmilphd@aol.com.

Most traumatic events encountered in life—earthquakes, chemical spills, terrorist attacks, plane crashes, street crimes—strike suddenly, without warning, and with little control. Correspondingly, medical, mental health, law enforcement, and administrative efforts typically focus on treating victims, survivors, their families, and other affected persons after the fact.

But one of the cardinal principles of crisis management (Miller, 1998c, 2006d, in press) states that, “*The best form of crisis intervention is crisis prevention.*” And for virtually no other type of major tragedy is education, training, and preparation so important in foreseeing and planning for emergencies as in the area of workplace aggression and violence. Consequently, in this article, special attention will be given to what crisis counselors and emergency mental health clinicians can do to help the public organizations and private companies they consult with reduce the risk of this kind of tragedy. Then the article will describe the measures that organizations can take to mitigate the short- and long-term traumatic effects of this special kind of traumatic event (Miller, 2008a, 2008b).

Workplace Violence: Facts and Stats

Several decades of research and practical experience (Albrecht, 1996, 1997; Blount, 2003; Denenberg & Braverman, 1999; Flannery, 1995; Johnson & Indvik, 2000; Kinney, 1995; Labig, 1995; LeBlanc & Barling, 2005; Mantell & Albrecht, 1994; Miller, 1997a, 1997c, 1998c, 1999a, 1999b, 2000e, 2001a, 2001b, 2002a, 2003a, 2005c, 2006a, 2008a, 2008b; Mitroff, 2001; Namie & Namie, 2000; Neuman & Baron, 2005; Potter-Efron, 1998; Schneid, 1999; Schouten, 2006; Shapiro, Jankowski, & Dale, 2005; Simon, 1996; Vega & Comer, 2005) have established some facts about violence in the workplace:

Homicide is the number one killer of women and the third leading cause of death for men in the workplace, after motor vehicle accidents and machine-related fatalities. You are about twice as likely to be murdered at work as to die from a fall, four times more likely than to be accidentally electrocuted, five times more likely than to go down in a plane crash, and many times more likely than to be killed in a terrorist attack. The majority of workplace homicides are committed by firearms. Most violence is perpetrated by people outside the company, but intracompany violence by employees or ex-employees is common, and most people find the prospect of

being harmed by a coworker far more frightening than by an outsider.

Workplace violence costs American business approximately \$4.2 billion a year. To put this in a more personal perspective, it boils down to a conservative estimate of more than \$250,000 per incident in terms of lost work time, employee medical benefits, decreased productivity, diversion of management resources from other productive business, increased insurance premiums, increased security costs, bad publicity, lost business, and expensive litigation costs. In terms of the human cost, most workers polled after an incident say that they are psychologically traumatized by the threat of future workplace violence, and a sizable proportion lose work time due to stress disability.

For every actual workplace killing, there occur more than 100 acts of sublethal violence, including fistfights, nonfatal shootings, stabbings, sexual assaults, vandalism, sabotage, bombings, and arson. Perpetrators who turn deadly often engage in threats and harassing behaviors before their actions escalate to killing, emphasizing the need for early boundary-setting and other preventive interventions. Verbal abuse and harassment can be even more destructive to employee morale and productivity than physical assault. The ironic reason is that employees who resort to fisticuffs create a palpable disturbance, cause potentially costly injury, and are an embarrassment to the company; consequently, they are likely to be assertively disciplined. But “mere” verbal threats, curses, snide remarks, and personal property sabotage (one of my patients had rotten food regularly placed in her desk drawer) typically aren’t taken as seriously, since they seem to affect few employees or stakeholders outside the direct targets of the nastiness.

Complaints about “minor” obnoxious and non-overtly violent antisocial workplace behavior are often treated by management as nuisances that get in the way of doing business and are thus dismissed with comments such as, “Grow up,” “Deal with it,” or “Work it out yourselves.” Ignoring the problem, however, typically emboldens the malefactor to escalate the abuse to more overtly physical aggression that eventually causes serious damage. Alternatively, the persecuted victim, rebuffed by management, feels that he has no choice but to take matters into his own hands and retaliates explosively, becoming himself the perpetrator of workplace violence, a dynamic very similar to that noted in many episodes of school violence over the past decade (Bender &

McLaughlin, 1997; Johnson, 2000; Miller, 2000d, 2002b, 2003b, 2003c, 2004a, 2004b, 2007b, 2007c, 2007d, 2008b; Pitcher & Poland, 1992).

The Workplace Violence Cycle

Accounting for individual variations, there appears to be a certain predictable pattern in the evolution of many workplace violence incidents (Denberg & Braverman, 1999; Kinney, 1995, 1996; Labig, 1995; Mack, Shannon, Quick, & Quick, 1998; Neuman & Baron, 2005; Potter-Efron, 1998; Simon, 1996). The cycle typically begins when the employee encounters a situation (actual or imagined) that he or she experiences as antagonistic or stressful. This may be a single overwhelming incident or a capping event to a cumulative series of stressors—the proverbial “last straw.” The worker reacts to this event cognitively and emotionally based on his predisposing personality, psychopathology, and life experiences. In the typical workplace violence perpetrator, this reaction often involves a noxious stew of persecutory ideation, projection of blame, and violent revenge fantasies.

As these thoughts and emotions continue to percolate, the individual increasingly isolates himself from the input of others and accretes a mindset of self-protection and self-justification in which a violent act may come to be perceived as “the only way out.” Blame continues to be externalized and vengeance brews as the worker broods on some version of, “I’ll show them they can’t do this to me and get away with it.” For some individuals, the intolerability of the perceived workplace injustice leads to hopeless suicidality with a retaliatory tinge:

“If they can screw me, I can screw them back—big time. Why should other people go on having what they want and enjoying themselves, when I can’t? I’ll show them they can’t do this to me and get away with it. I may be going out, but I’m not going out alone.”

The perpetrator fantasizes that, after he’s gone, his Ramboesque exploits will be reported to millions of people around the world; his name will be a household word. Far from meekly slinking away, our hero will leave this world in a blaze of martial glory—just like in the movies.

The actual means of carrying out this commando action will be dictated by availability and, in our society, the easy obtainability of firearms usually makes this the method of

choice. The operational plan may be executed impulsively and immediately, or it may undergo meticulous planning with numerous revisions. The final step is the violent act itself, which may occur any time from hours to months to years following the final perceived injustice.

Workplace Violence Prevention

Remember, *the best form of crisis intervention is crisis prevention*. But despite the growing recognition of workplace violence as an occupational problem, denial still appears to be the coping method of choice among American employers. Only 25% of the companies surveyed offer formal training to any employees in dealing with workplace violence, and less than 10% offer such training to all employees in the company.

It doesn’t take much to correct this situation and the practical payoff can be palpable. For example, at the start of the 21st century, if someone is going to “go postal” on the job, that person is probably *least* likely to be an actual postal worker. That’s because, in the past two decades, the U.S. Post Office has undertaken a concerted and effective program to reduce violence at work. By responding in a similarly forthright manner, the retail trade, which in the 1980s and 1990s had accounted for more than one-third of workplace violence deaths, has managed to cut its rate of homicide in half over the past decade.

Companies can do a number of things to reduce the chances of violence at work (Albrecht, 1996, 1997; Blount, 2003; Blythe, 2002; Caponigro, 2000; Crawley, 1992; Dezenhall & Weber, 2007; Flannery, 1995; Grote, 1995; Kinney, 1995, 1996; Labig, 1995; Mack et al., 1998; Martinko, Douglas, Harvey, & Joseph, 2005; Miller, 1998c, 1999b, 2001a, 2001b, 2005c, 2008a; Mitroff, 2001; Nicoletti & Spooner, 1996; Schneid, 1999; Simon, 1996; Yandrick, 1996): They can have clear, strong, fair, consistent, and clearly written policies against violence and harassment and institute effective grievance procedures; they can maintain a firm security program at the same time as they cultivate a supportive managerial environment that strikes a balance between reasonable employee autonomy and control over their work, and effective supervision and communication when necessary; they can provide periodic training in resolving conflicts through team-building and negotiation skills.

Organizations should have a clearly stated policy of *zero tolerance for violence*. This should be contextualized as a safety issue, the same as with rules about fire prevention or disaster emergency drills. Company policies should state clearly that any manner of threatening remark or gesture in the workplace is unacceptable and that anyone who engages in such behavior will face disciplinary action. All threats should be thoroughly investigated, albeit with reasonable sensitivity to all parties. Having official rules that apply equally to everyone makes enforcement objective and impersonal.

But in order to prevent the workplace from becoming a caricature of some totalitarian, thought-police regime of political correctness, these policies and procedures should leave room for well-informed managerial discretion and basic common sense. Definitions of reportable behavior, with specific examples, should be established, distributed, and role-played, as necessary. Plans should be put in place that specify how and to whom threats and offenses are to be reported, as well as a standardized protocol for investigating threats. Other policy and procedure points include security measures, complaint and grievance procedures, and services available for dispute mediation, conflict resolution, stress management, safety training, and mental health services. Most companies can develop and write up these protocols themselves. Organizations with a large, diverse, and/or complex work force may want to avail themselves of qualified outside consultants.

Workplace Violence: Response to Emergencies

Sometimes, despite the best efforts at prevention, a dangerous situation begins to brew and a violent confrontation seems imminent. Other times, the incident just explodes and personnel have to respond on the spot. Part of the pre-incident emergency planning should include a contingency for evacuating employees and others and for alerting authorities, but employees and managers still may find themselves trapped in the position of having to stabilize the situation until help arrives.

The following guidelines for handling workplace violence emergencies have been adapted from several sources (Blythe, 2002; Caraulia & Steiger, 1997; Gilliland & James, 1993; Labig, 1995; Miller, 1999b, 2000a, 2000b, 2002c, 2005a, 2007a, 2007c, 2008a, 2008b, in press), along with my own

comments and suggestions. As always, these recommendations do not take the place of comprehensive on-site planning, preparation, and training, but they can serve as an interim practical guide to responding to behavior-based emergencies of many types, including workplace violence.

Recognizing Warning Signs of Impending Violence

Nonspecific “red flags” that an employee may be on the verge of losing control may include: disorganized physical appearance and dress; tense facial expression or other distressed body language; signs of intoxication or inappropriate use of dark glasses or breath mints to mask alcohol or substance abuse; severe agitation, verbal argumentativeness, or outright threats, especially to specific persons; and/or the presence or evidence of weapons.

However, in many cases, there may be no perceptible warning signs. Aside from these general indicators, managers and employees should try to know the people they work with as well as possible so they can be alert to any significant changes in their appearance, mood, or behavior and take action as early as possible to prevent things from boiling over into a violent confrontation (Miller, 2003a, 2008a).

Defusing a Potentially Dangerous Situation

A potential workplace violence crisis can be thought of as occurring in several stages, each with its own set of recommendations for defusing danger. Like all protocols, don’t think of these as an unvarying sequence of discrete steps but rather as general categories of response that can change course or blend into one another, depending on the person and the circumstances (Caraulia & Steiger, 1997; Labig, 1995).

In the *anxiety phase*, the employee is becoming increasingly overwhelmed and agitated, and the response that is most needed at this stage is support. The focus of the intervention should be on how the employee feels and what his concerns are. This involves rapport building and active listening, the mainstay of crisis intervention.

“You seem upset about something, Fred. Whatever’s going on, I hope you’ll let me help you out.”

In the *defensive phase*, the employee comes to feel increasingly trapped and out of options. The response needed here is a directive one in which the employee is shown a safe and dignified way out of the danger zone. Helpful tech-

niques involve encouraging and modeling self-control, redirecting anger, using calming body language, giving limited choices, and gently but firmly setting limits.

“I know you’re angry about the last suspension, but I don’t want you to do anything that’s going to hurt you further. C’mon, take a deep breath and let’s step into the atrium and talk this out. Or do you want to go down to the cafeteria and get a cup of coffee? I’m buying.”

In the *acting-out phase*, the employee has already lost some control. The appropriate response is containment. Until the cavalry arrives, focus on the employee’s immediate behavior, set clear and reasonable limits, and use calming speech and body language. If the employee has not yet been violent, and security or law enforcement personnel have arrived, you may sometimes be able to use them to leverage cooperation from the employee.

“Okay, Fred, I hear you, you made your point. Let’s pull this thing back, okay? We can replace the computer, but I need you put down the fire extinguisher and do whatever the security people tell you till we get this thing sorted out. I called the authorities here because I don’t want you or anyone else to get hurt.”

In the *tension-reduction phase*, the crisis has largely passed and the employee should be ready to accept help in reducing his level of anxiety and anger. Assuming no serious harm was done and the employee is not actually in custody, the appropriate response is a supportive type of rapport that is helpful, understanding, and calm. Reinforcing a controlled and face-saving ending to the potentially dangerous episode is often the best insurance that it won’t be repeated, even if the employee’s behavior eventually results in disciplinary action, termination, or arrest.

“I’m glad we were able to settle this, Fred. It took guts to do the right thing. We’re going to let the medics check you out and the police ask their questions, and then, when the dust settles a little, we’re going to figure out what to do next, okay?”

Handling a Violent Episode

When the situation looks like it’s getting beyond the point where it can be defused adequately, then safety comes first. The rule is: *When in doubt, get the hell out.* Pay atten-

tion to the environment and to potential dangers, make a mental note of possible escape routes, and think about how to call for outside help. If you find yourself absolutely trapped in a potentially dangerous situation, heed the following guidelines (Blythe, 2002; Caraulia & Steiger, 1997; Flannery, 1995; Gilliland & James, 1993; Labig, 1995), supplemented by adequate training and practice.

Initial action: If possible, don’t become isolated with a potentially dangerous employee or customer unless you have made sure that security precautions have been taken to prevent or limit a violent outburst. But sometimes an interview or disciplinary session begins benignly enough, only to quickly start spiraling out of control. If this happens, casually interrupt the interview to call and request something, while actually calling for help. That’s why it is important to have a prearranged signal for just such an emergency. Some authorities recommend directly telling the subject you are summoning help in order to maintain credibility in the interaction and because this may actually reassure some subjects who are feeling out of control. Other subjects may panic and attack you if they think you’re calling for backup. Assess the situation and use your judgment.

Body language: Don’t behave in ways that could be interpreted as aggressive or threatening, such as moving too close, staring, pointing, or displaying provocative facial expressions or postures. Try to stand at an oblique angle facing the employee: Not directly in front of him, which could be interpreted as a challenge, and not behind him, which may signify a possible “sneak attack.” Observe the general rule of standing “two quick steps” away from a dangerous subject. Some authorities recommend asking the employee if you can sit down, as this may constitute a less threatening figure. Then encourage him to be seated as well. If you’re already standing, and it looks safe, try to slowly and unobtrusively maneuver yourself toward a doorway or other point of quick exit and always be scanning the environment for points of escape, but be careful not to be too obvious about doing this, which may antagonize the subject. Always move slowly and keep your hands where they can be seen.

Communication style: Keep the employee engaged in conversation about his feelings or about a specific problem, but avoid “egging him on.” Venting should not escalate to ranting. Keep the conversation going, pace it, and modulate your voice. Don’t shout, put a sharp edge on your voice, or use threats. Conversely, don’t mumble or speak hesitantly so that the employee has trouble understanding you, which

he may find irritating. Give the employee your undivided attention and use empathic listening skills, such as simple restatement of the employee's concerns to show you're "getting it."

Use common sense and your own good judgment, but generally don't attempt to logically reason with a subject who is under the influence of drugs or alcohol or is clearly irrational or psychotic. The purpose of your communication is not to try to "talk him out of" his gripes or delusions: You won't. Conversely, don't pretend to agree with the subject's distorted point of view, because the perceptible deceptiveness and insincerity of this gesture may further infuriate him. Rather, show empathy and concern for his real or imagined plight and suggest alternative ways of resolving the crisis.

Another principle of crisis communication: *When in doubt, shut up*. Use silence as a tactic and let the employee talk, as the more energy and adrenalin he expends, the sooner he will fatigue and the easier it will be to control the situation. However, avoid seeming like you're totally ignoring the employee and be sure to answer when spoken to. Also, if his own speech seems to be agitating him further, use verbal and nonverbal calming techniques to ratchet down the tension level while continuing to let him talk.

Communication content: Don't argue, give orders, or disagree when not absolutely necessary. Don't push your own authority or blather on in an officious, know-it-all manner. Conversely, don't be overly placating or patronizing, and don't condescend by using childish responses that are cynical, satirical, or insulting. Be careful with attempts to lighten the situation with humor. Persons under extreme stress tend to be very literal and concrete, and even well-intentioned levity may be misinterpreted as mocking or belittling his plight.

Don't make promises you can't keep, except possibly to buy time in an emergency situation. Avoid complex "why" and "what" inquiries that put the employee on the defensive; rather, use simple, direct, close-ended, yes-or-no questions. Calmly and simply explain the consequences of further violent behavior without provocation or condemnation. Set limits and give choices between two alternatives: "I want to talk with you about this, Fred. Do you want to sit down here or go outside for a smoke?" Try to de-escalate slowly, moving from step to step toward less agitated behavior.

Scene control: Whenever there's a commotion, people may flock to the scene, either to help or just gawk. Don't

allow a number of interveners to interact simultaneously with the employee in multiple dialogues, as this can be confusing and irritating. Have one intervener take charge. If this person is clearly ignored or rejected by the subject, try to find someone who can establish better rapport. Any physical restraint or take-down procedures should be carried out by personnel with specialized training in this area. Don't allow an audience to gather around the employee, cheer him on, insult him, or shout at him from a distance; this includes the media. Anyone who has no business being there should leave immediately. If professional crisis negotiators or law enforcement officers show up at the scene, brief them as thoroughly as possible and then let them take charge.

Guns and Weapons

In many cases of workplace violence, the subject is armed (Schaner, 1996). An employee may have brought a weapon to the scene with the clear intention of using it or kept it with him during his conversations with his boss or coworkers, "just in case." In other situations, a customer may have a dispute with the company and bring along a weapon for backup, or it may just represent a robbery attempt. In any of these cases, when abruptly faced with an armed life-and-death confrontation, some basic recommendations (Dubin, 1995; Flannery, 1995) apply, to be supplemented by adequate training and practice.

The first thing to do upon seeing the weapon is to acknowledge it with a neutral and obvious remark (e.g., "I see the gun"). Maintain your distance, keep your hands visible, and move slowly. Never tell the subject to drop the gun or attempt to grab it, as he may have another weapon concealed or may simply overpower you. As rapport develops, and if the subject appears ambivalent about using the weapon, request that he point it away while you talk. Appeal to his sense of competence and control: To avoid an "accident," ask if he will at least decock the gun (revolver) or put the safety catch on (semiautomatic pistol). If he flat out refuses, let it go and just be cautious.

If the subject seems willing to surrender the weapon, don't ask him to hand it over, but rather have him unload it, place it down in a safe, neutral corner, and back away. Some authorities recommend that the intervener then slowly pick up the gun and neutralize it. If you do this, be careful not to point it at the subject, as this may give him an "excuse" to pull another concealed weapon or otherwise attack you.

However, any contact with the weapon on your part can be dangerous because you don't know whether he'll suddenly change his mind and think you're trying to attack him. Therefore, to avoid being baited into going for the gun, wait till the subject has put it down safely, then ask him to calmly walk out of the room with you, leaving the weapon behind.

One of the principles of crisis negotiation is that the more time that passes without the subject's firing the weapon or otherwise injuring anyone, the lower the overall likelihood of violence occurring (Gilliland & James, 1993; McMains & Mullins, 1996; Miller, 2005a, 2006d, 2007a, 2007c). Initially, however, you should comply with whatever reasonable and safe demands the armed subject may make ("Sit over there." "Get my supervisor on the phone." "Hand over the money."), taking special care to avoid agitating him further. Continue to talk to the subject (unless he tells you to be quiet), reasonably empathize with the perceived grievance or his feelings about it, and acknowledge that he's in control of the situation.

Try to appear calm, but not nonchalant or cocky, and not intimidating, confrontational, or argumentative. Encourage the armed subject to talk out his concerns, but remember the difference between venting and ranting; the former serves to blow off steam, the latter can cause the pot to explode. Employ the relevant defusing strategies discussed above (and reinforced by your training) until the crisis is safely and successfully resolved or until qualified professionals have taken control of the scene.

Workplace Violence Recovery

Sometimes the worst case scenario happens and a violent incident stuns and horrifies the workplace. People may be killed, others physically wounded, some held hostage, and many emotionally traumatized. It is in the aftermath of such a dramatic episode that executives, managers, and the mental health clinicians they consult with typically engage in the most intensive collaboration to facilitate the recovery of affected personnel and the company as a whole (Miller, 1998c, 1999b, 2008a).

Plans, Policies, and Procedures

A particularly fruitful collaboration among executives, managers, and mental health professionals concerns proactively setting up policies and procedures for respond-

ing to the aftermath of a workplace violence incident. Many of these originated in specialized settings such as mental health clinics or law enforcement agencies and have been developed and adapted for the corporate world by psychology and management experts (Albrecht, 1996, 1997; Blythe, 2002; Caponigro, 2000; Dezenhall & Weber, 2007; Flannery, 1995; Kinney, 1995, 1996; Mantell & Albrecht, 1994; Miller, 1998c, 1999b, 2008a; Mitroff, 2001; Yandrick, 1996).

Media and public relations: A specially designated media spokesperson should brief the media and, more importantly, shepherd them away from grieving employees, family members, and eyewitnesses. A firm, forthright, proactive, and sincere approach to providing information is preferred, from someone in a high position within the organization or, alternatively, a qualified outside public relations spokesperson or firm. Companies should always be prepared to offer a concerned and honest answer to the question: "What is this organization doing for the survivors and the victims' families?"

Employees and families: Someone should be designated to notify the victims' families of the incident and be ready to offer them immediate support, counseling, and other services. Personnel managers should arrange time off for grieving and traumatized employees as appropriate. Following the initial stages of the incident, the mental health clinician should help managers and supervisors find ways for the employees to memorialize slain victims.

Law enforcement, physical security, and cleanup: Someone should be assigned to immediately check, protect, and/or restore the integrity of the company's data systems, computers, and files. A representative should be designated to work with local law enforcement. The crime scene should be kept intact until the police have gone over the area. A cleanup crew for the site of the attack should be available, pending approval from law enforcement investigators. Exquisite sensitivity to surviving staff's feelings about "cleaning up the mess, like nothing happened" is crucial, and such cleanup operations should be conducted in as respectful, even solemn, a manner as possible.

Legal measures: In-house legal counsel or the company's outside law firm should be notified about the incident and, if necessary, asked to respond to the scene. They should advise company executives and managers as to appropriate actions immediately following the incident and in the weeks and months ahead. Always remember that the greater the

sincere concern shown by the company for their employees, families, and stakeholders, the lower the level of contentious litigation that is likely to occur in the months and years to follow.

Mental health mobilization: In the best case, planning will have included detailed preparation and practice drills with the company psychologist or outside mental health consultant. In most cases, it simply means that the mental health clinician has become sufficiently familiar with the organization to know how to gather critical information and respond promptly and effectively at the time of a crisis. Unfortunately, in many organizations, post-incident mental health services are farmed out to generic EAP counselors who, competent enough to handle routine mental health issues, have little or no training in posttraumatic stress syndromes or corporate crisis intervention.

Company representatives should know how to contact their mental health professionals immediately, arranging for the clinicians to meet first at top levels of the organization for executive briefings and then scheduling meetings with anyone in the organization who needs to talk about what happened. A critical incident debriefing area (see below) should be established for the responding mental health professionals. Optional crisis intervention services should be made available for all potential workplace violence victims, not just immediate survivors or employees. A follow-up schedule should be arranged for the clinicians to return to the site for further services as needed or for referral of employees to their private offices or clinics for follow-up counseling.

Restoring Order: Posttrauma Crisis Management

In the immediate aftermath of a workplace violence incident, available personnel must begin the process of accounting for slain, injured, and surviving employees while awaiting the arrival of post-trauma professional service providers. Company officials must communicate the message that all personnel and family members will be provided the utmost care and concern. Mental health consultants should advise managers and executives that many of their employees will be destabilized, demoralized, and disoriented and that they will be looking to company authorities to restore order and their sense of confidence and psychological equilibrium. This is a critical time. Failure to demonstrate constructive grief leadership following a crisis can leave a corrosive stain on the morale of the company that will be hard to expunge. The

following are steps that mental health consultants can assist companies in taking that are designed to facilitate the expression of concern and restore order following a workplace violence trauma:

- *Demonstrate concern and caring* for those who have been harmed by the trauma. The clear message that employees and other organizational stakeholders need to hear is that management is going to do everything humanly and administratively possible to care for those affected by this tragedy.
- Within the limits of privacy and security, *open up communication channels and control rumors*. Describe what actions the company is taking to assist in recovery and what measures are being developed to reduce the risk of this kind of trauma happening again.
- *Assess the organization's personnel and business requirements* in order to restore business performance. Inform employees what it will take to get back to normal and approximately how long it will take.
- Following the immediate and short-term crisis interventions, *arrange for the post-trauma mental health team to return to the workplace* on a periodic basis to counsel and debrief employees as needed.
- *Conduct a thorough postincident investigation*. Remember another principle of crisis intervention: *20/20 hindsight = 20/20 insight = 20/20 foresight* (Miller, 2006d, 2008b). Questions asked during the postincident investigation may concern the nature of the perpetrator, his relationship to the organization and with coworkers and supervisors, his history of disciplinary action or termination, his role as a customer or other outsider, the actions that led to his dissatisfaction as an employee or customer, any restraining orders or other legal actions and their enforcement, the workplace stressors that may have been involved, financial pressures, drugs, alcohol, mental illness or personality disorders, any warning signs that should have been heeded, and the company's overall security and threat assessment procedures.

In general, if there is any positive outcome that can emerge from a workplace violence incident, it is what can be learned in order to reduce the chances of the same kind of tragedy happening in the future. To the extent that this is accomplished, a greater sense of control and safety will allow

the traumatized company to heal itself and get back to business.

Role of Executives and Leaders

This sense of control and safety begins with a strong message from top management that emphasizes the company's willingness to take appropriate responsibility, address the causes of the incident in a forthright manner, provide services for all who need them, and pursue every necessary step and reasonable action to ensure, as much as humanly and organizationally possible, that something like this never again catches the company unprepared. Indeed, all successful managers, at any level, manifest the qualities of true leadership in both ordinary and critical circumstances (Miller, 2008a).

Workplace Violence: Psychological Effects

Here is where the mental health clinician can have the greatest impact on corporate crisis intervention, both in terms of direct clinical services and in a consultative role (Miller, 1998c, 1999b, 2008a, 2008b).

Workplace Violence Response Patterns and Syndromes

Individuals affected by workplace traumatic events may include injured employees, employees remote from the scene, witnesses, family members, first responders such as police or paramedics, stakeholders such as suppliers or customers who knew the victims, or any others connected to the trauma (Kinney, 1995, 1996; LeBlanc & Barling, 2005; Mantell & Albrecht, 1994; Neuman & Baron, 1998, 2005).

According to one model (Kinney, 1995), employees can be conceptualized as falling into three general groups, following a trauma, composed of those who:

- *Recover quickly.* Many individuals will show a relatively rapid, spontaneous recovery, seemingly without the assistance of any type of mental health intervention. Some of these apparently stoic souls, however, may be internalizing their pain and grief, only to unload their suppressed emotional burden at a later date.
- *Require modest psychological counseling.* These individuals may need some mental health assistance

in order to regain their previous level of confidence, security, and safety but are unlikely to become long-term patients.

- *Develop serious psychological disorders.* These may include PTSD, severe anxiety or depression, or somatoform disorders that require more extensive psychotherapy and/or other clinical services.

Some authorities (Flannery, 1995; Mantell & Albrecht, 1994) have identified three basic stages of reaction in the aftermath of a workplace violence incident, which appear to bear some similarity to the stages of response to many kinds of disasters.

Stage one: Shock, disbelief, and denial. This stage of the workplace violence response begins immediately after the incident and may last anywhere from minutes to hours to days, occasionally for weeks or even months. In severe trauma cases, people may wander about, stunned and dazed by the event they have just experienced. This reaction usually dissipates over time, shading into the remaining stages.

Stage two: Cataclysm of emotions. Here, the victims may run a gauntlet of different feelings as they try to come to terms with their experience. This stage can last for a few days or linger for years and can include feelings of vengeance directed against the perpetrator of the violence, anger against the company for failing to protect them, rage against God, fate, society, or the criminal justice system, and self-blame for failing to take the proper action, misperceiving the obscure warning signs, or just being in the wrong place at the wrong time. Survivors may experience fear and terror, suffer from phobias and panic attacks as they attempt to return to the workplace, and develop hypervigilance, intrusive imagery, withdrawal, sleep disorders, and health problems. They may experience grief, sorrow, survivor guilt, self-loathing, confusion, and depression as they return to the workplace and are reminded of fallen coworkers by worksite "grief anchors," such as a desk, workstation, or locker, photos, nameplates, media accounts, anniversary dates, and so on.

Stage three: Reconstruction of equilibrium. By this time, the survivors have finally begun to regain their emotional and mental balance. They have a new outlook, not just about what happened, but about themselves and how they have coped and will continue to cope. There are still good days and bad days, but the movement is definitely in the direction of recovery.

Posttraumatic Stress Disorder (PTSD) in Workplace Violence

When the serious psychological impact of the workplace violence event persists beyond a month, employee victims may develop full-blown *posttraumatic stress disorder*, or PTSD (Miller, 1994, 1996, 1998b, 1998c, 2006c, 2007f, 2007g, 2008b; Miller, Agresti, & D'Eusanio, 1999). The symptoms of PTSD may include increased physiological arousal and hypervigilance, intrusive thoughts and imagery, numbing and dissociation, nightmares and flashbacks, and associated cognitive, emotional and behavioral disturbances.

According to Flannery (1995), PTSD symptoms seen in victims of workplace violence may have their own particular form and rationale. Traumatic events destroy one's sense of reasonable mastery and personal control. Some victims assume a stance of over-control, trying to avoid ever being vulnerable again. Others try to regain control by blaming themselves for what happened. The implicit assumption is that if the victim did something to put himself in harm's way, then he can somehow change this so that it will never happen again; blaming the company, supervisor, or coworkers is an analogous process. Still others give up completely and descend into drugs and alcohol. They seem to have developed the assumption that because they were unable to avert the violence at work, they are unable to control anything in their lives.

Disruption of caring attachments and basic human trust is related to the fact that workplace violence is perpetrated by other human beings. To make matters worse, other employees may distance themselves from the surviving victims in order to avoid "contagion" or to self-protectively search for some aspect of the victim's behavior that "caused" the violence. This reinforces the employee-victim's withdrawal and produces a vicious cycle of alienation and recrimination.

A sense of meaningful purpose in life is disrupted in the wake of workplace violence. Victims don't feel safe, no longer regard daily life at work or home as predictable or controllable, and lose their motivation to "carry on." The deliberate, conscious threat to or destruction of human life by others is frightening and demoralizing, raising the existential problem of evil that must be addressed before the victims can once again begin to invest their time and energy in work, family, and recreational activities (Flannery, 1995).

Impact of Mass Violence at Work

Most recent studies of workplace violence have focused on dramatic events such as mass shootings (Classen, Koopman, Hales, & Spiegel, 1998; Fergusson & Horwood, 1987; Hough, 1985; North, Smith, McCool, & Shea, 1989; North, Smith, & Spitznagel, 1997; North et al., 1999; Schwartz & Kowalski, 1991; Smith, North, McCool, & Shea, 1990; Trappler & Friedman, 1996). These studies have documented considerable psychological impact on victims, witnesses, and families.

Gore-Felton, Gill, Koopman, and Spiegel (1999) studied the psychological effects of a 1993 mass shooting at an office building in San Francisco. In this incident, 14 people were shot and many employees were trapped in the building for several hours. Within 8 days of the shooting, one third of the 36 employees who worked in the building where the shootings took place were found to meet clinical criteria for acute stress disorder, or ASD, and it was mainly these employees who went on to develop PTSD later.

In 1991, a gunman drove his truck into the front of a crowded cafeteria in Killeen, Texas, and began shooting customers indiscriminately, many at point-blank range. After being wounded by police, the gunman fatally shot himself. He killed a total of 24 people, including himself. North, Smith, & Spitznagel (1994) examined acute traumatic stress symptoms in the men and women who were present during the mass shooting. More than 80% of those who witnessed the violence reported experiencing intrusive recall of the traumatic event, and one-half to three-quarters of these individuals experienced hyperstartle responses, insomnia, and nightmares.

On May 5, 1992, during closing arguments of a divorce proceeding in the local courthouse of the small upscale St. Louis suburb of Clayton, Missouri, the estranged husband pulled two revolvers from his briefcase and shot his wife and both parties' lawyers. He fired at the judge, missing him, and then strode through the back hallway, firing at several people. By the time police shot and wounded the gunman, his wife lay dead and five others were wounded. The whole episode lasted less than 10 minutes.

Johnson, North, and Smith (2002) studied the aftermath of the Clayton courthouse shooting by interviewing employees who were present that day. They found that one-fourth

of the participants in the study had a diagnosable psychiatric disorder after the courthouse shooting incident. However, three-quarters of the affected subsample had histories of preexisting psychiatric disorder, which was believed to be a risk factor for an adverse posttraumatic reaction. Only 10% of the sample developed a new psychiatric disorder that they had not experienced prior to the incident, and half of these represented classic PTSD syndromes.

Despite the relatively low rates of psychiatric disorder after the courthouse shooting, mental health services were mobilized and used abundantly. Nearly half the sample received some form of mental health intervention, which may have reduced the rates of psychopathology. In fact, although almost all respondents reported some degree of psychological distress from the incident, most reported relatively good levels of functioning by the time of the study and described relatively minor long-term effects of this incident on their lives. This argues for the importance of timely mental health intervention.

Johnson and colleagues (2002) speculate that the higher rates of PTSD following the Killeen, Texas, massacre may relate to the larger scope and greater intensity of that incident, with 24 fatalities and the associated terror and horror for victims trapped by a gunman shooting them at point-blank range for a period of a quarter of an hour. In comparison, the Clayton courthouse shooting involved one fatality, a shorter period of activity (less than 10 minutes), and less intense exposure (few individuals even seeing the gunman). It is also possible that individuals regularly frequenting a courthouse are more mentally prepared for the possibility of such an event, or at least more used to being in the presence of assorted rough characters, and thus might experience fewer psychological problems afterward.

Psychological Interventions for Workplace Violence

In addition to policies and procedures consultation with company managers and executives, trauma therapists and crisis counselors may be involved directly in providing clinical services to surviving victims of workplace violence and their coworkers, as well as to families of surviving or slain victims. Although many of the principles of effective counseling and therapy are universal (Miller, 1998c, 2006d, 2008b), some special challenges and considerations apply to providing mental healthcare in the workplace context.

Benefits of Organization-Based Workplace Violence Interventions

First, although most authorities emphasize the advantage of early identification and treatment of workplace trauma and other PTSD syndromes, many companies, agencies, and insurance carriers are still reluctant to make psychological referrals after a traumatic incident at work, fearing that such actions will lead to increased legal action against them or excessive outlays for treatment and disability benefits. In fact, actual experience documents the opposite: Prompt and appropriate psychological care of traumatized employees can reduce the number of stress claims and the cash amount of legal settlements, because responsible action makes a positive statement about the company's commitment to employee well-being. Further, with proper intervention, the affected employees are less likely to develop costly substance abuse, chronic pain, somatization, or other traumatic disability syndromes (Albrecht, 1996; Denenberg & Braverman, 1999; Everstine & Everstine, 1993; Flannery, 1995; Martinko et al., 2005; Miller, 1998c, 1999a, 2001a, 2001b, 2005c, 2008a, 2008b; Schneid, 1999; Yandrick, 1996).

Model Psychological Intervention Programs for Workplace Violence

In the past few years, a number of preventive and reparative trauma treatment programs have been developed for the psychological management of workplace violence. These have been developed for diverse needs and populations, including responding to a wave of terrorist robberies at financial institutions in the Netherlands (Brom & Kleber, 1989), dealing with American workplace accidents and violence (Everstine & Everstine, 1993), handling the stressors sustained by law enforcement and emergency services personnel during critical incidents (Mitchell & Everly, 1996), managing workplace violence in the healthcare setting (Flannery, 1995), and addressing the trauma of bank robberies in the United States (Jones, 2002).

Organizationally-Supported, Clinician-Guided Approaches

Brom and Kleber (1989) outline several principles of intervention that underlie their program. To avoid the potentially stigmatizing effect of singling out individuals, assistance offered to traumatized employees is standardized and all involved personnel are asked to participate. Assistance is for-

mulated as an official program within the organization, with a clear delineation of staff roles and responsibilities. Management assigns a skilled staff member or clinical consultant who is in charge of victim assistance, has no direct association with the career of the traumatized employees, and is not bound to report on the employees.

In this model, the clinician's function is solely to support the traumatized employees immediately after the event and in the longer-term recovery period. Organizations develop clear policies and procedures with regard to the temporary absence of traumatized employees and, if necessary, the transfer of an employee to another position within the organization without penalty or repercussions.

Everstine and Everstine's (1993) program is similar. Treatment of traumatized employees is carried out by mental health professionals with specialized training and experience in crisis intervention and trauma therapy. All employees are encouraged to participate, but those who are particularly resistant to the group process may be referred for individual counseling or psychotherapy. The treatment services are individualized to meet the needs of each particular employee and his or her job environment. Where return to the original worksite is not possible, retraining and reassignment are implemented.

According to this model, when a traumatic event occurs at the workplace, it is management's responsibility to take decisive steps toward facilitating stabilization and recovery. For example, time should be set aside for employees to discuss and work through their reactions to the event. Employees should be given as much factual information as possible about the incident, as well as the condition of coworkers (within the limits of privacy), to mitigate dangerous rumors and restore a sense of control. Employees who are in the hospital or recuperating at home need information and support as well, and efforts should be made to prevent them from being alienated from their fellow workers.

Workplace superstitions about "bad luck" often take the form of unaffected workers avoiding or actively ostracizing the trauma survivors for fear that the victims' ill fortune could "rub off" on them or because the victims are defensively regarded as somehow responsible for their fate, similar to the circumstance surrounding some sexual assault and other crime victims (Miller, 2008b). These potential sources of conflict may be defused in group meetings, restoring needed cohesion and workplace support (Everstine & Everstine, 1993).

Critical Incident Stress Debriefing (CISD)

Critical incident stress debriefing, or CISD, is a structured group intervention that was originally developed for law enforcement and emergency services personnel but has been adapted for use in a wide variety of settings, including the workplace, disaster management, healthcare settings, and the military (Clark, 2007; Dyregrov, 1997; Everly, Flannery, and Mitchell, 1999; Miller, 1998c, 1999c, 2005b, 2006b, 2006d, 2007e, 2008b; Mitchell & Everly, 1996, 2003; Mitchell & Levenson, 2006). The CISD process is designed to promote the emotional processing of traumatic events through the ventilation and normalization of reactions, as well as prepare for possible future crises. A CISD debriefing typically is a peer-led, clinician-guided process, although the individual roles of clinicians and peers may vary from setting to setting. The staffing of a debriefing usually consists of a mental health clinician and one or more peer debriefers (i.e., fellow workers who have been trained in the CISD process and who may have been through critical incidents and debriefings in their own careers).

A typical debriefing takes place within 24 to 72 hours after the critical incident and consists of a single group meeting that lasts 2 to 3 hours, although shorter or longer meetings may be dictated by circumstances. The determining factor in group size is usually how many people will have time to fully express themselves in the number of hours allotted for the debriefing; for this reason the group can be anywhere from 5 to 20 personnel. Where large numbers of workers are involved, such as in mass disaster rescues, consecutive debriefings may be held successively over the course of several days to accommodate all the personnel involved.

The International Critical Incident Stress Foundation protocol – or "ICISF model" – for a CISD consists of seven key phases, designed to assist psychological processing from the objective and descriptive, to the more personal and emotional, and back to the educative and integrative levels, focusing on both cognitive and emotional mastery of the traumatic event:

1. *Introduction.* The introduction phase of a debriefing is the time when the team leader – either a mental health professional or peer debriefer, depending on the composition of the group – gradually introduces the CISD process, encourages participation by the group, and sets the ground rules by which the debriefing will operate. Generally, these involve confi-

dentiality, attendance for the full session, unforced participation in the discussions, and the establishment of a noncritical atmosphere.

2. *Fact phase.* During this phase, the group members are asked to briefly describe their job or role during the incident and, from their own perspective, provide some facts about what happened. The basic question is: "What did you do?"
3. *Thought phase.* The CISD leader asks the group members to discuss their first and subsequent thoughts during the critical incident: "What went through your mind?"
4. *Reaction phase.* This phase is designed to move the group participants from a predominantly cognitive mode of processing to a more cathartic, emotional level: "What was the worst part of the incident for you?" It is usually at this point that the meeting gets intense, as members take their cues from one another and begin to vent their distress. Clinicians and peer debriefers keep a keen eye out for any adverse or unusual reactions among the participants.
5. *Symptom phase.* This begins the movement back from the predominantly emotional processing level toward the cognitive processing level. Participants are asked to describe cognitive, physical, emotional, and behavioral signs of distress that appeared (1) immediately at the scene or within several hours of the incident; (2) a few days after the incident; and (3) continually, even at the time of the debriefing: "What have you been experiencing since the incident?"
6. *Education (or Teaching) phase.* Continuing the move back toward intellectual processing, didactic information is provided about the nature of the stress response and the expected physiological and psychological reactions to critical incidents. This serves to normalize the stress and coping responses and provides a basis for questions and answers.
7. *Reentry phase.* This is the wrap-up, during which any additional questions or statements are addressed, referrals for individual follow-ups are made, and general group bonding is reinforced: "What have you learned?" "Is there anything positive that can come out of this experience that can help you grow person-

ally or professionally?" "How can you help one another in the future?" "Is there anything we left out?"

This is not to suggest that these phases always follow one another in an unvarying, mechanical sequence. I've found that in practice, once group participants feel comfortable with the debriefing process and start talking, there is a tendency for the fact, thought, and reaction phases to blend together (Miller, 1999c, 2006b, 2006d, 2007e, 2008b). Indeed, as Mitchell and Everly (1996, 2003) recognize, it would seem artificial and forced to abruptly interrupt someone expressing emotion just because "it's not the right phase." As long as the basic rationale and structure of the debriefing are maintained, the therapeutic process will usually ensue. Indeed, on a number of occasions, previously silent members have spoken up at literally the last moment, when the group was all but getting up to leave. Clinician team leaders typically have to step in only when emotional reactions become particularly intense, or where one or more members begin to blame or criticize others.

Assaulted Staff Action Program

Increasingly, medical and mental health care professionals are finding themselves at risk for violence at their jobs (Miller, 1997a, 1998a, 2000a, 2000b, 2000c, 2000f, 2002c, 2007e, 2008b). Building on the work of Mitchell and Everly (1996), Flannery and colleagues (Flannery, 1995; Flannery, Fulton, Tausch, & DeLoffi, 1991; Flannery, Penk, Hanson, & Flannery, 1996; Flannery et al., 1998) have designed a comprehensive, voluntary, peer help systems approach called the *Assaulted Staff Action Program* (ASAP), for health care staff who are assaulted by patients at work. The program provides a range of services, including individual critical incident stress debriefings of assaulted staff; debriefings of entire hospital units; a staff victims' support group; employee victim family debriefing and counseling; and referrals for follow-up psychotherapy, as indicated.

The ASAP team structure is comprised of 15 direct-care staff volunteers. To depathologize the process and maximize its appeal, the approach is conceptualized as psychoeducational, rather than as formal clinical counseling or psychotherapy per se. The ASAP has three supervisors, and the ASAP team director is responsible for administering the entire program and for ensuring the quality of the services.

When combined with preincident training and stress management, the ASAP approach has reportedly proven effective in ameliorating the psychological impact of patient assaults on employees and in significantly reducing the overall level of violence institution-wide. In facilities where it has been applied, the program has proven to be cost effective in terms of reduced staff turnover, less use of sick leave, fewer industrial accident claims, and a reduction in medical expense as overall assault rates have declined. Indeed, Flannery and colleagues (1991, 1996, 1998) make the practical, bottom-line point that the costs associated with the entire program are far less than that of one successful lawsuit.

Flannery and colleagues (1995, 1996) recommend the following basic steps in implementing an organization's own ASAP: (1) develop administrative support for the program; (2) tailor the model for the individual facility; (3) recruit the team members; (4) train the team; (5) field the completed service. Each step reportedly takes about a month, so teams can be online within about 6 months.

Enhanced Debriefing Model

Jones (2002) has developed a specialized debriefing model for employee victims of bank robbery trauma who, he believes, may suffer the additional stress and trauma associated with repeated exposure to workplace triggers and cues. This *enhanced debriefing model* (EDM) incorporates a structured, time-limited, group-based intervention much like CISD but places special attention on workplace support in the recovery process. Another aspect of this model is its emphasis on consultation and training of managers before an incident occurs, although, as we've seen, most CISD-based models, including ASAP, emphasize proactive training.

The importance of work environment support in the recovery process is emphasized to the organization through ongoing consultation with human resource directors and managers. Accordingly, the EDM program begins in a consultative mode by providing an appraisal of workplace support and making suggestions designed to increase organizational cohesiveness, especially during the critical moments immediately following the trauma. For example, EDM may help the managerial staff of an organization identify possible non-supportive aspects of the work environment that may interfere with victim recovery.

Based on numerous individual and group interventions I've carried out with survivors of workplace violence, I can-

not stress enough the importance of organizational support and commitment to the process of helping traumatized employees. In one of the worst cases I can remember, a bank branch grudgingly arranged for a staff debriefing after a holdup, only because the service was mandated by their managed care contract. The branch managers clearly regarded the whole thing as a waste of time that cut into the employees' work hours. The most uncomfortable back room in the storage and lunch area was found for the debriefing, which was frequently interrupted by other employees coming in and out to get coffee or use the bathroom. Entering coworkers (who had not been involved in the robbery) gawked at the seated debriefees, and a few made audible sarcastic comments about "free time." Needless to say, the participants wanted the whole thing over with as quickly as possible, and little therapeutic work was accomplished.

The best case I can remember, in terms of company support, involved a hostage and shooting crisis perpetrated by a disturbed customer of a medium-sized investment firm, which resulted in two deaths and several injuries. Almost immediately, the firm's president suspended business as usual, arranged for temps to cover the basic needs of the company, offered his home to be used for almost round-the-clock debriefings of the almost 100 employees, and provided food, beverages, and in a few cases, bed and board to employees who were too upset to drive home. He and the senior management staff offered any kind of practical help they could to survivors and their families, personally checked on proper funeral arrangements for the slain employees, visited the employees who were in the hospital, and generally shared in the grief and recovery of the members of their staff. Far more than any specific clinical services I could provide, this natural, unselfish, human response to tragedy within the ranks on the part of senior staff – the true definition of "leadership" – helped this firm to heal quickly and move on, always holding a place of respect for their slain comrades, but honoring their memories by productively continuing their work.

Workplace Violence and Women

As more women join the workforce, they increasingly become the targets of violence. Certain special considerations affecting women on the job warrant special attention.

Homicide is the number one cause of death for women in the workplace. Although the leading instrument of death on the job for both sexes is a firearm, women are six times more

likely than men to be strangled to death. In the United States, while only one out of five people murdered at work is a woman, 40% of women who die on the job will die from homicide, compared to 10% of men. In other words, while men are more likely to die from falls, electrocution, or other industrial accidents, women are more likely to die from workplace violence (Kinney, 1995; Simon, 1996).

Types of Workplace Violence Against Women

Women are at increased risk for many different forms of workplace violence, including homicide, sexual assault, sexual abuse and harassment, gunshot wounds, stabbing, strangulation, physical beatings, verbal abuse, and psychological trauma. Both the number and the percentage of women who work outside the home have increased steadily throughout the 20th and early 21st centuries. At the same time, divorce rates are high and single motherhood continues to increase. Many women are relegated to low-wage and low-status service or clerical jobs that place them on the front lines as cashiers, waitresses, and so on, where workplace security measures are often meager or nonexistent. When violence does strike women, the repercussions are likely to impair both the financial and emotional well-being of their families (Kinney, 1995).

More women than men work in the retail industry, and women in these settings often work alone and unprotected, at high risk of being injured or killed. Moreover, employees in these low-status positions are less likely to have the clout to persuade employers to take threats seriously or to invest money in security precautions. In some cases, workers who “make trouble” are simply fired. In addition, the entry of greater numbers of women into the workforce is frequently accompanied by resentment by insecure men, who may feel that their jobs or promotions have been unfairly stolen by women or that working side-by-side with women diminishes the traditional manliness of their occupation (Kinney, 1995; Simon, 1996).

Sexual Harassment and Domestic Violence

Sexual harassment has become the quintessential form of interpersonal violation experienced by women on the job (Hoffman & Baron, 2001), and severe forms of sexual harassment can be regarded as a form of workplace violence. Even “mere” verbal intimidation or harassment can inflict acute

and long-lasting emotional harm. In addition, sexual harassment is sometimes a precursor of more overt forms of physical violence such as stalking, assault, rape, or murder in the workplace (Kinney, 1995; Schouten, 1996).

Domestic disputes have become the third major source of conflict leading to homicide in the workplace. A sagging economy usually brings an increase in domestic violence as unemployed husbands or boyfriends project their anger and frustration onto their wives or their female workmates. Rejection of on-the-job suitors or workplace harassers often places these women at increased risk of violence at the hands of the spurned and the jilted. When even initially consensual romances inside or outside the workplace sour, the rejected male abuser may become a stalker who usually knows where the woman works and generally has ready access to her place of employment. A common response of employers who are fed up with all the trouble is simply to fire the woman (Brownell, 1996; Friedman, Tucker, Neville, & Imperial, 1996; Hamberger & Holtzworth-Munroe, 1994; Hoffman & Baron, 2001; Kinney, 1995; Labig, 1995; Meloy, 1997; Miller, 1995, 1997b, 1998c, 2001c, 2008b; Walker, 1994).

How Women Can Protect Themselves

With regard to domestic violence spillover, sometimes legal restraining orders work and sometimes they just make matters worse. Much depends on the ability and willingness of local police to enforce them. Many domestic violence cases involve a victim who is ambivalent about leaving or staying with the abuser, which can prove extremely frustrating for bosses and coworkers who are trying to be helpful, because their well-intentioned suggestions may be rejected or misinterpreted by the confused or frightened employee: “Does she want our help or not?” People’s privacy at work should of course be respected, but if they are going through messy domestic battles or, for that matter, other personal crises that affect their jobs and their lives, they need to know that it is all right to confide in the right persons at work and that the proper protective or other assistive measures will be taken. At the same time, they may also need to be reminded of their obligation and responsibility to deal with personal problems that impair their job functioning and that might put other employees at risk (Hoffman & Baron, 2001; Labig, 1995; Pierce & Aguinis, 1997).

Companies can take several steps to protect employees from stalkers (Flannery, 1995; Hoffman & Baron, 2001; Kinney,

1995; Meloy, 1997; Miller, 1998c, 2008b; Pierce & Aguinis, 1997). The first priority is to establish a policy providing reasonable protective services to threatened employees. If possible, the employee's office or work station should be relocated to a place unknown to the stalker, and her work schedule altered to confuse the pursuer. Descriptions or photographs of the stalker should be provided to receptionists, security officers, and other relevant personnel. Law enforcement can be encouraged to enforce restraining orders by forging links between company security and local police. If the threat is acute, the employee at risk should be given time off. Silent alarms or buzzers should be placed at the threatened employee's work station, and security cameras should be deployed near entrances to her work area. Security measures work best when they are planned, coordinated, and integrated.

With regard to sexual harassment, companies can take several effective measures (Kinney, 1995; Schouten, 1996, 2006; Martinko et al, 2005; Miller, 1998c, 2008a, 2008b; Yandrick, 1996). A serious sexual harassment policy should describe the specific conduct that constitutes harassment and state unequivocally that such conduct is tolerated neither by the company nor by state and federal law. The policy should explain the employee's right to report sexual harassment without fear of retaliation and without having to directly confront the harasser, at least at the time of the initial complaint. The policy should have a grievance procedure that the harassed employee can follow, as well as sexual harassment hotlines for emergency situations; such hotlines are now required by law in at least 30 states.

Conclusions

The design and maintenance of behaviorally safe workplaces represents a vital collaboration between industry and the mental health professions. Employers must learn to take all threats to worker safety seriously and take action to deal with those threats. They must encourage all employees, men and women, to report any breaches of personal or company security. Violence prevention should be an equal priority with fire prevention as a corporate safety issue. Companies must have measures in place to deal with disciplinary matters, safe hiring and firing, escalating crises, ongoing emergencies, and aftermath effects. These measures will reduce the risk of avoidable tragedies.

Just as importantly, companies that encourage a fair and honorable corporate culture are more likely to earn the respect and loyalty of their employees (Miller, 2008a). These employees will be more productive, and higher productivity means greater profitability. Indeed, appropriate response to a workplace violence incident can often make the difference as to whether a small-to-medium-sized company or local branch can survive and continue doing business. Mental health professionals and organizational behavior specialists will have an increasingly vital role to play in advising, consulting, and providing direct clinical services to public organizations and private companies of all types at the start of this new century.

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A Study of the Psychological Factors in Outcomes for Officers Who Survive Ballistic Assault

Jennifer C. Swaim

Department of Psychiatry and Behavioral Sciences
Akron General Medical Center

Mary J. McMullen

Department of Emergency Medicine
Akron General Medical Center

Carolyn J. Williams

Department of Emergency Medicine
Akron General Medical Center

Jeffrey L. Moore

Department of Psychiatry and Behavioral Sciences
Akron General Medical Center

Alan D. Gilbertson

Department of Psychiatry and Behavioral Sciences
Akron General Medical Center

Abstract: *Among law enforcement personnel, who are subject to assault with firearms, there has been a trend toward decreased mortality and physical morbidity associated with the use of personal protective armor (PPA). Although there has been an increase in the rate of survival, studies of the unique psychological factors associated with this type of assault are essentially nonexistent. The prevalence and nature of the negative psychological sequelae associated with this type of assault and psychological injury, along with effective prevention techniques, were studied through retrospective interviews of registrants in two "body armor survival clubs." Significant relationships were found between available interventions and behavioral health outcomes. In addition to reducing the likelihood of poor health outcomes, departmentally based interventions were related to officers' ability to develop positive interpretations of the event and engage in fewer high risk behaviors. These findings suggest that departmental interventions, such as debriefings, are meaningful and may help improve outcomes for officers fired upon, but not wounded, in the line of duty. [International Journal of Emergency Mental Health, 2007, 9(4), pp. 281-290].*

Key words: *trauma survival, debriefing, law enforcement officer injury*

The Federal Bureau of Investigation (FBI) indicates that more than 57,000 police officers were assaulted in the line of duty in 2003 (Federal Bureau of Investigation & U.S. Department of Justice, 2004), with approximately 28.2% of these officers sustaining injury during the assault. Firearms were used in 1866 of these assaults, and of these individuals, 160

are known to have sustained injury. The number of law enforcement officers assaulted with firearms has shown a trend toward decreased mortality in the past 25 years since body armor has become widely available, and ballistic assault survival rates are correlated with this increase in availability (FBI & U.S. Department of Justice).

The decreasing trend of mortality is positive; however, this does not mean that the assaulted individuals are free from physical or psychological injury. While penetrating torso

Correspondence concerning this article should be directed to:
Jennifer Swaim, Ph.D., at jcswaim@gmail.com.

injuries from firearms can be minimized through the use of personal protective armor (PPA), penetrating wounds and blunt injuries still occur (McMullen, Martin, Williams, & White, 2003). Thus, despite advances in protective technology, a significant threat to life and limb continues to be involved in firearm assaults. An unknown aspect of assault survivorship is the prevalence and nature of the psychological consequences associated with persons who survive ballistic assault while wearing protective equipment.

Officers who have been shot but have had the severity of their injuries attenuated by the use of protective equipment represent a unique population of trauma survivors. Typically, officers who sustain penetrating injury in the line of duty receive significant support following the event. Anecdotal commentary from police chiefs, officers, and body armor survival club personnel indicate that the same degree of attention and support is not common when an officer is fired upon and struck but not invasively wounded, due to the protection offered by protective equipment. Although medical needs in both scenarios (penetrative and non-penetrative injury) are generally addressed promptly, the psychological aspects of these encounters are frequently overlooked or minimized in cases where officers are not invasively wounded. Minimization of the psychological aspects of the event, in addition to the lack of timely and proper evaluation and treatment, is thought to result in damaging consequences for an officer who has been involved in a critical firearms-related incident. To help improve post-shooting reactions, specific guidelines that encourage departmental support systems have been formally developed by the Police Psychological Services Section of the International Association of Chiefs of Police (IACP, 2004).

While mandated debriefings have been the source of some controversy in recent years, they are nevertheless important and efficacious, and there is some evidence that proactive departmental responses that facilitate the ability of officers to cope with stress reactions may be beneficial to police officers. The first study is a survey published by Loo in 1986. In this survey of 56 Canadian officers involved in traumatic events, open-ended inquiry identified having emotional support systems in place immediately following the shooting as a key need. Loo's (1986) research also suggests that reframing leave time following an incident as administrative leave rather than sick leave may help prevent the possibly negative connotations of utilizing a strategy intended to avert the development of severe symptomatology. A second

study (Robinson, Sigman, & Wilson, 1997) found that 63% of suburban police officers believed that a critical incident debriefing would help to cope with a stressful duty-related event. Most published studies that assess police involvement with shootings focus on the psychological impact of officers' use of deadly force (Klinger, 2001), with comparatively fewer studies concentrating on police officers as victims of a shooting (Brubaker, 2002; Federal Bureau of Investigation & National Institute of Justice, 1997; Loo, 1986; Martin, McKean, & Veltkamp, 1986). These studies provide evidence that significant psychological reactions for officers involved in ballistic assault exist. Given the direct exposure to the possibility of death or threat to one's physical integrity, which is among the criteria for post-traumatic stress disorders as defined by the Diagnostic and Statistical Manual-IV-TR (American Psychiatric Association [APA], 2000), the risk of developing post-trauma related stress reactions is expected to be higher among this population. Despite the likely incidence of post-trauma complications, to date, only one empirical study, an unpublished dissertation, has attempted to evaluate the unique experiences of those officers whose injuries are minimized through the protection provided by PPA (Westrick, 1999).

There is significant attention in the trauma literature regarding how characteristics of the traumatic event affect outcomes. Some authors indicate that individual characteristics may be contributing factors to the likelihood of a negative adjustment (e.g., Breslau, Davis, & Andreski, 1995), while other researchers associate the primary contributing factors to maladjustment to the nature and severity of the trauma (Brewin, Andrews, & Valentine, 2000). Previous research has indicated the need for further studies investigating the factors that contribute to resiliency under the assumption that a "hardy personality" may help diffuse the negative effects of traumatic events (Kobasa, 1979; Paton, Violanti, & Smith, 2003). Only one study utilized a longitudinal research design to investigate the interaction between individual characteristics and critical incident exposure in police officer post-trauma reactions (Hodgins, Creamer, & Bell, 2001).

This study of the psychological sequelae following ballistic assault survivorship involving PPA was a follow-up to McMullen and colleagues' (2003) investigation of physical injuries associated with this type of incident. The present study sought to further investigate the prevalence, nature, and impact of psychological consequences following non-penetrating injury while wearing PPA. Additionally, this study

was designed to identify factors that may foster psychological recovery, such as the effects of mandated counseling, impact of departmental support on officers' outcomes, and ability to eventually develop positive interpretations of the event.

The first goal in this exploratory study was to identify factors associated with both positive and negative outcomes following ballistic assault without penetrating injury. The design of our interview questions and initial analyses were organized to identify prevalence of increased substance abuse, sleep disruption, interpersonal problems, and negative career consequences. These were selected as key variables of interest to study in relation to three central questions. Do differences in negative stress consequences exist relative to the type of psychological support that was offered or sought? How is satisfaction with departmental support/psychological services offered related to effective recovery? Finally, is the ability to find positive meaning related to the critical event associated with improved outcomes?

METHOD

The most systematic national reporting of police officers injuries is through the National Institute of Justice under the Uniform Crime Reporting Program. However, this data bank does not record data that allow for the unique identification of those officers who are shot and injured while wearing personal body armor. Further, there is no known recording system for tracking officers who are fired upon but not injured in the line of duty. To obtain information on this unique population, the researchers utilized two industry databases: the International Association of Chiefs of Police (IACP) Dupont Kevlar Survivors' Club and Second Chance Saves.

The IACP/Dupont Kevlar Survivors Club is a voluntary reporting program. Started in 1987, the club accepted any law enforcement officer (LEO) whose use of personal body armor helped to save his or her life or prevent serious injury from firearms assaults as well as attacks with knives, clubs, chains, car and motorcycle crashes, and fires and explosions. The IACP/Dupont Kevlar Survivor's Club Executive Board approved our request for access to their data by providing limited contact information to the officers' agency information. The restriction on accessing a completed database limited our ability to contact officers who were in large departments or who had left their agency.

The Second Chance Saves Club began collecting data in 1973. Their computerized database included the officer's name, address, phone number, e-mail address, agency name with address and phone number, and information regarding the incident.

Both databases required outside verification of the event. Individuals who were not injured by firearms or who were not law enforcement officers injured in the United States were excluded from the study. A letter was mailed to each officer explaining the purpose of the study and giving them the opportunity to decline participation. Subsequently, the researchers attempted to contact each officer at least three times. Using these methods, 194 officers (191 men, 3 women) shot while wearing PPA were recruited for participation in this retrospective study.

Participants were initially studied to evaluate medical injuries associated with surviving ballistic injury while wearing PPA (McMullen et al., 2003) and were identified through their membership in "body armor survival clubs." Successful contact and enrollment in the original study regarding medical injuries yielded 332 officers (35.0% of the eligible participants). Of those participants, the psychological follow-up study includes those who were willing to participate in an additional survey of psychological issues, and could be contacted ($n = 259$ or 78.0%). Only 14 of the 332 individuals who could be contacted declined to participate in the follow-up study (4.2%). At least three attempts were made to contact each of the potential participants.

A semi-structured interview with each participant was conducted via telephone by trained researchers. The interview was designed specifically for this study to gather both quantitative and qualitative information on the nature of the critical incident in which the officer was involved, to evaluate the type of psychological support services offered following the incident, to gather further information regarding the long-term consequences experienced by each officer, and to obtain opinions and reactions to the event.

Related to the long-term consequences, information on the negative impact on officers' careers, interpersonal relationships, sleeping patterns, and degree of increased substance use/abuse following the critical incident was gathered. These variables were selected as representative of general distress in social, occupational, or other significant areas of functioning, as any long-term psychological distress would be expected to have a negative impact on one or more of

these domains of functioning. In our study we were interested in understanding the full spectrum of stress-related consequences that officers experienced, and therefore we used a broader definition of stress rather than limiting our survey to those officers who could officially be diagnosed with Posttraumatic Stress Disorder (PTSD; APA, 2000). Our rationale for this approach was that while officers may not meet the criteria for a formal disorder, the stress associated with the assault may still have had a negative impact on their lives.

As this was designed to be an exploratory investigation of what the researchers anticipated to be the likely sequelae, and as there was no attempt to render a formal diagnosis for a psychiatric condition, validated instruments were not utilized. Questions regarding long-term consequences were asked in a yes/no format (e.g., “Were you offered any psychological help/evaluation?”; “Did you experience problems with interpersonal relationships in the time after you were shot?”; “Did you have trouble falling asleep after the event?”). These questions were coded as binary responses prior to analysis.

All data were analyzed using the Statistical Package for Social Sciences (v. 11.0). The criteria for statistical significance were set a priori at .05. To reduce the number of analytic comparisons, a composite stress index was calculated. This index is a simple, non-weighted, averaged calculation taken from all measurements of stress response items.

RESULTS

Descriptive Statistics

The 194 participants in this sample represent 75% of those who indicated that they were willing to participate and were able to be contacted for interview. Information on age, race, present marital status, and other demographic data was not obtained, as it was not provided from the survival databases and was omitted from the interview to help reassure participants of the complete confidentiality of their responses. The average length of time between the date of interview and the date of incident was 13.4 years ($SD = 7.3$), with a range between 2 to 30 years post-incident. Tables 1 through 5 contain information regarding the frequency of responses obtained in our sample. Responses have been organized into groups for ease of interpretation.

Table 1
Frequency of Sleep Disturbance

	No	Yes	No Data
Trouble sleeping (general)	88 (45%)	106 (55%)	—
Difficulty falling asleep	128 (66%)	66 (34%)	—
Nightmares	110 (56%)	84 (43%)	—
Use of sleeping pills in 1st year	172 (89%)	21 (11%)	1(.5%)

Table 2
Frequency of Substance Abuse

	No	Yes	No Data
Increased alcohol	162 (84%)	31 (16%)	1 (.5%)
Use of prescription medications	174 (90%)	19 (10%)	1 (.5%)

Table 3
Frequency of Relationship Problems

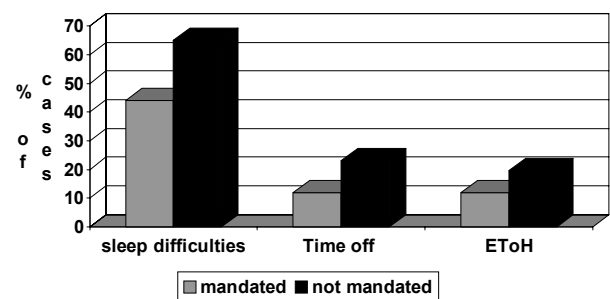
	No	Yes	No Data
Divorce	146 (75%)	8 (25%)	—
Relationship breakup	179 (92%)	14 (7%)	1 (.5%)
Abuse partner/spouse	190 (98%)	2 (1%)	2 (1%)
Unfaithful in relationship	186 (96%)	6 (3%)	2 (1%)

	No	Yes	No Data
Change jobs within 5 years	151 (78%)	42 (22%)	1 (.5%)
Retire	176 (91%)	12 (6%)	6 (3%)
Switch departments	160 (83%)	28 (14%)	6 (3%)
Leave police work	178 (92%)	9 (5%)	6 (3%)

	No	Yes	Don't Know	No Data
Time off for psychological issues	158 (81%)	34 (18%)	1 (.5%)	1 (.5%)
Departmental policy followed	16 (8.2%)	90 (46%)	87 (45%)	1 (.5%)
Policy in place at time of shooting	94 (49%)	99 (51%)	1 (.5%)	—
Sought psychological help on own	146 (75%)	47 (24%)	—	1 (.5%)
New policy since the incident	44 (23%)	128 (66%)	20 (10%)	2 (1%)
Offered psychological help	58 (30%)	135 (70%)	—	1 (.5%)
Debriefing mandated	102 (53%)	92 (47%)	—	—

Do differences in negative stress consequences exist relative to type of psychological support offered or sought? Chi-square tests of significance evaluating mandated debriefings and the presence of stress symptoms, across domains, showed no statistically significant relationship between whether debriefing was mandated or not and adverse psychological effects. Despite the absence of statistical significance at the .05 level, the trends in the observed frequency of collected data point toward certain post-trauma reactions that may be more prevalent when debriefing is not offered (Figure 1).

Figure 1. Disturbance levels by debriefing



Specifically, voluntary time off for psychological reasons was taken more frequently (23.0%) when debriefing was not mandated versus cases in which it was mandated (12.0%), self-reported increased alcohol use was greater when debriefing was not mandated (19.6%) than when debriefing was mandated (12.0%), and finally, sleep difficulties were more common when officers were not mandated to receive debriefing (65.0%) than when debriefing was mandated (43.0%).

A closer examination regarding the frequency and types of reported sleep disturbance, based on whether debriefing was mandated or not, shows that in all measured domains sleep disturbances were more often reported by those individuals who did not receive mandated debriefings. Specifically, when debriefing was mandated, difficulties with sleep onset were reported in 27% of cases versus 40% in the non-mandated debriefing group. The presence of nightmares was reported among only 35% of the mandated debriefing group versus 51% of the non-mandated debriefing group.

The prevalence of interpersonal relationship problems appears to be approximately equal between groups, as illustrated in Table 6. Similarly, the presence or absence of mandated debriefing procedures appears to have had little impact

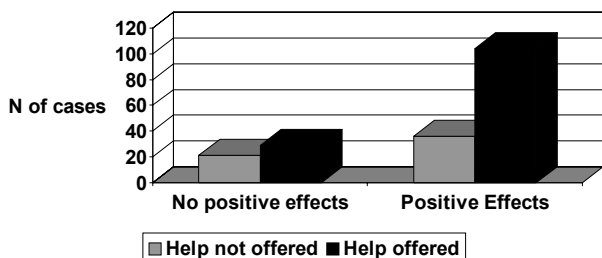
on rates of job change or retirement, as also shown in the same table.

Table 6
Frequency of Relationship Dysfunction and Job Change by Debriefing Group

	Debriefing Mandated	Debriefing Not Mandated
Divorce/breakup	30 (32.7%)	32 (31.3%)
Physical abuse	1 (1.1%)	1 (1.0%)
Unfaithful	2 (2.2%)	4 (3.9%)
Changed job within 5 year	20 (22%)	22 (22%)
Retired	4 (5%)	8 (8%)

How is satisfaction with departmental support/psychological services offered related to effective recovery? The analyses show that following the incident, being offered psychological help of any kind was associated with a greater likelihood of reporting positive effects from the experience: $\chi^2(1, n = 190) = 4.65, p < .05$. A graphical representation of this analysis can be found in Figure 2.

Figure 2. Effects of Departmental Support on Positive Interpretation of Event



Being offered psychological help was significantly correlated with job stress. As represented in Figure 3, job stress was reported significantly less often for those officers who reported being offered psychological assistance after their incident, $\chi^2(1, n = 187) = 4.8, p < .05$, than those who were not offered assistance.

Figure 3. Effects of Departmental Support on Experience of Job Stress



Higher stress levels were moderately correlated with employment transitioning. Changing jobs within 5 years of being shot was significantly related to the composite stress index, $r(186) = .59, p < .01$. The same index was moderately correlated with officers choosing to switch departments, $r(186) = .53, p < .01$.

Is the ability to derive positive meaning associated with improved outcomes? In this sample, 72.2% ($n = 140$) of respondents reported that they were able to derive some positive meaning from the experience, and 26.3% ($n = 51$) indicated that they found no positive meaning. Correlations calculated between the ability to identify positive interpretations of the event and our variables suggesting adverse psychological effects (substance abuse, sleep disruption, interpersonal problems, and negative career consequences) were all not significant.

Additional Finding

Increased use of alcohol after the critical incident was reported in 16% of cases overall, and utilization of a prescription medication was reported in 10% of cases. Self-reported increases in alcohol consumption were associated with higher scores on stress levels as measured by the composite stress index, a relationship that was statistically significant: $r(186) = .51, p < .001$. Although a chi-square comparison was not significant at the .05 level, the frequency of increased alcohol use was higher in cases where debriefing was not mandated (19.6%) than in those cases where it was mandated (12%).

DISCUSSION

The descriptive information presented in Tables 1 through 5 represents the first known published data on these variables regarding such a large sample of officers who have

experienced ballistic assault without penetrating injury. These data indicate that sleeping difficulties are a common event occurring in over half of this population (55%), and both difficulty with both sleep onset (34%) and nightmares (43%) are experienced frequently. These numbers are very high in comparison with population base rates for post-trauma symptomatology. A catchment area study published by Helzer, Robins, and McEnvoy (1987) found that only 15% to 16% of their subjects reported similar symptoms. Police officers frequently encounter disturbed sleep, with frequencies of clinical insomnia found in as high as 64.1% of officers (Neylan et al., 2002). However, the highest rate of nightmares found among police officers was 5%. In comparison, 43% of our respondents acknowledged having nightmares. Among our subjects, sleep difficulties were reported with greater frequency when debriefing services were not mandated than in those cases where they were, suggesting that despite the work-related source of the sleep impairment, debriefing procedures may help mitigate the impact.

Self-reports of substance use and abuse are generally believed to underestimate actual rates of occurrence. Nevertheless, 16% of this sample indicated that they had increased alcohol consumption following the event. This study found that officers who reported unhealthy levels of alcohol intake following the event were also likely to have higher scores on the composite stress index. Observed frequencies in reported patterns of drinking suggest that officers who participate in a mandated debriefing may be less likely to increase their alcohol use.

Do differences in negative stress consequences exist relative to the type of psychological support that was offered or sought? While statistically significant differences in negative stress consequences were not identified based on the type of psychological support offered, intergroup differences in the frequency of certain adverse effects were found. When debriefing was not mandated, officers reported an increased need for time off of work for psychological reasons (11% more frequent), increased use of alcohol (7.6% more frequent), and an increased level of sleep difficulties (22% more frequent). Closer examination of the pattern of increased sleep difficulties indicated elevations in reports of general sleep disturbance, difficulty with sleep onset, and prevalence of nightmares.

Previous research has shown that exposure to work events and PTSD symptomatology significantly increase alcohol usage (Violanti, 2004). These observed trends suggest

that mandated debriefings may be related to less frequent reports of alcohol abuse. It is possible that mandated debriefing interventions may be beneficial in attenuating post-trauma substance abuse behaviors, a concept that warrants further investigation.

In certain areas, most notably the frequency of adverse employment consequences (e.g., changing departments or leaving police work) and adverse relationship events, the observed cell frequencies were nearly identical in the “debriefing mandated” versus “not mandated” groups.

The potential positive or negative impact of debriefing programs is an area of considerable debate (e.g., Everly & Mitchell, 2000; McNally, Bryant, & Ehlers, 2003; Rose, Bisson, & Wessley, 2006). This debate intensifies when the issue of mandated debriefing is introduced. The results of our study support mandated debriefing programs, in that they are associated with certain benefits to this unique population of individuals. The greatest benefits may be in the areas of post-event alcohol consumption, sleep disturbance, and increased need for professional leave time. Departmentally mandated debriefings were not associated with any increased frequencies of adverse stress reactions either in terms of statistical significance or observed trends.

How is satisfaction with departmental support/psychological services offered related to effective recovery? Our results indicate that when psychological help is offered to officers following ballistic assault, they experience a heightened likelihood of being able to perceive some positive effects from the experience. Offering psychological assistance was also related to less frequent perceptions of job stress, which may have implications for officers’ career decisions. In fact, these results suggest that departmental interventions that enhance officers’ perceptions of support could possibly decrease officers’ perceived job stress. As offering psychological assistance appears to help attenuate the perception of job stress (which may, in turn, moderate job turnover) and is also correlated with the longer term likelihood of interpreting the event as having some positive impact on an officer’s quality of life, offering psychological support as a routine procedure following incidents of this nature may serve both the needs of these officers and their departments.

A perceived lack of support following a traumatic incident may increase the likelihood of negative outcomes. Brewin and colleagues (2000) found that severity of trauma and post-trauma-related indices (particularly lack of social support and

additional life stressors) were stronger predictors of PTSD in cases of adult military and civilian (non-cancer) trauma samples relative to pre-trauma variables including demographic factors. A departmental policy whereby all officers who have experienced a traumatic event are offered support may prove to be a key factor in diminishing both the severity and frequency of reactions to trauma.

Is the ability to find positive meaning related to the critical event associated with improved outcomes? Interestingly, a relationship between positive interpretations of the shooting incident and the prevalence of either positive or negative stress events was not found. The ability to achieve a positive interpretation of the event may mediate some of the other findings of this study; however, the nature of the data did not allow for statistical investigation of complex relationships.

Future Investigations and Limitations of Present Study

Binary responses such as the yes/no responses given throughout the data gathered in this study are difficult to evaluate statistically. Future investigations on these and similar phenomena should include a broader range of response options, enabling the use of more sophisticated statistical analysis and interpretation. Additionally, the nature of the database contact information used for this study made it much more likely that only those officers who remained in the workforce could be contacted. We were able to enroll only 20.2% of the individuals identified in the databases. As a result, this sample likely does not include those survivors who sustained the most severe adverse psychological consequences and were unable to continue employment. Thus, the findings of this study probably far underestimate the true extent of the post-trauma complications. Furthermore, the average length of time post-incident was 13.4 years. Longitudinal study designs able to follow such a population over time, with repeated measures on the variables of interest, may help identify and characterize those individuals most at risk for negative post-event adjustment.

Future research investigations may be most useful if they are constructed to focus on the areas of interest identified in this study and implement the use of validated psychometric instruments. Our results indicate that these key areas

of adverse impact include lack of perceived departmental support, disturbed sleep patterns, alcohol abuse, relationship difficulties, and job stress. Sleep disruption, in particular, appears to be a very common occurrence in this population. Further research is needed to understand how post-traumatic sleep disruption is related to healthy and adverse adaptation.

Additional studies that identify the key components contributing to officers' perceived support are needed. Future research should thoroughly document the specific types of departmental support available, whether all officers are offered the same degree of support following assault, and whether utilization of services is mandated.

Conclusion

The results of this study yielded the largest sample size to date of police officers fired upon in the line of duty who did not sustain penetrating injury. Valuable information regarding the importance and benefits of psychological debriefing procedures was obtained for this population. This study provides important information regarding the symptoms that appear to respond best to these interventional approaches, namely quality of sleep, likelihood of alcohol abuse, and experience of job stress.

Our findings pose an interesting question. A positive association between mandatory debriefing and improved outcomes was discovered, as was a positive relationship between psychological services being *offered* and improved outcomes, but no unique influence of actually *receiving* psychological support and improved outcomes was detected. Could it be possible that, if the departmental culture conveys the validating message that these events are so serious that they necessitate routine supportive interventions, the message itself becomes a more powerful factor in mediating positive outcomes than the actual intervention? While this hypothesis certainly needs further investigation, it raises an interesting possibility for future research.

Our findings provide additional support for the implementation of mandated debriefing processes on officers who are shot but who do not experience penetrating injury as a result of the assault. These results also suggest that certain symptoms, most notably sleep disruption, are relatively normal following this unique type of trauma.

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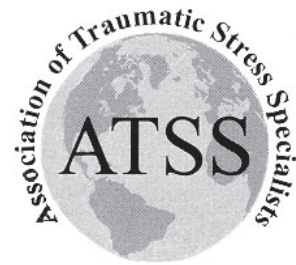
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Vicarious Trauma and First Responders: A Case Study Utilizing Eye Movement Desensitization and Reprocessing (EMDR) as the Primary Treatment Modality

Paul Keenan
Edge Hill University

Liz Royle
Pathways Through Trauma

Abstract: *Traumatic events can occur and adversely affect people during their lifetime. Natural disasters such as the earthquake in Pakistan in 2005 or the Tsunami in Asia in 2004, terrorist atrocities around the world, or personal events such as physical or sexual assault, can result in psychological difficulties for those people directly affected by these events. The diagnostic term Posttraumatic Stress Disorder (PTSD; Diagnostic and Statistical Manual of Mental Disorders, 4th edition, DSM IV, 1994) is generally used to explain the often-severe psychological sequelae (van der Kolk, 1996; Servan-Schreiber, 2004; Shapiro, 1995) that people may exhibit when directly affected by trauma. However, what of those people not directly involved in the trauma, but those who have borne witness to it, either by listening to the stories of survivors, or in the case of the helping professionals (such as police officers, nurses, doctors, psychotherapists, fire-fighters), actively working with survivors in psychological distress? This paper examines the potential psychological consequences for those in helping professions who are working with traumatized clients. This paper then focuses on a specific treatment intervention, EMDR, utilizing a case study by way of explanation. [International Journal of Emergency Mental Health, 2007, 9(4), pp. 291-298].*

Key words: *vicarious trauma, EMDR, helping professionals, police officers, cognitive schemas, stigma*

Paul Keenan MSc. PG Dip. RMN, is a European-accredited Consultant in EMDR. He is an accredited Cognitive Behavioural Psychotherapist with the British Association of Behavioural and Cognitive Psychotherapists and the United Kingdom Council of Psychotherapists. He is currently employed as a Senior Lecturer in Mental Health at Edge Hill University, Liverpool, UK. Mr. Keenan has been practising in EMDR since 1991 and has presented papers at many national and international conferences on the use of EMDR with Trauma, Peri-natal PTSD, Vicarious Trauma and Morbid Jealousy. He has also presented at various national and international CBT conferences on trauma and the combination of CBT and EMDR. As a member of the Humanitarian Assistance Programme (HAP), he has helped train clinicians in Turkey in 1999, following the earthquake and India in 2005, following the tsunami. Liz Royle MA, Dip PTS Couns, MBACP, is a European accredited Consultant in EMDR and an accredited ICISF trainer for Group Crisis

Intervention. As Senior Welfare Officer for Greater Manchester Police (GMP) up to 2004, she was responsible for leading a team of police welfare officers in the provision of 24 hour trauma support for police officers. Her research into police firearms officers and trauma was presented at the 2003 Research Conference for the British Association of Counselling and Psychotherapy and led to changes being implemented by GMP in their approach to trauma support. She now works with local authorities, security companies, police services and the voluntary sector providing crisis interventions, therapeutic support and proactive initiatives for managing trauma. She provided immediate and ongoing psychological support following the murder of DC Stephen Oake in 2003, the London bombings and the tsunami. *Correspondence concerning this article to Liz Royle at 346 Blackburn Road, Egerton Bolton, Lancashire BL7 9TR, United Kingdom; or send email to: liz.royle@pathwaysthroughtrauma.co.uk*

Helping professionals (HP), exposed to others' trauma in their daily working lives, are often traumatized and overburdened by narratives and events that happened to others (Martin, 2006). According to McCann and Pearlman's (1990) Constructionist Self-Development Theory (CSDT), people will give meaning to traumatic events depending on how, as individuals, they perceive them. These interpretations of the traumatic events may result in the HP experiencing changes in the way they view themselves, others, and their world. McCann and Pearlman (1990) coined the term *vicarious trauma* to describe these disruptions in cognitive schemas. Schemas are core beliefs about the self, others, and the world, often developed from childhood experiences and maintained and reinforced throughout one's life (Young, 1990). Neuman and Gamble (1995) purport that HP experiencing vicarious trauma begin to see the world through "trauma lenses." Pearlman and Saakvitne (1995a; p.31) state, "Vicarious trauma is an occupational hazard for nurses and other health professionals who care for and support trauma survivors."

Vicarious trauma (VT) is a process through which the HP's "inner experience about the self and the world is negatively transformed as a result of empathic engagement with trauma survivors" (Pearlman and Saakvitne, 1995a; p.279). Through exposure to their client's accounts of traumatic events and the realities of people's intentional cruelty to one another and the experience of reliving terror, grief, and yearning, the helper is vulnerable through empathic engagement as both witness and participant in these traumatic reenactments. These effects are cumulative and may be permanent (Pearlman and Saakvitne, 1995a). According to Dane and Chachkes (2001), VT develops over time and affects a person's professional and social identity. However not everyone who is vicariously exposed to traumatic narratives develops symptoms of VT (Lerias and Byrne, 2003). So what may contribute to its development?

Janoff-Bulmans' (1985) *Assumptive World Theory* posits the notion that individuals make assumptions about themselves and the world, the assumptions being, "*I am invulnerable,*" "*The world is just and makes sense,*" and "*I am basically a good person.*" When exposed to trauma or helping victims of trauma, these assumptions may be "shattered" (Janoff-Bulman, 1985). Imagine a police officer's or paramedic's personal experience of bearing witness to the 1989 Hillsborough football tragedy where 96 Liverpool football supporters lost their lives. Then consider the helper's potentially "shattered" assumptive world; "*I am not invulnerable,*"

"The world does not make sense, people are not supposed to die at a football match," and "*I don't believe I am a good person, I should have done something, I don't know how to help.*" This shattering of assumptions can lead to PTSD in those actually involved and VT for those who bear witness. A further possible explanation may be the helper's own personal trauma history. If a helper has personally experienced similar traumas to those of their client, this may well conjure up painful memories of their own traumatic experiences (Cunningham, 2003; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b).

According to McCann and Pearlman's (1990) CSDT, as the helper is exposed to the graphic details of the clients' trauma, disruptions in the psychological need areas of safety, trust, esteem, power, and intimacy may occur. (These themes will be explored later in the case study.) VT can result in the HP portraying cynicism, fear, sadness, and despair (Collins, 2001; Stevens-Guille, 2003; see Table 1 for further signs of VT). It should be remembered that VT is a normal response to working with traumatized people and witnessing their stories. It is not the result of the helper's inadequacies or inherent weakness. The effects of VT are unique to each helping professional, consistent with the individual difference premise in the CSDT.

While there are positive aspects of working with traumatized clients, such as a sense of competence in coping and maintaining an objective motivation, the concept of VT focuses upon the negative aspects of transformation within the inner self of the person working with victims of trauma (Bell, 2003). It is important to note that VT needs to be seen within the context of the work environment (Martin, 2006), as this environment can aid recovery or, conversely, stall it (Royle, 2006).

As stated previously, VT has been described as an "occupational hazard" (Pearlman and Saakvitne, 1995a; p.31) for mental health professionals. We are also becoming increasingly aware of how people suffering from a mental illness can be stigmatized and excluded by members of the public (Hayward & Bright, 1997; Hughes, 2000; Gilbert, 2000; Byrne, 2000; Crisp, 2000). Glozier and colleagues (2006) examined the attitude of nursing staff towards co-workers returning from work following a psychiatric or physical illness. They found that staff who had suffered from a psychiatric condition were much more likely to be viewed negatively than if they had suffered from a physical condition. What strategies or interventions, therefore, can be used to help the HP suffering

from VT? Attendance to the physical setting in the workplace (safe, private, comfortable), regular clinical supervision, team briefings, and balanced work and social life have been demonstrated to help sufferers of VT (Pearlman & Saakvitne, 1995a; Figley, 1995). However, for some people there is a need for personal psychotherapy in order for them to overcome their distress. This paper will examine one such treatment modality, Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995).

Signs of Vicarious Traumatization

- Reduced energy, exhaustion, lack of motivation, feeling that you have no time for yourself
- Disconnection from others; feeling that other people don't really understand; you don't feel close to people any more; difficulties with your partner or in other close relationships
- Emotional blunting
- Questioning career choice, feeling ineffectual
- Errors in maintaining professional boundaries, failure to set limits, a general sense of failure and resentment
- Social withdrawal
- Feelings of despair and hopelessness
- Feelings of weakness, shame guilt, *"my problems are nothing compared to theirs"*
- Loss of belief in the justice of life or in a sense of balance between good and bad, resulting in cynicism and bitterness
- Heightened sense of danger, feeling less secure, scanning for danger, including looking for violence and aggression in your environment
- Sleeping problems and nightmares
- Difficulties in concentration
- Lack of self control, increased anger, impatience, strained relationship with others
- Intrusivity and flashbacks
- Changes to your inner sense of identity and equilibrium, i.e. you find it harder to experience and integrate strong feelings, or to maintain an inner sense of connection with others or to feel grounded and anchored within yourself
- Changes to your world view or spirituality, i.e. you have lost or changed your philosophy of life, your values and beliefs about others and the external world

Herbert & Westmore (1999)

Eye Movement Desensitization and Reprocessing (EMDR)

In 1989, Francine Shapiro published her seminal paper "Efficacy of the eye movement desensitisation procedure in the treatment of traumatic memories." In 2005 the National Institute for Clinical Excellence (NICE) recommended EMDR and Cognitive Behavioural Therapy (CBT) for the treatment of posttraumatic stress disorder (PTSD). As an integrative psychotherapy, the efficacy of EMDR for PTSD is well documented in the literature, (Bleich, Kotler, Kutz, & Shaley, 2002; Chemtob, Tolin, van der Kolk, & Pitman, 2000; Clinical Outcomes Efficiency Support Team, CREST-2003; Department of Veterans Affairs & Department of Defence, 2004) with many randomised studies supporting its efficacy (Carlson, Chemtob, Rusnac, Hedlund, & Muraoka, 1998; Ironson, Freund, Stauss, & Williams, 2002; Power et al., 2002; Soberman, Greenwald, & Rule, 2002). For a critical review of the evidence see Maxfield and Hyer (2002). EMDR has also been used effectively in the treatment of other psychological problems, for example body dysmorphic disorder (Brown et al., 1997), non-psychotic morbid jealousy (Keenan & Farrell, 2000), phantom limb pain (Tinker & Wilson, 2005), and anxiety disorders (Shapiro, 2005).

What is EMDR?

The procedure in EMDR makes use of right, left, visual, kinaesthetic, and auditory stimulation while the client mentally focuses on traumatic experiences (usually memories). Traumatic memory has three components: an image, a physiological reaction to this image, and a negative evaluation of the self as a consequence of this image/recollection.

The procedure works with all three of these aspects by encouraging the client to think about the traumatic event while at the same time recognizing the physiological reaction in the here and now. The client is instructed to be aware of the negative evaluation of the self and then to receive bilateral stimulation from the clinician. The goal is to reduce the negative emotional response to the traumatic image and to reduce the level of physiological disturbance, along with a modification of the client's negative view of the self to a more realistic, appropriate, and adaptive view. The authors emphasise that although we refer to the "procedure" of EMDR, it is a psychotherapeutic process and therefore issues such as client safety, therapeutic alliance, comprehen-

sive assessment and case conceptualization, confidentiality, boundary issues, and a full explanation of the model with valid consent are paramount.

Principles of EMDR (Shapiro, 2001)

- This model regards most pathology as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognition, and consequent identity structures.
- Pathology is viewed as configured by the impact of earlier life experiences that are held in the memory in state-specific form (therefore remaining as unprocessed memories).
- Present day stimuli elicit the negative affect and beliefs embodied in these memories and influence the person to continue to act in a way consistent with these earlier events.
- EMDR facilitates more positive and empowering present affect and cognitions to generalize the associated memories throughout the neuro-physiological network and leads spontaneously to more appropriate behaviors, thoughts, and feelings.

This paper now focuses on the case of a helping professional suffering from vicarious trauma. It will describe his psychological assessment and case conceptualization, before exploring the use of EMDR as a potential treatment intervention.

Vicarious Trauma: A case study utilizing EMDR

Bruce (*name changed to preserve client anonymity*) was a serving police officer with family liaison responsibilities. He was suffering from cumulative trauma through his helping role and feeling increasingly helpless and isolated. He reported being overburdened by events that had happened to others, including murders, serious accidents, and suicides. The clinical diagnosis from the referring Occupational Health Unit was depression. Bruce had received general counseling and then a short course of Cognitive Behavioural Therapy. He did not feel any benefits from this and was referred for EMDR therapy some three years after his last significant incident. During this time, he had been on administrative duties and sickness leave.

On assessment with a trauma clinician, Bruce reported the following symptoms synonymous with VT:

- Disconnection from others, social withdrawal and suspiciousness
- Feeling ineffectual and lacking confidence
- Feelings of despair, horror, and being overwhelmed
- Feelings of weakness, shame, and guilt, continually examining his involvement in cases and questioning his actions
- Sleeping problems and nightmares
- Aversion of further exposure to trauma narratives and “bad news” (via friends and media), yet simultaneously obsessive thoughts about negative events and death
- Difficulties in concentration, memory recall, and inability to focus on work
- Increased anger, impatience, strained relationship with others, “looking for a fight”
- Intrusive images of situations he had been involved in
- Physical symptoms of a painful stomach and rash on his face

Bruce had previously served in the armed forces. He compared the difficult times he had encountered in the armed forces with those in the police service. He described his attitude as relaxed and philosophical then. He felt that the army had been supportive and empowered him, whereas the police service had a “them and us” management style. He felt cynical about the motives of those in police service management and sadness at how he had changed from being a highly confident and motivated individual. There was a complete lack of trust in his managers to support him in his role and a shattered belief in his own competence and self-esteem.

VT had led to disruption in Bruce’s cognitive schemas regarding his professional identity. His self-evaluation included phrases such as “*I am useless,*” “*I am worthless,*” “*I can’t stand this,*” and “*I am vulnerable.*” This exacerbated his feelings of despair and anger.

Bruce had been prescribed an anti-depressant, Citalopram 20mg, by his GP. He was a non-smoker and had a

low to moderate alcohol intake. His previously good self-care (running and cycling) had completely stopped some time ago. As stated earlier, VT is a normal response, not an inherent weakness. However, Bruce's environment had appeared to hinder his recovery. Bruce had concerns that he was viewed negatively by his managers and had found it very difficult to admit to a problem – a common issue within the police service (Royle, 2003). He felt stigmatized, isolated, and was worried that nobody, his clinician included, would believe his condition was genuine. Accessing support had been a lengthy process and he had waited three years before being provided with appropriate therapy. Problems regarding rehabilitation and being on administrative duties exacerbated this shame and feelings of inadequacy.

Bruce was referred for EMDR therapy (Shapiro, 1995) because this has been shown (NICE, 2005) to be an effective course of treatment for his intrusive images and also because the previous counseling had not been seen as helpful by Bruce. His clinician agreed with this but felt more importantly that EMDR would be the most effective way of dealing with the “shattered schemas” (Janoff-Bulman, 1985).

EMDR treatment plan and typical session

The treatment plan began with a consideration of client safety and building a therapeutic alliance (Shapiro 1995). A comprehensive assessment was made of Bruce's current situation and past history. Issues of confidentiality and boundaries were agreed upon and a full explanation of the model was given. Bruce gave his informed consent to EMDR. Relaxation methods and general stress management strategies were explored and evidence gained that he was committed to using these.

To reiterate, the procedure in EMDR makes use of bilateral stimulation while the client mentally focuses on the traumatic experiences. Visual stimuli, in the form of right-left eye movements (EM) were utilized with Bruce. The most traumatic memory targeted related to Bruce working with a family that had suffered a sudden and violent bereavement. This memory had resulted in intrusive imagery and thoughts that were still distressing him some three years later. The image he had was one of him leaving the house of the family and feeling tearful. The physiological reactions were those typical of anxiety. Bruce's negative evaluation of himself as a consequence of this recollection was *“I am vulnerable.”*

Bruce was encouraged to think about this image, while at the same time being aware of his current physiological reaction and the negative cognition of vulnerability. Bilateral visual stimulation (moving his eyes from side to side by following the movement of the clinician's hand) was then induced. Bruce noticed changes in his thoughts and emotions during subsequent series of eye movements. He remarked on confusion as to why he was “feeling wobbly” and a fear of breaking down at an operational debriefing. He remembered comparing himself with other officers who were less closely involved in the case and feeling vulnerable in comparison. During the processing, a shift occurred in Bruce's self-evaluation. Between EM sets, he began to report the following positive changes: *“We're all affected by different things at different times ... it's never going to be the same incident,”* and *“rather than being vulnerable, I can be strong because I know the risks and can assert myself in the future.”*

Bruce was encouraged just to think about this. The EM continued until he reported feeling calm and repeated the same positive cognitions. The clinician then returned to the original target image and asked him to notice his thoughts and feelings and whether these were different. Bruce reported no change to the image but a feeling of anger and a sense that it wasn't his fault. The clinician administered further EM and Bruce noticed his anger increasing and peaking before falling away. At this point, his thoughts were: *“I learned a lot from all this. I can take control of my own welfare.”*

Further EM led to a firmer emphasis on this more positive self evaluation, *“When I'm properly better, I think I'd like to talk to probationers and tell them what can happen”* and finally, *“I'm not vulnerable.”*

At this stage, Bruce reported feeling calm and confident in his ability to protect himself. His clinician asked him to hold this thought with the original image and administered further EM. When asked how true this new self-evaluation felt, Bruce believed it to be 100% true. He was asked to concentrate on his body to see if he noticed any discomfort, but he reported no residual discomfort. The session was closed with a safety assessment and a reminder that information processing could continue. Bruce was keeping a log of his thoughts, feelings, memories, and dreams between sessions, which would be useful in reviewing any changes in his mental state prior to the next session.

Outcome of Therapy

In three subsequent sessions using bilateral visual stimulation, Bruce similarly tackled the main incidents that had occurred in his duties as well as negative cognitions concerning power, safety, and self-worth. He was changed by his experience of VT and felt that it had actually made him stronger now that he had dealt with those issues. His anger and lack of confidence were processed. Bruce ended therapy with a belief in his ability to do a good job and better protect his professional boundaries. He had resumed his self-care, particularly in relation to exercise, and had, with his doctor's consent, discontinued the prescribed anti-depressants.

At the end of therapy, Bruce felt he needed to continue to build his confidence over time as he gradually returned to operational duties, but he was no longer overwhelmed and despairing about his role. Including assessment, he was seen for a total of eight sessions. Bruce's progress was reviewed by his therapist 15 months later. He remained free from medication and was able to undertake operational police duties. He reported feeling and acting more assertively in respect to his professional boundaries and was optimistic about his future.

Conclusion

Vicarious trauma (VT) may well be an "occupational hazard" (Pearlman and Saakvitne, 1995a; p.31) for the empathic helping professional (HP). This can lead the victim to experience wide-ranging psychological distress, including intrusive, aversive memories, lack of self-control, feelings of inadequacy and hopelessness, and social withdrawal (Herbert & Westmore, 1999). VT may also result in isolation in the working environment due the stigmatizing attitude of the victim's work colleagues and management (Glozier, Hough, Henderson, & Holland-Elliott, 2006). There are strategies that have been employed to lessen the likelihood of VT occurring, such as attending to the physical work setting (safe, private, comfortable), regular clinical supervision and team briefings, and a balanced work and social life (Figley, 1995). If, however, bearing witness to another person's tragedy does traumatize a helping professional, personal therapy can be an option. This paper has shown how one individual benefited from receiving EMDR, enabling him to return to work feeling more positive about his future. More research is required when considering the most effective treatment options for HPs; however, recognition that vicarious trauma is a

factor in the working life of HPs may at least encourage victims to seek psychological help earlier.

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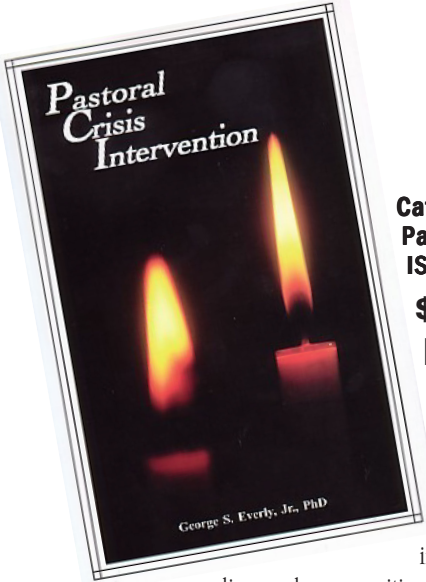
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Critical Incident Stress Management in a Mid-Sized Police Department: A Case Illustration

Abigail S. Tucker
Nova Southeastern University

Tamara Spaulding
Pembroke Pines Police Department

James Henry
Pembroke Pines Police Department

Vincent B. Van Hasselt
Nova Southeastern University

Abstract: *Pembroke Pines Police Department (PPPD), Pembroke Pines, Florida, collaborated with Nova Southeastern University (NSU), Fort Lauderdale, Florida, and the Federal Bureau of Intelligence (FBI), Miami Field Office, in the fall of 2001 to develop, train, and launch a specialized unit of crisis negotiators (Critical Response Team; CRT). The hallmark feature of the PPPD CRT was the expectation that all team members were trained in accordance with both the FBI's crisis/hostage negotiations model and the ICISF model of Critical Incident Stress Management (CISM). The deliberate result of this collaborative training provided PPPD with an "in-house" crisis response team grounded in standardized CISM principles and prepared to expand with forthcoming current best practices (e.g., peer support and specialized training) most notably Crisis Management Briefings (Malcolm, Seaton, Perera, Sheehan, & Van Hasselt, 2005; Sheehan, Everly, & Langlieb, 2004; Clark & Volkman, 2005). The purpose of this case illustration is to present the development and application of this agency's tactical execution of a police-based approach aimed at addressing the inherent CISM needs of law enforcement. Practical relevance and suggestions for future research are also discussed. [International Journal of Emergency Mental Health, 2007, 9(4), pp. 299-304].*

Key words: *Critical Incident Stress Management (CISM), Crisis Management Briefings (CMB), police-based model, crisis response, negotiators, law enforcement*

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Critical Incident Stress Management (CISM) is a collective term used to describe a strategic array of crisis interventions (Malcolm et al., 2005). One of the primary hurdles in the application of CISM in law enforcement is the "cop culture" that effectively communicates a barrier between police personnel and mental health professionals (Castellano, 2003; Malcolm et al., 2005; Miller, 1999). An additional area of caution when attempting to develop a strategic response to crisis intervention in law enforcement remains the distinct "police personality," which may offer the potential for either

effective coping skills or self-destructive habits (Blau, 1994; Miller, 1999). Despite the closed nature of police culture, current literature contends that law enforcement personnel are beginning to accept CISM (Malcolm et al., 2005; Mitchell & Levenson, 2006; Volkman, 2001). Castellano (2003) discussed the Cop2Cop Port Authority Police Department CISM program (a program offered following the events of September 11, 2001) and informed that police officers are aware of their intrinsic needs following a crisis and do not necessarily require the expertise of outside professionals. The subculture of police fosters the perception that only other law enforcement professionals understand their job and related job stressors (Goldstein, 1990; Patterson, 2003). Indeed, the application of CISM tactics with law enforcement without the use of peer support personnel has been cited as a common and erroneous mistake in prevailing literature (Mitchell & Levenson, 2006). The merge between a budding acceptance of CISM techniques and the police practice of “doing their own” offers a unique opportunity to expand CISM approaches within law enforcement professionals by learning from experience.

Development and Structure of Pembroke Pines Police Department Crisis Response Team

Development, Structure, & Training

The civilian population in the city of Pembroke Pines has risen by almost 75,000 in the past ten years. Currently there are 232 sworn officers working to meet the law enforcement demands of the city. Chief D. Guistino decisively initiated both the Crisis Response Team (CRT) and Special Weapons And Tactics (SWAT) teams and began training in September of 2001. They collaborated with the Miami field office of the Federal Bureau of Investigation (FBI) and with Nova Southeastern University (NSU), under the supervision of Special Agent Gregory Vecchi and clinical psychologist Vincent B. Van Hasselt respectively. The FBI’s model of crisis/hostage negotiations was adhered to and then supplemented by additional mental health training and role-play scenario training provided by NSU. The Pembroke Pines Police Department (PPPD) CRT operates in two teams (rotating coverage within each team but always training together as a unit), each led by a Team Leader, typically a Sergeant, with four additional team members/officers.

During the first year of crisis response training, the team also participated in local International Critical Incident Stress

Foundation conferences and completed, at minimum, the Basic Group and Advanced Group CISM training courses. To enhance their CISM and negotiations training, role-play scenarios conducted by NSU graduate students continuously examined their Active Listening Skills. Several of the PPPD CRT members have also continued their training by taking additional courses offered by the International Critical Incident Stress Foundation (e.g., Law Enforcement Perspectives for CISM Enhancement) over the years and, upon their return, shared their knowledge at regularly scheduled PPPD CRT trainings. The PPPD CRT utilizes its own Victim Advocate to assist in the execution of providing resources for follow-up care, vigilantly maintaining the CISM model of a continuum of care. The department as a whole (CRT included) continually receives pre-incident awareness training (e.g., roll-call trainings) under the strong support of Chief D. Guistino.

Initiating the Team

Approximately one year after they began training, the PPPD CRT was called to action by their own administration in response to a suicidal/barricade subject. Although the team never made contact with the subject, this marked its active status as a jointly trained crisis/hostage negotiations team and “in-house” CISM team.

Case Examples

In-House CISM

On August 6, 2004, Lisa Rojas was struck and killed by a truck on West Interstate Highway 75 (known as Alligator Alley), while she was on a leisure motorcycle trip with a friend. Lisa Rojas was a Crime Scene Technician with the Pembroke Pines Police Department; she was a beloved employee and known to the entire department as an unconditionally warm-spirited friend. Sergeant Tamara Spaulding, team leader of the PPPD CRT, was notified of Lisa’s untimely death by PPPD administration and she immediately initiated the CRT CISM response. Over the next week, in rotating teams of two or three members, the PPPD CRT attended each roll call, at every shift, and on all four floors of the department, effectively deploying Crisis Management Briefings (CMB) to all officers and employees.

The Crisis Management Briefing, one of the more recent offspring of CISM interventions, has been suggested for wide and versatile use among many audiences, including law

enforcement (Clark & Volkmann, 2005). The PPPD CRT actualized the intended goals of the CMB by providing information (e.g., rumor control, details about funeral services, family services, etc.); mitigating traumatic responses with stress inoculation/management education (e.g., psycho-education, stress-expectation training); and assessing the need for follow-up CISM intervention (e.g., offering psychological consultation referrals, remaining visibly present at viewings and the funeral; Clark & Volkman, 2005; Everly, 2000).

Subjective interviews with PPPD CRT members indicated two consistent factors that contributed to the positive delivery of “in-house” CISM interventions (i.e., CMB): their visible presence and their solidarity. Each team member, in their own words, explained the phenomena of “just being there” and reflected individual accounts of peers privately thanking them for coming out to the midnight shift, standing at the back of the funeral, and offering their support without forcing a dialogue. The second ingredient of solidarity highlights the “blue culture” of law enforcement. PPPD CRT pierced through police lingo, avoided the barrier of cultural unawareness, and met the blue-brotherhood desire to identify with the values of peers during a time of crisis (Goldstein, 1990; Patterson, 2003; Volkmann, 2001). The tally of integrating the CMB intervention with an “in-house,” police-based model subjectively worked for PPPD; but the team is not without lessons learned and openly reviews its CISM tactics.

Police-based CISM Offered to an Outside Agency

On July 2, 2004, while traveling in Pembroke Pines, Florida, Detective Orestes Lorenzo of the North Miami Beach Police Department (NMBPD) lost control of his vehicle after being cut off by another car; his seatbelt tore as a result of the collision and he was ejected from the vehicle. He succumbed to head injuries a week later, July 9, 2004. He was survived by his wife and three daughters. Sergeant Al Xixes, PPPD CRT member, led the CISM effort for the PPPD officers who first responded to the scene, again employing the CMB and offering follow-up services. CISM services to North Miami Beach (NMB) Police Department were offered. The following day NMB Chief of Police, Linda M. Loizzo, contacted the command staff at PPPD. The PPPD CRT initiated their CISM response on July 4, 2004.

Sergeant James Henry, PPPD CRT team leader, recalls opening their CMB interventions by advising NMBPD offic-

ers and employees, “You are your own best help.” The PPPD CRT repeated their previous success utilizing peer-based CISM crisis interventions. PPPD CRT responded as they would in accordance with their own CISM policy (e.g., with CMB at roll calls, one-on-one crisis intervention, their presence at the funeral, the unspoken solidarity, and armed with referral/resources in the community). However, the CRT remained keenly aware that, although cops themselves, they were still considered outsiders to this department and they candidly addressed that potential barrier. Patterson (2003) warns others to remain aware and actively recognize the barriers indigenous to “cop culture.”

Instead of offering their own “shoulders to lean on,” PPPD CRT members informed NMBPD personnel what to look in each other (i.e., expected traumatic stress reactions such as heightened startle responses) and suggested they actively seek ways to check up on each other, as well as Detective Lorenzo’s family. This strategic approach incorporated three efficacious factors: recognition of law enforcement culture that more readily accepts peer-based support; development of self-care coping strategies; and adherence to the multi-component, integrative nature of CISM. PPPD CRT involvement with NMBPD was poignantly reciprocated with the presence of NMB officers at Lisa Rojas’ funeral less than a month later (see above-mentioned case example “In-House” CISM).

Practical Lessons Learned: Areas for Improvement

CISM offers an effective, strategic continuum of care approach to crisis intervention that permits the flexible application of current best practices to acknowledge the specific needs of an agency utilizing the intervention (Roberts, Everly, & Camasso, 2005; Sheehan, Everly, & Langlieb, 2004). The PPPD CRT has adhered to this approach to crisis management with peer support, pre-incident training, specialized training, and by using a multi-component continuum of care. However, the team identifies two specific areas for improvement: the ability to assess for need, and the ability to provide CISM to the PPPD CRT in the event that a critical incident directly affects “one of our own.”

Sheehan, Everly, and Langlieb (2004) advised organizations to efficiently evaluate those involved when responding to critical incidents by appropriately providing crisis care, resources, and encouraging natural coping skills. Law en-

forcement populations do not diverge from the above-mentioned approach and indeed require triage and early assessment following trauma (Sheehan & Van Hasselt, 2003; Van Hasselt, Sheehan, Sellers, Malcolm, & Couwels, 2005). The PPPD CRT informally assesses the needs of each critical incident to which it responds but is limited by a lack of appropriate assessment measures and a standardized general order requiring evaluation upon return. To date, there remains a scarcity of assessments aimed at investigating law enforcement stress that are brief, applicable, and effective (Van Hasselt, Sheehan, Malcolm, Sellers, Baker, & Couwels, 2005). However, one tool, Law Enforcement Officer Stress Survey (LEOSS) is currently under development. Its variety of predicted uses includes early detection of stress encountered by police officers (Van Hasselt, Sheehan, Sellers, Baker & Feiner, 2003)

Additionally, Sergeant Tamara Spaulding, PPPD CRT team leader, reluctantly admits that the team's "Achilles heel" likely is the lack of another cross-trained, police-based CISM team in their local area. In a personal statement she advised, "I dread the day that my pager goes off because of one of our own CRT members." This legitimate fear (i.e., that mass disaster would strike the PPPD and one, if not several, of the CRT falls victim) has been a revolving discussion at PPPD CRT trainings and indeed spawned the concept for the present paper. To address this weakness, the PPPD CRT has offered their model in the hopes that continued research will incite practical application resulting in proliferation of police-based CISM. From a clinical perspective, the risk of compassion fatigue (Figley, 1999) remains a concern for the PPPD CRT. Police compassion fatigue poses a risk to law enforcement given the potential stress from exposure to trauma. Violanti and Gehrke (2004) confirmed that an officer's inherent responsibilities and characteristics heighten his/her risk for police compassion fatigue. It would appear that the added role of CRT may amplify what is already a complex vulnerability in law enforcement and warrant additional attention as well as preparative intervention (Figley, 1999; Violanti & Gehrke, 2004)

Conclusions and Suggestions for Future Research

For unpredictable mass disasters, civilians, employers, and law enforcement agencies alike are faced with the difficult task of coordinating emergency preparedness and crisis management. At the same time however, they must remain

respectful of the individual perceptions of their employees, occupational peers, and consulting professionals (Langlieb, Johnson, & Gandhi, 2005; National Institute for Mental Health, 2002). It is the primary conclusion of our case illustrations that when law enforcement agencies address crisis and stress management they have the viable choice to implement CISM crisis interventions within their agency while remaining loyal to their intrinsic culture. CISM continues to diversify by incorporating new research and strategies from the fields of emergency mental health, psychology, faith interventions, military procedures, individual CISM team experience, and current best practices from other organizations (Clark & Volkmann, 2005; Everly, 2003a, 2003b; Sheehan, Everly, & Langlieb, 2004). Research literature also acknowledges that law enforcement has developed its own best practices, inherent to its occupation and reliant on its culturally-specific personality traits that often serve to mitigate trauma response (Blau, 1994; Castellano, 2003; Malcolm et al., 2005; Miller, 1999; Patterson, 2003; Sheehan, Everly, & Langlieb, 2004; Volkmann, 2001).

The most resounding lesson learned from the Pembroke Pines Police Department Crisis Response Team is that its candid willingness to offer a police-based CISM approach, tactically providing a target-rich forum to share information, building acceptance, and developing a standardized model of specialized training and response to critical incident stress within law enforcement, remains its "Achilles heel," leaving its members vulnerable to compassion fatigue. Future directions for research should include training police-based CISM teams at county, state, and federal levels and assessing the direct effect on local law enforcement agencies; empirical analysis of cross-training police with both hostage/crisis skills and CISM; and standardizing the subjective material presented in this paper to provide a replicable model.

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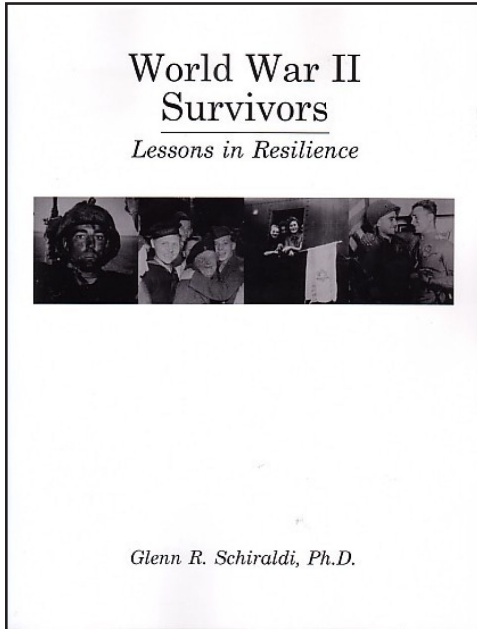
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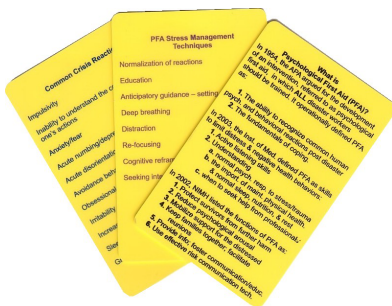
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Selected Annotated Journal Resources

Jessica R. Rothstein, M.S. and Karina E. Chapman, M.S.

Eisen, M.L, Goodman, G.S., Qin, J., Davis, S. & Crayton, J. (2007). Maltreated children's memory: Accuracy, suggestibility, and psychopathology. *Developmental Psychology*, 43, 1275-1294.

TYPE OF ARTICLE

- Original empirical investigation: 3 x 5 between subject design

OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine trauma history and posttraumatic stress in a sample of adolescents and young adults with HIV/AIDS.

OBJECTIVES/PURPOSE OF THE ARTICLE

- The present study was designed to add to the findings of the potential impact of maltreatment on children's memory and included physiological measures of stress. The study examined children who had been sexually abused (CSA), physically abused (CPA), sexually and physically abused (SPA), neglected, and included a control/non-abused group.
- The authors hypothesized that children who had been neglected would have the least accurate memories, due in part to their early deprived environments, as compared to those who had not been abused.
- It was believed that children who experienced high levels of dissociation, higher levels of psychopathology in general, and had lower cognitive functioning would display poorer memory and be more susceptible to misleading information when they were experiencing high levels of stress.
- The third hypothesis was that there would be an increase in cortisol from baseline to post-exam measure-

ment that would be indicative of high levels of stress. Additionally the authors believed that this would be related to poor event memory and increased suggestibility during an anogenital exam/venipuncture.

- As previous studies had indicated, the authors expected that older children would show better memory and less suggestibility to misleading information than the younger children in their sample.
- Conversely, it was hypothesized that younger children would have more errors in memory than older children based in part on their limited cognitive development and their susceptibility to social pressures.
- The authors hypothesized that during the anogenital exam/venipuncture the children's memory would be more resistant to suggestible information, and more suggestible for central than peripheral information.
- It was also suggested that those who had experienced CSA would be least susceptible to misleading information during the anogenital exam/venipuncture since the authors attest that this exam would be considered traumatic in and of itself and those who have been abused have excellent recall of trauma-relevant information.
- Finally, the authors hypothesized that the children who had a diagnosis of PTSD would exhibit better memory recall during the exam, since it could be considered similar to a traumatic experience and thus encoding would be high.

PROCEDURE

Participants

- Three hundred and twenty eight children (179 girls, 149 boys) who had sought services at Under the Rainbow (UTR) at Mt. Sinai Hospital in Chicago, which is an inpatient unit specializing in the assessment of child maltreatment, served as participants.

- Age stratification was conducted dividing the children into three age groups: 3-5 years old ($M = 4.1$ years), 6-10 years old ($M = 7.8$ years), and 11-16 years ($M = 12.3$ years).
- The sample was also categorized into five abuse statuses based on the child's experiences: sexually ($N = 58$), physically ($N = 75$), sexually and physically abused ($N = 29$), neglected ($N = 130$), and non-abused/control ($N = 36$). The authors note that the non-abused group had no past or current cases of physical abuse, sexual abuse, or neglect but was in contact with someone who was an alleged abuser and thus the reasons that they were seeking treatment at UTR.
- The sample was predominately from a low socioeconomic class, urban Chicago area, and 70.4% were African-American, 15.2% were Latino, 13.7% were Caucasian, while 0.6% were labeled "other" ethnic origin.

Procedure

- After completing informed consents, on the second day of their hospitalization the children were given a standard physical examination conducted by a nurse and staff physician. This exam included an anogenital portion and venipuncture (during the venipuncture, some children had to be physically restrained).

Predictor Variables

Cognitive Functioning Measures

- Scores on the Short Form of the Wechsler Intelligence Scale for Children—Third Edition (WISC-III) and the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) were used to obtain a measure of the children's cognitive ability. The subscales that were used from these measures include Block Design and Vocabulary. Children were administered either the WISC-III or WPPSI based on their age.
- A measure of receptive vocabulary was gained from administering the Peabody Picture Vocabulary Test, Revised (PPVT-R) which involves having children identify pictures of target words from a visual array. The children are presented the target words aurally.
- A short term memory (STM) score was acquired by administering the Memory for Sentences, The Memory for Objects, and Digits subtests from the Stanford Binet, 4th Edition (SB-4). Based on their age, participants were ei-

ther administered the Memory for Sentences or the Memory for Objects subtest.

- The measures in this domain were administered during the children's five day hospital stay.

General Psychology Functioning

- The Global Adaptive Functioning (GAF) used in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* was used to indicate the child's general psychological functioning. This measure is on a scale of 100 with lower points indicating lower levels of adaptive functioning.

Dissociation Measures

- The Child Dissociative Checklist (CDC) is an observer-report measure of dissociative behavior for children four years old or younger. Using a three point scale, the observers, parents or caretakers who had cared for the child for at least two months, answered questions such as, "*Child frequently talks to him or herself, may use a different voice or argue with self at times.*" Anchors of the scale included 0 (*not at all true*) to 2 (*very true*).
- The Children's Perceptual Alteration Scale (CPAS) is a 28-item self-report measure of dissociative experiences taken by children 6 years old and older. Children are asked questions such as, "*When I'm awake, I feel like I'm dreaming*" and asked to answer these questions using a 4-point scale with anchors of (*1 = never happens to me*) to (*4 = always happens to me*).
- The Dissociative Experiences Scale for Adolescents (A-DES) is a 30-item self-report measure of dissociative experiences for children 11 years old and older. Children taking this measure were asked questions like, "*When I am somewhere that I don't want to be, I can go away in my mind,*" using a 10 point scale with 0 (*never*) to 10 (*always*) indicating how often the experience happens to them.

Other Trauma-Related Measures

- The Child Depression Inventory (CDI-S) is a 10-item self-report measure of depressive symptoms that was administered to children ages 8-15 years old. The children are asked questions such as, "I feel sad," and are told to indicate how often they have felt that way during the past two weeks. They are given a scale which includes 0 (*once in awhile*), 1 (*many times*), and 2 (*all the time*). On this measure higher scores indicate more depressive symptoms.

- The Trauma Symptom Checklist-Child Version (TSC-C) is a 54-item questionnaire that assesses dissociation, anxiety, anger, sexual concerns, depression, and post-traumatic stress symptoms in children 8-15 years old. This scale is specifically used for children who have experienced trauma or have been abused. Children are asked questions such as, “Scary ideas or pictures just pop into my head,” and were asked to use a four point scale with anchors of 0 (*never*) to 3 (*almost all of the time*).

Outcome Variables

Event Memory Measure

- An anogenital exam/venipuncture memory questionnaire was designed specifically for use in this study. This questionnaire was administered after the child had received the anogenital exam/venipuncture.
- This measure includes 1 free-recall questions, 2 open-ended questions (with what the authors call 1 central and 1 peripheral question), 39 specific questions (22 central, 17 peripheral), 29 misleading questions (11 central, 18 peripheral) and 2 photo identification questions.
- The authors describe that the questionnaire has a set administration format and begins with the free-recall question, “Tell me everything you can remember about the doctor exam. What happened?” Additional prompts are used to gather more detailed information.
- After these questions, the children were asked a series of open-ended questions such as, “What did the nurse look like?” and “What did the doctor do when she examined your bottom?” as well as yes/no questions, “Did the doctor check your throat?”
- Misleading yes/no questions were balanced throughout the questionnaire to assess the child’s suggestibility.
- To categorize questions into central and peripheral, 11 adults who were unaware of the intent of the study watched an example videotape of a child having an anogenital exam/venipuncture and then rated all of the open-ended, specific, and misleading questions using a scale of 1 (*very peripheral*) to 4 (*very central*). Questions that received ratings of 2.5 or above were categorized as central. Those that received ratings less than 2.5 were categorized as peripheral.
- Central questions included, “Who took your clothes off from the doctor exam?” and “How many times did she

stick you with the needle.”

- Peripheral questions included, “What was the nurse wearing?” and “There wasn’t a mirror in there, was there?”
- Additionally, a photo identification question for the nurse and one for the doctor were included in this measure. The children were asked to identify the target person, who was present during their anogenital exam/venipuncture, from a photo line-up of five adults. Some of the line-ups included the target (target present) while others did not include a picture of anyone who had been present during the exam (target absent).
- On the fifth day of the child’s hospitalization, the children received the anogenital exam/venipuncture memory questionnaire described above. This was administered by a research assistant who was not present during the exam.

Anogenital Exam/Venipuncture Exam Measures

- The children’s stress level was measured by the doctor, nurse, and research assistant all of whom who were present during the child’s exam. They were asked to indicate the child’s general affect on a scale that had anchors of 1 (*very happy*) to 6 (*very unhappy*). The observers also rated the child’s level of crying on a scale of 1 (*not crying*) to 6 (*hysterical*). These ratings were made at the end of the exam but the observers were asked to consider the child’s distress during three points: the beginning (during a patella reflex test), during the anogenital exam, and during the venipuncture.
- The children were also asked to rate how they felt during the exam. They were administered these questions 30 minutes after their exam had concluded and were asked to rate their feelings at the same three time frames as the observers: beginning, during the anogenital exam, and during the venipuncture. The children used a four point scale with anchors of 1 (*very happy*) and 4 (*very unhappy*).
- Before the exam, the children were attached to electrocardiogram leads in order to measure their heart rate during the exam. A baseline measure of the child’s heart rate was also established by getting another reading of their heart rate 1-3 days after the child’s exam, at a matched time of day that was within 90 min of the time of the actual exam. Before taking this baseline measure the children watched a four minute watching a relaxing video.
- The children’s hypothalamic-pituitary-adrenal response

was measured during the anogenital exam/venipuncture by getting a sample of the child's salivary cortisol. A sample was gathered 20 minutes after the child's anogenital exam/venipuncture. Additionally a baseline sample was taken 1-3 days later at approximately the same time as the baseline heart rate readings and after the child had watched the relaxing video. Again the authors indicate that this measure was taken at a matched time of day that was within 90 min of the time of the actual exam.

RESULTS

- Regarding the age and abuse status, there was a significant difference ($p < .001$) in the units of information that older children provided on the free recall and open-ended questions of the memory questionnaire as compared to the younger age group.
- Similarly there was a significant difference ($p < .05$) in the age and abuse status, for open ended questions in that 6-11 year olds were more accurate than the other age groups.
- It was also found that CSA and CPA survivors were significantly ($p < .01$) more accurate in their responses to open-ended questions than children who were neglected.
- There was a main effect for abuse status and errors to misleading questions, or suggestibility ($p < .05$). Specifically, CSA and CPA victims were significantly less suggestible than children who had been neglected ($p < .01$).
- In regards to central and peripheral questions, the children were significantly more accurate in their responses to central question ($p < .01$). It was also found that children who were younger made more errors on the central questions rather than the peripheral questions as compared to the other groups ($p < .01$).
- When presented with misleading questions during the memory questionnaire, the two oldest age groups were significantly more accurate ($p < .001$) in their responses and less likely to make omission and commission errors than the younger children.
- It was also found that survivors of CSA, including those who had experienced both physical and sexual abuse, made significantly less omission errors ($p < .001$) than children who did not have a history of sexual abuse.
- Using the photo identification portion of the memory questionnaire it was found that 3-5 year olds made significantly more errors than children in the two older groups ($p < .001$) both for the target present and target absent arrays so that younger children both made more omission and more commission errors.
- Individual differences on dissociation scores on the CDC revealed a significant difference in that the CSA, CPA, and children who had experienced both sexual and physical abuse scored higher ($p < .01$) than those who had been neglected.
- In addition, the 6-10 year olds mean score on the CDC was significantly lower ($p < .05$) than children ages 3-5.
- Data also indicated that a PTSD diagnosis was significantly related to a child's abuse status ($p < .001$) in that those who were sexually and/or physically abused were more likely to be diagnosed with PTSD than the control group ($M = .03, SD = .17$) or children who were neglected ($M = .05, SD = .23$).
- In accordance with the authors' hypotheses, children who were abused had a positive correlation with CDC scores and PTSD diagnosis and negatively with GAF ratings. Similarly those who had higher GAF ratings or lower CDC scores scored poorly on measures of cognitive functioning. Furthermore self-reports of the children's trauma symptoms were significantly correlated with CDC scores, GAF ratings, and a diagnosis of PTSD. Children who were diagnosed with PTSD also were more dissociative.
- However, in regards to individual differences the abuse and maltreatment variables were not found to predict memory performance. Yet cognitive functioning ($p < .05$), self-report trauma symptoms ($p < .001$), and GAF scores ($p < .05$) were found to have a predictive quality for a children's memory performance. It was found that older children with higher ratings of cognitive functioning were less likely to make commission errors to the specific and misleading questions during the memory tasks than those children who had a history of trauma.
- It was also found that the children's CDC scores were negatively correlated ($p < .05$) with the child's omission errors on the doctor photo identification in the target-present condition. The authors relate that in accordance with their hypothesis about hypervigilance during stressful or trauma similar incidents, children with higher scores on the trauma measures were more accurate than the other groups in their identification.
- In regards to gender differences and observer ratings, girls were rated by observers as significantly more dis-

tressed ($p < .001$) during the exam than boys.

- Children's self-report ratings of stress increased from the start of the exam to the anogenital exam ($p < .001$) and specifically it was found that the oldest children reported higher levels of stress than younger children ($p < .01$).
- According to the authors, there was a significant increase ($p < .001$) from baseline in cortisol level of abused children after the exam as compared to baseline levels.
- Similarly, there was an increase in mean scores of heart rate from baseline to the anogenital exam to the venipuncture.
- It was also found that changes in cortisol level were negatively correlated with scores of GAF functioning ($p < .05$), in that lower scores on the GAF were correlated with higher cortisol levels.

CONCLUSIONS/SUMMARY

- On memory tasks, older children were less suggestible to misleading information and more accurate in their recall than younger children.
- Similarly, the oldest age group had better memory for central information than for peripheral information for specific questions concerning their anogenital exam.
- It was also found that neglected children were significantly more suggestible than abused children to misleading questions about their anogenital exam. Similar age trends were found in that older children were more accurate in their memory performance.
- Younger children also made more errors on a photo identification lineup task than the older age groups.
- Scores of abuse and trauma related psychopathology revealed that children classified as CSA and/or CPA scored higher on a measure of dissociation, lower GAF scores, and were more frequently diagnosed with PTSD. Also children with self-reported trauma symptoms had more commission errors to misleading questions than the non-maltreated group.
- Children with dissociative tendencies, a PTSD diagnosis, higher CDC scores, and lower GAF scores were rated by observers to be more distressed during the anogenital exam/venipuncture and had changes in cortisol levels. Similarly, there was a relationship to the children's performance on memory measures in that they made more commission errors. The authors suggest that in addition to these children having poorer memory skills related to

their exposure to trauma and tendency to dissociate, these children may be more apt to answer yes and have an affirmation bias in their answers.

CONTRIBUTIONS/IMPLICATIONS

- The results of this study indicate that children's memory, including their suggestibility to misleading information, may be influenced by trauma exposure.
- The findings also provide further evidence concerning maltreated children's physiological and emotional stress during physical examinations and in general higher levels of stress symptoms than those who have not been maltreated.
- However, the authors note that further studies featuring a larger sample size are needed. In particular, they indicate concerns due to the large number of variables in their study and state that some of their findings may be due to chance.

Davis, J.L., Byrd, P., Rhudy, J.L., & Wright, D.C. (2007). Characteristics of chronic nightmares in a trauma-exposed treatment-seeking sample. *Dreaming, 17, 187-198.*

TYPE OF ARTICLE

- Original empirical investigation: Passive observational design

OBJECTIVES/PURPOSE OF THE ARTICLE

- The purpose was to investigate chronic nightmares and delineate the difference between nightmares that can be classified as replicative, similar to, or dissimilar to the participants' trauma experience(s).
 - Specifically the authors hypothesized that replicative nightmares would be less prevalent than trauma-similar or trauma dissimilar nightmares.
 - However, in regards to those with replicative nightmares there would be poorer sleep quality, a higher number of nightmares, and in general show higher levels of distress than those with trauma-similar and trauma dissimilar nightmares.
- Moreover, this sample consists of civilians whereas previous studies of nightmares primarily have been with combat veterans.

PROCEDURE

Participants

- Participants were recruited via fliers, e-mails, and radio ads that were distributed August 2002-July 2006. To be included in the study, participants' nightmares must have occurred at least once per week for the previous three months.
- Participants were excluded from the study if they met criteria for psychosis or mental retardation, were younger than 18 years old, were actively suicidal or had a recent attempt or other parasuicidal behavior, and were currently drug or alcohol dependent.
- The final sample consisted of 94 people, of which 79% were women, 80% were Caucasian, 71% had at least some college education, 37% were married, 23% were divorced, who had a mean age of 39.9 years old ($SD = 11.99$).
- Participants had a mean of 4.6 traumatic events ($SD = 2.02$, range = 1-9). The most frequent types of trauma experience were: unwanted sexual contact (59.6%), car accident (58.5%), physical assault with a weapon (54.3%), and physical assault without a weapon (51.1%).
- Fifty-five percent ($n = 52$) of the participants met criteria for current PTSD and 64% met criteria for lifetime PTSD, although having a PTSD diagnosis was not an inclusion criterion.
- The sample for this study was part of two larger studies on the efficacy of a cognitive-behavioral treatment program for individuals who had experienced trauma and had frequent nightmares. As such, 49 (52%) of the sample came from the first study and 45 (48%) from the second study.

Control Variables

- The participants completed a demographic questionnaire which consisted of age, native language, marital status, highest level of education, ethnicity, vocational status, and household income.

Predictor Variables

Modified Trauma Assessment for Adults: Self-Report Version (TAA)

- The TAA is a measure that assesses a participant's lifetime history for exposure to thirteen types of traumatic events such as interpersonal traumas, sexual assault, serious accidents, natural disasters, witnessing a violent crime,

diagnosis of a serious illness, a family member or friend being deliberately killed, and other situations in which there is a fear of being seriously injured or killed or in which an injury occurred. For this study the TAA was modified and an additional five items were added which assessed for exposure to hate crimes.

- Participants were asked to indicate what traumatic events they had experienced. Follow up questions on those experiences included, the age the incident first occurred, the age of the most recent occurrence, their physical injury, and how they perceived their life was threatened.

Structured Clinical Interview for DSM-IV (SCID): PTSD Module

- The SCID is a formulated diagnostic interview used to assess if an individual meets criteria for diagnoses including in the DSM-IV.
- The PTSD Module of the SCID measures whether criteria are met for current and/or lifetime diagnosis of PTSD.
- It should be noted that only participants from the first study were administered this measure.

Clinician-Administered PTSD Scale (CAPS)

- The CAPS is a semi-structured interview, consisting of 17 questions assessing the frequency and intensity of PTSD symptoms, ultimately measuring whether criteria are met for current and/or lifetime diagnosis of PTSD.
- Both the total score of the measure (with a cut-off value of 65 to indicate PTSD diagnosis) and endorsement of individual symptoms to meet criteria for PTSD were included from this measure.
- Only participants from the second study were administered this measure.

Beck Depression Inventory-II (BDI-II)

- The BDI-II is a 21-item self-report inventory that assesses symptoms indicative of depression.
- Participants answered each question and indicate the severity of each symptom from four choices.
- The participants endorsed items were added together to produce a total sum score of depressive symptoms.

MPSS Self-Report (MPSS-SR)

- The MPSS-SR is a modification of the PTSD Symptom Scale which was altered to assess the severity and frequency of PTSD symptoms.
- The measure is a 17 item questionnaire that asks questions about PTSD symptom criteria for the DSM-IV.
- The frequency of PTSD symptoms is measured on a 4-

point scale ranging from 0 (*not at all*) to 3 (*5 or more times per week/very much/almost always*).

- The severity of PTSD is measured on a 5-point scale with anchors of 0 (*not at all distressing*) to 4 (*extremely distressing*).

Outcome Variables

Pittsburgh Sleep Quality Index (PSQI)

- The PSQI is a self-report assessment that measures an individual's problems and quality of their sleep.
- Participants were asked to rate the quality of their sleep and their difficulties for the one month period of time before the assessment.
- Previous researchers have indicated that a five is a cut-off score to distinguish "poor" sleepers from "good" sleepers with specificity of 86.5% and a diagnostic sensitivity of 89.6%.

Trauma Related Nightmare Survey (TRNS)

- The TRNS assesses chronic nightmare characteristics using Likert-type, categorical, and open-ended questions that ask about the frequency, severity, and duration of nightmares.
- The measure asks about the cognitions, emotions, and behaviors surrounding the nightmares.
- Of specific interest to this study, participants answered questions about their nightmares in regards to the trauma they had experienced and indicated whether their nightmares were "exactly or almost exactly like the trauma," "similar to the trauma," or "unrelated to the trauma."
 - Trauma-similar nightmares were defined as nightmares in which aspects of the actual trauma were featured but places, people, or specific acts were different.
 - Trauma-dissimilar nightmares were defined as nightmares that featured threatening or scary situations but did not include any clear aspect of the traumatic experience.

RESULTS

- A mean frequency of 4.01 nightmares per week ($SD = 3.78$) was found.
- Participants had a mean of 3.24 nights per week of nightmares ($SD = 1.96$) and 1.81 nights per week with > 1 nightmare ($SD = 2.09$).

- Nightmare severity was rated an average of 3.0 ($SD = 0.78$) on a four point scale with higher numbers indicating more disturbing dreams.
- Participants had a mean of 5.65 hours of sleep per night ($SD = 1.77$) with 37% indicated that on average it took > 1 hour to initiate sleep each night.
- The authors indicate that support was found for their hypothesis that replicative nightmares were less prevalent than trauma-similar or trauma dissimilar nightmares, in that 50% percent reported trauma-similar nightmares, 29.5% reported nightmares that were trauma dissimilar, while 20.5% reported replicative nightmares.
- However, those with replicative and trauma-similar nightmares were similar in that they had a larger frequency of nightmares per week and more nights with nightmares per week than those with trauma dissimilar nightmares.
- Those with replicative nightmares stated that they had a greater fear of going to sleep, less hours of sleep per night, a higher rating of depressive feelings upon waking, and poorer overall sleep quality than those with trauma dissimilar nightmares.
- Participants with replicative nightmares differed from the other groups in that they had a greater overall PTSD symptom severity and frequency, higher levels of depressive symptoms, and higher levels of avoidance and arousal symptoms.
- Additionally, those with replicative nightmares differed from those with trauma-similar nightmares in that they had a greater overall PTSD symptom severity and frequency and a higher degree of avoidance and re-experiencing symptoms.
- Furthermore, results indicate that those who could be classified as having PTSD had a greater severity and frequency of nightmares, slept less, had a poorer overall sleep quality, had a greater number of panic symptoms after waking from their nightmares, and had higher scores on measures of global depression.

CONCLUSIONS/SUMMARY

- The authors suggest that there is a difference between the experience of replicative nightmares, trauma similar nightmares, and trauma dissimilar nightmares for those who have experienced trauma.
- In addition, they state that there is a pattern between the PTSD symptoms an individual exhibits and type of nightmares they experience.

- Furthermore, the authors contend that their results indicate that individuals who have experienced trauma and have nightmares have a great degree of stress that remains while their PTSD symptoms have been controlled. Thus they suggest that independent of these individuals PTSD symptoms their posttraumatic response and functioning may be impaired.
- However, the authors note several limitations of the study including a sample of individuals seeking treatment for their nightmares which might skew their sample towards those who were experiencing nightmares that were more severely impacting their functioning thus the need to seek treatment. Additionally, they acknowledge that the majority of their sample was Caucasian women.
- Finally, they indicate that there are some methodological concerns in that participants in the two studies received some different measures and that information on whether the individual had experienced life long nightmares versus whether their nightmares occurred after trauma exposure was only collected in the second study.

CONTRIBUTIONS/IMPLICATIONS

- The study results may indicate that treatment for PTSD symptoms should also include treatment for nightmares, especially individuals who experience replicative nightmares, in order to help an individual's overall functioning.
- The authors suggest that further studies explore the length of time since the trauma was experienced to see if this factor also contributes to the occurrence of nightmares.
- Additionally, the authors suggest that future studies also include measures of psychopathology such as the Symptom Checklist-90.

Katz, L.S., Bloor, L.E., Cojucar, G., & Draper, T. (2007). Women who served in Iraq seeking mental health services: Relationships between military sexual trauma, symptoms, and readjustment. *Psychological Services, 4*, 239-249.

TYPE OF ARTICLE

- Original empirical investigation: Passive observational design

OBJECTIVES/PURPOSE OF THE ARTICLE

- The authors assert that American women serving in the current military conflicts in Iraq and Afghanistan in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) face unique conditions because it is the first time women are serving alongside men in active combat.
- This study assesses the experiences of these women in combat especially since the number of women who have reported having emotional difficulties and are seeking help upon return from combat is disproportionately higher than the number of men reporting emotional difficulties and seeking psychiatric services.
- The authors hypothesize that one of the reasons women may be experiencing more difficulty readjusting to their civilian lives is because their civilian role includes complying with family and social expectations that are vastly different than their roles in the military.
- Additionally, the authors purport that while in the military women experience different pressures than their male counterparts in that they are often the only female in their unit, they have a lack of facilities for personal hygiene, and a lack of privacy. The authors also suggest that women might feel the need to act "tougher" as well as experience high rates of gender discrimination, sexual harassment, and perhaps even sexual assault.

PROCEDURE

Subjects

- Participants were 18 women who had served in combat in OIF/OEF and had been referred to the Women's Mental Center for individual psychotherapy at the VA Long Beach Healthcare System in California.
- However, at the time of the study, two of the women had been discharged and had moved from the area. Since their referral included services for military sexual trauma (MST), they were included in the total demographics of women seeking services and the statistics concerning prevalence of MST but additional data for these women are missing.
- Additionally, one woman participated in the interview but refused to complete the self-report surveys thus limited information is available for her.
- A total of 15 women completed both the interview and self-report survey portions of the study.

Predictor Variables

- Interviews were conducted by the first author ($n = 10$) and by the second author who was a postdoctoral fellow ($n = 5$). These consisted of open-ended questions about what it was like to serve in OIF/OEF such as, “*What was it like being a woman? What was your experience? What were your thoughts about working with men and women?*”

Survey for Women Who Served in OIF/OEF

- This self-report survey consisted of a 20-question survey which asked about the women’s experience in OIF/OEF.
- 11 questions were demographics such as age, ethnicity, branch of service, length of service, highest rank, job description, description of a typical day, and location of service.
- There were three questions about how the participants felt as a women serving in OIF/OEF, for example, “*How might your experience have been unique because of being a woman?*”
- Two questions asked about injuries, “*Were you injured?*” and “*Did you witness others injured or killed?*”
- Three questions assessed the participants’ exposure to MST, “*Did you experience unwanted verbal comments of a sexual nature (e.g., cat calls, pressure for dates, comments about your body, verbal thoughts)?*” “*Did you experience unwanted sexual physical sexual advances (e.g., unwanted touching, grabbing, cornering)?*” and “*Were you sexually assaulted, attempted or completed rape? (e.g., being hit, choked, burned, forced sex, threatened, attempted, or did you agree to sex out of fear of consequences?)*.” Participants were asked to indicate how frequent each of the incidents occurred on a 5 point scale with 1 being “*not at all*” and 5 being “*daily*.”
- Finally, one question asked about readjustment to civilian life, “*What was the most difficult part of readjusting back to civilian life after service in OIF/OEF?*”

Iraq Readjustment Inventory

- This 16-item inventory concerned the women’s readjustment to their civilian live.
- Participants were asked to rate how difficult each item had been upon their return from combat in Iraq, Kuwait, or Afghanistan using a 5 point Likert-type scale with anchors of 1 = *not at all* and 5 = *extremely*.

- The authors note that this is the first version of this measure and that a 40-item version is currently being tested on both a large sample of men and women returning from OIF/OEF.
- The items were summed to compute a *Global Readjustment* scale.
- A *Social Responsibility* subscale was computed by summing eight items concerning the participant’s relationship with others such as, “*Feeling that others don’t understand what I went through,*” and “*Feeling pressure to be back to normal.*”
- The *Concerns About Iraq* subscale summed six items such as “*Feelings like I still have responsibilities in Iraq,*” and “*Mourning the loss of fellow soldiers who died in Iraq.*”
- The *Career Readjustment* subscale consisted of two items, “*Finding a new career,*” and “*Not knowing what to do next,*” however, internal consistency of this subscale was not reliable and thus it was not used in the comparative data analysis.

Outcome Variables

Clinician’s Symptom Severity Rankings

- Participants in this study were being treated by therapists and as such gross measures of their symptoms severity were obtained.
- The therapists rated the participants as having low, medium, or high symptom severity.

Military Sexual Trauma

- Using the three MST questions from the survey described above, a frequency of the number of women who experienced MST was obtained.
- If the participants answered yes to any of the three questions, regardless of the frequency, they were considered as having experienced MST. The authors note that this is consistent with the definition used by the Department of Veterans Affairs.

RESULTS

- The age of the participants ranges from 20 to 44 years with a mean of 30 years. Six of the women were African American, 5 were Caucasian, 5 were Hispanic, and 2 were Asian American.
- Seventeen of the participants served in the US Army while 1 served in the US Air Force. Four were in the

Reserves and 1 was in the National Guard.

- The average length of service overseas for the participants was 14.53 months with a range of 2.5 months-4 years.
- Data gathered indicated that the women were experiencing the following emotional and behavioral symptoms:
 - Eighteen women endorsed symptoms of irritability and problems concentrating.
 - Thirteen stated that they felt numb or detached from their feelings.
 - Eight complained of feelings of depression and anxiety.
 - Six related that they felt angry.
 - One woman met criteria for alcohol abuse in that she was drinking 3-6 drinks daily.
 - On original inquiry three presented for treatment due to issues concerning sexual trauma during their time in combat, however, during treatment ten of the women stated that they had experienced MST.
- The authors identified the following treatment issues for women returning from service in OIF/OEF:
 - Providing a space for the women to discuss what they experienced.
 - Aiding the women in transitioning from their military lives to their civilian life, including “having to adjust from being nonemotional and task-oriented in OIF/OEF to connecting with dissociated feelings,” (p. 242).
 - Helping the women deal with interpersonal relationships. The authors note that this included relationships that were not stable or healthy before the women’s military service and upon their return the women identified they were no longer comfortable with these types of relationships.
 - Assisting the women with feelings of fatigue, being overwhelmed, and unfocused as well as general feelings of being lost, unmotivated, or unproductive, which was a sharp contrast to the frenetic pace of their military lives.
- The data indicated that the following were unique experiences of women who served in OIF/OEF:
 - The women spent time thinking about their relationship with their men counterparts, and often felt as if they were being scrutinized.
 - The women expressed the need to show that they

were competent and needed to work hard or be “tough” in order to prove that they should be respected and were capable of performing the requirements of their jobs.

- In their relationship with other women in the military, the participants indicated that they often experienced jealous, trust issues, and a lack of respect.
- A high number of women reported experiencing MST ($n = 10, 56\%$).
 - Ten of the women stated that they had been sexually harassed (i.e., “experiencing sexually inappropriate, degrading or sexual comments”) and five indicated they experienced these incidents on a weekly or daily basis.
 - Six of these women related that they had experienced unwanted sexual advances on a weekly or daily basis.
 - Three of the women reported being raped or sexually assaulted.
- Nine participants (60%) stated that they witnessed the death or injury of another person.
- Seven participants (47%) indicated that they had been injured in combat; however, none experience a loss of a limb or other disfigurement.
- The *Global Readjustment* mean score (3.27) fell in the “somewhat” difficult range.
- The *Social Readjustment* mean score (4.33) indicated “considerable” difficulties.
- The *Concerns about Iraq* mean score (2.79) corresponded with a “somewhat” difficult time in readjustment.
- Clinician ratings corresponded with the participants ratings of distress (*Global Readjustment*: $r = .79, p < .001$; *Social Readjustment*: $r = .75, p < .001$; *Concerns about Iraq*: $r = .53, p < .05$).
- Finally, the participants who had experienced a MST had a significantly higher clinician symptom rating ($p < .05$) and greater difficulties in readjustment (*Global*: $p < .001$; *Social Readjustment* $p < .05$; *Concerns About Iraq*: $p < .01$) than those who had not experienced a MST.

CONCLUSIONS/SUMMARY

- The authors contend that the data from their study indicate that women who served in OIF/OEF do have a unique experience in combat and upon return to their civilian life

as compared to their male counterparts.

- These experiences include a higher rate of MST, symptoms of anger, anxiety, and depression.
- Additionally, the women expressed a need to be “tough” and prove themselves to the men they served alongside in combat while their relationships with women were filled with jealousy and lack of trust.

CONTRIBUTIONS/IMPLICATIONS

- The implications of this study suggest that additionally research is needed to explore the experience of women who serve in active combat situations, especially since the ability to generalize these findings is limited by the small sample size of this study.
- The authors also suggest that additional measures that could provide convergent and discriminate validity are needed in future studies.
- Furthermore, the themes that emerged in this study could be used for training purposes for treatment providers who work with women returning from military combat.

Sutherland, K. & Bryant, R. A. (2007). Autobiographical memory in posttraumatic stress disorder before and after treatment. *Behaviour Research and Therapy*, 45, 2915-2923.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To test whether overgeneral retrieval (i.e., increased specific retrieval and decreased categoric retrieval) in PTSD would decrease following treatment by administering the autobiographical memory test prior to and following cognitive behaviour therapy.

METHODS

Design

- A two (assessment point: pretreatment, posttreatment) x two (cue valence: positive, negative cue words) repeated-measures design was employed in which PTSD participants were administered positive and negative cue words to elicit autobiographical memories before and after treatment.

Participants

- Participants were 20 chronic PTSD patients (11 female, 9 male) with a mean age of 35.74 years ($SD = 9.84$) who were referred to the Westmed Hospital PTSD Unit following nonsexual assault ($n = 10$) or a motor vehicle accident ($n = 10$) and displayed a PTSD for at least 3 months based on DSM IV criteria.
- Exclusion criteria were determined by suitability for CBT and through clinical interview, and included: history of psychosis, organic brain syndrome, substance abuse, current suicidal ideation, history of childhood sexual abuse, being less than 17 years of age or more than 60 years of age.
- Diagnostic status was determined using the Clinician Administered PTSD Scale-2 (CAPS-2), a structured clinical interview that assesses 17-symptoms described by the DSM-IV PTSD criteria.
- The depression module of the Structured Clinical Interview for DSM-IV (SCID) was administered to index major depressive disorder. Seven participants met the criteria for major depressive disorder. Additionally, the Beck Depression Inventory-II was administered.
- Fifteen (75%) of participants were reassessed at an average of 15.1 months after the initial assessment.

Materials

- Cue words comprised five positive and five negative words selected from the 1000 most frequent English words and matched on frequency of usage. The positive words were happy, brave, safe, love, and special. The negative words were hurt, tense, angry, fear, and stress. The two practice words were egg, and chocolate. Each word was printed on a white card and the order of presentation was randomized, except that positive and negative words were alternated.

Procedure

- Following written informed consent and administration of the CAPS-2 and BDI-II, participants were asked to report the first specific personal memory triggered by each stimulus word.
- Participants were given a 60 second time limit and responses were audio taped. The experimenter read each word as the card was shown to the participant. If participants did not give a specific memory, the experimenter

prompted them with “can you think of a specific time—one particular event”. Analyses focused on participants’ first responses to the cue card.

- Participants then received eight once-weekly 90 minute sessions of CBT. This therapy entailed one session of education, six sessions of imaginal exposure combined with cognitive restructuring, and one session of relapse prevention.
- Six months after treatment an independent clinical psychologist who was blind to the responses in the initial assessment re-administered the CAPS-2, BDI-II and the Autobiographical Memory Test.
- An independent rater who was blind to group status coded audiotaped responses for specificity or categoric memory. A categoric memory was defined as descriptions of repeated events (e.g., ‘times I’ve gone jogging’). A second independent rater coded 20% of responses for specificity.

RESULTS

- Fifteen of the 20 participants who were initially assessed completed the subsequent assessment; five participants did not complete therapy. There were no differences between those who did and did not complete the second assessment in terms of initial CAPS-2, BDI-II or specific or categoric memories. Three participants at follow-up had major depressive disorder.
- At the 6-month follow-up assessment, nine participants no longer met the criteria for PTSD and six participants did meet the criteria. Participants who met the criteria for PTSD scored higher on the CAPS-2 than participants who no longer met the criteria for PTSD, $t(13) = 3.56, p < .005$. Cohen’s d effect size = 1.31.
- A 2 (participant group) \times 2 (cue valence) \times 2 (assessment point) analysis of variance (ANOVA) of specific memories indicated a main effect for valence: there were more specific memories for negative cue words than or positive cue words. There were no significant main or interaction effects when these analyses were repeated for participants who had high and low depression scores.
- There were no significant correlations between symptoms reduction and pretreatment specific retrieval.
- A 2 (time 2 diagnosis: PTSD, non-PTSD) \times 2 (assessment point: pretreatment, posttreatment) \times 2 (cue valence: positive, negative) mixed-model ANOVA yielded a significant effect of cue valence and a significant assessment

point by diagnosis interaction. Overall there were more categoric memories retrieved for positive cues than negative cues. Participants diagnosed with PTSD posttreatment recalled more categoric memories compared with those without a PTSD diagnosis.

- There were no significant correlations between symptom reduction and pretreatment specific retrieval.
- There was a significant negative correlation between change in CAPS-2 score and change in retrieval of specific memories for positive cues such that decreases in PTSD symptoms were associated with increased retrieval of specific memories of positive cues.
- There was a significant positive correlation between change in CAPS-2 score and change in retrieval of categoric memories for positive cues, suggesting that PTSD symptoms reduced category retrieval.
- While BDI-II change score did not predict increase in specific retrieval or decrease in categoric retrieval, CAPS change score was a significant predictor.

CONCLUSIONS/SUMMARY

- The major finding of this study was that as symptoms reduced after treatment, participants with PTSD retrieved more specific memories in response to positive cues.
- In their CARFAX (capture and rumination, functional avoidance, and impaired executive control) model of autobiographical memory, Williams and colleagues (2007) propose that deficits in specific retrieval may be attributed to reduced working memory functioning and deficits in prefrontal cortex functioning. According to this model, it is possible that as the current studies participants’ symptoms reduced, their working memory capacity increased and allowed for more effective retrieval search of memories in response to positive cues.
- The CARFAX model also proposes that overgeneral retrieval may reflect a defensive reaction that avoids specific memories to reduce aversive affect (Williams et al., 2007). While this position would predict increased retrieval of memories for negative cues as symptoms reduce; the current study found that symptoms reduction was associated with increased retrieval of positive memories.
- The third mechanism proposed by the CARFAX model is that individuals who engage in ruminative thinking contribute to categoric memories, which primes other negative categoric descriptors that perpetuate rumina-

tive self-focus (Williams et al., 2007). Consistent with evidence that rumination can directly increase categoric retrieval, it is possible that as the participants in the current study experienced symptom reduction, they were less prone to ruminate, and this led to better retrieval of specific memories.

- The authors suggest that overgeneral retrieval for trauma memories occurs because they are poorly integrated into the autobiographical memory base, and this motivates the individual to inhibit other autobiographical memories.
- Although the correlations between the changes in depression scores and specific retrieval were not significant, it is likely that low power contributed to the non-significant findings; reduction in depression tended to be associated with decreased retrieval of memories for negative cues.
- It is also possible that the skills that individuals learn during CBT may have taught patients to retrieve specific memories in those who responded successfully to treatment. Enhanced retrieval of positive memories may have made it easier for patients to experience and encode more positive events.
- There was no control group. Therefore, the study is limited because the authors cannot report whether the successfully treated PTSD cases still displayed overgeneral memory or not. Without a wait-list control group, it is also unclear whether observed changes represented the result of treatment or passage of time alone.

CONTRIBUTIONS/IMPLICATIONS

- The current study provides initial evidence of enhanced specific retrieval for positive cues as PTSD remits after therapy.
- Although it was presumed that symptom reduction led to improvements in retrieval of specific memories, it is also possible that more specific retrieval of positive memories contributed to recovery from PTSD.
- Accessing specific memories of positive experiences may contribute to symptoms reduction because it allows for more integration of memories that support safe and successful experiences. These can assist in placing the trauma in a context conducive to recovery.
- Cognitive restructuring often involves direct instruction on reducing ruminative thinking, especially on negative categoric memories, and this intervention may have di-

rectly reduced categoric retrieval in participants who responded positively to therapy.

- Future studies should index the tendency for treated PTSD patients to retrieve more positive recent events to determine whether successful treatment increases access to more positive experiences in the recent past.
- Administering a clinical interview prior to administration of the autobiographical memory test may have primed trauma related memories; this could be assessed by counterbalancing presentation of assessments.

Testa, M., Livingston, J. A., & Hoffman, J. H. (2007). Does sexual victimization predict subsequent alcohol consumption? A prospective study among a community sample of women. *Addictive Behaviors, 32*, 2926 – 2939.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine the association between the occurrence of adult sexual victimization and subsequent heavy episodic drinking in a large household sample of young women.
- To explore whether consideration of trauma symptoms improves prediction of women's drinking.

METHODS

Participants

- Participants were recruited from the Buffalo, NY area by random digit dialing. In-person initial interviews were completed with 1014 women, or 61% of eligible women identified. The sample was 75.3% Caucasian and 16.9% African American, with small percentages of Hispanic, Asian, Native American, and women of mixed or other backgrounds.
- Median household income for the sample was about \$35,000. Most participants had graduated from high school (95%) and 39.8% were enrolled in higher education.
- At Time 1 (T1) most were unmarried (76% never married, 3% divorced or legally separated), with an average age of 23.76 years.

- Of the 1014 women who completed T1, 927 (91.4%) completed all three parts of the study.

Materials

- Sexual victimization was assessed at each part using a modified version of the Sexual Experiences Survey (SES, Koss, Kidyics, & Wisniewski, 1987), which consists of 11 behaviorally specific items that assess unwanted sexual contact, verbally coerced intercourse, attempted rape, and rape resulting from force or incapacitation (e.g., from alcohol or drugs).
- Childhood sexual abuse was assessed at T1 with a series of 8 items adapted from Whitmire, Harlow, Quina, and Marokoff (1999) regarding unwanted sexual touching and intercourse experiences occurring before age 14 years. Women who reported at least one unwanted sexual experience before age 14 years were considered to have experienced childhood sexual abuse (CSA).
- The Revised Conflict Tactics Scales (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used at each assessment to measure women's experiences of intimate partner violence (IPV). Women responded yes or no to a series of items assessing minor and severe physical violence perpetrated by their intimate partners.
- At T1, women were asked whether at any time in their lives they had experienced any of seven traumatic events ("Criterion A" events) including natural disaster, serious accident, physical assault, and witnessing of someone seriously injured or killed. At T2 and T3, women were asked whether any of these events had occurred in the past 12 months. Women were assigned a score based on how many events they had experienced, ranging from 0–7.
- At T2, PTSD symptoms were assessed using the National Women's Study (NWS) PTSD Module (Resnick et al., 1993). The respondent was asked to indicate whether there has been a period of 1 month or more in which she experienced each of a series of 21 symptoms of PTSD corresponding to the DSM-III-R criteria. Items assessed avoidance, hyperarousal, and re-experiencing.
- At each assessment, women were asked a series of questions about their alcohol use. Researchers characterized this information in terms of frequency, quantity, and maximum consumption. Heavy episodic drinking was assessed with two questions about the frequency of consuming more than five drinks at one occasion and

frequency of drinking until intoxicated. These items were assessed on a six-point scale ranging from 0 (never) to 5 (5 or more days per week).

- Lifetime alcohol abuse and dependence was assessed at T1 using a computer administered version of the DIS, based on DSM-IV criteria (Robins, Cottler, Bucholz, & Compton, 1997).
- Age and ethnic background were assessed at T1, with ethnicity classified as either Caucasian (1) or non-Caucasian (0). Marital and parenting status was also assessed at each time period.

Procedure

- Eligible women were asked to participate in a longitudinal study of women's social experiences, consisting of 3 parts of data collection, 12 months apart.
- Initial participation involved a 2 hour session conducted at the Research Institute on Addictions, for which participants were paid \$50.
- At T1, data were collected using both a computer-assisted self-interview and a confidential personal interview with a trained female interviewer. Women were asked about sexual victimization experiences occurring since age 14. Women who responded positively to any item on the SES subsequently participated in a face-to-face interview regarding the most recent incident of sexual assault.
- At T2 and T3, questionnaire booklets were mailed to participants homes. Measures were similar to those used at T1 but focused on the past 12 months.
- Women who responded positively to one or more items on the SES were coded as experiencing sexual victimization. Women who reported an experience of completed or attempted sexual intercourse due to force or incapacitation were classified as experiencing rape.

RESULTS

- Women who reported rape at T1 reported higher levels of heavy episodic drinking (HED) and maximum drinks per occasion both concurrently (at T1) and over the following 12 months (T2). Similarly, women who reported rape at T2 reported heavier drinking at both T2 and T3.
- After controlling for demographic variables, lifetime rape experiences predicted frequency of HED. However, when lifetime IPV and number of traumatic events were added

into the third step of the regression, rape no longer had an independent effect on HED. Experience of any sexual victimization and lifetime rape improved prediction of maximum drinks per occasion.

- Controlling for demographic variables and T1 drinking in the first step of the regression equation, T1 rape made a modest significant contribution to prediction of T2 HED. However, when IPV and other traumatic events were entered into the third step, the effect of rape became non-significant. After controlling for T1 maximum drinks, T1 rape did not improve prediction of T2 maximum drinks. Results were similar when T1 any sexual victimization was substituted for T1 rape.
- The analyses were repeated substituting measures of T1 past year rape, T1 past year sexual victimization, T1 past year IPV, and T1 past year traumatic events in place of lifetime measures. After accounting for the strong effects of T1 heavy drinking, neither T1 past year rape nor T1 sexual victimization contributed to T2 HED or maximum drinks per occasion. Likewise, past year IPV and past year traumatic events did not contribute to prediction of T2 HED or maximum drinks in any equation.
- Similar analyses were repeated to examine whether past year sexual victimization at T2 predicted heavy drinking at T3. Controlling for T2 demographics and T2 drinking on the first step; followed by rape on the second step and T2 traumatic experiences on the third step, T2 rape did not predict T3 HED (nor did the other trauma variables entered on the third step). However, T2 rape improved prediction of T3 maximum drinks per occasion and remained significant after entering T2 traumatic events and IPV on the third step. Repeating the analyses with sexual victimization as the predictor was not significant in either equation.
- The modest effect of T2 rape on T3 maximum drinks per occasion was not mediated via PTSD symptoms.
- There was no support for the hypothesis that experiences of rape or sexual victimization predicted subsequent HED or maximum drinks among a subsample of women with a history of substance abuse disorders.

CONCLUSIONS/SUMMARY

- This study provides a prospective examination of the independent contribution of adult sexual victimization to subsequent drinking among a community sample of

young women. Baseline heavy drinking was positively associated with baseline reports of childhood sexual abuse, sexual victimization since age 14, and lifetime history of intimate partner violence, after controlling for demographic variables known to influence drinking.

- Although these findings are consistent with the hypothesis that victimization contributes to heavy drinking, it cannot be determined based on these cross-sectional data whether T1 heavy drinking occurs in response to or prior to victimization or whether preceded or perhaps contributed to the victimization.
- Using a conservative approach controlling for prior drinking level, there was little evidence supporting the independent role of sexual victimization in prospective prediction of heavy drinking over two time periods. Prior levels of heavy drinking explained nearly all of the variance in heavy drinking at the next time point, with rape and other traumatic experiences having little or no detectable impact.
- There was no evidence to support that women who met diagnostic criteria for substance abuse were more likely to exhibit heavy drinking subsequent to rape.
- Because of the absence of other prospective studies of the impact of sexual victimization on later heavy drinking, it is difficult to know whether these findings are an aberration or whether there is little relationship between sexual victimization and subsequent heavy drinking in the community sample.

CONTRIBUTIONS/IMPLICATIONS

- The negligible impact of sexual victimization on subsequent drinking does not mean that these experiences had no psychological impact, as rape was associated with higher levels of PTSD symptoms. Yet, higher levels of symptomatology were not associated with subsequent heavy drinking, suggesting that for the most part, women were not self-medicating by increasing their alcohol consumption.
- Victimized women may have benefited from social support and from a repertoire of active coping strategies that kept them from resorting to heavy drinking to deal with their trauma. Because of the fairly long intervals between assessments, short-term periods of increased drinking immediately following victimization are likely to have gone undetected.
- The findings of the current study do not negate the

importance of research aimed at understanding the underlying processes contributing to the frequent comorbidity of PTSD and substance abuse in clinical samples of women with a high rate of prior sexual assault. However, they acknowledge the danger in extrapolating from a clinical to a household sample.

- More research is needed to determine whether sexual victimization influences heavy drinking among the general population of women. Shorter assessment intervals, ideally, daily data collection, will provide more sensitive test for investigating the hypothesized relationship.
- The conclusion from the current study is that despite the substantial prevalence of sexual victimization among young women in the general population and the traumatic impact of these experiences, the prospective impact of these experiences on heavy drinking appears limited.

Allison, K. C., Grilo, C. M., Masheb, R. M., & Stunkard, A. J. (2007). High self-reported rates of neglect and emotional abuse, by persons with binge eating disorder and night eating syndrome. *Behaviour Research and Therapy*, 45, 2874-2883.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine rates of diverse forms of childhood maltreatment in persons with night eating syndrome (NES), binge eating disorder (BED), and an overweight/obese (OC) comparison group without disordered eating.
- This is the first study of the frequency of childhood maltreatment in patients with NES and the first to contrast two different forms of disordered eating using an OC group for control group.

METHODS

Participants

- Participants were recruited using broad media advertisements seeking participants for research and treatment studies being conducted at medical schools. The advertisements ran separately and targeted people who

thought they had eating problems (binge eating or night eating) or general weight problems.

- Potential participants for the BED and NES study groups were offered treatments if they so desired and were eligible for specific protocols. Potential participants for the NES and control groups, but not the BED group, were offered modest payments for completing the assessment procedures.
- Inclusion in the study required meeting full criteria for BED or NES or neither. Exclusion criteria included pregnancy, use of psychotropic medication in the past 3 months, or current participation in an eating disorder or obesity treatment program. Participants meeting criteria for anorexia nervosa, BN, or other severe current psychiatric problems requiring alternative immediate treatment were excluded.
- Additionally, NES and control participants could not be working a night shift or swing shift, or have diagnosed obstructive sleep apnea. NES participants were also required to have memory of their night eating episodes, excluding those with only parasomnic eating events (episodes of eating that occur episodically during the night when the patient is not fully awake).
- The study included 176 participants with BED, 57 participants with NES, and 38 control participants.

Materials

- The *Childhood Trauma Questionnaire* (CTQ) was used to assess five types of childhood maltreatment: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Participants rated items about childhood experiences on 5-point Likert-type scales.
- The *Beck Depression Inventory-II* (BDI-II) is a 21-item inventory that assesses the cognitive, affective, and somatic symptoms of depression. There are four levels of categorical scores ranging from none to mild levels to severe levels of depressive symptoms.

Procedure

- All participants were assessed by trained research clinicians.
- BED *DSM-IV* research criteria diagnoses were determined using the *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID-I/P) and confirmed by findings from

the Eating Disorders Examination Interview (EDE). The EDE assesses the frequency of different forms of over-eating, including objective bulimic episodes, as well as the number of days on which they occurred for the previous month. The EDE also assesses eating/meal patterns and is comprised of four subscales: dietary restraint, eating concern, weight concern, and shape concern.

- NES research criteria were also determined using a semi-structured interview, the Night Eating Syndrome and History (NESHI, unpublished interview) plus the analysis of 10-day food and sleep diaries. Food data were analyzed by a research dietitian. Criteria for NES included the consumption of 25% or more of daily caloric intake after the evening meal, as averaged over the week of diary records, and/or three or more nocturnal ingestions during the week. Participants wore wrist actigraphs to confirm their awakenings.
- Descriptive statistics were used to define basic characteristics of the three groups, and χ^2 analyses were used to test any differences in distribution of sex and race. Analyses were conducted to test for differences in the proportion of patients classified as exceeding clinical cut-points for each of the five forms of childhood maltreatment.
- Univariate analyses of covariance (ANCOVAs) were used to test for group differences in reports of the childhood maltreatment variables.

RESULTS

- The three groups differed significantly in age, ethnicity, and BDI scores. The three groups did not differ significantly in gender or either BMI or highest lifetime BMI.
- Reports of maltreatment were common across the three groups, with the BED group scoring above more clinical cut-points than the OC group, but not the NES group.
- A higher proportion of the BED and NES groups scored above clinical cut-points for a positive history of emotional abuse than the OC group.
- A higher proportion of the BED group reported emotional neglect than the other two groups, and a higher proportion of the NES group reported physical neglect than the BED group.
- For the overall sample, BMI was not significantly correlated with any of the CTQ dimensional scores. There were no differences between participants who met at least one cut-off score for maltreatment ($n = 217$) and

those who met no cut-off scores ($n = 54$) for current BMI or highest lifetime BMI.

- The BDI-II total score was significantly correlated with each type of maltreatment, with the exception of physical neglect.
- Participants who reported none to minimal levels of depressed mood reported significantly lower rates of emotional abuse and emotional neglect than those in the groups with depressed mood. Those with none to minimal depressed mood reported significantly lower rates of physical abuse than the severely depressed participants, and lower rates of physical neglect than the moderately depressed participants.
- ANCOVAs (controlling for age and ethnicity) revealed that the BED group had significantly higher levels of emotional neglect than the other groups and the NES group had higher levels of physical neglect than the BED group.
- Given the significant group differences in BDI scores, when ANCOVAs were performed that covaried for BDI, the pattern of findings was essentially unchanged except that when BDI was controlled for, physical neglect scores reported by the BED group were higher than those reported by the OC group.

CONCLUSIONS/SUMMARY

- This study provided the first report of levels of childhood maltreatment among persons with NES and compared those levels with those of persons with BED and non-treatment-seeking overweight and obese individuals.
- Higher rates of neglect and emotional abuse were associated with BED and NES participants than among overweight and obese participants without disordered eating.
- Participants with BED showed strikingly higher reports of emotional neglect, whereas physical neglect appeared more common in NES patients.
- All three groups reported very high rates of at least one type of maltreatment, ranging from 71% to 81% across groups.
- Childhood maltreatment rates in the BED and NES groups were generally higher than those reported in community samples, but were similar to those reported in previous studies of BED.
- Higher levels of depressed mood were significantly correlated with most forms of maltreatment. Additional cat-

egorical analyses revealed that moderate to severe levels of depressed mood, common to individuals with BED and NES, were significantly related to both emotional and physical abuse and neglect.

- Reported rates of physical and sexual abuse differed little across groups, whereas reports of emotional abuse and forms of neglect were higher in the BED and NES groups than the OC group and were associated with elevated depression levels.
- Cross-sectional design precludes statements regarding causality between high levels of maltreatment and the manifestation of BED, NES, and obesity.
- Since the participants were primarily Caucasian females, the results may not generalize to groups with other characteristics.

CONTRIBUTIONS/IMPLICATIONS

- The collective findings combined with the emerging literature linking child maltreatment with a broad range of

psychopathology supports the view that childhood maltreatment may be strongly associated with increased psychosocial problems in general, but not specifically with weight or eating disorder symptomatology.

- The findings are broadly consistent with a cognitive behavioral therapy model that posits that a lack of emotional support undermines self-esteem, and when coupled with physical neglect and lack of nourishment this triggers binge eating.
- Future research concerns the question of factors that represent vulnerabilities or serve as protective factors against developing negative sequelae of maltreatment. For example, research has found that body image mediates the relationship between sexual abuse experience and disordered eating.
- More definitive prospective research is needed to address these issues both across diverse obese and disordered eating groups and for different treatment methods.

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

I'm Not Alone: A Teen's Guide to Living with a Parent who has a Mental Illness

By Michelle D. Sherman, Ph.D. & DeAnne Sherman

Edina, MN: Beaver's Pond Press, 2006, 130 pages, Soft cover, \$20.00

Order from www.seedsofhopebooks.com or 1-800-901-3480

Continuing the theme of their first book, *Finding My Way: A Teen's Guide to Living with a Parent who has Experienced Trauma*, authors Michelle and DeAnne Sherman reach out to teens who are struggling to understand a parent with a mental illness.

I'm Not Alone is a three-part workbook or guided journal focusing on understanding mental illness, developing coping skills, finding hope, and identifying helpful resources. A common, and critical, theme permeating the book is that feelings are OK – neither right nor wrong, but OK. From the opening pages, the authors weave positive messages of hope and acceptance throughout their text. “You are not alone” is a pervasive theme.

Part One explains the basics of mental illness. After likening mental illness to physical illness, the authors define the major types of mental illness, including schizophrenia, depression, and bipolar disorder. Each diagnosis is clearly explained, and then further clarified using personable examples. The authors next address common addictions, followed by suggestions for dealing with suicidal thoughts and behaviors.

The next section transitions to treatment, explaining who to consider talking with and the available treatment options such as individual, group, and couples/family therapy. The authors make the important point that the decision for the parent to seek treatment is the parent's decision not the teen's. They assure the teens that even if the parent does not want help, the teens can still seek help so the teen can feel better.

Further, the authors make the additional point that recovery does not mean the mental illness disappears, but that

it can be managed so that the individual can resume their unique life.

Part Two offers practical advice for living with a parent who has a mental illness. This section begins with common emotions, such as anger, shame, and sadness, which teens may experience when living with someone who has a mental illness. Moreover, the authors provide a list of additional emotions teens may be experiencing. The authors stress the importance of allowing these emotions to surface. They highlight their point with a quote from Henri Nouwen, “The only feelings that do not heal are the ones you hide.”

The authors offer tools for coping, including gathering information, having fun, expressing feelings, relaxing, and engaging in physical activity. For example, they expand on expressing feelings by encouraging teens to consider whom they can count on: who would listen, encourage, respect without judging, and keep conversations private? An interesting exercise they suggest is to create a social map with yourself in the center circle, the people you trust in the middle circle, and the people you know but do not yet know if you can trust in the outer circle. With this map, then consider whom you can talk to in various situations.

The final section, Part Three, reviews the important lessons learned, then answers additional questions commonly asked about mental illness and coping. This section closes with several constructive resources, including helpful websites and books, a list of 66 feeling words, a list of activities to “help get through the rough times,” and a glossary.

Although the primary focus is on teens, the recommendations and suggested activities could apply to any family

member. The authors once again accomplish the tasks they set for themselves in the beginning of the book: helping teens help themselves and discover resources, including other people, who can help them.

I'm Not Alone will be a valuable tool to anyone working with teens that have parents with a mental illness, including mental health professionals, teachers, school counselors, youth group leaders, health care providers, and trauma responders.

Michelle D. Sherman, Ph.D., is a licensed clinical psychologist and a nationally recognized expert on the effects of trauma and mental illness on the family. She is the Director of

the Family Mental Health Program at the Oklahoma City Veterans Affairs Medical Center and the co-chair of the Family Studies Team of the South Central Mental Illness Research, Education and Clinical Center. She is also a clinical associate professor in the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center.

DeAnne M. Sherman, Michelle's mom, is a teacher with over 40 years of experience educating and empowering teenagers. In addition to being an experienced public speaker, DeAnne also volunteers her time teaching and mentoring junior high students in the performing arts.

Substance Abuse & Mental Health Services Administration

website: www.samhsa.gov

Reviewed: 30 JAN 2008

Updated: 30 JAN 2008

The Substance Abuse & Mental Health Services Administration's website (www.samhsa.gov) contains a wealth of information covering a wide range of topics, from substance abuse to suicide prevention to coping with traumatic events. SAMHSA's vision is that "people of all ages, with or at risk for mental or substance use disorders, should have the opportunity for a fulfilling life that includes a job/education, a home, and meaningful personal relationships with friends and family. SAMHSA works to achieve this vision through an action-oriented, measurable mission of "Building Resilience and Facilitating Recovery."

The website contains numerous articles, videos, webcasts, PowerPoint slides, and links to additional information. The home page lists major issues in the center column, and a helpful topic list in the left column. The right column has a section titled "I need help with..." which links directly to information on substance abuse, mental health, grants, statistics, training resources, and Frequently Asked Questions.

One topic area which IJEMH readers may find especially useful is "Coping with Traumatic Events," one of the "Spotlight" links from the front page. This area contains

major topics such as "Understanding Mental Health," "For Responders and Health Professionals," "For Students," "For Schools," "For Adults," and "For Families." Each topic contains links to articles or "fact sheets" such as "How to Deal With Grief," "Tips for College Students: *In the Wake of Trauma*," "Guide for Parents and Educators: *Tips for Talking to Children and Youth After Traumatic Events*," "Guide for Emergency Response and Public Safety Workers: *Tips for Managing and Preventing Stress*," and "SAMHSA Fundamentals of Disaster Planning and Response."

Drill deeper into the topic by clicking on the area, "Understanding Mental Health – After the Virginia Tech Tragedy," which leads to information on coping with trauma, myths about mental health, and social acceptance/anti-stigma campaigns. Further, clicking on the "Violence and Mental Illness" link yields information correcting the common misperception that the mentally ill are more violence prone. Rather, "People with psychiatric disabilities are far more likely to be victims than perpetrators of violent crime."

This mega site contains so much information, it is somewhat challenging to navigate. Clicking links may unpredictably take the user to a new page, open a new browser window,

or take you to a different agency without warning, such as stopalcoholabuse.gov, recoverymonth.gov, or pandemicflu.gov. Many pages post a Google-driven search box, with both basic and advanced capabilities, in the upper left corner as well as a fairly consistent internal link collection lining the bottom of the page to aid in navigation.

Each page is densely packed with information, without distractions such as pop-ups, blinking or moving text, or banner ads. The site loaded quickly via cable modem.

I recommend you add this comprehensive resource to your favorites or bookmarks.



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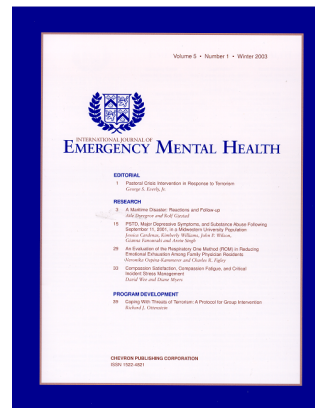
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