Purpose and Scope

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

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

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

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

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INTERNATIONAL JOURNAL OF
EMERGENCY MENTAL HEALTH

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

- *Research reports:* Empirical studies that contribute to the knowledge and understanding of traumatic disability syndromes and effective interventions.
- *Integrative reviews:* Articles that summarize and explain a topic of general or specialized interest to emergency medical, mental health, or public safety professionals.
- *Practice guides:* Reports of existing, developing, or proposed programs that provide practical guidelines, procedures, and strategies for working emergency service and mental health professionals.

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- *First person:* Personal accounts of dealing with traumatic stress and crises, either as a victim or caregiver, that provide insight into coping and recovery.

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

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

ORIGINAL ARTICLES

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

MEDIA REVIEWS - Daniel Clark, Media Review Editor

Editorial

It is with pleasure that I assume editorship of the International Journal of Emergency Mental Health with the present issue. For over a decade, IJEMH has provided active professionals in the fields of psychology, law enforcement, public safety, emergency medical services, mental health, education, criminal justice, social services, pastoral counseling, and the military with a resource that is not only scholarly and research-based, but also provides information that is immediately useful and practical to the working professional. It is this creative blend of scientific authoritativeness and hit-the-streets applicability that makes my new editorial role so exciting.

I would like to thank outgoing Editor, Dr. Richard Levenson, for his help in making this a smooth transition. Rich remains on the editorial board as Associate Editor and his continuing input will continue to be valued. I'm also grateful to Diane Gwin, Manager of Chevron Publishing, for her guidance and practical assistance in the innumerable nuts-and-bolts details that go into actually putting together and cranking out a quality journalistic product. Also, thanks to the reviewers of the articles for this and forthcoming issues; no peer-reviewed journal can exist without you, and I'll be calling on you again. To those reviewers on the panel who have not been tapped in a while: your turn is coming.

Finally, the contributors. Hey, listen, people: this is your journal, your place to say something that can make a difference in the lives of victims and helpers and have a real-world impact on the daily practice of emergency medical, public safety, and mental health services. We want to hear about your research, your clinical experiences, your development of practical programs for intervention, your review and integration of new ideas in the field, and your personal experiences as an emergency services professional. Unlike the 12- to 24-month turnaround that characterizes many academic journals, IJEMH strives to get your manuscripts reviewed, revised, and published as soon as possible. In your jobs, you typically have to think fast and work fast. Give us your insights and we'll do our best to keep up.

Indeed, the current issue contains a range of articles that track the emerging breadth and diversity of the emergency mental health services field, issues that range from the need for hard research data and practical intervention skills to questions of mortality, spirituality, and the very meaning of life. We rely on law enforcement professionals to be strong and healthy in their efforts to protect us and keep the social order. Accordingly, Colwell describes the wide variety of stressors experienced by police officers and makes recommendations for clinicians who work with this special population. Among the most tragic outcomes of extreme law enforcement stress is officer suicide and, unfortunately, we've lacked sufficient authoritative information on this subject to help guide potential intervention efforts. O'Hara provides a much-needed reality check in the form of hard data on officer suicide and its ramifications that will be useful both to researchers and to clinicians in the field whose task often includes helping their clients find the will to survive.

In fact, the struggle for survival is fought on many fronts, from neighborhood battlefields to hospital wards. Rom et al. describe a unique and innovative application of the mental toughness and peak performance training models of sports psychology to helping cancer patients survive and thrive. This positive, affirmative approach to treatment will be a powerful adjunct to medical and mental health practitioners who are searching for something beyond the standard "coping skills" training modules to jump start their patients' motivation for confronting their illness.

Working in the trenches of life and death cannot help but lead crisis counselors and emergency mental health practitioners to reflect on the larger existential issues of life's meaning and purpose. We're often skittish about directly

addressing our clients' spiritual questions and concerns for fear of appearing overly doctrinal or less "clinical" in our approach. But, as Nardi makes clear, dealing with such issues as suicide or serious illness virtually requires that spiritual issues – however conceptualized – be incorporated into treatment, and the article provides principles and guidelines for doing so in a constructive and healing manner.

In fact, one of the recommendations of Nardi's article is for the clinician to "know thyself," and this is the subject directly addressed by Ottens, Pender, and Nyhoff. Mental health professionals often collaborate with law enforcement and emergency services administrators to design and implement assessments to determine who is fit for the particular profession – But who assesses us? Sometimes, it requires taking a piercingly honest look at our own professional skills and personal qualities to determine what kind of work we're really cut out for; Ottens and colleagues apply a creative philosophical model to the subject of crisis counselor self-assessment.

In any field, we assess ourselves because we want to become better at what we do, and it is in this spirit of continual learning, skill improvement, self-evaluation, and contribution to others that I am proud to begin my editorship of IJEMH. Send us your ideas, tell us what you know, and let's take the integration of theory, research, and practice to a whole new level.

Laurence Miller, PhD
May 8, 2009

Police Officers' Experience with Trauma

Lori H. Colwell

Whiting Forensic Division, Connecticut Valley Hospital

Abstract: *This study examined officers' perceptions of the traumatic events they encounter on the job. Officers (N = 313) completed a survey asking about their experience with specific types of trauma, as well as what they considered to be their most traumatic event. They were given the opportunity to describe their unique perceptions of these events in response to open-ended questions. The results revealed vast variability in officers' experience with trauma in terms of the number, type, unique perceptions, and impact of these events. Results are discussed in terms of their implications for clinicians who treat officers affected with posttraumatic stress reactions and disorders. [International Journal of Emergency Mental Health, 2009, 11(1), pp. 3-16].*

Key words: *police officers; traumatic events; perceptions; treatment*

Police Officers' Experience with Trauma

Police officers are exposed to traumatic events with far greater frequency than is the average citizen (Anshel, 2000; MacLeod & Paton, 1999; Renck, Weiseth, & Skarbo, 2002; Robinson, Sigman, & Wilson, 1997; Stephens & Miller, 1998; Toch, 2002; Violanti, 2001; Violanti & Gehrke, 2004; Wilson, Poole, & Trew, 1997). They must be prepared to deal with violent, dangerous, and unpredictable situations that place them at risk for serious injury or death (e.g., shooting incidents, physical attacks, riots), and they even may receive threats to themselves and their families. They also are exposed to trauma more indirectly in their roles as emergency response personnel (e.g., accidents, rescue situations, ho-

micides, suicides) or in assisting victims of violence or trauma (e.g., victims of abuse, surviving family members). Any one of these situations can leave lasting emotional and psychological scars that can disrupt an officer's functioning and interfere with the ability to perform occupational duties adequately and safely (Abdollahi, 2002; Carlier, Lamberts, & Gersons, 1997; Evans & Coman, 1993; MacLeod & Paton, 1999; Martelli, Waters, & Martelli, 1989; Robinson et al., 1997; Violanti, 1996; Violanti & Aron, 1994).

What is Traumatic to an Officer?

Whether a specific event is perceived as 'traumatic' typically will vary from individual to individual and will depend on a host of factors including personality characteristics, life history variables, current stressors, and cognitive appraisals of the event itself. However, a number of researchers have found that certain events are perceived by police officers as a whole as being more stressful and more traumatic than others. For instance, Evans and Coman (1993) found the violent death of a partner in the line of duty and shooting an-

other human being in the line of duty to be among the most stressful field events reported by a sample of 271 officers. Using Spielberger and colleagues' (Spielberger, Westberry, Grier, & Greenfield, 1981) Police Stress Survey, Violanti and Aron (1994) found similar results in a sample of 103 police officers, with "killing someone in the line of duty" ($M = 79.4$ on a scale from 0 to 100) and "fellow officer killed" ($M = 76.7$) ranking as the top two most stressful events associated with police work. These events were followed by "physical attack" ($M = 71.0$), "battered child" ($M = 69.2$), and "high-speed chases" ($M = 63.7$). A sample of 600 British police officers reported that disaster or accident rescues, being shot at, colleague fatalities, and child fatalities were among the most stressful field events they had experienced, all with a mean value equal to or greater than 3.20 on a four-point scale (Mitchell-Gibbs & Joseph, 2001). These studies indicate that across multiple samples, events involving the death of a colleague or a child, threats of harm or the need to perpetrate harm, and major rescue operations rank among the most severe and most distressing events experienced by officers. In general, officers report that these most traumatic events are experienced with the least frequency (Mitchell-Gibbs & Joseph, 2001; Patterson, 1999).

Effect of Traumatic Events on Officers

With an interest in how these events affect police officers, numerous studies (Carlier et al., 1997; Carlier, Lamberts, Van Uchelen, & Gersons, 1998; Gersons, 1989; Kopel & Friedman, 1997; Martin, McKean, & Veltkamp, 1986; Renck et al., 2002; Sims & Sims, 1998; Stephens & Miller, 1998; Violanti & Gehrke, 2004; Wilson et al., 1997) have investigated the prevalence of posttraumatic stress disorder (PTSD) in this population. These studies have utilized a variety of assessment methods, including open-ended interviews, semi-structured interviews, and self-report questionnaires and checklists. They have recruited samples from the general population of police officers in both urban and rural settings, as well as samples of police officers who had experienced a particular, shared or unshared traumatic event in the recent past. Collectively, these studies report rates of PTSD ranging from a low of 7% (Carlier et al., 1997; Carlier et al., 1998) to a high of 86% (Sims & Sims, 1998).

Notably, the highest rates of PTSD were not confined to those studies sampling officers who *all* had experienced some traumatic event, nor were the lowest rates obtained only in samples of officers in general, suggesting no selection bias. For example, Kopel and Friedman (1997) interviewed a random sample of officers (i.e., not ones who had experienced a specific traumatic event) and found that nearly half (49%) met the criteria for PTSD. In turn, the officers in the studies by Carlier and colleagues (1997, 1998) all had experienced some traumatic event in the recent past and yet only 7% met the criteria for PTSD. Two thirds of the officers in one study (Manolias & Hyatt-Williams, 1993) reported a marked emotional reaction to a traumatic event they had experienced, whereas Hartley and colleagues (Hartley, Violanti, Fekedulegn, Andrew, & Burchfiel, 2007) found no association between traumatic police incidents and depression. Despite such variability, there is still sufficient evidence to warrant concern with respect to officers' risk of developing PTSD and other trauma-related disorders. This disorder can have extremely debilitating effects that can detract from safe and adequate job performance. Further, it is a significant factor leading to early retirement from the profession, with 43% of officers in one study identifying trauma as the specific reason for early termination from the force (Miller, 1995).

For those involved in treating or preventing trauma-related disorders in police officers, it is important to understand the process that unfolds when an individual experiences a traumatic event, including the many influences that shape his or her response. The studies described above have contributed immensely to our understanding of officers' experience with trauma. However, there are still gaps in our knowledge and understanding of police trauma, particularly as it relates to officers' specific reactions, thoughts, and perceptions about these events. The present study is an attempt to fill some of these gaps in the literature by compiling a comprehensive analysis of officers' experiences with traumatic events and by adding to this analysis of officers' unique perceptions regarding these events. More specifically, the present study sought to report: the type, perceived severity, and frequency of traumatic events experienced by police officers; officers' descriptions and unique perceptions regarding their most traumatic event (e.g., perceived controllability, negative impact, surprising reactions, lasting effects); and the relationships between officers' experiences with trauma and specific demographic and life history variables (e.g., gender, race, age, marital status, years experience, general stressors).

METHOD

Participants

Three hundred thirteen officers from 11 different agencies (municipal and sheriff's office) in Texas participated in the study. Sample demographics are reported in Table 1. The sample of officers had a mean age of 39.5 years and included predominantly Caucasian, married, college-educated males. These officers had an average of 15 years of law enforcement experience, ranging from one year to 37 years. The majority (78.3%) were of entry-level rank (i.e., officer, deputy, or detective) and primarily in either a patrol (60.4%) or an investigative (33.2%) position. More than one quarter (26.2%) reported prior military experience, averaging seven years, and 7.3% reported an average of five years of firefighter or emergency medical service experience.

Procedure

Ranking chiefs from 11 Texas police agencies were contacted and asked for their permission to administer a series of questionnaires to their officers. These administrators were informed of the nature and purpose of the study, the voluntariness of participation, and the proposed procedure for data collection. Once approval was obtained, a liaison officer from each agency was asked to brief the officers regarding the nature and purpose of the study prior to data collection, and the researcher provided a brief synopsis of how to describe the study to the officers.

Data collection was carried out on-site at the various police agencies during officer roll calls at shift changes. Following a brief description of the study, the officers completed a demographic questionnaire. The officers then completed a detailed questionnaire regarding their trauma histories. First, officers were asked to describe what they consider to be the

Table 1. *Sample Demographic Characteristics*

Demographic	Average / Frequency
Age	$M = 39.5$ ($SD = 8.3$)
Gender	
Male	91.1%
Female	8.3%
Ethnicity	
Caucasian	83.1%
Hispanic	8.0%
African-American	5.1%
Native American	1.6%
Asian/Pacific Islander	0.6%
Marital status	
Single	5.1%
Married	76.7%
Divorced/separated	16.6%
Widowed	0.3%
Common-law/partner	0.3%
Education	
High school/GED	11.2%
Some college	43.8%
2-year degree	12.5%
4-year degree	27.2%
Graduate school	4.5%
Years of policing experience	$M = 15.0$ ($SD = 7.7$)

most traumatic event they have experienced over their entire careers. Next, they answered specific questions about this event, including: the years of policing experience prior the event; the number of traumatic experiences prior to the event; the total number of traumatic events over their entire careers; the perceived controllability of the event; and the negative impact of the event on their overall well-being (e.g., sleep disturbances, anxiety) in the months that followed. Responses to these last two questions were rated on 5-point Likert-type scales.

Officers then responded to two open-ended questions: "What surprised you about your reaction to this event and how it affected you?" and "What has changed about the way that you think about this event now?" Finally, the officers rated the severity of 10 police-specific events (adopted from the Police Stress Survey; Spielberger et al., 1981) on a scale from 0 (not at all severe) to 100 (extremely severe) and indicated how many times they had experienced each of these events over the past six months as well as over their entire careers. The officers did the same for 10 common life events selected from the Holmes and Rahe (1967) Social Readjustment Rating Scale. Completion of the entire questionnaire took approximately 20-30 minutes[1].

RESULTS

Officers' Stressful and Traumatic Experiences: Perceived Severity and Exposure

Officers' responses regarding the severity and frequency of police-specific and general life events are reported in Table 2, compared with the validation data from the original instruments[2,3]. Regarding the police-specific events on the survey, the officers perceived the loss of a fellow officer in the line of duty as the most severe event. Killing another individual in the line of duty and the death of a child also were perceived as extremely severe, as all three of these events were rated above 80. The officers perceived physical attack or injury, incidents of child abuse, and high-speed chases or accidents as events of moderate severity, with average ratings of at least 60. Finally, the officers perceived death notifications, death scenes, fatal accidents, and solitary arrests as the least traumatic events (but still fairly traumatic, all achieving average ratings of at least 40).

With respect to the more general life events, the officers in the current sample perceived the death of a spouse as the most stressful event, with the death of a close family member also being highly stressful (i.e., average ratings greater than

80). Marital separation or divorce, personal injury or illness, a family member's injury or illness, and significant changes in finances were perceived as moderately stressful (i.e., average ratings greater than 60). Changes in residence or living conditions, changes in work responsibilities, and trouble with boss were viewed as the least stressful events (but still somewhat stressful, with average ratings greater than 40).

The officers in the current sample reported vast differences in their personal experiences with these police-specific and general life events. With respect to the 10 police-specific events, the officers reported experiencing from zero to 540 different events during the past six months, and from zero to more than 3,500 events over their entire careers (see Table 3 for a breakdown of specific events). In general, the events perceived by the officers as the most severe were experienced the least frequently. Over the officers' entire careers, the most frequently experienced events were solitary arrests (Med = 50), suicide/homicide scenes (Med = 15), incidents of child abuse (Med = 12), and fatal accidents (Med = 10); all others events were experienced at a median of less than 10. With the exception of killing another individual while on duty, nearly two thirds (58.3%) reported experiencing each of these events at least once over their entire careers.

As with the on-the-job events, officers' experiences of off-the-job stress and trauma were varied. These more general life events were much less common than the police-specific events, with the number of events ranging from zero to 20 within the past six months, and from zero to 400 over their entire lives. Once again, the events perceived to be the most stressful were experienced relatively infrequently. Over the officers' entire lives, the most frequently experienced event was a change in residence or living conditions (Med = 5); all other events were experienced with rarity. With the exception of the death of a spouse, at least half of the officers (51.9%) reported experiencing each of these events at least once over their entire lives (see Table 3).

Officers' Most Traumatic Events

The officers reported an average of 25.9 (SD = 103.4) traumatic on-the-job events, ranging from zero events (n = 9) to 1,250 events (n = 1). The specific type of event that officers reported as their most traumatic is presented in Table 4. The most common response was the death or serious injury of a child, reported by more than one quarter (27.5%) of the officers. Adult death scenes (e.g., homicide, suicide), fellow officers being killed or seriously injured in the line of duty,

Table 2. *Officers' Severity Ratings of Stressful On-the-Job and Life Events*

	Severity rating (0-100) *M (SD)*	
Event	Current Sample (*N* = 313)	Police Stress Survey Violanti & Aron, 1994 (*N* = 103)
Fellow officer killed on duty	93.1 (18.1)	76.7 (23.2)
Killing someone on duty	87.8 (26.3)	79.4 (27.9)
Death of child	82.3 (21.1)	*
Physical attack/injury	68.4 (25.5)	71.0 (27.6)
Child abuse/neglect	65.8 (25.3)	69.2 (31.0)
High-speed chase/accident	60.1 (27.1)	63.7 (28.4)
Death notification	56.7 (29.4)	52.6 (29.0)
Suicide/homicide	56.1 (26.1)	32.1 (21.1)
Fatal accident	54.9 (25.2)	*
Making arrests alone	40.9 (27.0)	37.2 (25.1)

Event	Current Sample (*N* = 313)	Social Readjustment Rating Scale Miller & Rahe, 1997 (*N* = 427)
Death of spouse	91.0 (24.6)	119.0
Death of close family member	84.1 (20.3)	92.0
Death of close friend	79.6 (21.1)	70.0
Marital separation/divorce	77.1 (25.2)	98.0
Personal injury/illness	68.7 (26.3)	77.0
Change in family member's health	68.1 (25.4)	56.0
Change in financial state	61.9 (28.3)	56.0
Trouble with boss	51.3 (25.9)	29.0
Change in work responsibilities	50.3 (27.3)	43.0
Change in residence/living conditions	40.8 (26.8)	42.0

Note. Items marked with an asterisk (*) were not included on the original Police Stress Survey.

and incidents that threatened or harmed the officer's life were the next most common. These were followed by situations in which a suspect's life was threatened, harmed, or taken and fatal or serious vehicle accidents. Least common were events involving uncertain danger (e.g., high-speed chase, hostage situation, arresting suspects) and notifying family members of a death. Temporally, these events occurred at a point midway through officers' careers, in terms of both years of service (*M* = 7.1 years) and on-the-job trauma experiences (*M* = 12.2 events). However, the range of responses varied widely:

Officers reported having only a few days on the job to more than 30 years of experience when they encountered their most traumatic event. Similarly, they reported experiencing no prior traumatic events to experiencing more than 1,000 prior to their most traumatic.

The majority of officers reported that they felt they had little (20.8%) to no (37.2%) control over these events. Their perceptions of the negative impact (i.e., sleep or memory disturbances, anxiety in similar situations) that these events had on their overall well-being in the months that followed

Table 3. *Frequency of Officers' Experience with Stressful On-the-Job and Life Events*

Police Event	Past Six Months (Med)	Entire Career (Med)
Fellow officer killed on duty	0	1
Killing someone on duty	0	0
Death of child	0	3
Physical attack/injury	0	5
Child abuse/neglect	0	12
High-speed chase/accident	0	6
Death notification	0	4
Suicide/homicide	1	15
Fatal accident	0	10
Making arrests alone	2	60

Life Event	Past Six Months (Med)	Entire Career (Med)
Death of spouse	0	0
Death of close family member	0	2
Death of close friend	0	2
Marital separation/divorce	0	1
Personal injury/illness	0	1
Change in family member's health	0	1
Change in financial state	0	1
Trouble with boss	0	2
Change in work responsibilities	0	2
Change in residence/living conditions	0	5

resembled a normal distribution, with 41.3% of officers reporting that it had "some effect." A fair number of the officers reported either "very little effect" (21.0%) or "a large effect" (25.3%), and very few officers reported either "no effect" (7.7%) or that the event "affected every aspect" of their lives (4.7%). As expected, the majority of officers rated their most traumatic event as being more severe on the 100-point rating scale than their peers rated these same events, with approximately 70% giving their event a higher rating than their peers did. Also expectedly, the greater the discrepancy between officers' own and their peers' ratings of an event, the worse the outcome on the individual officer, $r(268) = .31, p < .05$. This held true for all types of events: Officers who, in general, rated police stressors as more severe than their peers also reported a more negative impact from their most traumatic event, $r(271) = .28, p < .05$.

Demographics, stressors, and reactions to trauma. Chi-square analyses and independent samples t tests were con-ducted to determine whether demographic and stress history variables related to officers' perceptions of the impact of these events. Female officers ($M = 3.29, SD = 1.12$) reported a worse outcome from these events than did male officers ($M = 2.96, SD = 0.96$), $t(296) = 1.58, p < .05$, though this difference was small. However, there were no differences in negative outcome across the marital categories of single, married or partnered, and divorced or separated, $F(2, 292) = 0.66, p > .05$, nor were there differences across races, $F(4, 290) = 0.84, p > .05$. There was no relationship between age and negative impact, $r(296) = .11, p > .05$.

Officers who reported suffering more general life stressors within the past six months reported more difficulty following their most traumatic event, $r(254) = .26, p < .05$. There was no relationship between officers' recent exposure to stressful police events and their reported difficulty following this same event, $r(257) = .03, p > .05$. With respect to officers' on-the-job trauma histories, an interesting finding emerged.

Table 4. *Officers' "Most Traumatic Experiences" On the Job*

Experience	Frequency (%)
Child death/serious injury	23.3%
Homicide/suicide/death scene (adult)	17.8%
Fellow officer killed/seriously injured	13.9%
Life threatened (e.g., shot, shot at, physical attack/injury)	11.0%
Others' threatened/killed (e.g., aim/discharge weapon, injure/kill suspect, observe other officer(s) injure/kill suspect)	11.0%
Fatal/serious accident	10.7%
Uncertain danger (e.g., high-speed chase, hostage, suspect arrest)	6.1%
Death notification	1.3%
Other (e.g., disciplinary action, civil suit, administrative difficulties)	1.6%
Perceptions of control	
No control	35.5%
Very little control	19.8%
Some control	21.4%
A lot of control	15.0%
Total/complete control	3.5%
Negative impact	
No effect	7.3%
Very little effect	20.1%
Some effect	39.6%
A large effect	24.3%
Affected every aspect	4.5%

Note. Nine officers (2.9%) indicated that they had not experienced an event that they considered to be particularly 'traumatic.'

Officers who reported being exposed to more traumatic events *prior* to their most traumatic reported that this event had a more significant impact on them, $r(260) = .21, p < .05$. However, there was no relationship between the *total* number of traumatic events officers reported (i.e., including those experienced after their most traumatic) and the perceived negative impact of their most traumatic event, $r(252) = .06, p > .05$. The opposite was true for officers' years of policing experience. Though there was no relationship between years of service *at the time of the event* and perceived negative outcome, $r(296) = .03, p > .05$, there was a small but significant relationship between *total* years of service and perceived negative outcome, $r(297) = .14, p < .05$, with more experienced officers reporting a more negative outcome following these events; again, however, this relationship was small[4].

Officers' open-ended responses. Officers also provided responses to open-ended questions regarding what surprised them about their reactions to these events and what they have learned from these events. Table 5 presents a sum-

marized description of their responses. Many officers reported strange perceptual disturbances (e.g., tunnel vision, narrow focus, time distortions, heightened senses), and several acknowledged how these events shocked and horrified them, causing a more negative view of the world in general. However, a major theme across officers' responses was the wide variability – polarity, even – in their perceptions. For instance, some officers were surprised at their ability to remain calm, detached, and in control of their emotions during the event, whereas others were shocked at the intensity of emotions (particularly negative) they experienced and their inability to control them. Some reported particular difficulty in being able to detach from the situation, finding themselves personalizing the events and thinking about similar loved ones. Others reported feeling numb or being able to suppress their emotions during the event but experiencing a "flooding" of emotions afterward.

Many officers were surprised at the minimal impact these events had on their well-being, whereas others reported sur-

Table 5. *Officers' Reactions to Their "Most Traumatic Experiences" On the Job*

Category	Example
Physiological effects	Each time he would raise the gun I felt as though my head was being squeezed, like trying to squeeze all the air into one end of the balloon.
Shock/disbelief	How or why a person would actually commit an offense against a child.
Controlled emotions	I was relatively calm and performed in a rather detached manner emotionally. I did not get upset.
Lack of emotional control	I was sad to the point of tears and realized that men can cry and it's okay.
Personalization	My thoughts immediately went to my nephew, who was the same age.
Calm during, emotional after	Bottled up my feelings until I decided to let them out at a later date to cope with them.
Minimal impact	Even though I was taken back by the event, I was surprised that it didn't affect me more emotionally (being the first homicide victim I'd ever saw [sic.]).
Significant impact	How long I was affected emotionally and the lingering effects it had.
Quick reaction/training kicked in	The fact that I reacted in a timely manner surprised me. I had always been told that training for a situation helps, but I really never believed it.
Uncertainty/anxiety	As I pulled my weapon and began to squeeze the trigger, the suspect began to run and I hesitated for fear of hitting the houses that were behind him.
Performed duties adequately	That I was able to take control of the situation and do my job in a very stressful and confusing situation.
Helplessness/guilt	At first I didn't believe it had happened. I realized that it had occurred and began to blame myself because I was the one who advised my friend (by radio) of the location of the possible suspects.
Empathy	I was surprised that I had strong concerns for the suspect's mental well-being.
Resentment/anger	I had no feelings of remorse for the dead man, just his family.

prise at the lasting impact such events had on them – physiologically (e.g., sleep or eating disturbances, anxiety, hypervigilance), cognitively (e.g., recurrent thoughts, strong memories, reliving the experience), and emotionally (e.g., depression, anxiety, experiencing similar emotions in future situations). Some officers were surprised at how quickly they reacted and at their ability to perform their duties adequately, diligently, and professionally; others reported being surprised that they hesitated or second-guessed themselves and indicated that they felt helpless or somehow responsible for the incidents. Some officers reported empathizing with the individuals they were dealing with, whereas others described feeling anger, resentment, and no remorse toward the subjects involved, for various reasons.

There also was great discrepancy with respect to what the officers believed they had learned from these events. Table 6 summarizes these findings. For instance, many officers reported that these events led to an increase in self-efficacy and self-confidence, decreased anxiety about how to deal with similar future events, and a greater feeling of control over such situations. However, others reported lingering self-doubt about how they handled the situation and a real-

Table 6. *Officers' Perceptions of What They Learned From Their "Most Traumatic Experiences" On the Job*

Learning experience/increased awareness	I still think it was a senseless act but time and maturity has allowed me to see this as an invaluable learning experience.
Increased self-confidence/self-efficacy	I feel I am able to handle similar situations better now that I have experienced this.
Increased self-doubt	I frequently question myself and my decisions made during this incident.
Increased perception of control	I used to think that what happened was totally beyond my control. Now, I feel that, while some events are still uncontrollable, I can take steps to better protect myself.
Decreased perception of control	That for unknown reasons horrible accidents happen at unexpected times.
Continued impact	Whenever I remember it I still experience the same feelings.
Diminished impact	I now have many years worth of experience and time has lessened the severity of the trauma that this incident caused.
Changed personality (positive)	I tend to be more kind and understanding to others when dealing with similar incidents. More compassionate toward others in all related events I encounter at work and at home.
Changed personality (negative)	I think being in law enforcement for many years makes you callous to these types of situations. It's like we don't have the same emotions.
Changed perception of world/life (positive)	Made me think about what really is important in life, and not to take any day for granted.
Changed perception of world/life (negative)	Now I seriously dislike crazy people. 0 trust.

ization that certain events are beyond their ability to control. A number of officers reported that they still think about the event and still feel the same negative emotions (e.g., fear, sadness, anger) when they do so, whereas others reported that the event no longer bothers them and that time has healed any pain they once felt. Some officers reported that they felt that they are better officers and better people (e.g., more kind and compassionate, more prepared, more appreciative of life) for having experienced these events, whereas some acknowledged that they feel more hardened, cold, and detached as a result. Still others felt as though the event had not changed them or altered their perceptions in any way.

DISCUSSION

Officers' Experiences with Trauma

As expected, the officers in this study reported varied experiences with trauma. Some indicated that they had never experienced an event they would consider traumatic, whereas others reported more than 1,000. Likewise, some reported that they had only a few days on the job before encountering their most traumatic event, whereas others experienced their most traumatic event much later in their careers (30 years in some cases). A child death or serious injury was the most common 'most traumatic event' experienced, though still a wide range of events was classified as being the most traumatic. In general, officers perceived these events as being largely out of their control. Although a small minority (5%) reported significant difficulty dealing with the event in the months that followed, the norm was a more moderate reaction.

Officers' Perceptions of Trauma

Officers' responses to open-ended questions provided a better understanding of the ways in which officers construe the traumatic events they encounter on the job. Again, the theme was one of variability in officers' reactions. Some were surprised that they were able to remain calm and in control of their emotions whereas others did not expect to experience such strong, uncontrollable emotions. Some were able to remain detached from the situation whereas others reported that the events touched them personally. Some felt pride in their ability to perform their duties adequately whereas others were shocked that they had hesitated or expressed self-doubt in their handling of the situation. Some had expected the incident to have affected them more whereas others did not expect to have such a difficult time recovering

from the event. Finally, some indicated that they had gained confidence from the event or that the event had made them a better person whereas others reported more self-doubt, cynicism, or bitterness as a result.

These themes are consistent with a number of other studies that have examined officers' response to trauma. Irvine (2005), for example, studied a sample of New York Police Department officers following the terrorist attacks on the World Trade Center in 2001. As was the case with many of the officers in the current sample, these officers identified strongly with their roles as police officers and emphasized their dedication to saving lives. However, also like some of the individuals in the present study, they reported feeling stripped of their confidence, control, and power and noted a sense of helplessness and powerlessness. Some indicated that their general outlook on the world was shaken as a result, but many also highlighted the sense of shared humanity they felt just from being in the world with others.

Ferguson (2005) reported that personal identification with the victim was a major factor that contributed to the impact of a crime scene on officers in Chicago. Personal identification can occur when a victim reminds an officer of a loved one or, alternatively, when the dangerous nature of an event suddenly makes an officer aware of the impact of the job on his or her own family. Either event can trigger unexpected emotions in an officer who may be trying (and expecting) to remain detached and can cause an officer to feel vulnerable, anxious, guilty, and ineffectual in regard to this inability to 'control' emotions. Recent research has supported the notion that personalization of a traumatic event is related to more negative outcomes for officers (Colwell, Lyons, Bruce, Garner, & Miller, 2008).

Stress and Trauma

With few exceptions, the severity rankings for police stressors obtained in the current sample largely reflect those obtained by Violanti and Aron (1994) in their original validation study. Similarly, the rankings for the more general stressful events are fairly consistent with those obtained in Miller and Rahe's (1997) sample, with one exception: Officers in the current study perceived more personal events (e.g., divorce, personal health concerns) as less stressful than the deaths of significant others, whereas Miller and Rahe's (1997) general community sample perceived personal events as somewhat more stressful than the deaths of others. One possible explanation for this has to do with controllability. Policing is

a profession that affords officers a certain degree of control over others and over situations and, as such, officers may come to rely on this. It may be that officers perceive personal stressors as more within their ability to control and, thus, manageable, whereas those that are beyond their ability to control are perceived as more stressful.

Officers who were currently or recently undergoing high amounts of stress in general perceived their most traumatic police incident as more negative. This was true even though some of the officers reported their most traumatic event as being decades earlier. One reason for this is a natural tendency to cast the past in a light similar to the present. That is, having a negative outlook on life (presently) can color our perceptions of past events, leading us to interpret them more negatively (e.g., Abramson, Metalsky, & Alloy, 1989; Abramson, Seligman, & Teasdale, 1978).

Another notable finding was that the presence of general life stressors (e.g., divorce, the death of a loved one) impacted the officers' perceptions more so than the presence of police-specific stressors (e.g., death scenes, being attacked or shot at). One possible explanation for this finding is that the police stressors may be viewed by the officers as part of something they chose as a profession, whereas the life events seem more unexpected and uncontrollable. This might be further strengthened by the ways in which officers are trained for the job. Typically, they are taught to maintain a hardened exterior and to try to suppress emotions on the job. However, off the job this shield is not necessary, leaving officers just as vulnerable to general life stressors as others. As such, they may not even realize how other stressors affect them on a daily basis. Indeed, several studies suggest that it is the ongoing stressors of police work (e.g., organizational and bureaucratic structure, shift work, paperwork, lack of support), and not the traumas, that take the greatest toll on officers (Abdollahi, 2002; Evans & Coman, 1993; Patterson, 2002).

The data from the current study did not provide strong conclusive evidence regarding how variables such as age, years of service, and trauma history relate to officers' reactions to traumatic events. Numerous researchers (e.g., Carlier et al., 1997; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Long, Chamberlain, & Vincent, 1994; Martin et al., 1986; Stephens, Long, & Miller, 1997; Stephens & Miller, 1998; Violanti & Gehrke, 2004) have pointed to a cumulative effect of trauma such that increasing exposure to traumatic events places one at a higher and higher risk of posttraumatic stress reactions. However, others have found the opposite or no relationship (e.g., Hodgins, Creamer, & Bell, 2001). The present study revealed small but practically insignificant relationships between the negative impact of trauma and both the number of traumatic events that predated the most traumatic and total years of policing service.

It may be that it is just extremely difficult to measure these variables. For instance, some of these officers have 30-year histories with the police force, and it is very difficult from a memory perspective to ask them to recall how many traumatic incidents they have experienced over such a long history. Second, a reporting bias might occur, in that those who have been more affected by trauma in their life simply *define* more incidents as being traumatic or *believe* (due to their current difficulties adjusting) that they have experienced more traumatic events than they actually have. Thus, what is truly being measured may be more of a characterological tendency toward neuroticism which leads to them defining events as more traumatic. Indeed, in the present study, officers who tended to 'overrate' the severity of police stressors in relation to their peers reported more difficulty recovering from their most traumatic event. Even so, this relationship accounted for less than 10% of the variance in recovery, indicating that other variables more specific to the event itself also come into play.

Implications for Prevention and Treatment

As noted above, the general theme from analyzing the data was the great variability in officers' reactions and responses to trauma. Above all, this underscores the importance of tailoring treatment efforts to the individual, rather than assuming that the same approach will apply to the larger population. As treatment providers, it is important to keep in mind that each officer brings unique experiences, worldviews, interpretations, emotions, needs, resources, and coping strategies to the therapeutic table. A treatment approach that recognizes and considers each officer's individual response pattern likely will be the most effective. With this context in mind, a few specific treatment recommendations can be gleaned from the current data.

First, it is important for treatment providers to acknowledge how the different roles that officers have in these incidents can impact their reactions to them. For example, in a fatal accident scene, the officer who is first on the scene or

witnesses the crash likely will have very different emotions, thoughts, and behavioral reactions than the officer who is charged with notifying the surviving family members of the death of a loved one. Furthermore, supervisors may have a completely different set of emotions and reactions than their supervisees, particularly related to their roles as managers of the scene and the responsibility which that entails. No research to date has investigated the differential responses to trauma that these individuals might have but this would be a worthwhile endeavor for future research.

The way individuals appraise traumatic events, as well as the presence of ongoing stressors in their environment, has long been known as a key to recovery and coping (Anshel, 2000; Carlier, Lamberts, & Gersons, 2000; Hodgins et al., 2001; Lazarus, 1966; Lazarus & Folkman, 1984; Patterson, 1999). As such, it is important for clinicians to capture officers' thoughts and perceptions regarding the event (e.g., perceptions of threat, harm, or damage, sense of controllability, impact on self-worth or self-efficacy, personalization) as soon as possible following the event and at regular intervals thereafter. In the current study, officers who were undergoing higher amounts of stress in general perceived their most traumatic police incident as more negative, suggesting that perhaps their current perceptions were coloring their past perceptions. This has specific implications for treating officers affected by traumas. It is important for clinicians to encourage officers to restructure and re-interpret traumatic events in a way that is more positive and more meaningful to them, and in a way that enables them to maintain a sense of self-efficacy and control over their work. One therapeutic task might be to reinforce a greater appreciation of those things officers can control, and to encourage a greater acceptance of those which they cannot. In addition, clinicians may assist officers in learning to separate the past from the present and the present from the future, in order to facilitate healing and growth.

Further, recent research (e.g., Colwell et al., 2008) has highlighted that officers who personalize the traumatic events they encounter have more difficulty recovering from them. For example, a person who reminds an officer of someone he or she knows can serve as a retrieval cue that triggers unexpected emotions in an officer who may be attempting to remain detached. This may leave the officer feeling vulnerable, anxious, guilty, and ineffectual about this inability to 'control' his or her emotions. Therefore, another important aspect of working with traumatized officers may be helping them to develop sufficient appropriate outlets for emotional expression (both positive and negative), reinforcing areas of mastery and control in their lives, and helping them to work toward a healthy balance and separation of home and work.

Another finding that has important treatment and risk management implications is the fact that the presence of general life stressors impacted officers in the current sample more so than police-specific traumas. In addition, prior research has suggested that the more routine stressors associated with police work take the greater toll on officers (Abdollahi, 2002; Evans & Coman, 1993; Patterson, 2002). This speaks to the need for clinicians and administrators to consider the full range of stressors that police officers face, as well as a need for improved stress management services to assist officers in dealing with the routine hassles (both on and off the job) that continually place demands on an already overloaded system.

Finally, officers are exposed to potentially traumatic incidents at a level of frequency much higher than that of the general public, and yet they are socialized to maintain a tough, calm, detached exterior in any situation. In other words, they experience such events more frequently and yet are expected not to react to them as most individuals would. Aside from treating officers specifically affected by trauma, prevention is a key factor in reducing officer stress. In addition to promoting healthy stress management in general, it may be helpful to prepare and to inoculate new cadets for such experiences upon entry into the field. Mental health professionals can be instrumental in providing generalized training on common responses to trauma. Equally important, current officers could relay their own experiences in order to normalize these experiences for new cadets, so they do not become overwhelmed by unexpected emotions they may encounter on the job.

Conclusions

In sum, this study provides a snapshot of officers' experiences with trauma and the significance of these events in their lives. It is important to explore these experiences from the officers' own perceptions and in their own words, as this can guide the treatment process, provide insights for clinicians, and facilitate empathy when working with this population. By broadening our understanding of officers' experience with trauma, we hopefully can begin to alleviate some of the suffering experienced by those affected by these events.

NOTES

1. In addition to this questionnaire, the officers responded to several other measures, the results of which are reported elsewhere (Colwell et al., 2008).

2. Both original instruments – the Police Stress Survey (validated in Violanti & Aron, 1994) and the Social Readjustment Rating Scale (Miller & Rahe, 1997) – used an anchor event at a unit of 50 around which all other events were rated, whereas the current instrument did not. As a result, the actual ratings are not directly comparable; however, their relative positions are.

3. The Social Readjustment Rating Scale, originally published in 1967, was re-validated in 1997 to reflect current attitudes; the results are compared to this newer validation sample.

4. Analysis of variance of these same variables regrouped by quartiles was conducted to determine if a curvilinear relationship existed among the variables; no such relationships were observed.

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Police Suicide – A Web Surveillance of National Data

Andrew F. O'Hara

Badge of Life Program, Citrus Heights, CA

John M. Violanti

State University of NY at Buffalo

Abstract: Considerable research has been done on suicide in police work. It appears that the volume of literature on this topic has led to considerable controversy concerning the accuracy and validity of police suicide rates. This topic has given rise to a wide variety of speculative, often wildly exaggerated figures being circulated in the law enforcement community and media, much of which is not based on verifiable research or gathered in an organized, useful manner that can be shared and scrutinized. Such figures have been taken at face value, translated into widely varying rates and profiles that, because they lack any substantiation, do little to help and much to impede the meaningful development of programs that can address the problems of police stress, trauma, posttraumatic stress, suicide, and the promotion of improved general health in the law enforcement community. This paper represents an empirical attempt to gather descriptive police suicide data from all fifty states in the U.S. for one year – 2008 – and record it in a cohesive manner that may be useful to researchers, police agencies, and program developers. [International Journal of Emergency Mental Health, 2009, 11(1), pp. 17-24].

Key words: *police, suicide rates, surveillance*

The volume of literature on police suicide has led to considerable controversy concerning the accuracy and validity of police suicide rates. Aamodt and Stalnaker (2001) suggested that, although the suicide rate of 18.1/100,000 for law enforcement personnel is higher than the 11.4/100,000 in the general population, it is not higher than would be expected for people of similar age, race, and gender. Furthermore, the reasons that officers commit suicide are similar to those of the general population with the possible exception of legal problems. Hem, Berg, and Ekeberg (2002) published a systematic critical review of suicide among police. They

identified 41 original studies from North America, Europe, and Australia. Rates varied widely and were inconsistent and inconclusive. Most studies were conducted in limited specific police populations, where local and regional variations in suicide can affect the rates of police suicide. Stack and Kelley (1994) completed an analysis of police suicide data from the 1985 National Mortality Detail File. Statistically controlling for age, gender, and race, these authors found the police suicide proportional mortality ratio (PMR) rate to exceed the rate of matched controls by 8%. This rate was not significantly higher than the rate among white males in the general population.

National databases such as National Occupational Mortality Surveillance (NOMS) developed by the Centers for Disease Control (1998) provide accurate retrospective data on police suicides. However, they are currently updated to 1998,

Andrew F. O'Hara is affiliated with the Badge of Life Program in Citrus Heights, CA. John M. Violanti serves in the Department of Social & Preventive Medicine, School of Public Health & Health Professions at State University of NY at Buffalo. Correspondence regarding the article may be directed to badgeoflife@yahoo.com

leaving a gap in more recent police suicide rates. This paper represents an empirical attempt to provide a "snapshot" of police suicide data for the year 2008 based on internet surveillance methods. This will provide a general idea of more recent police suicide rates. Date was obtained from January 1 to December 31, 2008 encompassing all fifty states in the U.S. Other descriptive data related to police suicide were also collected.

METHODS

The expansive societal use of the internet proved to be of great advantage in our research. It is clear that in this age of vast, rapidly interlinking communications, a police suicide in even the smallest and most remote community is not only reported in that local area but, given both public and media interest in the subject, is reported by multiple media in a chain reaction that lasts several days to several weeks. Adding to the repetitious spread of these reports on the internet are the dozens of police websites, forums, and blogs, which are quick to re-report the event. This has greatly reduced the likelihood that a police suicide will go unnoticed.

News media internet reports provide a reliable means of establishing when, where, and why police suicides were occurring during a given year. Rainey and Runyan (1992) found that relying solely on news reports for information on fire- and drowning-related deaths would result in a 96% and 72% respective capture rate of reports. Further, the consistent application of the same surveillance terms throughout the year in our surveillance did much to ensure consistency of data gathering throughout 2008. Approximately 119,000 suicide-specific news articles were reviewed during the year for information relating to police suicides in the United States. Included in this suicide information:

- Date
- Location
- Department
- Age
- Rank
- Time on the job
- Means of suicide
- Statements by departments and medical examiners.

RESULTS

Descriptive information for this surveillance is displayed in Table 1. The data yielded ages for 59 officers that had committed suicide during 2008. Ages for the remaining 43 officers was accepted as due either to the shortage of information given by the department or incomplete reporting by the media. In an effort to find a workable age where one was missing, we relied on a median derived from tables provided by the Illinois State Police (Raub, 1987) and the State of Nevada Public Employees Retirement System. By taking an average service retirement of age 55 and a hypothetical hiring age of 21, a median age would be age 38 years of age. In looking at the above spread of ages, and seeing the known average age of the 59 officers to be 40.1 years of age, we felt

Table 1. Descriptive Data
Police Suicide Surveillance- 2008

Descriptive	N	(%)
Gender (n=102)		
Male	93	(91.2%)
Female	7	(9.8%)
Age (n = 59, Mean = 38.7 yrs)		
20-24	2	(3 %)
25-29	7	(12%)
30-34	3	(5%)
35-39	17	(29%)
40-44	11	(19%)
45-49	10	(17%)
50-54	4	(7%)
55+	5	(8%)
Years Police Service (n = 40, Mean = 12.2 yrs.)		
0-4	7	(17%)
5-9	4	(10%)
10-14	9	(22%)
15-19	7	(17%)
20-24	7	(17%)
25+	6	(15%)
Rank		
Below Sergeant	89	(88.7%)
Sergeant and above	11	(11.3%
Method		
Gunshot	136	(96.1%)
Hanging	3	(1.9%)
Auto	1	(0.97%)
Overdose	1	(0.97%)

comfortable that 38 was in a comfortable range for use with those officers lacking an identified age.

Because the distribution of police service years was closely correlated with age, we used a median time of 13 years police service for those found in the data. In cases in which the officer clearly had less than 13 years on the job but not specified in the web article, we used the smaller number based on a presumed hire age of twenty-one, generally a standard police hiring age throughout the United States. Suicides by officers separated from their employment by less than one year and exhibiting behaviors likely predictive of suicide attributable to their employment were included in the study.

An additional effort was attempted to list police suicide descriptive data by U.S. states. Table 2 displays this information.

DISCUSSION

The present study attempted to provide a recent descriptive view of police suicide rates in the United States. Results indicated that 102 actual police suicides were accounted for in 2008 via 119,000 web surveillance hits. If we consider two assumptions, the rate may be higher than we determined. The first assumption is that approximately 17% of police suicides are either misclassified as accidents or undetermined deaths (Violanti, 2007). The second assumption was that we possibly missed approximately 20 % of suicides due to our own review process, researcher error, or by news articles that conceivably might not have been fed into the internet. The latter assumption is robust, given the intensity of our review process and our observation during the year that police suicides are of high media interest, are reported by multiple news media from surrounding communities (press

Table 2. Police Suicide Descriptive Data by U.S. State

	Actual Number of Suicides	Average age (adj.)	Gender	Avg. Years on the Job (adj.)	Means	Comments
Alabama	2	38		13	gunshots	
Alaska	none					
Arizona	none					
California	14	41	12 male, 2 female	14	gunshots	2 were lieutenants.
Colorado	2	37	2 males	10	gunshots	1 murder-suicide
Connecticut	2	25	2 males	8	gunshots	1 was a sergeant
Delaware	none					
DC	none					
Florida	7	38	6 males, 1 female	8	6 gunshot, 1 overdose (male)	1 was a lieutenant
Georgia	none					
Hawaii	none					
Idaho	1	29	1 male	2	gunshot	
Illinois	4	40	4 males	12	gunshots	1 murder-suicide, 1 chief/1 lieutenant
Indiana	2	45	2 males	13	1 auto into tree, 1 gunshot	1 on duty
Iowa	none					
Kansas	2	38	2 males	4	2 gunshot	
Kentucky	none					
Louisiana	none					
Maine	1	38	1 male	22	gunshot	
Maryland	1	38	1 female	17	gunshot	attempt murder-suicide
Massachusetts	none					

Table 2. (continued)

	Actual Number of Suicides	Average age (adj.)	Gender	Avg. Years on the Job (adj.)	Means	Comments
Michigan	2	38	1 male, 1 female	9	1 hanging (male), 1 gunshot	1 Sgt, 1 murder-suicide
Minnesota	none					
Mississippi	1	24	1 female	2	gunshot	
Missouri	3	39	2 male, 1 female	8	gunshots	1 Co. Sheriff
Montana	none					
Nebraska	none					
Nevada	none					
New Hampshire	none					
New Jersey	9	44	9 males	13	gunshots	1 sergeant, 1 deputy chief
New Mexico	1	38	1 male	15	gunshot	
New York	9	37	8 males, 1 female	12	8 gunshots, 1 hanging (male)	2 lieutenants
N. Carolina	1	38	1 male	6	gunshot	1 sergeant
North Dakota	none					
Ohio	2	55	2 males	19	gunshots	1 murder-suicide, 1 chief
Oklahoma	none					
Oregon	none					
Pennsylvania	7	41	males	12	gunshots	
Rhode Island	none					
S. Carolina	1	43	1 male	22	gunshot	
South Dakota	none					
Tennessee	5	41	5 males	13	gunshots	
Texas	2	39	2 males	15	gunshots	1 murder-suicide, 1 lieutenant
Utah	5	38	5 males	18	gunshots	1 murder-suicide. 1 chief.
Vermont	none					
Virginia	2	44	2 males	12	gunshots	
Washington	none					
W. Virginia	1	46	1 male	10	gunshot	
Wisconsin	5	33	4 males, 1 female	14	gunshots	
Wyoming	none					
FEDERAL	6	39	5 males, 1 female	19	gunshots	

and television), and thus will almost inevitably appear in articles by other media repeated times—often for weeks. If we take these assumptions into consideration, the final count would be approximately 141 police suicides. This figure is surprisingly consistent with CDC/NOMS data and other current research (Violanti, 2007). We cannot verify this total without further investigation of accidental or undetermined police mortality data. Future research and the use of psychological autopsy methodology may help to clarify this data.

In terms of other results, it appears that officers in the age category 35-39 years are at a higher risk for suicide, with

29% of all suicides found in this age group. Additionally, those officers with 10-14 years of service are at an increased risk for suicide. Suicide among officers of lower rank and the use of firearms were prevalent. As indicated in Table 2, California led the nation in police suicides with 14, followed by New York (9) and New Jersey (9). There were seven murder-suicides in 2008 involving police officers. Six federal officers committed suicide. This information may be helpful for police organizational Employee Assistance Programs and trainers.

Also indicated in many of the web reports were other attributes of suicide:

- Behavioral indicators of suicide that were missed

- Suicide blamed on personal problems

- Suicide dismissed as a surprise or no warning signs reported

- Victim facing criminal charges

- Victim facing departmental investigation

These results are significant in terms of prevention. Twelve percent of officers showed clear warning signs of potential suicide that went unnoticed, while 64% of officers appeared to have slipped completely "under the radar," showing no noticeable signs or symptoms of distress before taking their lives. The latter is significant and highlights the ability of an officer to maintain a facade, a "front," before his peers. Law enforcement has its own code of conduct and subculture and officers feel a need to disguise signs of psychological distress for fear of being perceived as "soft" or weak (Arrigo & Shipley, 2004). Additionally, the high percentage of reportedly missed suicides would imply that officers are far more adept at disguising their intentions than previously expected (Slovenko, 2002).

It seems that many departments need to consider more effective methods of suicide awareness training and sensitivity. For example, Question, Persuade and Refer (QPR), a suicide gatekeeper program, is based on "being your brother's keeper" (Ramos, 2008) and watching for signs and symptoms of emotional distress. Even so, such a program can be frustrated by the long-established, embedded talent within the police culture for maintaining a protective mask to avoid detection.

A simple but effective program designed to prepare officers for stress and trauma before problems arise, rather than after, is proposed by the new Badge of Life program (O'Hara,

2008). The underlying principal of the program lies in recognizing the importance of the facade in law enforcement and the core belief that, for every suicide, there are countless other officers continuing to work while masking the effects of their own accumulated stress and trauma. The program proposes that training should focus on putting officers in charge of their own mental health, beginning at the academy and every year after with voluntary, confidential "mental health checks" with a therapist of their choice, undertaken with the same diligence as a yearly dental check, physical exam, or flu shot. Emphasizing that the efforts of law enforcement are better spent on overall mental health than just suicide and crisis management, the Badge of Life program offers positive incentives for participation, both for individual officers and administrators. Long-term goals include developing the individual resilience/hardiness of officers in the face of adversity, in addition to the focus of current suicide awareness/prevention programs on recovery. It presents, in essence, a form of inoculation against the negative impacts of later stress and trauma.

Violanti (2007) adds that officers are less likely than most to find healthy alternatives for dealing with situations other than stress; they tend, in fact, to turn to maladaptive coping strategies that include "escape avoidance" and "distancing." When such maladaptive strategies break down, the self-appraisal skills necessary for the success of a suicide awareness program will likely prove inadequate. As an alternative, Violanti suggests training officers in healthier self-care, rather than focusing on the surveillance of others. It is crucial that this training begin at the recruit level and focus new officers not only on the challenges to be faced, but on the personal skills and talents they have available to them. The importance of resilience, or "hardiness," (Antonovksy, 1987; Maddi, 2006) should be included in academy training, with emphasis on:

- A commitment to finding meaningful purpose in life,

- A belief in one's ability to affect the outcome,

- A belief one can learn and grow as a result,

- A willingness to accept uncontrollable outcomes.

Resilience/hardiness is a trait that is individual and does not make for a classroom exercise. This is where the focus of training and individual therapy, from the academy and then throughout the officer's entire career, can be on preparing for trauma *before* it happens, not waiting until after the damage has been done.

Discussions have suggested that police work, over many years, has its comparisons to the shorter tours of duty (albeit more frequent today) by the military in a war zone. Without debating the merits of that premise, however, we compared suicides in the United States Army, with a population of 675,000 soldiers, with that of police officers, population 861,000. The Army reported 128 suicides in 2008 (with 15 still pending; U.S. Army, 2009) compared to the 141 we found for law enforcement in that same year. We found the two remarkably consistent.

There are limitations to our research. While web-base surveillance is a fairly reliable source, the use of actual mortality statistics based on death certificates and autopsy reports are a best source. Unfortunately, nationwide collection of such data is a long and difficult task. The cooperation of police departments across the country is essential if this is to be accomplished in future research. Despite limitations, our year-long surveillance of more than 119,000 suicide-related news reports, followed by properly designed adjustments and accommodation for variables, yielded data not only consistent with past Centers for Disease Control/NOMS data, but also with independent reporting by a wide variety of police publications that take intense interest in the topic of police suicides.

Given the present stage of research on police stress, it is likely that inaccuracies will continue to exist in the reporting of police suicide, including underreporting, misclassification, the lack of updated nationwide data, and difficulty associated with collecting data. Exposure and job socialization in policing have profound impact on officers. Exactly how to measure the impact over time that police work has on individuals is a difficult question. It will likely take long-term prospective studies to make sense out of such exposure.

While we cannot yet be certain that police work by and in itself is a suicide risk factor, we can with some assurance state that it serves as a fertile arena for suicide precipitants, including relationship problems, culturally approved alcohol use and maladaptive coping , firearms availability, and exposure to psychologically adverse incidents. Contextually, police work is therefore a probable part of the causal chain of suicide.

In sum, this paper tells us that we need to look deeper into police suicides and their root causes. Perhaps to some degree we may be asking the wrong question. Suicide rates are important to understand, but the more important task is to determine how to prevent police suicides. We may be better informed if we know the inherent risk of police suicide in a quantitative, qualitative, and contextual sense.

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Playing the Game:
Psychological Factors in Surviving Cancer

Stephen A. Rom

Florida Atlantic University; Boca Raton, Florida

Laurence Miller

Florida Atlantic University; Boca Raton, Florida

Jennifer Peluso

Florida Atlantic University; Boca Raton, Florida

Abstract: *Cancer is a threat that can rob a person of their physical and mental wellbeing. While cancer awareness has ventured to the forefront of social consciousness, led by surges from Lance Armstrong and other celebrities affected by cancer, the medical world continually remains foiled in terms of regulating the many confounding variables that spawn cancer: toxins, pollutants, poor diet, etc. Yet there is a hope: one variable thought to affect cancer prognosis may be distinctly tractable: positive mental attitude (PMA). Principles of PMA that are readily utilized in the science of sports psychology to spur athletes to victory may be productively applied to the hospital arena. The parallels between sports and medicine are abundant, and can be utilized by the cancer patient to help secure victory. This paper describes the steps to victory, along with stratagems and concepts on how to keep the "opponent"—cancer—from gaining any further advantage. [International Journal of Emergency Mental Health, 2009, 11(1), pp. 25-36].*

Key words: *Cancer survivors, health psychology, mental toughness training, resilience, sports psychology*

Preparing for the Game: Building the Team

We've all heard the saying, "If you want something done right, do it yourself." Not so when it comes to fighting cancer. Besides the obvious—that the majority of cancer patients can't medically treat themselves—there are key psychophysiological factors to consider. Just as newborn ba-

Steve Rom is a journalist, author, and three-time cancer survivor. After overcoming his second cancer in 2002, he co-authored a book about his experiences with former Super Bowl champion, Rod Payne, Centered by a Miracle: A True Story of Friendship, Football, & Life. *He is currently pursuing a PhD in Health Psychology and can be reached at srom@fau.edu. Laurence Miller, PhD, is in private practice in Boca Raton, FL. Jennifer P. Peluso, PhD, is the Undergraduate Coordinator of the Department of Psychology at Florida Atlantic University. Correspondence regarding this article may be directed to docmilphd@aol.com.*

bies require social interaction to survive the initial stage of life and ensure proper neurological development in later years (Malle, 2004), cancer patients need similar nurturing—by as many hands as possible.

Family, friends, coworkers, neighbors, as well as the medical staff (and even fellow patients), can team up to provide the proper nurturing a patient requires during the three major stages of cancer: diagnoses, treatment, and recovery—both short- and long-term (Rom & Payne, 2006).

Sanders and Suls (1982) point out that the influences of socialization practices, interpersonal relationships, and social organization can be as crucial as blood counts and X-rays in determining whether health or illness will emerge as the victor. This means that recruiting as many people as possible is vital to overcoming the risk of feeling alone, which is a common stress factor when dealing with illness.

The best way to avoid this mental slide is to subscribe to the concept of *teamwork*. Boiled down, teamwork can be explained through the core components of sports psychology.

Cancer is an opponent

In the world of sports, the so-called "experts" (often media pundits) use the word *underdog* to try to inject drama into any sporting event. Cancer patients, because of the sheer mercilessness nature of their disease, are particularly susceptible to buying into the victim stereotype. The negative side effects of this cannot be discounted.

In their book, *Cancer Activism*, Kedrowski and Sarow (2007) examine the social stigma associated with cancer and how it can inhibit a patient's ability to fight his or her disease. One could become less inclined to talk about the illness, even feel inferior because of it (for men stricken with prostate cancer, in regard to sexual efficiency; for women with breast cancer, body image). Furthermore, the disinclination of cancer survivors to share their experiences ("reluctant champions," Kedrowski & Sarow termed them), deprives them of a vital option to utilize during treatment and recovery.

These trends may cause a cancer patient to experience what psychologists working in the field of law enforcement have called the *psychology of defeat* (Blum, 2000). Blum proposes that police officers, during times of deadly-force encounter and struggle with a dangerous suspect, can become overwhelmed and adopt an "I-cannot-overcome-this" mindset; he offers a set of strategies for counteracting this. Compared to a police officer's arsenal of mental and physical training, the average cancer patient is considerably less advantaged in possessing and marshalling the tools needed to overcome duress. To reduce this deficit, proper mental conditioning is needed as close to the diagnosis as possible.

Mental conditioning is nothing new to focused competition (which any survivor will tell you a fight against cancer certainly is); history has long supported a thread between mental toughness and competitive sports.

Ancient Spartans used athletic competitions as training for warfare because of the innate, ritualized combativeness common to both (Sherman, 2005). More recently, sports psychology has become a reservoir of information on *mental toughness training* (Bull et al., 2005) that has been applied to the areas of police psychology, military training, and health

care (Miller, 2006, 2008a, 2008b). To illustrate how a cancer battle mirrors the core components of sports and combat, consider the following: cancer has a defined opponent (the disease); a playing field or territory to defend (the patient's health); a strategy, or "game plan," used to combat the opponent (the medical treatment plan); observers/fans/cheerleaders (family, friends, coworkers, neighbors, and fellow patients); and, of course, the extremely high stakes (life or death—victory or defeat).

Clearly, it is fruitless for any individual, no matter how resolute, skillful, or powerful, to face an entire opposing team alone—an 11-man football team, nine-man baseball team, or five-man basketball team for example. Similarly, the cancer patient by him- or herself can hardly maintain the top level of mental and physical stamina and performance necessary to achieve victory. Thus, by not being aware, or failing to take advantage of the opportunity to build a strong team, a cancer patient might feel like the only life on the line is their own. In these cases, fate would rest solely on one's physical and mental abilities, which is a fleeting reservoir of human strength and energy (Fischer, Frey, et al., 2007). The situation could quickly become overwhelming, and a defeatist attitude could arise—"no one is counting on me, so why should I rise to the occasion? Why should I keep fighting?" Making matters worse, this could impede the medical staff from doing their jobs, perhaps already made more difficult because of the increasing disconnect between patient and medical personnel on a personal level. To most this may seem like the accepted status quo, but to the real victors, those who value teamwork and recognize the importance of it at all levels, this is something that needs to be corrected.

Doctors are teammates, too

It has become standard practice for medical practitioners to maintain a certain degree of emotional separation from the patient. This may be due to a fear of losing their objectivity or "professional edge," or even being blamed by the patient's family for their relative's death, which may be one reason that most doctors don't accept invitations to the funerals of patients they've treated. Though doctors do make drug recommendations daily, offer advice on treatment choices, or suggest practical comfort amenities, little or no personal interaction is made part of the relationship. This can cause patients to feel detached from the medical process, or perhaps even alienated—reduced to a name and number on a chart. The City of Hope National Cancer Medical Center pro-

vides a poignant message at the entrance to its campus in Duarte, California: "There is no purpose in curing the body if in the process you destroy the soul."

At the outset of the relationship, transparency of communication between patient and doctor must be established. This allows the doctor to sense and perceive what the patient is able to withstand—physically and emotionally—and in turn will show what medications and procedures they respond to best. It will also create an all-important trust factor, which will encourage the patient to communicate personal and medical information to their doctor. At the sports level, this is similar to a player wanting to perform better for a coach simply because the athlete knows the coach has his or her best interests at hand.

To make this role explicit, the process of treatment and recovery can often be made easier when a third party—a "coach"—steps in to encourage and motivate the patient, along with helping them regulate their psychological state and, in the end, better communicate to the doctor.

A player's advocate

A *cancer coach* serves a basic purpose: keep the patient centered during the cancer battle. The more centered, or balanced, the patient can be, the better chance the doctor has of doing an optimal job.

Cancer coaches are not a new concept. The American Cancer Society's Reach to Recovery Program, which pairs a survivor with a newly diagnosed patient, has assisted breast cancer patients (both men and women) for three decades. Similar programs exist for other cancers. A few years ago, the ACS started a patient navigator program that now operates in 87 locations and is planning to expand. Recently CNN reported that many advocacy groups and hospitals are using "professional" coaches—trained volunteers or paid workers who objectively help new patients navigate the maze of information and options.

Especially beneficial for the patient is when his or her coach wears multiple hats—mentor, cheerleader, advocate, friend, etc. The coach is most effective in this regard when they know the patient closely. With a personal connection, the coach has a vested interest and can battle alongside the patient while confidently knowing what "buttons to push" to help motivate. These are delicate decisions based on previous experiences with the patient, which a hired hand doesn't possess.

Recalling the analogy to police psychology, the first step for a coach is to make sure the subject is equipped with a *winner's attitude* (Garner, 2005). This can be viewed as a personal manifesto: "I've come this far, there's no way I'm going to fall." Or, "This will *NOT* be the end of me!" (In the words of the coach, "This will not be the end of YOU!")

The desire to win at all costs, however, is not ingrained in everyone. One trait all humans do share, however, is the desire and need to survive. No matter how severe the diagnoses, this part of our psychological makeup will allow ample foundation for any patient to build upon. The next step in taking a proactive approach to one's treatments and getting an edge on the disease is to come up with a "game plan."

Performing to Potential: Psychological "Game-Planning" and Cognitive Tactics

A *game plan* can be defined as a collection of psychological tactics and physical maneuvers to be employed when facing adversity. It should be executed in correlation with the medical team's treatment strategy, thus ensuring a harmonious interaction between medical staff and patient. The game plan should also include the patient's primary caregiver, as well as anyone else on the "team," such as a personal therapist, prayer partner, etc.

There may be many variations of the game plan, depending on the patient's personality and his or her physical limitations or strengths. A game plan might include creating an itinerary for the future (i.e. making long-term life goals). To be sure, the plan would call for taking a proactive approach to treatments, perhaps asking doctors and staff to be involved as much as possible, and kept informed at all times. A patient can even become a leader by motivating fellow patients, or encouraging caregivers when they become weary. Some patients even become involved in philanthropic activities as a way to cope. (One motivated boy with an incurable type of leukemia was featured on a cable news network in 2008. He spent his time preparing meals for homeless children in the area.)

When executing a game plan, mental conditioning will often come into play. Discussing the *mental toughness training* literature from sports psychology in connection with law enforcement training, Miller (2008b) outlines four primary aspects of mental toughness: confidence, motivation, focus, and resilience.

These psychological tactics, when used by a cancer patient, can considerably prepare them to handle any medical treatment plan. They may also allow a patient to regulate his or her internal energy mechanism for the purposes of regulating energy during a fight against cancer. The key is to know when to inject a burst of self-adrenalin (to "psych oneself up") and when not to ("psych oneself out").

During any sporting event, the crux of action is not continuous: there are ebbs and flows, breaks in competition. This allows time to relax, to regroup, plan ahead, or make adjustments to the initial game plan. Indeed, it's the same in the hospital. A great deal of time is spent waiting, planning, thinking, even praying, as the medical team coordinates treatments, personnel, logistics, etc. Once treatment time finally arrives (or results from procedures trickle in afterward), it's "game time," a point of heightened intensity when focus is needed more than ever.

One way to perform as optimally as possible in such critical situations is to maintain, no matter how difficult things become, a *positive mental attitude* (PMA). Maintaining PMA throughout the three primary phases of cancer—diagnoses, treatment, and initial recovery—can significantly increase chances of physical, mental, and emotional endurance. In the workplace, for example, cognitive processes have been shown to be the strongest and most consistent predictors of task perseverance and performance in traditional employment settings (Hunter & Hunter, 1984; Schmidt & Hunter, 1998; Thorndike, 1986).

One component of PMA can be described as *optimism*, which is a common catalyst to reaching proper cognitive, emotional, and behavioral responses. In fact, different coping styles between optimists and pessimists have been reported (Scheier, Weintraub, & Carver, 1986). Optimists use more positive coping such as problem-focused coping, seeking social support, and emphasizing positive aspects of the stressful situation. Pessimists, on the other hand, tend to use denial and distancing, both of which can be counterproductive for someone who is battling cancer. Optimism also has an effect on expectancies, and optimists are more likely to use positive interpretation and accept the reality of the situation in a constructive way (Scheier & Carver, 1992).

Another often-neglected benefit of optimism is that it is contagious. It could even inspire the medical staff and caregivers if the treatment process reaches a skid. "Is this my patient?" the doctor might ask, after noticing a sudden shift in demeanor of the patient from sullen to sanguine. "Where have you been all this time?"

To achieve the highest level of optimism at all points on the road to recovery, a number of cognitive tactics can be employed:

Relaxation

Relaxation training is an important psychological tactic to reduce pain and tension in injured areas and relieve psychological distress (Shaffer & Wiese-Bjornstal, 1999). Relaxation training can help reduce anxiety, irritability, and fatigue (Davis, Eshelman, & Mckay, 1995). It can also modify reactions to pain, increase the ability to deal with stress, and also reduce sleep disorders (Davis et al., 1995). Any way relaxation can be achieved—through massage, meditation, listening to music, watching uplifting movies/TV shows, praying, reading, etc.—should be attempted on a regular basis during treatment and recovery.

Breathing/Imagery

Breathing combined with imagery is one specific application of relaxation that is often used as a psychological intervention for injured athletes (Johnson, 2000; Ross & Berger, 1996). According to these studies, a psychological intervention that includes relaxation strategies (combining deep breathing and imagery) significantly reduces emotional distress and pain intensity, as well as speeds up recovery time.

Breathing exercises can also increase relaxation by reducing negative valence and arousal (Russell & Carroll, 1999a, 1999b; Russell & Others, 1989; Watson & Others, 1999). Similarly, they facilitate imagery; a patient is better able to summon the creative intelligence needed to facilitate an idyllic visual image.

Positive Affirmations

Patients should be encouraged to use uplifting statements during rehabilitation because these can generate positive emotions that improve the quality of the rehabilitation (Taylor & Taylor 1997) . In one study, physiotherapists reported that encouraging positive self-thoughts wasa more important strategy in treating injured athletes than mental imagery and relaxation (Ninedek & Kolt, 2000). In addition, a recent study reported a positive relationship between the

use of positive self-talk and home exercise completion in injured athletes who undertook ACL rehabilitation (Scherzer et al., 2001).

Hope-filled thinking

Hope-filled thinking, a concept built into the PMA framework, is the antithesis of what's deemed the *constrained action hypothesis* (McNevin et al., 2003; Wulf, McNevin, & Shea, 2001). Here, individuals who perform physical movements are asked to adopt an internal focus to try to consciously control their movements. This has been found to constrain the motor system, by disrupting automatic control processes. However, focusing on the movement by adopting an external focus is thought to allow unconscious or automatic processes to control the movement (Vance, Wulf, et al, 2004). Further research has demonstrated that an external focus of attention is more beneficial to performers than an internal strategy during motor skill performance and learning (Wulf, 2007, Wulf & Prinz, 2001).

This external focus is better suited for hope-filled thinking because it naturally projects outward, thereby making the patient become a core part of the process rather than an observer. In sports, an athlete does not compete in a bubble, but instead is part of a larger system—one of many subsets (athletes, coaches, personnel) working together as a unit.

In sum, the positive effects of hope-filled thinking during physical and emotional trauma can be profound. For one, hope-filled thinking—whether drawn from past experiences or introduced by encouraging human contact or positive environmental stimuli—dramatically increases outcome expectations. The effects of a lack of positive influences can range from increased risk perception to a negative neuropsysiological effect, either of which can seriously impede the patient from achieving a fulfilling, emotionally stable life, both in the home and community. Relatedly, knowing what type of thinking (or activities) to avoid can also increase outcome expectations.

Prevalent pitfalls

People sometimes reach out to anything to attain attachment (Forrest, 2008). This can be a mistake. One misadventure may involve the alluring world of cyberspace. Computers are everywhere and, while seemingly innocuous, spending time in this arena during the throes of cancer can be treacherous. Chat rooms are often a major part of the cyber world, but they can be hazardous for those who are mentally vulnerable. Without the filter of science, so much misleading information can filter in that, at best, the experience can be a waste of time. At worse, it can significantly inhibit a patient from rebounding after a difficult procedure (or the delivery of bad news).

Another potential pitfall for a cancer patient is to focus on negative media reports. Despite a well-intentioned desire to maintain normalcy and engage in the same activities during a cancer battle as before diagnoses, some major adjustments to daily living have to be made. This includes, mainly, shutting off the local news and setting aside the morning paper, each of which is bent toward negativity and human suffering.

In short, beliefs are positively correlated with feedback, and negative feedback (which can be found in unregulated chat rooms or sensationalist-based media outlets) can reduce the level of subsequent goal-setting and persistence (Wood & Bandura, 1989).

Making Adjustments: The Phenomenon of "Sudden-Change"

Even without a life-threatening illness, unexpected changes in plans occur regularly. It takes quick thinking, resilience, and a strong desire to surge past these obstacles to avoid much harm being done. Learning how to handle these "sudden changes" is a skill that most athletes and high-level performers deal with regularly. It's a skill that needs honing by a cancer patient.

There are often daily, unpredictable challenges to be met in the hospital; these can become progressively more difficult as the game goes on. Just as athletic success at the highest level requires suffering beyond the ordinary limits we'd expect individuals to endure (Bhurruth, 2008), so, too, does overcoming cancer … and perhaps more so.

Despite the severity of a cancer diagnoses (one that patients have described as instant dread, or feeling as if the world has stopped turning) there is opportunity to regroup. However this requires discipline. Without discipline, a patient can fall into the traditional cycle outlined by the *stage model* (Kubler-Ross, 1969).

The stage model explains that individuals dealing with grief or adversity progress through five stages: denial, anger, bargaining, depression, and acceptance. This model, while

not universal, has been corroborated by multiple clinical observations. However, there are few practical applications of this model that can help the cancer patient mount an effective psychological defense against the disease.

A psychological model derived from sports psychology (Hardy & Crace, 1990) is even more useful in the hospital arena because it conceptualizes the emotional reaction after injury as consisting of two phases: a reactive phase and an adaptive phase. While the *reactive phase* includes shock and negative emotions such as denial, anger, and depression, the *adaptive phase* includes positive emotion such as acceptance, hope, confidence, and vigor. These are the emotions a cancer patient needs to jumpstart a quick journey back to good health. Since time is critical, the reactive and adaptive phases are extremely vital.

In mounting a psychological defense against cancer, the patient often lacks the luxury of time to analyze the diagnosis, ponder the cause, or feel self-pity. Along with the disease itself, even the treatments for cancer (e.g., chemotherapy and radiation) can be draining to the physical and psychological energy needed to cope adaptively (see www.cancerfightingstrategies.com). This puts even more onus and urgency on the patient to focus on getting healthy. If this sounds imposing, it's good to know that, at least from a physiological standpoint, dealing with sudden change might not require previous experience. This is credited to the basic life process of *homeostasis*.

Walter Cannon (1914, 1939) used this term to refer to a state of biological equilibrium that could be derailed by stress, but that an organism usually tries to renew in order to return to health. Furthermore, Hans Selye (1956, 1973, 1975) developed the model of the *general adaptation syndrome* (GAS), which delineates the physiological response to different stressors—from infections, to toxins, to social stress and interpersonal power struggles.

The GAS allows an organism to utilize its physiological tools to cope with stress by employing the endocrine system to raise body awareness against a threat and heighten its internal defense mechanisms. This primal stage of defense stimulates the peripheral nervous system's sympathetic (arousal) system. Adrenalin is released into the blood stream along with the hormone cortisol, which has an anti-inflammatory effect on the body and an all-important neuro- and psychoactive effect on the brain.

Together with the body's natural defense mechanisms, a patient can also stay centered during treatments and recovery by aiming to maintain a strong cognitive grasp of his or her situation.

Mind over matter

Human beings do more than react; they also think. Accordingly, cognitive strategies are needed in the psychological battle against cancer. Putting oneself in the correct mindset is critical. And it can be achieved through a variety of means: employing basic humility techniques (yielding to the doctors and nurses, trusting their experience); applying the basic component of faith (believing in things unseen rather than seen); and, as noted previously, visualizing positive outcomes. This may require refocusing attention from the negative physical surroundings to more positive and aesthetic ones.

Utilizing every advantage when a patient feels as though the energy and fight is gone can be difficult, but it is not impossible. At these dire times there may be an opportunity to throw caution to the wind. A patient might start to utilize the advice and experience of someone they've neglected thus far as it may have previously seemed inappropriate or not needed. What could be discovered is that just one person's impact can help light a flame of inspiration. It could arise from a nurse, the patient in the adjacent room (or family member of that patient), or a distant relative, who, in a rare example, may have overcome wartime injury during an era that lacked penicillin—a story of inspiration that could motivate even the severely infirm. Indeed, anything can evoke a surge of inspiration, add a dose of perspective, and/or reinforce the motivation to win.

Game Plans in Action: Case Studies of Cancer Survivors

The following are three stories of cancer survivors who used teamwork, positive mental attitude, and hope-filled thinking to achieve victory over disease (sometimes multiple times).

Steve Rom is a 36-year-old, three-time cancer survivor. His first two cancers occurred two decades apart: at age 9, a grapefruit-sized tumor in his upper spine; and 29, acute lymphoblastic leukemia, which required a bone marrow transplant in May of 2002. In January of 2008, Steve was diagnosed with tongue cancer (a rare side effect of the bone marrow transplant). This came after Steve experienced pain while

swallowing, and found irritating soars on his tongue and inside his cheeks.

Steve, a newspaper sports journalist, had never been an athlete. However, as a lifelong sports fan, he valued the concept of teamwork and used it to help him overcome his two adulthood cancers.

"I used to feel alone and sometimes isolated growing up," said Steve, an only child from Los Angles. "I was raised by my mother who worked till late at night. Plus I rarely saw my dad, who lived out of state. But everything changed once I got diagnosed with leukemia. Suddenly it was 'Team Rom.'

Steve's biggest teammate fighting the adult cancer was a 6-foot, 4-inch, 300-pound former Super Bowl champion. His name is Rod Payne, and they'd met the previous summer.

Working at the *Ann Arbor* (Mich.) *News*, Steve wrote a story about Rod, a former University of Michigan All-American and backup center for the 2000 Super Bowl Baltimore Ravens. The two were markedly different. Steve, a Caucasian, was nearly half the size of his African-American friend. Yet it wasn't the mere physical differences that proved most salient: athletes and reporters normally don't get along. Nevertheless, the two became close. They spent many days and nights at Steve's campus apartment talking about football and life.

On a vacation to Los Angeles to visit his mother in December 2001, Steve experienced three days of severe flu-like symptoms. He went to UCLA Medical Center (the same hospital where he was treated as a child) where doctors diagnosed him with leukemia. Steve immediately called Rod. Within hours after the diagnosis, Rod redefined the role of "friend": he flew to L.A. to stay at Steve's bedside and become his "coach."

"It was like a dream when Rod showed up," Steve said. "I thought I had taken too much morphine."

Rod, who overcame 13 surgeries in the NFL (they caused his early retirement), said: "This was Steve's disease to fight, but I was going to be there calling plays for him."

Together with doctors, nurses, fellow patients, and an "army" of Steve's family members, coworkers, friends, and neighbors, Rod led Team Rom to battle against the potentially deadly blood disease.

Rod helped Steve get mentally prepared for his treatments. That sometimes meant Steve had to keep quiet and calm, allowing doctors and nurses to perform their jobs. This

wasn't always easy—such as during a particular blood transfusion that sent Steve into a frenzy.

"You have to trust what these doctors and nurses are doing," Rod told Steve, sitting next to his bed on a fold-up cot. "Most importantly, you have to trust God! He is the only one in control."

After a month of chemotherapy and radiation, Steve was in remission. However, doctors told him the game wasn't over; because of a rare chromosome that he had, named Philadelphia +, a risky bone marrow transplant was needed.

During the ensuing months that doctors searched for a donor—a time when Rod returned to Michigan and his job as a sports talk-radio host—Steve kept in touch with his friend by phone. Rod lifted Steve's spirits by focusing his thoughts on the many projects they would pursue once Steve defeated his disease—as well as the businesses they wanted to start, the books they wanted to write, the places they wanted to visit.

"That 'imagery-through-conversation' really helped me stay focused," Steve said. "It made me more determined to leave the hospital."

After a three-month search for a donor, Steve finally had his transplant. Following a 100-day recovery phase, Steve boarded a plane back to Michigan and the life that cancer tried to take away from him—again.

"Rod was there to pick me up from the airport," Steve said. "He looked larger than life."

Julie Davey, of Duarte, California, is a two-time breast cancer survivor. She was initially diagnosed in 1985, had a modified mastectomy, but in 1996 found herself diagnosed with breast cancer again. Julie had another mastectomy and has had no major physical problems since. Julie was a journalism professor at Fullerton (Calif.) College when she discovered the problem that led to her first diagnosis.

"I found a lump in my breast while showering," she said. "I had no other symptoms and was not performing a 'breast exam.' I just felt something hard under my skin and immediately went to the doctor."

With no personal history of illness, Julie was surprised by the diagnosis but not unprepared to handle it: her mental toughness had been whetted in her early adulthood years.

"I earned my college degree after getting married following my sophomore year," she said. "Then we moved to two

different states before I graduated. I still managed to complete my degree in four years."

"I had to take charge," she added. "I read as much as I could, I got proactive. I used the same approach to fighting cancer; I did not sit by and let doctors 'tell' me about breast cancer."

Julie describes herself as an "independent person," yet she utilized a team approach to overcoming her cancers.

"I've always believed in helping others and having others help me get the job done. I have never been shy about asking questions or asking the hard questions that most people are afraid to ask."

Julie said her husband, Bob, a former mayor of Duarte, California was her coach.

"He took over the role of cheerleader and strategist. We would talk each night and he would make a plan. We would go over what I would say to the doctor and what I would ask. And when I became fearful, he would quickly put the control back in my hands."

Along with Bob, Julie's team included "scores and scores of teachers and friends at Glendale[California] High School; friends of friends who've had breast cancer who cheered me up or shared with me the number of years they had survived; and many of my students [at Fullerton College] who found out about my surgery and told me they were going to pray for me. It was like I was the 'injured player' on the field but I was getting immediate help and the whole grandstand was cheering for me."

To help relax during treatments, or get a boost of energy when needed, Julie relied on music.

"I took my headphones and my favorite music with me wherever I went," she said. "I only put the headphones down when I had to answer a specific question."

Julie recommends music to others as a form of relaxation.

"It makes you feel like YOU are in control when all of those people are poking you, draining your blood, pushing you in wheelchairs. All of that can make you feel like THEY are in charge."

To further gain empowerment over the disease—and help others attain theirs—Julie created *Writing For Wellness*, a book about how writing provides therapy and healing during times of trial. The book, which Julie edited, arranged, and co-

wrote along with the class of the same name held at City of Hope Medical Center where Julie was treated for her cancers, has been featured on a number of Southern California news outlets.

"I wrote when I was angry, when I was happy, or when I was fearful," Julie said. "I wrote to friends to thank them for helping me, for the prayers they sent. I wrote my heart out and I felt better.

"Writing had been my life as a journalist and as a teacher of the subject. If I had been a chef, perhaps I would use cooking. I think we each have a skill and I recommend using that to comfort us when we are facing life-threatening illnesses."

Christine Pechera, an aspiring filmmaker from Los Angeles, survived a rare type of large B-cell sclerosing lymphoma. She was diagnosed in June of 2002, and after six months of chemotherapy began preparing for a bone marrow transplant.

The transplant was a success, but Christine relapsed in December 2005 and another transplant was required. On July 5, 2006, Christine received her donor's blood and was soon declared medically "cured." Though Christine often feels fatigued, she says she works diligently to maintain her busy lifestyle. She's working toward a master's degree. And thanks to a widely publicized search for a Philippine donor (Christina's Web blogs led to national news networks featuring her story), she continues to serve as an inspiration for others.

"To this day, I still get mail and messages from the newly diagnosed, those who say I inspired them," she said. "That keeps me going. Physically it's hard; I'm still not allowed strenuous exercise, so I'm just walking and going to the occasional yoga class."

Leading up to her first diagnosis, Christine had lost 15 pounds and "my head blew up like a pumpkin." Experiencing severe breathing problems, she landed in the emergency room and an X-ray (first looking for pneumonia) revealed a large tumor in her chest.

"The tumor was leaning on my superior vena cava, which is why my head blew up like a pumpkin," said Christina, who's had asthma since childhood but has never been seriously ill. "They gave me less than 30 days to live."

Making matters worse, her older brother and sister were both fighting cancer when Christine was diagnosed. (She

ended up being her brother's bone marrow donor, but lost him to the disease two years later.)

"Because my parents had already been through so much, I was determined not to allow fate to take another child away from them," she said.

Though she described herself as "the helper and not the helped" during her pre-cancer life, Christine learned to do things differently.

"When I got sick I felt like I was a burden, and I didn't want to 'bother anybody.' It was very humbling for me to ask for help. But I guess cancer taught me that you need to 'allow' your friends to be your friends."

Christine also used cognitive tactics to aid her in her defense against cancer. She listened to music to stay calm, and relied on her friends to help with errands and meals—"and keep me sane." Meanwhile, Christine's sister "helped with the marrow donor search. My little brother helped with my faith. And my mother was the Army, Navy, Air Force, and Marines all rolled into one."

Christine's advice for the newly diagnosed boils down to this: "Don't isolate yourself. Connect with other patients your age, because no matter how well-meaning your other team members are, you need those who know *exactly* what you are going through so you can have a sort of 'short-hand' to work with when you are talking."

Long-Term Victory: Preparing for Next Season

In sports, ultimate victory doesn't come in the final score of a single game; championships sometimes aren't won in a single season—it can take years to build a program. Likewise, the final outcome of a cancer battle may not immediately be clear, not even with a clean bill of health from the doctor (a proclamation of "remission" or "cured"). Completing treatments usually doesn't provide the patient with all the peace and strength needed to return to the life they once knew, at least not at the same capacity. There can be residual damage from treatment: a need to recover from extreme mental and physical wear, for example. On a psychological level, the patient has been out of his or her regular routine for so long (including work life, domestic life, and social life), that it can be intimidating, and possibly overwhelming, to return to everyday society.

In terms of the physical recovery, depending on the type of cancer involved, it may require having to relearn to walk, talk, eat, drive, interact with others, or even think without being confused, frustrated, or scared. Once back to "normal," there's still a chance of a reoccurrence of the disease, or developing short- or long-term complications. Risk of future disease, therefore, may be reduced by modifying health beliefs, attitudes, or behaviors, including decisions about using professional services (Kaplan, 2008). It may require physical rehabilitation, even psychological counseling, and other interventions (hypnotic therapy, spiritual counseling, seeing a life coach, etc.). At the very least, observing regular follow-ups with a primary physician is essential for long-term victory.

One way of ensuring a productive outcome from treatments, no matter what the physical prognosis, is for a cancer survivor to help other patients deal with the trials they are going through. If a survivor can harness the strength to share his or her story with others, either face-to-face or in the form of written or spoken word, the positive effects can be exponential. As is often the case however, most former cancer patients usually don't leap into this leadership role seamlessly. For some, it can be just as intimidating as initially facing the news of their illness. But transforming from a patient into a motivator is an easier process than might be imagined.

The first step is to forgive oneself. Indeed, it is not uncommon for those affected by cancer to feel as though they brought the illness upon themselves through stressful living, poor diet, even inheriting genes that are prone to illness. Similarly, patients may project this type of "ownership" of the disease onto other cancer patients, thereby assuming they, too, brought the illness upon themselves. This could further detour the survivor from offering help. Though this may seem highly unlikely to someone with a rational mindset, it is a distinct possibility in the mind of a person who has recently undergone extreme chemotherapy and radiation.

Studies have been made on the medical health-correlates of forgiving others by examining the relationship between self-forgiveness, other-forgiveness, and health (Wilson, Milosevic, Carroll, Hart, & Hubbard, 2008). These correlations further point out the need for cognitive skills to help overcome illness. By adopting self-forgiveness and a desire to help others, a major leap can be made to win the war against cancer, despite so many battles having been lost already, all with a name, all with grieving family members left behind.

Indeed, as devastating as the "epidemic" of cancer has become, there still seems to be hope. Since around 1990 cancer mortality per 100,000-population in the United States has been falling (Antman, 2004). This statistic is driven by decreasing mortality rates in the four most-common cancers: prostate, breast, lung, and colon. Although many debate the impact of cancer screening on treatment, the decrease in mortality for breast, colon, and prostate cancers is attributable to these practices. (The fall in lung cancer deaths is almost certainly credited to the significant numbers of Americans who have quit smoking within the past two decades.)

The reduction in cancer mortality may also rest on the patient's psyche, or a person's sense of wellbeing and self-reported happiness. Lowered stress of patients often leads to fewer psychological problems after disease (Scott-Sheldon, Kalichman, Carey, & Fiedler, 2008). And less disease will no-doubt benefit society by keeping those who may hold keys to future technological, medical, environmental, or social breakthroughs alive and well.

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Religious/Spiritual Beliefs: A Hidden Resource for Emergency Mental Health Providers

Thomas J. Nardi
Long Island University
Rockland Graduate Campus

Abstract: *This article identifies religious/spiritual beliefs as a hidden resource for Emergency Mental Health (EMH) providers. The purpose of the article is to encourage providers to examine their own world views, be they spiritual or religious or both, as they apply to their EMH services. The article also provides suggestions and guidelines for the education/training of EMH providers in understanding and utilizing survivors' religious/spiritual beliefs. [International Journal of Emergency Mental Health, 2009, 11(1), pp. 37-42].*

Key words: *religious beliefs, spiritual beliefs, education, training, emergency mental health*

Religion, Spirituality, and Mental Health

Reflections on the legacy of Hurricane Katrina usually focus on lives lost, people left homeless, and support systems shattered. But the legacy also includes lessons learned. Citing the research of Peregoy (2005) and Zhang and Snowden (1999), Dass-Brailsford (2008) noted that "disaster responders should be adept at recognizing the values, practices, and spiritual orientations that support a community's psychological and spiritual well-being" (p. 28). Dass-Brailsford was one of the volunteers who provided crisis and mental health support to Katrina survivors. Her comments were based upon her hands-on experience with the survivors. She reported survivors asking her to join them in silent prayer. She

Thomas J. Nardi, Ph.D., is a visiting professor of education with the Department of Counseling and Development at the Rockland Graduate Campus of Long Island University. He is also the Clinical Director of the New York Center for Eclectic Cognitive Behavior Therapy and a member of the International Critical Incident Stress Foundation. Correspondence regarding this article can be directed to Thomas.Nardi@liu.edu

noted that "encouraging coping behavior consistent with indigenous beliefs and customs may help ethnic minority clients heal rapidly" but also cautioned that "the first responders may have to suspend his or her spiritual beliefs to achieve this" (p. 28).

Similarly, Bartoli (2007) cites several authors who have argued that multicultural competence is increasingly intertwined with psychologists' ability to engage clients' religious or spiritual backgrounds and worldviews (Evans, 2003; Fukuyama, 2003; Fukuyama & Sevig, 1999; Lukoff & Lu, 1999; Pate & Bondi, 1992; Powers, 2005). As Evans (2003) writes, "counselors who…include spirituality in their work with clients epitomize the culturally competent counselor" (p. 170).

A recent survey (Delaney, Miller, & Bisono, 2007) found that "fully 82% of psychologists averred a positive relationship between religion and mental health, with 69% rating high (7-9) toward the 'beneficial' end of the 9-point Likert scale. Only a small minority (7%) perceived religion to be harmful (ratings of 1 – 4) to mental health" (p. 542). It is both interesting and ironic to note that these authors also found

that "almost half the psychologists surveyed (48%) described religion as unimportant in their own lives, compared with 15% of the general population" (p. 542).

The recognition of the importance to psychology of religion and spirituality can also be seen by the publication of the American Psychological Association's (APA) newest journal, *Psychology of Religion and Spirituality*. The journal springs from APA's Division 36 (Psychology of Religion). DeAngelis (2008) has noted over the past ten years there has been a fourfold increase in research citations for religion and spirituality, as well as the publication by APA of several books focusing on spirituality within psychotherapy.

Emergency mental health (EMH) providers come from a variety of professional disciplines. They also come from a variety of religious and/or spiritual traditions ranging from atheist to devout believers. As Bartoli (2007) pointed out, "each psychotherapist and each client, depending on their cultural background and life experience, will conceptualize religion and spirituality somewhat differently…it is essential to invite clients to articulate their understanding of these terms and to become conscious of one's own views on them as well" (p. 55).

Bartoli favors the definitions of these terms offered by Shafranske and Sperry (2005) that "religion implies an explicit affiliation with a religious institution, as well as adherence to specific dogmas or doctrines. Spirituality, on the other hand, refers to a person's individualized, internal, and values based connection to the transcendent, which is at times disconnected from mainstream and organized religious institutions" (p.55). It is for this reason that Delaney and colleagues (2007) reference Connors et al. (1996) and, Fuller's (2001) distinction between religion and spirituality by noting "people can thus meaningfully describe themselves as 'spiritual but not religious,' which is a common self-description in the 12–step programs that are widespread in American society" (p. 542).

To these definitions can be added the concept of religious/spiritual beliefs as part of one's world view, including the understanding of the genesis of crisis, emergencies, and disasters, man made or otherwise, as well as how best to cope, address, and ultimately find peace with what has occurred. It is this author's assertion that religious/spiritual beliefs can be a hidden resource in one's EMH work.

Spirituality: Recommendations for Training Psychotherapists

In her review of the literature related to the training of psychologists, Bartoli (2007) noted that "although literature regarding ways of addressing and incorporating spiritual and religious concerns and perspectives in clinical work are beginning to be available, very few of them are taught to emerging psychotherapists" (p. 57). She further asserts that "psychotherapists' internal distancing from…religion and spirituality, does not support religious and spiritual client's needs, because these needs are ignored rather than met" (p. 58).

Similarly, Delaney and colleagues (2007) also recognize the lack of training and concomitant lack of willingness of psychologists to address competently the religious and/or spiritual client. They did, however, note that non-religious therapists could be trained to work effectively with the spiritual and religious issues raised by their clients. They called for the graduate schools to follow the medical schools in offering courses related to religion and spirituality. The present author has provided undergraduate, graduate, and, institute level training on spiritual issues in counseling; the following sections offer a set of recommendations based on these principles and practices.

Know Thyself

Helping our clients achieve a measure of insight and self-knowledge implies our own ability to utilize this skill ourselves. A useful small group exercise and point of departure for such training involves a *Counselor's Beliefs Form*. This one-page form asks five questions, with ample space provided for a written response. These five questions assist the counselor in becoming more aware of what he or she believes and how these beliefs affect their counseling of others.

The questions are the following.

1. When I was younger, my religious/spiritual beliefs were:

2. Today they are:

3. The three most positive ways my beliefs do (did) influence me today are:

4. The three most negative ways my beliefs do (did) influence me are:

5. My beliefs will influence my counseling, (Not at all 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Totally)

Experience has shown that the Counselor's Beliefs Form encourages self-awareness and reflection on one's beliefs and experiences. It is a useful tool for group discussion and can serve as a powerful vehicle for sharing of one's self with others. It also allows for the instructor or facilitator to address or at least identify issues that may interfere with, or limit, the counselor's ability to work with a client's religious/spiritual beliefs. Identification of specific issues can allow the counselor to work on resolving them and achieving a degree of closure in that regard. The identified issues can be addressed in supervision sessions, personal therapy, or by further education via courses on religion/spirituality.

The Counselor's Beliefs Form also identifies the more helpful aspects of one's religious/spiritual belief. Cicero once said that a religion should be judged by its loftiest ideals, not by its lowest practices. The instructor/facilitator can process the loftiest ideals of the counselor's belief system. It is clinically useful for others to learn of the helpful aspects of religious/spiritual beliefs, particularly if their own experiences are not quite as positive.

The Counselor's Beliefs Form also allows for a subjective rating of the degree to which one's beliefs will affect one's counseling. It is not uncommon for participants to increase the assigned rating of the influence of one's beliefs on counseling after discussion of other's experiences.

Know Others

After determining and exploring one's own beliefs, the next step would be to do the same with the client. The EMH provider can assess the client's religious/spiritual beliefs very easily. A simple question or two, asked in a non-judgmental and neutral manner, can serve quite well. Open ended questions are preferable; for example, "What are your religious/spiritual beliefs?" rather than "Do you have any religious/spiritual beliefs?"

At times a simple observational statement can elicit information. For example, if the client is wearing jewelry that suggests a particular religious affiliation (e.g. a cross, a crucifix, a Star of David) the counselor can acknowledge the jewelry by saying "I notice you are wearing_____". This observation invites the client to share his or her affiliation, if one exists. A follow-up question by the EMH provider might be something such as "What does your faith tell you about this crisis?," "How can your beliefs help you to cope?," or even, "Please tell me more about your beliefs."

If the EMH provider understands and shares the client's religious/spiritual beliefs, he or she can work with and within those beliefs. If the EMH provider does not share them, but at least understands and respects them, he or she can still work with those beliefs. It is only when the EMH provider neither shares nor understands the beliefs that he or she will be unable to work with them.

Caveats

While understanding and working within the client's belief system can be very beneficial, several caveats are in order. First, the EMH worker must always be respectful of the client's own religious/spiritual beliefs or lack of such beliefs. It is never appropriate to proselytize or attempt to convert the client to a particular belief system.

Also, keep in mind that the client will be attempting to make sense of whatever emergency, natural disaster, or crisis has occurred. Religious/spiritual beliefs can provide solace at such times; however, it is not helpful, and indeed, can actually be harmful, to accept or encourage beliefs that assign blame, guilt, or responsibility. For example, this author knew a Roman Catholic priest who had gone to New Orleans after the devastation of Hurricane Katrina. This priest encountered a woman who shared with him her belief that the hurricane was "God's wrath" on the "sinfulness of the city." The priest was quick to clarify that God was not punishing the city for its "wickedness." The priest used his concept of a loving deity who cared about the plight of the survivors. He worked within the woman's belief system but focused on the more constructive and positive views of a Divine Being in man's life.

By contrast, the much-publicized comments by two prominent televangelists about the terrorist attacks of September 11 being God's punishment for America's immorality, would, in my view, define a divisive and destructive use of religious beliefs, rather than using religious beliefs in a constructive way. Research (Clay, 1996; Pargament, 1997, Kirkpatrick, 1997, Gorsuch, 1988) supports the assertion that those who view God as loving and caring, rather than wrathful and punishing, have better mental health, as seen in lower levels of anxiety and depression.

A final caveat: If the client were seeking specific theological guidance, he or she would seek out a clergy member from their particular denomination. The EMH provider's job is to provide unconditional support and comfort within what-

ever religious or spiritual or secular framework the subject is comfortable. Accordingly the EMH provider would do well to steer clear of theological or doctrinal issues, per se. The exception would be, of course, if the EMH provider was also an ordained member of the client's denomination. In general, coordinated emergency services are most effective when each professional does his or her job competently.

Conclusion: Spiritual Stability

In conclusion, there is ample evidence for the therapeutic benefits of understanding and utilizing a client's religious/spiritual beliefs. The first step for the EMH provider might be to examine his or her own beliefs. A strong grounding in one's own religious/spiritual beliefs can strengthen the EMH provider in many ways, including helping to avoid burnout and compassion fatigue (Baumeister, 1991).

Exploring and encouraging the supportive aspects of the client's beliefs can tap into an important and perhaps otherwise hidden resource. Respect and unconditional positive regard for the client's religious/spiritual beliefs is a requisite for successfully helping him or her in time of crises. Those involved in educating EMH providers would do well to consider including religious/spiritual sensitivity training to their curriculum.

Finally, the goal of the EMH provider might best be characterized as one of providing "spiritual stability." Spiritual stability connotes providing a solid support or centering for the client. It involves utilizing the person's religious/spiritual beliefs to provide an emotional anchoring. Spiritually stabilizing the person experiencing the crisis empowers him/her to cope better with the confusion, chaos, and changes that can be overwhelmingly frightful.

The goal of the EMH provider is to offer immediate support in times of crises. Religious/spiritual beliefs can prove to be an important resource for both the provider and the receiver of EMH services.

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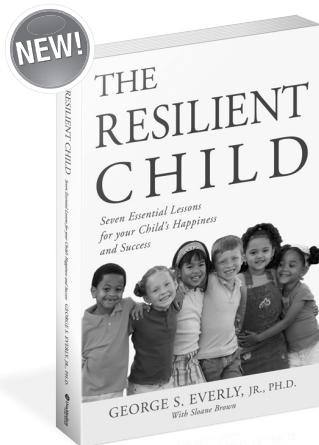Powers, R. (2005). Counseling and spirituality: A historical review. *Counseling and Values*, *49*, 217-225.

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Essential Personhood: A Review of the Counselor Characteristics Needed for Effective Crisis Intervention Work

Allen Ottens
Northern Illinois University

Debra Pender
Northern Illinois University

Daniel Nyhoff
Northern Illinois University

Abstract: *Crisis intervention work is a distinct specialty within the broader field of professional helping. This article presents two themes in recognizing the essential characteristics of successful crisis interventionists. We discuss the Aristotelian types of knowledge, techne, episteme, and phronesis as they apply to crisis work; identify core characteristics of therapeutic wisdom; and review the empirical findings on the characteristics of effective crisis counselors. [International Journal of Emergency Mental Health, 2009, 11(1), pp. 43-52].*

Key words: *Crisis counselor, attributes, knowledge, functional skills*

A general rule of thumb is that the *person* of the helping professional is a primary tool in any helping endeavor. Brammer and MacDonald (2003) have emphasized this exact point: "A growing body of evidence indicates that the personal qualities of helpers are as significant for the positive growth of helpees as are the methods they use" (p. 26). One source of that evidence is a recent meta-analytic review of psychotherapy outcome studies by Wampold (2001), who concluded that, ". . . therapists within a given treatment account for a large proportion of the [outcome] variance.

Clearly, the person of the therapist is a critical factor in the success of therapy" (p. 202). We believe that this conclusion applies equally to the helping endeavor that is crisis intervention. This probably does not come as a surprise to the reader, because the personality of the helping professional as a therapeutic factor, in diverse roles, seems intuitively obvious.

Many clinicians and theoreticians who write about crisis intervention have something to say about the facilitative attitudes, characteristics, or traits that define an effective crisis worker—and other less helpful ones that crisis workers need to modify or at least hold in abeyance. Although no one has come up with the definitive list that captures all such attitudes and characteristics, there is quite a bit of overlap and agreement among the authorities on crisis intervention.

In this article we discuss the role that the *person* of the crisis counselor plays in effective crisis intervention. We

Allen J. Ottens, PhD is Professor Emeritus, Counseling, Adult and Higher Education, at Northern Illinois University, DeKalb, IL. Debra A. Pender, PhD, LCPC, NCC, ACS, is Assistant Professor, Counseling, Adult and Higher Education, Northern Illinois University, DeKalb, IL, and is clinical director of the Southern Illinois Critical Incident Stress Management team. Correspondence regarding this article may be directed to Debra A Pender, email: dpender@niu.edu.

cover two broad topics: the distinctions between three kinds of knowledge that therapists, crisis workers included, need to possess, and a survey of attitudes, characteristics, and traits that, according to a variety of authorities in the crisis intervention field, tend to be possessed by crisis workers who are more likely to be rated as therapeutically effective and who would likely rate themselves as satisfied with their jobs.

Three Kinds of Knowledge

Recently, Grunebaum (2006) wrote a paper directed to family therapists that addressed such critical questions as: What leads to clinicians making good decisions when doing couples and family therapy? And, how do clinicians know what to do when faced with the predicaments that their clients bring in abundance to therapy? Of course, the same types of questions can apply to those who perform crisis intervention.

- How does one proceed when a client in crisis holds two incompatible goals—such as needing to be liked by all his employees, yet being pressed to lay off 25% of his workforce to keep the company afloat?

- What course of action should a crisis worker pursue to help an exasperated set of parents in crisis from acting too punitively against their child?

- How does one help a client who is faced with two equally difficult choices—such as staying and rebuilding after a devastating hurricane or moving out of state and starting fresh?

- How does one empower a seriously stressed caregiver of a cognitively-impaired elderly parent to proactively investigate community resources?

- How does one help a woman in a relationship crisis to realize that her boyfriend's chronic infidelity is likely not a "stage" that he is going through?

- When a suicidal client expresses ambivalence about taking his or her life, how can the crisis worker intervene in order to take positive advantage of the doubt the client has about following through on the threat?

Questions and dilemmas like these pose formidable challenges to crisis workers. How does one attempt to tackle them? How can clients be helped to negotiate them successfully? Where or to whom does the crisis worker turn for guid-

ance to help the client? Much of the challenge inheres in the fact that there exists no body of research that contains mathematically-derived answers or any panel of experts that has seen these kinds of crises time after time and knows what works under just such circumstances.

Grunebaum (2006) suggests the kinds of knowledge therapists need when facing predicaments like these by revisiting the work of Aristotle. According to Aristotle, there are three kinds of knowledge. *Techne* is the knowledge involved in applying one's craft or performing a skill. An artist, for example, who applies the principles of perspective when painting a landscape is demonstrating techne. Similarly, when a counselor conducts a mental status exam or structured assessment interview with someone in crisis, he or she is relying on this foundation of knowledge. In the helping fields, techne, or one's array of clinical skills, is usually acquired by observing, imitating, and being supervised by someone who is expert in the craft.

A second kind of knowledge, *episteme,* or the ability to reason mathematically or scientifically, is cultivated by reading scientific literature or evaluating research. All therapists, including crisis counselors, enhance their knowledge base by reading clinical or theoretical material—as you are doing at this precise moment. Often scientific and theoretical knowledge is efficiently conveyed through the written word or attending a lecture or class.

The third kind of Aristotelian knowledge and the one of most interest to Grunebaum is *phronesis*, or practical wisdom. It is the ability to make wise choices about human problems. But wisdom is an elusive concept. Some master clinicians can perform brilliant feats of therapy yet be at a loss to explain the rationale behind their method. To advance our discussion, we will extend the definition of wisdom a bit and consider the sort of characteristics often associated with it.

Baltes and Staudinger (1993) succinctly defined wisdom as "good judgment and advice in *important but uncertain* matters of life" (p. 77, italics added). Those italicized words certainly have special meaning for crisis counselors who constantly deal with clients' important life challenges that often go beyond the usual range of human experience. Crisis events tend to be unique to the person experiencing them, may not follow a predictable course, and may yield only to creatively applied interventions. This definition suggests that crisis counselors need again and again to tap into their knowledge base to draw upon wisdom.

It is generally recognized that wisdom is different than intelligence (Sternberg, 1990). Moreover, it has been argued that wisdom is what differentiates highly effective therapists from average ones (Hanna & Ottens, 1995). As important as epistemic knowledge is, it tends to be less correlated with therapeutic effectiveness than wisdom—or the positive personal characteristics of the therapist. Thus, Sternberg and Williams (1997) found that high grade point averages, high scores on the Graduate Record Examination, and well-honed research skills are not what make therapists effective facilitators of client change.

We need to ask: What positive personal characteristics are reflective of wisdom and how do they apply to the work of crisis counselors? A relatively short list of these characteristics of wisdom can be gleaned from Hanna, Bemak and Chung (1999), Hanna and Ottens (1995), and Sternberg (1990). Some of these are: (a) *Empathy:* Understanding the subjective view of others; (b) *Concern:* Compassion for others; nonpossessive caring; (c) *Recognition of affect:* Awareness of clients' emotions and feeling states; (d) *Deautomatization:* Being able to resist habitual, routinized thinking patterns (necessary in crisis situations where uncertainty holds sway); (e) *Dialectical reasoning:* Ability to negotiate opposing views; ability to consider multiple facets of a situation; fluidity of thought; (f) *Tolerance for ambiguity:* Seeing ambiguity as fundamental to the human condition; ability to manage despite uncertainty; (g) *Problem-finding and problem-solving:* Having the capacity to grasp and reframe problems in such a way as to make them manageable; (h) *Perspicacity:* Ability to intuitively apprehend the situation and see through it; and (g) *Metacognitive perspective:* Being able to recognize clients' assumptions; capacity to engage in self-monitoring and recognize when a new course of action is needed.

In the next section, we present characteristics of effective crisis counselors as enumerated by experts in the crisis intervention field. As you read these, keep in mind how they are congruent with the characteristics of wise therapists. Consider, as well, how they are more representative of personal qualities of the crisis counselor as opposed to intellective qualities.

Personal Characteristics of Effective Crisis Counselors: Sampling the Literature

The authors of the present article were curious about what theorists and practitioners in the field regard as essential personal characteristics of effective crisis counselors. We were most interested in those characteristics indicative of practical wisdom as opposed to specific clinical skills and scientific or theoretical knowledge. Culling from a sample of the literature, we found a wide assortment of such characteristics, which we sorted into six categories: (a) core conditions, (b) caring, (c) professional bearing, (d) positive outlook, (e) cognitive dexterity and flexibility, and (f) cultural self-awareness. In the next section, we examine and discuss the characteristics that cluster within each category.

Core Conditions

The core conditions promoting clients' progress in therapy—acceptance, genuineness, and empathy—as put forward by Rogers (1957, 1980), are well known to virtually all counselors and therapists. They are also personal characteristics of crisis counselors that are deemed essential by many of the authors of the literature sources we consulted (see for example, Collins & Collins, 2005; France, 2002; Greenstone & Leviton, 2002; James & Gilliland, 2005; Kanel, 2003). As noted above, empathy is recognized as an element of therapist wisdom.

Acceptance means valuing and prizing the client for who he or she is in a nonpossessive way. Crisis counselors exemplify acceptance when they respect their clients' rights to their feelings and beliefs. Cochran and Cochran (2006) underscored the point that clients in crises often share information they feel may be shameful or embarrassing. Thus, it behooves the crisis counselor to accept the client uncritically, without judging him or her as foolish or manipulative.

To be *genuine* (or authentic) means to be honest, as well as transparent and "real." Cavaiola and Colford (2006) stressed the importance of all the core conditions, especially genuineness which they regarded as "… a particular prerequisite for the crisis counseling relationship" (p. 31). Collins and Collins (2005) concurred, emphasizing how necessary it is for the crisis counselor to be honest with themselves and their clients. Moreover, as Cavaiola and Colford argued, genuine crisis counselors are comfortable with a range of client emotions, are confident in the helping role, and demonstrate a greater inclination to self-disclose.

Empathy is exemplified by the crisis worker deeply and accurately understanding her or his clients' subjective experience. Empathy requires the crisis worker to see the world from the perspective of the client—but without becoming

entangled in it. In order to be empathic during crisis intervention, Wiger and Harowski (2003) recommended gathering sufficient information so as to be sure the crisis counselor fully appreciates the clients' meanings and feelings. Extrapolating from Wiger and Harowski's recommendation, the present authors contend that it is the crisis counselor's *curiosity* that is the basis for empathy. Therapeutic curiosity drives the crisis counselor's efforts to understand, to make sense out of clients' experience. Without curiosity the counselor would not care. We ask the reader to consider whether the quality of curiosity belongs in a list of characteristics describing practical wisdom.

Despite being qualities indispensable to the crisis counselor, there is the danger that the application of the core conditions can be taken too far. An overly "genuine" counselor might be too free with self-disclosures and honest to a fault. For example, it hardly helps a grief-stricken client to hear a counselor describe her own prodigious efforts to work through the death of a loved one—and could leave the client wondering whether it is the counselor who really needs the help. A "too empathic" crisis counselor may become over-involved with clients and lose objectivity (Cavaiola & Colford, 2006).

Obviously, the core conditions are critical at all points during crisis work with clients, but may come into play most prominently when (a) rapidly establishing rapport with the client and (b) encouraging expression via active, empathic listening of the client's emotions (Roberts, 2005). To accomplish both of those goals, clients need to feel supported, understood, and safe.

Caring

Grunebaum (2006), in his essay on therapeutic wisdom, wrote that what matters most in therapy is that the patient feels the therapist cares for him or her. Caring, according to Brammer & MacDonald (2003), is associated with demonstrating compassion and concern toward clients. Caring is fundamental to the rapport-building stage of crisis intervention since it is unlikely that any sort of therapeutic relationship would develop if the client did not experience a caring attitude emanating from the crisis counselor. Thus, a caring attitude tells clients that the persons assisting them take a genuine interest in wanting to help them (Myer, 2001).

Caring is exemplified by reaching out both physically and emotionally toward those in crises, as well as by attentive listening (Greenstone & Leviton, 2002). Caring is also fundamental to creating a safe place for the client in crisis (Wainrib & Bloch, 1998). Caring may have to be communicated rapidly as in situations where the client is at life-threatening risk. In that kind of event, safety is foremost and the crisis counselor has no option but to quickly display caring of the most genuine quality—as one of the author's (A. O.) former supervisors once stated, "When a client in crisis taps you on the shoulder, you're 'it.'" For clients to trust, a caring relationship must be well established. Caring is an essential part of the crisis counselor's personal armamentarium when working with clients during the immediate aftermath and recovery phases of psychological trauma.

Caring is also exemplified in the follow-up phase of crisis intervention. The crisis worker needs to convey a genuine interest in the long-term recovery of the client and to adopt an "open door policy" for future contacts as needed. This is especially important, for example, if subsequent events resensitize clients to traumatic experiences or when clients are confronted with the anniversary of adverse events (e.g. death of loved one, natural disaster; Roberts, 2005).

On the downside, caring may exact a toll on crisis counselors. Known by a variety of terms such as *secondary traumatic stress* (Stamm, 1995), *compassion fatigue* (Figler, 1995), or just plain "burnout," it is widely recognized that providing care and compassion to those who are traumatized can be emotionally and physically exhausting. Dr. Bonnita Wirth, a veteran of psychotherapy practice described how she got quite a surprise after leaving her clinical practice:

> . . . *within weeks of closing my practice, I started sleeping through the night* for the first time in over three decades. *This was an astonishing revelation and the first time I realized the connection. For all of those years I had never considered that my chosen and beloved profession had a cost: a significant impact on my body, my sleep, and my ability to fully relax.* (Quoted in Rothschild, 2006, p. 96, italics preserved*)*

It behooves the crisis counselor to perform periodic self-assessments to gauge his or her subjective levels of professional quality of life and compassion fatigue as well as to prevent getting too compassionately entangled with clients (Rothschild, 2006).

Professional Bearing

Experts in the crisis field speak about an assortment of personal qualities that we have subsumed under the category "professional bearing." Effective crisis counselors tend to display inner strength, imperturbability, courage, and resoluteness. They are not easily taken aback. They can function in the face of extreme emotional reactions (Myer, 2001). James and Gilliland (2005) called this poise. Displaying this strength can have an ameliorative impact on the person in crisis. Greenstone and Leviton (2002) emphasized that one's stability, supportiveness, and ability to provide structure act as antidotes to the chaos of crisis. They stated, "Your strength, control, and calm in the crisis situation may exert the control the victim needs" (p. 9).

Cavaiola and Colford (2006) spoke about the calm, neutral demeanor of the crisis counselor and his or her confidence. By being calm and confident, the counselor conveys the message, "It's safe to express your strongest emotions and personal troubles. I won't be 'blown away' by them." This imperturbability is essential as the crisis worker helps the client ventilate those feelings (Roberts, 2005, p. 23). Cavaiola and Colford also recommended that crisis work requires counselors who have an adventurous spirit and who are not driven by a need to "rescue" clients. Being adventuresome suggests preferring the thrill of the unexpected rather than contentment with a routine; it demands someone who can thrive on a fast pace that oscillates between here and now. The crisis counselor who is there to rescue clients tends to be too caring to a fault. We might wonder if it is the client who is fulfilling this counselor's needs.

This last point relates to two other important facets of professional bearing: the counselor's psychological adjustment (see Hackney & Cormier, 2006; Neukrug & Schwitzer, 2006) as well as his or her ethical sense (Brammer & MacDonald, 2005). If the therapist is doing crisis work for his or her self-aggrandizement, then the client is made to suffer. An ethical counselor or therapist practices from the ethical principle of *beneficence* - doing no harm to one's client.

Lastly, the combination of poise, adventurous spirit, confidence, and psychological adjustment is what helps a crisis worker to stay energized and resilient. James and Gilliland (2005, p. 15) said that a crisis worker must have "bounce back" potential. Because crises are not always satisfactorily resolved, counselors must have the inner resources to draw on in order to remain feeling good about themselves.

One of the main threats to one's professional bearing—especially for beginning therapists—is the fear of not being competent to help (Pipes & Davenport, 1999). We believe this fear manifests itself commonly as well among beginning crisis workers. Pipes and Davenport described this as the fear that one does not have the know-how to be therapeutic toward a client. This fear, once it takes hold, accelerates rapidly and engulfs the novice crisis intervener, because in the midst of a crisis one's incompetence could be quickly exposed. What makes this an insidious fear is that there is always an element of realism attached to it. You *will be* confronted by a client with whom you have relatively little competence in treating. On the other hand, given that fact, it is probably healthy to harbor such a doubt—up to a point—so that the crisis worker does not become too impetuous or self-assured. To counter this fear, Pipes and Davenport suggested lowering one's expectations about "curing" clients. High performance standards work against crisis counselors, given that crisis work involves many situations where therapeutic "success" is rare. Crisis workers in the domestic violence field, for example, deal with clients who are caught in a revolving abuse cycle. They often return to unsafe environments despite the efforts of their therapists. Pipes and Davenport also reminded us that the core conditions— being warm, accepting, and affirming—are essential for making crisis intervention work. We second their recommendation and believe that it can be extended. When in doubt, it can help the crisis counselor to fall back on the qualities that describe wisdom. Resist stereotyping clients, be yourself, show concern, be empathic, look to find ways to negotiate opposing views, try reframing the problem. Remember that a wise crisis worker does not need to possess the pure intellect of an Einstein to be therapeutic. The crisis worker's effectiveness inheres in her or his personal characteristics.

Positive Outlook

We believe that what pulls a therapist and her or his clients through a crisis is the therapist's steadfast belief that the crisis can be surmounted. Roberts (2005), for example, has noted that providing the client hope and reassurance that she or he can be helped is a cornerstone on which rapport is based. A positive outlook means that the crisis worker is optimistic about clients' chances for recovery (Kanel, 1978). A positive outlook can serve as an antidote to clients in crises who can only myopically see hopelessness and foreclosure. This is likely what Wainrib and Bloch (1998) had in

mind when they wrote about the crisis worker creating a climate of hope for clients. Cavaiola and Colford (2006) spoke about crisis workers possessing the characteristic of optimism—a belief that clients are resilient, resourceful, and capable of recovery.

The appreciation of clients' strengths and resiliency lays the foundation for therapists to adopt an *empowering* stance toward their clients (Collins & Collins, 2005). For a host of reasons, clients in crisis often experience a diminished capacity to act or to make sound decisions; thus, in the short-term, crisis workers may need to take a more directive approach. However, an empowering crisis worker (a) respects clients' eventual potential to act on their own behalf, (b) favors working collaboratively whenever possible with clients, and (c) seeks to put control back into clients' hands. Empowerment means clients are helped to tap into personal resources such as past successful coping strategies and current support networks (Behrman & Reid, 2002). It also means helping clients obtain needed resources within their communities— those resources occurring naturally in clients' environments and others from the traditional social service delivery system (Fast & Chapin, 2000).

Writing from a cognitive-behavioral perspective, Meichenbaum and Gilmore (1982) recommended that, "The cognitive-behavioral therapist needs actively to expand on a natural reservoir of optimism and creative thinking in the face of countless discouraged patients" (p. 146). The opposite of that optimism is what Meichenbaum and Gilmore (1982) termed therapist *transresistance* which is that attitude of dispiritedness or hopelessness that the therapist displays *back* to supposedly "resistant" clients—those who show little improvement, dwell on how they have "failed," or otherwise communicate that they "can't change." Unfortunately, when clients concede to their therapists' transresistance, all hopes for therapeutic progress are dashed. What Meichenbaum and Gilmore tell crisis therapists is that when they communicate their own discouragement, even subtly, to discouraged persons in crisis, they risk delivering a profoundly disempowering blow to those clients.

Cognitive Dexterity and Flexibility

Our sampling of the crisis intervention literature contained more than a few references to the need for crisis workers to be of nimble mind. Time, or the lack of it, is one factor here. Certainly in the midst of a crisis, the therapist has little

opportunity to pause and reflect on the issue at hand (Cavaiola & Colford, 2006; James & Gilliland, 2005; Slaikeu, 1984). This is especially true if the therapist is working in a critical or intensive care unit. In this setting, treatment issues must be quickly prioritized and addressed in very short order, even as the client is at imminent risk of suicide (Shulman & Shewbert, 2005). Clients in crises, almost by definition, struggle to generate or apply alternative coping responses; they may need to rely on the crisis worker for some short-term adaptive problem-solving.

Cognitive dexterity and flexibility are needed just as much to adapt to the challenging needs and complicated life issues that comprise clients' crises. This can mean being very efficient at performing an assessment (Myer, 2001) because crisis workers must begin to intervene when they know only fragments about the events taking place (Cavaiola & Colford, 2006). Because clients in crisis often experience a temporary attenuation in their problem-solving and decision-making capacities, it behooves the crisis worker, when appropriate, to be more directive than he or she might ordinarily be. Being directive requires an active crisis worker who can make recommendations to meet clients' needs and who can galvanize clients into accessing their resources (Slaikeu, 1984).

The ability to "think on one's feet" comes into play in other ways during crisis intervention. Clients are often desperate, angry, or distrusting and will say or do things to test a crisis worker. If the crisis worker responds in the "wrong" way, it might shut the client down and jeopardize chances to build rapport. We strongly recommend that crisis workers have at the ready the basic outlines of convincing, honest, and satisfying rejoinders to these provocative client tests. For example, the first author (A. O.) recalls responding to a late night crisis involving an adolescent girl who, as he entered her hospital cubicle, spat out, "So you're the big psychology shrink who's supposed to 'help' me? Dude, I know you're only f—ing here to talk to me because someone's payin' you to!" Instantly, I needed to respond in a way that was not counteraggressive (I had to maintain *professional bearing*), demonstrate *caring*, and be absolutely *genuine* (a crucial *core condition*). "You're right!" I replied. "I do get paid a salary. But I could have waited until regular working hours to see you. I'm here now because I care." We invite you to craft your own response to this client. Applying cognitive flexibility in crisis situation taps into those characteristics that we associated with wisdom, such as perspicacity, dialectical reasoning, and especially deautomatization—think-

ing that is "outside the box," rather than more of the same routine strategies.

Cultural Self-Awareness

One personal characteristic or attribute that should not be overlooked is crisis workers' level of cultural self-awareness. Our sampling of crisis intervention literature found strong support for this characteristic among theorists in the field (e.g., Cavaiola & Colford, 2006; Collins & Collins, 2005; Greenstone & Leviton, 2002; Hoff & Adamowski, 1998; James & Gilliland, 2005; Kanel, 1999). Awareness of one's cultural background, as well as one's attitudes, biases, and values regarding diversity, has long been regarded as a key competency for performing cross-cultural counseling and psychotherapy (Carney & Kahn, 1984; Sue, Arredondo, & McDavis, 1992).

The crisis worker who accesses and brings to awareness her or his attitudes, biases, and experiences about cultural issues is displaying a metacognitive function associated with wisdom (Hanna & Ottens, 1995). Moreover, self-awareness is a prerequisite to the wisdom factor of empathy—the more we understand ourselves, the greater the likelihood that we can be attuned empathically to others.

Sue and Sue (2003) urged counselors and therapists to heighten their awareness of the values, assumptions, beliefs, and practices associated with *ethnocentric monoculturalism*—the manner in which U.S. society is structured to serve individuals and groups from the mainstream majority culture. Sue and Sue (2003) cautioned that ethnocentric monoculturalism is a pernicious and powerful force and that "as such, it is very important for mental health professionals to unmask or deconstruct the values, biases, and assumptions that reside in it" (p. 69). According to Sue and Sue, this involves, for example, unmasking and deconstructing beliefs about cultural superiority and inferiority, the power to impose standards, and lifting the "invisible veil."

Cultural superiority. One of the ways in which a sense of cultural superiority plays itself out is through the barely discernable contours of White privilege—the advantages the majority Euro-American culture bestows on those possessing "desirable" racial characteristics. This privilege allows White individuals to move about their world quite oblivious to how the realities of race get played out. Crisis workers who encounter racially and culturally diverse clients must become cognizant of how privilege tilts the societal playing field; they must also be open-minded and receptive to the idea that people of color will encounter crises elicited by discriminatory practices, bureaucratic hassles, capricious enforcement of laws, and the like—adversities that White privilege usually insulates against.

Cultural inferiority. In mainstream (i.e., White) America, a Eurocentric worldview holds sway. Ivey and Ivey (2007) have defined worldview as "the way we interpret humanity and the world . . . think of worldview as the way your clients see themselves and the world around them" (p. 45). Generally, one moves through daily life unaware as to how one's worldview influences decision-making, affective experiences, and perceptions. As opposed to Afrocentric or Native American worldviews, for example, a Eurocentric worldview provides a broad normative base that tends to prize competition over cooperation, hierarchical over egalitarian relationships, internal over external locus of control, cognitive over affective or extrasensory domains, a future focus over one grounded in the present, controlling nature over protecting nature, and so forth. Succinctly stated,

> Eurocentrism is the belief in the comparative superiority of Anglo American culture, in particular, and Euro-American culture, in general. Adherents affirm that what is normative for groups who either occupy or descend from European territories is a yardstick for evaluating other culturally distinct geographical groups (Jackson, 1986, p. 132).

A crisis worker from the White majority needs to be aware of how his or her inclination toward Eurocentric values can result in discounting other cultural perspectives. Thus, when clients construe that their conditions can be aided by the incorporation of indigenous methods of healing, the crisis worker might make a serious error by not regarding them as complementary treatment interventions. Among their recommendations, Sue and Sue (2003) urge that mental health professionals develop consulting and referral relationships with traditional healers in the community; moreover, they should be cognizant of how spirituality is a force in the lives of culturally diverse clients and how it can be integrated into Western treatment approaches. Ethical codes and standards of practice from the American Counseling Association (ACA, 2005; A.1.d), American Psychological Association (APA, 2002; Principle E), and the National Association of Social Workers (NASW, 2008; Value: Dignity & Worth of the Person) support the crisis counselor's action of honoring the

individual's choice of cultural-spiritual solutions. Each association's guiding documents also caution the crisis counselor to avoid practicing beyond one's competence (ACA, 2005, 2.C.a; APA, 2002, 2.01a, b; & NASW, 2008, 1.04, 1.05), therefore the crisis counselor must balance the demonstration of respect for client's choice of indigenous spiritual solutions without endorsing an indigenous spiritual practice beyond one's range of clinical expertise.

Consider the inclusion of indigenous sources of assistance when addressing the crisis of elder abuse. Moon and Williams (1993) found that Korean American, African American, and Caucasian American elderly women differed widely with respect to their tendency to first reach out to informal as opposed to formal (i.e., social service agencies) sources of help. For example, elderly Korean women (74%) surveyed were more than twice as likely as Caucasian (36%) to turn to relatives, friends, or clergy for assistance. This example underscores the need for crisis workers to be intimately familiar with indigenous helpers in the community.

The power to impose standards. It follows that if the dominant cultural group believes its worldview to be superior, then the dominant group is likely to impose its standards on less powerful groups (Sue & Sue, 2003). This describes a form of oppression. To the dominant group, its values, decisions, beliefs, actions, and perceptions are preferred, are deemed "right." Oppression involves *silencing or diminishing the voices* of those less powerful. Here, "voice" refers to the capacity to make free choices, to be autonomous, or to engage in self-expression. Silencing voice can be done in blatant fashion such as stripping away the voting rights of a minority group or denying its constituents access to fair trials. Less blatant but no less demoralizing ways to jam the voice of a minority group is to debase its forms of artistic expression, relegate to the margins its suggestions for social improvement, or label its spokespersons as "trouble-makers."

It behooves crisis workers to perform continuous self-monitoring—itself a metacognitive function and wisdom factor—of the values, actions, standards, and perceptions that rise to the surface when encountering culturally diverse clients in crises. For example, can the crisis worker hear the stories of oppressed or minority groups without imposing her or his worldview on them? What feelings, perceptions, values, or standards are triggered in you, the reader, at the prospect of providing crisis counseling to clients who

- are single, unmarried mothers heading households of children fathered by several different men;

- take fatalistic approaches (e.g., "it's God's will") to life's exigencies;

- express cavalier attitudes about taking safe-sex precautions to reduce the risk of HIV-infection;

- seek out your assistance only when crises have gotten well out of hand because their cultures are skeptical of formal sources of help.

Will your worldview find room for hearing, understanding, or validating the experiences of these clients or will your worldview act as a filter to diminish or distort their voices?

Lifting the "invisible veil." Sue and Sue (2003) emphasized that just because racism, sexism, and homophobia are outside of one's usual sphere of consciousness does not mean that they do not exist. White, straight, and male individuals have a hard time hearing the buzz of oppressive forces. White privilege, as previously mentioned, plays out underneath this veil—White individuals hardly ever need to consider race as an intervening variable in how they will be treated. Our recommendation for crisis workers is to be in touch with any tendencies toward "colorblindness." For White counselors or therapists this means recognizing the fact of race when working with clients of color and how that might play out during crisis intervention. It is easier to adopt a colorblind attitude (e.g., "Let's overlook the fact that race differentiates us and instead operate from the stance that we are 'human beings' after all") because it helps us avoid the embarrassment or guilt attendant to talking about race and culture.

Conclusion

In this article we made an argument for how crisis workers rely heavily on a knowledge base of practical wisdom. Although knowing how to apply technical skill is important in crisis intervention (e.g., when performing an assessment or making differential diagnoses), wisdom is the aspect of one's knowledge base that accounts for effective crisis intervention. A variety of characteristics associated with wisdom were presented and discussed.

Six distinctive personal characteristics of effective crisis workers have been identified on the basis of a review of literature from the field. These characteristics are: (a) core conditions, (b) caring, (c) professional bearing, (d) positive

outlook, (e) cognitive dexterity and flexibility, and (f) cultural self-awareness. The authors described how these personal characteristics come into play and can be capitalized upon during crisis intervention.

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Selected Annotated Journal Resources

Ian Goncher, MS and Rich A. Blake, B.A.

Muller, R. T., & Rosenkranz, S. E. (2009). Attachment and treatment response among adults in inpatient treatment for posttraumatic stress disorder. *Psychotherapy: Theory, Research, Practice, Training, 46(1), 82-96.*

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To investigate changes in attachment orientation after treatment in an inpatient program for adults with posttraumatic stress disorder. Also, to examine the association between these changes and symptom reduction.

PROCEDURE

Participants

- The total sample was made up of three subsamples. The treatment group consisted of 101 participants who completed admission and discharge questionnaires. Sixty-one of these participants completed the 6-month follow-up questionnaires and were designated as the follow-up group. The wait list group consisted of 46 participants who completed waitlist and admission questionnaires.

- The response rate for the wait list questionnaire was 49.6% and for the admission questionnaire it was 81.7%. Of those who completed the admission questionnaire, 87.6% completed the program, and 75.2% of this group filled out the discharge questionnaires. Of those completing the discharge questionnaires, 60.4% completed the follow-up questionnaires.

- The mean age of participants was 42.8 years (*SD* = 9.2).

- Sixty-four percent were women, and 41% were married.

- The median education level endorsed by the participants was "some university or college."

- The median family income was $65,000 (Canadian). The ethnic composition of the participant group was 91.9% European Canadian, 5.4% Aboriginal, 1.8% African/Caribbean Canadian, and 0.9% who designated themselves as "other."

- All participants reported the experience of a trauma of an interpersonal nature on the Trauma Assessment for Adults, Self-Report, and the Record of Maltreatment Experiences, Self-Report.

- All were diagnosed with posttraumatic stress disorder (PTSD) before their admission to the program that was confirmed through a structured interview shortly after admission (Clinician-Administered Posttraumatic Stress Disorder Scale).

- The inclusion criteria for the program specified that patients must be at least 18 years of age, have a diagnosis of PTSD and be considered appropriate for group-based treatment.

- The exclusion criteria for the program included current psychosis, another major Axis I disorder that was a primary treatment focus, an active substance use problem, and suicidality.

- A diagnosis of borderline personality disorder or another Axis II disorder was not an exclusion criterion.

- The program's psychiatrists reported that 75% of the patients were on medication.

- Participation in the current study was open to all patients admitted to the program.

Procedure

- The current study used a wait list comparison group methodology, in which participants were provided the option of entering into the study either at the time that they were placed on the wait list for the program or at the time of their admission to the program.

- The wait list group was comprised of participants who had completed wait list questionnaires and who then proceeded to complete the admission questionnaires at the time of their admission to the program.

- The mean amount of time between completing the wait list questionnaire packet and admission to the program was 60 days, which is approximately the same duration of the treatment protocol.

- All patients admitted to the program between March 2005 and September 2006 were presented with the admission questionnaires 3 days after their admission, during the assessment week, in a group session led by a research assistant.

- Discharge questionnaires were provided to participants 6 days before their discharge.

- Those who completed the discharge questionnaires were mailed the follow-up questionnaires 6 months after their discharge from the program.

- The current study was conducted at the Program for Traumatic Stress Recovery (PTSR) at Homewood Health Centre, a psychiatric hospital in Guelph, Ontario, Canada. The PTSR is a 28-bed, 8-week voluntary inpatient treatment program for adults with trauma histories.

- In the PTSR, treatment is conducted almost exclusively through group therapy.

- A multidisciplinary team primarily provides treatment. Therapists include a psychiatrist, psychologists, and social workers, and other members of the program staff include occupational and recreational therapists and nurses. According to the study, all primary therapists have more than 10 years of experience, and all have completed full training in the PTSR treatment model.

- The program consists of three phases. The first week is an assessment phase, during which patients are introduced to the program's core concepts and are evaluated regarding their ability to engage in treatment. During the treatment phase (weeks 2 through 7), the focus is largely on the establishment and maintenance of a sense of safety, and the emphasis is on the patient's current life. Patients attend daily groups, some are mandatory and some patients are referred to a group by the treatment team on the basis of individual needs or personal goals.

- The final week of the program consists of the discharge-planning phase. During this phase, patients are provided the opportunity to plan for their return to their home community.

Measures

- The Relationship Scales Questionnaire is a 30-item self-report questionnaire designed to measure adult attachment according to Bartholomew's (1990) four-category model. The authors computed the mean rating for each of the four attachment patterns, creating four continuous variables.

- The Relationship Questionnaire consists of four short paragraphs describing the prototype of each of Bartholomew's (1990) four attachment patterns. As with the Relationship Scales Questionnaire, four continuous variables corresponding to attachment patterns; anxiety and avoidance dimensions can also be calculated. This scale can be combined with the Relationship Scales Questionnaire by changing attachment scores to z scores and then averaging parallel scores. The underlying dimensions of attachment anxiety and avoidance can then be calculated from the resulting composite scores. Composite scores of the four attachment patterns and the two attachment dimensions were used for analyses in this study. In the current sample, alpha reliabilities for the composite scores ranged from .68 to .80.

- The Trauma Symptoms Checklist-40 (TSC-40) was used to evaluate adult symptomatology arising from childhood or adult traumatic experiences. It produces a total score as well as scores on six subscales: Anxiety, Depression, Dissociation, Sleep Disturbance, Sexual Abuse Trauma, and Sexual Problems. Alpha reliability of the TSC-40 ranges from .66 to .77 for the subscales and is .90 for the total score. In the current sample, the alpha reliability was found to be .92 for the total score.

- The Symptom Checklist 90 Revised (SCL-90-R) was used to measure psychopathology.

RESULTS

- Analyses were conducted to determine whether there were differences among the various subsamples on the TSC-40 total score, the SCL-90–R GSI and subscale standard scores, and the attachment variables. No signifi-

cant differences between those who did and did not complete the discharge, wait list, and follow-up questionnaires, indicating that there were no symptom or attachment differences between those participating and declining to participate at the various data collection points.

- Analyses also confirmed that there were no significant differences on any of these scores between those who did and did not complete the treatment program, indicating that there were no symptom or attachment differences between those who left the program early and those who remained in the program to its completion.

- To test the hypothesis that participants would demonstrate improvements on attachment over treatment, the authors conducted two 2×2 repeated measures multivariate analyses of variance, one for the four attachment patterns and one for the two attachment dimensions.

- When the four attachment variables were entered together as dependent variables to examine change over treatment in comparison to the wait list group, the overall interaction between time and group was significant, $F(4, 131) = 3.72, p < .01, \varsigma = .32$. When examining change in the four attachment variables between admission, discharge, and 6-month follow-up, the overall analysis was significant, $F(8, 45) = 3.171, p < .01, \varsigma = .60$.

- When examined together as dependent variables to examine change over treatment in comparison to the wait list group, the two attachment dimensions' overall interaction between group and time was significant, $F(2, 133) = 6.63, p < .01, \varsigma = .30$. Also, when investigating change in the two attachment dimensions (Attachment Anxiety and Attachment Avoidance) between admission, discharge, and follow-up, the overall analysis was significant, $F(4, 49) = 6.55, p < .01, \varsigma = .60$.

- When the SCL-90–R GSI was entered as the dependent variable and changes in the four attachment patterns as independent variables, the overall model was statistically significant for both treatment group, $F(4, 87) = 5.90, p < .001$, follow-up group, $F(4, 50) = 5.41, p < .001$, accounting for 21.3% of the variance in change in overall levels of symptomatology between admission and discharge and 30.2% of the variance in change between admission and follow-up.

- To further examine change in the SCL-90–R GSI, the authors entered change on the two dimensions of attachment anxiety and avoidance as predictors; the overall

model was statistically significant for the treatment group, $F(2, 89) = 7.49, p < .001$, and the follow-up group, $F(2, 52) = 10.96, p < .001$, accounting for 14.4% of the variance in change in overall symptom presentation between admission and discharge and 29.7% of the variance in change between admission and follow-up.

- In the treatment group, change in overall symptomatology was predicted by change in both dimensions of attachment anxiety and attachment avoidance. Additionally, changes in symptomatology in the follow-up group were also predicted by change in both attachment dimensions.

- When change in the TSC-40 total score was entered as the dependent variable and changes in the four attachment patterns as independent variables, the overall model was not statistically significant for the treatment group. However, it was significant for the follow-up group, $F(4, 50) = 2.93, p < .03$. In the follow-up group, change in scores on the four attachment patterns accounted for 19.0% of the variance in change in trauma symptoms between admission and follow-up. In that group, change in trauma symptoms was predicted primarily by change in secure attachment.

- To further examine change in the TSC-40 total score, the authors entered change on the two attachment dimensions as predictors, which resulted in an overall statistically significant for the treatment group, $F(2, 89) = 3.60, p = .03$, and the follow-up group, $F(2, 52) = 5.88, p < .01$. Change in scores on the two attachment dimensions together accounted for 7.5% of the variance in change in trauma symptoms between admission and discharge and 18.4% of the variance in change between admission and follow-up. In the treatment group, change in trauma symptoms was predicted by change in attachment anxiety; however, change in trauma symptoms was predicted by change in both attachment dimensions in the follow-up group.

CONCLUSIONS/SUMMARY

- The underlying dimensions of attachment anxiety and avoidance both exhibited a significant decrease over treatment in comparison to the wait list group; however, only the decrease in attachment anxiety was maintained after treatment.

- The authors' finding that both attachment dimensions had reductions during treatment but only the dimension

of attachment anxiety remained improved after follow-up is significant. The authors posit that the dimension of attachment avoidance may be more resistant to continuing changes than the dimension of attachment anxiety.

- The results indicate that positive changes in attachment over the course of treatment were associated with symptom reduction during treatment and maintenance of these reductions at follow-up.

- The authors stated that an unexpected finding was that the associations between attachment and symptom changes became stronger at follow-up than they were at discharge. This was particularly evident for change in trauma symptoms, for which the association with change in the four attachment variables only became significant at follow-up.

LIMITATIONS

- The current study's design does not allow for conclusions regarding the particular aspects of the program that may have contributed to the changes observed.

- With regard to the measurement of adult attachment, the authors used a somewhat older measure.

- The majority of participants were European Canadian women, and participants' median education level indicated higher than usual levels of education. This may, to some extent, limit the generalizability of the sample.

Dorahy, M. J., Corry, M., Shannon, M., MacSherry, A., Hamilton, G., McRobert, G., El-der, R., & Hanna, D. (2009). Complex PTSD, interpersonal trauma and relational consequences: Findings from a treatment-receiving Northern Irish sample. *Journal of Affective Disorders, 112(1-3),* **71-80.**

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- This study assessed the degree to which Disorders of Extreme Stress Not Otherwise Specified (complex PTSD)

was related to interpersonal trauma and interpersonal and community connectedness.

- To further assess the relation between PTSD and DESNOS (complex PTSD).

PROCEDURE
Participants

- Participants were 81 individuals in treatment at a center in Belfast serving those with Troubles-related trauma histories (i.e., those referred as a direct result of exposure to the political violence in Northern Ireland known as the 'Troubles').

- Staff at the center invited nonsuicidal patients currently in their caseload to participate in the study.

- The sample was between 19 and 73 years of age (Mean=40.5; *SD*=11.0) and contained 60 males (74.1%) and 21 females (25.9%).

Procedure

- Participants completed a clinician-administered interview format with a clinician not involved in their current care.

- Assessing clinicians were given instructions on how to administer each scale by a clinical psychologist familiar with the use of each tool. Assessing clinicians were also given an opportunity to conduct a practice assessment before the study began.

- Scoring was conducted by a clinical psychologist who did not administer the assessment battery.

Measures

- The Posttraumatic Stress Diagnostic Scale (PDS) was used to detect PTSD using the DSM-IV criteria.

- The Structured Interview for Disorders of Extreme Stress (SIDES) was used to detect complex PTSD/DESNOS. The SIDES contains 6 subscales to assess: 1) alterations in regulation of affect and impulses, 2) alterations in attention or consciousness, 3) alterations in self perception, 4) alterations in relationships with others, 5) somatization, and 6) alterations in systems of meaning. The current study used three markers of DESNOS. The first marker was DESNOS symptom severity, which equaled the summed severity for all DESNOS symptoms over the past month. The second marker was having a lifetime DESNOS diagnosis, which equated to being posi-

tive on all six symptom criteria outside the previous month, and the third marker was current DESNOS equaled being positive on all six symptom criteria in the past month.

- Trauma history was assessed with the Childhood Trauma Questionnaire (CTQ). The CTQ is a 28 item self-report inventory that screens for a history of childhood abuse and neglect. Five domains are assessed: 1) emotional abuse (e.g., verbal assaults or humiliation), 2) emotional neglect (e.g., failure to receive basic psychological needs, like love), 3) physical abuse (e.g., assaults to the body), 4) physical neglect (e.g., failure to receive basic physical needs, like food) and 5) sexual abuse (e.g., sexual contact or conduct).

- Additionally, trauma history was assessed using the Troubles-Related Experiences Questionnaire (TREQ). The TREQ is a recently developed self-report measure for assessing exposure to Troubles-related incidents in Northern Ireland in both childhood and adulthood.

- The degree to which participants felt connected to others and the community in which they live was assessed with the Community and Interpersonal Connectedness Scale (CICS), which was specifically developed for this study. The CICS was designed specifically for this study. It contains 5 items that assess the degree to which participants feel emotionally connected to their family, friends and community. In the current sample the community connectedness subscale had a Cronbach's alpha of .79 and the interpersonal connectedness subscale had an alpha of .68.

RESULTS

- The mean length of time in treatment before participating in the research was 6.9 months (range: 1–24 months).

- Forty-six participants were taking antidepressant medication, 32 were taking sedatives or anxiolytics (most commonly diazepam), 15 were on a course of neuroleptics and 14 were taking no psychiatric medication.

- Time since the Troubles-related traumatic event that lead to referral was at least 3 years in the majority of cases (71.3%). Only 2 participants had their referral trauma 3–6 months before assessment, while 49 (61.3%) participants reported their referral trauma more than 5 years before study participation.

- Of the 80 participants who successfully completed the PDS, 76 (95%) were positive for a diagnosis of PTSD. In

terms of the SIDES, 61 (75.3%) were positive for a lifetime history of DESNOS and 16 (20%) were positive for current DESNOS using the most stringent criteria of affirming all six symptom clusters in the past month.

- Along with the Troubles-related trauma that brought them to treatment, the large majority of the sample (77; 95.1%) had a history of childhood abuse, childhood neglect or both. Of those reporting emotional childhood abuse (54%, n=44), 17 (38.6%) were in the low range, 7 (15.9%) were in the moderate range and 20 (45.4%) were in the severe range. Thirty-seven participants affirmed childhood physical abuse (45.7%) with 14 (37.8%) in the low range, 7 (18.9%) in the moderate range and 16 (43.2%) in the severe range. Of those reporting a childhood sexual abuse history (18.5%, n=15), 3 (20%) were in the low range, 2 (13%) were in the moderate range and 10 (67%) experienced sexual abuse that fell within the severe range.

- Sixty-four (79%) affirmed emotional childhood neglect; 12 (19%) were in the low range, 5 (8%) were in the moderate range and 47 (73%) were in the severe range. Physical childhood neglect was reported by 71 (87.7%) participants, with 5 (7%) in the low range, 13 (18%) reporting moderate levels of physical neglect and 53 (75%) in the severe range.

- Regression models were conducted with the DESNOS severity measure as the criterion variable. The model indicated that the CTQ measure of sexual abuse and total psychological impact of Troubles-related trauma were the only significant predictors (Adjusted R^2 =.214; $F(2,75) = 11.489, p<.001$).

- The next model included associated symptoms and connectedness variables to ascertain if PTSD (i.e., PDS subscales) and emotional connectivity (i.e., CICS subscales) could explain additional variance in the DESNOS severity variable. This model explained 57.7% of the variance and the overall regression model was statistically significant ($F(7,68)=15.60, p<.001$).

- The next regression was conducted with PSS total score as the criterion variable; this model investigated if the same pattern of predictor variables would be evident for PTSD as for DESNOS. The subscales of the CICS, TREQ and CTQ were entered as predictor variables. This model explained 15.5% of the variance and the overall model was statistically significant [$F(1,74)=13.53, p<.001$].

- The final models were exploratory stepwise logistic regressions where the criterion variable was 1) the pres-

ence/absence of lifetime DESNOS and 2) the presence/absence of current DESNOS. Subscales from the PDS, CICS, TREQ and CTQ were all entered as predictors. The interpersonal connectedness subscale of the CICS, the arousal subscale of the PDS, and exposure to Troubles-related trauma in childhood appeared to significantly predict lifetime DESNOS. These three predictors indicated that 78% of the current sample would be classified with or without lifetime DESNOS correctly.

- With reference to current DESNOS, the exploratory stepwise logistic regression indicated that the CICS subscale of interpersonal connectedness, PDS avoidance, and CTQ emotional childhood neglect were significant predictors. These three predictors indicated that 85% of the current sample would be classified with or without current DESNOS correctly.

CONCLUSIONS/SUMMARY

- The author's first hypothesis was supported by current DESNOS severity being significantly related to childhood sexual abuse, current DESNOS diagnosis being associated with childhood emotional neglect and lifetime DESNOS being related to childhood experiences of Troubles-related incidents.

- Aside from these event-related variables (i.e., experiences in childhood of sexual abuse, emotional neglect and Troubles-related incidents), the only other etiologically-relevant variable associated with DESNOS was perceived psychological impact of Troubles-related exposure, which was significantly associated with current DESNOS severity. The authors conclude that this factor illustrates the importance of trauma perception on complex symptom outcome.

- The author's second hypothesis was supported by reductions in interpersonal connectedness (e.g., feeling emotionally disconnected from family members and friends) being related to all markers of DESNOS.

- The PTSD symptom of avoidance was significantly related to current DESNOS diagnosis and severity, and according to the authors, appears to be central to complex PTSD.

- The current findings suggest the presence of DESNOS implies the presence of PTSD, but they remain separate entities.

- According to the authors, the current results highlight the importance of assessing for difficulties associated with DESNOS, especially in the areas of affect regulation, self perception, dissociation and interpersonal disconnectedness.

LIMITATIONS

- The current study was limited to a relatively small sample of survivors of political violence in Northern Ireland, known as "the Troubles", related trauma which was assessed with self-report measures and retrospective reports of traumatic events.

- In addition, the limited sample size may result in questioning the reliability and generalizability of the exploratory logistic regressions.

- Adult trauma exposure was limited to Troubles-related events, and further work would benefit from including other measures of adult trauma.

Palm, K.M., Strong, D.R., MacPherson, L. (2009).Evaluating symptom expression as a function of a posttraumatic stress disorder severity. *The Journal of Anxiety Disorders, 23*, 27-37.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To assess the degree to which DSM-IV symptoms combine to define a primary construct underlying PTSD.

- To identify which symptoms are associated with greater severity of PTSD.

- To determine whether the symptoms and symptom patterns are influenced by gender.

PROCEDURE
Participants

- The data included in the present analyses were from the US National Comorbidity Survey Replication NCS-R public-use set.

- Questions regarding PTSD symptomatology were included in Part II of the NCS-R interview, which assessed disorders that were considered to be secondary aims of the NCS-R. A total of 5692 participants completed Part II of the assessment.

- A total of 4985 endorsed at least one traumatic event and 1946 met criterion A (i.e., had been exposed to a traumatic event and their response involved intense fear, helplessness, and/or horror). Of the 1946 who met criterion A, 757 participants were excluded from the present analyses because these respondents did not endorse either of two items: "did you have any emotional problems after the event like upsetting memories or dreams, feeling emotionally distant or depressed, trouble sleeping or concentrating, or feeling jumpy or easily startled?" or "did any of these reactions last for 30 days or longer?" Thus, a total of 1189 respondents were included in the analyses.
- PTSD criteria requiring higher thresholds were assessed first; in other words, symptoms were assessed in the following order: criterion C, criterion B, and criterion D.
- Following these guidelines, 1189 respondents received all criterion C symptom inquiries, 42 respondents did not receive any further symptom inquiries because they did not meet symptom thresholds for criterion C, and 65 respondents did not receive any criterion D symptoms because they did not meet symptom thresholds for criterion B.
- Of the 1189 respondents, 604 (50.8%) met criteria for lifetime PTSD, 326 (27.4%) met criteria for PTSD in the past 12 months, and 160 (13.5%) met criteria in the past 30 days.
- The current sample had a mean age of 42.6 years (*S.D.* = 14.9).
- The majority of the sample was female (73.4%).
- Of the 1189 participants included in the present analyses, 227 (19.1%) reported seeing a psychiatrist, psychologist, social worker, counselor, or other mental health specialist in the past 12 months.
- In terms of lifetime treatment utilization, 738 (62.1%) indicated that they had participated in a counseling session (30 min or longer) with a professional, 617 (51.9%) indicated being on psychiatric medication at some point, and 86 (7.2%) reported being hospitalized for psychological or substance use problems.

Procedure

- Prior to evaluating individual item response probabilities, the authors evaluated whether they could assume that one primary latent construct was being measured

and whether responses to each symptom were largely independent of responses to other symptoms.
- Given the three symptom domains defined by the DSM-IV are used to define a general level of PTSD severity, the authors considered a single dimension underlying response to the 17 symptoms, a bi-factor model, and a three-factor model.
- Confirmatory factor analysis of tetrachoric correlations were used to specify each of the three models in mPlus.
- Robust Weighted Least Squares method was selected.
- Estimation models used were: the Comparative FitIndex, the Tucker Lewis Index, and the root mean square error of approximation.
- The authors used a two-parameter model to provide information about how well each item discriminates among individuals with PTSD symptoms.
- The authors used Estimation of differential item functioning (DIF) to compare independent estimates of the severity of symptoms across gender.

RESULTS

- Results of confirmatory factor analyses suggest that fit indices from both the multidimensional model and the bifactor model were better over the unidimensional model.
- Results from the three-factor model suggested substantial shared variability across the three factors, with an average correlation of 0.80 (*S.D.* = 0.06).
- The bifactor model produced fit indices that exceed suggested cut-offs across all three indices.
- The symptoms' relation (e.g., factor loadings) to the primary dimension of PTSD across both models was analogous. Thus, the bifactor model fits the data best, but controlling for criterion specific variability did not substantially alter factor loadings on the primary dimension of PTSD.
- Severity estimates ranged from the lowest level of PTSD severity of -1.28 (symptom C1 "Not think about") to the highest level of severity at 0.855 (symptom C7 "No reason to plan for the future"). Several of the PTSD symptoms were associated with similar levels of PTSD severity, suggesting an overlapping or clustering of symptoms on the continuum of PTSD severity. For example, symptoms B2 "Unpleasant Dreams", C6 "Trouble feeling normal feelings", and C4 "Lost interest in things used to enjoy" had similar severity ratings between -0.232 and -

0.191. Despite some overlap, the PTSD symptoms indexed a broad range of PTSD severity.

- The majority of items discriminated similarly, with symptoms C3 "Unable to remember" (0.848) and B1 "Had unwanted memory" (2.390) suggesting the least and most discriminating items, respectively.
- Men and women indicated similar patterns of symptom endorsements with no significant differential item functioning (DIF) on 10 of the 17symptoms ($p < 0.05$), although on average women had slightly higher PTSD severity than men (Cohen's $d = 0.25$).
- Women were more likely than men to report feeling distant emotionally, and feeling easily startled at lower levels of PTSD.
- Men reported lack of plan for future, unwanted memories, unpleasant dreams, and short-temper at lower levels of PTSD than women.
- Finally, reports of experiencing flashbacks did not discriminate across levels of PTSD or among men when compared to women.

CONCLUSIONS/SUMMARY

- The author's state that continuous indices of PTSD severity may be useful as supplements to extend research of the clinical correlates, associated comorbidities, and clinical outcomes among individuals with a diagnosis of PTSD.
- The present study suggests that using a diagnostic system to assess the degree of PTSD symptomatology may best capture variability among individuals exposed to a traumatic event using a full range of PTSD symptoms.
- Research examining the relationship between particular symptoms and how they relate to different levels of PTSD could inform the development of more precise assessments of PTSD symptomatology and severity.
- The authors conclude that it appears that the DSM-IV PTSD symptoms as assessed in the NCS-R provides acceptable coverage at the low to moderate levels of the PTSD syndrome, but there may be a gap in symptoms that capture the range between of moderate to severe PTSD.
- Additionally, understanding where an individual falls on a continuum of PTSD severity could have important implications for appropriate treatment matching, such that someone with severe symptomatology would re-

ceive more intensive treatment than someone endorsing symptoms in the less severe range of the severity continuum.

- The authors state that current model does not imply a causal process, but an ordering process such that if a participant endorsed a higher severity symptom, it is expected that symptoms below that severity level would be endorsed.

LIMITATIONS

- Current findings are limited by the nature of the assessment (i.e., assessment procedures, the phrasing of questions) used in the NCS-R.
- The authors designated symptoms to be "absent" rather than "missing" if respondents were skipped-out of a section of the interview. Rather than assuming that responses were missing at random, the authors suggested that the decision to presume an absence of the symptom was most in line with the assumptions of the survey method. The authors conclude that this procedure may have decreased endorsement frequencies, as some of these respondents would have endorsed some of the symptoms if given the opportunity.
- There also may have been particular characteristics of the assessment items in the current study that impacted the author's findings. For example, phrasing of the questions in the NCSR as well as population characteristics can impact the relative severity of each symptom dramatically.
- The current analyses are also limited by the lack of more detailed information regarding experiences related to the individuals' traumatic event and associated symptoms.
- In the current study, the authors limited the analyses to examine the primary organization of DSM-IV PTSD symptoms along a latent unidimensional continuum.

Kubzansky, L., Koenen, K., Jones, C., & Eaton, W. (2009). A prospective study of posttraumatic stress disorder symptoms and coronary heart disease in women. *Health Psychology*, **28(1), 125-130.**

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To determine if a relation exists between high levels of PTSD symptoms and increased risk of incident coronary heart disease (CHD) in women.

METHODS

Participants

- Participants were obtained from the Baltimore cohort of the Epidemiologic Catchment Area (ECA) program, a study assessing the prevalence of psychiatric disorders in the general population.
- Three waves of surveys were administered in 1980, 1982, and from 1993-1996. Participants in the current study completed surveys during Wave 2 in 1982 and were surveyed in a follow up between 1993 and 1996.
- Wave 2 consisted of 1,741 women. There were 682 women excluded from the current study because there was either evidence of heart disease in their original interviews or there was missing data or incomplete procedures.
- Overall, there were 1,059 women included in the sample. The majority were white (59.9%) and nearly half the sample had at least a high school education (48.9%).

Materials

- The National Institute of Mental Health (NIMH) Diagnostic Interview Schedule (DIS) was used to assess PTSD and major depression.

Procedure

- PTSD was assessed during face-to-face interviews during Wave 2 using the DIS. Participants were asked an introductory question to determine if they had experienced a traumatic event within that past year. An affirmative response led to further questioning. Only 2.6% of the women met criteria for PTSD; therefore, symptom counts were used as a continuous measure to increase statistical power. Symptom levels were categorized as low, moderate and high recognizing that five symptoms are needed for a DSM-IV diagnosis.
- Depression and anxiety were assessed during Wave 2 with single item questions.
- Other cardiovascular risk factors were assessed during the second Wave including basic demographics, history of hypertension or diabetes, smoking status, and alcohol use.

- Cardiovascular outcomes were assessed during Wave 3 interviews by questioning and by using the National Death Index. Those who had experienced angina pectoris, fatal and nonfatal heart attack, or other cardiac death were considered positive for the outcome measure.
- Logistic regression models were used to estimate the risk of CHD as the outcome measure. PTSD symptom levels was a predictor, while age, race, smoking status, high blood pressure history, diabetes history, alcohol use, education, and income were controlled.

RESULTS

- Of the sample, 89.1% reported zero PTSD symptoms, 7% reported 1 to 4 symptoms, and 4% reported five or more symptoms. PTSD symptoms were higher among women with less income or who endorsed the depression or anxiety question.
- Eighty six women in the sample developed CHD. There were 30 nonfatal heart attacks, 27 fatal heart attacks, 15 other cardiac deaths, and 14 cases of angina pectoris.
- Women with more PTSD symptoms had a greater risk for coronary heart disease. For each additional symptom there was a 17% increase in risk. Women with five or more symptoms were at three times the risk as those reporting none.
- Depression and anxiety were independently associated with CHD, but when controlled for did not significantly change the effect of PTSD.
- Consistent with other research, the women in the sample with PTSD were more likely to smoke or consume more than two alcoholic beverages per day. However, The PTSD-CHD relation remained strong when these behaviors were controlled for.

CONCLUSIONS/SUMMARY

- Findings support a significant relation between PTSD and increased risk for CHD that had previously not been demonstrated in civilian women.
- This study differs from the previous research done with military men. In military men the likely exposure was combat, whereas in this study the type of exposure varied.
- Findings add to previous research that suggests that prolonged stress reactions can initiate disease processes.
- It is unknown how PTSD influences CHD, but it has been proposed that PTSD may directly affect biological

processes that lead to atherosclerosis and cardiovascular system damage.

CONTRIBUTIONS/IMPLICATIONS

- This was the first study examining the relationship between PTSD and CHD in civilian Women.

- One limitation of the study was that 285 women were lost to follow-up at Wave 3 and the results would be changed had they been included in the sample.

- The occurrences of CHD events were rare in the sample limiting analysis and interpretation. Civilian men were also of interest but there were not enough men with PTSD symptoms to analyze them.

- The type or severity of traumatic events was not evaluated and there was incomplete information pertaining to several risk factors. CHD was measured by self report, so bias and misclassification exits.

- Despite these limitations, the findings provide relevant information on the strength of the association after controlling for depression, trait anxiety, and other risk factors and its consistency with research in men.

- Those with PTSD should be considered an at-risk population for developing CHD. Further research should try to identify how PTSD specifically affects biological processes and if treatment for PTSD can lessen those effects.

Jurišiæ, B., & Marušiè, A. (2009). Suicidal ideation and behavior and some psychological correlates in physically disabled motor-vehicle accident survivors. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 30(1), 34-38.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine the relation between suicidal ideation and behavior, self-concept, and PTSD in those with permanent physical disabilities from motor vehicle accidents (MVA).

METHODS

Participants

- The sample consisted of 50 permanently disabled victims of MVAs. There were 43 men and seven women. Five participants had at least one extremity amputated. Of the participants, 42 were paraplegic and 3 were quadriplegic.

- Ages ranged from 17-60 years with an average of 38.37 years. The average age at the time of the MVA was 23.31 years. The average time since the MVA was 15.27 years.

- One quarter of the sample was employed, half were single, 46% married, and 4% divorced or separated. Sixteen percent of the sample completed primary school or less, 25% completed vocational school, 42% completed secondary education, and 14% earned a university degree.

- The participants communicated verbally and in writing and did not have mental impairment. Most of the sample were active members of the Paraplegics Association of Slovenia and participated in sports.

Materials

- An anamnestic data questionnaire and Slovene versions of standardized instruments were used to measure self-concept, PTSD symptoms, and suicidal behavior.

- Self-concept was measured using the Tennessee Self-Concept Scale 2 (TSCS:2). The revised Impact of Event Scale (IES-R) was used to assess PTSD symptoms. Suicidal ideation was measured using an instrument based on Beck and colleagues' classification model of suicidal behavior. The measure asks yes/no questions to assess passive ideation, intent, plan, and family history of suicide.

Procedure

- Participants received questionnaires at their local Paraplegics Association of Slovenia or by mail. The questionnaires were self-administered and took 30-45 minutes to complete.

- Most of the participants completed the survey before or after a group activity. Three respondents required a survey administrator because of their disability.

- Simple statistics were used to calculate psychological characteristics and correlation analyses were used to compare links between the variables.

RESULTS

- Of the sample, 56% reported a history of negative thinking, 36% reported suicidal thoughts, 28% reported planning an attempt, and 12% reported making an attempt. Three respondents had relatives with failed suicide attempts and six had relatives who died by suicide. Those with a family history of suicide were more likely to report suicide planning and attempts.

- The self-concept profiles of the participants were slightly lower than the population average and the lowest scores were on measures of family, moral, and academic self-concept.

- Most participants reported low levels of PTSD symptoms, but 10% reported experiencing symptoms within the week prior to completing the questionnaire.

- Suicidal ideation and behavior were negatively correlated with self-concept. The self-concept conflict subscale was positively correlated with suicidal ideation and behavior. The PTSD intrusion subscale was positively correlated with active suicidal ideation.

- The most significant factor influencing suicidal ideation was family history of suicidal behavior. Suicide attempts were predicted by hyperarousal and gender, and men were more likely to attempt suicide.

CONCLUSIONS/SUMMARY

- Findings were consistent with previous studies that suggested that a family history of suicide influences suicide risk directly and by increasing the likelihood of aggressive behavior. PTSD symptom severity, especially intrusion, increases the risk of suicide.

- Seriously injured MVA survivors retain PTSD-related problems years after the accident which can lead to personality changes and self-concept.

CONTRIBUTIONS/IMPLICATIONS

- The results of this study illustrate the importance of screening for family history of suicidal behavior in disabled MVA survivors so that relatives and hospital staff can be aware of risk.

- Social isolation because of unemployment could be addressed through actions by the government that could allow disabled MVA survivors employment opportunities.

- PTSD symptoms can be treated with cognitive-behavioral therapy and quality of life can be improved with pharmacological, psychological, and psychosocial treatments.

- This study is limited by a nonrepresentative small convenience sample, but still demonstrates possible relations between self-concept, PTSD symptoms, and suicidality.

Hobfoll, S., Palmieri, P., Johnson, R., Canetti-Nisim, D., Hall, B., & Galea, S. (2009, February). Trajectories of resilience, resistance, and distress during ongoing terrorism: The case of Jews and Arabs in Israel. Journal of Consulting and Clinical Psychology, 77(1), 138-148.

TYPE OF ARTICLE

- Original Empirical Investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine the trajectories of resilience and resistance in a nationally representative sample of people under the threat of mass casualty in Israel.

METHODS
Participants

- A nationally representative sample of Jews and Arabs over the age of 18 years living in Israel was obtained through the random selection of telephone landlines stratified by region. The overall response rate was 57%.

- The first wave of interviews, conducted between July 31 and October 9, 2005, consisted of 1,613 participants. Of these participants, 897 were excluded because they dropped out before Wave 2 of data collection. An additional 7 were excluded because of insufficient data. The final sample consisted of 709 participants who represented the population of Israel on gender, age, location of residence, and voting behavior.

Materials

- A structured survey instrument was administered that lasted approximately 30 minutes and was conducted in

Hebrew, Russian, or Arabic by trained interviewers using translated questionnaires.

- Terrorism exposure was examined by asking participants if they or a family member was involved in an attack during the Second Intifada, (a Palestinian uprising against Israel that lasted from September, 2000 to November, 2006).

- Loss of economic and psychosocial resources pertaining to the Second Intifada was measured with Norris's 10-item scale that the National Institute of Mental Health recommends for terrorism-related research post-9/11. Six items were used to assess posttraumatic growth.

- Social support was assessed using two single-item categorical indicators pertaining to current satisfaction with perceived support from friends and family.

- The 17-item PTSD Symptom Scale assessed the severity of symptoms in the past month from exposure to attacks that occurred at the beginning of the AL Aqsa Intifada in September of 2000.

- A five-item measure taken from the Patient Health Questionnaire was used to assess depression.

Procedure

- Participants completed phone interviews two times following rocket attacks approximately one year apart.

- During each wave, participants were categorized into four different trajectories based on their current traumatic stress and depression symptoms. They were considered resistant if they had no more than one traumatic stress-related symptom and no more than one depression symptom. If more than one symptom was present they were classified as distressed.

- Those who were not resistant during Wave 1 but were during Wave 2 were classified as resilient. Those not resistant at either time point were considered chronically distressed and those resistant during the first interview and not the second were placed in the category of delayed distress.

- A 4x2 repeated measures ANOVA was conducted to examine differences between the four trajectories. Multinomial logistic regression was not used because of only one observed value for the dependent variable, so parallel bivariate logistic regression was used instead.

RESULTS

- Of the participants 157 (22.1) displayed the resistance trajectory, 96 (13.5%) displayed the resilience trajectory, 73 (10.3%) displayed the delayed distress trajectory, and 383 (54%) displayed the chronically distressed trajectory.

- When compared to the chronic distress category, those who reported higher income or education or who identified themselves as male, Jewish, or secular were more likely to display the resistance trajectory. Less loss of resources and lower level of traumatic growth also increased likelihood of a resistant trajectory.

- Compared to the chronic distress category, having a higher income and being Jewish increased the likelihood of a resilient trajectory. Less loss of resources reported at either interview as well as less traumatic growth at Wave 2 increased the likelihood of a resilient trajectory.

- When comparing the delayed distress category to the resistant category, having a higher education and being secular increased the likelihood of resistance. Less loss of resources at Wave 2 decreased likelihood of a resistant trajectory.

CONCLUSIONS/SUMMARY

- Israelis are at risk to experience chronic distress as the result of terrorism. Arabs are at an elevated risk because their minority status is associated with fewer resources and they have been historically discriminated against and not fully incorporated into Israeli society.

- Social support and resources contribute to resistance and resilience.

- Findings were consistent with previous studies in Israel. However, compared to research conducted after the World Trade Center attack in New York the current study yielded a significantly lower percentage of resistant participants. This suggests that it is the chronic repeated exposure to terrorism over time that explains the greater risk in Israel.

- Findings suggest that less resource loss and lower traumatic growth predicts resiliency and that majority status, higher income, and greater social support from friends contributes to resistance and resilience.

CONTRIBUTIONS/IMPLICATIONS

- One of the study's limitations is that the participants lost after the first interview could have been systematically different than those retained. Another limitation is the variety of factors within each culture that may influence a cross-cultural comparison. A final limitation is the application of the PTSD concept to those who were not clearly exposed to a trauma.

- A strength of this study is that it is the first longitudinal study of resilience and resistance with those facing a constant threat of terrorism and war. Another strength is the large sample size.

- Findings add to the data suggesting that increased post-traumatic growth decreases likelihood of resistance and resilience.

- Prevention and intervention measures should be implemented and those with fewer resources should be a priority. Different trajectories may require different interventions.

- Those who are symptom free may not be as resilient as those who have symptoms but still maintain employment and take pleasure in interactions with others.

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

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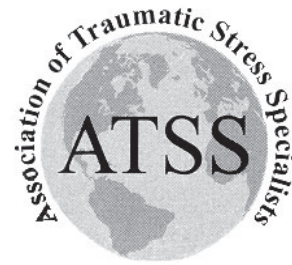
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P.O. Box 246
Phillips, ME 04966
Phone: 207-639-2433
Fax: 207-639-2434
E-mail: Admin@ATSS.info
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Handbook for Psychological Fitness-for-Duty Evaluations in Law Enforcement
by Cary D. Rostow and Robert D. Davis
Binghamton, NY: Haworth Press, 2004

Fit, Unfit, or Misfit? How to Perform Fitness for Duty Evaluations in Law Enforcement Professionals
by Kathleen P. Decker
Springfield, Charles C Thomas, 2006

Reviewed by Laurence Miller, PhD

Every time we dial 911, we expect that our emergency will be taken seriously and handled competently. Even in routine matters, citizens expect a certain level of civility and professionalism from public service personnel. For police officers, this task is doubly challenging because they are the only nonmilitary public safety professionals whom the law and society grant the authority – indeed, the obligation – to use coercive physical force, up to and including deadly force, to influence the behavior of citizens. Further, their decision to use such force is based largely on their own judgment as to what is appropriate in each particular situation. We rely on the police to protect us, and are quick to condemn them if we feel they have violated our trust.

If an officer develops a medical condition that affects his ability to perform his job, a supervisor or commanding officer may recommend or even order that the officer seek medical attention. If the problem persists, he may be referred for a medical fitness-for-duty (FFD) evaluation to assess whether he is physically fit to perform his duties.

Similarly, in cases where it is suspected that personal traits, disorders, or stress reactions are causing or contributing to problem behavior or substandard performance, and where this does not fall into a disciplinary matter, a formal psychological FFD evaluation may be ordered to determine if the officer is psychologically capable of carrying out the responsibilities of his job. The psychological FFD evalua-

tion thus combines elements of risk management, mental health intervention, labor law, and departmental discipline.

Surprisingly, then, only recently have law enforcement officials and mental health professionals collaboratively and systematically addressed the psychological FFD issues that relate specifically to police officers (IACP, 2005; Miller, 2007; Stone, 1995). The two volumes reviewed here represent distinct but complementary approaches to the theory and practice of law enforcement FFD evaluations, written from the perspective of psychologists and a psychiatrist, respectively.

Cary Rostow and Robert Davis' book, Handbook for Psychological Fitness-for-Duty Evaluations in Law Enforcement, is a soup-to-nuts guidebook on the clinical, legal, and administrative aspects of performing a law enforcement psychological FFD evaluation. The book opens by emphasizing how important it is for the evaluator to understand the police culture as a context for framing the evaluation and its conclusions. Another important topic concerns liabilities and the uses and misuses that an FFD report may be put to.

Subsequent chapters discuss the nuts-and-bolts mechanics of carrying out an FFD evaluation. Crucially important is defining the referral question: in practical experience, this is often too broad. Although a wide range of data may be relevant to the individual's overall psychological functioning, the focus of the FFD evaluation itself should be relatively specific to the question at hand. Sometimes, officers

are referred without clear indications for why an FFD evaluation is being ordered ("He's got an attitude problem"). In such cases, the psychologist may have to take responsibility for helping the referring agency refine its referral question ("What problematic behaviors is this officer showing that reflects his bad attitude?").

The book carefully delineates the core components of a comprehensive FFD evaluation, including reason for the evaluation (see above); relevant background information (and the key here is "relevant" – recent history of off-duty barhopping may be relevant; past marital infidelity or early childhood sexual abuse may not); careful review of records (note above issues of relevance); clinical interview and behavioral observation of the officer (for an experienced clinician, nothing can replace face-to-face contact); collateral interviews (in the police context, this will usually involve supervisors or coworkers, but occasionally family members or others may be contacted); psychological testing (remember "relevance"? – in my opinion, many evaluators over-rely on psychometrics to take the place of clinical observation, so pick your tests carefully); and the precious skill of distilling all this data into a set of succinct and practical conclusions and recommendations that the decision-maker can apply.

Other useful sections of this book contain summaries and explanations of relevant laws, statutes, and rulings that may apply to law enforcement FFD evaluations, such as Federal and regional statutes, the Americans with Disabilities Act, Family Medical Leave Act, and so on, as well as appendices illustrating sample reports, letters, and other important documentation. This is a handbook that should be kept close at hand by any psychologist who performs psychological FFD evaluations for law enforcement.

Far less common in this role are psychiatrists, who are typically more comfortable working in relatively controlled medical treatment settings than in the sometimes rough-and-tumble world of law enforcement. It is therefore refreshing to have this medical-diagnostic perspective in the form of Kathleen Decker's Fit, Unfit, or Misfit? How to Perform Fitness for Duty Evaluations in Law Enforcement Professionals. Not surprisingly, her descriptions of the common reasons for psychological unfitness tend to follow traditional diagnostic categories, which are sometimes overlooked by many psychologists who do these evaluations. Additionally, the author demonstrates a solid understanding of the uses and limits of many of the psychological tests commonly employed

in FFD evaluations which is an all-too-rare knowledge base for many psychiatrists who generally rely on psychologists to carry out and interpret the testing.

But the area in which the author's unique psychiatric perspective and experience makes its distinct contribution is in her discussion of the use of medication. She emphasizes the important point that many officers with diagnosed psychiatric conditions or syndromes that have been impairing their performance may be able to return to duty if properly treated. This probably will more likely be true in the case of a "sad cop" with a fluctuating mood disorder than with a "bad cop" with a longstanding narcissistic or antisocial personality disorder, but one of the vital recommendations that a competent FFD report should contain – a point also emphasized in Rostow and Davis' book – relates to what measures, if any, will restore this officer to fitness.

In my experience, the two main miscarriages of the FFD referral process involve: (1) improperly referring an officer for a psychological FFD evaluation in order to sidestep what should be an administrative disciplinary procedure (the "section-8" dodge); or (2) prematurely discharging an officer with a treatable psychological condition before determining if proper medication and psychotherapy could return him or her to fit duty (the "diagnose-and-dump" routine). Both of the books reviewed here encourage evaluators to avoid these traps by being sensitive to the cultural and political climate of the agencies they serve.

Decker also addresses the common barriers that keep law enforcement and mental health professionals from collaborating more effectively, but in attempting to cover too many topics in one book, some which appear peripheral to the main subject of FFDs, the result is that many of these topics receive only cursory coverage – e.g. gender and ethnic issues in policing, line-of-duty death, and police officer suicide. In addition, for all the emphasis on diagnosis and treatment, the book gives surprisingly short shrift to the topic of how to actually manage unfit officers. Readers are thus encouraged to seek more comprehensive sources of information on these topics.

Nevertheless, both of these books are valuable additions to the police psychologist's bookshelf, as each contains information that supplements the minimal shortcomings of the other, and they offer overlapping and complementary perspectives on the provision of law enforcement mental health services. Mental health clinicians who perform FFDE's

are tasked with making sensitive assessments and recommendations that will profoundly affect the lives and careers of law enforcement professionals and that will, in turn, have implications for the safety of countless citizens – don't we need all the good information we can get?

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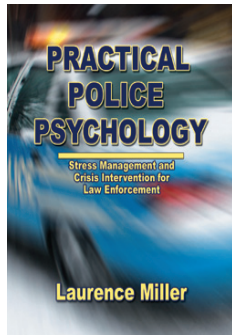
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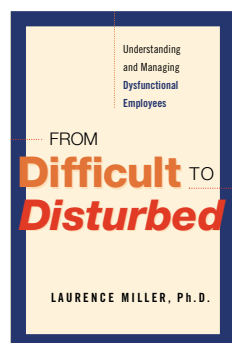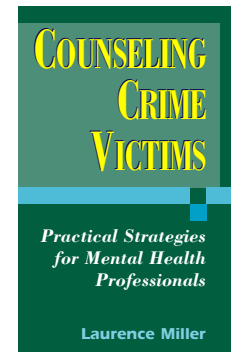
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