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INTERNATIONAL JOURNAL OF EMERGENCY MENTAL HEALTH

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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:

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Fostering
Human Resilience

George S. Everly, Jr., PhD, ABPP

The promotion of human resiliency represents a relatively new approach to dealing with mental health issues associated with crisis and disaster. It is generally accepted that psychological casualties invariably far exceed physical casualties in the wake of disaster, thus reliance upon traditional mental health resources to address such needs seems inadequate. General hesitance to seek such services, even when available, compounds the problem. Finally, there is evidence that public health and emergency response resources will be available in lower numbers than expected, at all levels within the system and throughout the continuum of care. A new approach is needed. That approach, we argue, must be a system based upon the promotion of human resilience.

Resilience is typically defined as the ability to withstand, adapt to, or rebound from challenges and adversity. This brief treatise is offered as a simple primer for any and all personnel who are likely to respond to, or in the wake of, crisis and disaster.

The reader will be introduced to three mechanisms designed to enhance resiliency:

- Psychological Body Armor - promoting personal resilience;
- Psychological First Aid (PFA) – promoting resilience in other individuals;
- Resilient Leadership – promoting resilience in groups;
- Critical Incident Stress Management – a systems approach to resiliency; and
- Pastoral Crisis Intervention – harnessing the power of the Faith Community

This book is especially directed to first responders, first receivers, public health and safety, and military personnel. It is designed to be a quick, practical, and informative guide to human resiliency in the wake of crisis and disaster.

Safety and the Violent Person:
Guidelines for Emergency Services

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Abstract: *Emergency service providers (EMS), police, health-care providers, counselors, and other helping professionals are at times called upon to provide services to violent or potentially violent individuals. Providing these services safely can be enhanced with six general guidelines that can be implemented to reduce the risk of violence or contain what violence may have already erupted. Thinking about medical/ psychiatric illnesses, call log information, scene surveillance, old brain stem functioning, early warning signs of loss of control, and the theories of violence may provide strategies to enhance both the safety and quality of services provided in these difficult situations. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 151-156]*

Key words: *emergency services, healthcare providers, risk management guidelines, safety, violent person*

Your beeper summons you to your emergency room to assess a drunken gang member. Are you safe as you enter the room? You are about to arrest an unknown suspect in a crime-ridden neighborhood. Have you conducted a scene surveillance? You are providing outreach to a family well-known for domestic violence. Are you safe as you ring the doorbell? You are a pastoral counselor working with youth. Are you in harm's way as you walk the streets? As you provide disaster relief services, do depressed and angry families present a risk of harm?

Recent years have seen increases in the levels of violence in our society (Flannery, 2012); emergency services

personnel (EMS), health care providers, counselors, and other helping professionals have not been exempt from this trend. Frequently, service providers are asked to provide assistance to patients, clients, or suspects who are violent or potentially violent when the needed services are being provided. Theses behavioral emergencies are high-risk critical incidents for service providers, service recipients, and near-by recipient friends and relatives, as well as innocent bystanders. Ensuring the safety of all concerned is of paramount importance.

Behavioral emergencies are defined as critical incidents in which the patient's, client's, or suspect's medical and/or psychiatric illness(s) by its inherent nature also poses the risk of imminent harm (Flannery, 2009). Common examples might include the intoxicated person who is badly cut and in need of sutures or the person with paranoid schizophrenia who is experiencing auditory hallucinations to harm others. Indeed, there is a robust medical and behavioral science literature documenting such behavioral emergencies. For

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more than forty years, the health care literature has documented the physical, sexual, nonverbal, and verbal assaultive violence directed at staff providers (American Academy of Orthopaedic Surgeons, Polk, & Mitchell, 2009; Flannery, Farley, Tierney & Walker, 2011). A similar literature has documented assaultive violence on EMS (Grange & Corbett, 2002; Mechem, Dickinson, Shofer, & Jaslow, 2002). A third literature records the many types of violent behaviors that police encounter (Miller, 2009; National Law Enforcement Officers Memorial Fund, 2009).

The purpose of the present paper is to outline six general risk management strategies to enhance safety and reduce the risk of harm when providing services to violent or potentially violent patients, clients, or suspects. This paper assumes that you have been properly trained in your specific professional discipline and that you will obtain any further needed training raised by the risk management strategies presented here. If you work with a partner(s), be sure that you are all in agreement about how you will implement any of the risk management strategies noted herein.

General Risk Management Strategies for Safety

1. Think Medical or Psychiatric Illness

Requests for behavioral emergency services usually are activated by a telephone call or some form of electronic text message. The request usually notes the site of the disturbance and some basic information about its nature. Often, this brief encounter will include some statement about any medical or psychiatric problem that may be involved. Since some medical and psychiatric illnesses are known to be associated with violence, bearing in mind the potential medical risk inherent in the call can serve to heighten the possible risk of harm and allow the responder in transit to begin to plan strategies for safety before arriving onsite. Common medical illnesses associated with the potential for violence include delirium, glycemic conditions, hypoxia, intracranial bleeding, Parkinson's Disease, porphyia, and thyroid conditions. Common psychiatric illnesses associated with potential violence include conduct disorder, domestic violence, psychological trauma, serious mental illness, substance abuse, and youth violence [See Flannery (2009) for a more complete listing.] As you arrive onsite, first and foremost, ask yourself if the medical/psychiatric condition that you are responding to contains the risk of potential violence.

2. Think Call Log or Admitting Chart

One does not usually consider the call log or the patient's admitting chart as a safety tool. However, if they are properly constructed and gather basic, essential information for enhanced service delivery, they can be utilized to enhance safety as well. The call log or chart may identify clients or suspects seen before. If properly constructed, it could provide information on the characteristics of the service recipient, the nature of previous incidents, and any previous acts of violence and their nature, as well as the time of the incident(s). This last category of information is important. Although violent events appear random, medical and behavioral science is learning that many apparent random acts of violence in fact have specific temporal patterns (Flannery, 2009; Grange & Corbett, 2002). Service providers are not at a constant risk of violence during the work day. Certain times present greater risk depending on the nature of the call. Depending on the type of violent incident for which assistance has been requested, the data base from a thorough log can indicate the general temporal time frame for the incident at hand and whether this particular service victim has been violent in the past at this time of the day. In today's computer age, the development of software to track the characteristics of patients, clients, or suspects is easily created and such knowledge can greatly enhance the development of appropriate risk management strategies for safety before the response team arrives onsite.

3. Think Scene Surveillance

Scene surveillance refers to a thorough analysis of the site to which the team has been called before the team hastens to provide needed services. Police are usually well-trained in scene surveillance but other service providers are usually not.

Ask yourself a basic question as you arrive onsite: Am I safe here? Before you exit your vehicle, scan the street for any citizens. Can you plausibly explain why they are there? Are any crying or angry? Does anyone have a weapon or potential weapon (e.g., baseball bat, glass beer bottle)? Scan behind trees, light posts, mailboxes. Scan balconies, porches, any open windows. If it seems safe and the victim is in the street, utilize a "care and cover" approach where one member of the team provides the needed medical/psychiatric care, while the other continues to monitor the scene. If the victim is in the home, approach the front door from the sides of the house. Listen for voices. How many? How angry? Without standing in front of the door, throw it wide open from the side. If no violence follows, enter quickly and again survey

the scene inside the house as you did outdoors. It is also wise to employ a "care and cover" approach inside as well. One can learn scene surveillance in consultations with local and state police or from companies who provide such training. Clearly, scene surveillance is a helpful risk management strategy for safety and is ignored at one's peril.

4. Think Old Brain Stem

In the human brain, the cortex is for rational thinking, problem solving, and implementing strategies to solve problems and conflicts. A second major component of the brain is the limbic system where feeling states are first registered and identified before being sent to the cortex for evaluation and problem solving. Feelings of anxiety, depression, anger, and fear, as well as calmness, joy, and peace all register in the limbic system. The third major component of the brain is the old brain stem. It is the seat of all of our vital functions for staying alive, such as breathing, sleeping, or feeling hungry. It is also the site of much of our instinctual behavior, including the fight or flight response for survival. Sometimes, when an individual is in a state of extreme stress or anger, the cortex's functioning is reduced and the person is driven by old brain stem functioning (Creedon, 2005). In such cases, reasoning with the patient, client, or suspect will not work as effectively, because they are largely being driven by instinctual behaviors. In such cases, if it is at all possible medically and/or legally, stop and wait. Give the individual time to calm down. Gradually, cortex reasoning will reassert itself and any needed services that are to be provided will be done in an environment where the risk of violence has been greatly reduced.

5. Think Early Warning Signs

Unless the service recipient is totally out-of-control as you arrive onsite, a recipient, even in tenuous and fragile control, will likely demonstrate early warning signs of potential loss of control and violence. An awareness of these early warning signs may permit the service provider time and strategies to defuse the potential violence and then provide any needed services safely for all concerned.

There are three groupings of early warning signs: medical illness, appearance, behaviors. The first grouping is medical illnesses associated with violence, as we discussed in the first guideline. Even if the person is in control at the moment, illnesses associated with violence can change that in an instant. The patient's admitting chart, school records, and past encounters with policing agencies may all contain information about high-risk medical or psychiatric illnesses.

The second grouping of warning signs refers to the individual's appearance. Is the service recipient's dress and appearance appropriate for the context? Is hair combed? Is any make-up applied properly? Assess for tense facial expressions for possible anger or fear. Assessed glazed eyes for possible drug or alcohol abuse. Inappropriate use of dark sunglasses may indicate substance abuse or paranoia. Similarly, long sleeves in hot weather may suggest intravenous drug use.

The third grouping of warning signs is that of certain behaviors. Here one would watch for signs of severe behavioral agitation, such as relentless pacing, pounding of fists, or kicking of inanimate objects. Verbal hostility and verbal argumentativeness are also signs of someone in tenuous control. Verbal threats to specific persons and any threats of weapons should always be taken seriously. A general rule of thumb for early warning signs is the more the warning signs, the greater the likelihood of violence, if steps are not taken to reduce the risk and enhance safety.

6. Think Theories of Violence

The sixth general guideline for safety in reducing the risk of violence comes from the large body of data that medicine, behavioral science, and criminology has to teach us about why individuals become violent. This information may be grouped into four differing theories of violence: cultural, biological, sociological, and psychological.

Cultural theory. Cultural theories look at society at large in their attempts to understand major trends. One of the more helpful cultural theories for understanding violence is the theory of anomie by Emile Durkheim (1997). Durkheim noted that every society has five major institutions that set the rules for acceptable behaviors for both adults and children. When these several institutions agree on rules and values, the citizens of the society known how to behave and a sense of community and cohesion follow. If there is a major upheaval in a society, these five basic institutions are themselves impacted, undergo major change, and may not be in agreement on the rules for sometime. Without the rules, citizens do not know what is expected of them and the sense of concern for others and community cohesion is lost.

Durkheim refers to these upheavals as periods of anomie. In anomic periods, mental illness, suicide, substance abuse, and violence all increase dramatically.

The United States today is experiencing one of these major societal shifts as we move from our industrial state where we manufactured goods and services, to the knowledge-based, computer and technology driven post-industrial state with its emphasis on computer-generated knowledge in a global economic, competitive environment. The Protestant Work Ethic value of the industrial state with its emphasis on hard work, self-denial, and concern for others has evolved into the post-industrial values of the self first, material acquisition, and instant gratification (Flannery, 2012). These latter values create an atmosphere where anomic violence of many types may erupt.

Biological theory. To date, there is no evidence to indicate that violence is genetic. However, medicine has established that injuries to the cortex or limbic system may result in violent acts in some cases. Moreover, violence has been associated with the medical and psychiatric illnesses noted in the first guideline. Persons with these illnesses are not held to be responsible for their violent behavior unless the individuals knew before hand that violence could ensue (e.g. substance abuse, noncompliance with effective medications to treat the illness). Although biological theories are relevant in some acts of violence, they could in no way account for the extent of the violence present in today's society.

Sociological theory. The sociological roots of violence receive extensive medial coverage, are widely understood, and thus will be addressed briefly here. Extensive research has focused on poverty, inadequate schooling, discrimination, domestic violence, substance abuse, easily available weapons, and the media. Clearly, not everyone with one or more of the sociological factors associated with violence becomes violent. However, some common examples of violence associated with these sociological links could include armed robbery that is associated with poverty, shootings or fist-fights rather than verbal conflict resolutions as a result of inadequate schooling, motor vehicle fatalities associated with substance abuse, and the like. It should also be noted that each of these sociological factors isolates individuals from one another. This absence of attachments or bonds to others further exacerbates the anomic lack of social cohesion and community.

Psychological theory. The psychological theories cover two domains: mastery skills and motivational states. Reasonable mastery skills include skills for personal self-care, such as time and money management, nutrition and exercise, and self comforting in times of stress. Mastery skills also include interpersonal skills such as sharing, empathy for others, and verbal conflict resolution skills. Finally, mastery skills include basic academic and computer skills, so that the individual is capable of contributing to society and earning a living. Individuals without these necessary skills may resort to violence to solve conflicts in the absence of more pro-social skills.

Repeated conflicts that are attempted to be solved by violence may in time lead the individual away from pro-social values to antisocial values. Some common antisocial motivations include catharsis by anger, dominance of others, enforcement of personal sense of justice, jealousy, revenge, selfishness, and the like.

These four theories of violence can provide service providers with a better understanding of the situation to which they have been summoned. An understanding of what may be the source(s) of the violence or potential violence may lead the service provider to understand the matter more clearly and develop more specific strategies to enhance safety onsite. For example, a victim of discrimination who is immediately accepted by the service providers as an equal human being may calm down quickly, where as an angry/verbal, unschooled poor youth may need more clear limit setting.

Assisting troubled individuals who are violent or potentially violent provides a needed service to the trouble individual, the immediate family, neighbors, and the community at large. Police, fire, EMS, health care providers, social workers, pastoral counselors, community outreach workers, and others provide such services quietly and effectively. Notwithstanding, how skilled they may be, violence always lurks in the background.

The six general guidelines outlined here for EMS and service providers and their managers are based on sound scientific research, are easily remembered, and may be implemented at little or no cost. Of further interest may be the specific safety guidelines for the commonly encountered situations involving psychological trauma, domestic violence, substance abuse, and youth violence. These specific guidelines may be found in Flannery (2009).

Helping troubled individuals is noble work. Safety is not optional.

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Police Suicide in Small Departments: A Comparative Analysis

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Abstract: *The majority of police suicide research has focused on larger police departments. Very little research has been done within small departments. The present study compared suicide rates between small and larger police departments. Two Hundred ninety-eight departments were drawn from the U.S. Public Safety Officer Benefits database totaling 119,624 officers. Annual suicide rates were calculated per 100,000 for each of four category (by size of department) and p-values from Chi-square tests were employed to assess differences in rates across categories. The annual suicide rate varied significantly across departments. Smaller police departments had a significantly higher suicide rate than large departments. Possible reasons include lack of availability for mental health assistance, increased workload and danger, and community visibility. [International Jounal of Emergency Mental Health, 2012, 14(3), pp. 157-162]*

Key words: *police, suicide, organizational size*

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Epidemiological evidence suggests an elevated rate of suicide within law enforcement (Violanti, Vena & Petralia, 1998; Forastiere, Perucci, Dipietro, Miclei, Rapiti, Bargagli, et al, 1994; Gershon, Lin & Li, 2002; Cantor, Tyman & Slater, 1999; Charbonneau, 2000; Hartwig & Violanti, 1999; Violanti, Fekedulegn, Charles, Andrew, Hartley, Mnatsakanova & Burchfiel, 2008; O'Hara & Violanti, 2009). A meta-analysis by Aamodt and Stalnaker (2001) suggests that the annual suicide rate of 18.1/100,000 for law enforcement personnel is higher than the 11.4/100,000 in the U.S. general population.

Because suicide is a relatively rare event, the majority of previous studies of police officer suicide have focused on larger police departments. Very little research has been done within small departments, where 49% of police departments in the U.S. employ fewer than 10 full time officers (Reaves, 2011). According to Lindsey and Kelly (2004), small town police officers face danger without the benefit of immediate backup that is available in larger jurisdictions. Often small town police officers may be the only officer on duty during any given shift. Lindsay and Kelly (2004) add that officers and their families in small towns come under close scrutiny because the majority of citizens in their jurisdiction know them. In turn, officers may have personal identification with persons involved in traumatic incidents or serious crimes that occur in their town, leading to an intensification of psychological after-effects.

The strain of being a small town police officer is reflected in attrition rates. Yearwood and Freeman (2004) found that larger police agencies reported an average attrition rate of 10.2 percent while their smaller counterparts report an attrition rate almost twice as high at 18.2 percent. Data gathered from 24 small departments showed that at least 30 officers switched to another force in the area in the past five years. Of those who transferred, 15 months was the average amount of time they spent at one department.

A rare quantitative analysis of police suicide in small jurisdictions was conducted by Campion (2001). The average number of police officers in these departments was 39. Eighty-nine of 150 (60%) police organizations surveyed responded involving 3,736 officers. Nine of the 89 departments reported suicides. One hundred percent of the suicides were committed off duty with a firearm. Sixty-four percent of the victims showed no notable indication that they intended to commit suicide. Forty-five percent were patrol officers, 18% were field officers and 9% were investigators.

It is evident that there is a lack of empirical research regarding suicide in small departments. In addition, no study to our knowledge has compared suicide rates between varying sized police departments. Utilizing data obtained from 298 police departments (PDs), the present study compared suicide rates between four different size categories of police departments: smallest, small, medium, and large.

METHODS

Two hundred and ninety eight police departments were randomly drawn from the U.S. Department of Justice Public Safety Officer Benefits database, Washington, DC. These 298 police departments had experienced officer deaths within the last ten years. The response rate was 100%. Through questionnaires, each department was asked to provide data on the reported number of suicides that occurred over the past ten years for on-duty, off-duty, and retired police officers. Additional information on the location (at worksite vs. away from worksite) and the method used (firearm, knife, hanging or asphyxiation) was available. However, the information on the location and method used was aggregated for each PD and therefore could not be linked to an individual suicide. The total number of police officers in these departments (n = 119,624) was used to create four categories of police department (PD) size: 1) smallest, ≤50 officers; 2) small, 51-200 officers; 3) medium, 201-500 officers; and 4) large, 501-6,500 officers. Annual suicide rates were calculated per 100,000 officers for each PD size category and p-values from Chi-square tests were determined to assess whether the rates were statistically different across these PD size categories. Six pairwise comparisons between the PD size categories were made using Chi-square tests; p-values were multiplied by six to adjust for multiple comparisons using the Bonferroni correction.

RESULTS

Of the 298 police departments, 86 (29%) reported one or more suicides in the past ten years. A total of 189 suicides were reported. Of the 85 PDs who reported information on the location of the suicides, 89% reported that the suicides occurred away from the worksite compared to 11% which occurred at the worksite (Table 1). Of the 81 PDs who reported the method of suicide, firearms were the most frequently reported method (91.4%); other methods included knives, hangings, asphyxiation, drug overdose and automobile (Table 2).

Of the 189 total suicides, 155 (84.7%) were committed by police officers who were employed at the time (10 of these were on-duty suicides (5.5%), 145 were off-duty suicides (79.2%), and 28 (15.3%) were committed by retired police officers. PD size was not reported for six additional off-duty suicides and these suicides were excluded from the analyses.

Annual suicide rates per 100,000 officers were calculated for each PD size category. The overall annual suicide rate was 15.3 per 100,000 officers (Table 3). The annual suicide rate varied significantly across the PD size categories:

Table 1. Location of Suicide as Reported by Police Departments*		
	Number of Police Departments	Percents
At worksite	9	10.59
Away from worksite	76	89.41
*1 Police Department did not report where the suicide(s) occurred.		

Table 2. Method of Suicide as Reported by Police Departments*		
	Number of Police Departments	Percents
Firearm	74	91.36
Other	7	8.64
*5 Police Departments did not report the method used to commit the suicides.		

43.78/100,000 for officers in the smallest PDs (≤50 officers), 13.67/100,000 for officers in the small PDs (51-200 officers), 26.39/100,000 for officers in the medium PDs (201-500 officers), and 12.46/100,000 for officers in the largest PDs (501-6,500 officers). More specifically, PDs that were smallest (≤50 officers) had significantly higher suicide rates than those classified as small (51-200 officers; $p = 0.028$) and large (501-6,500 officers; $p < 0.0001$).

DISCUSSION

Our results suggest that smaller police departments have a reported higher annual suicide rate than larger departments. A significant difference in the annual suicide rate across department size categories was found. The annual suicide rate for all departments of 15.3/100,000 officers was above the U.S. general population suicide rate of 11/100,000, with the smallest department rate being approximately four times the national rate (43.78/100,000). These results were somewhat surprising, as there is a general consensus that small departments have a sense of teamwork and a stronger sense of personal identity. Size also appears to have a motivating

effect (Moates & Kulonda, 1990). These group characteristics would seem to be more protective against suicide, lending to cohesiveness and support in times of stress and trauma (Hogg, 1992.)

Other results in the present study appear to be consistent with previous research. First, retired officers were less likely to commit suicide than currently employed officers (15.3% vs. 84.7%). In general, police officers are more likely to commit suicide while still working. Violanti and colleagues (1998) found the highest risk for suicide centered on 15-20 years of police service just prior to retirement, indicating a period of high anxiety over decisions to remain in police work or retire. Violanti (1983) found that officers in the 12-20 year career category had the highest stress scores, identifying this period as the "disenchantment" stage of police work. Hartley, Violanti, Fekedulegn, Andrew, and Burchfiel (2007) found that officers in this police service range had higher negative life event and depression scores than younger officers. Second, the proportion of off-duty suicides was much higher than on-duty suicides. Violanti (1996), in a comparison of five police departments, found that an average of 64% of suicides occurred away from the department. Campion (2001) found

Table 3. Annual Reported Suicide Rate by Police Department Size				
Department Size	Number of Departments	Number of Officers at Risk	Total Number of Suicides	Annual Suicide Rate*
≤ 50	88	2,284	10	43.78
51-200	74	8,046	11	13.67
201-500	55	18,568	49	26.39
501-6,500	66	90,726	113	12.46
Total	283	119,624	183	15.30
p-value**				< 0.0001

*Annual suicide rates are reported per 100,000 police officers..
**p-value is from chi-square test.

that 100% of suicides committed by officers in small PDs occurred while off-duty. Finally, concerning the method of suicide, the present study found that approximately 91% of officers used a firearm. Similar results have also been found in previous work (Violanti, 1996; Cronin, 1982; Danto, 1978; Campion, 2001).

Exploring Reasons for Small Department Police Suicide

A more challenging question is why small departments may have higher annual suicide rates than larger departments. There are several possible explanations to explore. First, there is likely a lack of availability for mental health assistance or peer support programs in smaller departments due to inadequate budgets. Geographic conditions may also play a part; many small departments are rural and cover wide jurisdictions where mental health services are limited. A national study conducted by Mental Health America (MHA) found that states with more psychiatrists, psychologists, and social workers per capita had lower suicide rates. The study also found that in states with more generous mental health parity coverage a greater proportion of the population received mental health services (Mental Health America, 2008). Larger departments have a better opportunity to establish internal programs such as Employee Assistance Programs (EAPs) or peer support programs should officers need confidential help for stress or trauma. Small departments may not have

this luxury, and may depend on outside sources to deal with officers experiencing difficulty. Officers are less likely to use outside sources because of confidentiality concerns.

Secondly, the workload in small departments may be more intensive than large departments. In some small departments, there may be only one or two officers on duty per shift. Those officers are responsible for handling all police calls, accidents, burglaries, or homicides for the entire jurisdiction. Small departments require their personnel to be more generalized in their knowledge and skills. Large departments are more decentralized and have specialized investigation units to handle different types of crimes such as sexual offenses, homicides, and traffic. In small towns, officers may have personal identification with individuals involved in traumatic incidents or serious crimes that occur in their town, leading to an intensification of psychological after-effects (Lindsay & Kelly, 2004). Work overload associated with such situations can lead to undue stress and trauma straining the officer's ability to cope effectively. The danger of working alone is also increased in small departments. Since there are fewer officers available, backups may not be possible, or if backup is available it may come from another agency some distance away. This can place added stress on small town officers.

Third, there is lack of anonymity in small town departments. Since there are so few officers in the department, they are well known throughout the jurisdiction and under community scrutiny. Unlike large departments where officers

are not known by the community when they leave work, small town police are identified as officers whether on- or off-duty. Such visibility can not only affect the officer's psychological well-being in terms of "getting away" from police work, but also his or her family. Additionally, peers in the department will be aware of any errors or disciplinary problems that occur among officers in small departments. This may lead to isolation and undue scrutiny by peers.

Fourth, due to budget limitations small police departments may lack training and intervention programs for officers in crisis. Most of the emphasis in training is placed on operational aspects of policing with very little funding available for wellness and psychological care (Violanti, 1996). If small police departments are to seriously address the issue of police suicide, they should consider adopting programs that larger departments find effective in reducing suicide and trauma in officers.

There are limitations to the present study. Due to confidentiality concerns, we were unable to obtain demographic information on individual suicides such as gender, age, and life circumstances. Secondly, suicides may be underreported. Suicide counts were based on recollections of chiefs and higher order personnel who were in the department for at least ten years. It is possible that difficulty recalling all suicides led to some underreporting and this could have occurred to a slightly greater extent in the larger departments.

The advantages of the present study are that it is the first quantitative comparison of small and larger police department suicides, and the study involves a national sample with a relatively large number of departments (n = 298) and police officers (n = 119,624). Further research is necessary to help clarify reasons for higher suicide rates in small police departments. Since the majority of departments in the U.S. are small, it becomes imperative that this problem be considered. Additionally, due the paucity of research on small departments, it is necessary that we explore further why such tragedies occur in these departments and how they may be best prevented.

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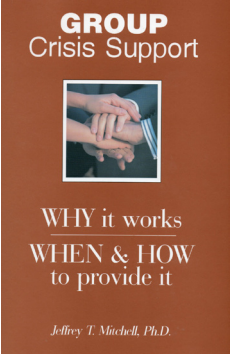
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The Effects of Mortality Salience and Conceptual Focus in CISM Providers: Implications for Mental Health Response to Mass Fatality Disasters

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Abstract: *On the basis of terror management theory (TMT) and cognitive-experiential self-theory (CEST), research has demonstrated that when individuals are experientially (rather than rationally) focused, mortality salience (MS) can engender worldview defense in the form of increased in-group bias, increased favoritism toward others who uphold cultural values, and greater derogation of those who threaten them. The goal of the present study was to replicate previously observed effects of mortality salience on worldview defense in a sample of disaster responders, specifically Critical Incident Stress Management (CISM) providers, and to examine the potential moderating effect of conceptual mode (rational versus experiential) on these effects. Sixty-two participants at the International Critical Incident Stress Foundation's 2011 World Congress were selected for participation in the study. Subsequent manipulation checks revealed that neither manipulation (mortality salience: MS versus non-MS or conceptual mode: rational versus experiential) was effective. This failure is discussed in terms of the potentially mortality salient nature of conference proceedings that preceded data collection, the depletion of self-control resources required to maintain a rational focus on conference presentations, participants' need to maintain their focus during future conference presentations, and profession-related practice effects that may have made it easier for some participants to maintain a rational focus. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 163-174].*

Key words: *mortality salience; terror management; cognitive-experiential self-theory; self-control resources; critical incident stress management; CISM providers*

Shortly after the terrorist attacks of September 11th, 2001, the American Psychological Association asked Pyszczynski, Solomon, and Greenberg "to write a book using terror management theory (TMT) to shed light on the 9/11 terrorist attacks on the World Trade Center and Pentagon" (Pyszczynski, Solomon, & Greenberg, 2002, p. ix). In doing so, they applied their theory to the reactions of the American public to the events surrounding the attacks (e.g., the surge in patriotism) as well as to the terrorists' acts. This was the first and, to date, the only known attempt to apply TMT to people's responses to a mass fatality disaster. Pyszczynski et al., however, did not consider the implications of their theory for those who worked the disaster sites during the rescue and recovery effort. This was unfortunate as the theory can potentially be used to understand responders' behavior

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and cognitions under conditions that are very likely to make them aware of their own mortality (i.e., *mortality salient*). Specifically, TMT would posit that mortality salient CISM providers would exhibit what terror management theorists have termed *worldview defense*: behaviors that include increased derogation of others who threaten their worldviews, more favorable responses toward those who uphold their worldviews (Greenberg et al., 1990; Greenberg, Simon, Pyszczynski, Solomon, & Chatel, 1992; Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989), and increased in-group bias (Castano, 2004; Harmon-Jones, Greenberg, Solomon, & Simon, 1996; Nelson, Moore, Olivetti, & Tippony, 1997; Ochsmann & Mathy, 2003).

Drawing on cognitive-experiential self-theory (CEST), Simon and her colleagues (1997) found that worldview defense was eliminated when their participants maintained a rational conceptual focus as opposed to an experiential (feeling-based) one. The experiential mode is important within TMT because it is the system within which "people's personal theories of reality reside—theories that automatically interpret, encode, and organize experience and direct behavior" (Epstein, Lipson, Holstein, & Huh, 1992, p. 328). It is also the least effortful and most efficient of the two conceptual modes and, thus, is dominant in most situations. While the experiential mode is associated with feelings, the rational mode is associated with intellect. It is relatively free of affect (Epstein, 1994) and is activated when environment cues suggest the need for rational analysis (Simon et al., 1997). For CISM providers (and other disaster responders), the ability to maintain a rational focus will likely mitigate the effects of MS during disaster responses.

The goal of the present quantitative quasi-experimental study was to replicate the previously observed effects of MS on worldview defense in a sample of 76 CISM providers who attended the International Critical Incident Stress Foundation's World Congress held in Baltimore, MD in February of 2011. A secondary goal was to examine the potential moderating effect of participants' conceptual mode (rational versus experiential) on worldview defense. It was hypothesized 1) that the mean level of worldview defense in mortality salient CISM providers would be statistically significantly higher than the mean level of worldview defense in non-MS CISM providers, 2) that the mean level of worldview defense in CISM providers instructed to respond experientially would be statistically significantly higher than the mean level of worldview defense in CISM providers instructed to respond

rationally, and 3) that there would be a statistically significant interaction between mortality salience (MS versus non-MS) and conceptual focus (experiential versus rational) when measuring worldview defense in CISM providers.

METHOD

Participants

An *a priori* (ANOVA: Fixed effects, omnibus, one-way) power analysis was conducted using the G*Power software (version 3.0.10; Faul, Erdfelder, Lang, & Buchner, 2007) to determine the appropriate sample size for this study. The International Critical Incident Stress Foundation (ICISF) agreed to permit data collection at their World Congress in February of 2011. The conference is typically attended by approximately 1,000 participants who are CISM providers for a wide variety of responder populations. Thus, assuming a large effect size, a minimum sample size of seventy-six study participants was sought for this study.

The opportunity to participate in the research study was announced in the Foundation's conference brochure. As an enticement, each participant who completed the study was eligible to participate in a raffle and had an equal chance of winning a prize. Because the conference brochure could not accommodate the participant invitation letter, it was made available on the ICISF website (http://www.icisf.org) and a link to it was also provided in the Foundation's advertising. Those participants who indicated on their registration form that they would like to participate in the study received a "Thank You for Participating" letter and a study admission ticket in their registration packet. Once turned in, the admission ticket was entered into the raffle to be held immediately after the data collection and participant debriefing had been completed. Raffle items included an iPad, a wireless mouse, a portable power strip, and 10 Starbucks cards (valued at five dollars each; for an approximate total value of $650.00). To avoid conference attendees agreeing to participate but leaving after turning in their ticket, only those participants who completed the study and were present for the raffle were eligible for the prizes. To facilitate data collection within the time period allocated for the lunch period, a bag lunch was also provided free-of-charge to participants.

Measures

All participants completed a questionnaire packet (see Table 1) that included two filler questionnaires, the experien-

Table 1. Packet Construction			
MS/Experiential	MS/Rational	Non-MS/ Experiential	Non-MS/ Rational
Filler Measures Experiential Instructions	Filler Measures Rational Instructions	Filler Measures Experiential Instructions	Filler Measures Rational Instructions
MS Prime	MS Prime	Dental Salience (non-MS) Prime	Dental Salience (non-MS) Prime
PANAS-X	PANAS-X	PANAS-X	PANAS-X
Sleep Patterns Questionnaire	Sleep Patterns Questionnaire	Sleep Patterns Questionnaire	Sleep Patterns Questionnaire
Experiential Instructions	Rational Instructions	Experiential Instructions	Rational Instructions
Worldview Defense Measure	Worldview Defense Measure	Worldview Defense Measure	Worldview Defense Measure
Demographic Questionnaire with Suspicion Probe	Demographic Questionnaire with Suspicion Probe	Demographic Questionnaire with Suspicion Probe	Demographic Questionnaire with Suspicion Probe

tial or rational instructions manipulation, the MS manipulation, the PANAS-X (Watson & Clark, 1994), a third filler questionnaire (the sleep patterns questionnaire), a repeat of the instruction manipulation, a worldview defense measure, and a demographic questionnaire that included a probe for suspicion.

Filler measures. A cover story was used to obscure the true purpose of this study so that the non-mortality salient participants would not be made mortality salient by a more accurate description of it. Participants were told that "The purpose of this study is to examine the personality characteristics that go together in providers of CISM services." To support this cover story, participants completed Rosenberg's Self-Esteem Scale (Rosenberg, 1965), a modified version of the IPIP Personality Scale constructed using items from the International Personality Item Pool website (see http://ipip.ori.org; Goldberg et al., 2006), and the Sleep Patterns Questionnaire (constructed and included after the PANAS-X for the purpose of supporting the cover story and providing an additional delay prior to measuring worldview defense).

Mortality Salience Manipulation. To manipulate MS, participants in the mortality salient groups were asked "to write a few sentences about what they think will happen to them when they physically die, and the emotions that the thought of their own death arouses in them" (Greenberg, Solomon, & Pyszczynski, 1997, p. 78). Those in the non-mortality salient groups were asked to answer similar questions focused on dental pain. Previously, dental pain has been successfully used by several investigators as a control manipulation (Arndt, Greenberg, & Cook, 2002; Fritsche, Jonas, & Fankhänel, 2008; Gailliot, Stillman, Schmeichel, Maner, & Plant, 2008; Goldenberg et al., 2001; Greenberg et al., 2003; Greenberg, Arndt, Schimel, Pyszczynski, & Solomon, 2001; Schmeichel & Martens, 2005).

The Positive and Negative Affect Scale—Expanded Form (PANAS-X). Although affect has repeatedly been excluded as a mediating variable in measuring the effects of MS, the use of a new population in the present study made it important to re-visit this possibility. Thus, the Positive and Negative Affect Scale—Expanded Version (PANAS-X; Watson & Clark, 1994) was used to measure affect. It has 60 items; and includes the two higher order scales of the original PANAS (Positive and Negative Affect; Watson, Clark, & Tellegen, 1988) and 11 lower order scales: fear, sadness,

guilt, hostility, self-assurance, attentiveness, joviality, serenity, surprise, fatigue, and shyness. Watson and Clark (1994) report that the internal consistency reliabilities for the two higher order scales are both high, "generally ranging from .83 to .90 for Positive Affect, and from .85 to .90 for Negative Affect" (p. 5). In addition, the correlation between these two scales "is generally low, typically ranging from -.05 to -.35" (p. 5). Their examination of the internal consistency of the 11 lower order subscales revealed that those with more items (five to eight) had higher reliability. Joviality was the most reliable (ranging from .88 to .94). Seven subscales had good reliability: fear, sadness, guilt, hostility, fatigue, self-assurance, and shyness. The remaining three subscales (attentiveness, serenity, and surprise) had slightly lower reliability coefficients. Watson and Clark suggest that these lower reliabilities "simply reflect the fact that they have relatively few items" (p. 13) and conclude that "the PANAS-X scales can be used to validly assess short-term, state affect" (p. 19). Having participants complete this measure also provided a delay and distraction after the MS manipulation (Greenberg, Pyszczynski, Solomon, Simon, & Breus, 1994).

Worldview Defense Measurement. In past research (e.g., Greenberg et al., 1994; Greenberg et al., 1992), worldview defense has been measured using participants' evaluations of two essays: one involving pro-American opinions and the other anti-American opinions. Similar essays made available on the TMT website (see http://tmt.missouri.edu/materials.html) for research purposes were used for this study. Spelling and grammatical errors designed into the anti-American essay were maintained. The order of presentation was randomized and counterbalanced across the study groups. Participants read each essay and then respond to five questions about the author using a 9-point Likert scale (where 1 indicates "not at all" and 9 indicated "totally"). The essay evaluation measures included three questions about the author: how much the participant likes the author, how intelligent the participant thinks the author is, and how knowledgeable the author was; two additional questions focused on each essay's content: how much the participant agrees with the author's opinion about America and how true the author's opinion of America is. As in past research, composite scores were calculated for participants' preference for the pro-American author by subtracting the mean of the three anti-American author items from the mean of the three pro-American author items. Similar composite scores for participants' preference for the pro-American essay were also calculated by subtracting the

mean for the anti-American essay items from the mean for the pro-American essay items.

Demographic Questionnaire. The demographic questionnaire asked participants to provide information that would be used for two purposes. First, due to the international nature of the ICISF World Congress, conference planners asked that participation be open to all those registering for the conference. Thus, screening of participants' appropriateness for this study was accomplished by including a question on the demographic questionnaire that asks whether or not they are a United States citizen. Those who were not were eliminated from the study after data collection. Due to random assignment of participants to the four study conditions, it was also expected that these individuals would be randomly distributed across the groups.

Four additional questions were used to describe the demographics of the study participants. Participants were asked to indicate their age, gender, the year that they took their first Basic Critical Incident Stress Management course, the number of CISM responses they have completed in the past 3 years, and their professional background.

Finally, due to the number of participants to be tested in a single session, it was impossible to track which participants (if any) were suspicious of the true nature of the study. Thus, to insure that any suspicious participants could be identified, an additional question was added to the demographic questionnaire that asked participants to describe their beliefs about the purpose of this study.

Experiential versus Rational Instructions. Based on Simon et al.'s (1997) findings that participants in an experiential mode (as opposed to a rational mode) experienced elevated death-thought accessibility and worldview defense, the second manipulation involved exposing participants to either experiential or rational instructions. As Simon et al. also found that a MS manipulation was only effective when participants were primed prior to both the MS manipulation and the measurement of worldview defense, these instructions were presented at both points in the study.

Participants in the experiential thought condition were instructed, prior to the MS/dental pain manipulation that

> *On the following page are two open-ended questions. Please respond to them with your first natural response. I am looking for people's gut-level reactions to these questions.*

After completing the PANAS-X, participants in the experiential thought condition read the following:

> The personality portion of the survey is over. Now, I would like you to complete a perceptual task. Research suggests that attitudes and perceptions about even very common everyday items may be related to basic personality characteristics. To further examine this idea, I would like you to complete the opinion questionnaires on the following two pages with your most natural response. Please follow the instructions provided and complete the questionnaires in the order they are presented. That is, do not skip around. Remember, I am looking for people's gut-level reactions to this task.

Similarly, participants in the rational thought condition were instructed, prior to the MS or dental pain manipulation, that

> On the following page are two open-ended questions. Please carefully consider your answers to them before responding. I would like you to be as rational and analytic as possible when considering your responses.

And, prior to completing the worldview defense measure, they were instructed that

> The personality portion of the survey is over. Now, I would like you to complete a perception task. Research suggests that attitudes and perceptions about even very common everyday items may be related to basic personality characteristics. To further examine this idea, I would like you to read the following two essays and complete the opinion questionnaires on the following pages with your most carefully thought out response. Please follow the instructions provided and complete the questionnaires in the order they are presented. That is, do not skip around. Remember to be careful and thorough in considering your responses.

Procedure

Assignment to Study Groups. Participants were randomly assigned to one of the four conditions in a 2 x 2 factorial design (see Table 2): MS/experiential, MS/rational, Non-MS/experiential, or Non-MS/rational groups. It was hypothesized that CISM providers will exhibit worldview defense after MS and that this effect will be heightened when they are in an experiential (rather than rational) mode of thinking.

Actual assignment to the study conditions was accomplished in two stages. First, the assignment to the MS/non-MS conditions, the rational and experiential conceptual focus conditions, and the counterbalancing order of the presentation of the essays were accomplished using two dice and those assignments were recorded on the data sheet. As the study packets were created, however, they were separated according to participant assignments to the MS/non-MS conditions. This procedure was necessary because participants were to be seated at round tables (with a maximum of 10 participants per table) and could observe their neighbors' responses. To prevent contamination of the non-MS condition, half of the tables were designated as MS and the other half as non-MS. Thus, randomization of participant assignments to the MS/non-MS conditions was dependent on where participants sat; however, preliminary inclusion of the MS/non-MS condition in the dice randomization process presumably would have insured that all participants had an equal chance of being assigned to any of the four study conditions.

Data Collection. Participants were tested in one large group at the International Critical Incident Stress Foundation's World Congress on February 26th, 2011. Upon entering the room, each participant's entry ticket was collected for the raffle held upon the conclusion of the study and the

Table 2. Participant Group Assignments			
		Level of Mortality Salience	
		Mortality Salient	Non-Mortality Salient
Conceptual Focus	Experiential	Group 1: MS/Experiential	Group 2: Non-MS/Experiential
	Rational	Group 3: MS/Rational	Group 4: Non-MS/Rational

debriefing process. Participants picked up their lunch and took their seat. They had 30 minutes to eat; and all but 2 or 3 were finished during this time period. While participants were eating, they were provided with an envelope containing all study materials. They were instructed to place the packet on the table in front of them and to wait for further instructions before removing any of the materials from it. Once all packets had been distributed and participants had had time to eat, the experimenter read from a script and instructed the participants to open their packets and place the contents on the table in front of them. Next, the experimenter instructed the participants to read through the consent form and, after having asked any questions they might have, to sign the form. All participants agreed to participate and signed their consent forms. To keep the names on the consent forms separate from the study packets, the signed consent forms were collected at this time.

During the first phase of the study, participants were asked to refrain from eating until after the timed writing task (MS manipulation) had been completed. They also were asked to complete all materials in order without flipping ahead or back to any other pages. At this time, they completed the two filler questionnaires that supported the cover story; and, when they were finished, they put down their pens and waited for the experimenter to start the timed writing exercise.

When all participants were ready, the experimenter read from the script to instruct participants on the timed writing task. They were told that once the writing task was concluded, they could continue with the remaining tasks at their own pace. They were also instructed that when they have completed all materials, they should place their materials into the provided envelope, seal it, and sit quietly while the others finish. When all participants had completed the study materials, all packets were collected and participants were fully debriefed. The raffle was held immediately after the debriefing.

RESULTS

Demographics

The initial sample included 82 conference participants. Nineteen were eliminated because they were not United States citizens. One additional participant was eliminated because that participant had no CISM training or experience prior to attending the World Congress. Approximately 65% of the final sample of 62 participants was female. They had an average age of 51 and a wide range of training and experience in providing Critical Incident Stress Management (CISM) services (see Table 3). In addition, these participants hailed from a wide variety of professional backgrounds, some of which are very likely to have a high incidence of critical incidents (see Table 4).

Manipulation Checks

In this study, there was one independent variable (mortality salience: MS versus non-MS) and one covariate (conceptual mode: rational versus experiential). Originally, the manipulation of MS was to be checked using an independent samples t-test. The t-test requires that three conditions be met: (a) that there be two simple random samples (SRSs) from populations that are *independent* of each other, (b) that both population be *normally distributed* or at least similar and without any outliers, and (c) that the variances for each sample be equal. While the samples of mortality salient and non-mortality salient CISM providers were independent of each other, an examination of each group's variance revealed that the distributions were too dissimilar to warrant use of the t-test. Therefore, the nonparametric Wilcoxon-Mann-Whitney test (see Tables 5 and 6) was used in place of the planned t-test.

The only manipulation check that approached significance occurred when using the WVD composite scores for the

Table 3. Participants' Age and Experience					
	N	Min.	Max.	Mean	SD
Age	61	31	72	51.30	10.08
Year of First CISM Training	62	1983	2011	1998.73	7.39
Time in Field (Years Since First Training)	62	0	28	12.27	7.39
Number of ICISF Trainings Completed	62	1	50	9.05	7.88
Number of CISM Responses in Past 3 Years	61	0	100	18.72	20.75

Table 4. Professional Background of Participants		
Professional Background	Frequency	Percentage
Chaplaincy	4	6.5
Employee Assistance Professional	3	4.8
Education	2	3.2
Fire	5	8.1
Law Enforcement	10	16.1
Medical Professions	8	12.9
Mental Health Professional	18	29.0
Military	7	11.3
Other	5	8.1
Total	62	100.0

Table 5. Mann-Whitney: Ranks				
Worldview Defense Measure	Mortality Salience Manipulation	N	Mean Rank	Sum of Ranks
WVD: Preference for pro-US Author	Mortality Salience	28	31.04	869.00
	Dental Pain	34	31.88	1084.00
	Total	62		
WVD: Preference for pro-US essay	Mortality Salience	28	26.68	747.00
	Dental Pain	34	35.47	1206.00
	Total	62		
Composite Preference for Pro-US Author & Essay	Mortality Salience	28	28.29	792.00
	Dental Pain	34	34.15	1161.00
	Total	62		

pro-US essay (questions 4 and 5); however, the test statistic indicated that the non-MS (dental pain) group demonstrated the higher preference rather than the mortality salient group. Unfortunately, this means that the MS manipulation was not successful.

To check the manipulation of conceptual mode, participants' essay responses to the MS manipulation were evaluated by three raters who rated the essays based on their assessment of whether they were predominantly thinking (rational) or feeling (experiential). Interrater reliability was subsequently examined using Cronbach's alpha. The alpha coefficient of 0.57 indicated that the raters' assessments were only moderately reliable. Correlations between each pair of raters were then conducted with the resulting alphas demonstrating that each pair was only weakly correlated (see Table 7).

Additional Statistical Analysis

Additional statistical analysis was performed on the study data, however, all results were found to be non-significant. For that reason, no further analysis is reported here.

DISCUSSION

Although neither of the manipulations in this study was successful, these results will still have some effect on study of Terror Management Theory (TMT) and Cognitive-Experiential Self Theory (CEST). Specifically, what is of importance is a consideration of the possible confounding variables that may have brought about this outcome. The manipulation of mortality salience may have been affected by the context within which the data was collected. Further-

Table 6. Mann-Whitney Test Statistics[a]			
	WVD: Preference for pro-US Author (Questions 1-3)	WVD: Preference for pro-US essay (Questions 4-5)	Composite Preference for Pro-US Author & Essay (Questions 1-5)
Mann-Whitney U	463.00	341.00	386.00
Wilcoxon W	869.00	747.00	792.00
Z	-.19	-1.92	-1.28
Asymp. Sig. (2-tailed)	.85	.06	.20

a. Grouping Variable: Mortality Salience Manipulation

Table 7. Cronbach's Alpha: Inter-Item Correlation Matrix			
	Conceptual Mode--Reviewer #1	Conceptual Mode--Reviewer #2	Conceptual Mode--Reviewer #3
Reviewer #1	1.00	.28	.35
Reviewer #2	.28	1.00	.32
Reviewer #3	.35	.32	1.00

more, the manipulation of conceptual mode may have been affected by profession-related practice effects in maintaining a rational focus, depletion of self-control resources during hours of focusing on conference presentations, and participants' need to maintain their focus during future conference presentations. Each of these possibilities is discussed below.

Mortality salient nature of the conference proceedings

Just prior to data collection, participants had attended a presentation entitled "Subliminal Decimation: May 2010 & the Worst Disaster in Tennessee History." Materials from this presentation show that it reviewed mental health services provided in the aftermath of the worst natural disaster, a flood that occurred in Tennessee on May 1st and 2nd, 2010. Many survivors are not yet back in their homes or had lost them due to foreclosure and bankruptcy. Case histories were presented on three flood survivors; one had suicidal ideation and the other both suicidal and homicidal ideation. In this regard, Pyszczynski et al. (1996) has demonstrated that death-related primes that occur in the real world (i.e., standing in front of a

funeral home) can also have a mortality salient effect. Thus, it would seem reasonable that the death-related content of this presentation (Riley & Breaux, 2011) could have acted as a confounding variable in this study.

Conference proceedings as a confounding variable

According to Muraven and Baumeister (2000), self-control is a limited resource such that efforts to cope with stress and negative affect tend to deplete it, making subsequent efforts at self-control more likely to fail. By the time data collection was done, participants had sat through at least 1½ days of presentations pertaining to lessons learned after responding to critical incidents. Some may also have sat through one to two days of pre-conference trainings on subjects related to the provision of these services. Thus, to varying degrees, their self-control resources required to maintain their attention on conference presentations may have become depleted. Because the experiential mode requires fewer internal resources and is the easiest to maintain, it is very likely that those participants who maintained their ex-

periential focus (despite being instructed to focus rationally) may have done so because they did not have the resources to do otherwise.

Muraven, Shmueli, and Burkley (2006) have also demonstrated that depleted study participants who were anticipating having to exert self-control in the future "performed more poorly in an intervening test of self-control than participants who were not depleted" (p. 524). Given that there was still a full day of presentations remaining in the conference schedule, it is possible that study participants were saving themselves for that task.

Professional background as a confounding variable

Participants in this study came from a wide variety of professional backgrounds (see Tables 4), some of whom need to maintain a rational focus in order to function successfully in their jobs. Thus, participants' professional background may have differentially affected their capacity for initiating and maintaining a rational focus.

According to Epstein (1994), "in most situations, the automatic processing of the experiential system is dominant over the rational system because it is less effortful and more efficient, and accordingly, is the default option" (p. 716). For some of the participants, then, it would be natural to respond experientially despite having been instructed to respond rationally and this did apparently happen in some cases. Many participants, however, appeared to respond rationally despite instructions to respond experientially. Epstein also points out that "because the experiential system is a natural, concretive system that interprets events in terms of past experience, it fosters appropriate responses to concretive, natural problems and inappropriate responses in situations that require unnatural or abstract responses" (p. 719). Thus, habitual responding in the experiential mode could be disastrous for those participants in this study who came from professions (e.g., law enforcement and fire fighting) where the ability to maintain a rational focus can make the difference between life and death; and, their ability to maintain their rational focus (even though it is more difficult to do so) may be what makes them effective at their jobs. In fact, Epstein assumes that there will be "important individual differences in the relative degree and effectiveness with which individuals use the two modes of information processing" (p. 719); and, this may be a factor that contributes to self-selecting themselves

for their respective professions. The strength model of self-control provides further support for this notion. According to this model, self-control is a limited resource that can be built up through repeated exercise (Muraven, Baumeister, & Tice, 1999). Habitual use of a rational focus during work-related tasks may have strengthened these participants' ability to maintain their rational focus despite being instructed to do otherwise.

Another consideration in this discussion is the fact that all participants were provided lunch prior to data collection. The lunch included a sandwich, a bag of chips, a cookie, and a soda (which could have contained sugar and/or caffeine). Gailliot et al. (2007) found that blood glucose dropped significantly after efforts of self-control and that subsequent low glucose lead to poorer performance on a subsequent self-control task. Thus, the meal provided to participants prior to data collection likely increased participants' blood sugar levels, leading to an increase in their ability to maintain a rational focus.

Conclusions

This study was a quantitative investigation of the effect of MS on a sample of CISM providers and the moderating effect of conceptual mode (rational versus experiential) on these effects. Sixty-two participants at the ICISF 2011 World Congress in Baltimore, Maryland participated in the study. Data was collected from participant responses to a study packet that included three filler measures, a mortality salience manipulation, rational or experiential instructions, a mood questionnaire, and a worldview defense measure. The manipulation of mortality salience (MS versus non-MS) was checked using the nonparametric Wilcoxon-Mann-Whitney test and the manipulation of conceptual mode (rational versus experiential) was checked using Cronbach's alpha. The results of both revealed that neither manipulation was effective; and, all other statistical findings were not significant. Despite these outcomes, the review of potential confounding variables may be useful to future researchers who aspire to study disaster response personnel or who are considering a conference setting as a possible data collection site.

The difficulty of conducting field research during disaster responses has been discussed by other researchers (Killian, 2002); however, the present study suggests that it may also be problematic to attempt to conduct research with disaster responders when they are involved in reviewing disaster
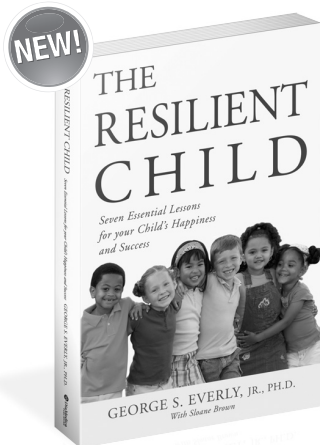
responses. For TMT research, the mortality salient nature of conference presentations prior to data collection may contribute to the failure of any attempt to manipulate MS by making the control group mortality salient. More broadly, other types of research (e.g., on in-group or cultural biases) may be similarly affected by mortality salient presentations. Thus, researchers thinking of conducting data collection at a conference should carefully consider the nature of the conference presentations.

For CEST-based research, the limited capacity of some participants to maintain a rational focus and the over-learned ability of other participants to maintain a rational focus may be confounding variables, especially among disaster workers. Even if maintaining a rational or cognitive focus is not relevant to a particular study, researchers considering a conference setting for data collection should consider whether their participants' level of self-control resources will have any confounding effect. Specifically, long hours spent attending to conference presentations and the restorative effect of eating or not eating a meal before data collection may affect participants' level of available self-control resources. Conference participants may also conserve their internal resources so that they will be able to attend to any remaining conference presentations. Depending on the nature of the proposed study, these variables may or may not be a concern; but, if they are, a different setting should be selected.

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The Burden of Disaster:
Part II. Applying Interventions Across the Child's Social Ecology

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Abstract: This second of two articles describes the application of disaster mental health interventions within the context of the child's social ecology consisting of the Micro-, Meso-, Exo-, and Macrosystems. Microsystem interventions involving parents, siblings, and close friends include family preparedness planning and practice, psychoeducation, role modeling, emotional support, and redirection. Mesosystem interventions provided by schools and faith-based organizations include safety and support, assessment, referral, and counseling. Exosystem interventions include those provided through community-based mental health programs, healthcare organizations, the workplace, the media, local volunteer disaster organizations, and other local organizations. Efforts to build community resilience to disasters are likely to have influence through the Exosystem. The Macrosystem – including the laws, history, cultural and subcultural characteristics, and economic and social conditions that underlie the other systems – affects the child indirectly through public policies and disaster programs and services that become available in the child's Exosystem in the aftermath of a disaster. The social ecology paradigm, described more fully in a companion article (Noffsinger, Pfefferbaum, Pfefferbaum, Sherrieb, & Norris,2012), emphasizes relationships among systems and can guide the development and delivery of services embedded in naturally-occurring structures in the child's environment. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 175-188].

Key words: *children, disasters, disaster interventions, mental health, social ecology, terrorism, trauma*

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Children are especially vulnerable to disasters (Norris et al., 2002), and their psychosocial responses are influenced by their personal physical and psychological make-up and by their interactions within expanding spheres of social influ-

ence including the family, neighborhood, community, and larger society. Disaster services and interventions protect and enhance existing social supports and foster resilience at multiple levels. Whether through disaster services and interventions or naturally-occurring social supports, children benefit from enhanced connections with, and assistance from, the nested environments encompassing and supporting them in difficult times. Ideally, the nested environments surrounding children are able to mitigate the effects of disaster and to initiate recovery and rebuilding efforts that limit disruption to children and their social ecology. This social ecology, as articulated by Bronfenbrenner (1977), consists of the Micro-, Meso-, Exo-, and Macrosystems. In a companion article, Noffsinger, Pfefferbaum, Pfefferbaum, Sherrieb, & Norris (2012) describe the use of the child's social ecology as a framework for systematically identifying, assessing, and addressing children's needs with respect to disasters. This article considers interventions available through the various layers of children's social ecology, which are particularly important for recovery.

Disaster System of Care

A "system of care" is a comprehensive network of child-serving programs including health and mental health, education, welfare, justice, and other child services as well as natural community support services such as faith-based and consumer programs organized to meet the needs of the children and families they serve (American Academy of Child and Adolescent Psychiatry, 2007). The disaster system of care includes both a public health focus, with a wellness orientation, and a clinical treatment focus, with an illness orientation. Based on the premise that most children recover from disaster experiences, the public health component addresses resilience and identifies those in need of services while the clinical component is designed to treat symptoms or maladaptive behavior (Ursano & Friedman, 2006).

The system of care functions first to identify children at high-risk and then to coordinate the appropriate services (Pynoos, Steinberg, Schreiber, & Brymer, 2006), which include government-supported services, school-based services, and other interventions delivered by professionals and para-professionals (Pynoos, Goenjian, & Steinberg, 1998). The government response helps to mobilize social organizations addressing education, health, and mental health across public, private, and volunteer sectors. School-based services address

both public health and clinical needs. Other interventions include outreach efforts, commonly provided by paraprofessionals, and clinical services delivered by professionals (Pynoos et al., 1998).

Interventions Available Through the Child's Social Ecology

Interventions that address disaster-related psychosocial needs of children are delivered through various entities within the child's ecosystem and at various times corresponding roughly with disaster management phases from preparedness to response and recovery. Interventions must be sensitive to the child's race, culture, and social and economic group status which may affect the child's exposure, vulnerability, and reactions to disasters as well as the availability, suitability, and delivery of interventions. Interventions are described below in accordance with ecosystems and their timing (preparedness, response and recovery), although the boundaries between categories are somewhat fluid especially in the case of a large-scale disaster with far-reaching effects. Once activated during or in response to a disaster, an intervention typically classified within one level of the ecosystem may temporarily function at another level. Social ecological systems that usually influence children indirectly may temporarily serve a more direct role.

Microsystem Interventions

The first layer encompassing the child is the Microsystem, which includes individuals and groups – especially parents, siblings, and close friends – with whom the child interacts directly and regularly (Bronfenbrenner & Morris, 2006). The uniqueness of children's ecology rests in their dependence on important others to meet their basic everyday needs and to prepare for and respond to disasters. Prinstein and colleagues (1996) identified three types of "coping assistance" children may receive following a disaster: (1) emotional processing, (2) reinstitution of familiar roles and routines, and (3) distraction. Reinstitution of roles and routines was reported most frequently, followed by distraction and emotional processing in school children seven months after Hurricane Andrew. Increased knowledge about the specific types of support benefitting children will aid our understanding of how, where, and what type of resources to provide in the post-disaster recovery environment.

Preparedness

Parents and families. Before a disaster strikes, parents can support their children by initiating family disaster planning and addressing their children's concerns that may arise in anticipation of potential disasters. Children's symptoms and functioning post disaster are related to their disaster exposure, so planning that helps to mitigate exposure will benefit children. In general, family disaster planning should include: obtaining local information on likely disasters and potential hazards and on school and community disaster/evacuation plans, developing a family emergency plan, creating a family communication plan with contact information for key individuals, and preparing an emergency supply kit (National Child Traumatic Stress Network (NCTSN), n.d.(b); American Red Cross, n.d.). In addition to regularly practicing plans, involving children in the emergency planning and the plan, by giving them developmentally-appropriate responsibilities, can enhance their sense of self-efficacy and resilience (Jacobs, Vernberg, & Lee, 2008). For example, children's bonds with their pets can be respected by including family pets in the family emergency plan. Plans for quickly re-establishing communication with parents and other individuals can help to promote a sense of security.

Response and Recovery

Parents. Disasters affect families in multiple ways. For parents, disasters impose increased demands as their attention shifts to the crisis and issues that arise in the disaster environment. Disasters have the potential to disrupt parenting functions involved in providing the safety, education, and affect modulation needed by children; to interrupt relational growth within the family; and to alter attachment and connections both within and external to the family (Miller, 1999). Thus, restoring family and parental functioning in the post-disaster environment is essential.

Parents can help promote children's resilience in the face of a disaster by shielding them as much as possible from exposure to disaster effects including injury, grotesque scenes, and frightening sounds and smells. Typically, reducing parent-child separation is linked to better child outcomes (Weems & Overstreet, 2008), though in the case of Hurricane Katrina, longer separations while evacuating children were related to fewer PTSD symptoms in children and parents (Scheeringa & Zeanah, 2008). This discrepant finding presumably underscores the primary importance of

assuring children's physical safety for both child and adult well-being. Parents should take an active role in helping their children process an event by clarifying child perceptions of current safety, providing factual information to counter rumors and misconceptions, and addressing misplaced guilt (NCTSN & National Center for Posttraumatic Stress, 2006). Parents can redirect their children from troubling thoughts and emotions toward more productive endeavors such as family activities and developmentally-appropriate restorative activities that are meaningful to the individual child and/or the larger community (Berkowitz et al., 2010). Examples include reinforcing a fence so the family dog stays secure, helping neighbors remove debris, and assisting in refurbishing a neighborhood park.

Parents should serve as gatekeepers for their children's exposure to disaster media coverage. Greater media exposure has been linked to more stress symptoms, even in children not directly affected by a disaster (Fairbrother, Stuber, Galea, Fleischman, & Pfefferbaum, 2003; Kennedy, Charlesworth, & Chen, 2004; B. Pfefferbaum et al., 2001; B. Pfefferbaum et al., 2003). Parents should monitor children's reactions to media coverage, discuss these reactions with their children, assist children in processing emotions, and redirect them to other activities as appropriate (R. L. Pfefferbaum, Gurwitch, Robertson, Brandt, & Pfefferbaum, 2003).

Siblings. Compared to parental support, empirical findings on sibling support are limited, but siblings do play an important role in children's functioning. Sibling support may compensate for a lack of support in other areas of a child's social network (Milevsky & Levitt, 2005). For example, Milevsky and Levitt (2005) found that receiving support from one's sibling served as a buffer in families characterized by low maternal support and other ecological risk factors. A study of Palestinian children exposed to military trauma clarified the bi-directional effect of trauma and the sibling relationship (Peltonen, Qouta, Sarraj, & Punamaki, 2010). Children who had more direct exposure to military trauma had higher rates of sibling rivalry; however, a strong, warm sibling relationship protected exposed children from PTSD, depressive, and other distress symptoms (Peltonen et al., 2010).

Peers. There is a growing awareness of the role of peers and classmates in children's adjustment after traumatic events. Prinstein, La Greca, Vernberg, and Silverman (1996) and Moore and Varela (2009) demonstrated the significance of different types of received support from important others,

including peers, within the child's Microsystem. In a study of the effects of Hurricane Andrew, children reported receiving support from parents, teachers, friends, and classmates, with the most assistance from parents, followed by teachers and close friends, and then classmates. The children's self-reported access to support from teachers and classmates was a significant predictor of posttraumatic stress three months after the hurricane (Vernberg, La Greca, Silverman, & Prinstein, 1996). A recent study of children involved in Hurricane Katrina demonstrated similar results. Children indicated they received support from parents, teachers, friends, and classmates. At 33 months post disaster, secondary adversities and low levels of support by classmates correlated with increased posttraumatic stress symptoms (Moore & Varela, 2009). These researchers cited devastation of the other components of the children's social ecology (e.g., parents, neighborhoods) for the importance of classmates in the aftermath of the disaster. While an evidence base is developing with respect to the importance of received support, further study is needed, particularly for prevention and intervention program development.

Children's perceptions of social support tend to play a stronger role in their adjustment than actual received support (Hardin, Weinrich, Weinrich, Hardin, & Garrison, 1994; Henrich & Shahar, 2008; La Greca, Silverman, Vernberg, & Prinstein, 1996). A good match between the child's needs and the type of support provided is another important consideration in enhancing functioning (Layne et al., 2009). Despite the supportive role that peers can play, including them in intervention programs may not always be recommended. For example, in a study of adolescents exposed to war, teens experienced higher levels of distress themselves when they perceived their peers as being distressed (Shamai & Kimhi, 2007).

Interventions Within and Beyond the Microsystem

Disasters disrupt various aspects of the child's Microsystem, and the resulting stressors can interfere with children's social support over time (La Greca, Silverman, Lai, & Jaccard, 2010). The Microsystem represents the most intimate and personal layer of a child's existence, but it is supported and influenced by the broader nested environments within the social ecology. Secondary events such as job loss, divorce, and relocation can sever children from the much needed support that was available in their schools and neighborhoods.

The post-disaster environment may necessitate reliance on supports within the Meso-, Exo-, and Macrosystems. Thus, it is essential that we understand the impact of these systems on children and bolster their capacities for providing an environment that fosters recovery and resilience.

Mesosystem Interventions

The second layer in children's social ecology is the Mesosystem, which involves connections between two or more Microsystems (Bronfenbrenner & Morris, 2006). Parents, teachers, and other adults in the community often join forces in a collaborative effort to provide support and resources for each other following a disaster. Increased extra-familial social support predicted lower posttraumatic stress reactions in children following Hurricane Katrina (Pina et al., 2008). The support that parents, extended families, and important others in children's Microsystems are able to provide individually is reinforced by the interconnections between them, thus strengthening their overall ability to provide for children's post-disaster needs. For example, a study of adolescents displaced by war in Chechnya, Russia, cited connectedness to peers, family members, and the greater community as beneficial to their overall functioning (Betancourt, Winthrop, Smith, & Dunn, 2002).

Social agencies and community partnerships previously unknown or underutilized may become decisive providers of post-disaster support for children. In response to disaster, Mesosystem entities begin to emerge and collaborate to assist with response and recovery efforts, ranging from the provision of surveillance and crisis intervention to more intensive clinical services. Schools are a major conduit for serving children's mental health needs during good times and bad. Faith-based organizations and other neighborhood-based groups play a major role in addressing disaster-related needs of children and families. Thus, the Mesosystem becomes activated in response to disasters by linking mental health services with schools, parents, extended families, and peers. Establishing and strengthening connections within the Mesosystem and developing processes for integrating efforts become particularly important in the aftermath of a disaster.

Preparedness

Schools. Similar to family disaster planning, school personnel should stay informed about the most likely crises and disasters in their area, develop and update disaster response

plans, and organize and implement practice drills. Other specific actions include defining roles of school staff in the event of a disaster, establishing and maintaining relationships with local professionals and agencies, and identifying students and staff who may have special needs or be especially vulnerable in a crisis (e.g., those with hearing impairment, autism, prior trauma exposure) (NCTSN, n.d.(a)). While parents need to be familiar with the school's parent-child reunification plans, schools are responsible for establishing procedures to maintain child security and prevent unauthorized individuals from having access to students. Schools also can be important dissemination points for preparedness interventions. Hazard education programs presented in Auckland, New Zealand, schools helped to increase children's awareness about local hazards, shaped more realistic risk perceptions, and enhanced students' knowledge of risk mitigation (Ronan & Johnston, 2001). Even more impressive were findings that these school-based programs led to children sharing information with parents and increased home-based hazard adjustments (Ronan & Johnston, 2001; Ronan & Johnston, 2003).

Response and Recovery

Schools. Schools facilitate Mesosystem activities for children, parents, and other adults, and they are a common venue for coordinating and delivering mental health services for children in general (Burns et al., 1995), following trauma (e.g., Jaycox, Stein, & Amaya-Jackson, 2009), and post disaster (e.g., Stuber et al., 2002). Schools provide access to children, and school-based services promote the recovery of students following disasters largely through the support teachers and peers provide to affected children. The facilitation of peer interaction and support in schools may lessen withdrawal and isolation and impact children's overall post-disaster adjustment. For example, among adolescents who developed PTSD after a shipping disaster, those who reported receiving little or no help from their schools had more PTSD symptoms (Udwin, Boyle, Yule, Bolton, & O'Ryan, 2000).

Through the provision of disaster mental health services, the school environment plays an essential role in fulfilling children's and families' post-disaster needs (e.g., Jaycox, Morse, Tanielian, & Stein, 2006). School-based disaster mental health services are accessible; they normalize the trauma experience; and they reduce the stigma associated with mental health care. Stuber and colleagues (2002) discov-

ered that 22% of children residing in lower Manhattan five to eight weeks after the September 11 attacks had received disaster-related counseling, and most (58%) had received the counseling from a teacher or school psychologist. School-based services, as compared to those conducted in settings less familiar to children and their parents, may assist with intervention participation and retention. Comparing the use of two interventions – one delivered at school and the other in a clinic setting – following Hurricane Katrina, Jaycox and colleagues (2010) found that while children improved with both treatments, more children participated in the school-based intervention. Chemtob, Nakashima, and Hamada (2002) also found that while there were no differences in effectiveness of school-based post-hurricane interventions, children were more likely to complete the group intervention.

Teachers may serve as clinical mediators for children post disaster because they occupy a central role in children's lives and because children and parents find them trustworthy (Wolmer, Laor, Dedeoglu, Siev, & Yazgan, 2005). Following a massive earthquake in Turkey, Wolmer and Yazgan (2003) employed a teacher-mediated intervention which began with a modified debriefing session and experiential activity for teachers. A parent component provided information about the intervention and psychoeducation about common disaster reactions. Teacher-facilitated meetings with children focused on psychoeducation, cognitive-behavioral techniques, play activities, and keeping personal diaries. The intervention was linked to decreased posttraumatic stress and dissociative symptoms but increased grief symptoms, which significantly subsided at six-month follow-up. Study results, along with feedback from teachers and students, suggested that the program initiated an adaptive grief process.

A variety of services can be delivered at schools. For example, school-based screenings can be used to assess children's disaster reactions and to identify those at risk. Generally, screenings should gather basic information about exposure and high-risk experiences during the disaster as well as students' individual subjective experiences and their stress and/or grief reactions. This information can aid parents and teachers in understanding the extent of student distress and guide clinicians in targeting at-risk students. School-based assessments also can be used to evaluate available and needed resources and help government agencies determine how to allocate resources (Pynoos, Goenjian, & Steinberg, 1995). Access to the children and the presence of established, trusting relationships with many families help school staff

to communicate the need for screenings and assessments to parents and, later, to help coordinate follow-up interventions.

Other school-based interventions include psychoeducation, which can be used to normalize common emotional reactions to the disaster and enhance positive coping skills while discouraging maladaptive coping such as risk-taking behaviors. Schools also can promote student coping by reestablishing normal routines and extracurricular activities such as band or athletics which can help reconnect students with peers and provide positive activities to distract them from disaster-related rumination. In the classroom, teachers may notice adverse effects of the disaster on student learning. A graduated curriculum that anticipates the distraction of trauma reminders while matching students' growing capacities in attention and concentration can help provide structure while students attain success (Pynoos & Steinberg, 2006). Effective classroom interventions also provide factual information about the disaster and response while dispelling rumors, aid class cohesion and support, and encourage help-seeking behavior (Pynoos et al., 1995). When more specialized services offered by mental health professionals are necessary, school staff should strive to offer school-based support in a way that does not compromise the intervention (Kruczek & Salsman, 2006).

Local religious organizations. Following a disaster, people often turn to faith-based organizations in their community, and faith-based organizations commonly mobilize to provide disaster services. For example, faith-based organizations responded following the September 11 attack on the World Trade Center (Sutton, 2003). Some actions maintained typical roles such as providing ongoing programs to help provide stability for children. Other actions were disaster-specific such as providing outreach and education about the Muslim faith to counteract reports of harassment of individuals who appeared to be of Middle Eastern descent and providing childcare for affected families. Faith-based organizations in Mississippi provided shelter, access to medical care, child services, transportation and communication services, and aid in completing disaster-related paperwork in response to Hurricane Katrina despite only 25% of them having prior disaster response plans (Pant, Kirsch, Subbarao, Hsieh, & Vu, 2008). Baton Rouge area churches provided food, financial assistance, clothing, counseling, transportation, child care, and shelter for Hurricane Katrina evacuees; they helped connect evacuees with federal and state resources; and they helped reconnect family members (Cain & Barthelemy, 2007).

Religious organizations also can respond to spiritual crises and questions that may arise as people struggle to make sense of a disaster, deal with devastation, and cope with injury and death. Faith-based providers can offer services that secular mental health professionals cannot, including specific types of prayer, confession, and rituals and sacraments. Pastoral crisis intervention integrates crisis and disaster mental health services with traditional pastoral counseling activities (Everly, 2000). Faith-based interventions are being developed and tested but, as with many disaster interventions, effectiveness data are limited.

Interventions Within and Beyond the Mesosystem

As individuals, families, systems, and communities attempt to recover and rebuild post disaster, children will likely receive support from within the nested environments of their social ecology. The efficacy of provided support depends on the type and source of support as well as children's abilities to seek it. Researchers have typically focused on the support children receive from parents, teachers, and friends rather than on the support provided by other social groups or networks existing within the Exosystem or Macrosystem. Within the Micro- and Mesosystems, children are likely to directly and indirectly receive tangible, informational, and emotional support. The naturally-occurring support that families, teachers, other adults, and peers provide can be augmented in the aftermath of disaster through information and services supplied by the greater social ecology. Disasters may cripple, as well as activate, a child's Mesosystem. For example, if a school is destroyed or the child and family displaced, the Mesosystem breaks down, making supports from the Exosystem and Macrosystem integral to children's recovery.

Exosystem Interventions

The Exosystem, the third layer of the child's social ecology, encompasses links between the child's immediate environment and the social settings in which the child does not have a direct, active role (Bronfenbrenner & Morris, 2006). Within the Exosystem are various institutions, structures, networks, and processes including state and federal agencies, transportation systems, and communication channels (Riley & Masten, 2005). A key consideration within the Exosystem is the family's degree of social integration

within the neighborhood and community (Bronfenbrenner & Morris, 2006). In the context of a disaster, social integration, while reflecting the destruction attributable to the disaster, may be strengthened by the collaborative efforts of various entities toward a collective recovery. Exosystem interventions include those provided through community-based mental health programs, healthcare organizations, the workplace, the media, local voluntary organizations active in disasters (VOADs), and other local organizations.

Professionals within the Exosystem often serve children by providing parents with the knowledge and resources to help them meet their children's needs in the aftermath of a disaster. Disaster preparedness and intervention programs should capitalize on the support that parents and families provide while educating families about children's reactions and the factors that influence those reactions and about the potential for differences in reactions of family members (Pynoos et al., 1995). These interventions can be delivered to individual families or small groups through clinics. Other interventions can be provided through mass media outlets that portray supportive parenting skills (Sanders & Prinz, 2008), convey information about warning signs that children need help, encourage parents to obtain professional help when necessary, and foster healthy behaviors.

Preparedness

Neighborhood preparedness programs. Though ideally part of the child's Mesosystem where there is regular interaction, neighborhood-based preparedness programs are more likely to be part of the Exosystem if they exist at all in an individual child's social ecology. Two federally-sponsored Citizen Corps programs – Community Emergency Response Teams (CERTs) and the Medical Reserve Corps (MRC) – are an integral part of disaster preparedness and response in some communities and exemplify organized volunteer programs that can provide a layer of support for children and families at the neighborhood level. CERT members are trained to care for themselves, their families, and their neighbors and co-workers in the event of a major disaster (U.S. Department of Homeland Security, n.d.). MRC provides a venue for medical, public health, and other health professionals to offer expertise during local emergencies and to support public health initiatives on a regular basis (Office of the Surgeon General, n.d.).

Community resilience building activities. Efforts to build community resilience constitute an emerging strategy in disaster preparedness that supports and promotes healthy individual, family, and community adjustment to mass casualty events. Resilience can be thought of as an attribute (e.g., ability, capacity), a process, and/or an outcome associated with successful adaptation to, and recovery from, adversity. A resilient community is one that copes effectively as a whole and learns from adversity. A resilient community has resources and structures in place that help create an ability to transform the environment through deliberate, collective action (Brown & Kulig, 1996/97; B. Pfefferbaum, Reissman, Pfefferbaum, Klomp, and Gurwitch, 2007; R.L. Pfefferbaum et al., 2008).

Response and Recovery

Mental health programs. Mental health interventions range from psychological first aid delivered at a disaster site to traditional clinical therapies delivered later in recovery. Mental health programs can work with local media outlets to draft brief public messages containing basic psychoeducation regarding common trauma reactions, signs that someone may need professional attention, and contact information (including hotlines) where the public can access services. This outreach can be coupled with or followed by screenings for trauma exposure and reactions. Various screening tools exist. They should be brief, asking general questions about disaster exposure and children's reactions, and they should be tailored to fit the specific disaster and secondary stressors that may have occurred since the disaster.

Mental health facilities may offer crisis intervention and stabilization (e.g., NCTSN and National Center for Posttraumatic Stress, 2006). Most crisis interventions include psychoeducation about typical trauma reactions, anxiety reduction strategies, and relaxation skills. A more detailed clinical evaluation may be indicated for youth who do not appear to recover within a month or so after a disaster. Cognitive behavioral therapy has been shown to be effective in many instances (e.g., Cohen et al., 2006). Other supportive and clinical psychotherapies also are available, and psychotropic medications may be needed for some children (Donnelly, 2009).

The federal government supports mental health services in a Presidentially-declared disaster if state resources are inadequate to meet the needs of disaster victims. Funded through the Federal Emergency Management Agency (FEMA), the Substance Abuse and Mental Health Services

Administration (SAMHSA) uses the Crisis Counseling Assistance and Training Program (CCP) to assist states in disaster mental health activities. The CCP supports short-term mental health interventions designed to provide emotional support, psychoeducation, basic counseling services, links to family and community support systems, and referral to traditional behavioral health services when indicated. The CCP is strengths-based and focuses on coping. At the community level, the program promotes partnerships with local disaster organizations and with local stakeholders to enhance community resilience and recovery (U.S. Department of Health and Human Services, 2009b).

Healthcare settings. While mental health centers may be the main providers of emotional and behavioral disaster services, children often present first to their teachers or pediatricians (Ko et al., 2008). Many individuals will talk with their physicians rather than seek out other supports, making healthcare professionals uniquely positioned to help connect survivors to other services and agencies (Reissman, Spencer, Tanielian, & Stein, 2005). Because they are on the frontline, healthcare providers should strive to be trauma-informed, and they should consider screening children and adolescents for trauma exposure and related symptoms (Ko et al., 2008) post disaster. Resources exist for healthcare professionals who may encounter children with traumatic stress symptoms related to medical conditions (see, e.g., NCTSN, n.d.(c)). Healthcare providers generally have ongoing relationships with families (Ko et al., 2008) enabling them to track services and provide continuity of care. These providers must be knowledgeable about empirically-based interventions to make referrals for specialized mental health services.

Macrosystem Interventions

The outermost layer of a child's social ecology, the Macrosystem consists of the laws, history, cultural and subcultural characteristics, and economic and social conditions that underlie the other systems in the model (Bronfenbrenner, 1977). Disruption, corruption, and failure at the Macrosystem level may exacerbate the disaster reactions of the individuals, families, groups, and communities it supports. Sociopolitical, cultural, and environmental programs and systemic initiatives at the national level can provide a foundation for positive change and enhanced resilience in the face of disaster. Macrosystem disaster programs and services that are established in localities affected by a disaster, such as those provided through SAMHSA and the American Red Cross, function-

ally become part of the Exosystem as they are activated in response and recovery.

Government and Social Policy

There is expressed attention to mental and behavioral health in federal policies that support disaster preparedness, response, and recovery. The National Health Security Strategy (NHSS) (U.S. Department of Health and Human Services, 2009a) promotes two goals: building community resilience and strengthening and sustaining health and emergency response systems. The NHSS promotes the use of psychological services as an essential element of "a prepared and responsive health system" (p. 11). For example, health care services include providing evidence-based behavioral health prevention and treatment services and monitoring behavioral as well as physical outcomes (U.S. Department of Health and Human Services, 2009a). In the event of a disaster, the National Response Framework's Emergency Support Function (ESF) #8 supplements state, tribal, and local resources in supporting Public Health and Medical Services which includes behavioral health needs (U.S. Department of Homeland Security, 2008).

Conclusions

Bronfenbrenner's (1977) social ecological theory provides an organizing framework for understanding the many ways children interact and relate, the social strata in which they function, and the people and systems that influence and support them. This framework emphasizes relationships among systems and can guide the development and delivery of services embedded in naturally-occurring structures within the child's social ecology. In designing services and programs to address both disaster-related trauma and the hardships that disasters create for those in their aftermath, practitioners, providers, and policymakers should consider the means through which families, peers, teachers and other adults, schools, social programs, services, policy, and other communal systems can assist in minimizing primary and secondary adversities.

Enhanced understanding of the processes that will be supportive of children and families post disaster can inform pre-event preparedness and planning efforts and can facilitate the creation of the requisite social support to protect children from the potentially life-changing adverse effects of disasters. While further study will be needed to establish an evidence

base for disaster interventions and services across the child's social ecology, it is essential that individuals, programs, and systems work together through intervention efforts to generate the greatest positive impact. Some of these efforts will emerge naturally within the child's social ecology. Others may need to be supported by public policies that seek to complement and enrich existing systems.

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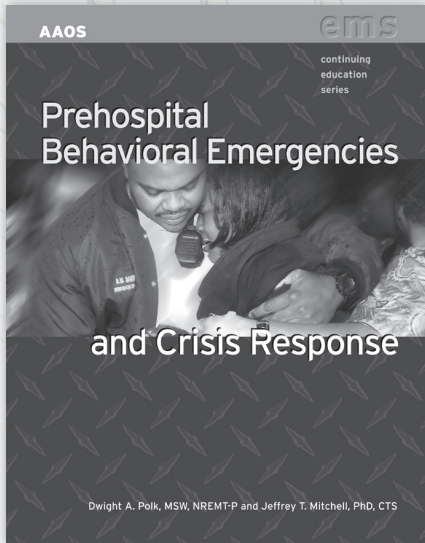
Prehospital Behavioral Emergencies and Crisis Response

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

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Perception of Change and Burden in Children of National Guard Troops Deployed as Part of the Global War on Terror

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Abstract: Changes in relationships, roles, and dynamics associated with deployment of troops to the Global War on Terror can create challenges for their families as non-deployed spouses and their children take on new responsibilities. Children, aged 6 to 18 years, of deployed National Guard troops were assessed to determine the children's perceptions about how their father's deployment would or did change them and their family, the burden the children experienced in relation to helping their mothers, and child- and parent-reported emotional and behavioral symptoms in the children. Endorsement of personal change was associated with psychological health. During deployment, recognizing personal change was associated with less perceived burden while perceived change in the family was associated with more perceived burden. In general, increased perception of burden was associated with increased psychological symptoms and problems. The children of deployed service personnel may experience burdens and challenges in relation to the changes associated with the circumstances of deployment. Helping children prepare for and manage changes in relationships, roles, rules, and routines may lessen adverse reactions to changes in the environment. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 189-196].

Key words: *burden, burden of care, change, children, deployment, families, military*

Introduction

The Global War on Terror has extended for over a decade, directly affecting a large number of families. Over 40% of the nearly 1.5 million Active Duty service members and 900,000 Reserve and National Guard forces have dependent children (U.S. Department of Defense, n.d.). Children of service personnel deployed to the Global War on Terror are at risk for a variety of emotional and behavioral problems (see e.g., Lemmon & Chartrand, 2009; Lester et al., 2010). Changes occur in family relationships, roles, rules, and routines in association with deployment and may create

a burden on the non-deployed spouse and children who may assume greater responsibilities such as helping their non-deployed parent (Lester et al., 2010; Park, 2011). The extent to which children anticipate and recognize changes and the burdens that accumulate over the deployment phases is largely unknown.

Reserve and National Guard troops face a number of unique challenges due to differences in demographics, training and preparation, non-military occupational responsibilities and stress, the degree to which they are integrated into and identify with military life, and access to support services (Kehle et al., 2010; Lemmon & Chartrand, 2009; Vogt et al., 2008) and their children are at increased risk for problems (Park, 2011). Thus, we conducted this exploratory pilot study of children of Oklahoma National Guard troops deployed as part of the Global War on Terror to explore the children's emotional and behavioral symptoms and problems in light of their perception of personal and family change and their experience of burden associated with their father's deployment. Data on military children were collected before, during, and after deployment.

METHODS
Recruitment of Participants

Participants were the children, aged 6 to 18 years, and spouses of Oklahoma National Guard troops who were deployed to Iraq in the Global War on Terror. The Oklahoma National Guard leadership notified families of troops about the study through a letter of support, and flyers advertising the study were distributed and posted at various National Guard facilities and functions. As required by the University of Oklahoma Health Sciences Center Institutional Review Board which approved this research, informed consent and/or assent were obtained from all participants. Participants received a $20 gift card to compensate for their time and effort.

Procedures

The assessments were conducted pre deployment, during deployment, and post deployment. The pre-deployment phase occurred while the soldiers were out of state training for deployment; they had not yet reached foreign soil or active combat but had been mobilized and separated from their families. Pre-deployment assessments were conducted over a three-month period just prior to deployment. Deployment assessments were conducted over a three-month period ap-

proximately six months after deployment. Post-deployment assessments were conducted over a three-month period approximately two to four months after the deployed service members had returned home.

Measures

BASC-2. Child emotional and behavioral symptoms and problems as well as adjustment and adaptation were measured using the *Behavior Assessment System for Children, Second Edition (BASC-2)* child self-report and parent-report scales, an instrument with good reliability and validity (Reynolds & Kamphaus, 2004). The *BASC-2* is tailored for specific age ranges—8 to 11 years and 12 to 21 years. Scoring the child self-report form resulted in *T* scores for four composite scales (internalizing problems, school problems, inattention/hyperactivity, and personal adjustment) plus an emotional symptoms index. Scoring the parent-report form resulted in *T* scores for three composite scales (externalizing problems, internalizing problems, and adaptive skills) and a behavioral symptoms index.

Change. Children were asked if they thought their parent's deployment would or did change them (personal change) or their family's life (family change). Possible answers related to personal change were "yes" or "no." Those answering "yes" were asked how their parent's deployment would or did change them. Possible answers related to family change ranged from "not at all" to "very much" on a five-point scale.

Burden of care. Burden of care was assessed by asking the children about helping or taking care of their non-deployed parent. Children were asked: "how often" they: (1) "have taken care of or helped" their non-deployed parent, (2) "have trouble knowing what" they "should do to help" their non-deployed parent, and (3) feel they "should do more to help" their non-deployed parent; responses ranged from "never" to "almost always" on a five-point scale. Children were also asked how hard it has been to "take care of or help" their non-deployed parent, with responses ranging from "not hard at all" to "extremely hard" on a five-point scale. Pre deployment and during deployment, children were asked how difficult it would be (pre deployment) or was (during deployment) for them to "chip" in to help at home more and to "take over new household duties/chores" during deployment, with responses ranging from "not at all difficult" to "extremely difficult" on a seven-point scale. Post deployment

children were asked how difficult it was for them to adjust to changes in duties/chores since their deployed parent returned home, using the same seven-point response scale as the previous question.

Data Analysis

PASW Statistics 18 was used for statistical analysis. Descriptive statistics including frequencies and percentages were calculated, and Pearson correlation coefficients were used to examine correlations between variables. The Wilcoxon signed rank test, a non-parametric test for two repeated measures, was used to determine if mean scores of variables were different across two different assessment periods (Siegel & Castellan, 1988). A significance level of 5% was used for establishing statistical significance.

RESULTS

Participants

Thirteen children, representing nine families, participated in the study. The sample included nine (69%) boys and four (31%) girls. Eight children represented sibling pairs from four families. Sixty-two percent ($n = 8$) reported their racial and ethnic background as white, 23% ($n = 3$) African American, and 15% ($n = 2$) American Indian. Forty-six percent ($n = 6$) of the children were between 8 and 10 years of age, 31% (n = 4) between 11 and 12 years, and 23% (n = 3) between 13 and 15 years. This was the first deployment experience for 77% ($n = 10$) of the children.

Child Emotional and Behavioral Symptoms (*BASC-2*)

Results from a prior report on this sample suggested an increase in "at-risk" and "clinically-significant" problems on the *BASC-2* from the pre-deployment phase to the deployment phase. The children's self-reported personal adjustment revealed statistically-significant improvement in each succeeding phase from pre to post deployment. Child-reported school problems and inattention/hyperactivity were more prominent during deployment than pre deployment with some apparent recovery post deployment in some of the children. Parent report revealed that adaptive skills declined during deployment but reached higher levels post deployment than pre deployment (Pfefferbaum et al., 2011).

Change

During the pre-deployment phase, 50% ($n = 6$) of the children thought deployment would change them (personal change). Examples of personal changes provided by the children included: appreciating the deployed parent more ($n = 2$), getting feelings hurt more easily ($n = 1$), becoming more emotional ($n = 1$), feeling greater anger ($n = 1$), and becoming less outgoing and funny ($n = 1$).

At pre deployment, 17% ($n = 2$) of the children thought deployment would not change their family's life (family change), 58% ($n = 7$) thought deployment would change their family's life "a little bit" or "some," and 25% ($n = 3$) thought deployment would change their family's life "a lot" while none of the children thought deployment would change their family's life "very much."

During deployment, 62% ($n = 8$) of the children thought deployment had changed them. Changes reported included: being sadder ($n = 1$), madder ($n = 1$), more sensitive ($n = 1$), more aggressive ($n = 1$), unable to sleep ($n = 1$), and tougher and more responsible ($n = 1$); feeling more scared ($n = 1$); crying more often ($n = 1$); standing up for oneself better ($n = 1$); and feeling closer to the non-deployed parent ($n = 1$).

During deployment, 15% ($n = 2$) of the children thought deployment had not changed their family's life, 46% ($n = 6$) thought deployment had changed the family "a little bit" or "some," and 38% ($n = 5$) thought it had changed their family's life "a lot" or "very much."

At the post-deployment assessment, 69% ($n = 9$) of the children thought deployment had changed them. Personal changes reported by the children included: being more emotional ($n = 1$), depressed ($n = 1$), stronger ($n = 1$), appreciative about what one has ($n = 1$), willing to help ($n = 1$), and proud of the deployed parent's service ($n = 1$); understanding the war and the National Guard better ($n = 2$); and realizing that things change ($n = 1$).

Post deployment, 8% ($n = 1$) of the children thought deployment had not changed their family's life "at all," 46% ($n = 6$) thought deployment had changed their family's life "a little bit" or "some," and 46% ($n = 6$) thought deployment had changed their family's life "a lot" or "very much."

Child report of personal change and family change were negatively correlated pre deployment ($r = -.56. p < .05$) and during deployment ($r = -.54, p < .05$). Child-reported personal change pre deployment was related to child-reported personal

change during deployment ($r = .51, p < .05$). Child-reported family change at different phases were not correlated.

Pre deployment, children who had experienced a previous deployment were more likely than children for whom this was the first deployment to believe that the upcoming deployment would change their family's life ($r = .61, p < .05$). No other differences in personal and family change related to previous deployments were significant.

BASC-2 and Personal and Family Change

See Table 1 for significant associations between *BASC-2* results and child report of personal and family change related to deployment.

Burden of Care

There were no significant differences in burden of care items across phases. During the deployment phase, children who had experienced a previous deployment reported helping their non-deployed parent more often than children who had not experienced a previous deployment ($r = .65, p < .01$). There were no other significant differences in burden of care items for those with and those without previous deployments.

Burden of Care and Personal and Family Change

There were no significant associations between either personal or family change and any burden of care items pre or post deployment. See Table 2 for significant associations between child report of personal or family change and burden of care during deployment.

BASC-2 and Burden of Care

See Table 3 for significant associations between *BASC-2* results and burden of care.

Post deployment, children's *BASC-2* findings were associated with pre-deployment and deployment phase child burden of care reports. Pre-deployment difficulty with household duties correlated with post-deployment school problems ($r = .52, p < .05$) and personal adjustment ($r = .56, p < .05$). How often children felt they should do more to help their parents ($r = .63, p < .05$) and how hard children reported it was to help their parents ($r = .51, p < .05$) during deployment were positively related to child-reported internalizing symptoms post deployment.

Table 1. Personal and Family Change and BASC-2		
Personal and Family Change	Child emotion/behavior	*r*
Pre Deployment		
Personal change	Child-report inattention/hyperactivity	-.59*
Family change	Child-report emotional symptoms	.63*
Family change	Child-report internalizing symptoms	.69*
Deployment		
Personal change	Child-report emotional symptoms	-.51*
Personal change	Child-report internalizing symptoms	-.55*
Personal change	Parent-report child internalizing symptoms	-.57*
Post Deployment		
Family change	Child-report school problems	-.52*
*Note: ** = p < .01, * = p < .05.*		

Table 2.
Personal and Family Change and Burden of Care

Personal and Family Change	Burden of Care	r
	Deployment	
Personal change	Difficulty knowing how to help NDP[1]	-.51*
Personal change	Felt they should do more to help NDP	-.50*
Personal change	Difficulty taking care of or helping NDP	-.63*
Personal change	Difficulty chipping in at home more	-.53*
Personal change	Difficulty taking over new chores	-.71**
Family change	Felt they should do more to help NDP	.51*
Family change	Difficulty chipping in at home more	.63*

Note: 1. NDP=Non-deployed parent. ** = $p < .01$, * = $p < .05$.

DISCUSSION

A prior report on the children in this sample described (1) a pattern of increased emotional and behavioral symptoms and problems during their father's deployment relative to the children's pre- and post-deployment status and (2) improved personal adjustment and adaptive skills post deployment relative to their adjustment and adaptation in the pre-deployment and deployment phases. Despite a deployment effect, the children appeared to be resilient and may have experienced emotional and behavioral growth over the course of their father's deployment (Pfefferbaum et al., 2011). Of course, this growth may have occurred independent of the deployment experience. In this report, we address the children's emotional and behavioral symptoms and problems, perceptions of personal and family change, and experience of burden associated with deployment.

Change and Burden of Care

Family dynamics change over the course of deployment generating new roles for, and demands on, children. The majority of the children in this study anticipated and experienced personal and family changes related to deployment. Pre deployment, children who had experienced a prior deployment anticipated more change, suggesting that they were realistic about what to expect, while those whose fathers had not deployed previously may have underestimated the potential for change. During the deployment phase, children whose fathers had been deployed previously reported "taking care of or helping" their mothers more often than children who had not experienced a previous deployment. Those with prior deployment experiences may have appreciated the stress on their families and sought to help their mothers.

There were no significant relationships between children's anticipated personal or family change and their self-reported experiences of burden pre or post deployment. During deployment, children's report that deployment had changed their life was negatively associated with burden while their report of family change was positively associated with burden. Thus, while no cause and effect relationship should be assumed, recognizing personal change during deployment was associated with less perceived burden while perceived change in the family was associated with more perceived burden.

Emotional and Behavioral Health, Change, and Burden of Care

Emotional and behavioral health in the children in this study was positively associated with the anticipation of personal change pre deployment and with the recognition, and perhaps embracement, of personal change during deployment. The findings with respect to family change were less clear and appeared to change over the deployment cycle. Pre deployment, children who anticipated family change reported more emotional symptoms and internalizing problems. Recognizing that the family had changed was positively

Table 3.
Burden of Care and BASC-2

Burden of Care	Child emotion/behavior	*r*
Pre Deployment		
Frequency of helping NDP[1]	Child-report inattention/hyperactivity	-.75**
Difficulty chipping in at home more	Child-report inattention/hyperactivity	.63*
Difficulty chipping in at home more	Child-report emotional symptoms	.58*
Difficulty chipping in at home more	Child-report internalizing symptoms	.63*
Difficulty taking care of or helping NDP	Child-report emotional symptoms	.61*
Difficulty taking care of or helping NDP	Child-report internalizing symptoms	.61*
Deployment		
Difficulty taking care of or helping NDP	Child-report emotional symptoms	.78**
Difficulty taking care of or helping NDP	Child-report internalizing symptoms	.79**
Difficulty taking care of or helping NDP	Child-reported personal adjustment	-.62*
Felt they should do more to help NDP	Child-report emotional symptoms	.60*
Felt they should do more to help NDP	Child-report internalizing symptoms	.72**
Difficulty knowing how to help NDP	Child-report emotional symptoms	.54*
Difficulty chipping in at home more	Child-report emotional symptoms	.63*
Difficulty chipping in at home more	Child-report internalizing symptoms	.58*
Difficulty taking over new chores	Child-report internalizing symptoms	.49*
Frequency of helping NDP	Parent-report child externalizing symptoms	.65*
Difficulty knowing how to help NDP	Parent-report child externalizing symptoms	.65*
Difficulty taking care of or helping NDP	Parent-report child externalizing symptoms	.55*
Difficulty taking over new chores	Parent-report child externalizing symptoms	.71**
Frequency of helping NDP	Parent-report child behavioral problems	-.77**
Difficulty taking care of or helping NDP	Parent-report child behavioral problems	.50*
Difficulty taking over new chores	Parent-report child behavioral problems	.61*
Frequency of helping NDP	Parent-report child adaptive skills	.87**
Post Deployment		
Difficulty knowing how to help parents	Child-report inattention/hyperactivity	.52*
Frequency of helping parents	Parent-report child internalizing problems	.59*
Difficulty knowing how to help parents	Parent-report child externalizing problems	.67**
Difficulty knowing how to help parents	Parent-report child behavioral problems	.69**
Difficulty knowing how to help parents	Parent-report child adaptive skills	-.71**

Note: 1. NDP=Non-deployed parent. ** = p < .01, * = p < .05.

associated with lower self-reported school problems post deployment. Interestingly, personal and family change were negatively correlated pre and during deployment. It may be that children who were psychologically healthier realized and accepted personal change and were not threatened by it. The prospect of family change, which was arguably less under the children's own control, was more likely to be associated with psychological and behavioral symptoms and problems. Deployment-related changes in the family may increase risk for psychological problems for children, and the families of children with problems may experience greater change as part of deployment.

Similarly, in general, increased perception of burden in the children was associated with increased psychological symptoms and problems as measured by both the child- and parent-reported *BASC-2* scores. Parental reports of *BASC-2* scores were not associated with children's burden in the pre-deployment phase perhaps because of the small sample size. During deployment, children's experiences of burden were positively associated with child-reported emotional and behavioral symptoms and problems, and better personal adjustment was negatively associated with children's report of how hard it was to take care of or help their parents. From the perspective of their mothers, when significant, burden was also consistently related to more emotional and behavioral symptoms and problems in their children. Post deployment, child- and parent-reported emotional and behavioral symptoms and problems were associated with burden. Like the findings of Lester and colleagues (2010), these results suggest that the experience of burden may persist from the pre-deployment and deployment phases in the form of emotional and behavioral problems in the short-term after the deployed father returns home.

The item measuring how often children "took care of or helped" their parents produced interesting results. While initially conceptualized to measure burden, the results suggest that helping more often was not universally experienced as a burden and may have reflected strength, at least for some children. In multiple instances, and across all phases of deployment, the endorsement of this item was associated with emotional and behavioral health. A larger representative sample and more discerning questions should be used in future studies to examine children's perceptions of the effectiveness of their efforts to help and to further clarify the relationship between aspects of their psychological health and experiences of burden.

Limitations and Strengths

A notable limitation of this exploratory pilot study was the small non-representative sample. It is unclear what motivated families to participate in the study. It is possible that those who were less troubled were comfortable volunteering for a study of this type, but families experiencing trouble may also have sought attention by participating. Given that we studied only National Guard families, the findings may not apply to children from other branches of military service and we were unable to compare the children of National Guard and Active Duty troops. Furthermore, our recruitment strategy that identified potential participants through National Guard leadership and functions may have biased the sample with an overrepresentation of families that were integrated into National Guard activities. The results also may have been skewed by using sibling pairs for some child-parent dyads thus exaggerating potential parent bias.

Strengths of the study were the use of the *BASC-2* which has age-related normative guidelines that were developed with data from large, nationally representative samples (Reynolds & Kamphaus, 2004); the use of parent and child informants; and the longitudinal design that assessed children pre, during, and post deployment. The pre- and post-deployment assessments were conducted relatively close to deployment, however. Thus the pre-deployment findings reflect the children's experiences soon after learning about deployment rather than during the time period before they knew about, and anticipated, deployment. The post-deployment assessment did not capture the children's experiences with late-occurring or enduring complications associated with reintegration.

Conclusions

The results of this study suggest potential avenues for helping the children and families of deployed service personnel. Children, and adults too, fear what they do not understand, and war and deployment are difficult to understand. Thus, assisting children—without overwhelming them—may help them appreciate what is likely to occur as part of the deployment situation. To normalize the experience, parents and other significant adults may ground children by emphasizing the many things that will not change with deployment and by identifying available support. Helping children prepare for and manage changes in relationships, roles, rules, and routines may prevent adverse reactions to change in their

environment, and it may enhance adaptation. Interventions should provide information about the potential changes and problems children and their families might anticipate as part of deployment, explore ways to deal with these changes, and promote and enhance emotional flexibility. In addition, attention should be directed to children who experience and resist personal and family changes. Finally, military children should be reminded that they, as well as their parents, are "serving their country" thereby giving meaning to their personal sacrifices.

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How to Choose the Right Operational Police Behavioral Health Specialist (OPBHS)©™1

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Abstract: A recent article (Dennis, December, 2011) stressed the need to consider the factors necessary when selecting an operational police physician. It seems apparent that equal attention should be given to the selection of the Operational Police Behavioral Health Specialist or Police Psychologist (OPBHS). This is intended to round-out selection considerations for these two important and essential positions on both Special Weapons and Tactics Teams as well as on Police Hostage and Crisis Negotiations Teams. Such considerations are crucial whether these teams are operationalized together, separately, or as part of the same unit. The previous outline headings, with some additions, will be utilized specifically to deal with the Operational Police Behavioral Health Specialist. Also, see Greenstone (2005). The issues to be considered for the OPBHS are: Candidate selection. (Also see Greenstone, 2005), Duties, Administrative, Clinical , Training involvement, Relationships, Liability and coverage (Dennis, 2011), Other considerations. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 197-208].

Key words: *Operational Police Behavioral Health Specialist; OPBHS; SWAT; Hostage and Crisis Negotiations; Police Special Teams*

Introduction

The services of the Operational Police Behavioral Health Specialist are vital to the overall success of Special Weapons and Tactics, and to Negotiations operations (Greenstone, 2005). Along with the police physician, or functioning independently, they both provide for the full range of care that may be needed by these special teams. To ignore either is to come up short in administering overall and comprehensive care. The stressors of special police operations are not without their consequences both immediate and long term for these officers. Care must be there, on site, when needed. These operational specialists can and do provide a sizable variety of services in addition to their primary concerns. The importance of each and of both must be appreciated.

Candidate Selection

The Operational Police Behavioral Health Specialist (OPBHS) will understand police work and want to be part of it. While a candidate may or may not be a sworn officer, hands-on knowledge and practical understanding must be part of the professional's vitae. It is one thing to explain to

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a candidate what an OPBHS does; another for them to have that knowledge resonating within them. Such resonance comes from experience. Many psychologists want nothing to do with this kind of work, and even may be threatened by it. Also, such involvement may be sought to satisfy personal needs, solve personal problems, or for the war-stories that can be told later. Volunteering for such an ongoing assignment is not enough. It must be for the right reasons. Consider them and evaluate them carefully. (See Figure 1)

Some of the important considerations and background might include:

Figure 1. Initial Selection Procedures

Ask: PhD, MD, or other licensed mental health professional at the doctoral level.

If no, eliminate

If Yes, ask Psychologist, Psychiatrist or Counselor?

If No, eliminate or plan to use in think tank as needed or desired.

If Yes, ask Police Officer?

If No, evaluate if needed for other supportive roles

If Yes, ask Trained Hostage Negotiator and SWAT trained?

If Yes, continue with interview and selection process as outlined.

If No, consider other Useful roles with the Team.

Selection Process as outlined(See Figure 2)

Not selected: Send home

Selected for role as Operational Police Behavioral Health Specialist.

1.Initiate training needed. 2.Orientation to the teams involved. 3.Reassess specialized skills and experience. 4.Issue necessary gear. 5.Establish needed schedules and call-out procedures. 6.Complete necessary team and departmental paperwork. 7.Send selection results to Chief of Police or Designate. 8.Decide how and what services will be provided both in the field as well as pre and post deployments. 9.Jointly decide what personal records will be maintained and how. 10. Integrate into teams. (adapted from Greenstone, 2005)

1. A doctoral level degree in psychology, counseling, psychotherapy, crisis intervention or very closely related, and broad-spectrum, areas of study.

2. Appropriate mental health licenses from the applicant's State authorizing independent, non-supervised practice.

3. A mature and fit professional who is used to making critical decisions. All aspects of maturity are important here; personal maturity, professional maturity, interpersonal maturity, austere environment maturity, leadership and follow-ship maturity, psychological maturity, social maturity and law enforcement maturity.

4. Experience working in austere environments.

5. Availability and flexibility.

6. Broad understanding of mental health issues faced by police, Special Weapons and Tactics Team members, and Hostage and Crisis Negotiations Teams members.

7. A team player with the necessary assertiveness and restraint.

8. An understanding of the police chain of command and where the OPBHS fits within that chain.

9. A police background that includes substantial field experience. This might be done as a regular officer or as a reserve or auxiliary officer. Are reserve officers considered police officers when on duty? This would be valuable to factor into the selection equation.

10. A seasoned officer with practical experience.

11. Training as a hostage and crisis negotiator and specialized tactical training would be an added plus. While the candidate should probably come with some of this training, much of it can and should be accomplished post selection and as a condition of selection.

12. Training and current licensing as an Emergency Medical Technician, Basic and Tactical, or higher would be an added plus factor. As such, this added skill set could broaden the effective service reach of the Operational Police Physician. (Greenstone, 2002)

13. A clear working knowledge of the issue of confidentiality and the State laws providing for this protection.

Selection (See Figure 2) should be by:

1. Letter of application

2. Interview

3. Credentials and licenses

4. Selection board from the tactical and negotiations teams

5. Assessment center simulations and performance evaluations

6. Training and orientation

7. Trial performance in actual or recreated situations; role plays.

8. Background checks in depth

9. Psychological testing and a psychological interview. Such an evaluation should be similar to those required of police officers in most States.

10. Training held in the actual types of situations and problems that will actually be faced by the OPBHS

11. Relative military and field experience

12. Police Psychologist experience

13. Strong background and recent training in Crisis Intervention, Post Traumatic Stress and Critical Incident Stress Debriefings and overall Stress Management.

14. Specialized training depending on the needs of the various team members.

15. To paraphrase Dennis (2011), having advanced degrees and mental health training does not in itself make a suitable OPBHS.

16. While the selection process should be as detailed and as in-depth as possible, accommodations can and should be made depending on the capabilities of specific agencies undertaking such a selection process.

OPBHS selection should be multifaceted and designed to seek out in detail those with hidden agendae and ulterior motives. Team leader interviews followed by a board or team interview may work very well. All decisions to select a candidate should be unanimous. The rationale here is that all members of the teams will have to work with the selected candidate. Role play situations that put the candidate under minor stress and which is critiqued, could help see the most accurate picture; or cause the candidate to withdraw.

Figure 2. USE THE DECISION TREE

Letter of interest from applicant

↓

Letter of interest from supervisor

→ Not favorable, eliminate

Team discussion of applicant's letter of interest

→ Not favorable, eliminate

Interview the Applicant

→ Not favorable, eliminate

Assess applicant Skills
With Assessment Center

Psychological Evaluation → Poor performance, eliminate

Pass / Fail Report Only → Problematic evaluation, eliminate

Final Decision by Screening Board

→ Selection approved by Team Commander and Chief of Police

⇓

Selection of New Team Member

↓

Event Planned by Teams to Welcome New Member

Equipment issued

Place on active roster

Training scheduled

This is serious business and we should be serious about our business. The successful candidate will be appreciative. The teams will be better served. Those is need will receive what they need and deserve from their professional team members. They can rely on that each and every time. (Greenstone, 2003)

Duties

The duties of the OPBHS are many and, by necessity, varied. Ideally, these duties would consist of providing comprehensive behavioral health care to members of the Special Weapons and Tactics Team and the Hostage and Crisis Negotiations Team. This care should be available before, during and after call-outs and mobilizations. Realistically, these duties may be limited by departmental constraints, the part-time status of the OPBHS, the availability of the OPBHS, and other relevant issues. The primary duties will often be seen when these teams are called into action, within austere situations and immediately post incident as necessity dictates. The OPBHS cannot be all things to all team members. Other resources may be available and should be utilized on an ongoing basis.

Administrative

Administrative duties and involvements of the OPBHS could include:

1. Developing suitable plans that would allow the OPBHS to be activated and to respond at any time.

2. Instituting back-up plans in the event that the OPBHS is unable to respond due to such things as illness, being out of the area of operations, or because of conflicting responsibilities.

3. Exploring the possibility of selecting and training an alternate OPBHS.

4. Entering into appropriate agreements with the hiring

agency and / or city that will allow the utilization of these services as required. These agreements will also be addressed under the "Liability and Coverage" section of this paper.

5. Obtaining and / or developing the proper tool for utilization within a field environment in order to accomplish the tasks at hand.

6. Securing proper field gear to be worn during call-outs and deployments.

7. Establishing personal and professional schedules that will allow all the needed involvement with the teams.

8. Familiarizing self and team members with the current laws governing the actions that might be taken by either SWAT or Negotiation Teams; and advising members about conforming to these requirements.

Clinical

Clinical duties may include:

1. Insuring proper psychological fitness of team members pre-deployment.

2. Monitoring the psychological fitness and attendant stressors in team members during deployment.

3. Attending to the post-deployment psychological and stress management needs of team members post deployment.

4. Assisting the Hostage and Crisis Negotiations Team during their interventions with hostage takers or barricaded subjects.

5. Providing coaching and / or intelligence gathering assistance to the Negotiation Team.

6. Assisting the SWAT Commander and the On-Scene Commander with assessment of the immediate situation being confronted and those involved in it.

7. Advising the SWAT Commander, the Negotiations

Team Leader and the On-Scene Commander concerning the psychological well-being of deployed team members.

8. Providing on-scene behavioral health care to team members as required. This might include formal as well as informal interactions.

9. Advising concerning the mental conditions, issues and needs of the subjects and victims encountered by the teams during a deployment.

10. Providing guidance concerning handling of hostages both during and post event.

11. Debriefing barricaded subjects, hostage takers and hostages post event.

12. Advising the Chief of Police or agency head concerning the psychological conditioning and resiliency of the special team members.

13. Referring teams members to competent and appropriate short term or long term care as needed.

14. Monitoring the conditions and progress of team members requiring ongoing psychological care.

Training Involvement

Training involvement may include:

1. Presenting appropriate and needed behavioral health-oriented training to team members that is pertinent to their field responsibilities.

2. Cross-training members of the teams as Peer Support providers to team members as needed. This would expand the reach of capabilities for the OPBHS and would be supervised by the OPBHS.

3. Participating in the training of the teams and sub-teams. This would include both SWAT and Negotiations.

4. Making recommendations for additional training for team members.

5. Working with the SWAT Team Commander and the Negotiation Team Leader to establish and direct training needs.

6. Consulting with the Chief of Police or agency head to determine additional desired training.

7. Assuring that training provided actually mirrors what

will be encountered and required in the field.

8. Developing and utilizing recreations of psychological situations likely to be encountered by team members and allowing them to develop and practice the skills necessary to manage such situations.

9. Providing resiliency training to prepare teams members for traumatic encounters.

Relationships

Dealing with and managing relationships in this context may include:

1. Ensuring an ongoing relationship with each member of the teams served.

2. Developing professional and / or therapeutic involvements as needed.

3. Managing relationships with other non- OPBHS professionals who may be needed for referrals as necessary. (Greenstone, 2002)

4. Ensuring that non-OPBHS who may be used for referrals are familiar with and accepting of the law enforcement culture and the problems that may be associated with their service.

5. Maintaining strong relationships with the team commanders, the on-scene commanders and the Chief of Police or other Agency Head.

6. Demonstrating to both teams and commanders that you understand your relationships with team members as well as your direct relationship to accomplishing the missions of the teams.

7. Providing those who may deal with the media with professional and accurate information for their dissemination as they may need. Many times correcting misconceptions and inaccuracies in how the media and the public views psychological issues faced by police, can be extremely helpful.

8. Assisting Training Academy personnel in developing appropriate and ongoing training that may benefit both SWAT and Hostage and Crisis Negotiators.

Liability and Coverage

Appropriate handing of liability issues for work per-

formed for SWAT and Negotiation teams might include:

1. Finding out what is already available to you because of your specific involvement with your department.

2. Checking with your malpractice insurance provider to see if you are currently covered for these activities or if a rider is needed to your current policy.

3. Investigating, with a trusted insurance agent, getting the coverage you need if you currently have none appropriate to these particular duties.

4. Checking with an already involved OPBHS to see what they might have in place that they could recommend to you.

5. Deciding that the liability exposure presented by this type of involvement is more than you want to experience. It is a serious choice.

6. Being very careful about how you put all of this together. Your personal and professional reputation as well as your license is always on the line. While the likelihood of problems admittedly is small, one problem can ruin your entire afternoon.

Other Considerations and Questions

In addition to the above, the OPBHS may need to address other issues that may arise from time to time or because of jurisdictional requirements or restrictions. Such issues must be addressed from the particular purview of police psychology and behavioral health to be of greatest benefit to the teams. Also, there are a great many questions that may arise about involvement and its responsibilities. These might include those in the following list.

The Questions that a Prospective Candidate for OPBHS Should Be Asking

1. What do I do?

2. What are my obligations to the team?

3. What about my liability exposure?

4. Do I need special liability insurance to cover me during my work on an incident?

5. What about time commitments?

6. What if I am called at 2:00 in the morning?

7. How can I respond to a team callout if I am a single parent?

8. How much training will I need to do this job?

9. How much time should I allow?

10. How involved should I become?

11. How much should I charge for my services to the team that I will serve?

12. Should I become a police officer or a reserve police officer?

13. Should I contract for a flat fee to cover my services?

14. Should I volunteer my time?

15. How much time should I give to the team?

16. Can I limit my involvement with the team?

17. Do I need to be there for the team every time they call on me?

18. How do I get the training that I need to do this job?

19. Should I get involved with the negotiations team and SWAT team at all? Is this for me?

20. What will my role be during an actual incident?

21. Will the negotiators and SWAT officers take me seriously if I'm not a sworn officer?

(Greenstone, 2005)

The Possible Responses to These Questions

What Do I Do?

First, talk to the person who invited you to work with these teams.

What did this person have in mind for you? If this person is not the team leader, how does the team leader feel about your involvement and what does this person see as your role? What about training for you? How will that be provided? Sometimes, it is very difficult to get into police negotiations and / or SWAT training programs if you are not a police officer or a police psychologist who works with these teams. Up-front training may offer some valuable insights that will be useful in making your decision to become involved.

What Are My Obligations to the Team?

Obligations to the team will probably be directly related to your agreed-upon involvement. If you are going to become involved in this way, you have a major obligation to the teams and their members. It is important to be there for them and the team as a whole whenever they need you. If that is too much, adjust accordingly. Just be clear with the team to avoid misunderstandings and bad feelings on both sides. Without such an understanding, your credibility as a mental health professional and team member could be in jeopardy.

What About My Liability Exposure?

There may be no exact answer to this question. If you are full time with a department and functioning as the police psychologist and your job description indicates that consulting to the negotiations and SWAT teams is part of the territory, you are probably okay. Even this may not be one hundred percent true in our litigious society. Part-time people probably pose a different problem. Check with your liability insurance carrier. Is this new involvement considered within the purview of your work as a psychologist or other mental health professional? Licensing boards may be helpful also. Approach this area with care, but be careful not to catastrophize either.

Do I Need Special Liability Insurance to Cover Me During My Work on an Incident?

Maybe. However, check the rules in your jurisdiction and also with your insurance carrier. This area of police work is just finding its way into the mental health field as an area of expertise. You may be clearing new ground.

What About Time Commitments?

This can be a problem if you do not think this through and do not understand what your role is with these special teams. If the team believes that they can depend on you being there when they need you, then you must be there when they need you. It is just that simple. Simplicity, however, begins to fade very quickly if you do not understand this concept from the outset. You can define your own time commitments to the teams, but any reasonable degree of involvement will require much time spent on your part. The teams will look to you for training, planning, assistance at actual incidents, development of training scenarios, post-incident debriefings,

and a myriad of other tasks both personal and professional. As they develop trust in you, they will come to have greater reliance on you as the needs arise. If you are married, or want to be for a reasonable period of time, you may want to be sure that your significant other really understands what you are getting into. It will not always be convenient for your partner either. Even though you have just spent several hundred dollars for theater tickets and just as the curtain goes up, you are called to the scene of a jumper who is all the way across town, you will need to respond. And that's the long and the short of it.

What if I Am Called at 2:00 in the Morning?

And you will be called at 2:00 a.m. or at any time for that matter. Experience shows that the callout comes at the most inconvenient times and at those times when one has just finished an entire workday and is worn out. It really does not matter. When called, you go. And when you go, nobody cares that you have had a long day and that you would rather be home sleeping. The expectation is that you will be as sharp as you need to be and that you have taken care of your personal needs yourself. You should show up at the scene ready to go to work at whatever task is necessary to support the team effort. This could include hauling equipment or cable, helping with installations, etc., as well as providing professional assistance and backup.

How Can I Respond to a Team Callout if I Am a Single Parent?

Problem! Obviously, you need an on-call babysitter. If this is a major problem area, it may be necessary to limit your involvement with the team for the benefit of all concerned. Work this out ahead of time.

How Much Training Will I Need to Do This Job?

Some states mandate the amount of training that is necessary (Texas Penal Code 16.02 and Texas Code of Criminal Procedure 18.20(23)). A minimum of forty hours of training in a course that requires practical applications as a part of course of instruction is a must. Retraining should occur annually. Training in related areas would also be helpful. Combining your professional training with the specific police hostage negotiations and basic tactical training should be sufficient for novices to this field. Continual training both within and without the team is critical. The team will depend

on you to have the best available information in all related areas at your disposal.

How Much Time Should I Allow?

As much time as it takes if you are serious about your involvement.

How Involved Should I Become?

Of course, this is a personal matter. Those who are involved probably would get more involved if they could. You may find that this is true for the team members also. As mentioned earlier, either it is for you or it is not for you. If you find your niche, you may find that you want to explore and to develop it to the fullest. For instance, hostage and crisis negotiations teams are often betwixt and between within the departmental structure. Some departments see their negotiations team as a phantom unit that springs to life only when needed, but that otherwise is largely disregarded in the overall scheme of things. Their involvement with each other and with you is important for morale and overall team effectiveness.

How Much Should I Charge for My Services to the Hostage and Crisis Negotiations Team?

If your involvement is part of your job description, no problem. Coming in from the outside may pose some problems. You can always try to arrange a deal that pays you your normal hourly rate for the actual number of hours worked with the team in training or at incidents. A backup psychologist or OPBHS used during times when the primary OPBHS Is out of the country, etc., may charge his usual rate. However, he is only used as back-up and not on a regular or ongoing basis. As a result the expense is minimal, but does provide for such assistance to the team on an as-needed basis. Another possibility is to contract for a flat rate. You would provide the needed input and services and draw a standard monthly compensation. Of course, this means that you could spend one hour or twenty hours for the same money. There is nothing wrong with this as long as you are clear about it. The reality is that you may need to be compensated. However, if the compensation is the sole motivator, perhaps it is time to reconsider your choice. There is nothing wrong with volunteering.

Should I Become a Police Officer or a Reserve Police Officer?

Now here is an excellent idea. Establish your credibility in this police-specific endeavor by learning to do the job of a police officer from the inside. Usually, reserve officers are not paid for their services, but they are provided with training and equipment. The training is worth its weight in gold to someone who really wants to get involved in this area. In Texas, for example, reserve officers are required to pass through several training levels that eventually result in a regular peace officer license. Most departments do require that reserve officers work for the department a defined number of hours per week or month. The reality is that a psychologist or OPBHS does not have to be a police officer to be an effective member of these teams. But, it sure helps.

Should I Contract for a Flat Fee to Cover My Services?

Explore this with your department. It may be a more realistic approach all around rather than charging your hourly rate.

Should I Volunteer My Time?

Yes, especially at first. Prove your worth to the team and to the department. It might make it easier to get the money flowing once they see the necessity of having you on board. And, it really is important to give something back. The rewards are not so bad either.

How Much Time Should I Give to the Team?

Give as much time as you want to and as much as you can. The more that they see you, and come to rely on your presence, the greater your credibility. Credibility with police officers takes time, but is worth the effort. Do not ever confuse their politeness toward civilians like yourself with credibility. You build credibility by credible involvement.

Can I Limit My Involvement with the Team?

Of course you can limit your involvement with the teams. You may want to start slowly and give more time as you find that you like working in this area. Be clear with the team and with the department about the amount of time that you are willing to give. Don't be shy about it. They may want

more from you, but they will appreciate your honesty. You can always increase your time given.

Do I Need to Be There for the Team Every Time They Call on Me?

If you tell the team that you will be there, be there! Most understand occasional illness or if you are out of town. If you have defined a limited role for yourself, this may solve the problem. But if you have signed on for the long haul, they will look for you when something happens. In reality, if you do not show up, nobody will say a word. But it will be quietly understood that they should not depend on you. The implications of this can be great or small according to how you have fashioned your relationship with the team.

How Do I Get the Training That I Need to Do This Job?

Ask for training. Even, insist upon it if you are to become involved. Training comes in various forms and you should take it upon yourself to find out what and where training is available in hostage and crisis negotiations and special weapons and tactics. You may be able to get the department to pay for or to provide your initial training, but be prepared to get the needed training regardless. Training is not uniformly provided across the United States. Each state does it differently. The tactical and hostage and crisis negotiations courses offered at various training centers might include the following:

1. Basic Hostage and Crisis Negotiations—40 hours

2. Advanced Hostage and Crisis Negotiations—40 hours

3. Accelerated/Recertification Hostage Negotiations—48 hours.

   This is a level III course and requires successful completion of

   the basic and advanced courses.

4. First Responder to Hostage and Crisis Situations—16 hours

5. Hostage Negotiations for Police Psychologists—40 hours

6. The Psychology of Hostage Negotiations—24 hours

7. Basic Tactical Training --- 40 hours.

8. Advanced Tactical Training --- 30 hours.

You may want to contact various police organizations such as the International Association of Chiefs of Police and get their training catalog. In more and more states and regions, professional organizations of tactical officers and hostage and crisis negotiators are being formed. Some have existed for many years and have developed their own in-house basic training programs. You may want to affiliate with the group in your area.

Should I Get Involved with the Negotiations Team or the Tactical Team at All? Is This for Me?

This should be your first question. This work is not for everybody. Talk to the team. Talk to others in our field who have become involved. See what they think. What problems have they encountered? Carefully consider your motives for considering this line of work in addition to your full-time job. Can you do it in a way that compliments what you are now doing? Does it feel right? You probably already know the answer to this question.

What Will My Role Be During an Actual Incident?

When you go to training, most of these types of questions will be answered. It will become obvious to you where you will fit in the overall scheme. Talking with other police psychologists who are involved with a team will help define your role. Even asking your teams what role they might want you to play during an incident might be helpful. Normally, the role of the Operational Police Behavioral Health Specialist is to assist the negotiators in profiling hostage takers and victims, and then helping to formulate negotiations strategies. You may also be involved in the negotiations room with the primary and secondary negotiators. You provide an extra set of eyes and ears during the negotiations. You also provide encouragement and stress management for the negotiators and tactical officers. Conceivably, you might be involved in intelligence gathering, talking with medical and psychiatric personnel about the subject, setting up equipment, updating the situation logs, or consulting with the special weapons and tactics team commander about courses of action. You may find yourself operating completely in the negotiations command post or moving between the negotiations unit and the incident command post. As with things of this nature, flexibility and adaptability are the key. Often, you are expected

to know more than you, or any other OPBHS for that matter, may know. It becomes an opportunity to pull together everything you were ever taught or trained to do and to put it all on the line at a moment's notice. The possibilities are endless.

Will the Negotiators and SWAT Officers Take Me Seriously if I Am Not a Sworn Officer?

That really depends on you. If you are not credible, it doesn't matter if you are sworn or not. If you do not have the background, training, and involvement with the team, you may not be viewed as serious, and hence not taken seriously. The fact that you may be a former officer or a current reserve officer, with your current department or with another department, establishes that you may know police work. If, however, your professional background, professional and hostage negotiations training, your tactical training , and a firm commitment to the team are not in place, your sworn status will probably do you little good. It all fits together to the benefit of the teams and you if you make sure that all the parts are present and properly represented.

Now What?

You know that when it is all said and done, it is really your decision whether or not to become involved. It is an important decision, to say the least. At the most, your involvement may give you the experience of a lifetime, both personally and professionally. You will make the correct decision for you. If it does not feel to you like your involvement is the right thing to do, it probably is not regardless of all of the other reasons in the "plus" column. Examine all that is involved and in the last analysis, let your personal energy guide you. As dictated by experience, this energy is very seldom wrong. (Greenstone, 2005)

Final Note

Functioning as an Operational Police Behavioral Health Specialist is a multifaceted job. It carries with it special responsibilities and requirements. Combined efforts of the OPBHS and the Operational Police Physician go a great distance in providing the standard and continuum of care that is needed, but often overlooked, when addressing police special teams. Be it the behavioral health specialist or the physician, both must be carefully and thoughtfully selected. They must

be there when the going is rough and there are no excuses for not providing the highest quality of care when needed. SWAT and Negotiators deserve this assistance and must be able to count on it. Even if department heads are overwhelmed by the suggestions in this writing and in Dennis (2011), that should not deter them from at least looking at this need and making plans to move in this direction at a suitable pace. It is hoped that the flow charts and diagrams provided will be a help in this challenge.

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Crisis Intervention Team (CIT) Training in the Jail/Detention Setting: A Case Illustration

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Abstract: *Research has documented the over-representation of persons with severe and persistent mental illness (SPMI) in jails and prisons. Further, increased attention has been directed to jail diversion programs and other attempts to prevent incarceration of adults with SPMI. Yet, regardless of available diversion programs, and recent trends in mental health within correctional settings, jails continue to see a disproportionate increase in inmates with SPMI. The purpose of this paper is to provide an overview of the research, public policy, and current best practices for the development and implementation of Crisis Intervention Team (CIT) Training as an in-house intervention in jail/detention-based settings. Our review provides support for deploying this specialized law enforcement response program to address the needs of mentally ill persons within jail settings. Strategies and issues in the utilization of the CIT model in detention contexts are discussed. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 209-216].*

Key words: *jail, detention, crisis intervention, CIT, Crisis Intervention Training*

Research and public policy have documented the over-representation of persons with severe and persistent mental illness (SPMI) in jails and prisons (Council of State Governments, 2007; Ditton, 1999; Freudenbert, 2004; James & Glaze, 2006; Lamberti & Weisman, 2004; Phillips & Mercke, 2003; Ruddell, 2006). In 2008, the National Institute of Mental Health estimated serious mental illness at a prevalence rate of 4.5% nationwide. By comparison, rates of serious mental illness in jail inmates range from 13% to

56% depending on the definition of mental illness (James & Glaze, 2006; Ruddell, 2006). Ascher-Svanum, Nyhuis, Faries, Ball, and Kinon (2010) estimated U.S. criminal justice system involvement for persons with Schizophrenia, not including cost of legal supervision (e.g., probation), to be well above and beyond generally expected health care costs of Schizophrenia, estimated in 2002 to be $62.7 billion, with $22.7 billion excess direct health care cost (Wu, Birnbaum, Lizheng, Ball, Kessler, Moulis, Aggarwal, 2005). Further, while exact prevalence estimates are difficult to ascertain, it is a sobering reality that suicide is now recognized as the

leading cause of death in detention and correctional settings (Noonan, 2010).

Many factors have contributed to the burgeoning focus on mental illness in the criminal justice system. First, dein-stitutionalization of the serious and chronically mentally ill is the primary explanation offered for the shift in both cost and responsibility to the criminal justice system (Freudenberg, 1994; Lamberti & Weisman, 2004; Lurigio & Fallan, 2007). However, there are other contributing factors including: the war on drugs, decentralized community mental health systems, the lengthy and restrictive process for involuntary commitment, psychiatric bed shortages, and increasing rates of under- and of un-insured persons with mental illness (Council of State Governments, 2007; Laberge & Morin, 1995; Lamb & Weinberger, 1998; Lurigio & Fallan, 2007; Race, Yousefian, Lambert, & Hartley, 2010). Moreover, along with the increasing SPMI population in jails and prisons nationwide, are the often inadequate mental health services which are generally limited to screening, administration of medications, and medical/medication management (Council of State Governments, 2002; Morris, Steadman, & Veysey, 1997; Scheyett, Vaughn, & Taylor, 2009).

This paper will focus on jail systems, which in the United States, are locally operated places of incarceration typically run by the County; prisons are managed by the state or federal government. County jails house inmates who are awaiting trial, serving short (typically less than one year) sentences, and/or awaiting transfer to other facilities (e.g., Community Corrections). This makes for a high turnover rate in groups of inmates with a wide range of criminal offenses (from individuals who have not yet been charged in a court of law, to non-violent misdemeanors, to violent felonies) and psychiatric disorders (e.g., schizophrenia, depression, substance abuse). Unlike mental health treatment facilities, jails cannot refuse admittance if a crime has been committed, regardless of mental status and presentation of a psychiatric disorder. This is particularly problematic in communities where specialized programming for offenders with mental illness is not available. In addition, there is consensus that jails have the same rates of persons with severe mental illness as prisons, but generally fewer mental health services (Council of State Governments, 2002; James & Glaze, 2006; Morris et al., 1997; Ruddell, 2006).

The Detention/Jail Setting

When police officers are confronted with a mentally ill person, they have three options: (1) transport them to a receiving psychiatric facility, (2) use informal verbal skills to de-escalate/diffuse the situation, or (3) arrest (Teplin, 2000). According to Teplin (2000), these possible actions are based on two basic concepts that guide police in all citizen encounters: (1) the duty of the officer to protect and serve the community, and (2) the governing reforms that stipulate the power of an officer to involuntarily protect an irrational person who may be of harm to self or others.

In a jail setting, the issues are not that different. According to the Bureau of Labor Statistics (BLS) Occupational Outlook Handbook (2010-2011 edition), the role of a Detention Deputy is to maintain security and inmate accountability, and prevent disturbances, assaults, and escapes. The job is described as "stressful and hazardous; correctional officers have one of the highest rates of nonfatal on-the-job injuries" (BLS, 2011). Detention officers have the option to: (1) refer/transport to mental health services (if available in the facility), (2) use de-escalation skills, or (3) employ force which may result in new criminal charges for the detainee as well as injuries to officers and inmates; and injuries within jail settings are common (Lamberti & Weisman, 2004).

In addition, a relatively rare, but high-risk outcome of those incidents, is police-assisted suicide, which occurs when a "person intentionally engages in life-threatening behavior to induce a police officer to shoot that person. His/her goal is to provoke the law enforcement officer to a lethal response" (USLegal). This phenomenon, often referred to as "suicide by cop", leaves the officers as the victim in a forced "execution" (Geberth, 1993). Research has supported the deployment of specialized law enforcement response units, such as those that receive Crisis Intervention Training (e.g., Hanafi, Bahora, & Demir, 2008), to address the needs of mentally ill persons in the community (see review by Tucker, Van Hasselt, & Russell, 2008).

Crisis Intervention Team Training

Regardless of available diversion, re-entry, or community-based treatment programs, seriously mentally ill persons are disproportionately represented and inadequately treated in

most jail systems. Our purpose here is to review and assess current trends in jail facilities at managing mental illness, particularly the use of Crisis Intervention Training (CIT) as an in-house intervention.

Historical Overview

In 1988, Memphis, Tennessee police officers responded to a call for service regarding a suicidal man diagnosed with Schizophrenia. The man on the scene was brandishing a knife, which officers ordered him to place on the ground. Instead, the man made a sudden move toward the officers. They were forced to shoot him, as they had been trained to do in such situations, and the young man died as a result. In response to this tragedy and subsequent public outcry, that year the Memphis Police Department joined with their local chapter of the National Alliance for the Mentally Ill (NAMI) and formed a new community-policing partnership that created specialized teams of officers trained to manage people in crisis: the Crisis Intervention Team (Vickers, 2000).

Widely known as the "Memphis Model," CIT provides road patrol officers 40 hours of training in mental health issues and related community resources. Training components generally include: (1) didactic presentations regarding the signs/symptoms of major psychiatric disorders, pharmacological interventions/medication side effects, and crisis intervention and de-escalation skills; (2) role-play exercises to facilitate crisis intervention and de-escalation skill acquisition; (3) mental health consumer perspectives; and (4) a detailed overview of the community resources available to officers referring persons experiencing mental health emergencies (Browning, Van Hasselt, Tucker, & Vecchi, 2011; Tucker, Van Hasselt, Vecchi, & Browning, 2011). Following completion of training, participating officers receive a CIT pin to wear on their uniform. This pin identifies them to mental health consumers as CIT officers, and is considered a source of pride by the officers wearing them (Vickers, 2000).

Research shows that the Memphis CIT model is functional, positively viewed by law enforcement professionals completing CIT, and most importantly, effective as evidenced by reduced arrest rates, increased access to mental health treatment, reduced injuries (to both officers and subjects), and (of particular relevance here) fewer jail suicides (Borum, Deane, Steadman, & Morrissey, 1998; Dupont & Cochran, 2000; Reuland & Cheney, 2005; Skeem & Bibeau, 2008; Steadman, Williams-Deane, Borum, & Morrissey, 2000).

Case Illustration

There are a considerable number of reviews and research reports on the development, implementation, and effectiveness of CIT as employed by police officers (e.g., Borum, Deane, Steadman, & Morrissey, 1998; Browning et al., 2011; Sellers, Sullivan, Veysey, & Shane, 2005; Steadman et al., 2000; Tucker et al., 2008) and criminal justice diversion programs (Hankinson, 2009; Parker, Foley, Moore, & Broner, 2009; Steadman, Stainbrook, Griffin, Draine, Dupont, & Horey, 2001). However, little information is available concerning the utilization of CIT with Detention Deputies in jail settings. An example of the successful application of this approach in the detention setting is described below.

In 1999, Adams County Sheriff's Office (ACSO) and Community Reach Center, a non-for-profit community mental health provider in Adams County, Colorado (located northwest of Denver) aligned and created a county-wide CIT Steering Committee. Over the years, the Adams County CIT Steering Committee has expanded to include representatives from six other major municipalities and cities including Thornton, Westminster, Norhglen, Commerce City, Brighton, and Federal Heights Police Departments. A major goal of this CIT Steering Committee was to provide CIT training to as many county law enforcement personnel as possible. To date, the CIT Steering Committee has been successful in training over 400 police officers, and the trainings continue, averaging two to three per year. In 2008, Sheriff Doug Darr of ACSO decreed that all jail deputies would be trained in CIT; and this progressive thinking has, to date, resulted in over 100 jail deputies "CIT pinned."

The ACSO requires that all deputies who wish to serve in the Sheriff's Office first be trained and spend a minimum of a year in the Adams County Detention Facility (ACDF)/ County Jail and now each deputy within ACDF will also have full 40-hour CIT course. The 40-hour, weeklong CIT course for the jail includes all of the standard CIT course work and hours of role-play, but tailors some of the training to their specific setting. For example the "Legal" presentation from the local District Attorney's Office focuses on Constitution Rights of inmates and involuntary treatment standards, while the role-plays are all formatted for crisis situations that would occur in a jail setting (e.g., suicidal person at Booking following charges of domestic violence).

Since training jail deputies in CIT, both the ACSO and Community Reach Center have been collecting CIT data

forms which are basic outcome assessments that the officers complete following their use of CIT. These data forms have revealed both similar and divergent results for jail deputies relative to previous research involving police officers (see Figures 1.1-2.2). Most notable were the findings on injuries and threats of harm to law enforcement. The data indicated that "wanting to harm others" was about the same as road patrol officers. However, the "threats of harm to police" was much higher in the jail setting. Further, the rate of injuries was high in the jail compared to the sample of CIT data obtained from the entire county (Figures 1.1, 1.2, 2.1, and 2.2). These results highlight a critical need for CIT training in jail settings due to what appears to be a higher risk of officer-assisted suicide threats in county jails.

One of the major successes in this jail-based CIT initiative has been the cultural shift within the facility. In 2009, ACSO started contracting their in-house mental health services directly with Community Reach Center in an attempt to increase the connection of mental health treatment provided from community to jail and back to the community. The overall goal was to reduce recidivism with improved mental health care and discharge planning. Then, in 2010, the Captain of the jail initiated the Critical Incident Review Team (CIRT) to mandate interdisciplinary review of all critical incidents in the jail, defined as suicide completions, suicide attempts, physical injuries to both inmates and staff, etc. The cultural shift of acknowledgement and acceptance is perhaps best reflected in interviews with jail-based deputies. Officer Jennifer Mendez (CIT pinned Officer, Coach, and Trainer), for example, stated:

"I believe CIT training has paid off for many deputies and civilian staff in untold ways. The program has been

Figure 1.1
Percentage of Calls with Injuries
Entire Sample

Injury to Civilian 11%

Injury to Police 0%

No Injury 89%
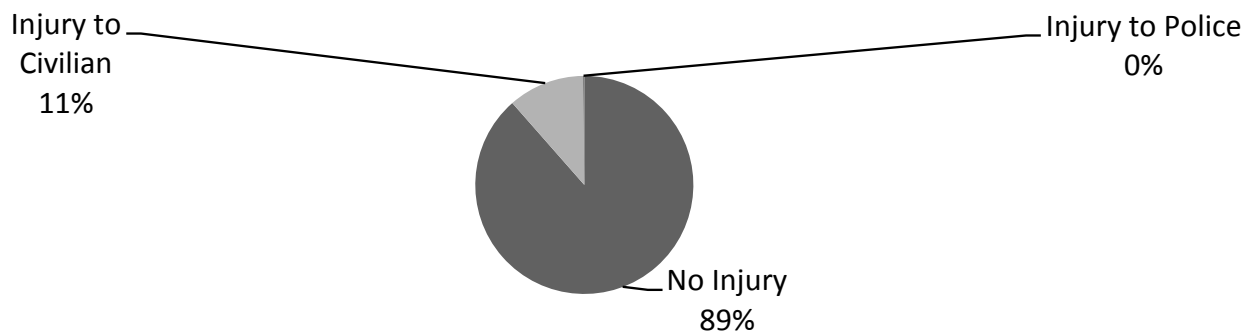
Figure 1.2
Percentage of Calls Resulting in Injuries
ACDF Sample Only

Yes 16%

No 84%
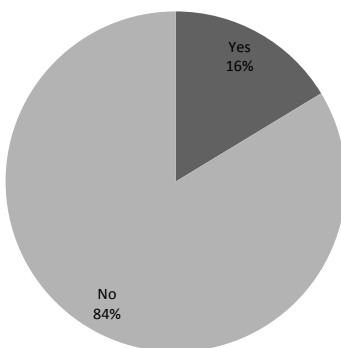
Figure 2.1
Percentage of Calls per Threat Type
Entire Sample
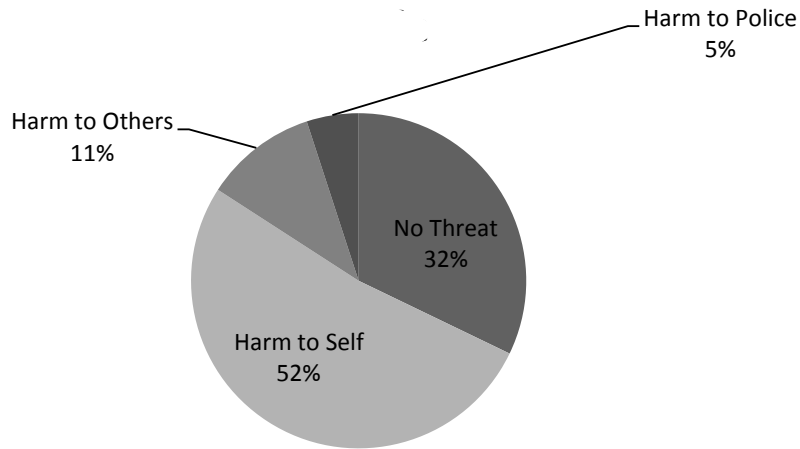
Figure 2.2
Percentage of Calls per Type of Threat Made
ACDF Sample Only
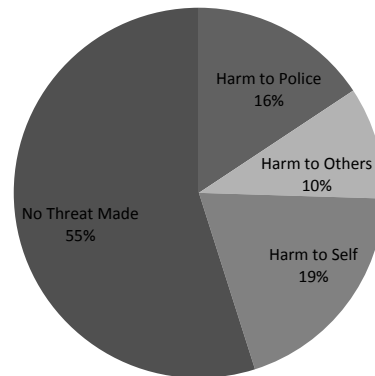
well worth the investment. Several peers have told me that it has opened their eyes and gets them to look at an individual in many situations in different ways. They truly see and understand where the emotions come from. I have seen several situations where deputies would normally have written an individual off, labeled them crazy, and moved on. After training, you see them stop for a moment to listen, and have gained so many facts and knowledge that would help de-escalate a highly emotional situation. I have heard many deputies say they felt like they were back in role plays again, except this time it is real; no time outs."

Deputy John Goodman related his CIT training and use of CIT in the jail to his experience in working the streets and underscored the need for specialized CIT response in jail settings:

"If you think about it, the street cop makes the first contact; we jail deputies end up dealing with this person for days or even weeks. Inmates entering intake are coming off the booze and the dope and it's only a matter of time before you realize that the person is also suffering from mental illness. For me it has made the difference between verbal communication versus physical contact."

Summary and Conclusions

The need for a specialized jail/detention-staff response to inmates with mental illness is highlighted with the identification and analysis of the over-representation of persons with severe mental illness and the under-utilization of behavioral health programming in jail settings. Case examples and subjective interviews indicate acceptance of this model, and support both the continued practice of specialized training, such as CIT, for jail staff. They also support the need for further research concerning the heuristic value of this model. Suggestions for future research directions include: (1) comparisons of non-correctional CIT programs with jail-based CIT, with a focus on skill retention and application (Compton & Chien, 2008), (2) analyzing the effect on officer and inmate safety, and reduction in high-acuity in-custody care needs (i.e., emergent hospitalization) as a function of CIT training in a jail facility, and (3) determining the impact of CIT training with jail personnel to enhance resiliency and coping skills. At this time, it appears that CIT training holds considerable promise in jail and correctional settings. However, additional investigative efforts are needed to clearly ascertain its utility in these contexts.

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Awareness and Utilization of Peer Support Programs in Singapore Public General Hospitals

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Abstract: *To address the effects of acute, chronic and cumulative stress in the healthcare environment in Singapore, the Ministry of Health provided funding to develop a comprehensive crisis response management system (peer support programs/PSPs) that increases mental health awareness, provides emotional support to affected staff during work-related critical incidents and assists hospital management to better understand the emotional needs of the employees. This paper reports the awareness and utilization of PSPs in Singapore public general hospitals about one year after they were set up. [International Journal of Emergency Mental Health, 2012, 14(3), pp. 217-224].*

Key words: *peer support program, CISM, work stress, Employee Assistance Program*

Objective

Healthcare workers are exposed to many safety and health hazards. In addition, stress and violence are noted to be high in health sector workplaces. In 2004, a local study reported the prevalence of psychiatric disorder among the doctors and nurses in a medium sized public hospital was similar to those in Britain (28-35%). Interestingly, only a very small percentage (<4%) actually sought help for their emotional problems. To address the effects of acute, chronic and cumulative stress in the healthcare environment in Singapore, the Ministry of Health provided funding to develop a comprehensive crisis response management system (peer support programs/PSPs) that increases mental health awareness, provides emotional support to affected staff during work-related critical incidents and assists hospital management to better understand the emotional needs of the employees. This paper reports the awareness and utilization of PSPs in Singapore public general hospitals about one year after they were set up.

METHOD

A general survey was conducted over two months across seven public hospitals in Singapore about one year after PSPs were introduced. Healthcare workers from different job categories were asked to complete a simple questionnaire

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which comprised of five questions. Their participation was strictly anonymous and voluntary.

RESULTS

Within one year of set up, about 70% of the staff in the public hospitals were aware of PSP with an average of 8.5% utilization rate. Those who were aware of the PSP were 14 times more likely to have utilized the services and 95% found the support helpful. The job categories who utilized PSP most were Nursing/Ward Managers (17.6%), HODs & above (16.1%) and Ancillary staff (14.1%) with more than 85% of HODs & above indicating that they would utilize the PSP if they experienced personal or work stress or a critical incident in the future. About 65% of the staff indicated that they would use PSP if they were experiencing personal or work stress or critical incident and they were 2.4 times more likely to do this if they were aware of the service.

Conclusion

Raising awareness of Peer Support Program services increases utilization rates. This is important in establishing Peer Support Programs within organizations.

Introduction

Healthcare workers are exposed to many safety and health hazards. In the event of any large scale disasters such as acts of terrorism and disease outbreaks e.g. SARS & Flu Pandemic, healthcare workers are essential frontline responders for the sick and injured. Local research findings of the psychological impact of SARS amongst Singapore health care workers in a regional hospital showed that two months post-outbreak, about 20% of the survey participants suffered from post-traumatic stress disorder (Chan & Chan, 2004a).

In addition, stress and violence are noted to be high in health sector workplaces (DuHart 2001, Gerberich et al 2004, Kowalenko et al 2005). Healthcare workers are often subject to abuse, threatened or assaulted during the course of their work by patients and relatives. While workplace violence affects practically all sectors and all categories of workers, the health sector is at particular risk. More than half of all workers in this sector may have experienced violent or traumatic incidents at some point in their careers (WHO, 2003). Chan & Chan (2004b) reported the prevalence of psychiatric disorders such as depression and anxiety among

the doctors (35%) and nurses (28%) in a public hospital was similar to those in Britain (28-32%). Interestingly, only a very small percentage (<4%) actually sought help for their emotional problems.

Hence it is important to address the effects of acute, chronic and cumulative stress in the healthcare environment in Singapore through the development of a comprehensive crisis response management system that increases mental health awareness, provides emotional support to affected staff during work-related critical incidents, aids recovery through timely appropriate referrals to relevant professional help and assists hospital management to better understand the emotional needs of the employees (Everly & Flannery, 2000).

In FY 07, the Ministry of Health (Singapore) accepted a proposal to develop Peer Support Programs (PSP) in all the seven public hospitals which would be funded under the Hospital Services Development Program from Jan 2008-Dec 2012. The PSP is a voluntary, system-wide, peer-help, multi-component crisis intervention procedure to assist employee victims of assaults or other acts of violence. Our PSP services include individual and group crisis interventions, consultation on crisis management to senior management, employee victim family interventions, in-house staff counseling services and referrals to mental health professionals as needed. The model of approach is based on the Critical Incident Stress Management (CISM) (Everly & Mitchell, 1999). The funding included one PSP Coordinator for each public hospital and training for 1200 peers (about 10% of staff in all public hospitals in 2006) in CISM and Mental Health First Aid (Kitchener & Jorm, 2004). The aim is to mitigate the possible negative impact of stressful events by building resistance and resiliency as well as provide assistance to aid recovery within the healthcare community.

Peer Support Programs have been established in various organizations but there has been limited reports on the awareness and utilization rates within these organizations. This is important as it helps to evaluate the usefulness of such programs. This paper reports the awareness and utilization of peer support programs in Singapore public general hospitals about one year after they were set up.

METHODOLOGY

A survey questionnaire is a simple 5-question self-report. Participants were asked to indicate their job category (Head of Department & above, Medical, Nursing, Allied

Health, Admin, Ancillary, Ward Manager), awareness of PSP in their hospital, if they had utilized the service within the last 12 months, if they had utilized the service was the support helpful to them, and would they use this service if they experienced a critical incident e.g. harassment, abuse, assault, loss, investigation etc. The survey questionnaire was intentionally kept simple to encourage participation.

The survey took place over 2 months (Oct-Nov 2009) and major efforts were made to ensure that there was a proportionate sampling of the staff in the various job categories represented in the hospitals based on the size of each of these categories i.e. Heads of Department/HODs & above (5%), Medical (5%), Nursing (20%),Allied Health (15%), Admin (15%), Ancillary (15%), Ward Manager (25%).

The survey questionnaires were sent to healthcare workers from the various job categories in the seven public general hospitals through their respective PSP Coordinators based on the sampling size mentioned above and participation was strictly voluntary. They were informed that their responses were completely anonymous and will be pooled into a collective database. The purpose of the survey was to assess the level of awareness and willingness to access PSP services by senior management and hospital staff, and, the satisfaction level of those who did utilize PSP services as this would provide feedback to the Ministry of Health on its usefulness.

Statistical Analysis

All statistical analyses were performed using SPSS 20.0 with statistical significance set at $p < 0.05$. Basic descriptive for the categorical variables were presented as n(%). The predictors for Awareness of PSP and Utilization of PSP were determined using Chi-square or Fisher's Exact test and multivariately adjusted using logistic regression analysis. Unadjusted and adjusted odds ratios with the 95% Confidence interval were presented.

RESULTS

A total of 1818 healthcare workers responded to this survey with a proportionate sample of each of the job categories fairly represented.

Table 1 shows that 69.5% of the participants were aware of the existence of PSP with the HODs topping the list (93.5%). At least 70% of Administration, Allied Health & Ward Managers (who are senior nurses) were aware of PSP

services while only 54.3% of the Medical (i.e. Doctors) were.

Compared with the other job categories, HODs (16.1%), Ancilliary (14.1%) and Nursing (10.6%) staff were the three categories that utilized the PSP services most. More than 90% of those who utilized the PSP services found it to be useful (Table 1).

For most of the job categories, more than 60% of the staff were willing to use PSP services if they experienced problems (e.g. work or personal stress or experienced critical incident e.g. harassment, abuse, loss, workplace investigation etc). Interestingly, more than 80% of the HODs would utilize PSP while less than 50% of the Medical staff would.

Staff who were willing to use PSP services if they experienced problems were more likely to be aware of PSP ($p < 0.001$, adjusted OR = 1.7 (95% CI 1.4 – 2.2)). Compared to Medical (with the lowest percentage of PSP awareness), Administration, Allied Health, HODs and Ward managers were statistically significantly more aware of PSP services (see table 2) but not the Ancillary and Nursing staff.

Table 3 shows that Ancillary, HODs and Nursing staff were most likely to use the PSP services compared to Administration staff, with Allied health showing a trend to use. Staff who are aware of PSP were also more likely to utilize PSP ($p < 0.001$, adjusted OR = 14.3 (95% CI 5.8 – 35.3). Those who are aware of PSP are also more likely to utilize PSP services if they experienced problems in the future ($p < 0.001$, adjusted OR = 2.4 (95% CI 1.5 – 3.8)).

DISCUSSION

The concept of workplace crisis intervention and Employee Assistance Programs (EAPs) is new in Singapore especially in the public sector. The PSP services which basically is an in-house EAP (Masi, 2005) is even less known. Hence the awareness of PSPs in the public hospitals at the end of one year, although only 69.5%, is actually very encouraging especially since those who were aware of PSP were 14 times more likely to have utilized the services over the last one year. In addition, healthcare workers are 2.4 times more likely to utilize PSP service if they experienced personal or work stress or a critical incident in the future if they are aware of such a service. This means that organizations with PSP needs to be highly visible and active in their activities; be involved in orientation programs and organize regular publicity events and training annually to the employees.

Job Category	N (%)	Aware of PSP	Utilized PSP	PSP helpful	Willingness to use PSP
				Table 1.	
			Subjects' Descriptive by Job Category		
Administration Staff	343 (18.9)	241 (70.3)	13 (3.8)	13/13 (100)	211 (61.5)
Allied Health	255 (14.0)	195 (76.5)	19 (7.5)	19/19 (100)	164 (64.3)
Ancillary Staff	205 (11.3)	118 (57.6)	29 (14.1)	27/29 (93.1)	137 (66.8)
Head of Departments	62 (3.4)	58 (93.5)	10 (16.1)	9/10 (90)	52 (83.9)
Medical	94 (5.2)	51 (54.3)	5 (5.3)	5/5 (100)	46 (48.9)
Nursing	519 (28.5)	343 (66.1)	55 (10.6)	51/55 (92.7)	355 (68.4)
Ward Managers	340 (18.7)	257 (75.6)	23 (6.8)	22/23 (95.7)	218 (64.1)
Total	1818 (100)	1263 (69.5)	154 (8.5)	146/154 (94.8)	1183 (65.1)

Values are n(%)

Job Category	Aware of PSP	Unadjusted p-value OR (95% CI)	Adjusted p-value OR (95% CI)
Table 2. **PSP Awareness – Unadjusted and adjusted predictors**			
Administration Staff	241 (70.3)	p = 0.004 2.0 (1.2- 3.2)	p = 0.012 1.8 (1.1- 2.9)
Allied Health	195 (76.5)	p < 0.001 2.7 (1.7- 4.5)	p < 0.001 2.5 (1.5- 4.1)
Ancillary Staff	118 (57.6)	p = 0.593 1.1 (0.7- 1.9)	p = 0.959 1.01 (0.6- 1.7)
Head of Departments	58 (93.5)	p < 0.001 12.2 (4.1- 36.4)	p < 0.001 9.7 (3.2- 29.2)
Medical	51 (54.3)	1.0	1.0
Nursing	343 (66.1)	p = 0.029 1.6 (1.1- 2.6)	p = 0.104 1.4 (0.9- 2.3)
Ward Managers	257 (75.6)	p < 0.001 2.6 (1.6- 4.2)	p < 0.001 2.4 (1.5- 3.9)
Willingness to use PSP			
No	377 (61.3)	1.0	1.0
Yes	874 (73.9)	p < 0.001 1.8 (1.4 – 2.2)	p < 0.001 1.7 (1.4 – 2.2)

Note: OR = 1 is the reference group.

Job Category	Utilized PSP	Unadjusted p-value OR (95% CI)	Adjusted p-value OR (95% CI)
Table 3. PSP Utilization – Unadjusted and adjusted predictors			
Administration Staff	13 (3.8)	1.0	1.0
Allied Health	19 (7.5)	p = 0.054 2.0 (0.99- 4.2)	p = 0.080 1.9 (0.9- 4.0)
Ancillary Staff	29 (14.1)	p < 0.001 4.2 (2.1- 8.2)	p < 0.001 5.0 (2.5- 10.1)
Head of Departments	10 (16.1)	p < 0.001 4.9 (2.0- 11.6)	p = 0.008 3.3 (1.4- 8.1)
Medical	5 (5.3)	p = 0.518 1.4 (0.5- 4.1)	p = 0.202 2.0 (0.7- 6.0)
Nursing	55 (10.6)	p < 0.001 3.1 (1.6- 5.7)	p < 0.001 3.1 (1.6- 5.8)
Ward Managers	23 (6.8)	p = 0.089 1.8 (0.9- 3.7)	p = 0.133 1.7 (0.8- 3.5)
Aware of PSP			
No (n = 542)	5 (0.9)	1.0	1.0
Yes (n =	149 (11.8)	p < 0.001 14.4 (5.9-35.2)	p < 0.001 14.3 (5.8-35.3)
Willingness to use PSP			
No	24 (3.9)	1.0	1.0
Yes	127 (10.8)	p < 0.001 3.0 (1.9-4.7)	p < 0.001 2.4 (1.5-3.8)

Note: OR = 1 is the reference group.

Although the number who utilized the PSP within the last one year was small (8.5%), 95% found the support helpful. Interestingly, the job categories who utilized PSP most were Nursing/Ward Managers (17.6%), HODs & above (16.1%) and Ancillary staff (14.1%) with more than 85% of HODs & above indicating that they would utilize the PSP if they experienced personal or work stress or a critical incident in the future. This is significant since it reflects that the PSP outreach has achieved recognition from senior management through to the ground staff. If senior management recognizes the importance and value of PSPs within their organizations, they will then provide the funds needed to train and equip the peers, and the activities needed to maintain the PSPs. In addition, these volunteer peers would then receive the recognition and support by their organizations of their time and effort in being part of the PSPs.

The limitations of this survey was the use of a brief, anonymous 5-question self-report questionnaire. It would be important to study the types of issues, whether work-related or personal, that affect the healthcare workers for which they would utilize PSP services and how the support had been helpful to them.

Conclusion

The PSPs in the public hospitals have achieved the objectives of providing emotional support to affected staff during work-related critical incidents and assisting hospital management to better understand the emotional needs of the employees. It is hoped that over time the public hospital PSPs will continue to establish credibility and accomplish the goals of improving the resistance, resiliency and recovery of healthcare workers affected by personal or workplace stress or critical incidents.

Acknowledgement

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Association of Traumatic Stress Specialists

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Selected Annotated Journal Resources

Dina Kulenovic, M.A., Alicia Dodds, M.A., and Catherine Ruscitti, M.S.

Tang, S. S., and Freyd, J. J. (2012). Betrayal trauma and gender differences in posttraumatic stress. *Psychological Trauma: Theory, Research, Practice, and Policy, 4,* 469-478. doi: 10.1037/a0025765.

TYPE OF ARTICLE

- Original empirical investigation

OBJECTIVE/PURPOSE OF THE STUDY

- To investigate the role of betrayal trauma in determining why women report higher rates of posttraumatic stress than men.

Betrayal Trauma Theory:

- Refers to the impact of experienced trauma in which the perpetrator is a close acquaintance to the victim.

- Posits that cognitive dissociation is an adaptive coping mechanism when the trauma occurs by the caregiver.

- Betrayal trauma has been linked to poorer psychological outcomes, including anxiety, depression and PTSD.

- It has been theorized that the frequency at which women experience betrayal traumas can be linked to higher rates of PTSD and dissociative disorders.

Hypothesis 1.1:

- High-degree betrayal (HB) experiences, regardless of gender, will be significantly more associated with PTSD, depression, anxiety, and dissociation, though it is expected there will strong gender associations with these symptoms.

- These same associations will also be stronger than those with medium-degree betrayal (MB) and low-degree betrayal (LB) potentially traumatic experiences.

Hypothesis 1.2:

- Women will report significantly higher rates of HB experiences than MB and LB experiences.

Hypothesis 1.3:

- Women will report higher rates of depression, anxiety, and PTSD than will men.

Hypothesis 2:

- Experiences of HB trauma will mediate the relation between gender and PTSD symptoms under the following conditions:

   o Gender must be significantly associated with anxiety, depression, and PTSD.

   o Gender must be significantly associated with HB trauma.

   o HB trauma must be significantly associated with PTSD, depression, and anxiety.

   o The addition of HB trauma to the model results in a significant decrease in the effect of gender on PTSD.

METHODS

Participants

- Participants were recruited from the University of Oregon Psychology Department Human Subjects Pool (HSP) and the general community.

- Participants from the general community were recruited through listservs of community organizations, flyers posted around the community, a public bulletin placed in the Asian Reporter, and advertising on the Portland site of Craigslist.org.

- Students from the University of Oregon were all enrolled in an introductory psychology or linguistics course and received course credit for their participation. They were unaware of the nature of the study.

- Of the 1,041 student participants, 705 were women and 336 were men and ranged from 16 to 54 years. Approximately 88% were between the ages of 18 and 21 years.
- From the 199 participants recruited from the general population, 129 were women and 70 were men between the ages of 18 and 68 years. Approximately 86% were between the age of 18 and 40 years.
- Of the community sample, the majority of the participants were Asian or Asian American (78.4%), recruited for the purposes of another study. All community sample participants received a $10 gift card for their participation.
- Within the university samples, the majority of students were Caucasian (78.9%).
- The majority of all participants had completed at least some college.

Measures
- The Trauma Symptom Checklist-40 (TSC-40) was used to assess a range of symptoms of PTSD. It is comprised of six subscales that include depression, dissociation, anxiety, sexual abuse trauma, sleep disturbance, and sexual problems.
- The Revised Civilian Mississippi Scale of PTSD (R-CMS) was used to measure symptoms of PTSD. The measure asks about feelings and behavior about the traumatic event, as well as how the participant is currently feeling.
- The Brief Betrayal Trauma Survey (BBTS) was used to examine trauma history. It assesses HB, MB, and LB experiences of trauma. LB trauma is characterized by experiences such as car accidents and natural disasters, MB traumas include sexual, emotional, and physical abuse by someone not close to the victim, and HB traumas refer to these same traumas, but by someone who is close to the victim.

Procedure
- Once recruited, all participants completed an online survey that was comprised of a brief demographics questionnaire, the TSC-40, the R-CMS, and the BBTS

RESULTS
Hypothesis 1.1:
- HB was significantly associated with outcomes of de-

pression, anxiety, and PTSD as predicted. LB and MB were also significantly, but less so, associated with symptom outcomes. There were also significant associations between gender and measures of depression, anxiety and PTSD.

Hypothesis 1.2:
- Though the effect size was small, gender had a significant effect on reported symptoms of PTSD. Women reported 45% more sexual abuse by someone close and approximately one third more sexual abuse by someone not close. Similarly, women experienced one third more emotional abuse than did men. Men reported two and a half times more physical assault by perpetrators not close to them and witnessed one third more attacks.

Hypothesis 1.3:
- Women reported significantly higher rates of depression and anxiety than men. Age was a significant covariant, but only for anxiety.
- Women reported higher levels of re-experienced PTSD symptoms than men, though their rates of avoidance and arousal were similar.

Hypothesis 2:
- Re-experiencing PTSD symptoms was found to be the only gender difference to occur, with women reporting higher rates than men. Therefore, this subscale was the only one used for analysis in the proposed model instead of the total PTSD score.
- The relation between re-experiencing HB trauma and gender was found to be significant, such that women reported higher rates of re-experiencing than men.

CONCLUSIONS/SUMMARY
- Traumatic events involving a high degree of betrayal were more strongly associated with symptoms of PTSD, anxiety, and depression than were events involving lesser degrees of betrayal regardless of gender.
- Women were found to have significantly higher rates of HB betrayal, especially due to sexual assault and emotional abuse compared to men.
- Women reported higher rates of anxiety and depression, though the effect size was small.
- Men and women reported relatively equal rates of overall PTSD.
- Women reported higher rates of re-experiencing symptoms, but not avoidance or arousal symptoms of PTSD.

CONTRIBUTIONS/IMPLICATIONS

- The results provide important implications with regard to the diagnosis of PTSD and other trauma-related disorders, in that the effects of betrayal should be considered when conceptualizing a traumatic event.

TYPE OF ARTICLE

- Meta-analytic review

OBJECTIVE/PURPOSE OF THE ARTICLE

- To interpret and integrate findings of qualitative studies focusing on children's perspective on trauma.

METHODS

- The literature search examined articles that consisted of empirical studies, were non-quantitative in methodology, and describe a traumatic event as defined by the DSM-IV.

- Articles that were considered were published from January 1, 1980 until September 1, 2009.

- The search criteria included research derived from children's accounts of their experiences with trauma, as well as articles where parents or caregivers were interviewed about their children. Children were defined as being 18 years of age or younger.

- The final sample consisted of 17 articles published from 2001 or later that met the described inclusion criteria.

- A number of themes were identified in the primary findings that were then divided into three separate domains:

  o The individual domain includes feelings, trauma impact, coping, giving meaning, identity, current outlook, phases, normalcy, growth, and negotiations.

  o The family domain includes parenting and inter personal relationships.

  o The community domain includes support and culture.

- A theoretical model that describes the relation among the three domains was developed.

RESULTS

- Children actively work on various aspects of their identity and sense of self following traumatic events.

- The type of trauma experienced was found to shape the child's current outlook on life, particularly with respect to their awareness of mortality after a serious trauma such a living through a car accident.

- Age and developmental level influenced the course and process through which the trauma is experienced.

- Close parental or caregiver relationships reduced the fear and insecurity felt following a traumatic event.

- Interpersonal relationships were found to be positively and negatively affected. Some children experienced loneliness and bullying due to having trouble integrating back into a social or academic setting. Others developed stronger relationships and received increased support from their peers in response to their experience.

- Culture was found to also influence how the children perceived and coped with the trauma..

CONCLUSIONS/SUMMARY

- The primary finding regarding the individual domain is that children are in a continuous process of negotiating normalcy and difference that influences how they cope with trauma. Community and family impact this psychological process.

- The cumulative findings suggest that child trauma should be viewed as a broad and complex phenomenon that is driven by experiences that impact both emotions and behavior.

- The role of parents is important, as their availability and personal well-being influences the child's experience.

- The type of trauma influences how the trauma is explained and what coping mechanisms are employed, as well as what the specific stressors that follow.

CONTRIBUTIONS/IMPLICATIONS

- The findings suggest that professionals who work with this population need to be mindful of numerous concepts beyond the symptoms of PTSD characterized by the DSM-IV.

- Fear, finding meaning, and bullying were found to be predominant and reoccurring themes following trauma, thus it appears as though they should be explicitly addressed and considered in treatment.

- In considering the findings on parental relationships, interventions designed for both children and parents may be valuable.

Lambert, J.E., Engh, R., Hasbun, A., &Holzer, J. (2012). Impact of posttraumatic stress disorder on the relationship quality and psychological distress of intimate partners: A meta-analytic review. *Journal of Family Psychology, 26*(5), 729-737.doi: 10.1037/a0029341.

TYPE OF ARTICLE
- Meta-analysis

OBJECTIVE/PURPOSE OF THE STUDY
- To examine the association between a trauma survivor's PTSD symptoms and his or her partner's perceived relationship quality and psychological distress, as well as potential moderators.

METHODS
- An empirical review of the literature was conducted via a search of three electronic databases using a combination of the following terms: partner distress, partner psychological distress, secondary trauma, secondary stress, and caregiver burden.
- Studies included in the present design were peer reviewed articles and dissertations published in English between 1992 and 2012 where PTSD symptoms were assessed (either categorically or dimensionally with self-report measures such as the PTSD Checklist or, sometimes, clinical interviews) and either the trauma survivor's partner's relationship quality (with self-reports measuring dyadic adjustment, marital satisfaction, or martial problems) or psychological distress were also assessed (with self-report measures such as the SCL-90 to examine anxiety, stress, and depression symptoms).
- Twenty-two studies were used for PTSD and partner relationship quality, while 25 studies were used for PTSD and partner psychological distress.
- The relation between PTSD and partner relationship quality was analyzed separately from the relation between PTSD and partner psychological distress.

RESULTS
- Greater PTSD symptoms in the trauma survivor were associated with a more negative perception of relationship quality by the survivor's partner. The effect size was small to moderate ($r = -.24$).
- Military status and gender of the partner significantly moderated the relation between PTSD and partners' perception of relationship quality. Being in the military (having a combat-related trauma) and being a female partner of a male trauma survivor were associated with a larger effect size (military $r = -.26$, vs. civilian $r = -.15$; male trauma survivor $r = -.26$, vs. female trauma survivor $r = -.13$). The fact that combat-related trauma may result in greater symptoms of anger and hostility than noncombat-related trauma may account for this difference.
- Greater PTSD symptoms in the trauma survivor were associated with an increase in psychological distress in the survivor's partner (including general distress, secondary trauma, and caregiver burden). The effect size was in the moderate range ($r = .30$).
- Military status and time since the traumatic event moderated the relationship between PTSD and partners' psychological distress. Being in the military and having the traumatic event more than five years in the past were associated with a larger effect size (military $r = .33$ vs. civilian r $= .14$, and recent trauma $r = .36$, vs. past trauma $r = .21$).

CONCLUSIONS/SUMMARY
- PTSD symptomatology is negatively correlated with partners' perception of relationship quality and is positively correlated with partners' psychological distress.
- Military status, gender, and length of time since the traumatic event may moderate these relationships.

CONTRIBUTIONS/IMPLICATIONS
- The present study highlights the need for greater research in this area, especially longitudinal studies, or studies that include male partners of female trauma survivors, non-military trauma, and same sex couples.
- Mental healthcare providers should consider the psychological distress and perceived relationship quality of trauma survivors' partners in treatment. Couples therapy may be beneficial.

TYPE OF ARTICLE

- Original empirical investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To explore the association between somatic symptoms and demographic and clinical variables such as gender, age, type of abuse, anxiety, posttraumatic stress, anger, dissociations, and depression in children and adolescents who experienced trauma in the form of abuse and/or neglect.

METHODS

Participants

- One hundred and sixty one children (ages 8-17 years) living in a residential home for foster children between 1996 and 2011 and their primary residential caregivers (i.e. "house parents").
- All children had experienced a trauma in the form of sexual abuse, physical abuse, emotional abuse, neglect, abandonment, and/or witnessing domestic violence.

Procedure

- Trained clinicians assessed the child participants between three and six months of the start of their residency. The assessments included psychosocial reports and gathering of background information.
- Children completed the Children's Depression Inventory (CDI), the Multidimensional Anxiety Scale for Children (MASC), and the Trauma Symptom Checklist for Children (TSCC).
- Primary caregivers completed the Child Behavior Checklist (CBCL).
- Twelve items on the MASC assessed somatic symptoms for child reporters and nine items on the CBCL assessed somatic symptoms for caregiver reporters.

RESULTS

- The majority of children (95.2%) self-reported at least one somatic symptom on the MASC and most caregivers (80.7%) reported that the child was experiencing at least one somatic symptom on the CBCL.
- Children who had been sexually abused were significantly more likely to self-report somatic symptoms compared to those who were not sexually abused.
- Females were more likely to self-report dizziness and feeling sick to the stomach than were males.
- Caregivers were more likely to report dizziness, nausea, stomachaches, and vomiting in females, and more likely to report restlessness in males.
- Age correlated negatively with self-reports of somatic symptoms, but positively with caregiver-reports of the same.
- Child, but not caregiver, reports of somatic symptoms correlated positively with scores on measures of anxiety, depression, posttraumatic stress, dissociation, and anger.
- Scores on the TSCC anxiety subscale mediated the relation between sexual abuse and self-reported, but not caregiver-reported, somatic symptoms, accounting for 33% of the variance.

CONCLUSIONS/SUMMARY

- Somatic symptoms are often present in children who have experienced trauma.
- Common somatic symptoms include feeling tense/uptight, jumpy, sick to their stomach, and/or having sweaty hands, which over 55% of participants reported.
- There were gender differences in reporting, symptom presentation, and/or coping mechanisms, with females being more likely to endorse dizziness and gastrointestinal distress, and caregivers being more likely to perceive males as experiencing restlessness.
- The type of trauma a child suffered did not correlate with self-reporting of somatic symptoms, except when the trauma was sexual abuse.

CONTRIBUTIONS/IMPLICATIONS

- Caregivers and healthcare providers should be aware of the likelihood that children will present with somatic symptoms after a traumatic event. This should be taken into account to provide the best treatment of posttraumatic symptoms as well as to avoid unnecessary medical tests.

TYPE OF ARTICLE

- Original empirical investigation

OBJECTIVE/PURPOSE OF THE ARTICLE

- To increase understanding of how survivors of complex trauma currently in treatment experience relationships with significant people in their lives.

METHODS

Participants

- Twenty-one participants were recruited from an outpatient clinic that specializes in the care of chronically and complexly traumatized survivors of events such as childhood physical abuse, childhood sexual abuse, domestic violence, rape, adult sexual abuse, neglect, and witness to crimes.
- All participants were engaged in individual or group psychotherapy.
- The sample was predominately female (86%) and ranged in age from 24 to 62 years.

Materials

- Participants were interviewed using the Multidimensional Trauma Recovery and Resiliency Interview (MTRR-I).
- The MTRR-I assesses an individual's life history, including experiences of trauma, and current functioning in the following eight domains: authority over memory, integration of memory and affect, affect tolerance and regulation, symptom mastery and positive coping, self esteem, self cohesion, safe attachment, and meaning making.

Procedure

- Participants were interviewed at the outpatient clinic, and were compensated financially for their participation.
- Interviews lasted 90-120 minutes.

RESULTS

- Three domains emerged from the analyses of responses on the MTRR-I: revisiting issues of safety, forming new ways of relating, and changing sense of self.
- Regarding revisiting issues of safety, themes included physical safety appearing to be less of an immediate concern, struggles with their perception of safety, increasingly making attempts to alter perceptions of safety, continuing intrusive memories or impaired sense of self-cohesion, nightmares, and ongoing dissociation.
- Regarding forming new ways of relating, themes included ability to regulate negative affect, improved communication, negotiation of healthier boundaries, navigating sexual and romantic intimacy, and an expressed desire for positive relating with family and significant others.
- Regarding changing sense of self, themes included improved feelings of self worth, increased empathy toward themselves and others, a change of sense of self in relationships related to shifts participants' observations of themselves through others' perspectives, increases in positive life experiences, greater ability to cope with stress, authenticity, fluctuating between power and vulnerability, negotiating self-blame and anger, and a desire for more control in one's life.

CONCLUSIONS/SUMMARY

- Results reflect the complexity of the trauma recovery process and the particular tasks that are addressed in recovery.
- This study highlights both external and internal elements of traumatic experience that include the interactions between the traumatic events and beliefs about the self in relation to the perpetrators.

CONTRIBUTIONS/IMPLICATIONS

- Treatment providers should be aware of conflicting experiences for patients with complex trauma. For example, while patients may no longer be in unsafe situation, perceptions and feelings of being unsafe may still persist. Similarly, while patients may report improved means of relating to others, they may still yearn for positive relationships with others. Also, while patients may report increased perception of themselves, they may still struggle with self-blame, anger, vulnerability, and control.

TYPE OF ARTICLE

- Original empirical investigation.

OBJECTIVE/PURPOSE OF THE STUDY

- To assess the relation between childhood sexual abuse (CSA) and childhood physical abuse (CPA) and key attitudinal and behavioral aspects of eating disorders.

METHODS

Participants

- Participants were recruited through a public university in Barcelona, Spain.
- The final sample consisted of 678 female undergraduate participants in Spain, of which 11.9% had experiences childhood sexual abuse and 2.8% had experienced childhood physical abuse.
- The sample had an average age of 22.0 years ($SD = 2.7$).

Materials

- Abuse was measured by the Traumatic Life Events Questionnaire (TLEQ), and eating disordered attitudes and behaviors were assessed by the Eating Disorders Examination Questionnaire (EDE-Q). Depression was measured using the Beck Depression Inventory (BDI), anxiety was assessed using the State-Trait Anxiety Inventory (STAI), and self-esteem was measured by the Rosenberg Self-Esteem Scale (RSE). Body mass index (BMI) was also calculated for each participant.
- The TLEQ is a 24-item self-report measure used to assess potentially traumatic events.
- The EDE-Q is a 29-item measure used to assess eating disordered attitudes and behaviors.
- The BDI is a 21-item self-report measure used to assess depression symptoms.

- The STAI is a 40-item self-report measure used to assess anxiety in adults.
- The RSE is a 10-item self-report measure used to assess the level of satisfaction one has with oneself.

Procedure

- Informed consent was obtained and participants completed the EDE-Q, TLEQ, BDI, STAI, and RSE in a classroom during the spring of 2007 and 2008.

RESULTS

- Results demonstrated that after adjusting for covariates (depression, state and trait anxiety, self-esteem, BMI, age, and socioeconomic status), lower scores on restriction of food intake, shape concerns, and the overall EDE-Q score were observed in female students who had suffered CPA.
- Physical abuse was inversely related to weight concerns.
- Students who were sexually abused showed significantly higher scores related to weight concerns than those who were not abused.

CONCLUSIONS/SUMMARY

- Results demonstrated those who experienced childhood sexual abuse were significantly more likely to have more weight concerns than those who were not.
- However, those who were physically abused as children were less likely to have weight concerns, shape concerns and restrict food intake, and had lower overall scores on eating attitudes and behaviors.
- These results conflict with research that indicates that CPA is correlated with eating disordered attitudes and behaviors.

CONTRIBUTIONS/IMPLICATIONS

- CSA is associated with an increase in weight concerns, which increases the risk for developing an eating disorder.
- Treatment providers working with sexually abused individuals should be aware of the increased risk of eating disorders in these individuals and be mindful of any disordered eating signs or symptoms that may arise.

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Posttraumatic Growth in Clinical Practice
Lawrence G. Calhoun & Richard G. Tedeschi
Routledge, 2013, 168 pages, Soft cover, $37.95

Posttraumatic Growth in Clinical Practice outlines a therapeutic perspective focusing on the premise that an encounter with major adversity can change people for the better. Introduced by the authors in 1995, the term "posttraumatic growth" (PTG) refers to the "experience of positive change that the individual experiences as a result of the struggle with a traumatic event (p. 6)."

These positive changes may be grouped into three categories: changes in sense of self, changes in relationships with others, and changes in the person's philosophy of life. As part of PTG, clients may report they feel stronger than they thought possible, and that 'little things' don't bother them as much. Clients may also report changes in relationships, with a sense of increased compassion or closeness with others, as well as an increased appreciation of life.

According to the authors, we encourage PTG by functioning as "expert companions," facilitators of growth who offer expertise in processes of healing and growth. One of our most efficient tools is a clear and quiet presence, focusing on listening rather than on problem solving. Expert companions assist by bringing positive changes and growth already occurring into the client's awareness. Expert companions are willing to listen to the worst parts, parts that others may shy away from, be unable to tolerate, or get tired of hearing.

The authors stress that the focus should not be only on the traumatic event itself, but even more so on the aftermath and the client's struggle with what has happened. Survivors of trauma often grapple with existential questions and spiritual questions raised by the trauma, which can be challenging for the expert companion. Assisting clients to confront these questions rather than avoid them offers opportunities for PTG.

This model appears, to this reviewer, to be extremely consistent with the tenets of Critical Incident Stress Management (CISM). Our focus in CISM interventions is on listening, and helping with those 'worst parts.' We facilitate naturally occurring recovery and growth through encouraging participants to 'tell their story' in as much detail as they like. A common question we ask in our Critical Incident Stress Debriefings, as we transition from the Teaching to Re-entry phase, "Is there anything positive you can take away from this tragedy/loss/event?" focuses on the potential for growth.

Extensive examples of client-clinician conversations illustrate the tenets of collaboratively creating a narrative with the client within the categories mentioned above.

The authors close with a chapter addressing the impact of such work on the expert companion. Potential risk factors outlined include the impact on beginning clinicians, the long-term impact of prolonged exposure to graphic and intense narratives, and the impact on the clinicians who are themselves trauma survivors. Also addressed is the positive side of this work, the satisfaction of helping and the potential for personal growth that clinicians may themselves experience. The authors close by reminding readers of the importance of self-care, both professional and personal.

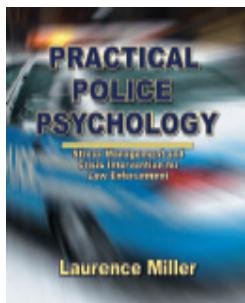I highly recommend this valuable resource to mental health professionals and chaplains working with traumatized individuals. This is a thorough and specific resource, replete with compassionate insights and recommendations. I encourage you to make room on your bookshelves for this excellent reference.

Lawrence G. Calhoun, PhD, is professor of psychology at UNC Charlotte and a licensed psychologist. Together with

Richard Tedeschi, he is one of the pioneers in the development of research and theory on posttraumatic growth. They have published several books, including the Handbook of Posttraumatic Growth: Research and Practice (2006) and Helping Bereaved Parents: A Clinician's Guide (2004). Dr. Calhoun teaches undergraduate and graduate students.

Richard G. Tedeschi, PhD, is professor of psychology at UNC Charlotte, where he teaches personality and psychotherapy. He is a licensed psychologist specializing in bereavement and trauma, and has led support groups for bereaved parents since 1987. He serves as a consultant to the American Psychological Association on trauma and resilience.
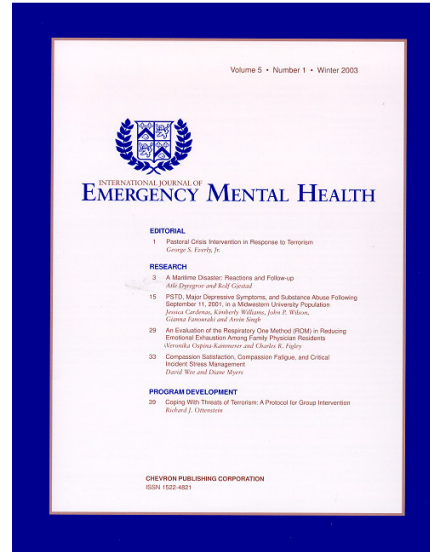
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