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

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

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

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

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## Editorial

We seem to be living in a time of disasters. As I write this, toxic oil is gushing into the Gulf of Mexico, whole neighborhoods are being swallowed up into storm-produced giant sinkholes in Guatemala, war is looming between North and South Korea, and the Southeast U.S. is bracing for the worst hurricane season in a quarter-century. Meanwhile, Chile and Haiti still struggle to recover from their earthquake devastation. So it's apt that the emerging theme of this issue is the many roles of disaster responders in preventing and alleviating the suffering of victims and survivors.

Many novice responders, with the best of humanitarian intentions, may be unaware of the brute practicalities involved in traveling to and living within a disaster scene. The two articles by Ottenstein and Greenstone remind us that, if you're going to respond to a disaster, you'd better remember to bring the batteries, toilet paper, and bottled water, because you can take nothing for granted in terms of preparation. These authors present the basic realities of packing your kit bag so you can function as efficiently and comfortably as possible.

Responders may arrive at various stages of a disaster: as it's unfolding, in the thick of it, or in the aftermath. One of the immediate tasks that often confronts first responders is the presence of stunned, panicked, and traumatized victims. Adapting a protocol used in responding to victims of crime and terrorism, Miller offers a set of practical strategies for stabilizing victims psychologically so that they can better care for themselves during the recovery process, and so that long-term posttraumatic sequelae will be minimized.

When the next Big One hits, we're going to need lots of mental health counselors fast, and in such a large-scale mobilization, general mental health clinicians may have to

accelerate their learning curve in acquiring crisis intervention and trauma therapy skills to apply to needy victims. So it is encouraging that Hamblen and colleagues report on the success of their Cognitive Behavioral Therapy for Postdisaster Distress training module that can quickly bring mental health counselors up to speed in utilizing basic cognitive-behavioral therapy techniques to help disaster survivors. "All hands on deck" means that we may also need to stretch across disciplines; Everly and colleagues present a program for training nurses in Psychological First Aid.

Even as we endeavor to meet the challenges of new disasters, we can't neglect the lingering effects of calamities past. New therapeutic innovations that are rigorously tested will be welcome, as is Sakai and colleagues' report of their use of Thought Field Therapy with PTSD-afflicted orphans of the Rwanda genocide. Missionaries and chaplains who were caught in the maelstrom of that genocide were vicarious victims as well, and Feldbush and Mitchell describe a psychospiritual retreat program for healing the minds and renewing the spirits of these dedicated helpers.

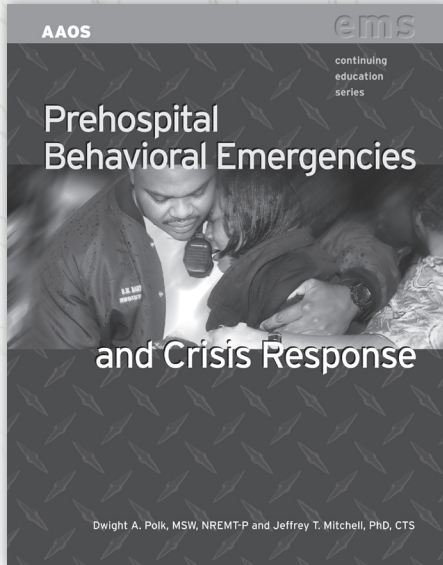
Demonstrating the expanding applicability and maturing flexibility of the group psychological debriefing approach, Mitchell describes a Post-action Staff Support program for aiding law enforcement bereavement counselors and grief support personnel who need to regroup from their dedicated efforts to help others deal with the ultimate loss.

I'm especially proud of this issue, then, for the creative and empirically validated way it brings together the spirit of humanitarian care with a range of practical, nuts-and-bolts techniques for helping effectively.

*Laurence Miller, PhD*

*June 2, 2010*

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



## **Prehospital Behavioral Emergencies and Crisis Response**

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

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

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

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

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



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## Preparing for Disaster Deployment: Suggestions for the Disaster Responder

Richard J. Ottenstein  
Workplace Trauma Center, Eldersburg, MD

**Abstract:** *The purpose of this article is to help disaster relief workers to adequately prepare for responding to a disaster. It is intended to be a practical guide based on the author's many experiences in providing relief work throughout the world. This article addresses physical and mental health, personal safety, comfort and communication needs. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 3-6].*

**Key words:** *disaster, deployment, disaster responder*

Before deployment to a disaster site, a disaster relief worker should carefully plan and pack to better prepare himself for the experience. These considerations are important for his/her own health, comfort, and welfare, and, in many cases, for those of his/her fellow workers as well.

Prior to travel, check for necessary immunizations. Because of the serious risk of disease outbreak, all appropriate immunizations should be completed. In the United States there is an organization called Passport Health ([www.passporthealthusa.com](http://www.passporthealthusa.com)) which provides immunizations needed for the area of the world one is traveling to. They also provide health information and supplies for travelers. Other health organizations also provide similar services. Another important health-related website is The United

States Government's National Center for Infectious Diseases Travelers Health Bulletin ([www.cdc.gov/travel](http://www.cdc.gov/travel)). It contains important checklists for those traveling to a disaster area.

Be aware of the profound emotional impact this activity may have upon you. Arrange for post-deployment debriefing if it is not already in place. During the deployment take time to assess your own reactions to what you are encountering. Utilize colleagues to serve as sounding boards and a support system. Keep a diary or journal to help organize your own personal experience. Look out for the well-being of your colleagues.

A disaster area is an extraordinarily dangerous environment. Notwithstanding the issues of disease and contamination, there are many hazards one would not anticipate. This

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could range from nails, glass, and other debris being where they are not expected, to possibilities of structural collapses or debris falling from overhead. Always be aware of what is around you in all directions, including underneath and overhead. Social conflict may pre-exist or may arise following a disaster. Be aware of your security resources and carefully consider where you will be traveling (particularly by yourself).

Bring your own supply of personal medications as well as antibiotics. Take at least double the supply you expect to need in case your return is delayed. If you have more than one travel bag, split your supply between the two bags in case one gets lost or stolen. Have a colleague carry a back-up supply of any medication which you cannot go without. It may not be possible to obtain medications in the area you are traveling. If travelling in foreign countries be sure to bring medications in their original containers with a doctor's note verifying the prescriptions.

If you expect to be traveling to remote areas, a small handheld GPS may be helpful in finding your way back. Bring extra batteries and consider bringing a small solar battery recharger because batteries and electricity may not be available in all areas.

Two way personal walkie-talkie-type radios with at least a 5 mile range can be helpful for outreach teams if they become separated. They are inexpensive and may be a primary means of team communication if cell phones and land lines are inoperable.

Be certain to become educated on the cultural and religious issues and customs of the population you are serving. It is very easy to unintentionally offend people if you don't understand their culture.

Carry copies of your travel documents stored somewhere other than where you are carrying your originals. Also have someone at home and someone else on your team carry a copy so that if the originals are lost or stolen you have some documentation. If you are responding with

professional skills and have a professional license bring extra copies of your license.

Know your mission, the limits of your mission, and who you are serving. If your mission is to be expanded, be sure it is with the approval of the appropriate authorities.

Communication with home is an important way of staying grounded. Ability to communicate will depend on available equipment and infrastructure as well as cost. If traveling abroad, contact your cell phone carrier to understand the costs associated with international roaming. In some cases a cell phone carrier may offer special rates or even free service for disaster relief workers. If internet is available, services such as Skype provide low cost long distance service.

Finally, your personal health and safety is essential to the success of your mission. If you take unnecessary risks and become ill or injured you have added to the problem rather than helped. Assess your own current health status and make an honest assessment of your ability to function in the anticipated environment. Consult your personal physician if in doubt. If you find you are not able to withstand the environment and demands of the particular disaster situation, there are many other ways you can be of help.

### *Supply list*

Your list of supplies will be determined by such variables as time of year, known conditions on the ground, the logistical resources of the organization with which you are working, baggage restrictions, and your own personal needs. Read carefully any supply lists provided by any agency that is deploying you and be sure to follow their guidelines.

Table 1 outlines some suggested equipment that can serve your needs and make the deployment safer and more comfortable.

A short, basic list of suggested food items to bring with you when you deploy is detailed in Table 2.



Table 1.  
Equipment

Item	Type or Style	Reason
Multi-Tool	Brands such as Gerber, Leatherman, Victorinox	In the field repairs, self rescue, useful utensils.
Flashlight	Headlamp style is most useful	If sleeping in tent or shelter, it is great for reading at night or moving around after dark. Useful in doing damage assessment.
Sleeping bag, pillow, etc	Based on temperatures expected	Personal comfort and if lodging will not be available.
Mosquito netting	Designed to go around bed area	Only if in tropical areas.
First aid kit	Choose for type of circumstances on the ground	Include personal supply of antibiotics, anti diarrhea medicine.
Ipod or MP3 player with noise cancelling headphones		Helpful if sleeping in loud environments. Helps for times of relaxation.
Reading material	Leisure	For relaxation.
Reading material	Professional	Materials needed for best service delivery.
Batteries	As needed for equipment	Used if in the field.
GPS	Handheld/portable	Extra battery, car and wall charger.
Cell phone	Bring car and wall charger	
Two way radios	5 mile or greater range	If working in teams in the field.
Insect repellent		If in mosquito borne disease epidemic area, spray clothes and mosquito netting with Sawyers clothing repellent prior to travel. Check for allergies to the product.
Sun screen		
Hand Sanitizer		Soap and water may not be readily available.
Lumbar (Fanny) pack	With water bottle holder	Useful to keep necessary items on hand if one wishes to avoid carrying a backpack while working.
Multi pocket vest		
Knife, fork, and spoon		
Flip flops, or plastic shoes		Useful when using mass showers.
Toilet paper		May not be available when in the field.

Table 2.  
Useful food items

<b>Food item</b>	<b>Packaging</b>	<b>Reason</b>
Tuna and salmon	Pouches	Can supplement basic food such as rice or pasta, easy to open, no preparation, easy to pack
Iced tea and lemonade powder	Individual pouches for water bottles	If only water is available it provides a change of beverage
Electrolyte supplements	Individual pouches for water bottles: i.e.: Gatorade	Can help to prevent dehydration and add flavor to water
Coffee and or tea, sweetener and creamer	Instant or bring coffee press or drip coffee maker	Requires available hot water
Energy/Protein bars	Individually packaged	Easy energy supplement and can serve as a quick breakfast. Easy to pack
Dried fruit, nuts, snacks	In small, re-sealable plastic bags	Easy snack, supplements diet if other foods and fruits are not available
Bottled water	Bottles	Bring a few bottles just in case, even if water is supposed to be available
Crackers	Pack in plastic containers	Great if bread is not available.
Peanut butter	Plastic jar	Good as meal or snack

## Disaster Non-Preparedness: The Orange Bag Denial

James L. Greenstone  
Fort Worth, Texas

**Abstract:** *If denial exists anywhere, it exists here. The seemingly unconscious process of refusing those implements of survival that might be needed during a disaster scenario because acceptance also means acceptance of the likelihood of a disaster occurring, is the focus here. Disasters do and will occur. Refusal of the implements of survival denies that reality. Acceptance confirms it. Perhaps acknowledgement of this process will impact the individual's frame of reference or psychological structuring, and thereby affect observed behavior (Sherif & Sherif, 1956). [International Journal of Emergency Mental Health, 2010, 12(1), pp. 7-10].*

**Key words:** *Orange bag denial; denial; disaster; preparedness; Katrina.*

### The Issue

Perhaps the reason that persons refuse to prepare for the onset of a disaster relates to the new psychological term recently coined, "Orange Bag Denial" (Greenstone, 2009). Manmade and natural disaster will occur. One has only to look around to confirm this reality.

Many will remember a few years ago when, in a prominent way, a product came on the market that promised to provide sufficient supplies to help an individual to survive the first 72 hours of a disaster, man-made or natural. These provisions were carefully provided in an orange canvas

backpack that sold for about \$30 - \$35. In the opinion of this author, the supplies provided would have probably cost more than the \$35 price tag if one were to purchase them separately. In addition to the flashlight, batteries, water, food, tools, and the like, the size of the backpack allowed for personal gear such as extra clothing and other supplies. Altogether the pack was still light enough for even the slightest individual, who does not like to carry anything on her back, to carry the bag and to move around with ease.

### The Search

Being a "preparer," this writer and preparer has long had a personal "go bag" ready for the various circumstances in which he might find himself (Greenstone, 2008). Even so, this new orange bag was of some interest. So, as one might expect, it was quickly determined that they were readily available at most Super "XXX" Stores in the area. What was found there was surprising and yet not completely unexpected.

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*A Diplomat of the American Board of Examiners in Crisis Intervention and retired as Director of Psychological Services for the Fort Worth, Texas Police Department, James L. Greenstone, Ed.D., J.D., DABECI is now a member of the Graduate Faculty in Psychology and Human Services, of Capella University and Walden University. Correspondence regarding this article can be directed to Drjlg1@charter.net.*

An individual search of the store was begun. This was probably because of an aversion to asking for directions. Anyway, the bags were nowhere to be found even though advertised. Finally, several employees were approached for directions to the bags. They were found standing together obviously discussing profit and loss statements. They were not knowledgeable about the bags and could not recall seeing them on the store shelves. The manager was summoned. He knew about the bags. He explained that they had been removed from the shelves because they were not selling. That was the next inkling that something was afoot. Further, he explained that he was about to return the bags to the supplier but that they were still in the store stock room.

In the stock room, the bin was full of these orange emergency bags. The manager was queried if the bags were still available for sale. He said that they were and that he would sell them at an incredibly good price on as many of them as were desired. The price was so good, all were purchased. An immediate thought was that they could be given as Christmas or Chanukah gifts. Who knew?

After the bags were purchased and loaded into the car, they were transported to be used as “presents.”

## The Results

When it was mentioned to a very smart wife that the bags would be given as gifts, she warned against such actions. Not fully understanding the issues, this author argued, disagreed, and finally acquiesced. This proved to be the correct choice. The rest was amazing.

There were several family members and fellow preparers, with whom this writer was close personally, and to whom the bags might be given. Not so much as a holiday gift, but later because of concern about their readiness if something bad happened.

Most of the few close friends to whom the orange gifts were given were visibly and verbally shocked by this expression of kindness. To the person, their eyes bugged, they appeared stunned; they asked why such a gift would be given to them. Several were shocked and asked, “Do you know something that I don’t?”

Therein was born the concept of the Orange Bag Denial. It occurred to this author that acceptance of the gift would also mean an acceptance of the possibility that a disaster might occur and that the contents of the orange bag might have to be utilized. In the alternative, not to accept the bag, as a few did, in essence was avoidance and a denial of such a possibility. In other words, “If I do not take the bag designed for a disaster, maybe I will be spared the disaster. On the other hand, if I accept the bag, then also I have to accept the fact that a disaster may occur for which I may need these supplies.”

## Some of the Related Numbers and Findings

There are at least four stages of preparedness denial. According to Eric Holdeman (Holdeman, 2008), Director of Emergency Management for King County, the four stages are:

1. It won’t happen;
2. If it does happen, it won’t happen to me;
3. If it does happen to me, it won’t be that bad; and
4. If it happens and it is bad, there is nothing that I can do to stop it anyway.

In a August 2006 poll conducted by Time Magazine, it was reported that most American citizens were not prepared for a disaster and had their “heads in the sand.” Half surveyed said that they had experienced a disaster. Only 16% of those said that they were adequately prepared for another disaster. Many justified their poor preparation by indicating that they did not need to prepare because that they did not live in areas of high risk for any kind of disaster (Ripley, 2006).

Facts seem to support the assertion that 91% of Americans live in places of significant risk to some type of disaster situation that could dramatically affect their life. This study was conducted by the Hazards and Vulnerability Research Institute at the University of South Carolina (Ripley, 2006). There seems to be fine line, according to this quoted article, between optimism and foolishness. In a country whose citizens, many times, distrust its leaders, the vast majority continue to think that in a disaster our government, local, state

and national, will quickly come to our aid as in non-disaster times. The response to Hurricane Katrina is the strongest current counter-testimony to this ill-conceived belief.

## Conclusion

Maybe all of this is just the hyperactivity of a psychologically-oriented mind (Greenstone & Leviton, in press). Who knows? I've got my bag. Or, maybe we need to get our heads out of our...sand, and readjust to the real world need to prepare.

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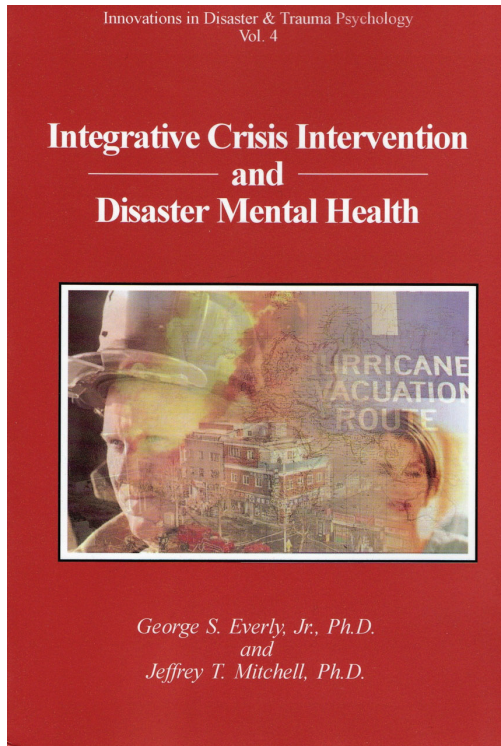
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## On-Scene Crisis Intervention: Psychological Guidelines and Communication Strategies for First Responders

Laurence Miller, PhD

**Abstract:** *Effective emergency mental health intervention for victims of crime, natural disaster, or terrorism begins the moment the first responders arrive. This article describes a range of on-scene crisis intervention options, including verbal communication, body language, behavioral strategies, and interpersonal style. The correct intervention in the first few moments and hours of a crisis can profoundly influence the recovery course of victims and survivors of catastrophic events. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 11-20].*

**Key words:** *Crime victims, crisis intervention, disaster response, emergency mental health, emergency services, first responders*

Readers of this journal know that effective emergency mental health intervention for victims of crime, natural disaster, or terrorism begins the moment the first responders arrive. For most incidents, this will consist of police, fire-rescue personnel, paramedics, and sometimes special mental health trauma clinicians; indeed, many police departments are establishing Crisis Intervention Teams, or CITs, composed of law enforcement and mental health personnel to respond to crime-related crises (Miller, 2006). In other

cases, the first mental health contact will occur in a hospital emergency room or outdoor emergency medical area set up near the scene, as in the case of a mass casualty disaster or terrorist attack (Miller, 1998, 2003, 2004).

Whoever the first responders are, they should be aware that they are in a unique position to help crime or disaster victims deal with the impact of their ordeal, to help restore a sense of safety and control to an otherwise fearful and overwhelming situation. How responders interact with victims from the first moments of contact can have a profound impact not just on the victim's later psychological adjustment, but also on how this individual participates in any further encounters with the agency that the responder represents. First responders themselves may not even be aware of the impact they have on crime and disaster victims, but those victims often report that the treatment they received in

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the immediate aftermath of the incident greatly influenced their future perceptions of, and interactions with, the law enforcement, medical, mental health and disaster response systems, as well as their ability to move on with their lives. Victims who receive the support they need – starting with first responders – not only recover more quickly, but will be more inclined to cooperate with the subsequent investigation of the incident and prosecution of any crimes committed. They are also more likely to work with the public safety officers in their neighborhoods in other, more general, aspects of community participation and citizenship (Herman, 2002; Miller, 2006, 2008).

Yet many public safety personnel and even some medical and mental health clinicians feel somewhat uncomfortable dealing with crime or disaster victims on-scene, partly due to personal factors and partly to lack of training. With regard to the latter, this article will offer some practical guidelines for police officers, paramedics, rescue personnel, and mental health clinicians who may be first responders to a crime or disaster scene (Gilliland & James, 1993; Herman, 2002; Kleespies, 1998; Miller, 1998, 2003, 2004, 2006, 2008).

## **Effects of Crime and Disasters on Victims and Survivors**

First responders may face a confusing scenario when arriving at a crime or disaster scene. Traumatized victims may be in a state of shock and disorientation during the initial stage of the crisis reaction. The victim has just endured an experience totally beyond his or her control, and will most likely feel helpless, vulnerable, and frightened. Some survivors will display virtual physical and emotional paralysis, rendering them unable to make rational decisions, speak coherently, or even move purposefully, much less seek medical attention or discuss the incident with authorities. Other survivors will be in a state of fight-or-flight panic, and some may actually try to flee the scene. Some victims of crime may be confrontational or combative with arriving police or paramedics, adding to the confusion as to who is the victim and who is the offender; the latter is most likely to occur in cases of barroom brawls, domestic disturbances, neighbor disputes, or civil disturbances.

Although most survivors recover some semblance of normality over time, for others long-term psychological effects of disaster or crime victimization may include persisting anxiety, depression, phobic avoidance, physical symptoms,

substance abuse, PTSD, shattered sense of safety and security, “mean world syndrome,” cynicism, and distrust. Victims may be unable to function normally at their jobs or family life. Again, much of the lasting impact of crime or disaster traumatization may depend on the actions of first responders in the immediate post-impact minutes, hours, and days (Miller 1998, 2006, 2008).

## **What Crime Victims Say They Need From First Responders**

Police officers, and occasionally paramedics, mental health clinicians, and other first responders, often complain that when they try to help trauma victims at the scene of a crime or disaster, their efforts are sometimes misinterpreted, unappreciated, or rebuffed. In a study that focused specifically on crime victims’ feelings, perceptions, and wishes with regard to police interactions at the scene, Herman (2002) found that most of these victims are actually quite clear about what they feel they most need from the initial police contact at the crime scene. Their responses tend to cluster in four categories, and the lessons can be applied to all first responders.

### *Regaining a sense of safety and control*

Crime victims want the responding officer to interview them in a safe, quiet location, preferably away from the immediate scene of the crime. They want to be reassured of their safety, that the immediate crisis is over, and that the perpetrator can’t harm them again. They would like the officer to speak in a calm, reassuring voice, not pepper them with questions in a brusque, staccato tone. They especially don’t want officers stating or implying judgments about what the victim could or should have done before, during, or after the crime; victims feel bad enough without these recriminations.

### *Being allowed to vent*

Victims want time to talk about their experience. For most victims, the crime or disaster is the most horrible thing that’s ever happened to them, and they need the opportunity to describe the event at their own pace and in their own way. This may prove frustrating to investigators who are eager to get “the facts” as quickly as possible. Although some gentle prodding and guiding may be appropriate to keep the narrative on track, officers should try to hold their questions or



comments until the victims have finished telling their story. The presentation may be emotional and rambling, as it often is with individuals under extreme stress, but ultimately, officers will get a more complete picture if they let the victim tell it his/her own way. What officers can and should do is reassure, normalize, and validate the victim's experiences and reactions so that he/she does not feel even more stigmatized by thinking he or she is acting crazy or being a crybaby for expressing her feelings.

### *Knowing how to access additional support*

Officers or other first responders should describe the upcoming steps in the criminal investigation and legal proceedings. Without further frightening the victim, they should inform him/her of the possibility that emotional "delayed reactions" may occur over the next few days and, importantly, that new memories of the crime may emerge, in which case officers want the victim to feel confident enough in them to be willing to call them with such additional information. Indeed, victims themselves say they'd like officers to make the first move in encouraging further contact with law enforcement, since victims often feel embarrassed or intimidated to call on their own; some don't want to be seen as a "pest."

### *Being referred to community services*

Finally, crime victims are typically frightened, confused, and in pain, and most of them understand that there's a limit to what the first responder can do in his/her law enforcement role. So victims want information about community services and other agencies that are set up for crime victim assistance. Taking the time to ensure that the victim knows what comes next and what to do about it can be a positive step in the direction of improved police-victim and police-community relationships. Said one victim:

"There were two cops who showed up pretty fast after I dialed 911, and they were, like, total opposites. The first, a little guy, was all businesslike, asking questions, what did the attacker look like, was he short or tall, and so on, and I started getting confused and started crying, and the cop just gives me this look, like 'what's wrong with you?' So then, the other cop, the bigger one, asks the first guy to go get something from their car, like I think I wasn't supposed to know that this was their way of letting the other guy take over without embarrassing the first guy. But, anyway, the big cop was more patient, he let me say what I wanted to say, told me

how I could get home, or did I want to go to the hospital, or need a ride home, like giving me a choice, you know? It was more the way he said it than anything else that made me feel he was really trying to help me, not just get the whole thing over with, like the first guy, the little cop."

## **On-Scene Crisis Intervention**

As noted earlier, the first point of contact between the first responders and the crime or disaster victims is often at the scene itself, although this contact may take place in an ambulance, hospital emergency room, or open-air medical area if the victim is already receiving treatment. Here, the responder is confronted with a victim whose emotional behavior may run the gamut from numbed unresponsiveness to raw panic. Aside from providing medical and psychological first aid, a frequent practical task of the first responder is to obtain as much information as possible from the victim about the crime itself in order to maximize the possibility of apprehending any at-large perpetrators, preventing further violence or injury, and planning for aid to other potential victims. Balancing concern for victim welfare and the need to obtain detailed information is thus a delicate dance and requires some degree of interpersonal skill on the part of the interviewer. The following are some practical recommendations for first responders who have to deal with crime or disaster victims on-scene (Clark, 1988; Frederick, 1986; Miller, 1998, 2006, 2008; Silbert, 1976).

### *Introduce Yourself*

As soon as you arrive, identify yourself by name and full title to the victim and bystanders. Even if you are in uniform, have a picture ID tag, or clearly look like a police officer, firefighter, paramedic, soldier, or mental health clinician, the victim may be too distraught to understand who you are. You may need to repeat the introduction several times. Remember that crime victims, especially sexual assault victims, who are still in shock may respond to you as if you are the criminal, especially if you arrived quickly on the scene. Children traumatized by adults may respond with fear to any new adult in their environment.

### *Apply Medical First Aid*

The first priority is to make sure any physical injuries get treated. In fact, with serious injuries, any further police

investigation or mental health intervention may have to be deferred to the hospital setting after the victim's medical condition has been stabilized. Yet a substantial number of crime or disaster victims may have few or no significant physical injuries, at least not ones that are immediately detectable (recall the thousands of dust-coated, but otherwise uninjured downtown-New Yorkers on 9/11). If the direct victim is the child or other family member of the interviewee, the parent or relative may be physically unhurt, but emotionally in shock at the attack on their loved one.

It is typically the job of paramedics to render emergency medical care. But even if you are a police officer, National Guard soldier, or mental health clinician, you as the first responder on the scene may sometimes have to apply basic first aid until further medical help arrives. Whoever carries out this task, calmly explain to the crime or disaster victim what you're doing, especially when you are touching the victim or performing an otherwise intimate procedure, such as applying a breathing mask, removing clothing, or placing an IV line. If possible, let the victim help you treat him/her if she wants. This may be as simple as having him hold a bandage on his arm or letting her undo her own clothing, but it can offer a much-needed restoration of control in a situation where the victim is otherwise reeling in a state of helpless disorientation. In particular, many children respond well to this self-helping maneuver. Other victims may be so paralyzed with fear that they "forget" how to do simple things like untying shoelaces or unbuttoning a shirt.

### *Respect the Victim's Wishes*

Similar to the above, this principle is more generally related to restoration of the victim's sense of control and should be followed whenever reasonable, within the bounds of medical safety. If, for example, the victim wants a family member or friend to remain with her during treatment or questioning, let that person stay. Don't take offense if a sexual assault victim refuses to let you touch, treat, or even talk to her: you may look, act, speak, smell, or have the same name as the perpetrator. Child victims are often unable to express their fears and may just flail or shout for you to get away. Perhaps another member of the emergency response team can interview or treat that victim more comfortably.

### *Validate the Victim's Reactions*

Always try to validate the traumatic ordeal the victim

has been through and, as realistically as possible, reinforce his or her resilience and coping efforts thus far. In general, build on the victim's own resources to increase his or her feelings of self-efficacy and control:

"I can see this must have been a terrible experience for you. Most people would be feeling pretty much like you are under these circumstances. But I'm glad to see you're handling it as well as you are." [Or, if they're not handling it well: "But we're going to help you get through this."]

### *Interview Sensibly and Sensitively*

After ascertaining that the victim is physically intact and in good enough emotional shape to have a conversation, briefly verify essential details of the criminal or disaster incident: "Please tell me what happened to you. Did it happen here or in another location?" Police officers should do whatever they can to secure the crime scene while calling for appropriate backup, if necessary. If possible, remove the victim from the scene to a safer or more neutral location. Be sensitive and tactful with onlookers and media, and cooperate with paramedics and other responders. Mental health clinicians who are on-scene can assist and advise law enforcement personnel in sensitively conducting interviews.

Avoid even unintentional accusatory or incriminatory statements such as "What were you doing in that building so late at night?" These not only needlessly upset and retraumatize the victim, but also erode trust, making further interview and treatment attempts extremely difficult. Conversely, try not to overuse platitudes such as "Everything will be all right," which will doubtless sound hollow and insincere to a victim whose world has just been shattered. More helpful are simple, supportive, concrete statements such as "It's okay now. We're going to go to a safe place so the doctors can make sure you're alright and you can tell us what happened."

Avoid statements or implications indicating to an adolescent or young adult victim that you think he or she should "act your age." Most people don't behave like their normal selves right after they've been severely traumatized and many crime or disaster victims may regress to a childlike, dependent mental state immediately after the incident. In such cases, simple, nonjudgmental statements such as "I can understand why you're upset" or "What can I do to help?" can ease the victim's distress.

Even the most hardboiled investigator or no-nonsense medic should understand that a sympathetic, supportive, and

nonjudgmental approach can do much to restore the crime or disaster victim's trust and confidence and thereby facilitate all aspects of the investigation and medical treatment. So listen to the victim if he/she wants to talk, even if he/she digresses, rambles, or strays off topic. Let the victim express emotion if necessary to "get it all out," but learn how to deflect and contain unproductive spewing. At the other extreme, tolerate silence without feeling compelled to jump in with a question or comment. At this stage, don't press for more detail than necessary for purposes of immediate treatment or case investigation – crime or disaster victims will be forced to tell their stories again and again at multiple points in the investigatory process.

When necessary, use a combination of open-ended and closed-ended questioning:

"Can you remember what your attacker looked like? Tell me. About what age was he? What race do you think he was? Was he taller than me? Was he thin or stocky? What else can you remember? That's all right – take your time."

If the victim seems to be getting more and more agitated, disoriented, or panicked during the narrative, employ *diversionary reality questions*. These serve to defocus the victim's attention from the most horrifying aspects of the event, while keeping the topic related to the subject in question, for example:

**Victim:** The guy who jumped me in the clothing department was a new hire. I never saw it coming. He just started beating me. They never check the background of these new guys. We're all going to be killed here. We're all dead sooner or later.

**Responder:** How many people work here?

**Victim:** About thirty.

**Responder:** Okay, was there anything different about the guy who jumped you? How long has he worked here?

### *Present a Plan*

Related to the issue of restoring control is having some kind of clear plan to provide further structure and order to an otherwise overwhelming situation. You don't have to feel bound to follow the plan to the letter if contingencies change, but some structure is almost always better than none. It's also useful to back up this plan with concrete suggestions for action:

"We're going to move to a safe area, have the medics take care of these cuts, then I'm going to ask you a couple of questions, if that's all right. After I'm done, I'm going to explain what happens next in the process, then I'll give you a card with some phone numbers of victims' assistance agencies you can contact. I'm also going to give you my card, and you can contact me at any time for any reason. Do you understand? Do you have any questions?"

### *Employ Humor Judiciously*

A well-placed witticism may put some needed perspective on the crisis and ease an otherwise tense situation, but traumatized people tend to become very literal and concrete under stress, and well-meaning humor may be mistaken for mocking or lack of serious concern. As with all such recommendations, use your judgment.

### *Utilize Interpersonal Calming and Coping Techniques*

Never overlook the interpersonal power of a reassuring presence, both verbally and physically. Project a model of composure for the victim to emulate. Eye contact should be neither a detached glance nor a fixed glare, but more of a concerned, connected engagement. Stand close enough to the victim to provide proximal contact comfort, but don't crowd or intimidate by invading the victim's personal space. Use physical touch carefully. Sometimes a brief pat on the shoulder or comforting grasp of the hand can be very reassuring, but it may frighten a victim who has just been physically assaulted. Take your cue from the victim.

One technique I've found useful on-scene for both victims of crime and distressed responders during critical incidents is what I call the *therapeutic hand-clasp* (Miller, 2006, 2008), which can be adapted to a regular handshake for both men and women, or a more supportive handhold, usually for female victims and children. For a subject who feels like or looks like he/she losing control, ask that person to squeeze your hand and "mentally transfer" the overwhelming emotions into this physical activity:

"Okay, just squeeze my hand and try to put the fear into my hand, just hold on and let it drain into my hand like an electric current, like you're discharging a battery. Feel yourself relax as the fear drains away. That's it, all the excess fear and tension is flowing out of you: you can handle this, you're

getting stronger, you'll make it, you'll be okay. All right, take a deep breath, and let go slowly when you're ready."

At subsequent intervals during the critical incident, this technique can be repeated silently and unobtrusively when necessary, appearing like a normal handshake. With practice, it can be internalized so all the subject has to do is think about it, or clench his or her own fist to re-evolve the tension-reducing feeling. The technique is nothing magical and the subject knows it, but it is simple to use and relies on the basic yet powerful therapeutic principles of psychological suggestion, human physical contact, and interpersonal support.

Other kinds of body activity can be therapeutic as well. To break the sense of physical and mental paralysis that often accompanies posttraumatic numbing, have the victim take a little walk with you, let him get a drink of water, or give him some simple but useful task to perform. Just being able to move one's body around in a productive way can sometimes restore a feeling of efficacy and control: "Gee, my legs still work, I can move my hands, so I guess I'm not a complete basket case." Even where there has been a limiting physical injury, there is almost always some activity or body function that the victim can perform. Anything that will show the victim that there's some shred of normality left, that something still "works," contributes to a sense of safety and hope.

With extremely distraught, disoriented, regressed, or psychologically immobilized victims, you may have to provide a *breakthrough stimulus* to capture the person's attention. This may involve shouting, making a loud noise, or gently shaking the severely traumatized victim to break the numbing spell of dissociation that he or she is entombed in (Everstine & Everstine, 1993). This technique should be reserved for situations where it is an emergency matter to get the subject's attention and cooperation, such as getting him/her out of a dangerous area quickly. Otherwise, you may risk further traumatizing an already overfrightened victim. Forget about slapping the victim's face. That's for the movies and almost never works in real life; besides, you could risk further injury, not to mention a lawsuit. No cold water in the face, either – but giving the victim a sip of a cold drink often helps.

Sometimes you may have to physically restrain a victim who has been severely traumatized, who is under the influence of drugs or alcohol, or who is in the throes of a psychotic episode, for his or her own protection or the protection of

others. Here, however, you should think more in terms of supportive containment than restraint per se. Sometimes people who are out of control can derive a primitive sense of safety and peace by being enveloped in a cocoon of benevolent external containment. Use the minimum amount of force and restraint necessary, for example, wrapping the distraught victim in a blanket as opposed to pinning his arms. Again, remember that if the subject is not actually being arrested, physical restraint should be used only as a last resort, and only in the interest of the subject's own safety and of those around him.

Another technique that often works with severely traumatized victims is referred to as *augmented behavioral mirroring*. For example, you may encounter a victim sitting on a curb or on a hospital cot, rocking rhythmically back and forth, humming to herself. Gradually imitate and replicate her movements, until both of you are in a comfortable rhythm, and then augment with the repeated phrase, "It's all right, you're safe. It's all right, you're safe" or some equivalent phrase (Everstine & Everstine, 1993). Once again, these types of specialized techniques should be reserved for extreme situations.

## Active Listening Skills

Active listening techniques comprise the fundamental skill set for any kind of crisis intervention. They are multi-purpose communication tools that can be effectively applied to a variety of both emergency and routine clinical and law enforcement settings, and they have reached perhaps their greatest degree of refinement and sophistication in the field of hostage negotiation, where life and death can literally hinge on the tone of a voice or the turn of a phrase (McMains, 2002; McMains & Mullins, 1996; Miller, 2005, 2006; Noesner & Webster, 1997; Slatkin, 2005). I have found many of these techniques to be useful for on-scene crisis intervention with crime and disaster victims, as well as for phone interventions and in-office contacts with distressed and distraught patients. Remember, the purpose of on-scene crisis intervention is not psychotherapy, it's stabilization – although the seeds of the victim's ultimate recovery are often planted by the first responder's immediate actions. During and immediately following a crisis, the following active listening interventions can serve the dual purpose of calming the victim and allowing the gathering of further information for law enforcement investigation and/or clinical treatment.

## *Emotion Labeling*

Emotion labeling helps the subject clarify what he's feeling. It contributes to a state of calmness by reducing internal confusion. Sometimes, just giving an intense feeling a name shows that the emotion is understood and that the subject is less out of control than he might have thought. Also, by focusing on the crime or disaster victim's emotions, you allow a break from discussing frightening events and fears about the future, and at the same time, let the victim know you're interested in how he feels about things, not just what kind of information you may want from him about the incident.

Indeed, with a disturbed or incoherent victim, it may not be immediately apparent what he wants – in fact, he may hardly be clear about this himself. In such cases, the initial step may be to clarify what he's thinking and feeling. In general, respond first to emotion, not content. That is, address yourself to the victim's emotional state, while sidestepping any fearful words or imagery. But be careful not to convey the impression that you're ignoring or discounting his issues if that's what he really wants to discuss. The important thing is to demonstrate to the victim that you are tuned in, that he has your undivided attention, either by an "um-hmm"-type interjection or by encouraging him to go on. Utilize emotion labeling phrases, such as: "You sound...", "You seem...", "I hear...", and so on.

**Victim:** What if the guy's still here? Did they catch him yet? He's gonna find me. We have to get out of here or I'm gonna die.

**Responder:** You sound like you're feeling really frightened.

## *Paraphrasing*

Paraphrasing is basically recasting the victim's statement in your own words. This accomplishes several things. First, it reinforces empathy and rapport, i.e. if I can restate your meaning in my own words, then I must have a pretty good understanding of what you're experiencing, which conveys to the victim that "I'm really hearing you." Second, effective paraphrasing actually clarifies what the victim is saying: think of it as the clarification-of-content equivalent of the clarification-of-feelings that occurs with emotion labeling. Third, it encourages the victim to slow down and listen, which may have a calming effect of its own. It also promotes a verbal give-and-take that does not automatically put the victim on the defensive. Finally, just hearing one's own thoughts

spoken aloud by someone else can provide clarification and a feeling of being heard and understood.

When paraphrasing, summarize in your own words what the subject has just told you.

**Victim:** What if the guy's still here? Did they catch him yet? He's gonna find me. We have to get out of here or I'm gonna die.

**Responder:** So you think you're still in danger.

The responder should be careful not to add or embellish, as in: "I understand it's never easy to know when you're completely safe. We live in a dangerous world, so a lot of people are scared..." This is not an effective response because it may serve to further frighten the victim. Remember, the overall goal of the on-scene intervention is to calm things down, not stir them up.

Structure paraphrases in a way that solicits confirmation of the victim's thoughts and feelings. This can be explicit, like adding "– right?" at the end of your paraphrase. Or it can be more subtle, such as leaving your paraphrase dangling by the intonation of your voice, or following your restatement with silence, creating a verbal vacuum for the victim to fill. Paraphrasing wordings can include: "Are you telling me...?" "What I hear you saying is..." "Let me see if I have this right..." "So..." and similar phrases.

As always, if you are not sure what the victim just said or meant, ask him to repeat it: "I don't know if I got all that, Sir. Could you say it again, please. I want to make sure I understand exactly what you're telling me."

## *Reflecting/Mirroring*

Here, the responder repeats the last word or phrase, or the main word or phrase, of the subject's statement in the form of a question, thereby soliciting more input without actually asking for it. It also allows the responder to buy time if he or she cannot immediately think of an appropriate emotional label or paraphrase, while still encouraging the victim to focus on what she has just said. Early in the encounter, it allows information to be gleaned in a nonthreatening, nonconfrontational way, and is a generally good initial rapport-builder.

**Victim:** What if the guy's still here? Did they catch him yet? He's gonna find me. We have to get out of here or I'm gonna die.

**Responder:** We have to get out?

**Victim:** Yeah, the guy might still be around, waiting to attack me.

**Responder:** You think he might still be here?

### *Minimal Encouragers*

Minimal encouragers are nothing more than the little conversational speech fillers we all use to indicate that we're paying attention to someone during a conversation. In the context of on-scene crime or disaster crisis intervention, these consist of short utterances and questions that let the victim know that the responder is listening, but that don't interfere with the victim's narrative flow. Indeed, the purpose is to encourage the victim to keep talking. Examples include: "Oh?" "I see." "Yeah." "Uh-huh." "When?" "And?" "Really?" "You do?" "He did?"

### *Silence and Pauses*

Aside from just buying time, silence can be used strategically. For one thing, in a relatively active conversation, your silence encourages the victim to fill in the gaps, which keeps him talking. Following a statement by silence is also a way of emphasizing a point you've just made:

**Responder:** I know this looks like it's gotten out of control, but not everything that starts bad, ends bad. It doesn't have to end bad [pause].

You can also use silence to frame the victim's point or to encourage elaboration:

**Victim:** I'm trying to think positive about this, but what am I supposed to do, just take your word for it that I'll be safe?

**Responder:** [stays silent and maintains a reassuring presence].

**Victim:** I guess you wouldn't lie to me about something like that, would you? I mean what would be the point?

Like all active listening techniques, silence and pauses are best used in combination with other techniques, and may be particularly effective when used in conjunction with minimal encouragers. Be careful about too much silence, however, because you don't want the victim to think she's being ignored or was forgotten about. Again, try to understand the victim's perspective as well as possible and fine-tune your approach.

### *"I" Statements*

People under extreme stress often become suspicious and defensive, and any comments or statements that are too directive may sound like an insult or attack. In such circumstances, "Maybe you ought to..." will be interpreted as "You better, or else..." To keep potentially accusatory-sounding "you's" out of the conversation, use I-statements to clue the subject in on what effect she's having on the responder's perception, while at the same time allowing for some subjectivity and personalization of the responder; victims will generally respond better to a responder whom they regard as a flesh-and-blood human being who cares, instead of some cop, doc, or rescuer who's barking orders. The basic model is "I feel...when you...because..."

This technique may help defuse intense emotions, and may help refocus the victim during an emotional crisis.

**Victim:** You don't give a shit about me – all you want is to get your damn information so you can solve your case. You're just like that first cop that was here – you guys are all alike.

**Responder:** When you're yelling like that, it's hard for me to focus on what we're talking about.

Or:

**Responder:** I don't know about anybody else, but all I want to do is hear what you have to say.

### *Open-Ended Questions*

This technique has wide applicability in both law enforcement and clinical crisis intervention work, from police interview and interrogation to suicide prevention and on-scene intervention with crime and disaster victims. Here, the responder asks questions that cannot be answered with a simple yes or no. This encourages the victim to say more without the responder actually directing the conversation. This technique may be used in combination with other active listening techniques, such as minimal encouragers, reflecting/mirroring, and silence. In addition, open-ended questions can be followed or combined with closed-ended queries:

**Victim:** I know I'll never get over this. My whole life's gonna be ruined now.

**Responder:** How?

**Victim:** What do you mean, “how?” Everything’s ruined, nothing’ll ever be the same. It’s all screwed up.

**Responder:** I really want to understand this. Can you give me an example?

## CONCLUSIONS

In the real world of psychotraumatology, there is no strict dividing line between crisis intervention, short-term stabilization, and long-term therapeutic approaches. Each type of intervention may blend into the next and cycle back to previous ones as clinical needs dictate (Miller, 2008). The important thing is for both first responders and follow-up clinicians to be familiar with as wide a range of intervention options as possible in order to be able to help quickly in a comprehensive and flexible way.

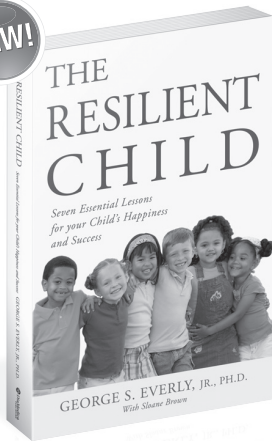
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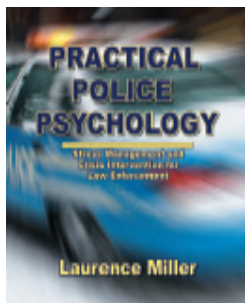
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**George S. Everly, Jr., PhD** is one of the "founding fathers" of modern resiliency and stress management. He is on the faculties of The Johns Hopkins University School of Medicine and The Johns Hopkins University Bloomberg School of Public Health.

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## The Use of Psychological First Aid (PFA) Training Among Nurses to Enhance Population Resiliency

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**Abstract:** *Disaster mental health research has found that psychological casualties from a given disaster can be expected to far outnumber physical casualties. Amidst a shortage of mental health professionals and against the backdrop of natural disasters, continued terrorism, and pandemic influenza, there is a striking need to expand and operationalize available human resources to enhance the psychological resiliency of those affected. Through the utilization of psychological first aid (PFA) as an early crisis intervention tool, and by virtue of their occupation and experience, nurses are particularly well-suited to assume a leadership role in expanding the disaster mental health presence beyond the existing cadre of mental health clinicians. Here, we characterize the importance of integrating PFA in the context of other nursing functions, to augment mental health surge capacity in disaster settings. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 21-32].*

**Key words:** *resilience; disaster mental health, workplace psychological first aid, disaster nursing*

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### Mental Health Challenges in Disaster

Post-disaster wounds are not always visible, targeted, or acute. National Guard and military reservists are returning to their communities after serving in warzones and bringing with them a virtual epidemic of psychological injuries including posttraumatic stress disorder (PTSD), depression, domestic violence, and even suicide (Seal, Bertenthal, Miner, Saunak, & Marmar, 2007). Current literature indicates that the prevalence for PTSD, the most researched post-disaster psychological disorder, ranges from 11%-40% among those

who have been exposed to a human made or natural disaster (Corrarino, 2008; Hamblen et al., 2009; Litz & Schlenger, 2009; Mak, Chu, Pan, Yiu, & Chan, 2009; Norris & Rosen, 2009; Seal et al., 2009; Shubert et al., 2008; Thavichachart, et al., 2009; Veterans Affairs, 2009). Recent data also suggest that physical health and PTSD may be interdependent, further underscoring the need for PTSD mitigation efforts (Shubert et al. 2008; Vanderploeg, Belanger, & Curtiss, 2009). Against the backdrop of natural disasters, continued terrorism, war, and pandemic influenza, these findings highlight the need for dramatically expanding upon available human resources to achieve early intervention for and enhanced mitigation of such adverse psychosocial sequelae. (Hamblen et al. 2009; Perrin, McCabe, Everly & Links, 2009; Watson, 2009).

For more than ten years, experts have concluded that the psychological casualties of a disaster will outweigh the physical by at least an estimated 4:1 ratio (Everly, 2005; Flynn, January 2008, May 2008; Parker, Barnett, Everly & Links, 2006; Shubert et al., 2008; Vanderploeg et al. 2009). However, recent studies have revealed a broad range of unmet mental health service needs following a variety of events including Hurricane Katrina, SARS, California wildfires, and wars in Iraq and Afghanistan (Jenkins, Hsu, Sauer, Hsieh, & Kirsch, 2009; Mak et al., 2009; Norris & Bellamy, 2009; Norris & Rosen, 2009; Rosen, Matthie, & Norris, 2009; Seal et al., 2009). The United States Department of Health and Human Services reports that there are currently 3,291 mental health HPSAs (health professional shortage areas) within the United States, equating to an estimated ratio of 10,000 individuals in need to one practitioner (United States Department of Health and Human Services [USDHHS], 2010). Under the best of circumstances, we assume that all mental health clinicians are adequately trained to provide disaster mental health services, but this we understand to be an unrealistically optimistic appraisal. Analyzing available resources, we will illustrate how and why nurses are an ideally-suited – but currently underutilized – healthcare cohort for enhancing community mental health surge capacity through bolstering of resiliency. In doing so, we will briefly re-examine the construct of “resiliency” and describe the relevance of Psychological First Aid (PFA) training for nurses as a tool for building it, along with recommendations for more broadly operationalizing PFA training among nurses.

## **Resiliency Re-examined: A Tripartite Disaster Mental Health Model**

In times of great challenge and adversity, most people will seek guidance and leadership, rather than simply spontaneously acting on their own (Everly, Strouse, & Everly, 2010). This, we believe, is the case whether the threat to public health is of natural or human origin, including terrorism. Historically, the public mental health approach to such challenges has been to increase access to treatment for individual and family services. As aforementioned, such efforts have proven to be markedly inadequate as the mental health surge can easily outstrip the mental health resources of most North American communities. As a result, perspectives have shifted to alternative intervention options.

Traditional formulations viewed resiliency as the ability to adapt to or rebound from the psychological and behavioral perturbations associated with crisis, trauma, or disaster (Bonnano, 2004). From a public health planning perspective, however, the aforementioned definition lacked specificity that would easily lead to curriculum and intervention formulation. Consequently, Kaminsky and colleagues (2005) proposed that the terms *resistance* and *resilience* be used to denote the respective abilities to adapt to (resistance), and rebound from (resilience) the psychological and behavioral perturbations associated with crisis, trauma, or disaster (Kaminsky, McCabe, Langlieb & Everly, 2005, 2007).

While many crisis intervention models exist, one model with an outcome-driven continuum consistent with all three phases of a disaster is the Johns Hopkins Tripartite Model of disaster mental health. This model encompasses three main concepts (the “three Rs”): to build resistance or psychological armor (pre-event), enhance resiliency (acute-event), and facilitate recovery without disrupting the quality of one’s life (post-event), “aligning the most suitable intervention for achieving the desired outcome” (Everly, Welzant, & Jacobson, 2008; Kaminsky et al., 2005, 2007).

While this paper does not minimize the importance recovery has within the tripartite model, its goals are to explicate the potential of nurses as a critical healthcare workforce asset for building community resiliency in the wake of disasters – specifically, by training nurses in the resiliency-building skill set of Psychological First Aid, as we discuss below.

## Psychological First Aid and Resiliency

Contrary to previous beliefs, early crisis intervention has been found to be an effective tool in mitigating further distress, particularly due to its immediate application and continuum across all phases of a disaster. A disaster mental health study focusing on the 9/11 terror attacks on the World Trade Center found that “early brief interventions at the worksite were the most effective post-disaster treatment,” (Boscarino & Adams, 2008; Boscarino, Adams, & Figley, 2005).

Psychological First Aid (PFA) is defined as “the provision of a supportive and compassionate presence designed to enhance natural resilience and coping, while facilitating access to continued care, if necessary” (Everly & Flynn, 2006; Parker, Barnett, et al., 2006). PFA is an extension of caring and focuses on the immediate biopsychosocial needs and five principles of crisis intervention: safety, calming, connectedness, self-efficacy, and hope, while building an action plan of recovery (Corrarino, 2008; Hobfoll et al., 2007; Maunder et al., 2008; Rodriguez & Kohn, 2008). While utilizing PFA to address the mental health needs of survivors, public health practitioners will personally benefit from its intervention, enhancing their own well-being and perception of safety, both physically and psychologically (Everly, Smith, & Welzant, 2008; Everly, Welzant, & Jacobson, 2008; Maunder et al., 2008; Parker, Everly, et al., 2006; Shubert et al., 2008). PFA is not a substitute for, nor a form of delivery of, professional mental health care, and is only one aspect of a larger need for service (Everly & Parker, 2005). PFA does, however, serve as a means of mitigating adverse consequences associated with a disaster – analogous to the use of CPR in basic life support.

Although PFA has been recommended for more than 50 years, its usage among first responders is very limited (Parker, Barnett et al., 2006). This lack of usage may be due to any one of the following: the persistent stigma associated with mental health; concern that training will increase anxiety or increase the workload; denial of the need for such interventions (organizational/political history); insufficient research supporting its efficacy; limited resources trained in its use; limited funding; and lack of clarity as to who is the best resource for delivering the first aid (consumers, military, pastoral, public health workforce; Everly, Sherman, et al., 2008; Flannery, Farley, Rego, & Walker, 2007; Flynn, 2006; Flynn, June 2008; Hobfoll et al., 2007; Williams, Nocera, & Casteel, 2008).

In an effort to expand utilization by embedded providers, develop an evidence base, and remove PFA from the “stigma” of mental health interventions, The Johns Hopkins Center for Public Health Preparedness developed a one-day PFA program designed specifically for individuals with no mental health training. This program is based upon the guiding principles elucidated by Drayer, Cameron, Woodward, and Glass (1954), Hobfoll and colleagues (2007), and Raphael (1986). After reviewing these resources, active elements were distilled into five practical skills that could reasonably be taught in a one-day training program. The elements were formulated into an acronym for easy memorization and utilization: RAPID – PFA.

The distilled core elements of the Johns Hopkins’ RAPID PFA were identified as follows.

- Reflective listening – the essential bedrock for all aspects of “therapeutic communications”
- Assessment of needs – recognition of behavioral and mental health needs of those affected
- Prioritized attention to severe vs. mild reactions – psychological triage
- Intervention – cognitive behavioral interventions such as reframing and “optimistic thinking”
- Disposition - assistance in regaining functionality for the performance of key foundational aspects of activities of daily living OR facilitate access to continued care

Here, we argue how and why nurses currently represent an ideal cohort for receipt of PFA training toward the ultimate goal of applying these skills in times of crisis and disaster so as to enhance community resilience.

### Nurses: A Critical Cohort for Receipt of PFA Training

While the majority of the healthcare workforce has ample experience and training in physical health interventions (first aid, cardiopulmonary resuscitation, and basic trauma life support; American Heart Association [AHA], 2008; Campbell, 1996; Hecht, 2005), healthcare workers’ relative lack of training and experience in mental health interventions can have deleterious implications for recipients of care. Indeed, in the event of a disaster, it is felt that training frontline personnel in crisis intervention will have

a positive impact on a survivor's psychological outcome (Everly, Beaton, Pfefferbaum, & Parker, 2008) and provider's well-being (DeSimone, 2009). Alongside preparedness and response efforts, post-disaster mental health services should become part of the primary care setting (Ablah, Hawley, Konda, Wolfe, & Cook, 2008; Everly & Parker, 2005; Everly, Welzant et al., 2008; Ruzek, Young, Cordova, & Flynn, 2004; Watson, 2009).

Regardless of where a disaster occurs, hospitals and community health clinics will remain the focal point for those in need of acute medical and psychological care (Becker & Middleton, 2008). Of major importance, within such settings nurses outnumber physicians by four to one across the United States (American Association of Colleges of Nursing [AACN], 2008; Nursing Advocacy, 2007), making them an underutilized, but potentially integral part of disaster preparedness and effective surge response (Chan & Wong, 2007; Hick, Barbera, & Kelen, 2009). By virtue of their occupation, experience, and training, nurses are well-positioned to take a leadership role in expanding the disaster mental health presence beyond the existing cadre of psychologists, psychiatrists, and other mental health clinicians.

On a daily basis, nurses encounter and must adapt to stressful, traumatic, or difficult situations (American Nurses Association [ANA], 2007, 2008; Chan & Wong, 2007; Flannery et al., 2007; Heinz, 2004; Jackson, Firtko, & Edenborough, 2007). Nurses have extensive direct contact with patients, possess high ethical standards, and have been shown to have a positive impact on patient outcomes (by reducing complications and mortality rates; ANA, 2007, 2008; Chan & Wong, 2007; Heinz, 2004). Furthermore, their core principles of practice – assessing, planning, implementing, and evaluating (APIE) holistic, patient-centered care (ANA, 2006, 2007, 2008; Chan & Wong, 2007) – “closely parallel the phases of disaster management (mitigation, planning, response, and recovery)” (National Association of School Nurses [NASN], 2006).

Based on these occupational characteristics and as the largest healthcare provider cohort (with 2.4 million registered nurses and more than 500,000 licensed practical and licensed vocational nurses in the U.S.), PFA training among nurses is logical (United States Census Bureau, 2009). Nurses can substantially boost provision of disaster mental health services through their early and continued mental health assessments of disaster survivors, not only in hospital settings, but when

deployed in the field as well. Such ongoing, nursing-driven assessments could help mitigate the recognized problem of under-referral of survivors to needed mental health services in post-disaster settings. (Norris & Rosen, 2009; Rodriguez & Kohn, 2008; Rosen et al., 2009). While nurses have been found to be hardy in the face of occupational stressors (Garrosa, Moreno-Jiménez, Liang, & González, 2008; Jackson et al., 2007; Judkins, Massey, & Huff, 2006; Lancee, Maunder, Goldbloom, & coauthors, 2008; Wu et al., 2009), self-care is an extremely relevant concern for this frontline cohort. Indeed, PFA training in nurses could not only potentially impact the mental health needs of other healthcare worker colleagues and the needs of patients and families both inside and outside of a disaster, but PFA may enhance self-care (one of the PFA competencies), as well (ANA, 2007; Becker & Middleton, 2008; Chaffee, 2009; Everly, Welzant, & Jacobson, 2008; Garrosa et al., 2008; Hughes, Grigg, Fritsch, & Calder, 2007; Jackson et al., 2007; Maunder et al., 2006, 2008; O'Boyle, Robertson, & Secor-Turner, 2006; O'Boyle, Robertson, & Secor-Turner, August 2006; Parker, Everly et al., 2006; Pendry, 2007; Perrin et al., 2009; Rooze et al., 2008; Rutledge et al., 2009; Secor-Turner & O'Boyle, 2006; Tomczyk et al., 2008; Veenema, Walden, Feinstein, & Williams, 2008; Zurmehly, Martin, & Fitzpatrick, 2009).

Analogous to a cardiac arrest scenario wherein skilled application of first aid principles can minimize negative impact, a nurse trained in PFA can minimize the psychological impact of any traumatic event, while building resistance and enhancing resiliency. Early intervention and adequate training are essential. Unfortunately, most nurses have not yet received any disaster training (Littleton-Kearney & Slepiski, 2008; Rebman & Mohr, 2008; Weiner, Irwin, Trangenstein, & Gordon, 2005; Weiner, 2006). As of 2006, only twenty (20) schools of nursing offered programs in disaster preparedness and management across the United States (Veenema, 2006). Recent research has delivered unprecedented insights into nurses' perspectives in anticipation of a bioterrorism attack, revealing that nurses experienced many concerns and needs that were not being addressed or considered during disaster preparedness development (O'Boyle et al., 2006; O'Boyle et al., August 2006; Secor-Turner & O'Boyle, 2006). Most prominent among these were issues of personal and family safety, physical and psychological support, institutional commitment to their well-being, and order amidst chaos (Maunder et al., 2008; O'Boyle et al., 2006; O'Boyle et al., August 2006; Secor-Turner & O'Boyle, 2006). Actively engaging

nurses in disaster mental health, through PFA training, is likely to help mitigate these concerns and perceived risks, (Maunder et al., 2008; Wu et al., 2009) while sharpening their skills to help others mitigate distress.

Moreover, during a disaster, when surge capacities are maximized and the availability of nurses minimized, nurses will inevitably feel the added stressors of functioning at an even greater level with limited resources. According to Maunder and colleagues “a severe pandemic would cause high mortality, high healthcare demands, high absenteeism among healthcare workers, rationing of basic healthcare supplies and extraordinary stress...Under such circumstances, the healthcare system could not afford a further loss of professionals due to the effects of stress...” (Maunder et al., 2008). As a decade-long nursing shortage winds down and before imbalances in supply and demand reappear due to trends in the composition of the nursing workforce and added stressors (Buerhaus, Auerback & Staiger, 2009; Maunder et al., 2008), a window of opportunity presently exists to empower nurses and reduce worker distress by building resilience and resistance, through PFA (Maunder et al., 2008). Studies which evaluated psychological disorders in healthcare workers (primarily nurses) after they cared for SARS patients concluded that years of experience, perception of training, and moral support by administrators were protective against psychological disorders and revealed lower incidence rates of psychological disorder when compared to the general public. (Lancee et al., 2008; Maunder et al., 2006) Several studies have shown that a healthcare professional’s willingness to respond during any disaster is related to three key concerns: surge capacity, the safety of loved ones, and personal protection (Becker & Middleton, 2008; Chaffee, 2009; O’Boyle et al., 2006; O’Boyle et al., August 2006; Rooze et al., 2008; Veenema et al, 2008).

As mental health services such as PFA become more mainstream among nurses, empirical data should expand in efforts to maintain best practices and effective outcomes; improve services; and gain feedback on what is expected and perceptions of use (Norris & Bellamy, 2009). In line with suggestions made by Gebbie and Turnock in 2006, public health practice competencies can be achieved by requiring public health credentialing for healthcare employment. Just as basic cardiac life support certification is mandated and available to any clinician on- or off-site, PFA would fit nicely into this schema (Gebbie & Turnock, 2006).

As the Joint Commission on Accreditation of Health-

care Organizations requires initial and continual assessment of employee competencies, about half of the State Boards of Nursing across the United States now require nurses to obtain and submit continuing education credits with every license renewal (Whittaker, Carson, & Smolenski, 2000). In the hospital setting, nurses are required to maintain BLS and ACLS certifications. PFA certification could and should become an added standard within any healthcare institution, thereby meeting some of these competency standards.

The Nursing Emergency Preparedness Education Coalition (NEPEC), formerly the International Nursing Coalition for Mass Casualty Education (INCMCE), promotes mass casualty education for the nursing workforce aided by schools of nursing, nursing specialty organizations, and governmental agencies (National Emergency Preparedness Education Coalition [NEPEC]). While the NEPEC recommends and disseminates curriculum guidelines and competencies to educate and prepare nurses for mass casualty incidents, to our knowledge the nursing profession – similar to the mental health disciplines – fails to mandate psychological crisis or disaster mental health intervention training as part of the standard nursing curriculum (NEPEC, 2003). According to researchers, as few as four to five hours were spent on disaster preparedness within the nursing curriculum across the United States during the academic years 2000-2001 and 2002-2003. (Weiner, 2006; Weiner et al., 2005). While schools of nursing contend with the quality and quantity of disaster preparedness curricula, those already working in the field remain poorly prepared. PFA is one tool, like CPR, that can be taught and certified annually to both providers and students in a timely fashion; perhaps even with the use of simulation technologies.

## Conclusion

Not all disasters can be prevented, but our acute response to them can be enhanced. We have learned much since the formative years of the discipline of disaster mental health; thus, the progression of this field has been highlighted with a myriad of “lessons learned.” We had assumed that existing mental health resources would be adequate given any disaster in North America. The terrorist attacks in New York City and Hurricane Katrina’s effects upon Louisiana and surrounding states taught us that the mental health surge could quickly exceed the capacity of mental health services. Functional capacity was seen to quickly shrink in the face of two important factors. First, not all mental health clinicians are trained in the

principles and practices of psychological crisis and disaster intervention. The disciplines of psychology, psychiatry, and social work do not require specific training in crisis or disaster intervention, yet there is a dangerous assumption of tactical competency in the field. Second, not all mental health clinicians are trained nor characterologically disposed to perform the requisite functions of disaster mental health intervention under often challenging field conditions.

In the nascent research stages of disaster mental health, we did not fully understand the differentiation of benign versus malignant “psychological injuries” that may be encountered and the requisite need to establish a hierarchical triage system (Everly, 1999). Prior to 1999, there was little understanding of psychological triage and the need for the establishment of a field surveillance and triage system (Mitchell, Gochfeld, Shubert, et al., 2007; Shubert, Ritchie, Everly et al., 2008). Lastly, we underestimated the utility of utilizing indigenous professional resources who were: 1) already “embedded” in the community, and 2) already trained in emergency functions and incident command, (e.g., emergency services personnel).

Nursing professionals represent one of those overlooked resources. As with all professional disciplines which will respond to psychological needs post disaster, some form of specialized training is essential. However, PFA training can provide the fundamental tools needed to functionally prepare nurses, as well as other occupational groups, to respond to the mental health surge following disasters. As nurses are already integrated into the provision of other post-disaster services, they can serve as a surveillance system and first-line response to attend to psychological emergencies – with the subsequent capability of triaging to the next level of care, consistent with traditional medical models of the continuum of care. Nurses can provide services to both primary survivors and other responders.

Bridging the gap between best practices and research remains a challenge in disaster mental health, as research lags behind the services offered post-disaster. Expanded PFA training of nurses represents an example of such a bridge. Barriers of limited resources and time for such training must be acknowledged, but these hurdles will become smaller as the training progresses.

We now have empirical data to support the urgency of expanding disaster mental health surge capacity. In addition, we know that interpersonal support represents the single most powerful agent to enhance human resiliency. The next step is

to put these results into action by training nurses in PFA and by utilizing PFA-trained nurses to boost community resilience in a disaster mental health context. The notion of ongoing certification in PFA remains an interesting idea to consider as we strive to build sufficient capacity in the public health emergency preparedness system.

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## Training Community Therapists to Deliver Cognitive Behavioral Therapy in the Aftermath of Disaster

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**Abstract:** *In this paper we examine the effectiveness of disseminating Cognitive Behavioral Therapy for Postdisaster Distress (CBT-PD) to community therapists in Baton Rouge, Louisiana following Hurricane Katrina. One hundred four therapists attended a two-day training in CBT-PD with on-going case consultation. Pre- and post-training, therapists rated eight core cognitive behavioral therapy elements on their importance, how well they understood how to deliver the element, and how confident they were in their ability to deliver the element. Post-training they completed a CBT-PD knowledge questionnaire and session fidelity forms. Seventy-seven clients completed satisfaction questionnaires and reported on how often they utilized the skills taught in CBT-PD. Therapists showed significant improvements in their ratings of the importance of various elements of cognitive behavioral therapy, their knowledge and understanding of those elements, and their confidence that they could use them effectively. Immediately following the training 90% of therapists demonstrated excellent retention of CBT-PD. Self-report measures from both therapists and clients indicated that critical session elements were delivered. This work suggests that CBT-PD can be applied in a real-world setting and that community therapists can be trained in relatively short time spans with on-going support. This finding is especially important in the disaster field given that communities are likely to find themselves in emergency situations in which a number of non-expert trauma therapists will need to deliver trauma services. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 33-40].*

**Key words:** *Dissemination, training, cognitive behavioral interventions, disaster*

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In recent years considerable effort has been expended to promote and disseminate empirically-supported treatments in the field of psychology. In 1995, the American Psychological Association (APA) developed the Task Force on Promotion and Dissemination of Psychological Procedures (American Psychological Association [APA] Task Force of Promotion and Dissemination on Psychological Procedures, 1995). It was expected that once these treatments were identified, they would be widely utilized in clinical practice and would improve clinical care. However, despite these efforts, the acceptance and utilization of empirically-supported treatments have been slow.

Disasters provide a unique challenge as they are by definition unplanned and of large scale. Program administrators are faced with the need to quickly organize and train practitioners to provide appropriate mental health interventions to sometimes thousands of persons with a broad range of clinical need. Best practices for disseminating disaster interventions are therefore critical as time is short and the need is great.

According to the Federal Emergency Management Agency (FEMA), on average, there are 31 disaster declarations in the United States each year (Federal Emergency Management Agency [FEMA], 2007). Although not all disasters require a mental health response, many do. In a study of mental health problems following Hurricane Katrina, Kessler and colleagues compared mental health problems 6 months post-Katrina to a representative sample from the same area pre-Katrina. Mental health problems were more than twice as likely post-Katrina (Kessler, Galea, Jones, & Parker, 2006). Despite the great need for services, only about half of the people in need of help with mental health sought services. Of those who did not seek services, about half said they wanted services but reported that services were unavailable, that costs were prohibitive, or that they lacked transportation (Wang et al., 2007). Previous writings have likewise emphasized the need for disaster mental health services to be acceptable, accessible, and proactive (Hodgkinson & Stewart, 1998).

It is important to distinguish between mental health services delivered in the immediate aftermath of a disaster from those required in the longer-term response. In the immediate aftermath, services typically focus on safety and stabilization, whereas longer-term interventions are designed to treat mental health problems and disorders. Psychological First Aid (PFA) is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and to foster short- and long-term adaptive functioning. It is for use in diverse settings by mental health specialists, including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps (Brymer et al., 2006). Widespread training in PFA occurred following the September 11, 2001 terrorist attacks, Hurricane Katrina, and the 2004 Florida Hurricanes, although evaluation of the training was not reported. One study did report promising results in training clergy to provide PFA.

Following a one-day training in PFA, over 90% of participants reported being able to recognize signs of symptoms of stress and over 80% thought the training would be useful if a disaster were to occur (McCabe et al., 2007).

With respect to the longer-term response, a few studies have examined whether community providers can be trained to effectively deliver evidence-based psychosocial treatments. In a prototypical randomized controlled trial, experienced clinicians are provided with extensive training, including training cases with an hour of supervision for every hour of therapy and on-going weekly supervision for protocol cases. Only a few studies of cognitive behavioral therapy (CBT) have used non-expert clinicians as providers, but they show promising results.

Foa and colleagues (Foa et al., 2005) reported that rape crisis counselors achieved results similar to academic researchers when providing CBT to rape victims with PTSD. However, counselors received extensive training and weekly supervision for two years. Thus, it is unclear how well results would generalize to a more typical setting with less training.

In a second study, community-based clinicians were trained in a cognitive behavioral therapy to help survivors of a bombing in Northern Ireland who had developed PTSD (Gillespie, Duffy, Hackmann, & Clark, 2002). Five clinicians from a range of professional backgrounds, including psychiatry, nursing, and social work, were trained in the treatment. None of the clinicians had previously specialized in trauma treatment. Clinicians received a two-day training in the CBT for PTSD followed by supervision of cases. Ninety-one patients with PTSD and comorbid disorders received the treatment. Significant improvement in PTSD symptoms was achieved with an effect size of 2.47, which is larger than the average CBT randomized controlled trial effect size of 1.27 (Van Etten & Taylor, 1998). This study provided more support for the idea that CBT can be used in community settings.

A final study was a randomized, controlled trial of a cognitive behavioral PTSD treatment for school children exposed to violence (Stein et al., 2003). Three psychiatric social workers located in the schools received a two-day training in the manualized treatment, as well as weekly group supervision. Sixth graders who endorsed exposure to violence and clinical levels of PTSD symptoms were randomized to CBT or a wait-list delayed treatment condition. Treatment

adherence ratings indicated that, on average, 97% of the required treatment elements were completed and that quality of sessions was moderate to high. At post-test, students in the CBT group reported significantly fewer symptoms of PTSD and depression than did students in the wait-list condition.

There are several important differences between the training that occurred as part of these studies and the training that would be required to respond to a major disaster. The first is therapist selection; in each of these studies researchers worked with clinicians from a single agency. A second difference is number of therapists; in each of these studies there were relatively few therapists to train and supervise. In addition, in the study by Foa and colleagues (Foa et al., 2005), considerable time was spent training and supervising clinicians, which would not be feasible following a major disaster. In contrast, effective response to a disaster could require the training of more clinicians from different agencies in less time and with less intensive supervision.

Following the September 11, 2001 terrorist attacks, researchers at Columbia University in New York were provided with an opportunity to determine whether they could quickly and efficiently train a large number of frontline clinicians from many different agencies to deliver an evidence-based treatment for PTSD (Marshall, Amsel, Neria, & Jung Suh, 2006). One hundred four community-based therapists received a two-day training in prolonged exposure for PTSD. Results from the pre-training assessment indicated that therapists were moderately favorable regarding the active components of the treatment, but felt that they lacked the skill to adequately deliver the exposure treatment. No post-training or treatment adherence data were available.

Taken together, these studies indicate that it may be possible to train community therapists in a variety of non-academic, real-world settings to provide effective CBTs. Rape crisis counselors, community mental health clinicians, and school-based counselors were all able to learn CBTs and delivered them with successful outcomes. However, limited information is available regarding the effectiveness of training community therapists to deliver disaster interventions. It is likely that these therapists differ significantly from therapists selected to participate in a research study. Only one study was identified that trained community therapists to provide PTSD treatment following disaster and that study only looked at pre-training attitudes (Marshall et al., 2006).

In this paper we examine the effectiveness of disseminating Cognitive Behavioral Therapy for Postdisaster Distress (CBT-PD; Hamblen, Gibson, Mueser, & Norris, 2006) to community therapists in Baton Rouge, Louisiana after Hurricane Katrina. CBT-PD was developed to focus more broadly on postdisaster distress rather than PTSD. Postdisaster distress encompasses a range of cognitive, emotional, and behavioral reactions to disaster, including symptoms of depression, stress vulnerability, and functional difficulties. Postdisaster distress is not a psychiatric diagnosis. Within certain limits, distress is perfectly natural and normal and can be expected to improve on its own. Sometimes, however, this distress becomes severe and/or prolonged enough to interfere with quality of life. Postdisaster distress was assessed with the Short Post-Traumatic Stress Disorder Rating Interview-Expanded (Norris et al., 2006; Norris, Hamblen, Brown, & Schinka, 2008), a measure of disaster-related PTSD symptoms, depression, stress vulnerability, functional impairment, and perceived need for assistance.

This study goes beyond previous studies in several important ways. First, therapists were recruited from the community at large to participate in InCourage, a mental health initiative sponsored by the Baton Rouge Area Foundation to provide free treatment to individuals affected by Hurricane Katrina. Thus, therapists were not selected to participate in a research study. Data were gathered as part of a larger program evaluation initiated by the Foundation to determine the effectiveness of InCourage (Hamblen et al., 2009). Second, our evaluation of the training is more systematic than in previous studies. Kirkpatrick (1998) proposed a four stage model for evaluating training programs including, 1) reaction: how participants react to the training, 2) learning: changes in participants' knowledge, attitude, and skills due to the training, 3) behavior: how participants' behavior changes as a result of the training and 4) results: what occurred as a result of participants attending the training. In this study we focus primarily on learning and behavior. With respect to learning, we measured changes in therapists' attitudes about cognitive behavioral interventions after training as well as their knowledge gained regarding the specific intervention. In terms of behavior, we asked both therapists and clients to report on whether critical session elements took place. Results of the training (e.g., client outcomes) are reported elsewhere (Hamblen et al., 2009).

## METHOD

### Participants

*Therapists.* Therapists from greater Baton Rouge were recruited for the InCourage program through the mailing lists of state licensing boards for psychologists, professional counselors, and clinical social workers. Application packets were sent to 111 psychologists, 279 professional counselors, and 1332 social workers residing in the East Baton Rouge Region. Interested therapists were asked to complete an application. To be eligible, therapists were required to show proof of license and insurance and to hold at least a master's degree in a mental health field. Therapists were selected based on 1) the date their application was received, 2) having at least a master's degree in a mental health field, 3) proof of license and insurance, and 4) background in CBT. A small committee of mental health professionals, both local and national, reviewed applications and made the final selection decisions. A total of 205 therapists completed an application of which 113 were selected as InCourage providers and were invited to one of the two-day trainings. One hundred eleven therapists attended the full two-day training, of which 104 completed both pre- and post-training questionnaires. Therapists were required to sign contracts indicating that they would 1) attend a two-day training; 2) attend bi-weekly case consultation calls; 3) complete standardized evaluation, billing, and fidelity forms; 4) deliver CBT-PD; and 5) accept \$80 per therapy hour. All invited therapists attended the training and 100% completed both pre- and post-training questionnaires.

Most (77%) of the 104 therapists who completed the pre-training questionnaire were women. Their ages ranged widely from 30 to 74 years ( $M = 50$ ,  $SD = 10$ ). All had either a masters (71%) or doctoral (29%) degree and no less than 2 years previous clinical experience ( $M = 16$ ,  $SD = 8$ ). Most therapists (63%) had used a manual in therapy before, and few expressed serious concerns about their use. Most considered themselves to have at least a partial cognitive behavioral orientation (most important orientation - 45%, second most important - 25%).

*Clients.* Clients were recruited for the InCourage program through advertisements, clinician referrals, and direct calls to the Baton Rouge Crisis Intervention Center. Eligible clients 1) currently lived or worked in the Greater Baton Rouge Area; 2) had been impacted by Hurricanes Katrina or Rita, according to a broad definition that included direct

and indirect effects of the hurricane; and 3) met a moderate cut-point for distress on the Sprint-E (Norris et al., 2006), a 12-item scale assessing psychological reactions to a focal disaster. The cut-point was set at 3, which is indicative of a possible need for treatment (Norris et al., 2008). The program began around January 1, 2007. Before the program closed to new clients in January 2008, 444 clients met eligibility criteria and accepted a referral to the program. Of those referred, 205 (46%) enrolled in the program by December 31, 2007 and, of those enrolled, 102 (50%) completed treatment (defined as completing at least 8 out of 10 sessions). Enrolled participants were predominantly female (81%) and either African American (57%) or non-Hispanic White (40%). The majority were middle-aged (68% age 40-64), but younger adults (25% age 18-39) and older adults (7% age 65+) were also represented. Similarly, the majority had a high school degree or some college (60%), but some participants had college degrees (26%), and some lacked a high school diploma (14%). Most participants (69%) had lived in Orleans Parish or Jefferson Parish before being displaced to Baton Rouge by Hurricane Katrina.

### Measures

*Therapist measures.* Immediately following the 2-day training, therapists completed an 11-item self-report measure developed to assess knowledge about CBT-PD. Items addressed key aspects of CBT-PD. Specifically, therapists were asked to identify the four primary emotions challenged in the intervention, the 5 steps of cognitive restructuring taught in the intervention, whether the intervention is only for individuals with PTSD, and whether clients should use problem solving when their thoughts are not supported by the evidence. The range of possible scores is 0-11.

Attitudes about CBT were assessed using a 24-item self-report measure, modified from Marshall and colleagues (Marshall et al., 2006), to assess therapists' attitudes about eight different CBT elements including the use of a manual, the use of assessment, psycho-education, breathing retraining, pleasant activity scheduling, coping skills, cognitive restructuring, and the use of practice exercises. The measure has three subscales: Importance ( $\alpha = .79$ ), Understanding ( $\alpha = .91$ ), and Confidence ( $\alpha = .94$ ). Therapists were asked to rate each CBT element from 1 (not at all) to 10 (extremely) on the element's importance, how well they understood how to deliver the element, and how confident they were in their



ability to deliver the element. Each subscale was scored as the average of the ratings across the eight elements of CBT. The maximum possible score for each subscale is 10. Therapists completed the measure before and after the two-day training.

Fidelity forms assessed the presence or absence of critical session elements. Therapists completed measures after each therapy session. The number of critical elements ranged from 4 to 7 depending on the particular session, each scored as 0 (absent) or 1 (present). Session fidelity was scored as the average of the elements, with scores ranging from 0 (all elements absent) to 1 (all elements present).

*Client Measures.* The client measure focused on clients' reports of satisfaction and use rather than on their symptom outcomes. At the end of treatment, clients were asked to report on five-point scales how helpful they thought critical intervention elements were from not at all helpful to extremely helpful. For each element, they also rated how often they used the element: never, 1-4 times, 5-10 times, or more than 10 times. Clients were also asked to write down the five steps of cognitive restructuring taught in the intervention.

## Training

The two-day training in CBT-PD included a combination of modalities such as lecture, practice exercises, expert demonstration (including live and video demonstrations), and role plays. The training began by providing therapists with a solid rationale for the intervention. In presenting the rationale, trainers reviewed effective treatments for common psychiatric disorders after disaster and shared the philosophy behind the development of this intervention. The goal here was twofold: first, to educate clinicians on the types of problems they might see among individuals presenting for CBT-PD, and second, to establish the credibility of the treatment with the clinicians. Next, clinicians were taken step-by-step through each session of the intervention. Session goals were emphasized and suggestions for meeting those goals were provided. Clinicians were shown how to use the manual during the session, how to integrate handouts into the teaching of the intervention, and how to address specific problems that might arise.

After a new technique was described, the trainers demonstrated the technique and clinicians had an opportunity to participate in a role play to promote skill acquisition. For example, following a lecture on cognitive restructuring, cli-

nicians engaged in a group practice exercise in which they brainstormed typical disaster-related cognitions and then tried to identify alternative thoughts. Next the trainer demonstrated cognitive restructuring using a clinician volunteer and a real example. Finally, clinicians actively practiced the cognitive restructuring in small group role plays.

Barriers to implementation were openly discussed and debated throughout the training. Specific barriers addressed included the effects of manuals on the therapeutic relationship, therapists' concerns about manuals not being able to meet clients' individual needs, credibility of the manual, and therapist confidence. From the beginning, trainers emphasized the importance of the therapeutic relationship when using manualized treatments and encouraged therapists to focus on the development of a therapeutic alliance. A second area of emphasis was on demonstrating the flexibility of the manual and showing how the manual can be tailored to meet individual client needs.

Follow-up consultation is crucial to ensuring fidelity to the intervention. Therapists attended a bi-weekly case conference with an expert selected by Hamblen. The purpose of these calls was to provide therapists with on-going support in the intervention and to increase adherence to the manual.

## Procedure

All InCourage therapists who attended the CBT-PD training were asked to complete measures before and after the training. Data were collected using a double envelope procedure; questionnaires were sealed in an unidentified internal envelope and then placed into an identified outer envelope. In this way, pre- and post-questionnaires could be linked together, but once the internal envelopes were removed from the outer envelope, the respondent's identifying information could be removed.

Once trained, therapists received referrals from the InCourage program and delivered the 10 session CBT-PD intervention (see Hamblen et al., 2009 for more information on the treatment and its effects). At the end of each session, therapists completed fidelity forms which served the dual purpose of a billing form. Clients also completed measures, including some that asked about what occurred during the intervention. This measure was completed by the client in private and mailed directly to program evaluators. Of the 102 program completers, 77 (75%) returned this questionnaire.

## RESULTS

Pre-training and post-training means on attitudes regarding CBT are shown in Table 1. Despite their high pretest averages, therapists' opinions improved significantly from pre- to post-training. Their ratings of the importance of CBT increased an average of 0.3 points,  $t(95) = 1.85, p = .07$ . Ratings of their own understanding increased by 1.5 points,  $t(95) = 7.05, p < .001$ , and their confidence increased by 0.4 points,  $t(95) = 2.34, p < .05$ .

The improvements were greater when therapists who had "perfect" scores at pretest were excluded. For the remaining therapists, importance ratings increased an average of 0.5 points,  $t(90) = 3.56, p < .001$ . Ratings of their own understanding increased by 1.5 points,  $t(93) = 8.28, p < .001$ , and their confidence increased by 0.6 points,  $t(79) = 3.41, p < .001$ .

Out of 11 possible points on the CBT-PD knowledge scale, 90% scored 10 or higher, 8% scored 8-9, and only 2% scored below 8. In a series of regression analyses predicting post-training outcomes, quiz scores were positively related to increases in ratings of importance,  $\beta = .37, p < .01$ , knowledge,  $\beta = .42, p < .001$ , and confidence,  $\beta = .42, p < .001$ .

Therapists' reported fidelity was extremely high across all sessions. Session fidelity scores ranged from .98 (Session 1) to 1.0 (Session 10).

Of the 102 clients who completed treatment, 91 provided posttest data and 77 (85% of the post-treatment evaluation sample) returned the satisfaction and use questionnaire. Most reported that the three critical elements of CBT-PD, breathing retraining (72%), pleasant activity scheduling (76%), and cognitive restructuring (73%) were very or extremely helpful. The majority also reported using these skills 5 or more times (69% for breathing retraining, 58% for pleasant activity scheduling, and 70% for cognitive restructuring). Clients generally showed good skill acquisition. The majority were able to list three of the five steps of cognitive restructuring (75%) and more than half (57%) could accurately list all five steps.

## DISCUSSION

In this paper we examined our ability to effectively disseminate a cognitive behavioral intervention for postdisaster distress to practicing mental health therapists in the community. Even before the two-day training, most attending therapists considered the various elements of CBT to be important, rated their knowledge as at least moderate, and were reasonably confident that they could employ the methods of CBT effectively. Nevertheless, the training was effective in educating the therapists about CBT. Therapists who were not already at the maximum score at pre-training, showed significant improvements in their ratings of the importance of various elements of CBT in therapy, their knowledge and

Table 1.  
Therapist Attitudes about Cognitive Behavioral Therapy Before and After the 2 Day Training (n = 96).

Dimension	Pre-Training		Post-Training		t
	M	SD	M	SD	
Importance	8.55	1.55	8.88	1.07	1.85
Understanding	7.54	1.68	8.96	1.23	7.05**
Confidence	8.63	1.33	9.04	1.27	2.34*

\*  $p < .05$ , \*\*  $P < .001$

understanding of those elements, and their confidence that they could use them effectively. In addition, therapists generally scored extremely high on the knowledge quiz, indicating that the training was effective in teaching them the specific techniques necessary to deliver CBT-PD.

When asked to report on whether they delivered critical session elements, therapists uniformly endorsed that they had. While it is possible that these ratings reflect high compliance with the intervention, it is also possible that therapists felt pressure to endorse these items because the form was also used as a billing measure. Because the variability on fidelity was so low, we were unable to look at which client and/or therapist variables predicted compliance.

The majority of clients reported that they had regularly used all three critical session elements: breathing retraining, pleasant activity scheduling, and cognitive restructuring. As a check on how well clients were taught cognitive restructuring, three quarters could list three of the five steps of cognitive restructuring and over half knew all five steps. This provides additional evidence that therapist adherence to the manual was high.

This study provides support to the growing literature that community therapists with a prior interest in CBT can quickly and effectively be taught to deliver manualized, cognitive behavioral interventions. A specific strength of the study is its focus on treatment for disaster in a real-world, non-research setting. In addition, it extends what has been shown about postdisaster trainings by examining the impact of the training on therapist attitudes and includes both therapists' and clients' self-reports of the presence of critical therapeutic elements.

There were also some limitations. First, because the training and therapy were done as part of a community program, we were not able to videotape sessions to measure fidelity, as would typically be done in a controlled trial. Therefore, we have no objective measure from which to assess fidelity. However, client report does support the notion that the majority of therapists introduced the critical session elements and that they had taught them well enough that clients could recite the steps of cognitive restructuring, the element believed to be the active component of the therapy.

A second potential limitation is that we cannot say what the critical elements were in the dissemination plan. As an example, we do not know if there were certain aspects of the two-day training that were critical to dissemination and others

that were unnecessary. If the training could be shortened, it would increase the feasibility of the training. Similarly, we do not know the value of the on-going case consultation calls with respect to increasing therapist adherence. However, our inability to identify the active components of the dissemination plan does not threaten the validity of our results. Instead, it suggests important questions for future research.

The decision not to assess clients' pre-treatment knowledge and use of the skills associated with CBT-PD could be seen as an additional limitation. We did not measure clients' knowledge of cognitive restructuring or their use of skills such as breathing, retraining, and positive activity scheduling before the treatment because we assumed each would have been minimal. However, having pre-test data on these points would have strengthened our ability to infer that the knowledge and skills were directly attributable to participation in CBT-PD.

In sum, this work suggests that CBT-PD can be applied in a real-world setting and that community therapists can be trained in relatively short time spans with on-going support. This finding is especially important in the disaster field given that communities are likely to find themselves in emergency situations in which a number of non-expert trauma therapists will need to deliver trauma services.

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## Treatment of PTSD in Rwandan Child Genocide Survivors Using Thought Field Therapy

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**Abstract:** *Thought Field Therapy (TFT), which utilizes the self-tapping of specific acupuncture points while recalling a traumatic event or cue, was applied with 50 orphaned adolescents who had been suffering with symptoms of PTSD since the Rwandan genocide 12 years earlier. Following a single TFT session, scores on a PTSD checklist completed by caretakers and on a self-rated PTSD checklist had significantly decreased ( $p < .0001$  on both measures). The number of participants exceeding the PTSD cutoffs decreased from 100% to 6% on the caregiver ratings and from 72% to 18% on the self-ratings. The findings were corroborated by informal interviews with the adolescents and the caregivers, which indicated dramatic reductions of PTSD symptoms such as flashbacks, nightmares, bedwetting, depression, isolation, difficulty concentrating, jumpiness, and aggression. Following the study, the use of TFT on a self-applied and peer-utilized basis became part of the culture at the orphanage, and on one-year follow-up the initial improvements had been maintained as shown on both checklists. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 41-50].*

**Key words:** *Adolescents, genocide, child survivors, PTSD, Rwanda, TFT, Thought Field Therapy, trauma*

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The dire psychological consequences of war and organized violence have been extensively reviewed and reported (e.g., Kienzler, 2008; Miller, et al., 2006; Ziegler, 2010). The incidence of posttraumatic stress disorder (PTSD) in children of war is particularly high (Ehnhold & Yule, 2006; Thabet & Vostanis, 2000). In a study of orphans ten years after the 1994 genocide in Rwanda that left more than one million children without parents, 44% of a sample of 68 orphans still met the full criteria for PTSD, based on structured interviews (Schaal & Elbert, 2006). Knowledge about effective treatments for populations devastated by war, however, is limited, especially with children and adolescents. The present study investigates the use of Thought Field Therapy (TFT) with 50 adolescents who had been orphaned during the genocide in Rwanda twelve years earlier and who met criteria for

PTSD on a standardized PTSD checklist completed by their caregivers at the start of the study.

TFT combines the manual stimulation of acupuncture treatment points, the mental activation of targeted symptoms and traumatic memories, and related procedures. Developed by clinical psychologist Roger Callahan (Callahan, 1981; Callahan, 1995; Callahan, 2001; Callahan & Callahan, 2000), TFT can be taught by a therapist in a clinical setting and is self-administered by the client in clinic and in the client's own settings.

TFT has been used in the treatment of PTSD with refugees (Folkes, 2002), survivors of war trauma (Johnson, 2001), and survivors of natural and human-made disasters (Feinstein, in press). While such reports suggest that TFT may be an unusually effective treatment for PTSD in the aftermath of catastrophic events, few controlled investigations have been conducted. Two recent randomized controlled trials treating PTSD using a derivative of TFT called Emotional Freedom Techniques have, however, produced strong favorable outcomes (Church, Piña, Reategui, & Brooks, 2009; Church et al., 2010). The current study, based on multiple case data (after Kazdin, 1982), investigated outcomes of TFT treatments with childhood survivors of genocide. The study was conducted in the context of a trauma relief deployment by invitation of the staff at an orphanage in Rwanda.

## METHOD

### Participants

The study, conducted in April 2006, included 50 students (27 male; 23 female), ages 13 to 18, attending a day school that was part of an orphanage in Rwanda. Of the 400 students attending the school, 188 were old enough to have been survivors of the 1994 genocide in Rwanda 12 years earlier. All completed a PTSD symptom inventory. Those with the most severe symptoms were also rated by their caregivers on a standardized PTSD checklist. Of these, the 50 given the highest scores on the caregiver checklist were selected to be in the study. The 27 males in the study were residents at the orphanage; the 23 females lived with foster parents.

These 50 adolescents were treated by four practitioners over a three-day period. The practitioners included a licensed psychologist, two licensed clinical social workers, and a paraprofessional with extensive training and experience in both TFT and disaster relief procedures.

## Measures

A review of psychological interventions for post-traumatic reactions in children and adolescents suggests the importance of utilizing both child and parent measures in clinical studies (Stallard, 2006). In conformance with this suggestion, two standardized checklists to assess participants' PTSD symptoms were utilized: one completed by the participants and one by their caregivers. The Child Report of Post-Traumatic Symptoms (CROPS) and the Parent Report of Post-Traumatic Symptoms (PROPS; Greenwald & Rubin, 1999) were translated into the native Kinyarwanda language according to recognized standards for test translation and approved by the test's first author (Greenwald) in 2006.

Because the students were orphans, their teachers—who also served to guide, discipline, and counsel them and in many cases were their only caregivers—did the parental assessments. The PROPS inventory is still valid, according to its first author, if scored by “any adult who is with the child frequently and knows him/her well” (R. Greenwald, personal communication, March 2, 2006). The three caregivers doing the PROPS ratings selected students with whom they were most familiar, and the same caregiver rated the same students on immediate pre- and post-treatment assessments, as well as on each of the follow-up assessments.

The CROPS self-inventories were administered the day before the start of treatment in a group setting and then immediately upon the completion of the treatment sessions. The students completed the inventory independently if they were able to read and understand it or with staff assistance if they required help. The therapists were not involved in the administration of either inventory. Another measure, used by the students, was a verbal Subjective Units of Distress (SUD) self-rating (Wolpe, 1973). Students were asked by the therapist to rate their level of distress relative to a traumatic memory or other concern that was a focus of the treatment, on a scale of 0 to 10, at various points during the treatment session as a process measurement.

## Procedures

Informed consent content was developed with the school/orphanage staff and presented to the students at an assembly so all received identical information and heard the same answers to the many questions that were asked. The students were told that the visiting therapists were going to

see if they might be able to help them with intrusive memories from the genocide, and that they would also be teaching them some ways that might help them to better relax and sleep. They were also told that the therapists wanted to learn from them what was helpful, thus the questionnaires. Participation was completely voluntary. Students were asked to raise their hands to indicate that they understood the intent of the program and that they were willing to participate. There was 100% agreement and ultimate participation. The therapy team was there at the invitation of the orphanage's director, who was also a university professor in Kigali. While the complications of attempting to obtain Institutional Review Board (IRB) approval in Rwanda at the time made a formal IRB process unfeasible, the possibility was explored and the protections provided by an IRB were all discussed with the director and built into the study.

Of the 188 students at the orphanage who were survivors of the genocide, the 50 selected for the study, based on their scores on the PROPS caregiver inventory, each exceeded the PTSD cutoff score, which is 16 (Greenwald & Rubin, 1999).

Thus 100% of the adolescents in the study were rated as being above the PTSD cutoff on the PROPS inventory prior to treatment. These 50 participants were administered the CROPS self-rating inventory one day prior to their first treatment session. Only 72% of these students (36 of 50) met the criteria for PTSD prior to treatment. While this might give the appearance that the caregivers overestimated the students' level of distress (rating 100% in the PTSD range), discussion of this question with the caregivers led to possible alternative explanations, such as that some of the students may have dissociated from the genocide events or been in denial about or concealing their symptoms on the self-inventory.

The 50 participants were each provided an individual Thought Field Therapy (TFT) treatment session of 20 to 60 minutes duration. No pre-set time-limit was established, and the session was able to continue as long as the therapist judged appropriate. The participants were treated with TFT for multiple traumas, anger, rage, guilt, grief, and chronic pain. The TFT *basic algorithm* level of treatment was utilized, with corrections for *psychological reversals* as needed. The basic treatment algorithms and psychological reversal corrections utilized in the study are described in Callahan's (2001) *Tapping the Healer Within*.

Each therapist was randomly assigned approximately one-fourth of the participants, and each therapist saw each of

his or her participants on three consecutive days. On one of those days, the TFT session was administered, on another day a four-minute progressive relaxation technique was taught during a five- to ten-minute session that also involved supportive counseling, and on the other day, a two-minute diaphragmatic breathing technique was taught during a five- to ten-minute session that also involved supportive counseling. The order for each treatment condition was pre-selected and varied among the students. Kinyarwanda-English translators were used in all sessions.

This design was a last-minute deviation from the original plan, which was to have three TFT sessions administered to each participant on three consecutive days. However, a contingent of three of the seven-member therapist team was unexpectedly called to another part of the continent to assist in an emergent situation, making it impossible for the remaining four therapists to provide three extended treatment sessions to each of the 50 participants within the three days available.

The brief progressive relaxation and diaphragmatic breathing sessions were introduced to make it possible for each of the participants to still have the intended three sessions with a therapist. In this revised design, the relaxation and breathing sessions were conceived of as placebo conditions—with each of the three treatments provided in random order—allowing the participants to act as their own controls. The data collection strategy, however, improvised at the last moment to accommodate the new developments, was not adequate for an analysis that would allow that objective to be fulfilled. The study is, therefore, properly understood as a systematic investigation of clinical outcomes without a comparison condition.

The CROPS inventories were re-administered immediately following the diaphragmatic breathing and progressive relaxation sessions as well as after the TFT treatment. The PROPS inventories were re-administered within a day of the end of all three sessions, allowing the caregivers time to observe and interact with the students they were responsible for rating. Follow-up assessments were conducted at 3 months, 6 months, and 12 months post-treatment.

## RESULTS

Scores on both the PROPS and CROPS inventories were significantly reduced at the end of treatment, with reductions holding at one year follow-up. Table 1 shows the mean scores

on both inventories prior to treatment, immediately following the treatment sessions, and at one year. Standard deviations and probabilities that the pre- and immediate post-treatment differences were by chance are also presented. Table 2 shows the percentage of students who were above the PTSD cutoff for each inventory pre-treatment, immediate post-treatment, and on one-year follow-up. Table 3 shows a pre-treatment SUD (subjective units of distress) score on the most disturbing traumatic memory and a post-treatment score. Other SUD scores were taken throughout the treatment for specific areas of focus (fear of dark, anger, discomfort with other adolescents, etc.), but the table is limited to scores on the most disturbing memory which was, by design, taken at the start and end of the TFT treatment session.

## DISCUSSION

Although each participant received only a single TFT session rather than the three TFT sessions originally planned, all outcome measures exceeded the .0001 level of confidence that the symptom reduction was related to the treatment. These scores were corroborated by informal interviews with the adolescents and the caregivers which indicated dramatic reductions of symptoms such as flashbacks, nightmares, bedwetting, depression, withdrawal, isolation, difficulty concentrating, jumpiness, and aggression. While these scores and impressions from informal interviews provide a faithful accounting of measurable, observable, and reported subjective effects of the treatment, therapists not familiar with TFT and related clinical approaches may find these outcomes improbable. They are, however, consistent with reports

Table 1.  
Pre- and Post-Treatment and 1-Year Mean Scores on Caretaker and Child Reports of Posttraumatic Symptom Inventories in Adolescent Rwandan Genocide Survivors (N = 50)

Inventory	Pre-Treatment Mean (SD)	Post-Treatment Mean (SD)	p-value for Paired t-test	1-Year Follow-Up Mean (SD)
PROPS*	35.20 (8.09)	8.18 (4.04)	< .0001	8.51 (5.10)
CROPS*	23.70 (8.90)	11.42 (8.94)	< .0001	10.69 (7.18)

\* Cut-off scores for PTSD: PROPS = 16, CROPS = 19

Table 2.  
Percent Meeting PTSD Criteria Pre-Treatment, Post-Treatment, and at 1-Year (N = 50)

Inventory	Pre-Treatment (%)	Post-Treatment (%)	1-Year Follow-Up (%)
PROPS	100	6	8
CROPS	72	18	16

Table 3.  
Subjective Units of Distress Scores in a Single Thought Field Therapy Session with Adolescent Rwandan Genocide Survivors (N =50)

Measure	Start of Session Mean (SD)	End of Session Mean (SD)	p-value for Paired t-test
SUD score	7.58 (2.29)	0.31 (0.73)	< .0001



from other deployment teams using similar interventions (see Feinstein, 2008). Clinicians who have not worked in a setting where trauma at the level of the Rwandan genocide is the common background of an entire community may also find comments about the social context within which the treatment was administered to be informative.

## Social Context

Each year, beginning on the anniversary of the start of the genocide, Rwandans observe a one-week mourning period (sometimes longer for survivors, and observed as a two-week mourning period at the orphanage). They stop work and school, attend programs of solemn remembrance, and perform personal commemorations for loved ones lost, while refraining from singing, dancing, and other forms of celebration. Many visit the Kigali Memorial Center, which was opened in April 2004 on the 10th Anniversary of the Rwandan genocide. The Center is built in the city of Kigali on a site where an estimated 250,000 victims of the genocide are buried in mass graves. The Center includes exhibitions of all the major genocides around the world while emphasizing the Rwandan genocide, where close to one million died during 100 days of continuous murder and torture. The memorial includes thousands of photos of babies and children who were lost, as well as graphic descriptions and photos of the actual genocide. Upon visiting the memorial, the American team involved in the current study found themselves using TFT to self-treat for the traumatic experience of viewing the haunting images, mass graves, and other evidence of a massacre of such unimaginable magnitude

While the Kigali Memorial Center and annual mourning period are part of the country's healing and determination that lessons be learned so such human atrocities never happen again, visits to the Center and the concentrated focus on the genocide can also be re-traumatizing for those who lived through the horrors. Many of the orphans experienced intensification of their symptoms during the orphanage's two-week annual observance. Cultural beliefs may also unwittingly intensify symptoms. For instance, Rwandan psychiatrist Dr. Athanase Hagemimana observed that the Rwandan reaction to trauma is often somatic and frequently involves panic symptoms such as shortness of breath (Wulsin & Hagemimana, 1998). In Rwandan culture, shortness of breath may be interpreted as having been caused by an ances-

tor who never received proper burial. During the genocide, proper burials were often not feasible, so normal reactions to re-experiencing the trauma during the two-week observance could resurface and exacerbate the unsolvable dilemma that loved ones had not received proper burial, as well as to engender a sense of powerlessness in the presence of the symptom (Hagemimana et al., 2003). While previous studies have shown that TFT can be helpful in addressing the somatic manifestations of trauma (Sakai et al., 2001), such cultural dynamics must be understood by the therapist.

The current study and its one-year follow-up were, by design, both carried out during the two-week anniversary observance. Besides the practical matter that the orphans were then available for treatment, planning the follow-up assessments during the mourning observances allowed a more robust test of the durability of the treatment outcomes because any reactivated PTSD was likely to be at its height during this period. An interesting observation at the one-year follow-up interviews and assessments was that participants who reported a return of trauma symptoms at the start of the anniversary observance consistently demonstrated to the team, unsolicited, how they had self-treated using TFT and described how their symptoms remitted.

A finding that provides context for the current study is that of the initial CROPS self-ratings for the 188 orphans old enough to have been survivors of the genocide, 63% (118) met or exceeded the PTSD cutoff score prior to treatment. While very little data is available that provides reliable estimates of the proportion of the more than one million genocide orphans that are still suffering from PTSD a decade or longer after the genocide, this percentage is considerably higher than the 44% found by Schaal & Elbert (2006) of 68 orphans interviewed using a structured format based on DSM PTSD criteria. But even the lower figure represents a sobering glimpse into profound suffering that goes largely untreated in Rwanda even though, as the current study suggests, treatments that are apparently efficient and effective are available.

## Illustrative Case Vignettes

Two accounts of the 50 TFT treatment sessions (both cases treated by the first author as part of the current study) illustrate PTSD treatments using TFT within this social context.

### *First case.*

A 15-year-old girl, one of the few survivors from her village, was three at the time of the genocide. Her family and other villagers had taken refuge inside the local church. At dusk men bearing machetes stormed into the church and started a massacre. The girl related how her father told her to run and not look back for any reason. She started to run as fast as she could. However, she heard her father yelling and screaming in a frenzied, frantic way, “like a crazy man.” Even though she remembered that he had said not to look back, she kept hearing him scream and turned to see what was happening. She watched, horrified, as a group of men with machetes murdered her father.

Every day following the attack, which had occurred 12 years earlier, she had flashbacks (“daymares”) of seeing her father being killed as well as unrelenting nightmares about the scene. As we added tapping on the specific acupuncture points to her telling of the story, her heart-wrenching sobbing and depressed affect suddenly transformed into smiles. When I asked her what happened, she reported having accessed fond memories. For the first time she could remember her father and family playing together. She said that until now she had no childhood memories besides the genocide.

Then I directed her back to her feelings when she thought about what had happened in the church. The interpreter, who was a pastor, looked at me hesitantly, as if to ask: “Why are you bringing it back up again when she was doing fine?” But we needed a complete treatment. The girl started crying again as she remembered seeing other people being killed. She recalled how she had escaped, and she realized that her father’s quick thinking had saved her life by getting her to run while distracting the perpetrators’ attention.

We continued to work through each of the traumatic events using the same tapping protocol. She cried upon re-experiencing each of the horrors she witnessed while hiding outside with another young child. After about 15 or 20 minutes focusing on and treating the intense disturbing affect brought up by this and a number of other scenes, she started laughing. I asked her what was coming up for her and she talked about her father. Her mother didn’t want the children eating sweet fruits because they were not good for their teeth. But her father would sneak them home in his pockets and when her mother wasn’t looking, he would give them to the children. She was laughing wholeheartedly, and we laughed with her. We processed a number of additional scenes. Finally

when asked “What comes up now as you remember what happened at the church,” she said thoughtfully, and without tears, that she could still remember what happened, but that it was no longer vivid as if it were still happening. It was now faded in the distance, like something from long ago. She started to talk about other fond memories. Her depressed countenance and posture were no longer evident. When she was seen again during the next two days, she described how for the first time she had no flashbacks or nightmares and was able to sleep well. She looked cheerful and told us how elated she was about having happy memories about her family.

### *Second case.*

A 13 year-old-boy related that he was terrified of the dark. There were no electricity or lights at the orphanage, so he would sit on his bed when the sun went down and tremble. He would be shaking and scared until the other children went to bed. Genocide traumas often occurred at dusk. We focused on his fear of the dark, and the genocide stories he had been told by older survivors. He grinned from ear to ear as the TFT treatment algorithm was completed. He proudly announced at the end of the session, “I am not afraid of the dark any more.”

When we arrived the next day, he excitedly greeted our bus and was bubbling over with joy. He had been able to play with the other children after dusk until bed time the night before. He was “high fiving” the treatment team with exuberance and a broad, triumphant grin. Not being able to play with the others after dark had made a huge difference in the quality of his life at the orphanage. He said he wanted to show how he felt inside, and he did a somersault and said he finally felt free! He was so appreciative of what he referred to as “getting my life back” that when we were leaving Rwanda, he tried to give me one of his three marbles as a gesture of appreciation. His only possessions were his clothes, his slippers, his blanket, and three marbles.

## **Follow-up Assessments**

The 3-month, 6-month, and 12-month assessments all used PROPS and CROPS ratings as well as informal interviews. The elimination or strong reduction of nightmares and flashbacks were frequently mentioned. The three teachers who did the original ratings were available for all three subsequent assessments and each rated the same students they

had rated immediately before and after the treatment. All 50 adolescents were also available for each of the subsequent assessments (a few were no longer at the orphanage but were notified and voluntarily returned for the assessments).

Follow-up mean scores were significantly lower than pre-treatment scores on all measures. At one year, they were almost identical to the scores immediately following treatment (PROPS mean score of 8.52 immediately after treatment and 8.24 a year later; CROPS mean scores of 10.68 and 11.71, respectively). However, at the 3-month follow-up, the orphanage was in a crisis that might have led to its having to close. This had the orphans, as well as their caregivers, under a great deal of fear and stress. This fear and stress was reflected in the 3-month ratings, which spiked to 16.69 on the PROPS (still, the pre-treatment score was 35.23) and 17.08 on the CROPS (pre-treatment score was 23.55). By the 6-month follow-up, the crisis had passed and the mean scores had come down to close to the immediate post-treatment scores (PROPS 8.86; CROPS 14.70).

These follow-up ratings, however, reveal very little about the lasting impact of the initial treatment sessions. After working with the 50 adolescents that were part of this study during the first three days of the two-week mourning period, the treatment team turned its attention to the remaining 350 children. Since the initial 50 had the greatest signs of psychological disturbance, and also because they were participants in this study, they all received individual treatments. Group sessions were often used with the remaining children, while individual sessions were reserved for those whose responses in the group sessions indicated a need for individualized attention. As a result, tapping for psychological difficulties, whether traumatic memories or problematic emotions, became part of the community's culture. If a boy woke up screaming in the middle of the night, his bunkmates would guide him in tapping to help him go back to sleep. Sometimes one child would start self-tapping for an undisclosed problem and seven or eight others would start self-tapping as well. This mutual support was particularly evident to the treatment team upon returning for the one-year follow-up, seeing and hearing about the students helping one another with reactions to the genocide anniversary. The low scores on PTSD symptoms at one-year follow-up suggest that a) the initial TFT session or b) the subsequent self-application of TFT helped preserve the gains recorded immediately after the first treatment session, but it is not clear which, or if the combination was necessary.

## Limitations of the Study and Implications for Further Investigation

The current investigation was an uncontrolled outcome study utilizing a standardized self-report inventory, a standardized caregiver inventory, both patterned after DSM IV criteria for PTSD, and SUD self-ratings. Statistical analyses were restricted by the study limitations. A randomized controlled trial that compared TFT with a wait-list control and a recognized PTSD treatment such as CBT, using the same measures, would be a next step for future investigations.

In the current investigation, the therapists who provided the treatment also designed the study, selected the assessment instruments, supervised the data collection, chose the person who performed the statistical analysis, and wrote the final narrative. While scientific procedures were adhered to faithfully, allegiance to the approach being studied and other biasing factors may have influenced the findings.

Outcome assessments were based on self-reports by the participants (SUD and CROPS ratings) and on subjective reports (PROPS ratings) by teachers or caregivers who were involved in the lives of each participant, lending themselves to subjective bias. Confidence in the current findings could have been strengthened if independent observer-assessors had been used or if the outcome assessments were supplemented by more in-depth measures. Possibilities to consider for subsequent research might include (a) formal interviews structured around PTSD criteria or (b) behavioral measures such as school grades or frequency of incidents where disciplinary action was required.

The relaxation and breathing sessions, initially introduced to control for placebo effects and other artifacts, ultimately became confounding variables. While there is no evidence or logic suggesting that four minutes of training in a relaxation technique and two minutes of training in a breathing technique would reverse severe longstanding PTSD, their influences on the clinical outcomes could not be ascertained. However, at the one year follow-up, there were no reports of self-administered progressive relaxation or diaphragmatic breathing, with the participants reporting and demonstrating use of TFT when asked what they found to be most useful to them.

A minor confounding variable in the study was that after the participants received their TFT session, they became enthused about the relief they experienced and spontaneously

shared what was helpful to them with their classmates or bunkmates. As a result, some of the participants were already familiar with and had preconceptions about the treatment protocol before receiving their TFT session. In addition, the field conditions were such that, although the participants were beyond hearing distance while waiting to be treated, they could observe those being treated at the far end of the warehouse classroom. As they watched crying, depressed, or angry classmates come into smiles and laughter, they keenly observed what they were doing that seemed to bring about these changes. The meridian tapping was visible, and a few of the children learned the basic procedure as they waited for their turn. This and the sharing of the method with peers who had not yet had their treatment session may have created an unmeasured expectation effect in a small proportion of the participants.

The meaning of the one-year follow-up CROPS and PROPS scores is unclear. The increase in PTSD symptoms at the three-month follow-up and the reduction down to post-treatment levels by the one-year follow-up may have been a result of the crisis that was occurring at the orphanage at the time of the three-month follow-up, as speculated above, but the trend may have been due to entirely different, unknown factors. Moreover, since use of tapping procedures for emotional difficulties became part of the culture at the orphanage, the impact of the initial treatment cannot be separated from the impact of the change in culture which perpetuated the use of TFT as a self- or group-initiated psychological relief measure. The combination, however, seemed potent and it is standard procedure that following TFT treatments, clients are taught to use the method on a self-help basis routinely or as-needed.

## CONCLUSIONS

The last-minute change in design, where only a single TFT treatment session was administered, instead of the three that were initially planned, seemed likely to compromise the study. In the end, however, it provided the basis of one of the most striking dimensions of the study's findings: a single TFT session of 20 to 60 minutes brought about a marked reduction in symptoms of a large majority of adolescents who had suffered with severe PTSD symptoms for more than a decade. Controlled research studies are now needed to substantiate these preliminary findings.

A recent randomized controlled trial referred to earlier (Church et al., 2009) also used a one-session treatment design, working with 16 institutionalized adolescent boys in Peru, all of whom had been abused and showed symptoms of PTSD on standardized inventories. The reduction in PTSD symptoms, following a single session of a derivative of TFT for the 8 participants in the treatment group, was highly significant ( $p < .001$ ) while none of the 8 participants in the wait list control group showed a significant change on subsequent testing. Neither the authors of this study nor of the Peru study (D. Church, March 21, 2010, personal communication), however, are recommending that a single session is the ideal format for treating longstanding PTSD. The single-session design in both cases was done for expediency, and both teams of investigators were surprised by the strength of the outcomes. Both teams also recognized that additional sessions might have benefited an unknown proportion of the participants.

As a postscript, after the treatment team completed the initial two-week individual and group treatments with the 400 children and adolescents, they trained the caregivers so they could follow up as needed as well as introduce the approach to children new to the orphanage. Reports have been encouraging that the skills could be successfully transferred from the treatment team to the staff to the children. With the wounds of massive and wide-scale trauma appearing in so many parts of the world, an approach that appears unusually effective and that can be readily taught to and implemented by community leaders would seem worthy of intensive investigation.

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## A Time for Renewal: A Lessons-Learned Review on the Role of CISM in Caring for Missionaries After the Rwandan Genocide

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**Abstract:** *In 1994 more than 800,000 people were killed in the Rwandan genocide. Seventh Day Adventist missionaries were forced to evacuate the country under conditions of extraordinary stress and personal threat. Their Church was faced with the necessity of rapidly developing a spectrum of support services to assist the distressed missionaries and their family members in the immediate aftermath of the catastrophe. Individual missionaries, and sometimes their entire family units, had witnessed horrific atrocities perpetrated against members of their congregations and the general public. In some situations of their own church members actively participated in the murders. Church leaders combined their efforts with the resources of the International Critical Incident Stress Foundation to provide immediate, multifaceted support services to the missionaries and their families. This article briefly describes the breadth and depth of the specific Critical Incident Stress Management (CISM) program that was developed and provided to Rwandan Seventh Day Adventist missionaries in April of 1994. The results of a brief post-support evaluation survey are presented. [International Journal of Emergency Mental Health, 2010, 12(1), pp.51-56].*

**Key words:** *Catastrophe, Critical Incident Stress Debriefing, Critical Incident Stress Management, crisis, CISM, CISM, disaster, distress, genocide, International Critical Incident Stress Foundation, Rwanda, Seventh Day Adventist Church, stress, support services*

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### Introduction

Sixteen years have passed since the Rwandan genocide and the efforts of ICISF to assist a group of Seventh-day Adventist missionaries who had been evacuated during the slaughter. From April through July, 1994 at least 800,000 people – and perhaps up to a million - were killed in an horrific genocide of enormous scale in Rwanda. The dead were mostly from the minority Tutsi tribe, but many from the Hutus also died. The socio-political-military lead-up to the genocide is complex and will not be recounted here, but the slaughter began in earnest on April 6 in the capitol

city of Kigali, and quickly spread throughout the country as men, women, and children were shot and butchered, based on ethnic identity. On April 9 the evacuation of foreigners began; among them were missionaries from several church groups, including the Seventh-day Adventist Church, a Protestant denomination. The 105-day massacre finally ended as a ceasefire was announced on July 18th.

Within days of their evacuation, the Adventist missionaries were flown to Washington, DC and then bused to a retreat site in southern Virginia. Representatives from the International Critical Incident Stress Foundation (ICISF) and the Adventist Chaplaincy Ministries Department (ACM) at the Seventh-day Adventist Church world headquarters collaborated in a three-day program that included a Critical Incident Stress Debriefing and a wide range of other supportive activities. Recently the authors of this article agreed that it was time for a retrospective on those eventful three days at the retreat in the Blue Ridge mountains of Virginia.

## Adventist Workers in Rwanda

The Adventist church operates one of the world's largest Protestant missionary programs. While local members administer the work of the church, pastor its congregations, and run its institutions in many parts of the world, in other areas the specialty skills of missionaries are still much needed – particularly in education and medical work. To equip these specialists for service, the church operates a periodic Institute of World Missions at Andrews University in Michigan and elsewhere.

At the time of the genocide, most of the Seventh-day Adventist missionaries in Rwanda were connected with either the Adventist University of Central Africa (AUCA) and stationed in a rural setting, or they were assigned to the Adventist dental and medical clinics in the capitol city of Kigali. Since 1990 the area around the university had witnessed periodic armed conflict, including attacks from an armed group from Uganda that resulted in the murder of a Tutsi teacher and some students. The culmination of these conflicts was the genocide of 1994, during which at least 50 students and professors from the university and large numbers of area residents were killed, causing the school to close for an entire year. Students and staff - including the about-to-be evacuated missionaries - were traumatized as they witnessed the massacre around them. Gangs of killers thronged the school property, butchering people who had retreated there

for sanctuary. People were killed in the open on campus and bodies were stacked in the university buildings. Meanwhile, in Kigali and in the surrounding countryside, missionary workers at the medical and dental clinics were subjected to similar scenes of carnage. Frequently, open truckloads of bodies were seen being driven through the streets of the capitol. It was from scenes such as these that the missionaries were evacuated to their homes in several countries.

## The Church Responds

A few months before the genocide, while attending the annual conference of the Association of Professional Chaplains, this article's first author had attended an introductory workshop on Critical Incident Stress Management and was impressed with the group support process called Critical Incident Stress Debriefing (CISD). This structured, crisis focused, conversational/educational tool appeared to have therapeutic benefits. The news of the missionaries' evacuation prompted the recommendation that Dr. Jeffrey Mitchell should be invited with his ICISF team to conduct a CISD for the missionaries. ACM Director Dick Stenbakken, and the ACM Associate Director (first author) presented the ICISF proposal to top church administrators. The world church president, Pastor Robert Folkenberg, and his team gave their immediate approval to implement the plan. Dr. Mitchell quickly agreed to personally participate in the planning, development, and presentation of the crisis support services.

After a lengthy, multi-site, telephone conference call with Dr. Mitchell that was designed to assess the needs of the missionaries, a detailed plan to assist them was formulated. The plan recommended that the church fly the evacuated personnel from wherever they were to Washington, DC. Since most had been rapidly evacuated from Rwanda under extremely stressful circumstances and, therefore, left without their personal possessions, they were given funds and time to shop for essential toiletries and other necessities. They were then bused to Camp Blue Ridge, a church retreat center in the mountains of Southern Virginia. There a combined team of ICISF personnel and Adventist Church personnel, who were experienced as military and healthcare chaplains, was to conduct a three-day, multifaceted CISM support program and an educational workshop on traumatic stress. The participants were deeply religious and the CISM services were, therefore, linked to Church meetings, prayer, and thanksgiving services and memorials for those who had been murdered. The main concept of the retreat was to use the experience to



not only bring healing to the traumatized employees, but to also learn about how the church could better handle future critical incidents. Although it had been less than two weeks since the evacuation, most of the missionaries came to Camp Blue Ridge, near Montebello, Virginia for the April 26-29, 1994 retreat. The camp is blessed with a natural setting that is therapeutic in itself. Coupled with the prospect of three days of rest, conversation, spiritual reflection, good food, and recreation, the stage was set for a meaningful application of carefully selected CISM strategies.

## The Program

With the theme of A Time for Renewal, the retreat was under the overall direction of Chaplain Dick Stenbakken and the associate director of the department; US Navy chaplain Larry Roth also served as a key member of the team. Supper, brief medical screening check-ups, and an informal reception and registration opened the program on Tuesday evening.

After Wednesday morning's breakfast and devotions, Dr. Mitchell and the ICISF team began a successful and intensive day-long trauma support and educational program with nearly 50 missionaries and their children. Dr. Mitchell's team consisted of the three chaplains serving as the professional support members of the team, with a husband and wife team, Greg (paramedic) and Maggie Valcourt (trauma nurse), and Phil Mc Donald (Federal Emergency Management Agency [FEMA] training coordinator) functioning as peer support personnel. They led a Critical Incident Stress Debriefing with more than 30 adults. It is generally recommended that this small group CISD process should be used only with groups of about 20 or fewer; however, under extraordinary circumstances it is possible to successfully conduct a CISD for a larger group. The missionaries all had the same affiliation, and were closely bonded as a result. They also had the same training, often knew one another, and had experienced many of the same horrific events. After discussing the options with the church leaders and with many of the missionaries, the CISM team came to the conclusion that the CISD process was the most appropriate.

Concurrently, teams of CISM personnel from the State of Virginia conducted shorter interventions with the children and youth. There were three groups of children. Children in the first group, up to age 5, were given supervised play. The second group, age six through twelve, were given a shortened version of the CISD, appropriate to their age. The third group,

thirteen to seventeen, were provided with a standard CISD that was shorter in duration and involved more interactive discussions with the group leaders. The interventions for the two older groups of children were provided simultaneously in different camp locations by two different Virginia teams. The two teams quickly noted that common signals of distress were present and that the CISD was an important intervention for these groups.

The afternoon featured a concluding ICISF team educational presentation for the adults on The Dynamics of Traumatic Stress and How to Cope. The children, meanwhile, were given opportunities for a variety of supervised recreational activities. The work of the team was viewed as a crucial aspect of helping our missionaries cope with their stress.

After the departure of the ICISF team in the evening, the retreat continued under the leadership of the three chaplains. Thursday morning and afternoon focused on an operational debriefing and dialogue with church leaders. The morning session focused on organizational issues, such as: What happened? How did we respond? What went wrong? What went right? What did we learn to apply in the future? What recommendations can we give to church leadership? These issues were dealt with chronologically – before, during, and after the event. Church leadership was excluded in the morning only to promote open and free discussion. From this process a practical set of recommendations was developed and later presented to our world church administrators.

Thursday afternoon a question and answer session was conducted with representatives of several of the church departments that administer the overseas missionary program. Represented was the office of church president, executive secretary (who oversees missionary appointments), treasurer, and risk management. This session was very important in providing support and relevant information.

The capstone of the retreat came Thursday evening with A Service of Remembrance and Hope. Throughout the program a recurring theme had been the grieving and unfinished business of losing friends and co-workers who had been killed – or who often vanished - without any of the typical farewell rituals. The program sought to facilitate healing and hope through a service using liturgy, candles, music, Scripture and sharing of memories. When the service ended and people were free to either stay or leave, the entire group remained for two hours talking and praying together. The program was therapeutic in that it elicited the articulation

of thoughts from some youth who had not yet been able to share their feelings.

### Impact and Results of the Retreat

At the conclusion, the missionaries rated the experience on a 1-10 scale (table 1), noting first “What I Anticipated,” and then “What I Experienced.” Though not a scientific study, this helped us determine the relative impact of the experience and its component parts; in nearly all categories experience exceeded anticipation and expectations. Below is a summary of key portions of the evaluation. “A” represents the participants anticipation or expectations; “E” represents the participants actual experience, and “D” is the difference between the two.

Written comments on the evaluation were informative. When asked what part(s) of the retreat were most valuable, men responded with “the fellowship, the love and concern that all of you had for us;” “being together as a complete group. Jeff and associates were very good and helpful;” “memorial service;” “qualified, but down-to-earth people leading out.” Women stated “talking and listening to each other;” “memorial service;” “fellowship.” And youth said “the recreation and activities;” “memorial service.” When asked what they might change or other suggestions, one attendee recommended adding at least one day of unstructured time, and another stated that he would have liked to have

the intervention even sooner after the evacuation. This last comment reflected a widespread feeling that it would be best for some type of critical incident support to be available on site, or at least immediately after incidents such as they had experienced. It was strongly suggested that someone should be sent to meet the evacuees and provide immediate individual assessment and support services to those returning from the missions.

The retreat had raised the awareness level of several CISM-related means of support, for which the missionaries expressed appreciation – as well as a desire that their Rwandan friends, who had been left behind in a still war-ravaged land, might someday receive the same care.

### What We Learned

During the fourteen years between the retreat and the eventual retirement of this author as director of the Adventist Chaplaincy Ministries Department, I ran into many of these same missionaries in subsequent travels throughout the world. Their first comments were nearly always words of appreciation for the retreat and reflections on what they remembered most – the fellowship, the group sessions, one-on-one support, the memorial service and so on. Through the lens of memory, minutes taken during the retreat and subsequent review with the missionaries themselves, I am convinced of the several key points that follow.

Category	Men			Women			Kids (oldest 2 groups)		
	A	E	D	A	E	D	A	E	D
CISD	5.2	8.8	+3.6	5.4	9.2	+3.8	3.4	6.4	+3.0
Stress education	6.1	8.7	+2.6	6.0	8.7	+2.7	3.8	5.5	+1.7
Operational debriefing	6.3	8.3	+2.0	5.2	8.8	+3.6	5.0	8.8	+3.8
Q & A – church leaders	6.5	8.0	+1.5	5.3	7.9	+2.6	4.0	6.0	+2.0
Memorial service	6.0	8.8	+2.8	5.9	9.5	+3.6	5.4	9.0	+3.6

- CISM, as a multi-component system, is a powerful tool to facilitate recovery and healing.
- The need for adequate preparation is important. Our attendees recommended that the Institute of World Mission have a strong module on coping with stress in traumatic situations.
- The need for early intervention is equally important; care should not be delayed. While we did a good job of bringing people together as quickly as we did, our folks were clear in wanting someone for an immediate intervention and assessment - from which could come plans for a comprehensive retreat, etc.
- CISM benefits from multi-disciplinary teamwork. In this case the collaboration of mental health professionals and clergy was important.
- The need for follow-up is great. Our follow-up plan included the availability of a 1-800 phone number, the services of our chaplains and the various supervising departments of the church. The plan would have been even stronger, however, had we included a more strategic use of mental health professionals for follow-up services.

From a CISM perspective, some of the key lessons learned follow.

- Although the telephone conference call was extremely helpful in determining the psycho-social and spiritual needs of the traumatized missionaries, it was inadequate to handle the strong emotions generated during the discussion. When the facilitators heard someone crying on the phone during the conference call, it was hard to identify specifically who needed assistance, encouragement, or support. At least one person dropped off the call and they were hundreds, if not thousands, of miles away from trained people who could provide crisis support. The telephone conference call convinced us of the necessity of bringing everyone together at a retreat center.
- The blending of Seventh Day Adventist chaplains into the support team coupled with the linking of CISM support services with prayer, religious ceremonies, and spiritual references was crucial to the success of the program. Most of the ICISF and State of Virginia CISM team members were not of the same faith and

the chaplains were essential in bridging the gap cause by the diversity in religious backgrounds.

- Flexibility in approach to crisis management and to the various support services was an absolute requirement for all CISM team members. We were dealing with a fairly large group of people who had been severely traumatized and virtually every step of the program had never been applied under such unusual circumstances.
- The core principles of crisis intervention, proximity, immediacy, expectancy, innovation, pragmatism, simplicity, and brevity, were guidelines for the CISM team throughout the entire program.
- We affirm that the guidelines for small group support services such as the Critical Incident Stress Debriefing (CISD) are well founded and essential for the success of these services. Such guidelines include the requirements for those participating in a CISD to be from the 1) same operational unit, 2) that their operation is complete, and 3) that they have experienced roughly the same level of exposure to the traumatic event. We were, however, faced with a particularly difficult problem in the presentation of the CISD to this group. The thirty or so adult missionaries were not part of the same operational or work unit and their experiences, although equally disturbing, were not of the same exact overwhelming event. The CISM team considered all the options available to us and concluded that there were sufficient bonds between the missionaries and that their experiences were so similar that the CISD was, in fact, warranted.

## A Word of Thanks

We are deeply grateful to Greg and Maggie Valcourt, Phil Mc Donald, the Virginia CISM Team, and the ICISF organization for their work on behalf of our missionaries evacuated from Rwanda in 1994. Their work – a ministry of healing to us – was a very important part of helping our missionaries and their families cope with the trauma of genocide.

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## Post-Action Staff Support for the Concerns of Police Survivors Organization (COPS)

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*“Concerns of Police Survivors, Inc. provides resources to assist in the rebuilding of the lives of surviving families and affected co-workers of law enforcement officers killed in the line of duty as determined by Federal criteria. Furthermore, C.O.P.S. provides training to law enforcement agencies on survivor victimization issues and educates the public of the need to support the law enforcement profession and its survivors.” - COPS Mission Statement*

**Abstract:** *This concept article presents an overview of a post-action staff support (PASS) session that has been effective in meeting many of the emotional needs of a large, diverse group of volunteers who serve as support personnel for grieving family members, significant others, and co-workers at the annual National Police Survivors Conference in the Washington, DC area. This particular approach to the PASS process is not a fixed, rigid approach. Instead, it is adaptable and flexible and it can be altered as necessary to suit specific populations with special needs. The key elements of the two-hour PASS session have evolved over many years to the current form presented in this article. [International Journal of Emergency Mental Health, 2010, 12(1), pp. 57-60].*

**Key words:** *Concerns of police survivors, Critical Incident Stress Management, CISM, line of duty death, grief, National Police Survivors Conference, post-action staff support, PASS*

### Introduction

Approximately every 53 hours within the United States' law enforcement communities an agent or officer is killed while on duty (National Law Enforcement Officers Memo-

rial Fund, 2009). That statistic translates to between 140 and 160 law enforcement deaths in an average year. Each officer's death impacts the lives many other people. Spouses, children, family members, friends, colleagues and the community all suffer the loss (Concerns of Police Survivors, 2010).

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In 1984 the Concerns of Police Survivors (COPS) organization was founded as a non-profit organization to assist the families, significant others, and co-workers of law enforcement personnel who die in the line of duty according to Federal government criteria. COPS serves the needs of more than 15,000 families who have been touched by the death of law enforcement loved ones. Among other

services, the COPS organization provides scholarships for children of law enforcement personnel killed in the line of duty, counseling reimbursement, trial and parole support, the COPS Kids summer camp, COPS Teens Outward Bound programs, and special retreats for spouses, parents, siblings, and others in need of ongoing grief support (Concerns of Police Survivors, 2010).

Each year in May, COPS conducts the National Police Survivors Conference during National Police Week. The Washington, DC-based conference is attended by representatives of more than 600 families. About a hundred of the families have suffered a loss during the previous year. The remainder is made up of families who return to the conference to honor the memories of loved ones killed in previous years. The conference provides group education and support services, individual counseling, crisis support, memorial services, and family crisis support. Nearly two hundred COPS staff and volunteers provide direct and indirect services to the families, significant others, and co-workers of slain law enforcement personnel. Upon completion of the week's intense activities the staff is often in need of post-action staff support before they depart for their homes.

## **The Problem**

The COPS organization, which conducts the National Police Survivors Conference, relies on numerous dedicated and caring volunteers and the operational support of various law enforcement agencies and organizations to supplement its small professional staff. Volunteers are drawn from all over the United States to provide administrative or emotional support services during the conference. Some are mental health professionals, but most are peer support personnel. The majority of the volunteer staff have received Critical Incident Stress Management (CISM) training in the past, but a few do not have the benefits of that training.

The pace of the conference is intense and the volunteers are exposed to powerful emotions in the family members, significant others, and co-workers who participate in the conference programs. The two-hour post-action staff support (PASS) meeting is provided on the departure day, after the main conference programs have all concluded. Most of the personnel who need the PASS session are preparing for a day of travel to reach their homes. The COPS organization is concerned for their volunteers' emotional health. The PASS session is therefore considered an obligation for both

the new and veteran staff members. Most of the volunteer staff members arrange their travel so that they can stay for the 9:00 a.m. PASS session, but there are a few who would rather not be there. In any case, most are watching the clock because their departure times follow closely the conclusion time of the PASS meeting.

There are many services that can be provided to support staff. They range from individual telephone support to one-on-one counseling, and to large group sessions (Dyregrov, 2003; Everly & Mitchell, 2008; Mitchell, 2006, 2007; Potter & LaBertheaus, 2000). The COPS organization relies most heavily on the large group meeting format because its volunteers come from many different places and represent a broad array of organizations. Most know each other because they have been coming to the National Police Survivors Conference for many years. Others are new to the program.

The large group of volunteers (usually about 60 people) who attend the PASS session are, without doubt, a diverse group with an astonishing assortment of backgrounds and experiences. Even their experiences at the National Police Survivors Conference vary enormously. Follow-up with this group is quite difficult because of the geographical distances between the participants in the PASS session. There is, obviously, a major challenge to present a PASS session that will be meaningful to this large and diverse group. The following section presents an overview of the PASS program selected to accommodate the needs of the COPS organization. With some adaptation, it can easily be applied to other large, diverse groups who have worked together on intense, complex programs in their own communities.

## **The COPS "PASS" Session**

The large group is gathered in a private meeting area and set up in a large circle so that everyone can see each other. The team leading the group thanks the participants for meeting together and explains the purposes of the meeting. The main objectives of the post-action staff support process are to briefly review the experiences, to discuss particularly difficult aspects of the group's experience, and to assure that personnel in the group are emotionally supported as they end their intense work. A few important guidelines, such as the importance of listening to each other and the need to maintain confidentiality regarding the discussion, are presented by the team. The participants are asked to state who they are and their primary assignment in the program that has just con-

cluded. Then the discussion begins. The PASS leader uses the questions below to generate discussions within the group.

1. *Challenges.* What challenges did you face during your work with the survivors?
2. *Concerns.* Are there people you supported during the last few days about whom you are worried or concerned or about whom you need some feedback or follow-up from your colleagues attending this session?
3. *Care.* Did you witness actions or behaviors on the part of your colleagues that indicated to you the level or depth of care your colleagues had for others?
4. *Crazy.* Did you encounter any people or situations during your support work that struck you as “crazy” or “out of control,” “bizarre,” or just “strange?” How did those experiences impact you?
5. *Consumption.* As you know, grief brings out the best and worst in human beings. The consumption of alcohol or the use of drugs by the survivors may complicate or block the support you are attempting to give them. Did anything like that happen while you were working with the grieving survivors?
6. *Choke; Contamination.* This type of work is quite difficult because you are being exposed to the pain and grief in the lives of others. Were there any moments that caused you to get choked-up while you were trying to help others? Let me ask another question or two along the same lines. Did anyone end up feeling emotionally contaminated and hurting as a result of this work? What do you think would help you most now as you prepare to depart?
7. *Colleagues.* As you think back on the work you just completed, are there colleagues, who shared in some of these experiences, about whom you are a bit worried? Who are they and why do you feel concern for them?
8. *Culture.* Every human experience is an opportunity to learn something or to expand the general culture of our work. What lessons have you learned from your experience that can enhance or expand your personal culture of helping others?
9. *Continuation.* How many of you are first timers in a

program such as you experienced during the last few days? How many of you have more than five years of experience? How many have ten? How many have fifteen? How many have over twenty? For those with experience: What makes you continue in this work? Those who are new to this work: Do you think you would like to do more of it in the future?

10. *Conclusion.* Let’s summarize some of the key points of our discussion and give you some guidance that may be helpful for you in the days to come. The session leaders then provide some stress management and recovery guidelines for the staff attending the PASS session.

## Concluding Remarks

Many of the participants in the PASS session provide verbal evaluations of their experiences with the PASS experience. They are overwhelmingly positive and encouraging of future efforts. They especially like hearing comments from their colleagues in the session because these alleviate certain concerns they have about the grieving survivors, and their colleagues often reassure them that additional help will be made available for the distressed family members or co-workers. When they finish the PASS session they feel affirmed and appreciated by their colleagues. They consider the session essential in bringing their work with grieving families to an end before they depart for their home. One veteran volunteer commented that the PASS process is far better than in the early days of the National Police Survivors Conference when the volunteers finished their work and simply went home with no attempt at supporting them. Another volunteer stated that the PASS session “closes the chapter” on their grief work and allows the volunteers to move forward with less “emotional baggage.”

Staff support is crucial in the maintenance of healthy personnel who continue to voluntarily expose themselves to pain and distress in the lives of others. It assures that highly dedicated and caring people can continue to make a positive impact on the lives of others well into the future.

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## Selected Annotated Journal Resources

Brynn Huysen, M.S. and Rich A. Blake, M.S.

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**Munroe, C. D., Kibler, J.L., Ma, M., Dollar, K.M., & Coleman, M. (2010). The relationship between posttraumatic stress symptoms and sexual risk: Examining potential mechanisms. *Psychological Trauma, 2*(1) 49-53.**

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### TYPE OF ARTICLE

- Original Empirical Investigation.

### OBJECTIVE/PURPOSE OF ARTICLE

- To investigate the relation among symptoms of posttraumatic stress and sexual risk behaviors, sexual sensation-seeking and sexual compulsivity in a sample of female African American college students.

### METHODS

#### Participants

- For this study, 30 African American females attending an undergraduate university in the Southern United States who had previously engaged in sexual intercourse were assessed.
- Mean age was 23 years (SD=6 years). Participants identified their marital status as unmarried (n=26), separated or divorced (n=3) or married (n=1).

#### Materials

- Posttraumatic Stress Checklist-Civilian Version (PLC-C) was used to measure PTSD symptoms experienced in the past month.
- Sex Risk Behaviors Questionnaire was developed by the researchers of this study and used to measure sexual risk behaviors (e.g., number of lifetime sexual partners, frequency of vaginal penetration without a condom

within the previous three months, and frequency of sexual intercourse while under the influence of alcohol within the previous three months).

- Perceived Sexual Control Inventory was used to assess participants' perceptions of control of sex drive and sexual risk behaviors.
- Sexual Sensation-Seeking Scale was used to measure sexual aspects of sensation-seeking.
- Sexual Compulsivity Scale was used to assess the presence and frequency of compulsive sexual thoughts and behaviors.
- Traumatic Life Events Questionnaire (TLEQ) was used to assess previous exposure to traumatic events.

### Procedure

- During an initial interview, participants completed demographic information and the PLC-C. During the second interview, participants were given the remaining questionnaires. Researchers reviewed the TLEQ responses with each participant to ensure that the emotional response to the traumatic event evoked fear, helplessness or horror.

### RESULTS

- Greater intensity of PTSD symptoms were significantly associated with a higher number of sexual partners over one's lifetime, higher frequency of vaginal penetration without a condom within the previous three months, engaging in sexual intercourse while under the influence of alcohol within the previous three months, and lower perceptions of sexual control.
- Greater intensity of PTSD symptoms was not significantly associated with sexual sensation-seeking or compulsive sexual behavior.

- Perceptions of sexual control were significantly negatively correlated with the frequency of vaginal penetration without a condom within the previous six months, but not significantly associated with number of lifetime sexual partners.
- Participants who endorsed engaging in sexual intercourse within the previous three months while under the influence of alcohol reported that they perceived themselves to have less sexual control than those participants who did not endorse engaging in sexual intercourse within the last three months while under the influence of alcohol.

### CONCLUSIONS/SUMMARY

- This study supports existing research that sexual risk behaviors are associated with posttraumatic stress symptoms in females and that symptom severity may influence sexual risk.
- Perceptions of control in sexual situations may have a greater influence on sexual risk behavior than does sexual sensation-seeking or sexual compulsivity.

### CONTRIBUTIONS/IMPLICATIONS

- High-risk sexual behaviors are one explanation for the increasing rates of HIV among African American women and this research examines how posttraumatic stress is related to these behaviors.
- The findings highlight the need for future research to examine the association between perceived control, posttraumatic symptoms and sexual risk behavior in African American women in order to better understand related cognitions regarding control and how to effectively treat them.

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**Kaltman, S., Green, B.L., Mete, M., Shara, N., & Miranda, J. (2010). Trauma, depression, and comorbid PTSD/Depression in a community sample of Latina immigrants. *Psychological Trauma, 2(1)*, 31-39.**

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### TYPE OF ARTICLE

- Original Empirical Investigation

### OBJECTIVE/PURPOSE OF ARTICLE

- To investigate the relation among previous trauma experiences, mental health, and immigration-related factors in a sample of Latina immigrants.

### METHODS

#### Participants

- Latina women who immigrated to the United States and received health and social services in counties surrounding Washington, DC.
- Of the sample, 69 women met diagnostic criteria for major depressive disorder, 64 women met criteria for both major depression and PTSD and 61 women did not meet criteria for an Axis I diagnosis.
- The average age of participants was 30.6 years (SD=6.7), the average number of years of education was 9.6 years (SD=4.2), approximately half of the sample was married, and 66 percent of the sample reported working at least part-time in the last three months.
- On average, participants had lived in the United States for an average of 8.0 years (SD=5.1).
- Of the participants, 66% reported exposure to one or more traumatic events, with the average being 2.4 events (SD=2.1). The most frequent type of abuse reported was physical violence in adulthood.

#### Materials

- Demographic questions included age, ethnicity, employment status, marital status, education level, country of origin and years living in the United States.
- Composite International Diagnostic Interview (CIDI) was used to assess for major depressive disorder.
- Hamilton Depression Rating Scale (HDRS) was given to participants one week after they met criteria for major depressive disorder via the CIDI to ensure that symptoms were not transient.
- Structured Clinical Interview for DSM-IV-Nonpatient Version (SCID) was used to assess for PTSD.
- Stressful Life Events Screening Questionnaire (SLESQ) was used to determine previous exposure to traumatic events

## Procedure

- Demographic data were gathered at screening interviews and participants were given the CIDI to determine existence of a depression diagnosis. Participants who met criteria via the CIDI were given the HDRS one week later to confirm that diagnostic criteria were met.
- At a second interview, all participants were administered the SLESQ and the PTSD section of the SCID.

## RESULTS

- On average, participants who did not meet any diagnostic criteria were older than participants who met diagnostic criteria for depression or depression and PTSD.
- Not being married was associated with a higher risk of depression or depression and PTSD.
- Education and employment status were not associated with mental health status.
- Number of years living in the United States was associated with a decreased risk of depression or depression and PTSD.
- Fewer years residing in the United States were associated with higher frequency of exposure to trauma.
- On average, participants who met criteria for depression and depression and PTSD reported exposure to more types of traumatic experiences than did participants who did not meet criteria for an Axis I diagnosis.

## CONCLUSIONS/SUMMARY

- Marital status, previous trauma exposure, and years living in the United States are associated with mental health status in Latina immigrants.
- This study supports existing literature that frequency and type of trauma exposure correlate with mental health issues.

## CONTRIBUTIONS/IMPLICATIONS

- Further research is needed to identify risk factors for depression and PTSD in the Latina population.
- Because trauma exposure is so high in this population, research should investigate decreasing stigma and increasing access, availability and utilization of mental health services for the Latina population.

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**Holbrook, T.L., Galarneau, M.S., Dye, J.L., Quinn, K., & Dougherty, A.L. (2010). Morphine use after combat injury in Iraq and Post-Traumatic Stress Disorder. *The New England Journal of Medicine*, 362(2), 110-117.**

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## TYPE OF ARTICLE

- Original Empirical Investigation.

## OBJECTIVE/PURPOSE OF ARTICLE

- To investigate the relationship between morphine administration and subsequent development of PTSD in a sample of physically injured U.S. military personnel.

## METHODS

### Participants

- The sample consisted of 696 military personnel who were physically injured (without a traumatic brain injury) during Operation Iraqi Freedom (January 2004-December 2006) and brought to a medical treatment facility.
- Of this sample, 243 patients met criteria for PTSD following the injury and 453 did not meet criteria following the injury. The average ages of patients in each group were 24.1 years (SD=5.9) and 24.3 years (SD=5.3), respectively. The sample was 99% male.

### Materials and Procedure

- Data were gathered from the Navy-Marine Corps Combat Trauma Registry. Medical encounter forms were reviewed, which included demographic information, mechanism of injury, arrival time at the facility, doses and route of medication administration and time between arrivals at facility at medication administration.
- Injury severity was assessed by trained medical staff using the Abbreviated Injury Scale and the Injury Severity Score.
- Existence of PTSD diagnosis was obtained through the Career History Archival Medical and Personnel System and verified by the medical records of participants. Patients were assessed for PTSD by licensed clinicians at treatment facilities ranging from 1-24 months following the injury. Criteria from the DSM-IV-TR were used to determine diagnostic status.

## RESULTS

- No significant differences in patient demographics and mechanism of injury were observed between the PTSD and non-PTSD groups.
- In this study, 61% of patients who subsequently developed PTSD were given morphine upon arrival at the treatment facility and 76% of patients who did not develop PTSD were given morphine upon arrival at the treatment facility.
- The time lapse between onset of injury and initial administration of morphine was one hour or less in 71% of patients.
- Subsequent diagnoses of PTSD were given to 40% of patients who were administered low doses of morphine (2-9 mg), 40% of patients who were administered moderate doses of morphine (10-20 mg) and 23% of patients who were administered high doses of morphine (over 20 mg).

## CONCLUSIONS/SUMMARY

- The administration of morphine immediately following injury was significantly and independently associated with a decreased risk of subsequent PTSD development.

## CONTRIBUTIONS/IMPLICATIONS

- PTSD prevalence is rapidly growing, specifically among injured military personnel. More research is needed to examine psychopharmacological factors related to PTSD and the possible benefits of opiates as a mechanism of secondary prevention of PTSD.

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**Hoyt, T., Pasupathi, M., Smith, B.W., Yeater, E.A., Kay, V.S., & Tooley, E. (2010). Disclosure of emotional events in groups at risk for posttraumatic stress disorder. *International Journal of Stress Management*, 17(1), 78-95.**

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## TYPE OF ARTICLE

- Original Empirical Investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine patterns of emotional disclosure in groups at risk for PTSD.

## METHODS

### Participants

- The sample consisted of 71 Operation Iraqi Freedom veterans, 40 first responders, and 289 undergraduate students.
- The veteran group was recruited through internet postings on websites focused on post-deployment networking. Twenty percent of the sample served in the National Guard, and 80% served in the U.S. Army. Seventy-two percent of the sample was enlisted and 28% were officers. The mean age was 31.1 years.
- The first responder group was 65% firefighters, 20% emergency medical personnel, and 15% police officers. The mean age was 30.9 years.
- The undergraduate group, included as a not-at-risk control group, was significantly younger ( $M = 20.6$ ) and had significantly more females (68%).

### Materials

- A demographic questionnaire was administered to all three groups. The veteran and first responder groups were asked additional questions regarding length of service and trauma exposure.
- The Posttraumatic Stress Disorder Checklist (PCL) was administered to the veteran and first responder groups using a cutoff score of 50.
- A 10-item version of the Modified Social Support Survey (MSSS) was administered to the veteran and first responder groups.
- The Likelihood of Disclosure scale, which was developed specifically for this study, was used to measure disclosure of emotions to specific persons, and was modified to accommodate each group.

### Procedure

- The veteran group completed a survey online and was not compensated for participation.
- The first responder group completed the survey as part of a larger research packet and was compensated \$75 for a three hour session.

- Analyses conducted included a confirmatory factor analysis (CFA) of the Likelihood of Disclosure Scale, a comparison of disclosure between the at-risk groups and the undergraduate group using a 2 x 2 x 2 mixed ANOVA, and regression models of the relation among disclosure, social support, and PTSD in the at-risk groups.

## RESULTS

- Model fit statistics for the Likelihood of Disclosure Scale were significant  $\chi^2(25, N = 400) = 70.31, p = .007$ ; Comparative Fit Index = .98, Tucker-Lewis Index = .96, Root Mean Square Error Approximation = .8.
- Results of the ANOVA comparing disclosure,  $F(1, 395) = 4.89, p < .05, \eta^2p = .01$ , revealed significantly lower disclosure for both positive and negative emotions for the at risk groups than for the undergraduate group.
- Regression models revealed that the effect of social support on PTSD was mediated by disclosure, and the fit of the model was confirmed by path analysis,  $\chi^2(4, N = 101) = 18.50, p < .01$ ; CFI = .97, TLI = .87, RMSEA = .06.

## CONCLUSIONS/SUMMARY

- The results of this study indicate that groups at risk for PTSD are less likely to disclose emotions related to traumatic experiences than college student are to disclose emotions related to daily events, and that amount of disclosure depends on the person to whom emotions were being disclosed.
- These results suggest social support is associated with less PTSD, and this relation is mediated by emotional disclosure.
- The results suggest that the disclosure of positive emotions is associated with less PTSD, and that disclosure of negative emotions to other at-risk individuals with a similar experience is associated with more PTSD.

## CONTRIBUTIONS/IMPLICATIONS

- Disclosing emotions to social supports beyond those with similar experiences appear to be important to reintegration and recovery in groups at risk for PTSD.
- There seems to be little utility for the disclosure of negative emotions, whereas disclosing positive emotions appear to be beneficial to recovery.

- Clinicians should be mindful that the benefits of social support may depend on disclosure, and encouraging disclosure of positive emotions may facilitate treatment.

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**Rutkowski, L., Vasterling, J.J., Proctor, S.P., & Anderson, C.J. (2010). Posttraumatic stress disorder and standardized test-taking ability. *Journal of Educational Psychology, 102*(1), 223-233.**

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## TYPE OF ARTICLE

- Original Empirical Investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine the impact of posttraumatic stress symptoms on performance on standardized tests.

## METHODS

### Participants

- The sample consisted of 645 active duty Army soldiers with combat service in Iraq. The average age was 25.03 years, and the sample was 91.7% male. Participants had an average of 3.91 years in the Army.
- In terms of military occupational specialty (MOS), 234 participants served in the infantry, 152 in electronic and mechanical maintenance, 101 in communications and intelligence, 43 in health care, 54 in supply, and 27 served in other occupations.

### Materials

- The Posttraumatic Stress Disorder Checklist, Civilian version (PCL-C) was used to assess PTSD symptom severity.
- The Automated Neuropsychological Metrics (ANAM) logical reasoning task was used to assess grammatical and logical reasoning.
- The NES3 Vocabulary Test was used to assess general verbal ability.
- Combat exposure was measured using the Combat Experiences Scale from a modified version of the Deployment Risk and Resilience Inventory.

## Procedure

- Participants were drawn from a larger pool of participants from the Neurocognitive Deployment Health Study, and were administered measures prior to deployment (Time 1) between April and December 2003, and following deployment between January and May 2005.
- Data were analyzed using a latent regression Rasch model that allowed for the addition of covariates in the item response theory models.

## RESULTS

- At Time 2, the results of the logistical reasoning models were significant,  $c2(1) = 84$ . Results were also significant when entering PCL total scores into the model and controlling for Time 1 scores,  $2 = -.01$ ,  $t(636) = -5.15$ ,  $p < .01$ .
- Results for vocabulary models were also significant,  $c2(1) = 84$ , even when controlling for Time 1 scores,  $2 = -.01$ ,  $t(647) = -5.00$ ,  $p < .01$ .
- There were no significant effects for PTSD symptom clusters.

## CONCLUSIONS/IMPLICATIONS

- The results of this study suggest that posttraumatic stress symptoms significantly impact test-taking ability, especially for those with the highest levels of symptoms following exposure to combat. Additionally, it appears that this impact is for the PTSD syndrome and not for any individual symptom cluster.
- Those with the highest levels of symptoms are 13% less likely to answer a logical or vocabulary reasoning item correctly when compared to those with the lowest symptom levels.
- Students at risk for PTSD may be at a disadvantage on standardized tests, and may benefit from educational counseling and test-taking skills interventions.

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**Felmingham, K., Williams, L., Kemp, A., Liddell, B., Falconer, E., Peduto, A., et al. (2010). Neural Responses to Masked Fear Faces: Sex Differences and Trauma Exposure in Posttraumatic Stress Disorder. *Journal of Abnormal Psychology, 119(1), 241-247.***

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## TYPE OF ARTICLE

- Original Empirical Investigation

## OBJECTIVE/PURPOSE OF THE ARTICLE

- To examine the predication that trauma would elevate brain activity in autonomic fear processing networks more so in women than in men.

## METHODS

### Participants

- The sample consisted of a non-traumatized control group (22 women, 20 men), a trauma exposed control group (9 women, 12 men), and a group diagnosed with PTSD (13 women, 10 men).

### Materials

- Trauma history was screened using the Traumatic Event Questionnaire, and psychiatric diagnoses were screened using the Composite International Diagnostic Interview.
- The Clinician Administered PTSD Scale (CAPS) and the Structured Clinical Interview for DSM-IV were administered to the PTSD group.
- The Depression, Anxiety, Stress Scale was used to assess mood during the week of testing.
- A fear perception task was used during scanning, and fMRI images were obtained using a 1.5T Siemens Vision Plus scanner using gradient echo echoplanar protocol, meaning that only one nuclear spin excitation per image was used.

## Procedure

- Neutral and fear face stimuli were presented in a backward masking paradigm so that a neutral or fear target stimuli (e.g., can you give an example?) was presented for 16.7 ms, followed by a neutral face mask for 163.3 ms. Brain activity was examined comparing reaction to neutral and fear stimuli.
- A 3 X 2 random-effects ANOVA was used with group belonging and gender as between subjects factors.

## RESULTS

- Results of the ANOVA indicate significant interaction effects for group and gender for the left amygdala, left hippocampus, bilateral insula, and right brainstem.

## CONCLUSIONS/SUMMARY

- The results of this study suggest that there are significant gender differences in reactions to masked fear stimuli associated with trauma exposure and PTSD.

- The largest difference appears to be in the dorsal brainstem when comparing women with trauma exposure and PTSD to men in all of the other groups.
- Men exhibited greater hippocampal activity, but only for those with PTSD. This was an unexpected finding, and suggests that men with PTSD may have increased activation of inhibitory networks for fear and arousal.

## CONTRIBUTIONS/IMPLICATIONS

- This study reports new evidence for gender differences in neural responses to fear stimuli in those with trauma exposure and those with PTSD that warrants further research to further examine hippocampal functioning and contextual processing.



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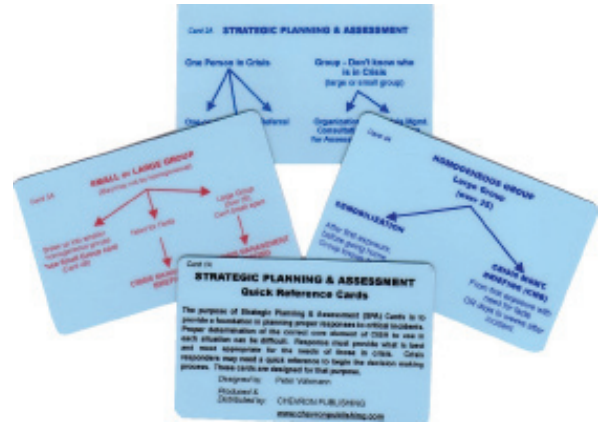
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**The Ethics of Terrorism:  
Innovative Approaches From an International Perspective (17 lectures), Eds.**

Thomas Albert Gilly, Yakov Gilinsky, Vladimir A. Sergevnin  
Springfield, IL, Charles C. Thomas, (2009), 223 pages, plus table of contents and contributors 5 pages,  
plus indices 10 pages. \$62.95/100, H.C.

Reviewed by H.H.A. Cooper, LLB, MA

The literature in the field of terrorism has expanded exponentially over the past four decades. It poses considerable challenges for the impartial, informed reviewer. This is particularly the case with the numerous offerings generated post 9-11. The research, as evidenced by the content, the bibliographies, and the indices, leaves much to be desired. Works on terrorism tend to be written by highly-opinionated people and their presentations can hardly be expected to be free from one kind of bias or another. That being said, the task of the reviewer has to be focused, primarily, on the utility of the work for the prospective audience to which the review is directed. Ideally, it should answer the reader's questions: Why should I read this book? What is in it of interest for me? Addressed to an extensive, varied audience, those questions are susceptible of a number of answers, some more helpful than others. The challenge presented by this book is especially acute for a reviewer seeking to be impartially helpful to the wide-ranging readership of this Journal. In short, there is a little something written in it for everyone regardless of discipline or professional preference. Conversely, there is much that, as a consequence, would likely be dismissed less on grounds of academic merit than of relevance to a particular reader's needs.

This book is a very ambitious undertaking. It links together, not always very harmoniously, the essays of seventeen authors of widely differing backgrounds, experience, and ethnic provenance. That, in itself, is a major challenge, both for the editors as well as any reviewer. Some contributions are distinctly more relevant to the overall theme than others. Of notable concern, in the present context, is the absence among the contributors of any mental health profes-

sional. There are many interesting questions raised by this work that would have benefitted from a serious presentation of the perspective of one deeply versed in both the mental health field and terrorism. One such, who receives but the briefest of mentions, is that great Italian psychiatrist, the late Franco Ferracuti. Another, who might usefully have found a mention, is the late Dr. David Hubbard (*The Skyjacker: His flights of fantasy*, 1973). There are, happily, among the living a number who could have filled the bill. There is, consequently, an unfortunate lack of proper attention to the psychological make-up of the terrorist personality, which has a significant bearing on ethical issues both from the perspective of the perpetrator and those seeking to understand his or her motivation.

Similarly, the treatment of the gender issue here seems to have been distorted not merely by a lack of specialist perspective but also by an inadequate familiarity with the literature on the subject, (Gilly, pages 159/160), "With few exceptions.... in recent research, criminologists have demonstrated little concern about the participation of women in terrorist activities." Women's participation in terrorism certainly did not begin with the recent suicide bomber, or the Chechen "black widows." It commanded the attention of terrorism specialists more than thirty years ago. Serious ethical issues going back to Old Testament times are posed, for example, by the tragic career of Nora Astorga. A noteworthy issue arises out of this with respect to terrorism research generally. However useful the Internet for locating relevant sources of data, it is no substitute for the laborious reading of such works as that presently reviewed in order to evaluate their worth.

Anthologies always pose a difficult problem for the reviewer; selection of particular contributors for attention is often dictated by subjective preference rather than individual merit. Some of these essays, while worthwhile perhaps in their own expressed field of reference, must be judged to have but tangential connection with either ethics or terrorism and only rarely a significant relationship to both. A notable exception is Chapter 14, titled Ethics of Terrorism by Valdimir Baloun. This contribution is outstanding, scholarly, and, perhaps, the only one that truly hews to the theme expressed in the book's title. It is, despite its necessary emphasis on "Islamic terrorism," remarkably open-minded, especially in its examination of the reactions of those exposed to it. He poses a number of pertinent questions of an ethical nature in this regard, (page 179). He deals, courageously and perceptively, with The Holocaust and anti-Semitism and the way both phenomena have, in Hegelian terms, shaped subsequent actions and reactions to them. He comments that "It would seem that if Europe had not had its Jews it would have had to invent them," (page 181). His treatment of the tenets of Islam, though necessarily constrained by its brevity, is cogent and pertinent as a lead-in to its relationship to modern terrorist manifestations. Few would disagree with the observation that "Islam is a very strict religion, which a priori can't find common ground with this new ethics of the West." But, on both sides, there has been an increasing disinclination to find any livable accommodation between the two. In particular, the Palestinian/Israeli struggle has become "owned" by fanatics on both sides, (p. 184). It is a truism that those unaffected directly by acts of terrorism see the phenomenon as somewhat remote...."until terrorism hits Europe or the United States, the reaction is more or less indifferent," (p. 185). Ethical analysis of the topic is obviously colored by propinquity.

Of special interest from a mental health perspective are Dr. Baloun's observations under Terrorism Motivated by Religion, (page 185). Referring to perpetrators from bin Laden's organization, "...they work themselves into an almost psychotic state," and "...in this it's possible to detect real signs of megalomania." This, as the author points out, is not confirmed solely to the adherents of Islam. He speaks of "Devout fanatic terrorists," ...inhabiting... "a psychotic world while outwardly they become machines, which can be likened to schizophrenic forms of mental illness," (p.

185). Justification is sought by the device of "...verses of the Koran taken out of context," (page 186). It is not only deluded terrorists who resort to this stratagem, but, often enough, those who seek to understand them. The "unthinking fanatic," (page 186), is as much deluded by him or herself as by the machinations of others. Dr. Baloun, following a well-centered philosophical discussion, observes, "I also believe that fanaticism of any kind cannot be fought with armies in the sense of a 'normal, war,' (page 189). "In particular, following Heidegger, he takes the view of conscience and its application as being a very personal experience involving choice, (also a Koranic precept), and "In ethical discussions there remains the open question whether the "absence of conscience" is limited only to psychopathic individuals as the traditional understanding implies," (page 186). He raises further the interesting interrogatory, "Does every person necessarily perceive that terrorism, slavery, and so forth are morally wrong?" (page 188). Thus, "...judging any ethics of Islamic 'terrorism' is extremely difficult," (page 189). Or, it might be added, of any other kind of terrorism.

Selection of contributors, save for such as Dr. Mengele, is an invidious task. That other contributions have not received a similar, extended notice by this reviewer ought not to be interpreted as meaning, in any way, that they are dismissed as irrelevant or unmeritorious. Rather is it that choice has been mediated by assumed readership preferences. A review, rather like the donut sample offered upon entry to Krispy Kreme, is an enticement, and invitation to proceed to a more sumptuous consumption of the book itself. A review is not a substitute for such an exercise. A diligent reader will discover his or her own points of interest, areas of agreement, or dispute. "The mine is always bigger than the gem."

*Professor H.H.A. Cooper, former Director of the Criminal Law Education and Research Center, (CLEAR), NYU and Deputy Director of the NYU Center of Forensic Psychiatry, was Staff Director of the National Advisory Committee Task Force on Disorders and Terrorism, U.S. Department of Justice, (1974/1977). He has taught at The University of Texas at Dallas for the past 26 years. He is inter alia, the author of Ethics and Assassination, published in the Journal of Applied Security Research, 2009.*

## Communication in Crisis and Hostage Negotiations (2nd Edition)

By Arthur A. Slatkin, Ed.D.

Charles C. Thomas, 2010, Softcover

Reviewed by Richard Levenson, PsyD, CTS

Every once in awhile a book comes along that is right on point, well-written, and both evidence- and experientially-based. Such is the case for Dr. Arthur Slatkin's second edition of *Communication in Crisis and Hostage Negotiations*. In fact, despite its focus on law enforcement and emergency services personnel, Dr. Slatkin's work has many audiences, including those practitioners in psychotherapy and counseling, as well as pastoral counseling and those in the sub-fields of industrial psychology such as human relations and personnel.

Immediately, one is impressed with the ease in which Dr. Slatkin presents his material. Terms, definitions, and background research are explained and used in a clear conversational style making the book easily digestible. However, the astute reader soon realizes that Dr. Slatkin's work is a treasure of information and one which should be immediately available to both trainers and their candidates of hostage negotiation teams. Indeed, I would urge all mental health critical care specialists to obtain and devour this book as it can only enhance your professional skills at many levels.

At it's core, *Communication in Crisis and Hostage Negotiation* relies heavily on training the hostage negotiator in the psychological technique (indeed, communication technique) of active listening in dealing effectively with the Hostage Taker. Active listening, then, confirms that a hostage taker is understood and that "they and what they say count." There are many components to active listening, including how to listen, speak about action, and personal sharing between the hostage negotiator and the hostage taker. There are many sub-levels of communication, both verbal and non-verbal, and Dr. Slatkin covers them nicely and includes exercises, scenarios, and role plays to reinforce and perfect what he terms is the both the art and science of effective communication.

Most importantly, though, are the human qualities that Dr. Slatkin views as critical in the selection and making of a hostage negotiator. Psychological mindedness, patience, sincerity, a capacity for empathy, the ability to be comfortable and able to relate with anyone in a plain spoken way, a non-judgmental manner that includes tolerance, flexibility, open-mindedness, and ease of expressiveness - together with rigorous, professional training - seem to be the make-up of the most successful hostage negotiators.

If the taking of hostages is a crisis, then Dr. Slatkin's specialized crisis intervention techniques must be a part of the emergency responder's repertoire. In that regard, Dr. Slatkin again does an outstanding job of providing intervention strategies for barricaded, terrorist, developmentally disordered, mentally disabled, suicidal, assaultive, substance abusing, incarcerated, foreign language-speaking, and elderly subjects. There are also techniques presented to deal with resistance, impasse, stalemate, and deadlock, as well as stratagems which likely work via verbal interventions that are just outside of the subject's awareness.

In summary, *Communication in Crisis and Hostage Negotiations*, represents Dr. Slatkin's 25+ years of expertise as a member of various hostage negotiating teams and details what are the necessary characteristics of the people who should undertake such an assignment. It is an outstanding work and really should be considered the "gold standard" in the field of Hostage Negotiation communications. *Communication in Crisis and Hostage Negotiations* is a professional manual - and one which will be of significant value to members of law enforcement at local, state, and federal levels for many years to come. It should be required reading for all police, corrections, emergency services personnel, and members of the clergy who serve on such teams.

--Richard L. Levenson, Jr., Psy.D., CTS  
Associate Editor, IJEMH

## **This is Your Brain on Trial**

### **The Forensic Evaluation of Traumatic Brain Injury: A Handbook for Clinicians and Attorneys (2nd ed.)**

Edited by Gregory J. Murrey & Donald Starzinski  
Boca Raton: CRC Press, 2008

### **Clinical Neuropsychology in the Criminal Forensic Setting**

Edited by Robert L. Denney & James P. Sullivan  
New York: Guilford Press, 2008

### **Neuropsychology in the Courtroom: Expert Analysis of Reports and Testimony**

Edited by Robert L. Heilbrunner  
New York: Guilford Press, 2008

Reviewed by Laurence Miller, PhD

Although the “Decade of the Brain” is long over (that was so 90’s), neuropsychology continues to be a growing field, and will become even more so with the expected flood of traumatically brain-injured (TBI) military veterans that will be seeking treatment in the coming decade. But, apart from clinical care, neuropsychology often enters the legal arena in two main ways: (1) brain-injured patients may seek compensation and, since many of the symptoms and disabilities are subjective, neuropsychological evaluations may be ordered in civil cases to ascertain the validity of the claimed impairment; (2) brain injury can be associated with impulsive and poorly-controlled behavior and this may be used as a defense in criminal cases as grounds for diminished capacity or an insanity defense, or to question competency to stand trial. Three recent volumes, all edited anthologies, tackle these issues, each from a slightly different perspective.

*The Forensic Evaluation of Traumatic Brain Injury: A Handbook for Clinicians and Attorneys* is a slim, but comprehensive and tightly organized guide to the basics of civil forensic neuropsychology as they apply specifically to traumatic brain injury (TBI). Chapters cover the forensic roles of neurologists, psychiatrists, neuropsychologists, and neurorehabilitation specialists in evaluating TBI cases for purposes of compensation or personal injury. Additional chapters focus on the clinician as forensic examiner and expert witness, carefully illustrating the process of expert

testimony in the adversarial litigation setting. While not intended as a stand-alone text in forensic neuropsychology, experienced clinicians can refer to this compact volume as a handy review, while novices will find it a good introduction to the field, whetting their appetite for further study and training.

Moving from the civil to the criminal courtroom, *Clinical Neuropsychology in the Criminal Forensic Setting* examines the impact of brain dysfunction on matters related to the criminal justice system. These include chapters on the admissibility of neuropsychological evidence in court; criminal competencies to waive Miranda rights, stand trial, and be sentenced; the insanity defense and diminished capacity; prediction of future dangerousness; assessment of malingering; and neuropsychology in the juvenile justice system. Additional chapters provide guidance in the nuts and bolts of conducting a criminal forensic neuropsychological evaluation and preparing a report, and in testifying in criminal court. Both scholarly and practical, this comprehensive volume can serve as a text for courses in criminal forensic neuropsychology and will be useful to any clinician that performs these kinds of evaluations and testifies as an expert witness in criminal cases.

In case you still didn’t have enough of a flavor for how neuropsychological evaluations are actually conducted and expert testimony plays out in the real world of civil forensic neuropsychology, *Neuropsychology in the Courtroom: Expert Analysis of Reports and Testimony* utilizes extensive case

history descriptions to flesh out the various chapter topics, which include traumatic brain injury, multiple chemical sensitivity, electrical brain injury, anoxic brain injury, chronic pain, and pediatric neuropsychology cases. A useful section painstakingly analyzes a mild traumatic brain injury case from the triple perspective of the treating clinician, plaintiff's expert, and defense expert. Other chapters focus on issues of trial testimony, cross-examination of expert witnesses, and the pitfalls of clinical-forensic hubris. Although the

case-study orientation serves as a welcome supplement to other contributions in this field, this volume is less satisfying as a unitary text, and its lessons can most fruitfully be assimilated and appreciated after more rigorous study of the substantive issues in forensic neuropsychology. If you do neuropsychological evaluations for the courts – or are planning to – keep these three volumes handy, as each makes its own unique contribution to the field.

## **Chicken Soup for the Badge-Covered Soul**

### **Police Ethics and the Jewish Tradition**

by Stephen M. Passamaneck  
Springfield, IL: Charles C Thomas, 2003

### **Jews in Blue: The Jewish American Experience in Law Enforcement**

By Jack Kitaeff  
Youngstown, NY: Cambria Press, 2006

### **Spiritual Survival for Law Enforcement: Practical Insights, Practical Tools**

by Rabbi Cary A. Friedman  
Linden, NJ: Compass Books, 2005

Reviewed by Laurence Miller, PhD

A generation ago, there were few Jews in law enforcement; today, we have organizations like the Shomrim (literally, the “Watchmen” or “Guardians”), a fraternal order of Jewish police begun by the NYC Police Department, and the number of Jewish officers continues to grow around the nation and the world. These three books each approach the role of Jews and Judaic philosophy in law enforcement from different perspectives.

*Police Ethics and the Jewish Tradition* begins with the concept of law enforcement officers as shomrim, the guardians and moral agents of a civilized society, and the ethical responsibility that this entails. The author, a rabbi, reserve deputy sheriff, and police chaplain, draws upon Jewish philosophy and religious tradition to illuminate the ways in which these suffuse the principles and practices of ethical

law enforcement. Topics covered include group loyalty and responsibility, bribery and gratuity, deception and corruption, and police training and discipline. Biblical and Talmudic sources are cited to illustrate specific points such as the use of deceptive and coercive practices in criminal interrogation (“With the crafty, one may be crafty” – Talmud), balanced by the strong Jewish prohibition against bearing false testimony. While stretching the connection in a few areas, this book nevertheless does a masterful job of finding the moral foundations of ethical policing in the ageless traditions of Jewish lore.

If you want proof that Elvis (yes, that one) was really a Jewish cop (no, really), then check out *Jews in Blue: The Jewish American Experience in Law Enforcement* by police psychologist Jack Kitaeff. Here, too, the theme of police

officers as *shomrim* suffuses the narrative, as the author interweaves historical fact with colorful stories of Jews in federal, state, and local law enforcement roles. It also highlights the vital role that Jewish officers have played in the development of the field of police psychology, as well as such now-standard law enforcement protocols and practices as hostage negotiation and peer counseling. And then there's that Elvis thing...

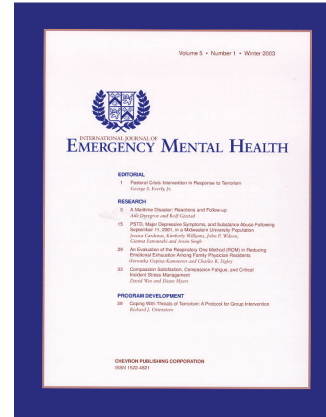
Somewhat more ecumenical in scope, Rabbi Cary Friedman's *Spiritual Survival for Law Enforcement* attempts to apply Jewish pastoral counseling and social support traditions to the larger practice of police chaplaincy. Emphasizing the

importance of a spiritual perspective in coping with both the daily stresses and destabilizing traumas of law enforcement, the book goes beyond platitudes to provide some refreshingly practical guidelines for spiritual counseling and self-help that can be utilized both by chaplains and rank-and-file officers of all faiths.

Combining wisdom, compassion, hard-nosed reality, humor, and a little *chutzpah*, all three of these books exemplify an inclusive, non-doctrinaire approach to the role of faith, ethics, and spirituality in the field of law enforcement. You don't have to be Jewish to enjoy these books and you will likely come to appreciate the message of your own faith by reading them. It couldn't hurt.

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