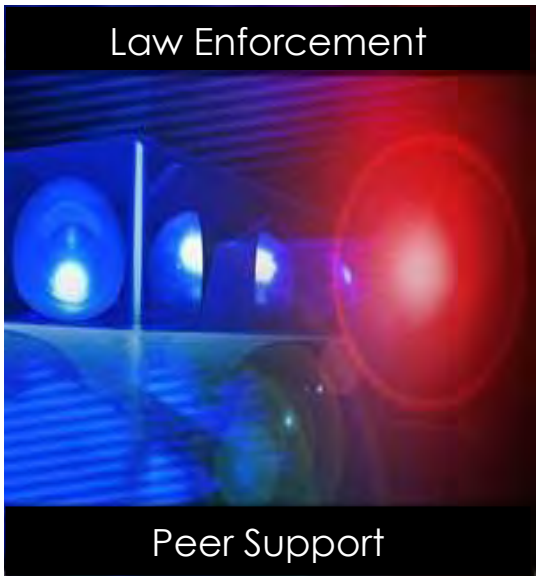
POLICE AND SHERIFF
Peer Support Team
MANUAL

Reference and Resource Manual
Fifth Edition



JACK A. DIGLIANI, PhD, EdD

Police and Sheriff Peer Support Team Manual

Also by Jack A. Digliani:

Reflections of a Police Psychologist
Stress Inoculation: The Police
Law Enforcement Critical Incident Handbook
Firefighter Peer Support Team Manual
Law Enforcement Marriage and Relationship Guidebook

For more information and to download free copies of the Police and Sheriff Peer Support Team Manual, the Law Enforcement Critical Incident Handbook, and the Law Enforcement Marriage and Relationship Guidebook visit www.jackdigliani.com

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To order *Reflections of a Police Psychologist* visit Xlibris.com.

For further information about police psychology, officer wellness, and other topics of interest visit Copsalive.com, Badgeoflife.com, and Policeone.com.

Manual Information and Suggestions for Use

The use of the terms *officer* and *police officer* are intended to include civilian police department employees, deputy sheriffs, state troopers, police agents, park rangers, and other law enforcement or peace officers at all levels of government. Although many issues are presented and discussed in terms of police officers and policing, they are equally applicable to those outside of police work.

The *Police and Sheriff Peer Support Team Manual* consists of relatively independent handout information that has been instrumental in the training of new peer support team members. It is intended to be used as a reference, review, refresher, and training resource.

The Manual is designed so that peer support team members and others may examine the *Contents* and select topics of interest. The individual topic documents are designed so that they may be used independently of one another. Therefore, some information pertinent to the topic title may appear in more than one document. Some documents are in outline form and are best understood in conjunction with the *Police and Sheriff Peer Support Team Training Program*.

The Manual includes some information that is applicable only to the law enforcement agencies of Larimer County, Colorado. Other Manual information is applicable only to the police agencies of the State of Colorado. However, the majority of Manual information is applicable or can be readily adapted to address the issues inherent within all police agencies and police (and other) peer support teams.

The Manual includes documents and information created by the author and others. In cases where the source of specific information is known, the source has been cited. The author acknowledges the contributions of sources and authors whose thoughts and ideas have been incorporated into general knowledge and are no longer readily identified or cited.

The Manual is intended to be a companion publication to *Reflections of a Police Psychologist*.

Suggestion for Printing the E-version of the Manual

A two-sided print of the Manual from the e-document provides for a left side comb, spiral, or other binding which allows the viewer to see the entire contents of the Manual when opened to the *Contents* pages. The two-page view of the *Contents* facilitates the location of specific Manual topics and additional titles of interest.

"Good psychotherapy, counseling, and peer support is similar to trapeze, timing is everything…" (J.A. Digliani)

Police and Sheriff Peer Support Team Manual

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Introduction

Police officers have supported one another since the inception of police forces. In the early years when police officers experienced emotional difficulties or troubling stressors, whether or not work related, they could always rely on the traditional *B and B* (booze and buddies) for solace. As you might expect, the results produced by the B and B method of stress management were sometimes less than desirable. Although booze and buddies still exist today, police officers now have several alternatives for assistance when dealing with stress-related difficulties. In many contemporary police agencies, these alternatives include the option of working with members of the department's peer support team.

Police peer support teams have proven their worth and have demonstrated their effectiveness for many years. They have established their place in the police mentality and have become an integral part of many law enforcement agencies.

Some police administrators do not recognize the need for peer support teams. This is because most agency employees (1) have access to a jurisdiction-wide employee assistance program (EAP) and (2) most agency health insurance benefit plans include a provision for psychological counseling.

The availability of EAP and health plan psychological counseling for police officers represents a significant advancement in the delivery of counseling services. However for officers, EAPs and health plan counseling, although helpful, appear insufficient. They are helpful in that they are utilized by some officers who might not otherwise seek assistance. They are insufficient in that despite their availability, they do not and cannot meet the needs of many police officers.

Peer support teams occupy a support niche that cannot be readily filled by either an EAP, health plan provisions, or a police staff psychologist. If an agency wants to do the best it can to support its officers, a peer support team is necessary. Incidentally, a peer support team is one of the most valued resources for a police agency staff psychologist - many staff psychologist counseling and pre-emptive intervention programs are designed to incorporate the efficacy of peer support.

If you are reading this as a member of a police peer support team, your agency has recognized the value of peer support. This means that your department has endorsed the principles of peer support and has willingly committed resources to make peer support available. As a peer support team member, you recognize this commitment and have assumed the responsibility to function within the parameters of your agency's peer support team policy, operational guidelines, and training.

If you are reading this and your agency does not have a peer support team, I encourage you to initiate a discussion about developing one. With appropriate member selection, training, and ongoing clinical advisement or supervision, a peer support team can become an invaluable asset to any policing agency.

This manual is dedicated to the men and women that give much of themselves to comprise our police and sheriff peer support teams…JAD

Peer Support Team Mission, Members, and Interactions

Peer Support Team Mission

The Peer Support Team (PST) functions as a support and debriefing resource for employees and their families. The PST provides support to personnel experiencing personal and work related stress. It also provides support during and following critical or traumatic incidents resulting from performance of duty.

Peer Support Team Members:

- Provide peer support and facilitate peer support team debriefings within the parameters established by law, departmental policy, operational and ethical guidelines, and their training.
- Attend regularly scheduled peer support team meetings and in-service training.
- Develop and maintain enhanced knowledge and skills in recognizing stress reactions to critical incidents and the chronic stressors of policing and non-work environments.
- Remain in communication with the peer support team psychologist and engage the psychologist for clinical supervision in accordance with departmental policy and operational guidelines.
- Resolve issues or conflicts that may arise between themselves and department investigators, supervisors, or administrators by working for cooperation, understanding, and education. In cases where such resolution is not readily achieved, they contact their team coordinator and team psychologist immediately for assistance.
- Make appropriate referrals when issues exceed the parameters of peer support.
- Provide peer support services to other agencies on request and as approved through mutual-aid policies.
- Remain mindful of the trust placed in them by those who seek peer support.

Peer Support Interactions:

- are founded in similar experiences, background, or history
- are characterized by elements of functional relationships
- encourage exploration, empowerment, and positive change
- avoid the creation of dependency
- are guided by ethical and conceptual parameters
- are different than “friends talking”
- can be a one-time contact or ongoing
- may involve an evaluative component
- can be part of a comprehensive professional counseling program

Peer Support, Counseling, and Psychotherapy

Peer support. Peer support is based in some common experience or history. In this way, peer support differs from counseling and psychotherapy. There are two levels of peer support: *Level I* peer support consists of the support found in the everyday positive interactions of friends, co-workers, and others. *Level II* peer support involves persons that have been trained in the principles of peer support, endorse specified ethical standards, function under clinical supervision, and are members of a peer support team.

Counseling. Counseling involves a professional therapeutic relationship wherein a specially trained or licensed clinician endeavors to help another person to understand and to solve past or current issues and difficulties.

Psychotherapy. Psychotherapy is a form of counseling that is used as a treatment for mental disorders. It is the treatment of mental and emotional disorders through the use of psychological techniques and assessments with the goal being relief of symptoms or personality alteration.

The Peer Support Team Member Role

It is the responsibility of peer support team members to:

- specify the PST member role and the parameters of PST member interactions.
- clarify, then specify the PST member role and the parameters of any *possible* PST member interactions.
- advise and explain the limits of confidentiality of peer support team members in PST interactions.
- function within the parameters of statute, departmental policy, operational guidelines, and peer support training.

Police peer support team members function in multiple roles. The confidentiality protections afforded to peer support team members do not apply when a peer support team member is functioning in a role other than peer support. Therefore, it is important for peer support team members to remain aware of when they are and are not functioning in their peer support role. When interacting with others, unless clearly functioning in a peer support role, PST members should ask themselves:

- Is this a peer support interaction or just a friendly conversation?
- Is there a possibility that the person believes that he or she is talking to me in my peer support role even though I'm uncertain?

If uncertain…ask, "Are you talking to me as a member of the peer support team? Is this peer support?" If "yes", specify the limits of PST member confidentiality and continue the conversation as peer support.

Peer support: *Think* -"What is this person trying to tell me?" "How might I help?"

At times, peer support interactions can be stressful. Try to relax and focus on the interaction. Keep in mind that a functional peer relationship is inherently supportive. You do not need to force anything to be effective.

Peer Support: Stage Model of Peer Support

Peer support interactions often involve contacts wherein a fundamental peer support relationship provides supportive assistance to persons confronting a relatively transient stressful or traumatic period in their lives. However, peer support has the potential to help others who are confronting more comprehensive and enduring difficulties.

Peer support can assist persons to initiate and maintain long-term positive life change. Such change involves many factors, including personal effort – *effort for change* and a secondary *effort for consistency* to maintain change. The Stage Model of Peer Support is an excellent framework for providing peer support in all situations, including those situations involving comprehensive life change.

Stage Model of Peer Support

Stage I *Exploration* (the current picture: What's going on?)
Stage II *Person Objective Understanding (*preferred picture: What do I need or want?)
Stage III *Action Programs* (the way forward: How do I get what I need or want?)

Stage I: Exploration

1. Attending
2. Engaged (active) listening
3. Genuineness
4. Empathy
5. Concreteness
6. Non-judgmental
7. Transparency
8. Reflection and paraphrasing
9. Respect
10. Trust
11. Supportive summary
12. Field assessment

Stage II: Person Objective Understanding

Self-disclosure
Advanced accurate empathy
Immediacy
Confrontation

Guidelines for Supportive Confrontation

Confrontation does not have to be dramatic. "I don't understand how what you're doing is helping. In fact, it may be making things worse" is a useful low-key confrontation: (1) The first rule of confrontation is - do not confront another person if you do not intend to increase your involvement with him/her. (2) Do not confront when angry. (3) Confront only if you experience feelings of caring or some sense of connection. (4) Confront only if the relationship has gone beyond the initial stages of development or if basic trust has been established.

If all of the above conditions are present but you feel that the person would not benefit from confrontation, you should (1) avoid confrontation, (2) keep exploring, (3) strengthen the relationship, and (4) help the person become ready for the challenges inherent in confrontation.

How to Confront Constructively

1. Distinguish between observations and inferences. Communicate the distinction clearly. State inferences tentatively.
2. Present the data on which the inferences are based before stating the inference.
3. Use "I messages" throughout the confrontation.

Stage III: Action Programs

Concrete workable goals
Set priorities
Check behaviors
Make it effective
Move from less serious to more serious when possible
Consider the person's values
Develop relapse-prevention strategies

(See *Peer Support Team 10-Step Action Plan* and *Peer Support Team Action Plan Worksheet)*

To provide the highest quality peer support: Remember -

1. A common mistake is trying to move from Stage I to Stage III too fast.
2. Help the person reframe, reinterpret, and re-conceptualize dysfunctional thoughts and behavior.
3. Remain mindful of the transactional nature of the *person-environment* relationship.
4. Frame the problem so that it has a resolution (discuss the idea that some things cannot be changed, therefore the difficulty must be addressed in ways other than effecting it directly).
5. Do not become the client of the person you are trying to help.
6. Avoid imposing your world view.
7. Use care when working with people that you dislike or with whom you have a troublesome history.
8. If you are not able to work comfortably with a person for any reason, refer to another peer support team member or appropriate supportive resource.
9. Refer to professionals when appropriate. This includes specialists outside of the counseling profession, such as attorneys, financial advisors, and so on.
10. Remain within the parameters of your departmental PST policy, your PST operational guidelines, and your PST training.
11. Avoid creating or encouraging dependency.
12. Peer support team members are committed to enhancing a person's independence and self-determination.
13. Utilize appropriate follow up.
14. Contact your team coordinator or clinical supervisor as appropriate.

If *you* have unfinished psychological or emotional business, seek appropriate counseling. Do not work out your issues in your peer support interactions…or in the language of the 1960's, "*Donõt lay your trip on the person y*

Digliani, J.A. 2010. *Reflections of a Police Psychologist*, Revised ed., Xlibris
Egan, G. 2006. *The skilled helper*, 9th ed., Brooks/Cole, Belmont, CA
Eisenberg, S. & Delaney, D.J. 1977. *The counseling process*, 2nd ed., Rand McNally:Chicago

Peer Support Team 10-Step Action Plan

Peer Support Team 10-Step Cognitive-Behavioral based Action Program

The following steps represent a guide for the development of an action plan. The *Steps* are comprised of questions that are often useful to consider when confronting difficulties and attempting change. The *Peer Support Team 10-Step Action Plan* may be used by others with or without the involvement of PST members.

Action plans should be implemented only after appropriate exploration and consideration. The success of any action plan depends upon not implementing it prematurely. There must be sufficient planning and development to make it most effective.

Action Plan Steps

Step 1: Have I clearly identified the problem?

Step 2: How am I thinking about the problem?

Step 3: Are my thoughts rational or irrational?

Step 4: Is there a better way for me to re-think or conceptualize the problem?

Step 5: What do I want to change?

Step 6: How should I specify and prioritize my desired changes?

Step 7: What are the possible obstacles to my desired changes?

Step 8: How will I overcome these obstacles?

Step 9: How and when will I implement my plan?

Step 10: How will I evaluate the outcome and maintain positive change? How will I prevent a relapse to dysfunction?

Action plans are most helpful when they are written. As a peer support team member you can use the *Peer Support Team Action Plan Worksheet*, design a specific action plan format to meet the specific needs of the person, or assist the person design an action plan. Any of these will improve the action plan's effectiveness.

When it comes to action plans, be creative. Assist in creating something that works for the person you are trying to help.

Peer Support Team Action Plan Worksheet Summary

The *Peer Support Team Action Plan Worksheet* (Appendix A) may be used in conjunction with peer support and the information included in the *Peer Support Team 10-Step Action Plan*.

Step 1

What is the issue? What am I **WORRIED** about? Have I clearly identified the problem?

→ IDENTIFY THE ISSUES, WORRIES, AND PROBLEMS TO BE ADDRESSED.

Steps 2-4

Are my thoughts rational or irrational? Do I need help to understand the difference? Is there a better way to think about or conceptualize the problem? What are my **OPTIONS**?

→ IDENTIFY OPTIONS. RECONSIDER IRRATIONAL CONCEPTUALIZATIONS. CONSIDER: *choices*, *decisions*, AND *likely consequences*. Think of options as *opportunities* to move forward.

Step 5

What do I want to **CHANGE**?

→ DO I NEED TO CHANGE MYSELF OR MY ENVIRONMENT? MAYBE SOME OF MYSELF AND SOME OF MY ENVIRONMENT. CONSIDER: *development of coping skills*.

Step 6

SPECIFY and **PRIORITIZE** desired changes and goals.

→ MAY INVOLVE CHANGING THOUGHTS, FEELINGS, BEHAVIORS, AND ELEMENTS OF THE ENVIRONMENT.

Step 7

What are the **ROADBLOCKS**? What obstacles are in the way of change?

→ ANTICIPATE THE DIFFICULTIES OF POSITIVE CHANGE.

Step 8

PLAN to address or overcome the obstacles.

→ IT IS EASY TO THINK ABOUT OBSTACLES AS OVERWHELMING. DEVELOP A CREATIVE ACTION PLAN THAT INCLUDES OVERCOMING OBSTACLES.

Step 9

IDENTIFY how and when you will **IMPLEMENT** your action plan.

→ IMPLEMENT THE ACTION PLAN.

Step 10

How will I **EVALUATE** the outcome and **MAINTAIN** positive change?

→ EVALUATE THE OUTCOME OF THE ACTION PLAN. REVISE AS NEEDED. PLAN TO PREVENT RELAPSE TO DYSFUNCTION.

Joanne Rupert & Jack A. Digliani

Peer Support Team: Helpful Phrases

The following sentences and phrases may be helpful during peer support interactions.

Supportive:
It's good to see you…
I'm glad you're ok (here, uninjured, to see you, etc)…
You have been through a lot…
That was one heck of a call…

Exploratory:
What happened…
Did something stressful happen to you recently?
Bring me up to date on…
Tell me more.
Let's take some time to go over this…
Can you help me understand…
How would X help you Y…
What would happen if you did (did not) do…
What are the likely consequences of…
Do you see any alternatives (options, implications, etc) to…
What I think you're saying is…is this accurate?
You feel…because…?
If I'm following you, you feel… because…
Have you thought about how this could be different?
I'm not clear on…can you help me to better understand?
What are your thoughts/feelings on this (making it better, coping, etc)?
What are your greatest fears about…
Can you talk more about your thoughts/feelings about…
What will the next few days be like for you?
What are your plans for the next few days?
It's been __ days since __. How are you doing? What has been happening?
What is happening now for you?
How will you deal with this experience (anger, pain, incident, loss, etc)?

Combination of Supportive and Exploratory:
That's a lot to deal with. This sounds like a difficult time for you. Let's see if we can come up with a plan to manage things over the next few days…do you have any ideas?

Assessment:
How would you describe your feelings (thoughts) right now?
Have you had any thoughts or feelings which are strange or unusual for you?
Have you had thoughts of suicide or hurting yourself?
Are you thinking about harming someone else in any way?

These suggestions for peer support do not represent an exhaustive list. In this regard, you are limited only by your imagination, training, perceptions, and appropriate boundaries. In peer support communication there is no substitute for *common sense*.

Peer Support Tips

Useful things to remember when providing peer support:

- Find a comfortable physical setting when possible
- Keep in mind that privacy may be very important for the person
- Clarify your PST role and specify PST limits of confidentiality
- Be mindful of timing and circumstances
- Develop a working alliance
- Engage appropriate humor when appropriate. Don't overdo it!
- Make it safe for communication
- Proceed slowly – it is not helpful to be perceived as "rushed"
- Listen closely – speak briefly
- Listen for metaphors that can be used in exploration - use similar metaphors when appropriate
- Do not assume that you know the persons feelings, thoughts, and behaviors
- Avoid interruptions and distractions (from *you* and the environment)
- Process information in a supportive manner – engage attentive body language, practice active listening, maintain a non-judgmental attitude, use reflective statements, paraphrase
- Help the person explore (Stage I support skill) but avoid relying *solely* on questions. Over-questioning can increase a person's defensiveness and decrease the effectiveness of peer support
- Do not move from Stage I *Exploration* to Stage III *Action Programs* too quickly
- Notice resistance – communicate to process alternatives
- Emphasize strengths – encourage empowerment
- When in doubt, focus on emotions and feelings
- When you don't know what to say, say nothing or "Tell me more"
- Pay attention to nonverbal behaviors (*mind* yours and *notice* theirs)
- Agreement does not equal empathy – you do not need to agree with the views of a person to be empathetic
- Do not reinforce dysfunctional thoughts and behaviors
- Gently confront dysfunctional thoughts and behaviors
- Remember, if you confront too much too soon, the person will likely disengage from you and peer support
- Do not assume change is easy – identify and discuss obstacles to change
- Conduct a field assessment for suicidal thinking and behavior if warranted
- Summarize periodically and at the end of the support meeting
- Stay within the boundaries of your peer support training
- Bring your interactions under clinical supervision
- Refer to available professional resources when appropriate

From: Meier, S.T. & Davis, S.R. (1997) *The Elements of Counseling*, 3rd ed., and Digliani, J.A. (2010) *Reflections of a Police Psychologist*.

Peer Support Team: Questions and Answers

As a Colorado police peer support team member with a clinical supervisor é

Do I need to check with my clinical supervisor or team coordinator before I engage in a peer support interaction?

No. As a trained peer support team member you may initiate or respond to a request for peer support. Independent peer support team member interactions which are in compliance with law, peer support team policy, and team operational guidelines are appropriate and encouraged.

How do I respond to a person who asks if peer support interactions are confidential?

When asked if peer support interactions are confidential, you should fully explain the limits of peer support team member confidentiality. Remember to include that PST information must be provided to your clinical supervisor. An unacceptable reply to this question would be some cursory remark such as, "yeah, they're confidential, there's a law…".

What happens when a person to whom I have been providing peer support waives his or her privilege of confidentiality?

When a person to whom you have been providing peer support waives confidentiality, the content of his or her peer support communications become available for disclosure. This means that you may communicate information received from the person in peer support interactions, *but only to those identified in the waiver*. A person normally waives confidentiality for some reason, usually so that you can communicate with family members, supervisors, lawyers, and so forth. Regardless of the reason, under the waiver, the information communicated to you by the person becomes available. PST members must remain aware that the prohibition against revealing peer support information without consent (within confidentiality limits) restricts only the peer support team member. The person with whom you are involved in a peer support interaction is free to discuss any or all of the peer support interaction. In other words, the recipient of peer support does not need your permission to reveal any information you provided. This includes anything that you said and anything that you did, and this information can go *anywhere*. Bottom line, remain professional.

Do confidentiality waivers have to be in writing?

Although there is a common practice which allows verbal confidentiality waivers in certain circumstances, it is best to have a written waiver before disclosing any protected information.

What do I do if a person confesses to a crime or talks about criminal behavior during a peer support interaction?

To answer this question fully would involve addressing all possible combinations of several variables. For our purposes, suffice it to say that in this situation, peer support team members should contact their clinical supervisor immediately. The appropriate action will then be decided upon and implemented. Some of the variables which must be considered are (1) whether you advised the person of the limits of peer support team member confidentiality. If yes, this likely means that the information was communicated because the person wants to confront the consequences of his or her behavior with your support, (2) you failed to advise the person of the confidentiality limitations. It may be that the person communicated this information with an expectation of confidentiality (which does not make it confidential), (3) the type of information presented, (4) whether you are a mandatory reporter of actual or suspected child abuse or neglect, (5) whether you are a police officer, and (6) whether the information involves a crime within a domestic relationship. Regardless of the circumstances, you should (1) stop the conversation in this area immediately, (2) continue peer support but do not further discuss the incident, (3) advise or re-advise the person that information indicative of criminal conduct is not protected, (4) tell the person that it would be better if a more comprehensive confidential resource was contacted to discuss this information, (5) inform the person that you must contact your clinical supervisor, (6) contact your clinical supervisor, and (7) assist the person to contact a more comprehensive confidential resource if requested (all referral resources have the responsibility to advise the person of any limitations of their confidentiality). If the person continues to talk about criminal behavior, you must act in a manner consistent with your police officer position.

Discussion: Stopping the conversation when a person begins to discuss information indicative of any criminal conduct is not a peer support effort to assist the person to conceal or cover-up past or on-going criminal behavior. Quite the contrary, peer support interactions encourage honesty and the assumption of personal responsibility. Instead, stopping the conversation and following up as indicated recognizes the fact that you can better assist the person if you are not placed in a position where you might become a witness in a possible prosecution. As it is, you may be required to take action and/or testify based upon the information already presented. No matter what the specifics are in any case, if persons present information indicative of any criminal conduct, *do not leave them alone*, especially if the person is a police officer. Stay with the person until otherwise directed by your clinical supervisor. Peer support team members are committed to helping others, however *peer support team members are not required to, and do not jeopardize themselves professionally or ethically by concealing ongoing or past criminal activity.*

What do I say to an internal affairs investigator who asks me about my peer support conversations with an employee being investigated?

Policy prohibits a peer support team member from disclosing information without consent, even during an ongoing administrative investigation. This prohibition is necessary for the proper functioning of the peer support team. If you are contacted by an administrative investigator and asked about your peer support

interactions with an employee, you should politely remind the investigator that to respond to the inquiry would amount to a violation of the department's peer support team policy. If the recipient of peer support wishes to waive confidentiality for the investigator, you may communicate freely. Administrative, and for that matter, criminal investigators should not be permitted to "fish" the peer support team in an effort to obtain information.

What do I say to a criminal investigator who asks me about my peer support conversations with an employee being investigated?

Information indicative of any criminal conduct in peer support interactions is not protected by law or department policy. The first thing you should do is contact your clinical supervisor. Together, you will determine whether there is information which is indicative of any criminal conduct. If it is determined that the recipient of peer support provided you with information indicative of criminal conduct, you must respond as you would if you received this information in a non-peer support interaction. To avoid complications and undermining the credibility of the entire peer support team you must remember to specify the confidentiality limits of peer support team members *before* beginning your peer support interactions.

Am I covered by my agencyõs policy and oper providing peer support to personnel from other agencies?

Yes, within the parameters of your agency policy. Under mutual aid policies and the PST operational guidelines, there are provisions for assisting other agencies. Your coverage is dependent upon meeting and remaining within the criteria specified in the policy and operational guidelines.

Should I keep records or notes in reference to my peer support interactions?

No. As long as you remember to bring your PST interactions under supervision, there is no requirement or need to keep a record. Many persons would be reluctant to utilize peer support if they thought that peer support team members were maintaining a record of their interactions. It is acceptable to record the number of your peer support contacts and the amount of time that you spend in your peer support role. This is for statistical purposes only. It can be used to determine the activity and utilization of the peer support team. Some agencies require that this information be recorded, and you can do so without concern.

Why is clinical supervision necessary? It is not required by C.R.S. 13-90-107(m).

Of the three viable options for peer support team structure (coordinator, clinical advisor, and clinical supervisor), the most professionally developed is the clinical supervisor model. The clinical supervisor option enhances the delivery of peer support services. It provides for PST clinical oversight, support for PST members, and is a resource for PST referral. In itself, C.R.S. 13-90-107(m) does not require any type of peer support team structure. However, PST members are afforded the protections C.R.S. 13-90-107(m) only when "functioning within the written peer support guidelines that are in effect for the person's respective law enforcement

agency or fire department." In reality, if a department PST was not concerned about the protection specified in this statute, it would not need written guidelines. *The statute does not require that peer support teams meet its standards*. The statute was intentionally written so that police and fire departments interested in having a PST and the protection specified could develop their team in a manner that best served their needs and funding capabilities. This is accomplished through the PST written guidelines. In this way, the statute serves the guidelines, not vice versa. When clinical supervision is required by PST written guidelines, it is because the agency has endorsed the values inherent in PST clinical oversight. Clinical supervision is then necessary in order to secure the protection of C.R.S. 13-90-107(m).

What if I fail to bring a peer support interaction under supervision?

This question pertains to peer support team members structured under a clinical supervisor, but it may also apply to peer support teams organized with a clinical advisor. An intentional violation of any of the primary obligations of team members as specified in the operational guidelines is a serious matter. It is not difficult to keep your PST interactions under supervision. Failing to bring your peer support interaction under supervision represents a serious breach of PST member ethical standards of conduct. In the event that such behavior is discovered, peer support team administrative censure, up to and including removal from the peer support team, is likely.

What happens if I fail to act in compliance with the PST policy and guidelines?

An intentional act of non-compliance with the peer support team policy or operational guidelines is a serious breach of trust and commitment. It is justification for removal from the peer support team. Unintentional non-compliance or well-intentioned errors can be evaluated on an individual basis, but may also result in removal from the peer support team. It is not difficult to remain in compliance with the team policy and operational guidelines. In order to stay within the parameters of these documents you must review them periodically. After all, you cannot act within the behavioral standards of the peer support team policy and operational guidelines if you do not know what they are. The policy and guidelines exist to (1) protect peer support team members, (2) to protect the recipient of peer support services, and (3) to provide for the highest possible quality of peer support. They require clinical supervision so that there is a "ladder of escalation". This means that the peer support team member has a specified course of action in cases which exceed the limits of peer support. Additionally, the team's monthly meetings and in-service training encourage the enhancement of fundamental peer support skills. Peer support team members endorse these values. A peer support team member that has lost connection with these values cannot continue with the peer support team. To do so would damage the peer support team and worse, may damage those that the team is committed to supporting. There is no faster way to undermine the efficacy of the peer support team than by having one of its members operating outside its policy or guidelines. One peer support team member has the ability to defeat years of successful peer support team performance. *The reputation of a peer support team and the willingness of employees to engage in peer support are truly this fragile*.

Peer Support Team Limits of Confidentiality

In Colorado, police peer support team (PST) member confidentiality is specified and limited by law (C.R.S. 13-90-107*m*) and departmental policy. Upon inquiry from investigators, some information discussed in PST interactions cannot be held in confidence. Other information must be reported or otherwise acted upon.

PST confidentiality protections under C.R.S. 13-90-107(m) apply only when the peer support team member is functioning in the peer support role, within the parameters of written peer support guidelines, and involved in *individual* interactions.

Limits of Confidentiality

The privilege of confidentiality for peer support team members acting in their peer support role does not include:

1. Circumstances wherein the PST member is a witness or party to an incident which prompted the delivery of peer support.
2. Information relating to mental illness where there is an imminent danger to self or others, or there is reason to believe that a person is gravely disabled (C.R.S. 13-90-107) (C.R.S. 27-65-105).
3. Information indicative of alcohol or other substance intoxication or abuse where there is a clear and immediate danger to self or others (C.R.S. 13-90-107) (C.R.S. 27-81-111) (C.R.S. 27-82-107).
4. Information indicative of any criminal conduct (C.R.S. 13-90-107).
5. Discussion of information with the peer support team clinical supervisor as specified in PST Operational Guidelines. *(Peer support team members have a primary obligation to discuss their peer support interactions with their clinical supervisor when so specified in their PST Operational Guidelines.)*

Duty to Report or Take Action

Peer support team members who are peace officers (or function in another capacity specified in C.R.S 19-3-304) have a duty to report:

1. Information indicative of actual or suspected child abuse or neglect (C.R.S. 19-3-304) (C.R.S. 13-90-107). (Psychologists are mandatory reporters under C.R.S. 19-3-304. Non-peace officer members of the PST must discuss such information with their clinical supervisor, a psychologist. The clinical supervisor must then report the information. Therefore, even when a PST member is not required by C.R.S. 19-3-304 to report actual or suspected child abuse or neglect, it will be reported. *This makes all PST members de facto mandatory reporters.*)

Peer support team members who are peace officers have a duty to take action:

1. When there is information indicative of domestic violence and there is probable cause to believe that a crime has been committed. Arrest is mandatory under such circumstances (C.R.S. 18-6-803.6).

(See *Peer Support Team Confidentiality Complexities*)

Colorado Revised Statutes (C.R.S.) 13-90-107.
Who may not testify without consent

Paragraph (m) of C.R.S. 13-90-107 *Who may not testify without consent* was enacted into law in 2005, making Colorado the fourth state to enact some form of peer support team member confidentiality legislation. C.R.S. 13-90-107(m) was amended to include "emergency medical service provider or rescue unit peer support team member" in 2013.

C.R.S. 13-90-107(m):

(1) There are particular relations in which it is the policy of the law to encourage confidence and to preserve it inviolate; therefore, a person shall not be examined as a witness in the following cases:

(m) (I) A law enforcement or firefighter peer support team member shall not be examined without the consent of the person to whom peer support services have been provided as to any communication made by the person to the peer support team member under the circumstances described in subparagraph (III) of this paragraph (m); nor shall a recipient of individual peer support services be examined as to any such communication without the recipient's consent.
(I.5) An emergency medical service provider or rescue unit peer support team member shall not be examined without the consent of the person to whom peer support services have been provided as to any communication made by the person to the peer support team member under the circumstances described in subparagraph (III) of this paragraph (m); nor shall a recipient of individual peer support services be examined as to any such communication without the recipient's consent.

(II) For purposes of this paragraph (m):
(A) "Communication" means an oral statement, written statement, note, record, report, or document, made during, or arising out of, a meeting with a peer support team member.
(A.5) "Emergency medical service provider or rescue unit peer support team member" means an emergency medical service provider, as defined in Section 25-3.5-103 (8), C.R.S., a regular or volunteer member of a rescue unit, as defined in Section 25-3.5-103 (11), C.R.S., or other person who has been trained in peer support skills and who is officially designated by the supervisor of an emergency medical service agency as defined in Section 25-3.5-103 (11.5), C.R.S., or a chief of a rescue unit as a member of an emergency medical service provider's peer support team or rescue unit's peer support team.
(B) "Law enforcement or firefighter peer support team member" means a peace officer, civilian employee, or volunteer member of a law enforcement agency or a regular or volunteer member of a fire department or other person who has been trained in peer support skills and who is officially designated by a police chief, the chief of the Colorado state patrol, a sheriff, or a fire chief as a member of a law enforcement agency's peer support team or a fire department's peer support team.

(III) The provisions of this paragraph (m) shall apply only to communications made during individual interactions conducted by a peer support team member:
(A) Acting in the person's official capacity as a law enforcement or firefighter peer support team member or an emergency medical service provider or rescue unit peer support team member; and
(B) Functioning within the written peer support guidelines that are in effect for the person's respective law enforcement agency, fire department, emergency medical service agency, or rescue unit.

(IV) This paragraph (m) shall not apply in cases in which:
(A) A law enforcement or firefighter peer support team member or emergency medical service provider or rescue unit peer support team member was a witness or a party to an incident which prompted the delivery of peer support services;
(B) Information received by a peer support team member is indicative of actual or suspected child abuse, as described in section 18-6-401, C.R.S., or actual or suspected child neglect, as described in section 19-3-102, C.R.S.;
(C) Due to alcohol or other substance intoxication or abuse, as described in sections 27-81-111 and 27-82-107, C.R.S., the person receiving peer support is a clear and immediate danger to the person's self or others;
(D) There is reasonable cause to believe that the person receiving peer support has a mental illness and, due to the mental illness, is an imminent threat to himself or herself or others or is gravely disabled as defined in section 27-65-102, C.R.S.; or
(E) There is information indicative of any criminal conduct.

Peer Support Team Confidentiality Complexities

The protection against testifying without consent afforded to those specified in C.R.S. 13-90-107 applies to courtroom testimony within the state of Colorado court system. For peer support team members this protection applies only to circumstances and information which is not exempted in paragraph (m) of C.R.S. 13-90-107.

Peer support communications are protected from disclosure during internal or administrative investigations by applicable department policy and adopted peer support team operational guidelines. If these protections are not written into department policy and/or guidelines, there is no protection.

The prohibition against testifying without consent for peer support team members specified in C.R.S. 13-90-107 (m) does not apply to the federal court system. In a federal court proceeding, the information exchanged in peer support interactions is subject to disclosure. This is important to remember because incidents involving municipal, county, or state officers frequently move into the federal court system when there is an allegation of civil rights violations. These claims are normally pursued in federal court under *Section 1983, Title 42, The Public Health and Welfare, United States Code*. In such actions, peer support team members can be compelled to testify. This is the reason that peer support team members should support officers involved in shootings and other critical incidents *without discussing the incident*.

While it is often helpful for involved officers to discuss their actions and experiences during and following a critical incident, such discussion is best left to state and federally protected confidential resources such as spouses, attorneys, and psychologists.

Peer support team members must not be lulled into a false sense of security or confidentiality by the provisions of C.R.S. 13-90-107(m).

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Peer Support Team Member
Authorization for the Release of Information

Name (please print) _____

Agency _____

I knowingly waive my privilege of confidentiality as specified in departmental policy and C.R.S. 13-90-107(m), *Who may not testify without consent*.

I hereby authorize the following Peer Support Team member(s)
_____
_____
_____

to release information exchanged in our peer support interaction(s) to
_____
_____
_____

Type of information to be released
_____
_____

Includes information about drug and alcohol use/abuse/dependence ___yes ___no

This release of information may be revoked at any time. This *Authorization for the Release of Information* shall expire one year from today's date unless revoked earlier.

_____
Signature of person authorizing release of information

_____
Date

_____
Witness (if present)

The Concept of Stress

Stress is a multifaceted and complex phenomenon. It appears to be a factor for all living organisms. The concept of stress has its origin in ancient writings and has developed significantly over the past several decades.

Stress: Hans Selye (1907-1982), an endocrinologist and researcher, defined stress as "the nonspecific response of the body to any demand, whether it is caused by, or results in, pleasant or unpleasant conditions." A more contemporary and alternative view of stress maintains that the idea of stress "should be restricted to conditions where an environmental demand exceeds the natural regulatory capacity of an organism" (Koolhass, J., et al. 2011). Simply restated, in Selye's view the intensity of the stress response is positively correlated with the combined intensity of *all* current demands. Therefore, as the totality of demands increase, the magnitude of the stress response increases. In the latter view, stress is hypothesized to occur only when the demands exceed those of everyday living. Included in these demands are the biological processes necessary to sustain life.

The concept of stress differs from that of *stressor* and *challenge*. *Stressor* is the term used for the demands that cause stress. Therefore, stressors cause stress. *Challenges* are a particular type of stressor. Stressors that are perceived as challenges do not appear to produce the negative effects associated with stress. Instead, challenges are frequently experienced as re-energizing and motivating. Whether a stressor is perceived as a challenge or a difficulty is influenced by many factors. Among these are: type and intensity of the stressor, stressor appraisal, perceived capability to cope with the stressor, available support and resources, individual personality characteristics, and likely assessed outcomes. This is why a stressor that represents a challenge for one person may cause significant stress in another.

Stressor: a demand that initiates the stress response. Stressors can be psychological or physical, low to high intensity, short to long duration, vary in frequency, and originate in the environment or internally.

Fight or flight: a phrase coined by Walter B. Cannon (1871-1945) to emphasize the preparation-for-action and survival value of the physiological changes that occur upon being confronted with a stressor. The fight or flight response later became associated with the Alarm phase of the *General Adaptation Syndrome*.

General Adaptation Syndrome (GAS): (Selye, H.) the GAS is comprised of three stages: alarm, resistance, and exhaustion. *Alarm* is the body's initial response to a perceived threat and the first stage of general adaptation syndrome. During this stage, the body begins the production and release of several hormones that affect the functioning of the body and brain. During the *resistance* stage of GAS, the internal stress response continues but external symptoms of arousal disappear as the individual attempts to cope with stressful conditions. In the final stage of the GAS, *exhaustion*, the prolonged activation of the stress response depletes the body's resources, resulting in permanent physical damage or death (http://www.ehow.com/facts_6118452_general-adaptation-syndrome.html).

Homeostasis: "steady state" – an organism's coping efforts to maintain physiological, emotional, and psychological balance.

Overload stress: stress which is the result of a high intensity stressor, too many lesser intensity stressors, or a combination of both that exceeds normal coping abilities.

Deprivational stress: stress experienced due to lack of stimulation, activity, and/or interaction. An example of an environment likely to produce deprivational stress is solitary confinement. Deprivational stress is also the principle underlying the child discipline intervention know as *time out*.

Occupational stress: stress caused by job demands. Each occupation is comprised of a cluster of *unavoidable* stressors. These are demands that are inherently part of the job. For police officers, interacting with non-cooperative persons is an unavoidable stressor. If not managed appropriately, occupational stressors can result in detrimental physical, emotional, and psychological responses. *Avoidable* occupational stressors may also become problematic when present in sufficient quantity and intensity. An example of an avoidable occupational stressor is a poorly designed department policy that fails to adequately address the issue for which it was written. A poorly written policy is an avoidable stressor because it could be re-written in a way that better addresses the reason for its existence.

Stress Management – Insights into the transactional nature of stress

Epictetus: (A.D. 55 –135) (1) "Men are disturbed not by things, but by the view which they take of them." (2) "It's not what happens to you, but how you react to it that matters." Epictetus was one of the first early writers to recognize the intimate and inextricable relationship that exists between individuals and their environment.

Hans Selye: (1) "Man should not try to avoid stress any more than he would shun food, love or exercise" (2) "It's not stress that kills us, it is our reaction to it." (3) "Mental tensions, frustrations, insecurity, aimlessness are among the most damaging stressors, and psychosomatic studies have shown how often they cause migraine headache, peptic ulcers, heart attacks, hypertension, mental disease, suicide, or just hopeless unhappiness." (4) "Adopting the right attitude can convert a negative stress into a positive one." Selye is recognized by many researchers as the first person to specify the processes of biological stress. He is sometimes referred to as "father of stress research."

R.S. Lazarus (1922-2002) (1) "Stress is not a property of the person, or of the environment, but arises when there is conjunction between a particular kind of environment and a particular kind of person that leads to a threat appraisal." Lazarus maintained that the experience of stress has less to do with a person's actual situation than with how the person perceived the strength of his own resources: *the personõs cognitive appraisal* and *personal assessment of coping abilities*.

Koolhaas, J., et al. "Stress revisited: A critical evaluation of the stress concept." Neuroscience and Biobehavioral Reviews 35, 1291–1301, (2011).

Signs of Excessive Stress

Impaired judgment and mental confusion
Uncharacteristic indecisiveness
Aggression – temper tantrums and "short fuse"
Continually argumentative
Increased irritability and anxiety – feeling like a "time bomb"
Increased apathy or denial of problems
Loss of interest in family, friends, and activities
Increased feelings of insecurity with lowered self esteem
Feelings of inadequacy

Warning Signs

1. Sudden changes in behavior, usually uncharacteristic of the person
2. Gradual change in behavior indicative of gradual deterioration
3. Erratic work habits and poor work attitude
4. Increased sick time due to minor problems and frequent colds
5. Inability to concentrate, impaired memory, or impaired reading comprehension
6. Excessive worrying and feelings of inadequacy
7. Excessive use of tobacco, alcohol, or drugs
8. Peers, family, & others begin to avoid the person because of attitude/behavior
9. Excessive complaints (negative citizen contact or family member complaints)
10. Not responsive to corrective or supportive feedback
11. Excessive accidents or injuries due to carelessness or preoccupation
12. Energy extremes: no energy or hyperactivity
13. Sexual promiscuity or sexual disinterest
14. Grandiose or paranoid behavior
15. Increased use of sick leave for "mental health days"

Excessive stress can be expressed in physical or psychological symptoms, including:

Muscle tightness/migraine or tension headache
Clenching jaws/grinding teeth or related dental problems
Chronic fatigue/feeling down or experiencing depression
Rapid heartbeat/hypertension
Indigestion/nausea/ulcers/constipation or diarrhea
Unintended weight loss or gain - changes in appetite
Cold and sweaty palms which is not normal for the person
Nervousness and increased feelings of being jittery
Insomnia or sleeping excessively – strange dreams or nightmares
In extreme cases – psychotic reactions/mental disorder

Examples ð

1. From cheerful and optimistic to gloomy and pessimistic.
2. Gradually becoming slow and lethargic, increasing depression.
3. Coming to work late, leaving early, sick time abuse.
4. Rambling conversation, difficulty in sticking to a specific subject.
5. Lack of participation in normally enjoyed activities.

Stress Management There are various effective stress management strategies. Stress management strategies can be as simple as making minor adjustments in your diet, and as complex as implementing major life changes. Stress management includes:

Renegotiating your life: There is no substitute for renegotiating and changing a stressful lifestyle. Renegotiating lifestyle frequently requires reassessing personal values, resetting personal boundaries, disputing irrational thoughts, discontinuing dysfunctional behavior, and increasing healthy activities (such as physical exercise).

Breathing exercises: Controlled, intentional, diaphragmatic, and rhythmic breathing have been used as a means to manage stress for as long as there has been recorded history. The utility of controlled breathing has been well-demonstrated across many personal and occupational environments, including marriage and family relationships, policing, firefighting, and the military. Relaxation breathing is likely the most effective low-effort/high-benefit relaxation strategy available.

Meditation: Meditation has been used since antiquity to train the mind, alter consciousness, and to induce relaxation. There are many forms of meditation.

Relaxation training: Relaxation training involves learning how to induce physical and psychological relaxation. There are many variations of relaxation training including progressive muscle relaxation, tense-release muscle relaxation, and whole-body relaxation. Mental imagery, directed scenarios, cognitive coping statements, and other-sense imaginations are frequently a component of relaxation training.

Massage and Manipulation: Manipulation of muscles and nerves for relaxation.

Body scan: Body scanning is a relaxation technique wherein a person mentally scans his or her body and learns to identify tension areas within the body. Once the area of tension is identified, relaxation skills are applied so that the tension is reduced and a greater degree of overall relaxation is achieved.

Biofeedback: In biofeedback, instruments are used to measure specific physiological activity known to be associated with stress. These measurements comprise the "feedback" that is then used to direct relaxation efforts or other desired physiological changes. The physiological measures of biofeedback include brain wave activity, muscle tension, heart rate, heart beat interval, respiration rate, blood pressure, blood flow, extremity temperature, and electrodermal conductivity. By learning to appropriately influence one or more of these physiological measures, overall stress levels can be reduced. Biofeedback may be applied in the treatment of several medical conditions as well as to induce relaxation.

Hypnosis: Hypnosis is a trance-like state in which you have heightened focus and concentration (Mayoclinic.com). The hypnotic state can be induced in another person by a therapist (hypnotherapy) or it can be self-induced (self-hypnosis). Many persons find hypnosis useful as a stress management tool. This is due to the focused and relaxed state inherent in the hypnotic induction and process. Hypnosis also has a show business history. When used for entertainment, hypnosis it is called "stage hypnosis".

For more information about stress, stressors, police occupational stress, and stress management see *Some Things to Remember* and Chapter 3 of *Reflections of a Police Psychologist*.

Critical Incident Information

Critical incidents:

are often sudden and unexpected
disrupt ideas of control and how the world works (core beliefs)
feel emotionally and psychologically overwhelming
can strip psychological defense mechanisms
frequently involve perceptions of death, threat to life, or involve bodily injury

Perceptual distortions possible during the incident:

slow motion
fast motion
muted/diminished sound
amplified sound
slowing of time
accelerated time
dissociation
tunnel vision
visual illusion
heightened visual clarity
automatic pilot
memory loss for part of the event
memory loss for part of your actions
false memory
temporary paralysis
vivid images

Possible responses following a critical incident:

heightened sense of danger
anger, frustration, and blaming
isolation and withdrawal
sleep difficulties
intrusive thoughts
emotional numbing
depression and feelings of guilt
no depression and feelings of having done well
sexual or appetite changes
second guessing and endless rethinking of the incident
interpersonal difficulties
increased alcohol or drug use
grief and mourning

Factors affecting the magnitude of traumatic response:

Person variables – personality, view of reality, personal history, beliefs and aforethought, assessment of self performance, perception of alternative options, coping abilities, degree and result of stress management and stress inoculation training.

Incident variables – proximity, sudden or planned, blood and gore, age of others, personal history of suspects involved, suspect or others behavior, accompanied by other officers at time of incident, other officers involved, actual circumstances of the event.

Traumatic Stress: Shock, Impact, and Recovery

Various researchers have identified several predictable responses to traumatic events. These responses can be reduced to three principle phases: *shock*, *impact*, and *recovery*. This pattern of response is often observed following exposure to a critical incident. The shock, impact, and recovery response pattern can vary in intensity and duration, and is commonly seen within the experience of *posttraumatic stress* and *posttraumatic stress disorder*.

Shock—psychological shock (P-shock) is often the initial response to a traumatic incident. (The symptoms of physical shock, more precisely called *circulatory shock*, may also be present. Circulatory shock is a life-threatening medical condition and requires immediate medical attention). P-shock is comprised of a host of discernable reactions including denial, disbelief, numbness, giddiness, bravado, anger, depression, and isolation. P-shock reactions, although common following trauma, are not limited to trauma. P-shock can occur in response to any significant event. Football players who have just won the Super Bowl frequently respond to questions from sports interviewers by saying, "I can't believe it" (disbelief) or "It hasn't sunk in yet" (no impact).

Impact—after the passage of some time, the amount of time differs for different people, there is impact. Impact normally involves the realization that "I could have been killed" or "This was a grave tragedy." These thoughts and the feelings that accompany them can be overwhelming. Officers should never be returned to full duty while they are working through any overwhelming impact of a traumatic incident. Police agencies should have policy directives which provide for administrative or other appropriate leave until an experienced police psychologist evaluates and clears the officer for return to duty.

Recovery—recovery does not follow impact as a discreet event. Instead, with proper support and individual processing, impact slowly diminishes. As impact diminishes, recovery begins. A person can experience any degree of recovery. No or little recovery can result in lifetime disability. Full recovery involves becoming stronger and smarter, disconnecting the memory of the incident from any enduring disabling emotional responses, and placing the incident into psychological history. Without recovery, persons remain *victims* of trauma. With recovery, they become *survivors*.

<u>Posttraumatic Stress (PTS)</u> - expected and predictable responses to a traumatic event. PTS normally resolves within one month of the incident through the person's self-management and personal psychological resources. External psychological and emotional support systems are also of great value for the resolution of PTS. Clinically significant impairment is absent in PTS.

<u>Posttraumatic Stress Disorder (PTSD)</u> - a constellation of clinical symptoms which meet the specific criteria for the PTSD diagnosis (including clinically significant impairment). PTSD requires professional treatment to produce the most positive possible outcome. PTSD is often accompanied by a degree of *depression*.

Trauma: Chronological History and Psychological History

Officers who have experienced traumatic events want to place the incident behind them and move on. The difficulty for many officers is that the incident continues to impact their lives in less than desirable ways. This is because the incident, while in c*hronological history*, is not yet in *psychological history*. The incident is in chronological history the instant that it is over. However, this is not the case with psychological history. When thoughts and other stimuli associated with the incident evoke powerful distressing responses following the incident, the incident is not in psychological history.

Placing the incident into psychological history involves disconnecting the memory of the incident from the gut-wrenching or negative emotional responses experienced during or immediately following the incident. When an incident is in psychological history, conditioned responses are minimized. Thoughts of the incident may produce emotional responses, but they will not be disabling. The person will be able to move forward, no longer being psychologically stuck in the incident.

A major component of traumatic incident recovery is placing the event into psychological history.

The ability to place experiences into psychological history is also important in everyday life. This is especially true of functional interpersonal relationships. In functional interpersonal relationships persons are able to emotionally move beyond the memory of minor transgressions and prevent such memories from continually exerting an undesirable influence on the relationship.

According to psychologist Albert Ellis, PhD (1913-2007), author of *Rational-Emotive Behavioral Therapy* (REBT) there are 12 primary irrational ideas that cause and sustain psychological difficulty. Irrational idea number 9 is presented here because of its relevance to "placing the event into psychological history" and as a reminder of what can be accomplished:

REBT Irrational Idea Number 9: *The idea that because something once strongly affected our life, it should indefinitely affect it* – Instead of the idea that we can learn from our past experiences but not be overly-attached to or prejudiced by them.

Ellis, A. (2004). *Rational Emotive Behavior Therapy: It Works for Me--It Can Work for You*. Amherst, NY: Prometheus Books.

How to Recover from Traumatic Stress

1. Accept your emotions as normal and part of the recovery/survival process.
2. Talk about the event and your feelings.
3. Accept that you may have experienced fear and confronted your vulnerability.
4. Use your fear or anxiousness as a cue to utilize your officer safety skills.
5. Realize that your survival instinct was an asset at the time of the incident and that it remains intact to assist you again if needed.
6. Accept that you cannot always control events, but you can control your response.
7. If you are troubled by a perceived lack of control, focus on the fact that you had *some* control during the event. You used your strength to respond in a certain way.
8. Do not second-guess your actions. Evaluate your actions based on your perceptions at the time of the event, not afterwards.
9. Understand that your actions were based on the need to make a critical decision for action. The decision likely had to be made within seconds.
10. Accept that your behavior was appropriate to your perceptions and feelings at the time of the incident. Accept that no one is perfect. You may like/dislike some actions.
11. Focus on the things you did that you feel good about. Positive outcomes are often produced by less than perfect actions.
12. Do not take personally the response of the system. Keep the needs of the various systems (DA's office, administrative investigation, the press, etc) in perspective.

Remember, police critical incidents happen because you are a police officer and there are circumstances beyond your control, not because of who you are as a person.

Positive Recovery – keep in mind that you are naturally resilient.

1. You will accept what happened. You will accept any experience of fear and any feelings of vulnerability as part of being human. Vulnerability is not helplessness.
2. You will accept that no one can control everything. You will focus on your behaviors and the appropriate application of authority. You will keep a positive perspective.
3. You will learn and grow from the experience. You will be able to assess all future circumstances on their own merits. You will become stronger and smarter.
4. You will include survivorship into your life perspective. You may re-evaluate life's goals, priorities, and meaning. You will gain wisdom that can come from survivorship.
5. You will be aware of changes in yourself that may contribute to problems at home, work, and other environments. You will work to overcome these problems.
6. You will increase the intimacy of your actions and communications to those you love. You will remain open to the feedback of those who love you.

Getting Help

No one can work through the aftermath of a critical incident for you, but you do not have to go it alone. Keep an open mind. Allow your family, friends, and peers to help. Seek professional assistance if you get stuck, if you do not "feel like yourself" or if your friends or family notice dysfunctional emotional responses or behavior. Do not ignore those who care about you. Stay connected to your loved ones.

This page adapts and includes information from the Colorado Law Enforcement Academy Handbook and *Reflections of a Police Psychologist* (Digliani, J.A., 2010).

Suggestions for Supporting Officers Involved in Shootings and Other Trauma

The following "Suggestions for Supporting Officers Involved in Shootings and Other Trauma" were written by Alexis Artwohl and published in her book, *DEADLY FORCE ENCOUNTERS*, co-authored by Loren Christensen (1997) (reprinted with permission). The thoughts and comments of Jack A. Digliani are represented in italics (added with permission).

1. Do initiate contact in the form of a phone call or note to let a traumatized officer know you are concerned and available for support or help (don't forget to acknowledge their significant others). In the case of a shooting, remember that the non-shooters who were at the scene are just as likely to be affected by the incident as the shooters. Remember that there are many other events besides shootings that traumatize cops. When in doubt, call. *Do not fall into the trap that so I donõt have to.ó Your expressions of support overly persistent or intrusive.* *Avoid becoming*

2. Offer to stay with a traumatized officer/friend for the first day or two after the event if you know they live alone (or help find a mutual friend who can). Alternatively, you could offer for the officer to stay with you and your family. *This type of support for an officer living alone can be quite beneficial for the first few days following a traumatic incident.*

3. Let the traumatized officer decide how much contact he/she wants to have with you. They may be overwhelmed with phone calls and it may take a while for them to return your call. Also, they and their family may want some "down time" with minimal interruptions. *As in the past, the Peer Support Team (PST) will continue its efforts to advise others through email or other appropriate means when involved officers need a communication hiatus.*

4. Don't ask for an account of the shooting, but let the traumatized officer know you are willing to listen to whatever they want to talk about. Officers may get tired of repeating the story and find "curiosity seekers" distasteful. Be mindful that there is usually no legally privileged confidentiality for peer discussions. *A privileged communication relationship does exist between officers and certain others including psychologists, attorneys, licensed or ordained clergy members, spouses, physicians, and other licensed or supervised mental health professionals. In Colorado, members of a law enforcement or fire department peer support team are protected from testifying without consent under the provisions of C.R.S. 13-90-107(m), however this protection is limited and does not apply to òinformation incriminative of conduct.ó PST member confidentiality under C.R.S. 13-90-107(m) does not include protection against being compelled to testify in federal courts. PST members are ethically responsible for specifying the limits of confidentiality protections prior to engaging in any peer support interactions.*

5. Ask questions that show support and acceptance such as, "Is there anything I can do to help you or your family?" *In some cases where the pre-existing relationship will support it, just doing instead of asking is appropriate.*

6. Accept their reaction as normal for them and avoid suggesting how they "should" be feeling. Officers have a wide range of reactions to traumatic events. *If part of their reaction includes thoughts or feelings of homicide or suicide, or should you observe behaviors consistent with the C.R.S. 27-65-102, you should immediately contact the PST or take other appropriate action.*

7. Remember that the key to helping a traumatized officer is nonjudgmental listening. *Just listening without trying to solve a problem or imposing your views can go a long way to support traumatized officers.*

8. Don't say, "I understand how you feel" unless you have been through the same experience. Do feel free to offer a BRIEF sharing of a similar experience you might have had to help them know they are not alone in how they feel. However, this is not the time to work on your own trauma issues with this person. If your friend's event triggers some of your own emotions, find someone else to talk to who can offer support to you. *It's worthwhile to keep in mind that frequently perceive a critical incident in a somewhat unique way. However, there is enough overlap in our experiences to allow us to relate to some degree to the experience of the involved officers. A good rule to follow: If the involved officer asks you a question about your experience or how you handled a past incident, respond fully to the question, then re-focus on the officer. If additional questions are asked, respond in a similar fashion...the officer is requesting more information from you. Your responses are likely to normalize the feelings, thoughts, and behaviors which may be new or strange to the officer. Keep your responses concise and talk in plain language. Do not get stuck in your own unresolved issues. The last thing an officer who has experienced a critical incident needs is to become your therapist.*

9. Don't encourage the use of alcohol. It is best for officers to avoid all use of alcohol for a few weeks so they can process what has happened to them with a clear head and true feelings uncontaminated by drug use. *Remember, alcohol is a behavioral disinhibitor in small dosages and a central nervous system depressant in larger quantities. It is best not to be affected in either of these ways when attempting to process a traumatic event. Additionally, in order to avoid over stimulation and symptoms of withdrawal, caffeine intake should remain close to normal. Caffeine is a diuretic and vasoconstrictor. It's stimulant pr can cause a jittery feeling. Even small amounts of caffeine can interfere with sleep onset and maintenance in those not accustomed to it. Excessive amounts can result in caffeine intoxication. Bottom line: Officers should stay within their normal limits of caffeine consumption.*

10. Don't "congratulate" officers after shootings or call them names like "terminator" or otherwise joke around about the incident. Officers often have mixed feelings about deadly force encounters and find such comments offensive. *Mixed emotional responses can include feelings of elation that the officer survived the incident and performed well, while at the same time realizing that he or she had to injure or kill another person in order to survive. Mixed feelings, along with a heightened sense of danger, are two of the most common after-effects of shooting incidents.*

11. Offer positive statements about the officers themselves, such as, "I'm glad you're O.K." *Traumatic incidents frequently bring forward emotions and thoughts not present in everyday living. Making positive statements demonstrates support and caring. This frequently helps officers deal with the issues inherent in traumatic experiences.*

12. You are likely to find yourself second-guessing the shooting, but keep your comments to yourself. Critical comments have a way of coming back to the involved officer and it only does harm to the officer who is probably second-guessing him/herself and struggling to recover. Besides, most of the second-guessing is wrong anyway. *Keep in mind that the best anyone can do is to make reasonable decisions based upon perceptions and the information available at the time. No one really knows what it was like for a particular officer to be involved in a particular incident. Saying such things as ò I wsohuel)d shhaovue l ddl ohmæ vé eó dbor n e almost always damaging. Remember that* <u>*every cop, every day*</u> *makes decisions based on limited and sometimes inaccurate information.*

13. Encourage the officers to take care of themselves. Show support for such things as taking as much time off as they need to recover. Also encourage the officer to participate in debriefings and counseling. *Officers involved in shootings and other serious critical incidents are engaged in debriefings and counseling as specified by department policy. Remember, employees may, at any time, seek confidential assistance from the staff psychologist, the PST, or the Employee Assistance Program for any intensity event or ongoing stressor. To access the names of PST members contact Dispatch.*

14. Gently confront them about negative behavioral and emotional changes you notice that persist for longer than one month. Encourage them to seek professional help. *A general rule of confrontation: confront to the degree that the underlying relationship will support. In other words, if done in a caring way, the closer you feel to a person, the more you can confront without jeopardizing the relationship or creating harm. If this rule is followed, the likelihood of the officer responding positively to the confrontation is maximized.*

15. Don't refer to officers who are having emotional problems as "mentals" or other derogatory terms. Stigmatizing each other encourages officers to deny their psychological injuries and not to get the help they need. *Getting through critical incidents is hard enough. We do not need to make it more difficult on each other by derogatory labeling. This includes general attitudes communicated in everyday speech as well as specific comments following a particular event.*

16. Educate yourself about trauma reactions by reviewing written materials or consulting with someone who has familiarity with this topic. *The staff psychologist and PST have several handouts and other material which can assist you in learning more about trauma and traumatic responses. Contact any member of the PST to obtain this information.*

17. Officers want to return to normality as soon as possible. Don't pretend like the event didn't happen but do treat the traumatized officers like you always have. Don't avoid them, treat them as fragile, or otherwise drastically change your behavior with them. *It is normal for officers who have been through a traumatic experience to become a bit more sensitive to how others act toward them. This increased sensitivity is usually temporary. You can help the involved officer work through this sensitivity as well as larger aspects of the incident aftermath by just being yourself.*

18. Remember that in this case, your mother was right: If you don't have anything nice to say, don't say anything at all". *In the final analysis, we cannot know which side of a critical incident we will find ourselves: an officer looking to others for support or an officer attempting to provide support. Our strength and defense lies in how we treat each other.*

Critical Incident Management and Return to Duty Protocol

Preparation and Stress Inoculation Training: Officers should receive instruction in agency procedure & critical incident stress inoculation, and participate in the *Psychologist And Training/Recruit Officer Liaison* (PATROL) program prior to working independently (See *Reflections of a Police Psychologist*, Chapter 2, *Field Training and PATROL*, 2010. Digliani, J.A.).

Concept of *second injury* - *s*econd injury occurs when an officer is treated poorly following a critical incident, even if unintentionally. Second injury is especially likely if the poor treatment comes from his or her department. Remember, you don't have to intend harm to do harm.

1. Remove from scene/controlled environment/away from suspect's family/not isolated/gatekeeper and peer support (See *Officer-Involved Incident Protocol)*
   Officer notification of spouse, family/notification by policy if incapacitated
   On-scene support (peer support team, psychologist)/confidentiality
   Contact from top administrator (chief or sheriff). *Ongoing* admin/staff support
   Replacement of weapon (if taken as evidence) with like weapon/return of badge if clothing is taken and badge is not evidence/replacement badge if badge is taken as evidence
   Issues of officer blood sample – voluntary, probable cause, or policy
   Police vehicle considerations if vehicle is assigned
   Administrative leave pending processing of incident/press releases/telephone, email screening/officer and officer's family security
   Trauma Intervention Program – initiation into psychologist support program

2. Recognition of personal risk – recognition of officer's perceptions, conceptions, emotions, effort, and actions – appoint department contact officer
   Attorney for officer if requested without negative consequences for officer
   Clear distinction between criminal and administrative investigation: Miranda advisement? Garrity advisement?

3. Family involvement: spouse/children (immediate support, security, nature of incident, issues of vulnerability, peer reactions, work, school, released press information, extended family responses, etc)
   Prepare for possible negativity: press, segments of community, family members of suspect, other sources

4. Debriefing if appropriate, other support interventions if debriefing is unwarranted. Debriefing: voluntary, invitation of participants – consider support persons, dispatch personnel, other agency personnel/individual follow-up/peer support team member reach-out, timeframe (see *Guidelines for Conducting a Police Critical Incident Debriefing* and *Peer Support Team and Debriefing Issues*)

5. Expedite criminal and administrative investigations, district attorney, review boards, etc - expedite closure for involved officers

6. Consider scheduled court hearings and assigned off-duty work/evaluated on an individual case basis – Consider any other incident-specific factors

RETURN TO DUTY

1. Return to scene – often accompanied by investigators during walk-through, but need experiential perspective. Officer is accompanied by staff psychologist and experience is processed. Consider spouse or others if requested by the officer. *Caution considerations*: Issues of retraumatization or vicarious traumatization.

2. Firing range if shooting incident – shoot loaner gun if actual weapon is still held as evidence, shoot actual weapon when returned. Psychologist or PST member accompanies officer at firing range during weapon firing if needed. Otherwise, range experience psychologically and emotionally processed in later meeting with staff psychologist.

3. Officer Wellness Assessment (OWA) - conducted as part of the Trauma Intervention Program by the staff psychologist. The OWA is designed to determine the optimal timing for the initiation of the graded re-entry to duty (#4). (See *Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program*)

4. Graded re-entry – program design: modified duty (uniform/non-uniform), buddy officer partner (may be selected by involved officer from anywhere within the department, contacted by officer and/or psychologist), consider off-duty work and specialized assignments during reentry (normally restricted), alteration if needed as program progresses. Important that officer works the assigned shift during reentry. Upon successful completion the officer is returned to full duty. Throughout process: mechanism of *safety net*, periodic contact with psychologist and additional psychological support if necessary. Peer support.

5. Follow-up - scheduled appointment(s) subsequent to completion of graded re-entry. Timing and number of follow up appointments vary as deemed appropriate (for baseline follow up: after two, four, and eight weeks of full duty – beyond eight weeks as needed). Family members scheduled for appointments as needed. Year of *firsts*, peer support team and departmental reach-out. Peer support team member assigned (selected by involved officer) for one year.

TIP handout packet: (use additional as needed)

Critical Incident Information – page 22
Traumatic Stress: Shock, Impact, and Recovery-PTS/PTSD – page 23
How to Recover from Traumatic Stress – page 25
Some Things to Remember – page 46

Trauma Intervention Program

The Trauma Intervention Program (TIP) is comprised of several components designed to support and assess police officers exposed to potentially traumatic circumstances. Ideally, the first step in traumatic exposure management is previous training in stress management and stress inoculation, as well as participation in the PATROL program. However, whether or not an officer has received such training or participated in the PATROL program, the TIP is initiated following the exposure to a potentially traumatic incident.

The TIP is initiated within the conceptualization that it is the person/incident transaction which determines the degree, if any, of actual individual traumatization. It is possible for an officer to experience no appreciable traumatization following an event which would normally be considered a police "critical" or "traumatic" incident.

The TIP summarizes and includes elements of the *Critical Incident Management and Return to Duty Protocol*. It is primarily comprised of the following features which are implemented in situation-specific appropriate sequence:

1) previous stress management training and participation in PATROL
2) on-scene support
3) initiation into a counseling program
4) assessment and appropriate intervention
5) psychological visit to the incident location
6) firing range and processing
7) reintroduction to equipment
8) officer wellness assessment
9) graded re-entry to duty
10) appropriate follow-up

- On-scene support is provided by the peer support team and when necessary, the staff psychologist.
- The involved officers immediately become clients of the staff psychologist. This establishes the relationship necessary for privileged communication. A supportive counseling program is initiated.
- As part of the counseling support program the incident site is revisited and the events/location/actions are psychologically and emotionally processed. Timing is important. The site visit is conducted when assessed appropriate.
- If the incident involved the use of firearms, involved officers shoot a non-qualifying course of fire for the psychological experience of shooting. Following this, they shoot a qualifying course of fire. The psychologist accompanies the officer at the firing range if needed. The experience is processed.
- There is a reintroduction to equipment including firearms, sound of police radio traffic, uniform, police vehicle, and other work items or experiences associated with the incident.
- The TIP OWA is initiated. (See *Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program*)
- A graded re-entry to duty in the form of a *Return to Duty Protocol* is designed and implemented.
- Appropriate follow-up is arranged.

Mandated Counseling and Psychological Fitness for Duty Evaluation

At times it becomes necessary to mandate officers into counseling. If a police agency does not have a staff psychologist, a mental health professional outside the agency is utilized.

Mandating officers to counseling is appropriate when: (1) there are significant concerns about an officer's welfare or (2) there is a concern about an aspect of the officer's performance, and (3) it is thought that counseling will help the officer and (4) the officer refuses to seek counseling voluntarily. In cases of mandated counseling there is the hope that counseling, even if involuntary, will help the officer.

Mandated counseling programs are sometimes utilized in conjunction with officer *performance improvement plans*.

Ordering officers to counseling is different from ordering officers to undergo a psychological fitness for duty evaluation (FFDE). When an officer is ordered to counseling, the agency has concerns regarding the officer but normally there are minimal or no concerns about the officer's ability to continue working.

A psychological FFDE is ordered in cases where the agency has a concern about the officer's ability to continue working. This concern is related to the officer's perceived state of mental health and emotional stability. In mandated psychological FFDEs the privilege of confidentiality should be specified in order to establish officer informed consent. The evaluating psychologist then completes the evaluation and reports the findings to the police agency. Three determinations are possible: (1) the officer is psychologically fit for duty, (2) the officer is not psychologically fit for duty, or (3) the officer is not psychologically fit for full duty, but capable of working in some modified duty capacity. If officers are found psychologically fit for duty, they return to work. This finding may include a recommendation for ongoing counseling.

If officers are found psychologically unfit for duty, they are placed on leave and psychological intervention is initiated. Following treatment, they are reevaluated. If found fit for duty on reevaluation, they return to work. If reevaluated as unfit for duty, other options must be considered. Other options include additional therapy and subsequent reevaluation, additional therapy with modified duty and reevaluation, and occupational or total disability.

Fitness for duty circumstances can become complex. They can involve city retirement administrators, risk management, city personnel departments, opinions from other clinicians, police union representatives, insurance companies, property rights, attorneys, and the court system. The same is true if officers are found unfit for full duty but capable of working modified duty.

It is possible for officers to be mandated into counseling *and* ordered to undergo a fitness for duty evaluation, however, once ordered for a FFDE the officer must be placed on administrative leave. Any ordered FFDE completed within a mandatory counseling program must be completed at a time when it is most compatible with the counseling effort.

Fitness for Duty Evaluation, Officer Wellness Assessment, and the Trauma Intervention Program

The officer wellness assessment (OWA) associated with the Trauma Intervention Program (TIP) is different from a fitness for duty evaluation (FFDE). For the most part, officers undergo a FFDE following some identified problem. The problem that prompts a FFDE usually involves a perceived difficulty in the officer's state of mental health and emotional stability. Fitness for duty evaluations utilize one or several assessment instruments or "tests", performance and personnel records reviews, psychological and physical history review, clinical interview and assessment, and mental status examination.

FFDEs are conducted independently of any existing counseling program. This means that if an officer is in counseling, the psychologist (or therapist) that is providing counseling services does not complete the FFDE (even if qualified to do so). The reason for this is the ethical prohibition of *dual-relationships*. This prohibition is based upon the premise that a psychologist involved in a therapeutic relationship with an officer cannot be fully objective during a FFDE. Therefore, any FFDE of the officer must be completed by a second, independent, and qualified psychologist/evaluator.

In the OWA incorporated into the Trauma Intervention Program, the primary goal is to assess whether there is a newly developed incident-related clinical disorder that would prevent the officer from returning to duty (See *Stressor Related Disorders-DSM*). The OWA includes ruling out an incident-caused exacerbation of any preexisting psychological condition.

The primary goal of a TIP OWA assessment is made possible by the fact that the majority of officers involved in duty related critical or traumatic event were not experiencing psychological or performance difficulties prior to the incident. Therefore, most officers assessed in the TIP OWA come from a history of health, not a history of dysfunction. This, coupled with the fact that most officers perform professionally during critical incidents (in compliance with their training, state statute, and departmental policy), makes a FFDE unnecessary. Under these circumstances, any ethical concerns inherent in dual-relationship are managed without difficulty. This means that even if the officer has a counseling history with the staff psychologist, the staff psychologist may complete the OWA.

An officer should not be made to undergo a traditional FFDE simply because he or she performed as trained and as expected during a critical incident (See IACP below).

In the TIP OWA the staff psychologist completes a mental status examination, clinical interview and wellness assessment over several meetings with the officer. During this process, pre-incident psychological difficulties (if any) are assessed and sub-clinical psychological issues are addressed. In the TIP OWA psychological tests are used only when indicated and are not routinely applied.

TIP OWA: If there are no circumstances which would prevent the officer from returning to duty, the officer is returned to duty in accordance with the TIP and the specifically designed Return to Duty Protocol. If the TIP OWA suggests any type of

clinical impairment resulting from or triggered by the incident, continued psychological and any other appropriate intervention is indicated.

If during the TIP OWA there is an assessed need for a FFDE, the FFDE is completed by an independent evaluator. The results of the FFDE are then integrated into the TIP therapeutic effort, whether or not the officer is assessed as fit for duty.

The need for a traditional FFDE during the TIP has been the exception much more than the rule. The TIP OWA has proven itself completely adequate in an overwhelming majority of incident-related circumstances wherein the TIP has been initiated.

International Association of Chiefs of Police (IACP)

In their effort to continue to best serve the policing community, the IACP has defined "Psychological Fitness-for-Duty Evaluation" and provided guidelines for the use of FFDEs following an officer-involved shooting.

Psychological Fitness-for-Duty Evaluation Guidelines:

"A psychological FFDE is a formal, specialized examination of an incumbent employee that results from (1) objective evidence that the employee may be unable to safely or effectively perform a defined job, and (2) a reasonable basis for believing that the cause may be attributable to a psychological condition or impairment. The central purpose of an FFDE is to determine whether the employee is able to safely and effectively perform his or her essential job functions."

Officer-Involved Shooting Guidelines:

"It should be made clear to all involved personnel, supervisors, and the community at large that an officer's fitness-for-duty should not be brought into question by virtue of their involvement in a shooting incident. Post-shooting psychological interventions are separate and distinct from any fitness-for-duty assessments or administrative or investigative procedures that may follow. This does not preclude a supervisor from requesting a formal fitness-for-duty evaluation based upon objective concerns about an officer's ability to perform his or her duties. However, the mere fact of being involved in a shooting does not necessitate such an evaluation prior to return to duty."

From: www.theiacp.org

Stressor Related Disorders ðDSM

There are several stressor-related disorders identified in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Most police officers are familiar with *posttraumatic stress disorder* but are unaware that there are other psychological responses associated with stressors.

Never self-diagnose. Police officers should contact a professional clinical resource with any questions or concerns about stressors and stressor related disorders.

Adjustment Disorder

- with depressed mood
- with anxiety
- with mixed anxiety and depressed mood
- with disturbance of conduct
- with mixed disturbance of emotions and conduct
- unspecified

Acute Stress Disorder

- symptoms present for at least 3 days but no longer than 1 month

Posttraumatic Stress Disorder

- duration of symptoms for more than 1 month
- with dissociative symptoms
- with delayed expression – symptoms appear 6+ months following the incident

Posttraumatic Stress Disorder for Children 6 years and younger

Other Specified Trauma-and Stressor-Related Disorder

- Persistent complex berevement disorder

Unspecified Trauma-and Stressor-Related Disorder

Conversion Disorder (Functional Neurological Symptom Disorder)

- psychological stress is "converted" into a physical symptom
- the symptom or deficit is not better explained by another recognized medical or DSM disorder (various subtypes)

Brief Psychotic Disorder

- duration of symptoms of at least 1 day but less than 1 month
- with or without marked stressor(s)
- with postpartum onset –onset within 4 weeks postpartum
- with catatonia

Associated Mood Disorders

- mood disorders that may co-exist with stressor related disorders (various anxiety and depressive disorders)

Additional DSM information can be found online at: www.DSM5.org

Issues, Strategies, and Concepts

Peer Support Considerations

When attempting to assist persons dealing with traumatic or stressful circumstances, peer support team members should consider the following. These issues, strategies, and concepts should be used when appropriate and in conjunction with the support skills of the *Stage Model of Peer Support*.

- shock, impact, recovery
- concept of 2nd injury
- vicarious or "secondary" trauma
- retraumatization
- splitting of environments
- fear vs helplessness vs vulnerability
- role of reinforcement/conditioning
- Popeye philosophy
- second-guessing paradigm
- chronological history and psychological history
- the walk and talk
- surface lesson/deep lesson
- options funnel vs threat funnel
- the 2 and 2 - "I know what this is, I know what to do about it" and "stronger and smarter"
- survivorship vs victimization
- resiliency and recovery
- stay grounded in what you know to be true
- having the right vs is it right
- I'm in trouble vs I'm alive
- PTS vs PTSD
- intervention as the 2nd best option – best option: time machine
- clinical supervision
- involvement of professional counseling services
- peer support in conjunction with professional counseling

SPA and helpful PST Information

- If you are not being used or feel underutilized as a peer support team member, increase your **Self-initiated Peer support Activity (SPA**). SPA activities include shift-briefing presentations, follow-up contacts, and new reach-outs.

- Police authority in America is intentionally limited. American society accepts a margin of risk for law enforcement officers. This influences the public acceptability of particular police tactical behaviors.

- *Every cop, every day* makes decisions based upon limited and sometimes faulty information. This information is interpreted through many filters including police training, current circumstances, and each officer's personal history of experience. This is a major factor in post-traumatic incident *second guessing*.

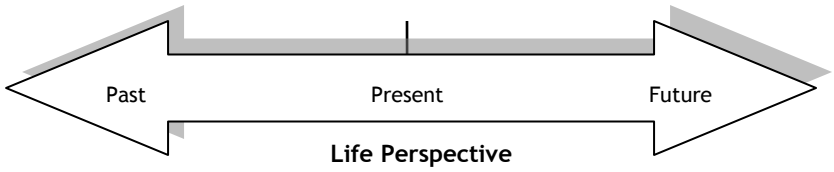
Life Management: Life by Default ðLife by Design

Life management can be considered from one of two primary life perspectives: *life-by-default* and *life-by-design*. These perspectives are conceptual constructs and describe a continuum along which a person can engage life. It is unlikely that anyone lives life totally by default or by design. Most people live sometimes or most times by default, and sometimes or most times by design. Life-by-default differs from life-by-design in that life-by-default is what you get if you do not practice life-by-design. Not much thought or effort goes into life-by-default. Persons who are oriented toward life-by-default often feel powerless. They subscribe to the "This is my life. What can I do about it? It is what it is. What will be, will be" life position. This is very different from the life-by-design philosophy of "taking life by the horns." Life-by-default does not mean that life experiences are or will be undesirable. Quite the contrary, life experiences can default to very desirable circumstances. It is a matter of probability. The probability that life will default to something great and wonderful is less than the probability of desirable outcomes in life-by-design.

Life-by-design is best described by a single word: *intention*. Persons oriented toward life-by-design act intentionally and accept responsibility for their decisions and behaviors. Life-by-design persons are not passive observers of life. They do not wait for life to simply unfold. They feel empowered and they act in ways to direct their lives. In life-by-design there is no illusion that all things can be directed, controlled, or even influenced. Instead, there is respect for what might be changed and what must be accepted. There is recognition of the influence of personal values, societal values, and cultural influences.

Life-by-design persons do not blindly accept the values of their childhood. They consider all values, adopt those that are appropriate for them, and live accordingly.

Life-by-design is thoughtful, mindful. To engage life-by-design, persons must accept reasonable risk, endorse the idea that they can decide many things for themselves, and use this knowledge to make a difference in their lives. Making an effort to accomplish this is the first step toward moving from a life-by-default to a life-by-design and a functional life perspective.



A functional life perspective draws from the past (mindful of consequences and lessons learned) while maintaining a view of the future (potential for actualization).

Issues of Behavior, Change, and Communication

Remain mindful of your body language and what you communicate nonverbally. Nonverbal behaviors speak loudly, forcefully, and continuously.

Work on *your* issues — trust others (family members, peers, etc) to work on theirs.

Mindfulness vs Obsession. Remind yourself of the changes that you wish to make and maintain. You do not need to obsess about desired change but you must remain mindful. Take yourself seriously when attempting to implement change. Change is unlikely if your effort to change is too casual.

When dealing with others, decide what is negotiable. Where is your flexibility? Consider couples and group goals. If you agree to participate in a goal or activity that is not your personal preference, you accept the responsibility to support it, or at the very least not gripe about it. Once you agree, be a good sport-try to have a good time.

Positive sentiment - Negative sentiment. Previous experience and existing emotion can influence current perceptions. Try to evaluate the communication of others in context and as it occurs. Do not get stalled by historical negative sentiment. Give others a second chance. *Look* for the positive in order to *experience* the positive.

You *can* change, you *can* do things differently. It may feel a bit strange at first but don't quit. Persistence and adaptation are skills to be learned.

When attempting behavior change, you are looking to influence one part of your brain (the automatic thinking and behavior part) with another part of your brain (the intentional thinking and behavior part). You can influence your brain in positive ways.

Communicate to Motivate

Communicating to motivate another person involves finding something positive to say or to do. It provides realistic acknowledgement and encouragement. You may still complain, provide feedback, and offer guidance, however communicating to motivate avoids the personal criticism which often decreases the effort of others.

Self-communication (self-talk). You can *communicate to motivate* with yourself! Talk to yourself in ways that avoid self-criticism. Find something positive in your effort.

Exemplary or good communication takes more effort than "short-cut" or poor communication. Moderated humor can be useful. Good communication is not always "all business"...it can be fun and enjoyable.

Ask appropriate questions to clarify confusion. Appropriate: *Can you help me to better understand your point of view?* Inappropriate: *Do you have anything sensible to add?* (This implies previous comments have not been sensible and is personally invalidating)

Listen without bias. Discuss differences. Accept influence. Negotiate. Compromise. Make choices and take responsibility. Decide. Decisions can be tentative and "experimental". Assess and reevaluate. Adjust if and when necessary.

Considerations for Change

- People can change.
- People do not change easily.
- Behavior is often related to reinforcement schedules.
- Behavior can be functional or dysfunctional.
- What is considered functional and dysfunctional behavior is dependent upon a system of values and specific cognitive conceptualizations.
- Thoughts that drive some behaviors may be considered functional or dysfunctional, and rational or irrational (with gradients of these variables).
- Many dysfunctional behaviors are learned and can be unlearned.
- In the change process, if the change is functional, ethical, and desired, it should be maintained. If the change is dysfunctional, it should be abandoned.
- Dysfunctional behavior is normally reinforced in some way (it meets some need). If you meet the need being met by dysfunctional behavior with more functional or acceptable behavior, the dysfunctional behavior will likely decrease or stop.
- The probability of change increases when there is a positive role model. Change is more likely to occur when the role model is respected or significant in some meaningful way.
- Support, peer support, and positive reinforcement aid the change process.
- The probability of change is enhanced with the enhancement of a person's self-esteem.
- Change is more likely as a person's competence and confidence increases.
- Change is complicated by untreated underlying mental disorders and/or substance addiction. Such conditions themselves can be a focus for change.
- When seeking to implement change, self-acceptance is important. The change process is enhanced when a person accepts who he or she is, while *simultaneously* targeting specific thoughts or behaviors for change.
- Do not underestimate the *potential* for change, the *possibility* of change, or the sometimes *difficulty* of change. However, keep in mind:

The *difficult* is not the *impossible*.

Burnout and Boreout: Signs and Symptoms

The concept of burnout has been in existence for many years. It was first conceptualized and named by psychologist Herbert Freudenberger in 1974. Burnout is used to describe "someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (Freudenberger, H.J.& Richelson, G.,1980, 13. *Burn out: the high cost of high achievement*. New York: Bantam Books). Burnout can occur in all areas of life, including work, marriage, family, sports, avocations, and hobbies.

Some Signs and Symptoms of Police Officer Burnout

- A sense of dread, "nervous" stomach before shift
- Fatigue – feeling tired most of the time, no energy
- Easy to anger, irritability, lack of tolerance, lack of interest
- Low self-esteem, feelings of low mood and depression
- Negative outlook on life, life meaninglessness, job meaninglessness
- A sense of being trapped, without options, "boxed in"
- Tension headaches, increased migraines, muscle aches
- Nervous stomach, eating and digestive disturbances
- Increased use of alcohol, nicotine, or other drugs
- Sleep disturbances , anxiety dreams or nightmares
- Sexual dysfunction: no desire, inability to perform, or hypersexuality
- Uncharacteristic negative behavior or "acting out"
- Lack of concern for behavior consequences
- Carelessness on the job, poor officer safety
- Increased citizen and family complaints
- Increased problems with coworkers and supervisors

Some Signs and Symptoms of Police Officer Boreout

Boreout is a term first used by Swiss management consultants Peter Werder and Philippe Rothlin to describe the feeling of being understretched at work. Boreout is the opposite of burnout. Persons that are bored out have lost interest in what they do and lack a sense of identification with their work. For officers, boreout can occur after the challenge of learning how to be a police officer diminishes, when they feel underemployed or underutilized, or upon being reassigned, transferred, or promoted (some officers will be overwhelmed by the demands of being reassigned, etc, others will not be challenged or have enough to do). To address boreout officers need to reevaluate their position, rewrite job descriptions, initiate new tasks and job functions, take on rewarding challenges, talk to supervisors to address assignment parameters, and expand job responsibilities. The answer to boreout is *creativity*.

Considerations for Coping with Police Burnout and Boreout

1. Withdraw – for a short time, take a break from the job
2. Rediscover – the values that first brought you to policing
3. Reengage – the job with rediscovered values and recreated parameters
4. Reclaim – your career, your marriage, and your life

Anger: Get Educated

Got a problem? Everyone gets mad sometimes. So how does one tell the difference between a bad day and chronic anger? Ask yourself or someone you are trying to help these questions:

1. Do you often find yourself irritable and annoyed?
2. Do you find that certain people or situations make you furious?
3. Are you often irritable and don't know why?
4. Do you often use obscenities in your speech or mind?
5. Do you often think of people who upset you in terms of "a—hole", "jerk' etc.?
6. Do you have trouble giving someone a genuine compliment?
7. When something goes wrong, do you generally blame someone else?

If you answered "yes" to any of these questions, you may have a chronic anger problem.

Steps to alleviate *Chronic Anger Syndrome*

- Awareness is the first step. You may or may not be angry for a good reason. Anger can be 90% history and memories.
- Disrupt anger. Count to 10, write a letter, go for a walk, etc. Channel anger into something positive. Do not allow anger to control you or cause you to engage in bad or negative behaviors.
- Relaxation. Learn to disrupt or alter your anger response. Practice deep breathing. If answering telephones makes you mad and you must answer telephones, use relaxation strategies to interrupt and terminate your anger response.
- Change your environment. If you find yourself getting angry when you do X, find some reasonable and acceptable alternatives to X.
- Try silly humor. Looking at things from a humorous point of view diffuses anger and keeps things in perspective.
- Solve problems. If certain events, circumstances, or people irritate you, deal directly with the situation in an *appropriately* assertive manner. If necessary, ask for the help of others to address or resolve the issue.
- Learn skills. In order to resolve a situation wherein you find yourself chronically angry you may need to learn new skills. If you cannot swim and you get angry every time your child asks you to take her swimming, you can deal with your anger by learning to swim. This would create a mutual activity that could prove enjoyable for both of you.

Jerry L. Deffenbacher, PhD. Colorado State University-Department of Psychology

Summary of De-escalation Strategies

1. Remain calm, try to stay in the "adult". Speak in a clear, concise manner. Remember you are trying to engage the adult in the other person. Avoid trigger words and profanity. Your goal is to increase your influence and voluntary compliance.

2. Assess initial and *ongoing* level of threat. Utilize the interview stance unless more protective positioning is warranted. Maintain the appropriate personal distance for the interaction. Arrange for assistance and backup if necessary.

3. Remain aware of your surroundings and options. This includes formulating an escape route to a cover position should it become necessary.

4. Communication: content-message-delivery. Delivery influences the message communicated via the content. Communication occurs within an environment or context. Practice engaged listening. Ask for the person's help to accomplish what you want. Use words like "we", "our", and "together". Explain the limits of police authority, follow-up with information about what you can do. Remain mindful of nonverbal behavior.

5. Provide acceptable options and alternatives within the present context. If possible, permit the person a face-saving way to resolve the issue, especially in the presence of family or friends. Keep cultural and ethnic differences in mind. Monitor your stereotypical preconceptions and feelings.

6. Unless intended, as in the use of the *short order*, try using an educational or informative approach in the place of an authoritative approach. Unless *duty-bound* to take action immediately, you can use the educational or informative approach. Remain professional. Communicate with respect. Be helpful and friendly to the degree possible. Be responsive. Avoid dishonesty. Follow through on what you say. Remember, you can always move to an authoritative approach if needed or if other strategies fail.

7. Acknowledge the emotional state of the person. Ask for their cooperation in allowing you to assist them. This increases the probability of successful problem resolution. A sense of humor can also go a long way but don't overdo It. Apologize if you're wrong or you make a mistake. Start over.

8. Proximics. Remain attentive to your personal spacing. Think: attention and psychological availability vs. apathy and intimidation.

9. Know yourself: what thoughts and beliefs are you bringing to the transaction? Perceptions, conceptualizations, core beliefs, and world views effect our interactions.

10. Tolerance within boundaries. Allow for psychological differences and various behaviors within acceptable boundaries. It's ok to allow some "blowing off steam".

11. Stay alert. You must be prepared to defend yourself or otherwise act immediately should circumstances warrant. In duty-bound circumstances, tactical options become the priority.

Warning Signs of Alcoholism ðInformation

1. Do you ever drink after telling yourself you won't?
2. Does your drinking worry your family?
3. Have you ever been told that you drink too much?
4. Do you drink alone when you feel angry or sad?
5. Have you ever felt you should cut down on your drinking?
6. Do you get headaches or have hangovers after drinking?
7. Does your drinking ever make you late for work?
8. Have you ever been arrested because of your drinking?
9. Have people annoyed you by criticizing your drinking?
10. Have you ever felt bad or guilty about your drinking?
11. Have you ever substituted drinking for a meal?
12. Have you tried to stop drinking or to drink less and failed?
13. Have you ever felt embarrassed or remorseful about your behavior due to drinking?
14. Do you drink secretly to avoid the concerns of others?
15. Do you ever forget what you did while you were drinking?
16. For women - Have you continued drinking while pregnant? (even small amounts)
17. For women - Have you continued drinking while breastfeeding? (even if only between feedings or in small amounts)
18. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
19. Have you ever had to take a drink while at work to feel better?
20. Do you feel shaky, unsettled, or sick if you do not have a drink for a few days?
21. Have you ever stockpiled alcohol to avoid anxiety about not having it available?
22. Do you hide alcohol to avoid the concerns of family or friends?
23. Do you plan activities to insure that alcohol is available?
24. Do you look for happy or sad occasions to justify drinking alcohol?
25. Has the availability and consumption of alcohol become an overriding concern?

Some Information About Alcohol

The earlier an individual begins drinking, the greater his or her risk of developing alcohol-related problems in the future.

Any alcohol use by underage youth is considered to be alcohol abuse.

A drink can be one 12-ounce beer, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled liquor.

The liver is the primary site of alcohol metabolism, yet a number of the byproducts of this metabolism are toxic to the liver and may cause long term liver damage.

The short-term behavioral effects of alcohol follow the typical dose-response relationship characteristic of a drug; that is, the greater the dose, the greater the effect.

Drinkers expect to feel and behave in certain ways when drinking. Expectations about drinking can begin at an early age, even before drinking begins.

Most people who use alcohol do so without problems. However, about 17 percent of alcohol users either abuse it or are dependent on it.

Any successful physiological treatment for alcoholism must also include a psychological component.

Children of alcoholics are more likely than children of nonalcoholic parents to:

- suffer child abuse
- exhibit symptoms of depression and anxiety
- experience physical and mental health problems
- have difficulties in school
- display behavior problems
- experience higher healthcare costs

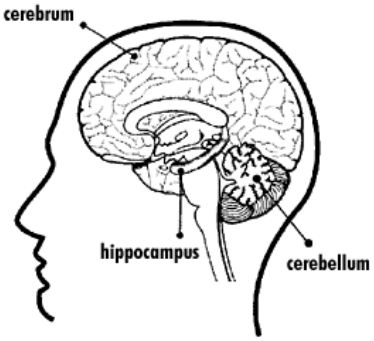
Biological (genetic) and psychosocial factors combine with environmental factors, such as the availability of alcohol, to increase the risk for developing drinking problems.

The perception of risk, risk taking, acting on impulse, and sensation-seeking behaviors are all affected by alcohol use.

Individuals who are intoxicated may misread social cues, overreact to situations, and not be able to accurately anticipate the consequences of their actions.

It has long been observed that there is an association between alcohol use and aggressive or violent behavior. Clearly, violence occurs in the absence of alcohol, and drinking alcohol alone is not sufficient to cause violence. However, numerous studies have found that alcohol is involved with about half of perpetrators of violence and their victims. This relationship holds across cultures and for various types of violence. In the United States, alcohol use is a significant factor in:

68 percent of manslaughter cases
62 percent of assault offenders
54 percent of murders
48 percent of robberies
44 percent of burglaries



Regions of the brain affected by alcohol

From: http://science.education.nih.gov/supplements/nih3/alcohol/guide/info-alcohol.htm

Some Things to Remember

When confronting change and managing stress there are some things that you can do that can help. Most of the following suggestions are self explanatory, some are not. This is because some of them are specialized and are most often used within the parameters of a specific counseling program.

Some Things to Remember

- Watch how you talk to yourself (relationship with self)
- Relaxation breathing-*breath through stress*-inhale nose/exhale mouth
- Maintain a high level of self-care, make time for *you*
- Keep yourself physically active, not too much too soon
- Utilize positive and appropriate coping statements
- Enhance your internal (self) awareness and external awareness
- Remember the limits of your personal boundary
- Practice stimulus control and response disruption
- Monitor deprivational stress and overload stress
- Use "pocket responses" when needed/consider oblique follow-up
- Apply thought stopping/blocking to negative thoughts
- Identify and confront internal and external *false messages*
- Confront negative thinking with positive counter-thoughts
- Break stressors into manageable units; deal with one at a time
- Relax, then engage in a graded confrontation of what you fear
- A managed experience will lessen the intensity of what you fear
- Only experience changes experience, look for the positive
- Reclaim your marriage; reclaim your career; *reclaim your life*
- Stressor strategies: confrontation, withdrawal, compromise (combination)
- Match coping strategy with stressor – the strategy must address the stressor
- Remember: transactions and choice points = different outcomes
- *Work*: do not forget why you do what you do (Occupational Imperative)
- Utilize your physical and psychological buffers
- Healing involves changes in intensity, frequency, and duration
- Use your shield when appropriate (psychological shield against negativity)
- Things do not have to be perfect to be ok
- Create positive micro-environments within stressful macro-environments
- Think of strong emotion as an *ocean wave*- let it in, let it fade
- Trigger anxiety— *I know what this is; I know what to do about it*
- Goal to become *stronger and smarter* (with the above = the 2 and 2)
- *Walk* off and *talk* out your anxiety, fears, and problems (walk and talk)
- Being vulnerable does not equal being helpless
- Enhance resiliency – develop and focus your innate coping abilities
- Develop and practice relapse prevention strategies
- Develop and utilize a sense of humor, learn how to smile
- Time perspective: past, present, future (positive – negative)
- Things are never so bad that they can't get worse
- Do not forget that life often involves selecting from imperfect options
- Access your power: the power of confidence, coping, and management
- Stay grounded in what you know to be true
- Keep things in perspective: keep little things little, manage the big things

Transactional Analysis
Concept Summary: Personality, Communication, and Pathology

Transactional Analysis (TA) is a theoretical framework first developed by Eric Berne, MD, in the 1950's. TA is an "ego state" psychology. It utilizes the idea of ego states to construct theories of personality structure, function, and development. In addition, TA is a model for interpersonal communication, social interaction, and psychopathology.

Fundamental Concepts of Transactional Analysis

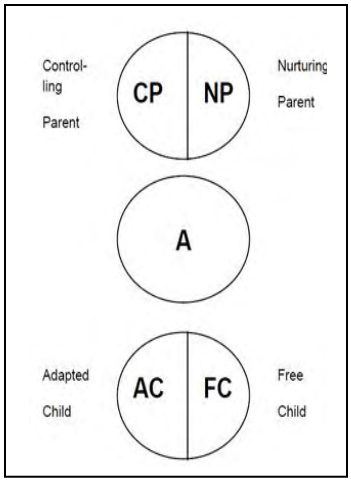
Ego state – a system of feelings accompanied by a related set of behavior patterns
Psychic energy – the theoretical force that energizes the various ego states
Executive power – the ego state with the most psychic energy has executive power
Stroke – the fundamental unit of social action (may be positive or negative)
Transaction – the basic unit of social intercourse (complementary, crossed, or ulterior)
Time structuring – withdrawal, rituals, activities, pastimes, games, intimacy
Games – complementary ulterior transactions leading to some payoff (see page 49)
Racket – strategy for getting "permitted" feelings while having feelings "not allowed"
Life script – beliefs that persons have about themselves and about the world
Life position – I'm ok-you're ok, I'm ok-you're not ok, I'm not ok-you're ok, I'm not ok-you're not ok (life position can influence the Games that are played)

The Ego States -There are three primary ego states: Parent, Adult, and Child

Parent: a state in which people behave, feel, and think in response to an unconscious mimicking of how their parents (or other parental figures) acted, or how they interpreted their parent's actions. For example, a frustrated person may shout at someone because they learned from an influential figure in childhood that this seemed to be a way of relating that worked. The Parent can be *controlling* or *nurturing*.

Adult: a state of the ego which is most like a computer processing information and making predictions absent of major emotions that could affect its operation. While a person is in the Adult ego state, he or she is directed towards an objective appraisal of reality.

Child: a state in which people behave, feel and think similarly to how they did in childhood. For example, a person who receives a poor evaluation at work may respond by looking at the floor, and crying or pouting, as they used to when scolded as a child. Conversely, a person who receives a good evaluation may respond with a broad smile and a joyful gesture of thanks. The Child is the source of emotions, creation, recreation, spontaneity, intimacy, resistance, and rebelliousness. The Child can be *adapted* or *free*.

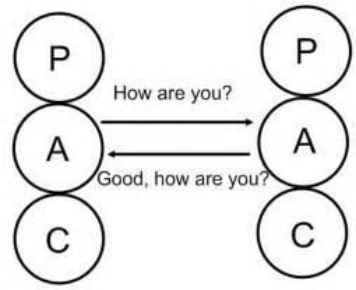


The ego states of TA

(http://en.wikipedia.org/wiki/Transactional_Analysis and J.A. Digliani)

Transactional Analysis Transactions – There are three primary types of transactions: Complementary, Crossed, and Ulterior.

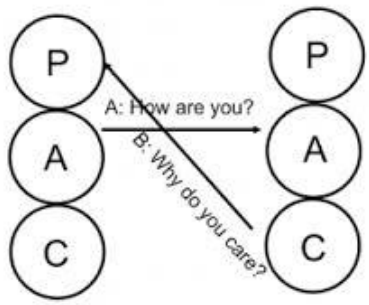
Complementary: In a complementary transaction, a person receives a stimulus in the ego state intended by the sender of the stimulus, ("How are you?" sent from Adult to Adult) and responds from this ego state to the originating ego state of the sender ("Good, how are you?" sent from Adult to Adult).



Adult-Adult Complementary Transaction

Complementary transactions can involve exchanges between any of the ego states. They are the simplest type of transaction.

Crossed: In a crossed transaction, an ego state different than the ego state which received the stimuli ("How are you" sent from Adult to Adult) is the one that responds ("Why do you care?" sent from Child to Parent).

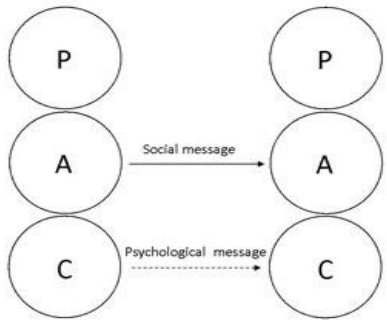


Adult-Child Crossed Transaction

Crossed transactions often result in a change of ego states for the participants. For example, Joe asks his supervisor, "What time is it?" (Adult-to-Adult). Joe's supervisor responds, "Stop worrying about the time and get back to work" (Parent-to-Child). Joe replies, "Yes, sir" (Child-to-Parent). Notice that Joe's last communication to his supervisor is a complementary transaction, Child to Parent. It is Joe's supervisor that crossed Joe's initial request for the time by responding from his Parent. Also notice that in this exchange, Joe does not learn the time of day. Their transactions are likely to end here.

Ulterior: In an ulterior transaction, there is a psychological message underlying the social message.

For example: Joe asks Mary, "Would you like to come over and listen to music?"(this is the social Adult-to-Adult message). Joe likes Mary and wishes to spend time with her. The hidden psychological Child-to-Child message in Joe's communication is *I would like to be alone with you*. Mary likes Joe and responds to his social message with one of her own, "Yes, I would love to come over and listen to music" (a seemingly Adult-to-Adult communication) but she accepts and responds to the psychological Child-to-Child message. Mary's psychological reply is, *I would like to be alone with you too!*



Ulterior Transaction

There are several variations of ulterior transactions but all involve social and psychological messages. Ulterior transactions are the most complex.

Rules of Communication in Transactional Analysis ðDrama Triangle

There are three rules of communication in Transactional Analysis:

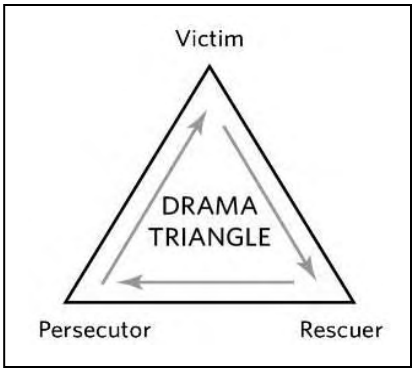
(1) So long as the transactions remain *complementary*, communication may continue indefinitely.
(2) Whenever the transaction is *crossed*, a breakdown (sometimes only a brief, temporary one) in communication results and something different is likely to follow.
(3) The outcome of transactions will be determined on the *psychological* level rather than on the *social* level.

Games

Games are an important component of Transactional Analysis (TA) theory. A game in TA is an "ongoing series complementary ulterior transactions progressing to a well-defined, predictable outcome. Descriptively, it is a recurring set of transactions…with a concealed motivation…or gimmick" (p.48, *Games People Play*). The Games of TA include: *Now I got you - you son of a bitch*, *See what you made me do*, *Schlemiel*, *Rapo*, and *Wooden leg*. All Games have an unconscious element and a payoff for the players. Berne identified over 100 games people play. Many Games can be readily understood in terms of the Drama Triangle.

Drama Triangle

The drama triangle is a psychological and social model of human interaction in transactional analysis first described by Stephen Karpman, MD, in 1968. The roles involved in the drama triangle game are identified as the Rescuer, the Persecutor, and the Victim. "Role switching" is common within the drama triangle.



The Rescuer - "Let me help you". The Rescuer takes responsibility for the well being of others. This often leads to others feeling that they cannot help themselves. In this way, they become Victims. The Rescuer keeps Victims dependent by making them feel that cannot get along without their Rescuer.

The Rescuer of the drama triangle is not the same as a person rescuing others during a disaster or in an emergency. The Rescuers of the drama triangle act out of an unconscious ulterior psychological need. The payoff for the Rescuer of the drama triangle is often an exaggerated sense of superiority and self-esteem, and a feeling of "What would they do without me".

The Persecutor - "It's all your fault". Persecutors normally start off as Rescuers or Victims. However, Rescuers are many times trying to rescue others that do not want to be rescued. When the act of rescue is rejected, the frustrated Rescuer becomes a Persecutor…"I'm trying to help, what's wrong with you!"

The Victim - "Poor me". Victims are sometimes helped by Rescuers when help is not needed or wanted. In reality, persons can become genuine victims, such as a victim of an assault or robbery. This is different from the Victim role of the drama triangle. In the drama triangle the Victim contributes to the game and receives some payoff. Victims surrender the responsibility for their well being to the Rescuer and either fail to confront the unwanted behavior of the Rescuer or seem to be ok with it. However, in the game of the drama triangle, Victims eventually persecute their Rescuers.

Like all complex games, drama triangles prevent psychological equality in relationships and can produce significant co-dependence. Transactional analyst Claude Steiner best described the dysfunction of the drama triangle: "…the Victim is not really as helpless as he feels, the Rescuer is not really helping, and the Persecutor does not really have a valid complaint" (Claudesteiner.com). Drama triangles will continue as long as someone is willing to be the Victim. The way to break the dysfunction of the drama triangle and other games is to deprive the players of the payoff.

Psychopathology

Contamination: personality difficulties arise when the Adult ego state becomes "contaminated" by either the Child ego state, the Parent ego state, or both. Such contamination can prevent accurate "real world" perception. According to TA, such contamination can produce psychological symptoms and otherwise impair healthy personal and social interactions.

Exclusion: individual ego states may become impermeable to the influence of the other ego states. When this happens, the affected ego state is said to be *excluded*.

The primary goal of TA therapy is to diminish contamination and exclusion, strengthen the Adult ego state, and end the dysfunction of Games.

Complexity of Transactional Analysis

This simplified view of Transactional Analysis does not capture the complexity and full utility of Transactional Analysis theory. Interested peer support team members that wish to learn more about Transactional Analysis are referred to the original works of Eric Berne and other prominent TA authors.

Application of the Transactional Analysis Conceptual Model in Peer Support

- Thinking in TA terms helps to keep you in your desired ego state
- TA provides a framework to understand the behavior of others
- TA provides a "way to think" in your life and a way to support others
- TA is not offensive – it does not pathologize
- A discussion of TA principles does not normally invoke defensiveness
- TA provides a framework for discussion of patterns of behavior
- TA supports plans of action and desired change
- TA lends itself well to "Immediacy"

Berne, Eric. *Games People Play*. Grove Press, Inc., New York, 1964.
Berne, Eric. *Transactional Analysis in Psychotherapy*. Grove Press, Inc., New York, 1961.
Harris, Thomas A. *I'm OK, You're OK*. Harper Row, New York, 1967.

Officer-Involved Incident Protocol ðGatekeeper

The *Officer-Involved Incident Protocol* was originally developed in 2005 and revised in 2012 by the various Larimer County, Colorado law enforcement agencies and the District Attorney's Office (Eighth Judicial District). The following text is quoted directly from the *Protocol* and specifies the role of gatekeeper when the *Protocol* is initiated.

GATEKEEPER RESPONSIBILITIES

If at all possible, gatekeeper responsibilities should be fulfilled by a supervisor.

- Ã Ensure compliance with sequestration responsibilities
- Ã Notify Peer Support Team if not already accomplished
- Ã Restrict access to involved officer to prevent contamination of possible trace evidence and communication about the incident.
- Ã Restrict physical contact with the involved officer by all parties until evidence processing of officer is completed by investigators. Family members, Peer Support Team members and command officers may be present but shall have no physical contact with the officer until evidence processing is completed.

Coordinate with Investigator/Crime Scene Team (CST) assigned to collect evidence from the officer.

- Ã Collect evidence from involved officer when requested by investigations supervisor (see Officer As a Crime Scene)
- Ã Coordinate replacement uniform or personal clothing if needed
- Ã Notify designated firearms officer for a replacement of officer's weapon.
- Ã Do not isolate the officer after physical evidence collection is completed. The officer should be allowed to move about freely.
- Ã Act as a conduit for information exchange between the officer and the investigative team. Keep the officer informed throughout the investigative process as to what is happening and what will happen in the future.
- Ã Work in concert with the assigned Peer Support Team member in order to accomplish peer support responsibilities (see "Peer Support Team") and protect the officer and family from unwanted intrusion.

Officer-Involved Incident Protocol ðPeer Support Team

The *Officer-Involved Incident Protocol* was originally developed in 2005 and revised in 2012 by the various Larimer County, Colorado law enforcement agencies and the District Attorney's Office (Eighth Judicial District). The following text is quoted directly from the *Protocol* and specifies the role of peer support team when the *Protocol* is initiated.

PEER SUPPORT TEAM

Overview

For agencies that maintain a peer support team, the team is part of a comprehensive response to an officer-involved incident.

The peer support team is comprised of personnel trained in peer support and functions under the supervision of the agency psychologist or other agency mental health professional (hereafter referred to as "psychologist").

The goal of the peer support team and agency psychologist is to minimize the likelihood of traumatization to the officer and his/her family.

Mission

The peer support mission is to provide the officer and family members with emotional and psychological support, stress management, and education. In addition, peer support team members help with trauma recovery, coping strategies to deal with the investigative process as it unfolds, issues surrounding the officer's response to colleagues and the media, and the facilitation of the officer's return to duty.

The interactions of persons engaged with members of the peer support team and the agency psychologist are confidential within the limits prescribed by agency policy and state statutes.

Responsibilities

The peer support team has the following responsibilities:

Ã Respond to the location where the officer is sequestered and coordinate with the officer assigned as gatekeeper to best meet the needs of the officer.

Ã Assist the officer by providing support to address any identified or perceived emotional or physical need.

Ã Help the officer to appropriately dissipate any heightened emotional and physical arousal. This may be accomplished by assisting the officer to process the intense emotional and physical reactions that are sometimes associated with critical incidents.

Ã Identify any signs of a complicated response which might indicate a need for support services or intervention beyond peer support.

- Facilitate notification, contact, and the needs of the officer's family.

- Minimize the possibility of "secondary trauma" (i.e. feeling traumatized not by the event but by the reactions of others to the event and the officer).

- Mentally prepare the officer for the investigative process and the eventual community response.

- Assist the officer in determining his/her psychological readiness for the walk-through of the crime scene.

- Assist the officer in any other way consistent with the mission and goals and of peer support.

- Assist the agency psychologist as needed to prepare the officer for return to duty (see attached "Critical Incident Management and Return to Duty Protocol").

Information

- Peer support serves a supportive function and does not interfere with the investigative process.

- Peer support team members that were directly involved in or witnessed the incident must not function or be utilized in a peer support role.

- Peer support team members, when functioning in their peer support role must not be assigned any investigative or evidentiary responsibilities.

- Peer support team members may be assigned gatekeeper responsibilities only when no other viable option exists and only when there are other peer support team members available to fulfill the responsibilities specified for the peer support team.

- The agency psychologist or a peer support team member designated by the agency psychologist should coordinate the timing of any critical incident group debriefing with criminal investigators so that the efficacy of the debriefing and the integrity of the investigation are not compromised.* (see INVESTIGATIVE SUPERVISOR RESPONSIBILITIES)

Peer support teams function within the parameters of agency-specific policy and operational guidelines.

******Author's note:* The long-standing practice of conducting a debriefing within 72 hours of a critical incident is no longer thought to be essential in order to derive any possible debriefing benefits. Debriefings may be conducted with greater timeframe flexibility when deemed appropriate. (See *Guidelines for Facilitating a Police Critical Incident Debriefing* and *Peer Support Team and Debriefing Issues* for current debriefing concerns.)

Other *Officer-Involved Incident Protocol* information that is important for peer support team members to know:

(1) In the section titled "THE POLICE OFFICER INVOLVED"

- Ã Peer support personnel who are not involved in the incident or its investigation will be made available to you

(2) In the section titled "SUPERVISOR AT THE SCENE"

Move involved officer from scene

- Ã Arrange transport to a pre-designated location by a non-involved supervisor or officer
- Ã Assign personnel to serve as the gatekeeper as it relates to access to the involved officer until relieved (see Gatekeeper Responsibilities)
- Ã Sequester involved officer(s) with non-involved peer support officer until investigative interviews
- Ã Involved witness officer(s) should not talk among themselves

(3) In the section titled "INVESTIGATIVE SUPERVISOR RESPONSIBILITIES"

Coordinate with Peer Support Team

- Ã The primary objectives of coordinating with the peer support team are: (1) meet the highest standards of incident investigation, and (2) enhance the welfare of involved employees through peer support.
- Ã If a critical incident group debriefing is deemed appropriate by the agency psychologist, expedite investigative interviews so that involved employees that wish to participate in the debriefing may do so without concern of incident investigators.
- Ã Contact the agency psychologist or peer support team coordinator should any conflict arise between the responsibilities of incident investigators and the efforts or goals of the peer support team.

The information included in the Larimer County, Colorado *Officer-Involved Incident Protocol* may be useful to out-of-county agencies planning to develop similar protocols and/or interventions.

Peer Support Team
Limits of Confidentiality - Debriefing

Debriefing Statement for Police Peer Support Team Members

Read the following paragraphs aloud to the group prior to the start of the debriefing.
Provide a copy to each participant as appropriate.

1. Debriefing is a group process. In a group setting such as a debriefing, peer support team members do not have a statutory privilege of confidentiality. *Therefore, information discussed during the debriefing is not confidential*.

2. Participants in a debriefing have a primary ethical obligation to respect the information disclosed by others during the course of the debriefing. It is ethically inappropriate to discuss or "gossip" about the information presented by others during the debriefing.

3. Mandatory reporting. Police officers, firefighters, psychologists, hospital personnel, clergy, as well as many other professionals are required by C.R.S. 19-3-304 *Persons required to report child abuse or neglect* to report any actual or suspected child abuse or neglect. (In the event that you are not a mandatory reporter, you must consider that (1) there may be mandatory reporters in the group, and (2) your clinical supervisor is a mandatory reporter. When the debriefing is brought under supervision such information will be reported.)

4. Clinical Supervision. Peer Support Team members of the Loveland Police Department (*or*) Larimer County Sheriff's Office have an obligation to discuss debriefing information with our Peer Support Team clinical supervisor and staff psychologist, Dr. Jack Digliani. (Other PSTs, specify *your* clinical supervisor)

5. (Read the following if you are a peace officer or if there are peace officers in the group) In accordance with C.R.S. 18-6-803.6, *Duties of peace officers and prosecuting agencies ðpreservation of evidence*, peace officers who determine that there is probable cause to believe that a crime or offense involving domestic violence has been committed are required to make an arrest without undue delay. Therefore, be advised that peace officers must take action under such circumstances if disclosed in debriefing.

6. Legal matters: You control the information that you present. However, if you have any legal questions or concerns, the Peer Support Team recommends that you not discuss it here. Instead, you should consult with your legal representative.

Guidelines for Facilitating a Police Critical Incident Debriefing

The efficacy of Critical Incident Stress Debriefing (CISD) as developed by J. T. Mitchell and G.S. Everly (Phase model) and other critical incident debriefing has been the topic of recent debate. For several years, conducting debriefings after a traumatic incident has been the standard of intervention for emergency service personnel. However, recent research has provided some evidence that CISD debriefing may not always be helpful, and in some cases may be harmful. The harm that may be caused by CISD debriefing may come in the form of: (1) disrupting the normal psychological trauma integration process of participants, (2) the retraumatization of individual debriefing participants, and (3) the vicarious traumatization of a previously non-traumatized involved participant or support person.

To minimize the probability of disrupting normal psychological integration processes, retraumatization, and vicarious traumatization, debriefing participants should be assessed prior to the debriefing and continually monitored during the debriefing. Debriefing with a focus on *resiliency* (resiliency debriefing: recovery information, etc) has emerged as an alternative to the more structured sequential phases of CISD.

Formal debriefing of any type should be reserved for incidents where there is a significant probability of incident-participant traumatization. This suggestion is based upon research which indicates that an overuse of the debriefing process may diminish its process efficacy. This does not preclude the use of individual or small group support meetings in the place of formal debriefing.

Prior to the debriefing facilitators should obtain as much information as possible about the incident. Find out what happened, who was involved, the extent of injuries, was there a death, how did the incident end, and so on. Ask to examine pictures of the scene. Visit the location of the incident if necessary. This information provides a basic idea of the issues likely to surface during the debriefing.

A challenging task of the primary facilitator is to assess how to best assist those in attendance. Most groups will need little facilitation, some will need a lot. The circumstances of the incident and the group size & composition should always be taken into consideration when facilitating a debriefing.

Phase and Freeezeframe Debriefing Models

If debriefing is appropriate, the CISD **phase** (Mitchell, J. T.) and **freezeframe** (Digliani, J.A.) models help facilitators structure the debriefing process. Application of these models must remain flexible. Actual debriefings do not move orderly from one phase to another, nor do frames remain distinct. Instead, the debriefing process is characterized by issues arising in different ways at various times. Implementing a rigid structure or engaging in overcontrol will diminish the debriefing benefits. Elements of the phase and freezeframe models can be used in combination.

Phase Model for Peer Support Team Members

Introductory Phase: Group members should be allowed a short time to settle into the debriefing setting. The setting should be comfortable and quiet, and not accessible to

the general public. Chairs should be comfortable and set in a circle or other functional conversational arrangement. Peer support team members should sit randomly within the group. Following the informal socializing which normally occurs during this period, the team member acting as primary facilitator should call the group into session. The primary facilitator should introduce self.

- Acknowledge and thank the group for attending the debriefing.
- Explain that team members are there to help and that the debriefing process is a support function.
- Emphasize that team members are not experts who will analyze others behavior. We are what they are - people who work in emergency services, and that we, like others, occasionally have difficulty understanding why things happen as they do.
- Explain that a debriefing is not an incident performance critique - it is a forum for everyone present to discuss their experiences and feelings about the incident should they decide to do so.
- Read confidentiality statement and obtain confidentiality commitment.
- Introduce team members and *briefly* comment on the history and experience of the team.
- Request that those present introduce themselves, identify the agency they work for (if multiple agencies are involved), and state what job they do.

Fact Phase: At the completion of the introductory phase it is often useful for the group to establish what is known of the incident. This can be accomplished by asking for a chronological account of the incident. Facilitators can assist the group in this task by asking questions similar to, "How did you become aware of this incident?" and "What did you see as you approached?" The actual questions depend upon the circumstances of the incident. Do not hurry through this phase. If you obtained information prior to the debriefing, many of the group will not know as much as you do about the facts of the incident. (See *The use of ò you ó* in **General Debriefing Information** – page 59)

The dynamics of the group process will often lead the group from the Fact to the Thought phase. This is a natural transformation. If this does not occur, facilitators can assist the group into the Thought phase by presenting "thought" statements or asking "thought" questions. Frequently, there is no clear distinction between the Fact and Thought phases. Facts and thoughts tend to emerge simultaneously or intermittently.

Thought Phase: The thought phase helps debriefing participants move from a description of the facts (as known) to the thoughts they have or have had about what they know of the incident. In many cases, participant thoughts will change as more factual information becomes known.

Reaction Phase: The reaction phase is that portion of the debriefing where group members discuss how they were affected by the incident. Facilitators should provide an opportunity for everyone to become involved, however avoid compelling group members to speak. Emotional processing in a group forum can be uncomfortable for some people. Individual follow-up should be initiated when appropriate.

- Trust the group process.
- Participants will utilize the group process differently.
- Develop a tolerance for silence as well as the expression of strong emotion.
- Trust participants to make the best of the debriefing.

When the reaction phase appears complete, facilitators can initiate a discussion of likely emotional responses. This marks the beginning of the impact phase. The impact phase can easily be introduced by utilizing some of the information presented by the group during the previous phases.

Impact Phase: Facilitators should discuss the range of normal reactions often experienced after a traumatic incident. Pertinent handouts can be distributed and discussed. Within reason, encourage individuals to talk about their particular responses. This processing may lead to several transitions from the cognitive to the emotional and vice versa

- Normal reactions include experiencing no difficulties.
- Information presented is processed in the "here and now".

The impact phase is followed by the information phase.

Information phase: The information phase provides time for team members to present information which might be helpful to the group. It may consist of critical incident stress information, stress-reduction techniques, outline of referral sources, etc. Pertinent handouts are distributed. This phase is characterized by a transition from the behavioral-cognitive-emotional context of the debriefing to the cognitive-informative.

- Information presented is oriented for future use.
- Information usually not processed in the "here and now".

In the Information phase facilitators move toward issue closure and debriefing termination. Reorganization represents the final phase.

Reorganization Phase: Facilitators should provide a summary of what has occurred during the debriefing and deal with any manageable unfinished business. Group questions are addressed. Group plans for further action, if necessary, are specified. If group size permits, ask each participant, "Do you have any questions or closing comments?" If the group is too large for individual inquiry this can be accomplished by generically asking, "Questions, comments?" If questions are too complex for a brief and adequate response, arrange to meet with the person following adjournment. Acknowledge the efforts of the group. Terminate the debriefing.

- Establish contact with persons needing issue processing and closure.
- Individual follow-up arrangements are made if needed, and referral sources and recommendations are provided.

Freezeframe Model

The freezeframe model utilizes an exploration of fact (information, behavior), thoughts (cognition), responses (emotion), and personal resiliency within each "frame" of a critical incident. To use the freezeframe method, the primary facilitator requests chronological information from the group. When the account of the incident reaches a point of significance, the facilitator freezes that frame and initiates processing. This sequence continues until the entire incident is debriefed. Freezeframe facilitation is especially useful when debriefing large groups, complex events, or incidents where many persons were involved.

Actual freezeframe processing: The freezeframe can be easily started by asking a question similar to, "How did this call come in?" (1) If through dispatch, the events in the dispatch center become the first frame to process. Once this frame is frozen, you can begin exploration of the perceptions, thoughts, behaviors, and feelings of those involved. This is done by asking questions similar to, "What were your thoughts at the time?" "Do you remember a feeling?" "Did a feeling accompany that thought?" "What did you do?" etc. (2) If the incident began by observation, your first frame involves the perceptions of the observer. Explore this by asking, "What did you see, hear, etc." "When did you first become aware of....?" etc. Continue processing with questions similar to, "What feelings emerged in this frame?" "How are you feeling in this frame?" etc. Facilitate until all issues within the frame are processed. If discussion begins to drift out of the current frame, re-focus the group on the frame being processed. Frames range from *narrow* to *wide* and will vary during the debriefing.

When nearing resolution within each frame it is often helpful to provide a *brief* summary, such as "We've learned X, and that it seemed like Y, and felt Z for several group members". Follow this with a general exploratory question, "Is there anything more that we should consider in this frame?" Once the frame is *cleared* in this manner, move to next frame. After several frames are processed, provide a *brief* summary of all previous frames and move on. Repeat until completion. Make mental or discreetly written notes about significant issues that have surfaced. Address these when appropriate. This might be within a frame, between frames, or following the processing of all frames.

Timing is important when using the freezeframe. If you move too fast through a frame or from one frame to another, everyone that needs to do some work within the frame will not have an opportunity. If you move unnecessarily slow, the group will feel that the process is "heavy" and cumbersome.

General Debriefing Information

1. The use of "you". The *you* in the above questions is often the plural *you*. It frequently is used to address the group and initiate group discussion. "You" becomes the personal *you* when helping an individual explore and process incident events, perceptions, feelings, etc.
2. Assist the group or an individual to cognitively process a frame by reflecting the factual information presented and asking about accompanying thoughts, "You saw a man running from the car, what was your first thought?" "You saw a man running from the car, what did you think was happening?" etc. The same

can be done for emotional processing, “You saw a man running from the car, do you remember feeling anything?” “You saw a man running from the car, what did that feel like for you?” etc. You can also facilitate emotional processing following cognitive processing, “You saw a man running from the car and thought that the car might be stolen, do you recall a feeling which accompanied that thought?”

3. Prior to the debriefing it can be helpful to identify a person who was involved in the incident and is not overly troubled by talking about it. After obtaining consent, he or she becomes your "go to" person for process assistance during the debriefing if necessary.
4. Discuss how unavoidably *every cop, every day* confronts work stressors in a manner consistent with personal experience. Unforeseen contingencies which arise out of the “routine” often create the circumstances characteristic of critical incidents. Talking about such contingencies can help debriefing participants process difficulties with *second guessing*.
5. Do not use the group to work out your personal issues. Get separate assistance for yourself to process personal issues which may be triggered during a debriefing.
6. Personal support persons who have not been directly involved in the incident (spouses, other family members, friends, etc.) normally represent no processing difficulty and may be permitted to attend a debriefing if requested by a participant and a special support relationship exists. However, this should be considered only when it is clear that the potential benefit outweighs the possible risk.
7. Major concerns for support persons attending debriefings include vicarious traumatization and confidentiality. Personal support persons must be monitored for traumatization and consent to the confidentiality agreement.
8. There are times when uninvolved-in-the-incident administrators and supervisors express a desire to participate in an incident debriefing for the purposes of obtaining information and/or demonstrating support to those involved. This is not a good idea. It is not a good idea because the presence of any uninvolved person that is not a recognized personal support person tends to suppress the group process and inhibit open discussion. This is especially true for police chiefs, sheriffs, and other high-ranking officers. In some circumstances it may do no harm for a police chief or sheriff to provide an in-person, *brief* statement of support to the group just prior to the start of a debriefing. However, for the most part it is best for uninvolved officers, supervisors, and administrators to contact involved persons independently and outside the debriefing process to demonstrate their support.
9. Peer support team debriefings do not constitute a privileged communication environment. Clinical debriefings, those facilitated by qualified mental health professionals are deemed privileged in several states, including Colorado. Know what confidentiality limitations apply and state them clearly. Allow debriefing participants to decide for themselves how much and what type of information to share.
10. It is important that debriefing facilitators remain flexible and respond to the needs of the group members. Different groups will need different things from the debriefing process. Take a deep breath, relax, and gather your thoughts before beginning debriefing facilitation. Trust the group process and avoid the idea that you are completely responsible for the outcome of the debriefing.

Cautionary Statement

The current research involving the efficacy of critical incident debriefings remains confusing. There are several studies which seem to support the effectiveness of debriefing and several which suggest that debriefing as currently practiced does little to help and may in fact be harmful to at least some participants. This last finding is especially troublesome because of the ruling ethic in medicine and psychology which is "First, do no harm."

In reference to critical incident debriefing, the following can be stated with some degree of confidence:

- Debriefing seems to help many debriefing participants "feel better."
- Anecdotal information demonstrates that most debriefing participants find the debriefing helpful.
- "Feeling better" and being "helpful" does not establish the clinical efficacy of critical incident debriefing.
- Critical incident debriefing may help some participants and not others.
- Critical incident debriefing may not be benign. It may create difficulties for some participants.
- CISD phase debriefing is only one element of the broader conceptualized Critical Incident Stress Management model (CISM) developed by Mitchell and Everly. When CISD is applied independently of CISM, the efficacy of CISD may be altered. This may account for some of the research findings involving CISD.
- There is no conclusive evidence that debriefing of any kind prevents the development of posttraumatic stress disorder or other stress-related disorders.
- To minimize potential harm, all debriefing participants should be assessed for participation appropriateness prior to the debriefing.
- Participation in debriefing should be voluntary.
- *Resiliency debriefings* (which avoid phases & frames and instead focus on health & recovery) seem to avoid the possible pitfalls of traditional debriefings.
- Only additional well-designed research will clarify the efficacy and dangers of critical incident debriefing as currently practiced by most agencies.

Police agencies should consider the above information prior to establishing critical incident debriefing policies. The appropriateness of *peer support team debriefings* should be assessed and approved by a mental health professional. Appropriately trained peer support team members should debrief with caution and only with clinical oversight.

Suggested debriefing handout packet:
Peer Support Team Limits of Confidentiality-Debriefing – page 55
Incident and Debriefing Information (participant handout) – page 63
How to Recover from Traumatic Stress – page 25
Some Things to Remember – page 46

Optional additional debriefing handout information:
Critical Incident Information – page 22
Traumatic Stress: Shock, Impact, and Recovery-PTS/PTSD – page 23
Trauma: Chronological History and Psychological History – page 24

Peer Support Team and Debriefing Issues

Summary of Primary Debriefing Issues

Peer support team: PST members that were directly involved in or witnessed the incident should not function or be utilized in an incident peer support role.

Peer support team members as gatekeeper: Ideally, peer support team members would not be assigned gatekeeper duties. However, in some circumstances PST members must as function as gatekeepers for the sole reason that no other personnel are available.

(1) PST members should be trained in the role and responsibilities of gatekeeper.
(2) PST members should be assigned the role and responsibilities of gatekeeper only when no other option exists *and* there are other PST members available to provide peer support.
(3) PST members accept the gatekeeper role because they are aware that it contributes to the welfare of involved officers/employees.
(4) When serving as gatekeeper, PST members do not function in a peer support role.

Critical incident debriefing and incident investigation: The peer support team psychologist or a PST member designated by the psychologist should coordinate the timing of any critical incident group debriefing with criminal investigators so that the efficacy of the debriefing and integrity of the investigation are not compromised.

Conducting a debriefing within 72 hours of a critical incident is no longer thought to be essential in order to derive any possible debriefing benefits. Debriefings may be conducted with greater timeframe flexibility when deemed appropriate.

Incident investigator and investigative supervisor responsibilities:

(1) Coordinate efforts with the peer support team and PST psychologist.
(2) Expedite investigative interviews so that involved employees that wish to participate in any approved group debriefing may do so without investigator concern that their participation may compromise the investigation.
(3) Contact the PST psychologist or coordinator should any conflict arise between the responsibilities of incident investigators and the efforts or goals of the peer support team.

The primary objectives of *investigator-peer support team* coordination are:

(1) to meet the highest standards of incident investigation and
(2) enhance the welfare of involved officers/employees through peer support.

Incident and Debriefing Information (participant handout)

Involvement in a critical incident can produce various emotional and psychological responses. Some of the responses, though uncomfortable, are normal and usually temporary. They are normal because they are part of the process by which we integrate the traumatic event into our life experience.

It is possible to feel well following a critical incident, participate in the incident debriefing, and come out of the debriefing feeling a bit unsettled. This is not concerning unless the feeling is uncomfortably intense. The unsettled feeling that can be generated by a debriefing is often related to mild anxiety caused by psychologically revisiting the incident. This feeling usually diminishes within a brief period of time.

Information - Following a critical incident or the incident debriefing you may:

- feel unsettled; not quite "yourself."
- replay the incident over and over in your mind.
- wonder why you did or did not do certain things.
- wonder why others did or did not do certain things.
- wonder why you are having particular feelings.
- not sleep normally.
- have dreams, even nightmares, about the incident.
- have dreams that include incident-specific themes.
- experience appetite changes – overeating or no appetite.
- find yourself drinking more alcoholic beverages.
- notice a difference in your sex drive or ability to perform.
- feel less safe than prior to the incident.
- think more about those closest to you.
- have feelings that seem unusual or *out of character* for you.
- think more about life and death, or the meaning of life.
- worry more about your job, your welfare, and the welfare of your family.
- feel a bit numb, edgy, irritable, angry, anxious, or "down."
- experience gastrointestinal problems.
- feel physically uncomfortable – headache, fatigue, and so on.
- wonder when your life will return to normal.

Most importantly, you may not experience any of the above.
It is not abnormal to feel ok following a critical incident.

Many of the responses that can follow a critical incident will diminish within a month. Significant improvement is often experienced within two weeks.

Rarely, thoughts of suicide or of harming others are present following a critical incident. If you have suicidal thoughts or thoughts about harming others, you should tell someone and seek professional assistance immediately.

Take care of yourself. For the next several weeks: (1) watch how you talk to yourself, (2) be patient with yourself and others, (3) engage in mild exercise, (4) practice self-care by doing things that are calming and rewarding, (5) stay connected to those that you care about and who care about you, (6) some alone time is ok but do not isolate yourself, (7) avoid alcohol as a means of coping, (8) engage your support resources.

Suicide Prone Individuals

Suicide prone individuals may demonstrate some or all of the following features in response to problems everyone faces:

1. *Particular disposition* to overestimate the magnitude and insolubility of problems. Little problems seem big, big problems seem overwhelming.

2. *Incredible* lack of confidence in their own resources for solving problems.

3. *Tend* to project a resulting picture of doom into the future.

4. *The suicide-prone* person has somehow incorporated the notion of the acceptability or desirability of solving problems through death.

5. *Death* is viewed as relief.

6. *Either/Or thinking*. Either X or suicide (death).The person does not give credence to in- between options. This kind of thinking creates a *false dilemma*.

7. *Hopeless and helpless* perspective, meaninglessness. "There's no point to living."

HELPFUL THOUGHTS:

Motivation – Suicide, suicide attempts, and suicide threats can be representative of a person's perceived need to escape, manipulate others, punish him/herself or others, or a combination of these. A sense of humiliation or embarrassment, or an undesired environmental event (prison sentence, illness, divorce, exposure of secret activity, etc.) frequently increases thoughts and probability of suicide.

Statement - "Even though you may be thinking of suicide, it is worthwhile to talk to others about options or alternatives." (The longer the person talks to you, the less likely it is that they will follow through on their suicidal threat)

Remember - Suicidal persons are often depressed and see no positive prospects for the future. They often think or say things like, "The world would be better off without me", "I have nothing to live for", and "There's no hope".

The best thing that you can do for a suicidal person is to help provide *realistic hope*. If a person is experiencing intense suicidal impulses, hospitalization will likely become necessary. The strength of such suicidal impulses can vary in intensity over time.

Suicide through the involvement of police:
1. Blaze of glory suicide
2. Fate suicide (undecided) (related to Suicide by cop)
3. Suicide by cop – the person has decided to suicide but is unable to do it by himself (concept of "already dead", nothing to lose, no escape plan, etc)
4. Police as symbolic of all that is wrong in society or government: this may be focused directly at police officers or indirectly by the view that the police function as a barrier to what one hopes to accomplish (the police as a repressive arm of government)

Suicide Potential

There are many life events and experiences that increase the potential for suicide. These are some of the more common.

Stressful life situations:

Divorce or relationship break-up – includes divorce of family member or friend
Loss of job or position – loss of perceived status in society
Death of a loved one or acquaintance
Unwanted pregnancy or feeling pressured to have an abortion
Undesired change of environment
Perceived failure in any life area

Signs of depression:

Changes in appetite – changes in eating habits
Loss of interest in sex
Sleep difficulties
Isolation from friends and family
Self-medicating with alcohol and other drugs
Low mood and mood swings
Poor performance at work
Feelings of hopelessness
Loss of meaningfulness

Greater risk of suicide if:

History of suicide attempts
A family history of depression and suicide
Public trend of suicide
Little or no support system
Harsh criticizing family
Behavior that never seems to be good enough for significant others

Immediate danger signs:

Talking about suicide – direct or veiled. Saying "goodbye" in unusual manner
Giving away treasured items – arranging for permanent care of pets or livestock
Sudden peace within difficult circumstances with no obvious change of circumstances
Formulation of a suicide plan – the more thought out and detailed, the more risk
Obsession with the notion or idea of death – purchasing lethal items (guns, drugs, etc)

If you believe someone is suicidal:

Trust your suspicions – treat all suicidal perceptions seriously. Express your concerns.
Do not leave the person alone if you feel the person is imminently suicidal.
Be supportive. Contact or refer to appropriate resources. Follow up as appropriate.

Even if you swore not to keep a deadly secret,

SIG-E-CAPSS

SIG-E-CAPSS is a mnemonic used to identify and assess the most common symptoms of depression. In SIG-E-CAPSS, there is the presence of or impairment in one, more, or all of the following areas.

S - Sleep
I - Interest
G - Guilt
E - Energy
C - Concentration
A - Appetite
P - Psychomotor retardation
S - Sexual dysfunction
S - Suicidal ideation

BATHE

BATHE is another mnemonic that can be useful when attempting to assist others. BATHE can be applied in general supportive settings as well as screening for depression and suicidal thinking. BATHE helps to structure the peer support interaction so that potentially vital pieces of information are not missed.

B	Bother/Background	What is Bothering you the most right now?	Helps to determine current circumstances.
A	Affect	How is that Affecting you?	Helps to determine how the person is responding to current circumstances.
T	Trouble	What is it about this that Troubles you the most?	Helps to prioritize the difficulties of the current circumstances.
H	Handle	How are you Handling that?	Helps to assess the coping abilities and coping strategies of the person.
E	Empathy	Express:Empathy/understanding of the p e r s concerns	Helps to establish supportive rapport between you and the person.

BATHE as represented here is the work D.L. Powell, MD. The information in column four has been added by Jack A. Digliani.

Suicide Risk and Protective Factors

Suicide Risk Factors - The first step in preventing suicide is to identify and understand risk factors. A risk factor is anything that increases the likelihood that persons will harm themselves. Risk factors are not necessarily causes.

- Previous suicide attempts.
- History of mental disorders, particularly depression.
- History of alcohol and substance abuse.
- Family history of suicide or a childhood history of maltreatment.
- Feelings of hopelessness and helplessness.
- Impulsive or aggressive tendencies.
- Barriers to accessing mental health treatment.
- Loss (relationship, social, work, financial).
- Perceived loss of respect, standing in the community, or feelings of shame.
- Diagnosis of physical illness or long-term effects of physical illness.
- Initiation of long-term incarceration.
- Easy access to lethal methods.
- Unwillingness to seek help because of perceived stigma.
- Cultural and religious beliefs (Japan – Seppuku, Martyrdom, political protest).
- Local epidemics of suicide.
- Isolation, a feeling of being cut off from people.
- No support system.

Suicide Protective Factors - Protective factors buffer people from the risks associated with suicide. A number of protective factors have been identified.

- Effective clinical care for mental, physical, and substance abuse disorders.
- Easy access to clinical intervention.
- Family and community support.
- Support from ongoing medical and mental care relationships.
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide.
- Feeling loved and respected by significant others.

Some Types of Suicide

- Blaze of glory—to be remembered or to make a statement
- Fate suicide—let another or circumstances decide
- Suicide by cop—suicide by provoking a police officer to shoot
- Protest suicide—political, social, or other cause
- Cause suicide—political or military objective
- Psychotic suicide—delusion/command hallucination
- Medical suicide—terminal illness or health/chronic pain issues
- Hopelessness suicide—depression, loss, mood disorder
- Revenge suicide—punish someone
- Honor suicide—avoid disgrace
- Shame suicide—exposure of secret activity, embarrassment
- Guilt suicide—sense of responsibility for tragic event; guilt for surviving
- Anger suicide—anger at self or others

Police Officer Suicide Risk Factors

The first step in preventing police officer suicide is to identify risk factors. A risk factor is anything that increases the likelihood that an officer will harm him/herself.

Police officer suicide risk factors:

Veiled or outright threats of suicide. Development of a suicidal plan.
Marital, money, and/or family problems.
Recent discipline or pending discipline, including possible termination.
Over-developed sense of responsibility. Responsibility absorption.
Frustration or embarrassment by some work-related event.
Internal or criminal investigations; allegations of wrongdoing; criminal charges.
Assaults on an officer's integrity, reputation, or professionalism.
Recent loss, such as divorce, relationship breakup, financial, and so on.
Little or no social support system.
Uncharacteristic dramatic mood changes. Being angry much of the time.
Increased aggression toward the public. Citizen complaints.
Feeling "down" or depressed; feeling trapped with no way out.
Feelings of hopelessness and helplessness.
Feeling anxious, unable to sleep or sleeping all the time.
History of problems with work or family stress.
Making permanent alternative arrangements for pets or livestock.
Increased alcohol use or other substance abuse/addiction.
Family history of suicide and/or childhood maltreatment.
Uncharacteristic acting out; increased impulsive tendencies.
Diagnosis of physical illness or long-term effects of physical illness.
Recent injury which causes chronic pain; overuse of medications.
Disability that forces retirement or leaving the job.
Self isolation: withdrawing from family, friends, and social events.
Giving away treasured items. Saying "goodbye" in unusual manner.
Easy access to firearms or other lethal means (a constant for police officers).
Unwillingness to seek help because of perceived stigma.
Sudden sense of calm while circumstances have not changed.

Police officers should not avoid other officers they think might be suicidal.

Peer Support Team: If you observe any of the behavior associated with suicide risk in another officer, contact should be initiated. Discuss your observations. Show you care. Introduce the subject of suicide. *Do not hesitate to bring the subject of suicide into the open*. Conduct a field assessment and follow through on your observations. If you feel that the officer is imminently suicidal, ask for his or her weapon if armed, and do not leave the officer alone. Contact your clinical supervisor immediately. Together, with your clinical supervisor, arrange for the appropriate intervention.

If the officer is not imminently suicidal, spend some time with him/her. Listen closely and provide emotional support. Contact your clinical supervisor. Provide information about available resources, including staff psychologist, police chaplains, the Employee Assistance Program, and community resources. Engage in appropriate follow-up.

The point is, do not hesitate to do something. You may save a life.

Helping a Person that is Suicidal

The following guidelines may be helpful when trying to help a person that is suicidal.

1) Take all suicidal comments and behaviors seriously.
2) Initiate a conversation. Express your concern and willingness to help. Be yourself. Listen closely without being judgmental.
3) If the person is intoxicated, arrange for detoxification. If the person is known to have an ongoing alcohol or substance use problem, support and encourage the person to seek and engage appropriate treatment.
4) Be mindful of what you say because the person may be overly sensitive to your remarks, but you do not have to "walk on eggshells".
5) Remain calm: the person may express strong emotion. This will normally dissipate naturally. You may also be emotionally affected. Accept your emotions as a natural and normal part of your caring interaction.
6) Acknowledge the person's difficulties without minimization or overstatement. Do not joke about what is serious to the person.
7) Avoid trying to "cheer up" the person. Instead, focus on listening and supporting.
8) Avoid providing problem solutions or recommendations unless asked. Encourage the person to seek professional assistance if necessary.
9) Bring the issue of suicide into the open. Ask about the person's current thoughts and feelings about suicide.
10) Ask about past suicidal thoughts, feelings, and attempts.
11) Ask about the availability of lethal means for suicide. Easy access to firearms is especially dangerous.
12) Remove firearms and other lethal means if necessary. Control potentially lethal prescribed medications if warranted.
13) Determine if there is a suicidal plan – the more detailed and complete the plan, the greater the suicidal risk.
14) Suicidal thoughts are often the result of depression. Talk to the person about depression and that depression can be effectively treated. Assure the person that with appropriate treatment for depression, suicidal thoughts and the feeling of wanting to die will diminish. Help to provide *realistic hope*.
15) Do not hesitate to ask for help from the suicidal person. Ask the person to cooperate with you and your efforts to help.
16) If the person is not imminently suicidal, spend some time with him or her, "provide an ear" and other emotional support. Depending on the circumstances and your relationship, encourage, assist, or insist that he or she engage professional services. If warranted, arrange for the person to be with others 24/7 for continued support and to add an additional level of safety.
17) If you feel that the person is imminently suicidal do not leave him or her alone. Contact the police or other emergency resource. Keep in mind that if the person refuses voluntary intervention, emergency involuntary evaluation and treatment may be necessary.
18) If you feel that the person is somewhat suicidal but you do not feel competent to assess the level of suicidality, do not leave him or her alone. Contact the police or other available assessment and support resource. Do this even if the person objects. This is the best way to keep the person safe.
19) Do not keep a suicidal secret. If necessary, gently explain that you must share the information provided to you and that you must contact others.
20) Follow up as appropriate. Factors influencing appropriate follow up include your history with the person, your current relationship with the person, the current circumstances, how much future involvement you are willing to have with the person, and anticipated future circumstances.

Common Misconceptions about Suicide

FALSE: People who talk about suicide won't really do it.
Almost everyone who commits or attempts suicide has given some clue or warning. Do not ignore suicide threats. Statements like "you'll be sorry when I'm dead," "I can't see any way out," — no matter how casually or jokingly said may indicate serious suicidal feelings.

FALSE: Anyone who tries to kill him/herself must be crazy.
Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

FALSE: If a person is determined to kill him/herself, nothing is going to stop them.
Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

FALSE: People who commit suicide are people who were unwilling to seek help.
Studies of suicide victims have shown that more than half had sought medical help in the six months prior to their deaths.

FALSE: Talking about suicide may give someone the idea.
You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true — bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

Source: *SAVE - Suicide Awareness Voices of Education*

Level of Suicide Risk

Low — Some suicidal thoughts. No suicide plan. Says he or she won't commit suicide.

Moderate — Suicidal thoughts. Vague plan that isn't very lethal. Says he or she won't commit suicide.

High — Suicidal thoughts. Specific plan that is highly lethal. Says he or she won't commit suicide.

Severe — Suicidal thoughts. Specific plan that is highly lethal. Says he or she will commit suicide.

Source: http://www.helpguide.org/mental/suicide_prevention.htm

National 24/7 Suicide Hotlines
1.-800-SUICIDE (1-800-784-2433),
1-800-273-TALK (1-800-273-8255)
Military suicide hotline: 1-800-273-8255

Suicide by Cop

There are those who seek to be killed by the police. *Suicide by cop* (SBC), *victim-precipitated suicide*, and *decedent-precipitated suicide* are contemporary terms for this too frequently observed phenomenon.

Persons intending to be killed by police officers act in ways that compel officers to defend themselves. In the majority of cases, persons so disposed will point a firearm at police officers. Many of these people are armed with functioning, loaded weapons, and a percentage of these persons will not hesitate to kill police officers or others in their effort to die at the hands of the police.

Some persons intending SBC are in possession of air, pellet, BB, or replica weapons. They use these to threaten officers. Others have no weapon at all but act as if they do. These persons posture or "draw" to make officers believe that they are armed.

Some persons indifferent to life will sometimes engage in SBC behavior. They may point a weapon at an officer or otherwise threaten officers and let "fate" decide the outcome. This circumstance combines the *fate suicide* with *suicide by cop*. Persons in this frame of mind do not care whether they live or die. They do not comply with officers' orders, threaten officers, and may compel officers to defend themselves.

Some persons that attempt suicide by cop want to die and have chosen firearms as the means. However, because they do not have a firearm, they choose the police as their instrument of death. In these cases, subterfuge is common.

Many of those seeking to be killed by the police are suffering from depression or other mental disorders. Some have recently undergone a "last straw" life experience.

What of those persons who wish to die by firearms and possess loaded, functional weapons but choose SBC? Why do they not shoot themselves? Several factors are suspected in these cases, including:

1. Social concerns - there is still a social taboo against suicide.
2. Suicide by cop allows suicidal persons to die without actually killing themselves.
3. Fear - an inability to follow through with suicide.
4. Religious prohibitions against suicide (SBC as a religion "loophole"?).
5. Concerns over life insurance policies.
6. Wanting to go out in a blaze - Wanting to make the news.
7. Punish, embarrass, or make a public statement to someone.
8. Anger against the police, particular persons, or society.
9. A desire to confront or harm police officers.
10. Psychological inability to kill oneself.

Officers must remain aware that persons considering suicide by cop may be willing to kill police officers or others to fulfill their wish to be killed by police.

Death, Loss, and Survivorship

The following is a summary of issues involved in death, loss, and survivorship.

1. *Learning of the death*. Shock and denial are common initial responses to death, especially if the death is sudden and unexpected. Disbelief and confusion are frequently experienced.

2. *Reactions to death*. Many factors influence how intensely we feel the loss. Among these are the nature of attachment, spiritual views, the age of the deceased, how the person died, the similarity of the deceased to those we love, and the extent of the void that the person's absence leaves in our life. The death of another can also trigger our own fears of death and memories of previous traumatic events or losses.

3. *Grief and mourning*. Grieving takes time. This is important to remember because American culture is not readily accepting of lengthy grieving or mourning periods. Instead, there is the idea that a person needs to put the loss behind them and get on with life. There is no correct way to grieve. People deal with loss in different ways for different periods of time. The public expression of grief is *mourning*.

4. *Coping with loss*. It is common to experience powerful emotions. Confront emotions openly. Strong emotion may feel overwhelming. Breathe through it.

5. *Specific reactions to loss*. There are many possible reactions to loss. Common and normal reactions include sadness, crying, numbness, loss of appetite, inability to sleep, fatigue, anger and frustration, finding it difficult to be alone, or wanting to be alone. Utilizing your support system is the best way to deal with the pain of grieving.

6. *Stages of grief*. Many clinicians have identified what they refer to as stages of grief. Although such stages differ in terminology, the basic structure of the stages involve (1) an initial shock and denial, (2) a subsequent impact and suffering period, followed by (3) some adjustment and degree of recovery (similar to exposure to any traumatic event). However, grieving is a complex process; it does not progress clearly from one stage to another. It is normal to once again have feelings long thought to have disappeared.

7. *Healing*. Acknowledge and accept your feelings. You may experience seemingly contradictory feelings such as relief and sadness (for example, relief that a burden of care or the person's suffering has ended, and sadness due to the loss). This is normal. Keep in mind that your emotional attachment does not end upon the death of someone you care about. Remember, bereavement is the normal process by which human beings heal from loss.

8. *Surviving the loss*. Surviving the death of someone you care about involves honoring the memory of the person by acknowledging what the person contributed to your life. From here, you can further honor the person by reengaging life. It is important to remember that similar feelings can follow the death or loss of pets, non pet animals, and even plants and inanimate objects that have acquired some special meaning (like losing a family heirloom). Brain studies show that the same neural pathways of grief are activated regardless of the loss.

The Effects of Exposure to Death ðDeath Imprint

The exposure to the death of others can evoke various emotional responses in police officers. There are many factors that influence an officer's emotional response to death. Among these are the actual circumstances of death, the age of the deceased, whether the officer killed the person or played some role in the death, the number of those that have died, the relationship of the deceased to the officer, the maturity and personality of the officer, the world view of the officer, and whether the officer feels that he or she could have prevented the death.

At one end of the psychological death exposure spectrum lie the emotional responses of sensitization and traumatization. Such traumatization frequently includes the experience of death anxiety, fear, and depression. At the other end of this spectrum lie emotional numbing, indifference, and insensitivity. This can result in an almost robot-like response to death. This response makes being around death less stressful. It also makes killing easier, a psychological state-of-mind experienced by some combat soldiers. In the middle of these extremes are the more psychologically healthy responses to death, although the entire range of emotional responses may include various intensities of underlying or superimposed experiences of anxiety, depression, guilt, grief, and denial.

For police officers, death is a more-than-usual topic for thought. For one thing, police training encourages officers to think about death; their own as well as others. This is present in officer safety training, firearms training, self-defense training, police tactics training, and first aid.

Police officers are also encouraged to think about death by the very nature of their work. Street and investigative experience exposes officers to death in various ways, including crimes against persons, natural deaths, and deadly traffic accidents.

Every police officer is taught and soon learns that there are those in our society that would look to intentionally harm or kill police officers. This is the reason for the professional emphasis on officer safety. Officers must always be prepared to defend themselves. This is why police officers live in a world of *assumption of possible threat*. This is very different from those in most other occupations, who live in a world of *assumption of safety*. It is the possible threat to their personal safety that has given rise to the often stated mantra of police officers, "Whatever it takes to go home." As part of their careers, many officers have had to defend themselves against a person intent on harming them. This can create situations wherein officers must use deadly force to keep from being seriously injured or killed.

For officers there is also exposure to death by the now more prevalent than ever *suicide by cop* scenario. Persons intent on dying at the hands of police intentionally provoke officers into shooting them. They may or may not have an actual means to harm a police officer; they may or may not have the intent to harm a police officer. Regardless, officers cannot bet their lives on the probability that such a person is not in possession of a lethal weapon or that the person will not act against them in their attempt to be killed by the police. (See *Suicide by Cop*)

If a police officer has not been personally exposed to the experiences described above, he or she certainly knows of other officers that have. This creates a type of vicarious death exposure. Either way, direct or indirect exposure to death seems a common aspect of the psychology of police officers.

Issues for Peer Support

Peer support team members recognize that differential police assignments expose officers to various probabilities of death exposure.

Investigators, especially those involved in crimes against persons are the most likely to be exposed to death. This is because of the *funnel effect*, wherein the cases involving homicide or death get funneled to a relatively small number of officers. The fact that many investigators must also attend autopsies further increases their death exposure. Some investigators learn to effectively manage death exposure; they must do so if they are to continue in their assignment. To outsiders, these investigators sometimes appear "cold" or "callous".

Police patrol officers, patrol deputies, and state troopers are the next group of officers most likely to be exposed to death. They are the first responders to homicides, are more likely to be involved in deadly force street encounters, and are responders to deadly traffic accidents. Patrol officers (and detention officers) may also be exposed to death in a sudden and unexpected manner. This contributes to a *shock* factor that is seldom a part of the experience of investigators. Normally, when investigators arrive on scene the incident is over or under some degree of police control. Therefore, the shock experience for investigators is mitigated.

Detention deputies or jail officers are the least likely to be exposed to on-the-job death (in the sense that there are many more deaths that occur outside of a detention facility than occur within). This lower probability, in conjunction with the modern detention facility anthem that "Nobody dies on my watch!" makes a death within a detention facility especially difficult for some detention officers. This may be due to the fact that (1) detention officers are not exposed to death very often and so do not develop death exposure coping skills and (2) detention officers may feel that they have failed in their duty if an inmate dies or completes suicide in their custody.

Upon the death of an inmate, some detention officers report that in addition to having to deal with the actual circumstances of the death, they are often fearful of being disciplined, including losing their job. This fear is related to the idea that they may have somehow failed to meet facility standards for the protection of the inmate. Of course, detention officers can fail in their duties and death of an inmate may result. However, this fear seems to be present regardless of the circumstances, even in cases where detention officers have followed policy and procedure to the letter and have performed well by every assessment.

In reality, detention officers, like all others, can perform their duties in an exemplary manner and still be unable to prevent anyone from dying on their watch. In spite of excellent policies and procedures, exemplary performance, reasonable health status evaluation, high security, and all due diligence, detention officers cannot control their work environment to the degree necessary to prevent the possibility of death.

No one in any environment can prevent the possibility of death. This exposes the notion that "Nobody dies on my watch!" for the fantasy that it is. It should be replaced by the more realistic "I will do my best to prevent anyone from dying on my watch!" This statement acknowledges an officer's personal commitment to duty, recognizes human limitation, and more accurately describes the human condition. The best that any detention officer can do for himself or herself, an inmate, other officers, and other coworkers is to influence the *probability* of death. This is accomplished by following operational procedures, completing scheduled checks, observing suicide watches, conscientiously practicing officer safety, exercising due diligence, and so on.

In summary, the degree of death exposure for officers in specific assignments may assist or impede them in developing a means of coping with death.

If death exposure is managed in a functional way, it can result in a psychological perspective which enhances officers' death-coping abilities. In turn, this allows officers to work in their assignments without a great deal of death anxiety or distress. However, no matter how officers conceptualize death or how well an officer copes with death exposure, there is always the risk of *death imprint*.

Death Imprint

When officers experience anxiety about death, it often involves thoughts about their death, the death of loved ones, the inevitability of death, the identification of a deceased person with still living loved ones, the future loss of loved ones, and memories of those that have already died. The actual degree of experienced distress varies and is dependent upon the intensity and duration of the generated anxiety. However, even officers that have found a way to cope with death exposure can be emotionally overwhelmed. This can occur (1) due to the circumstances of a particular case, (2) when a particular case causes a *tipping point* in an officer's ability to manage death anxiety, or (3) gradually over time with continued death exposure. Regardless of the cause of death anxiety, such emotional decompensation is sometimes called *death imprint*.

Death imprint becomes possible when even the best of our coping defenses fail and the anxiety or depression pertaining to death which is normally suppressed reaches some degree of expression.

Death Imprint and Peer Support

Death imprint is frequently an issue following the experience of a traumatic incident. It is a component of posttraumatic stress disorder. Peer support team members must remember that there does not have to be an actual death for a person to be effected by death imprint. Near death or serious injury that might have resulted in death is enough to trigger death imprint.

Death imprint and the accompanying anxiety are often beyond the scope of peer support. Although peer support can be a valuable asset to someone experiencing death imprint, peer support team members that suspect serious reactions involving death imprint should notify their clinical supervisor, and make appropriate referrals or support the person to seek professional help.

Recognizing Mental Disorders ðField Assessment

Recognizing a person suffering from a mental disorder can be difficult. Serious mental disorders such as schizophrenia, depression, and bipolar disorder, when severe, are easily recognized. It is the more moderate degrees of these and similar conditions that represent the most challenging assessment and resolution problems for police officers.

Police officers must be skilled in making mental illness *field assessments*. At minimum, police mental illness field assessments must (1) determine if there is reasonable cause to believe that a person is mentally ill, and, if yes, (2) due to the mental illness, is the person a danger to him/herself or others, or gravely disabled. Simply stated, *gravely disabled* is a condition wherein persons are so seriously mentally ill that they are unable to care for themselves, are endangered by this incapability, and require immediate intervention to avoid unintentional self-harm.

Signs (behaviors and other things observable) and symptoms (information reported to you by the person) are the primary components of police field assessments. Observations of reliable other persons can be used in field assessments.

When conducting a field assessment, a person's behavior must be evaluated within context. Many behaviors and emotional responses which might indicate mental illness in one context might not in another.

During field assessments, look for:

1. Odd, bizarre, or otherwise unusual behavior.
2. Sudden changes in behavior (including verbal communication).
3. Major changes in mood: depression or mania (also: *bipolar disorder*).
4. Pressured speech – inability to moderate speech production.
5. Inability to "track" conversation or to stay on topic.
6. Extreme anxiety, panic, or fright.
7. Delusions: disorder of thought (formal thought disorder).
8. Hallucinations: disorder of perception (*auditory* common in schizophrenia).
9. Dementia: impairment in memory and executive function.
10. Delirium: impairment of consciousness (also: drug induced *excited delirium*).

Keep in mind that mental illness is *symptomatic* and differs from *intellectual developmental disorder* (formerly called *mental retardation*).

Officers that have completed a field assessment and have determined that there is reasonable cause to believe that a person is mentally ill and, due to the mental illness, is a danger to self/others or gravely disabled cannot leave the person alone.

Police officers must consider involuntary detention for evaluation and treatment as authorized under C.R.S. 27-65-105, *Emergency procedure* when necessary.

Recognizing *Intellectual Developmental Disorder*

Intellectual Developmental Disorder has its origin in the historical notions of "feeble mindedness" "mentally defective" and "mental retardation". These concepts were associated with the intelligence quotient (IQ) and measures of intelligence.

As defined today, Intellectual Developmental Disorder "is characterized by deficits in general mental abilities such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience" as well as "significant impairment in adaptive functioning" with "onset during the developmental period" (DSM-5).

Persons with Intellectual Developmental Disorder:

- may look like adults but their intelligence and functioning can be that of a child (depending on the degree of impairment).
- may not be capable of responding or reasoning as an adult.
- may be easily influenced by others. When this happens they may get into trouble due to a lack of mature judgment.
- often experience the emotional and sexual drives consistent with their level of maturation and chronological age.
- may be quite sensitive to their perceived deficits. As compensation, some may become "street tough". Those closest to "normal" are most likely to come to attention of police in this manner.
- may wander around the community watching or otherwise interacting with children because they can understand them. People may become concerned and contact police.
- may be fascinated by the police uniform and equipment.
- may not maintain normal, socially acceptable distances when carrying on a conversation - including closer-than-normal childlike social distances or increased social distance characteristic of being fearful.
- may not be able to appreciate the gravity of noncompliance with police commands.

Intellectual Developmental Disorder and Mental Illness

It is possible for a person to be diagnosed with intellectual developmental disorder and one or more specific mental illnesses.

Suggestions for Interacting with Persons that are Mentally Ill or Suicidal

1. Always be cautious and remain alert.
   - Human behavior is ultimately unpredictable.
   - Assessment of threat level is complicated by drugs/alcohol/mental illness.

2. Take time to consider the situation. Unless ***duty bound***, proceed thoughtfully.
   - Obtain information from others if possible.
   - Do not hesitate to call for assistance. A team approach is often successful.
   - Talk to the person. State your purpose: "I am here to help."

3. Communication: Avoid abusive language and threatening behavior.
   - Many disturbed persons are already frightened.
   - The person may become frightened upon arrival of police.
   - Communicate to develop rapport and trust: use first names if appropriate.
   - If applicable, bring the issue of suicide into the open: "How long have you thought about killing yourself?"
   - Avoid challenges - "You don't have the guts to kill yourself."
   - If appropriate, explain what you are going to do before you do it. This normally decreases anxiety and lessens the probability of acting out.
   - De-emphasize authority when appropriate.
   - Most mentally ill persons will respond to officers who display a caring attitude. Ask for the person's help to accomplish your goals. Appropriate supportive touch can be useful in some cases (use with caution and only when indicated).
   - Consider the "short order" if necessary or if rapport fails.
   - Never assume that the person cannot understand you.
   - Contact relatives or friends of the person if necessary for disposition.
   - Use physical force only as the situation demands.
   - *Never emphasize officer safety.*

4. Do not allow yourself to be angered.
   - The person may be very adept at provoking anger (name calling, threats, etc.).
   - Anger directed at police officers is often displaced.
   - The person's anger responses are frequently the result of frustration or fear.
   - If you remain calm, you lower the probability of the person acting out.
   - Many persons will resist to a point, then voluntarily comply with your directions.

5. Avoid excitement.
   - As a general rule, keep outside stimulation to a minimum.
   - A calmer, more stable environment increases the probability of compliance.

6. Avoid deception.
   - It is sometimes tempting to lie to bring about a resolution, however deception is often unnecessary and may be harmful. Exception: when life is at risk any strategy or technique that you reasonably think might accomplish your goal is justified.

Some Psychoactive Medications

Many medications have more than one use. Some of the specified medications may be used to treat non-psychiatric conditions. Brand names are in standard print (some medications have more than one brand name). Generic names are specified in *italics*.

Antianxiety Medications

Atarax, Vistaril *hydroxyzine*
Ativan *lorazepam*
Buspar *buspirone*
Centrax *prazepam*
Dalmane *flurazepam*
Doral *quazepam*
Equanil, Miltown *meprobamate*
Halcion *triazolam*
Klonopin *clonazepam*
Librium *chlordiazepoxide*
ProSom *estazolam*
Restoril *temazepam*
Serax *oxazepam*
Tranxene *clorazepate*
Valium *diazepam*
Xanax *alprazolam*

Medication Side Effects

All medications have potential side effects. Potential side effects include headache, gastro-intestinal problems, sleep abnormalities, nightmares, sweating, rapid heartbeat, and even depression with suicidal thoughts.

Peer support team members should encourage all persons taking psychoactive and other medications to immediately report distressing side effects to their medical provider.

Barbiturates (used for anxiety and seizure disorder)

Amytal *amobarbital*
Luminal *phenobarbital*
Nembutal *phentobarbital*
Seconoal *secobarbital*
Veronal *barbituric acid*

Antidepressant Medications (some are also be used to control anxiety, seizure, bipolar disorder, and as an adjunct to other medications)

Abilify *aripiprazole*
Adapin, Sinequan *doxepin*
Anafranil *clomipramine*
Asendin *amoxapine*
Celexa *citalopram*
Cymbalta *duloxetine*
Desyrel *trazodone*
Effexor *venlafaxine*
Elavil, Endep *amitriptyline*
Lamictal *lamtrigine*
Lexapro *escitalopram*
Limbitrol (Librium/Elavil)
Ludiomil *maprotiline*
Luvox *fluovaxamine*

Antidepressant medications (continued)

Marplan *isocarboxazid*
Nardil *phenelzine*
Norpramin *desipramine*
Pamelor, Aventyl *nortriptyline*
Parnate *tranylcypromine*
Paxil *paroxetine*
Pristiq *desvenlafaxine*
Prozac *fluoxetine*
Remeron *mirtazapine*
Serzone *nefazodone*
Sinequan *doxepin*
Surmontil *trimipramine*
Tofranil *imipramine*
Triavil (Elavil/Trilafon)
Viibryd *vilazodone*
Vivactil *protriptyline*
Wellbutrin, Zyban *bupropion*
Zoloft *sertraline*

Antimanic Drugs

Lithium Carbonate
- Eskalith
- Lithane
- Lithobid
- Lithonate
- Lithotab

Tegretol *carbamazepine*
Valproic acid
- Depakote *divalproex sodium*
- Depakene *sodium valproate*

Antiparkinsonian Drugs

Akineton *biperiden*
Artane *trihexyphenidyl*
Cogentin *benztropine*

Sleep Aid Medications

Ambien *zolpidem*
Desyrel *trazodone*
Silenor *doxepine*
Elavil, Endep *amitriptyline*
Lunesta *eszopiclone*
Rohypnol *flunitrazepam*
Rozerem *ramelteon*
Sonata *zaleplon*

Antidepressant Medication

There are several types of depression medications (antidepressants) used to treat depression and conditions that have depression as a component of the disease, such as bipolar disorder. These drugs improve symptoms of depression by increasing the availability of certain brain chemicals called neurotransmitters. It is believed that these brain chemicals can help improve emotions.

Major types of antidepressants include:

Tricyclic antidepressants (TCAs) are some of the first antidepressants used to treat depression. They primarily affect the levels of two chemical messengers (neurotransmitters), norepinephrine and serotonin, in the brain. Although these drugs are effective in treating depression, they have more side effects, so they usually aren't the first drugs used.

Monoamine oxidase inhibitors (MAOIs) are another early form of antidepressant. These drugs are most effective in people with depression who do not respond to other treatments. Substances in certain foods, like cheese, beverages like wine, and medications can interact with an MAOI, so these people taking this medication must adhere to strict dietary restrictions (see below). For this reason these antidepressants also aren't usually the first drugs used.

Selective serotonin reuptake inhibitors (SSRIs) are a newer form of antidepressant. These drugs work by altering the amount of a chemical in the brain called serotonin.

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are another newer form of antidepressant medicine. They treat depression by increasing availability of the brain chemicals serotonin and norepinephrine.

From: WebMD.com

Stimulants for ADHD

Adderall *dextroamphetamine*
Cylert *pemoline*
Desoxyn *methamphetamine*
Focalin *dexmethylphenidate*
Ritalin, Concerta *methylphenidate*
Vyvanse *lisdexamphetamine*

Non Stimulants for ADHD

Intuniv *guanfacine*
Kapvay *clonidine*
Strattera *atomoxetine*

Alcohol and Drug Intervention

Anabuse *disulfiram* (alcohol antagonist)
Depade, Revia *naltrexone* (block effect, alcohol craving)
Topamax *topiramate*
Campral *acamprosate* (alcohol craving)
Librium, Valium, Xanax, etc. *benzodiazepines* (for alcohol rebound anxiety)
Parlodel *bromocriptine* (craving – especially cocaine)

Opiate Replacement Therapy (Opiate replacement therapy targets the symptoms of narcotics craving and withdrawal)

Methadone (synthetic opiod)
Suboxone *buprenorphine* and *naloxone*
LAAM (Levo-alpha acetyl methadol)

Antipsychotic Medications

Clozaril *clozapine*
Compazine *prochlorperazine*
Geodon, Zeldox *ziprasidone*
Haldol *haloperidol*
Loxitane *loxipine*
Mellaril *thioridazine*
Moban *molindone*
Navane *thiothixene*
Prolixin *fluphenazine*
Risperdal *risperidone*
Saphris *asenapine*
Sparine *promazine*
Serentil *mesoridazine*
Serlect *sertindole*
Seroquel *quetiapine*
Stelazine *trifluoperazine*
Taractan *chlorprothixene*
Thorazine *chlorpromazine*
Trilafon *perphenazine*
Zyprexa *olanzapine*

Medications Used to Treat Dementia

Aricept *donepezil*
Exelon *rivastigmine*
Namenda *memantine*
Razadyne, Reminyl *galantamine*

Medications Used to Quit Smoking

Chantix *varenicline*
Zyban *bupropion*

Foundation Building Blocks of Functional Relationships

1. **Emotional Connection**: all relationships are characterized by feelings or the emotional connections that exist between or among relationship members. Love is one such feeling. Feelings and the emotional connection frequently alter or influence perceptions and behaviors.

2. **Trust**: is a fundamental building block of all functional relationships. Trust is related to many other components of functional relationships including fidelity, dependability, honesty, etc.

3. **Honesty**: functional relationships are characterized by a high degree of caring honesty. There is a place for "not hurting others feelings". However, consistent misrepresentation to avoid short-term conflict often results in the establishment of dysfunctional patterns such as long-term resentment, invalidation, etc.

4. **Assumption of honesty**: with trust, we can assume honesty in others. A relationship in which honesty cannot be assumed is plagued with distrust and prone to suspicion. Such relationships are characterized by persons trying to mind read and second guess the "real" meaning of various interactions.

5. **Respect**: respect is demonstrated in all areas of functional relationships – verbal communication, non-verbal behaviors, openness for discussion, conflict resolution, etc. Without respect, relationships cannot remain functional because problem-resolution communication is not possible.

6. **Tolerance**: the acceptance of personal differences and individual *preference*s are vital to keeping relationships working well. A degree of mutual tolerance makes relationships more pleasant & less stressful.

7. **Responsiveness**: your responsiveness to others helps to validate their importance to you and reflects your sense of meaningfulness of the relationship. This is especially important in hierarchical relationships.

8. **Flexibility**: personal rigidity frequently strains relationships and limits potential functional boundaries. Highly functional relationships are characterized by reasonable flexibility so that when stressed, they bend without breaking. Many things are not as serious as they first seem. Develop and maintain a sense of humor.

9. **Communication**: make it safe for communication. Safe communication means that others can come to you with any issue and expect to be heard. Listen in a calm, attentive manner. Allow the person to express thoughts and feelings without interruption. Communication factors: *content-message-delivery* (Content - the words you choose in the attempt to send your message, Message - the meaning of what you are trying to communicate, Delivery - how you say what you are saying. Delivery includes nonverbal behavior and defines the content message). Remember: Protect less – communicate more. *Confrontation guidelines*: a caring manner, appropriate timing and setting, present your thoughts tentatively, move from facts to opinion.

10. **Commitment**: long-term functional relationships are characterized by *willingness* to work on problems, acceptance of personal responsibility, attempts to see things from other perspectives, conflict resolution, and the ability of members to move beyond common transgressions. Life is complex. People are not perfect. You must decide what is forgivable. If forgivable, put it in the past and move on. *Psychological history and chronological history*.

Remember: All of us have *special status* people. Spouses, significant others, etc. are special status people. It is ok to do some things differently for those with special status. For instance, comply with their wishes at times even though it's not your preference. They will return this courtesy, resulting in an improved relationship. Do you really need to assert dominance in every circumstance? Do you need to win every argument? Can you see things from viewpoints other than your own? These are important issues in functional relationships and *Life by Default - Life by Design*. (See *Trauma: Chronological History and Psychological History* and *Life management: Life by Default - Life by Design*)

Foundation reinforcers of functional relationships: (1) the assumption of good faith in your partner and (2) the absence of intentional harm.

When talking or otherwise interacting with special status people (especially your spouse), *do not forget with whom you are interacting*. Remaining mindful that you talking to or interacting with a special person in your life will help you to moderate your behavior and maintain a MOB (Mindful of Blocks) mentality. This will help you to remain calm, respectful, and measured in potentially emotionally charged interactions. As a result, you will avoid behavior that you may later regret. For example, have you ever found yourself apologizing following a conversation with someone you care about by saying something like "I'm sorry, I shouldn't have spoken to you that way"? If so, you did not maintain a MOB mentality during the conversation.

Conceptually, the relationship is supported by the foundation blocks, while the foundation blocks can be damaged or repaired by the relationship they support.

It is a sad fact that some police officers talk and interact more politely and less contentiously with co-workers, strangers, and offenders than they do with their spouse, family members, and other loved ones.

Issues in Interpersonal Relationships and Family Systems

- Rules and myths
- Generational boundaries
- Alliances and coalitions
- Function and dysfunction
- Homeostasis
- Underflow

In combination with *Some Things to Remember* and *Gottman's Marriage Foundation Tips* *Building Blocks of Functional Relationships* provide an excellent framework for those wishing to improve their marriage and other personal relationships.

Gottmanôs Marriage Tips

Couples researcher, psychologist John Gottman identified seven tips for keeping marriages healthy. In combination with the *Foundation Building Blocks of Functional Relationships* and *Some Things to Remember* they provide an excellent framework for those wishing to enhance or improve their marriage.

• *Seek help early*. The average couple waits six years before seeking help for marital problems (and keep in mind, half of all marriages that end do so in the first seven years). This means the average couple lives with unhappiness for far too long.

• *Edit yourself*. Couples who avoid saying every critical thought when discussing touchy topics are consistently the happiest.

• *Soften your start-up*. Arguments first "start up" because a spouse sometimes escalates the conflict from the get-go by making a critical or contemptuous remark in a confrontational tone. Bring up problems gently and without blame.

• *Accept influence*. A marriage succeeds to the extent that the husband can accept influence from his wife. If a woman says, "Do you have to work Thursday night? My mother is coming that weekend, and I need your help getting ready," and her husband replies, "My plans are set, and I'm not changing them". This guy is in a shaky marriage. A husband's ability to be influenced by his wife (rather than vice-versa) is crucial because research shows women are already well practiced at accepting influence from men, and a true partnership only occurs when a husband can do so as well.

• *Have high standards*. Happy couples have high standards for each other even as newlyweds. The most successful couples are those who, even as newlyweds, refused to accept hurtful behavior from one another. The lower the level of tolerance for bad behavior in the beginning of a relationship, the happier the couple is down the road.

• *Learn to repair and exit the argument*. Successful couples know how to exit an argument. Happy couples know how to repair the situation before an argument gets completely out of control. Successful repair attempts include: changing the topic to something completely unrelated; using humor; stroking your partner with a caring remark ("I understand that this is hard for you"); making it clear you're on common ground ("This is our problem"); backing down (in marriage, as in the martial art Aikido, you have to yield to win); and, in general, offering signs of appreciation for your partner and his or her feelings along the way ("I really appreciate and want to thank you for . . . ."). If an argument gets too heated, take a 20-minute break, and agree to approach the topic again when you are both calm.

• *Focus on the bright side*. In a happy marriage, while discussing problems, couples make at least five times as many positive statements to and about each other and their relationship as negative ones. For example, "We laugh a lot;" not, "We never have any fun". A good marriage must have a rich climate of positivity. Make deposits to your emotional bank account.

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Police Marriage: Extramarital Affairs

"There is a true test of marital fidelity. The test has three components: (1) you are attracted to a person not your spouse, who is also attracted to you, (*yes, it is possible to be attracted to a person who is not your spouse*), (2) the person makes it known to you that he or she is available and willing to engage in romantic or sexual activities, and (3) you believe that you can engage in such activities and not be discovered. You pass the test if you walk away and redirect your emotional energies to your spouse and into your marriage" (Digliani, J.A., 2010. *Reflections of a Police Psychologist,* 161).

There are three general categories of extramarital affairs:

1) Emotional affair (little or no physical contact – can last days to years)
2) The infamous "one night stand"
3) Ongoing sexual affair (may also be emotional and can last days to years)

A person may also engage in multiple affairs of various types and combinations.

Discussion

Some rationales and motivations for extramarital affairs:

1. "To save my marriage" - (the marriage is not meeting various needs and so the person goes outside the marriage to fulfill what is perceived to be lacking. In this way, the person can stay in a marriage that might otherwise need to be ended)
2. "If I can get it, why not take it?" - (this perspective comes from a "me first" and hedonistic approach to marriage and life. It completely disregards marriage commitment and the emotional well-being of the spouse)
3. "It just happened" "We didn't plan it" - (this rationale denies personal responsibility, decision making, and marriage commitment)
4. "It's your fault, not mine. If you treated me better…" – (this position denies personal responsibility and attempts to shift the responsibility for personal behavior to the spouse)

Can an affair be good for a marriage? Although an affair may focus a couple on improving their marriage, I have never known an affair to be good for a marriage.

Can an affair be overcome in a marriage? Yes, to varying degrees, in some marriages.

Affairs and addiction to sex: current diagnostic information – DSM-5

Nymphomania and *satyriasis* (excessive sexual drive) ICD-10

Process addictions - *Soft* addictions

Peer Support: How would you as a peer support team member assist a person who comes to you with information that (s)he is having an affair or that they have just discovered that their spouse has had or is having an affair?

Considerations for Successful Retirement

Retirement Issues

Retiring from the police department after many years of service represents a major life transition. Many officers look forward to retirement and the opportunities it presents, however, major life changes, even when desired, can be stressful and potentially overwhelming.

For successful retirement from policing, officers need to prepare. Although having sufficient funds is important, this preparation should go beyond financial considerations. Officers need to prepare psychologically. This is best accomplished by life-by-design considerations and should begin years before actual departure.

To help officers better decide when they should retire and to help them psychologically prepare for the transition out of policing, peer support team members can assist those considering retirement by discussing or providing them with a copy of the *Retirement Checklist*.

Retirement Checklist

1. Have you planned your financial circumstances to meet your retirement needs?

2. Have you discussed your retirement with your family? How will it affect their lives?

3. Have you arranged for medical insurance benefits?

4. Is it time for a change? Have you given all that you reasonably can to policing?

5. Are you still connected to policing or have you checked out years ago? If you are still connected and it is not time for a change, continue your career. If you have checked out and it is not time for a change, reclaim your career. If it is time for a change, pursue retirement. *Do not end your successful police career as a ROD (Retired on Duty) officer*.

6. Are you prepared to lose the prestige associated with being a police officer?

7. Have you thought about who you are without the badge? What will be your personal identification after retirement? Will "retiree" or "retired police officer" work for you? What will you put in its place? For some officers, being a retired police officer is enough. For others, it is not. For the latter, the identity of functioning in new role can be helpful, such as business owner, volunteer, sports enthusiast, grandparent, hiker, and so on. It can be just about anything, as long as it feels right. When considering retirement it's best to remember the old adage, "It is better to retire *to* something than to retire *from* something".

8. How will you occupy the time normally spent at work? Hopefully, not with food, alcohol, or computer video games. Many officers that have never had a serious problem with overeating, drinking too much, and spending unproductive days in front of a computer when working, develop these problems after retirement.

9. Following retirement, there is frequently some measure of boredom. Most officers will deny this. They say things like "I'm busier now than when I was working." It is seldom true. I am uncertain why it is so difficult for retired officers to admit that their lives have slowed down. After all, isn't that part of the reason for retirement? Of course, this may not be true for all former officers. It is likely that some retired officers are busier retired than when working. But for most of them, things slow down. Newly retired officers frequently report feeling as if a great weight has been removed from their shoulders (even if they are busier, what is keeping them busy is often less stressful than policing). The stress reduction experienced by most officers upon retirement is often remarkable.

10. Time structuring and time management is important in retirement. Even the pleasure of travel, sports, and coffee with friends can eventually wear thin. This is especially true if your police friends are still working and you find yourself alone much of the time. Managing time and making it meaningful is a primary challenge of retirement.

11. How will you continue to contribute to your community? After a career of public service, many officers enjoy continuing some form of community service.

12. How have you prepared for your retirement? Help yourself by writing out a retirement action plan. Consider support counseling for you and your family.

Responding to these questions and thinking about these issues will better prepare you for retirement.

As mentioned, retirement is a transition. Transitions take time. Once retired, be patient. It may take some time to find your retirement rhythm.

Police Retirement and Emotional Abandonment

Upon retirement, some officers talk about feeling emotionally abandoned by the department and former coworkers. To address this, some police agencies have developed programs which actively involve retired officers. These programs include volunteer services and assignments, social events, and ongoing access to the police building (which encourages ongoing transaction with working police personnel). As desirable as these programs have proven to be, it seems that most departments lack them.

Retired officers that feel emotionally abandoned and have a desire to stay connected or reconnect with their agency and former coworkers have at least two options, (1) wait for someone to reach out to them (a low probability event) or (2) initiate contact and reestablish the supportive relationships which once existed (much more likely to produce positive results).

Working police officers that have had close ties with a now retired officer can reach out. The reach out does not have to be anything elaborate…an occasional telephone call or invitation for coffee will do. Even if a retired officer does not feel emotionally abandoned, such efforts will almost certainly be appreciated.

Keeping Yourself Healthy

Supporting others in stressful circumstances can in itself be stressful. Peer support team members can be vicariously traumatized, retraumatized, or otherwise emotionally overwhelmed in their attempt to help others. Peer support team members will be able to better support others if they remember one of the most basic principles of peer support – *even supporters need support*.

You're important. Take care of yourself. Take care of your family. Allow them to take care of you. Positive family bonds are excellent buffers against stress.

To feel better and to remain a functional family and peer support team member do what you can to keep yourself healthy. To maintain a healthy lifestyle consider the following:

- Exercise regularly.
- Maintain an active lifestyle.
- Eat and drink a healthy diet.
- Maintain interests, hobbies, and relationships outside of policing.
- Do not hesitate to ask for support during stressful times.
- Practice what you have learned in PST training. No one is immune to stress.
- Utilize healthy stress management strategies that have worked for you in the past.
- Experiment with new stressor management strategies.
- Maintain or reclaim your life, family, relationships, and career.
- Utilize and implement *Some Things to Remember*.
- Keep a positive attitude.
- Do not expect perfection – from yourself or others.
- Develop a sense of humor. Learn to laugh at yourself.
- Remain mindful of your personal boundaries.
- Apply and practice *life by design*.
- Support one another - seek support from other peer support team members.
- Remain mindful of *The Imperatives*.

<u>Stay connected to your clinical supervisor or advisor</u>. This relationship establishes direct *support for the peer supporters*. As a natural consequence of this relationship, your clinical supervisor or advisor is supported by you and other peer support team members.

Peer support team members endorse the support principle. They avoid the idea that "I'm a peer support team member. I help others. I don't need or ask for support."

The Communication Imperative

Persons will respond to the message they received and not necessarily the message that you intended to send.

The Relationship Imperative

Make it safe!

The Occupational Imperative

Never forget *why* you do *what* you do.

Digliani, J.A. (2010) *Reflections of a Police Psychologist*, page 256.

Peer Support Team Action Plan Worksheet

Step 1

What are the issues? What am I **WORRIED** about? Have I clearly identified the problem(s)? → IDENTIFY THE ISSUES, WORRIES, AND PROBLEMS TO BE ADDRESSED.

Steps 2-4

How am I thinking about the problem? Are my thoughts rational or irrational? Do I need help to understand the difference? Is there a better way to think about or conceptualize the problem? What are my **OPTIONS**? → IDENTIFY OPTIONS. RECONSIDER IRRATIONAL CONCEPTUALIZATIONS. CONSIDER: *choices*, *decisions*, AND *likely consequences*. Think of options as *opportunities* to move forward.

Step 5

What do I want to **CHANGE**? → DO I NEED TO CHANGE MYSELF OR MY ENVIRONMENT? MAYBE SOME OF MYSELF AND SOME OF MY ENVIRONMENT. CONSIDER: *development of coping skills*.

Step 6

SPECIFY and **PRIORITIZE** desired changes and goals. → MAY INVOLVE CHANGING THOUGHTS, FEELINGS, BEHAVIORS, AND ELEMENTS OF THE ENVIRONMENT.

Step 7

What are the **ROADBLOCKS**? What obstacles are in the way of change? → ANTICIPATE THE DIFFICULTIES OF POSITIVE CHANGE.

Step 8

PLAN to address or overcome the obstacles. → IT IS EASY TO THINK ABOUT OBSTACLES AS OVERWHELMING. DEVELOP A CREATIVE ACTION PLAN THAT INCLUDES OVERCOMING OBSTACLES.

Step 9

IDENTIFY how and when you will **IMPLEMENT** your action plan. → IMPLEMENT THE ACTION PLAN.

Step 10

How will I **EVALUATE** the outcome and **EXPLORE** more options after I have implemented my action plan? → EVALUATE THE OUTCOME OF THE ACTION PLAN. REVISE AS NEEDED. SPECIFY RELAPSE PREVENTION STRATEGIES.

Joanne Rupert & Jack A. Digliani

Comprehensive Model for Police Advanced Strategic Support (COMPASS)

Positive and supportive agency administrators - Positive organizational environment

Pre-hire psychological assessment independent of police staff psychologist

Agency commitment to *staff psychologist* and *peer support team* concepts

Early involvement of staff psychologist
(1) Establishes psychologist/officer relationship
(2) Breaks down "shrink" stereotype
(3) Stigma reduction for seeking help

In-service recruit academy: staff psychologist presentations -stress inoculation, critical incident protocol, preparation for FTO program, PATROL, function of peer support team, role and responsibilities staff psychologist, and other relevant topics

Psychologist and Training/Recruit Officer Liaison **(PATROL)** program:
Trainee officer meets with psychologist at least once per Field Training Officer (FTO) training phase. PATROL is independent of FTO training but coordinated with FTO program. Spouse invited. Spouse program. Training, work, and non-work issues. Confidential setting. PATROL is a preemptive psychological support program for officers-in-training and their families

Enhances psychologist/officer relationship
Continues stigma reduction for seeking help

Police staff psychologist: provides (1) psychological services for employees and their families - couples counseling (2) training and clinical supervision of the Peer Support Team (3) support for peer support team members (4) critical incident protocol development, (5) coordination with other support resources, (6) liaison with other agencies, (7) Make it Safe Initiative, (8) other services as appropriate - *Employee Assistance Programs (EAP) and insurance plan community counseling services can be beneficial but appear insufficient to provide the range of support services optimal for police officers. The staff psychologist is in a unique position to overcome the reluctance of many officers to seek professional support when needed*

Preemptive programs – programs designed to assist officers prior to the development of difficulties – includes the PATROL program, the computer crimes child pornography investigators quarterly contact support program, Proactive Annual Check-In (PAC), and the TIP program.
In-service presentations (presented periodically) – stress inoculation, health and wellness, critical incident protocol and trauma intervention program, police marriage and family issues, interacting with special populations, officer suicide prevention, interacting with suicidal persons, and other relevant topics

Retirement preparation program ð(1) Practical issues (financial, etc), (2) Psychological and emotional issues
(3) Departing the police role, (4) Family and other social issues

Peer Support Team (PST): comprised of officers and others trained in peer support and functioning within written policy and operational guidelines:

(1) Structured with Coordinator, Clinical Advisor, or Clinical Supervisor
(2) Clinical supervision and "ladder of escalation" (referral, advisement, and immediate supervision when needed)
(3) Monthly in-service training and group supervision
(4) Integral part of staff psychologist pre-emptive and intervention programs
(5) *Major concepts* – interest, commitment, credibility, supervision, confidentiality, limitations of peer support, remaining within the boundaries of PST training, referral, special programs, and reach out

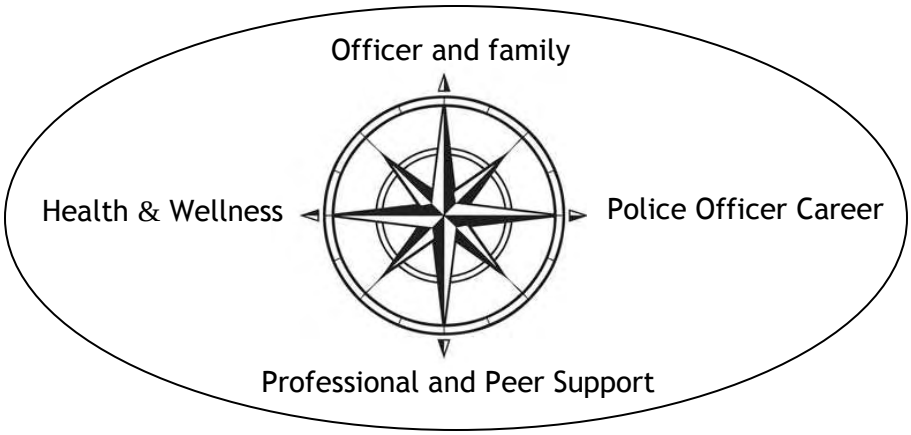
Spouse and family programs: specialized programs involving the PST and staff psychologist designed to support the spouse and family members of police officers

Peer Support Team Brochure
Peer Support Team Newsletter
PST shift briefing programs
PST debriefings - interventions
PST poster information

Police staff psychologist and peer support team members: the staff psychologist and uninvolved members of the peer support team are made available to officers involved in *supervisory inquiries* and *internal investigations* – this information is specified within the officer-advisement investigative documents

Transitional adjustment support: when officers retire, resign, or are terminated they are eligible for three visits with the staff psychologist beyond their employment

Retiree programs: programs for officers that retire from the department in good standing that offer volunteer opportunities, occasional or periodic social activities, and other meaningful continued involvement with the agency - recognition for years of service to the department and community



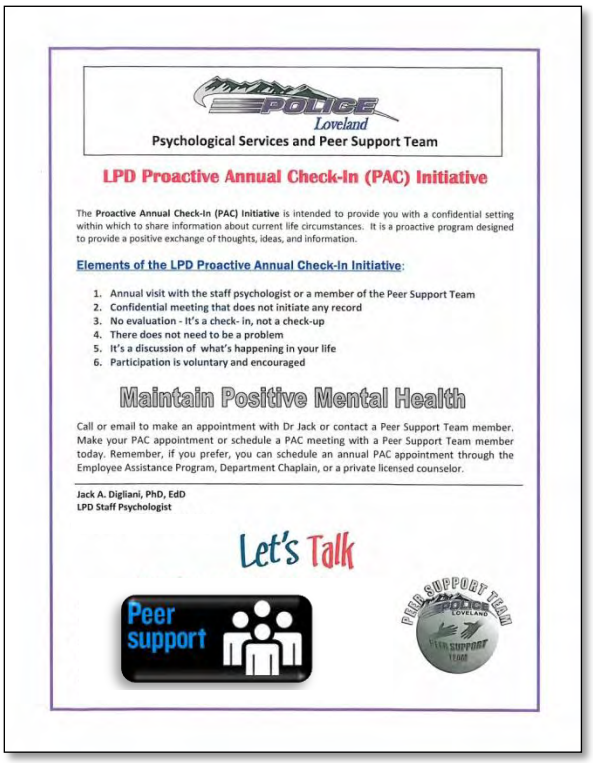
The Digliani COMPASS

Helping police officers to find their way.

Proactive Annual Check-in

Elements of the Proactive Annual Check-in:

1. **Annual visit with the staff psychologist or a member of the Peer Support Team**
2. **Confidential meeting that does not initiate any record**
3. **No evaluation - It's a check-in, not a check-up**
4. **There does not need to be a problem**
5. **It's a discussion of what's happening in your life**
6. **Participation is voluntary and encouraged**



Psychological Services and Peer Support Team

LPD Proactive Annual Check-In (PAC) Initiative

The **Proactive Annual Check-In (PAC) Initiative** is intended to provide you with a confidential setting within which to share information about current life circumstances. It is a proactive program designed to provide a positive exchange of thoughts, ideas, and information.

Elements of the LPD Proactive Annual Check-In Initiative:

1. Annual visit with the staff psychologist or a member of the Peer Support Team
2. Confidential meeting that does not initiate any record
3. No evaluation - It's a check- in, not a check-up
4. There does not need to be a problem
5. It's a discussion of what's happening in your life
6. Participation is voluntary and encouraged

Maintain Positive Mental Health

Call or email to make an appointment with Dr Jack or contact a Peer Support Team member. Make your PAC appointment or schedule a PAC meeting with a Peer Support Team member today. Remember, if you prefer, you can schedule an annual PAC appointment through the Employee Assistance Program, Department Chaplain, or a private licensed counselor.

Jack A. Digliani, PhD, EdD
LPD Staff Psychologist

Let's Talk

Peer support

Psychological Services and Peer Support Team
Proactive Annual Check-in Poster
Loveland Police Department

Jack A. Digliani, PhD, EdD
Police Psychologist
www.jackdigliani.com

Police Primary and Secondary Danger

The primary danger of policing is comprised of the inherent risks of the job, such as working in motor vehicle traffic, confronting violent persons, and exposure to traumatic incidents. Sadly, there is an insidious and lesser known *secondary danger* in policing. This danger is often unspecified and seldom discussed. It is an artifact of the police culture and is frequently reinforced by police officers themselves. It is the idea that equates ñasking for helpò with weakness and in one's profession, and in one's mind, is the number one killer of police officers.

The ñMake Police Officer Safe Initiative

Make it safe for officers to ask for psychological support

The Make it Safe Initiative is a concerted effort to reduce the secondary danger of policing.

The Make it Safe Initiative seeks to:

(1) make it personally and professionally acceptable for officers to engage peer and professional psychological support services without fear of agency or peer ridicule or reprisal.

(2) reduce officer fears about asking for psychological support when confronting potentially overwhelming job or other life difficulties.

(3) change organizational climates that discourage officers from seeking psychological help by reducing explicit and implicit organizational messages that imply asking for help is indicative of personal and professional weakness.

(4) alter the profession-wide law enforcement culture that generally views asking for psychological help as a personal or professional weakness.

(5) improve the career-long psychological wellness of officers by encouraging police agencies to adopt long-term and comprehensive officer-support strategies such as the Comprehensive Model for Police Advanced Strategic Support.

How serious is police secondary danger?
So serious that some officers will choose suicide over asking for help.

Twelve primary elements of the Make it Safe Police Officer Initiative

The Make it Safe Initiative encourages:

(1) every officer to "self-monitor" and to take personal responsibility for his or her mental wellness.

(2) every officer to seek psychological support when confronting potentially overwhelming difficulties (officers do not have to "go it alone").

(3) every officer to diminish the sometimes deadly effects of secondary danger by reaching out to other officers known to be facing difficult circumstances.

(4) veteran and ranking officers to use their status to help reduce secondary danger (veteran and ranking officers can reduce secondary danger by openly discussing it, appropriately sharing selected personal experiences, avoiding the use of pejorative terms to describe officers seeking or engaging psychological support, and talking about the acceptability of seeking psychological support when confronting stressful circumstances).

(5) law enforcement administrators to better educate themselves about the nature of secondary danger and to take the lead in secondary danger reduction.

(6) law enforcement administrators to issue a departmental memo encouraging officers to engage psychological support services when confronting potentially overwhelming stress (the memo should include information about confidentiality and available support resources).

(7) basic training in stress management, stress inoculation, critical incidents, posttraumatic stress, police family dynamics, substance use and addiction, and the warning signs of depression and suicide.

(8) the development of programs that engage pre-emptive, early-warning, and periodic department-wide officer support interventions (for example, proactive annual check in, “early warning” policies designed to support officers displaying signs of stress, and regularly scheduled stress inoculation and critical incident stressor management training).

(9) agencies to initiate incident-specific protocols to support officers and their families when officers are involved in critical incidents.

(10) agencies to create appropriately structured, properly trained, and clinically supervised peer support teams.

(11) agencies to provide easy and confidential access to counseling and specialized police psychological support services.

(12) officers at all levels of the organization to enhance the agency climate so that others are encouraged to ask for help when experiencing psychological or emotional difficulties instead of keeping and acting out a deadly secret.

If law enforcement officers wish to do the best for themselves and **to make a change. It's time to make a difference.**

www.jackdigliani.com

Implementing the Make it Safe Police Officer Initiative

Implementing the Make it Safe Police Officer Initiative is not difficult. In fact, many police agencies have already implemented or are planning on implementing several elements of the Initiative.

The Initiative is not an "all or nothing" proposition. Various elements of the Initiative can be implemented independently of one another. Although it is best to move forward with the entire Initiative, a partial implementation is better than no implementation.

There is no "one right way" to implement the Initiative. It is ok to be creative. Make the *Make it Safe Police Officer Initiative* work for you.

Changing the police culture will not be easy. It helps to keep in mind that many departments have already made significant strides in officer-support efforts. Some departments and officers will welcome the Initiative and will work for its implementation. Others will not. If you feel that the Initiative has merit, take care of yourself, and do what you can for others and your department. Do not get discouraged and do not give up. The elements of the Initiative are easily implemented by initiating processes, strategies, and programs already well known to law enforcement agencies.

Considerations and recommendations for implementing the elements of the Make it Safe Police Officer Initiative:

The Initiative encourages: (1) every officer to "self-monitor" and to take personal responsibility for his or her mental wellness.

Implementation: Many officers are pretty good at picking up signs of distress in others. But as an officer, have you ever thought of applying this skill to yourself? Accomplishing this simply requires you to make an honest and *ongoing* self-assessment. Although denial can be or become an issue, many officers know when they are in trouble. However, knowing you are having difficulty is not enough. You must also know what to do about it. One of the things that you can do about it is to seek appropriate assistance.

The Initiative encourages: (2) every officer to seek psychological support when confronting potentially overwhelming difficulties (officers do not have to "go it alone").

Implementation: Why limit yourself to personal stress management ideas and strategies when dealing with stressors that begin to tax your coping abilities? You can supplement your solo stress management efforts by engaging outside support. Outside support comes in many varieties, ranging from talking with a trusted friend to professional counseling. The next time you feel stressed, take a chance and talk to someone you trust. You may be pleasantly surprised at the outcome.

The Initiative encourages: (3) every officer to diminish the sometimes deadly effects of secondary danger by reaching out to other officers known to be facing difficult circumstances.

Implementation: Even if an officer is not exhibiting outward signs of distress, if you know that he or she is dealing with circumstances that would be difficult for nearly everyone, try reaching out. Too often, officers will shy away from other officers in distress for a variety of reasons, including not knowing what to say or do. But think about this - in years of policing and psychological practice I have had officers time after time talk about how an unanticipated kind word from another officer made a positive difference. It does not take much, and it's not like you need to form a life-long relationship. Sometimes just a few supportive words can make a remarkable difference.

The Initiative encourages: (4) veteran and ranking officers to use their status to help reduce secondary danger (veteran and ranking officers can reduce secondary danger by openly discussing it, appropriately sharing selected personal experiences, avoiding the use of pejorative terms to describe officers seeking or engaging psychological support, and talking about the acceptability of seeking psychological support when confronting stressful circumstances).

Implementation: Veteran and ranking officers are in a unique position to influence the police culture generally and organizational climate specifically. They can do this for better or for worse. If you are a veteran or ranking officer, make a positive difference. As mentioned, you can help to reduce secondary danger by openly discussing it, appropriately sharing selected personal experiences, avoiding the use of pejorative terms to describe officers seeking or engaging psychological support, and talking about the acceptability of seeking psychological support when confronting stressful circumstances.

The Initiative encourages: (5) law enforcement administrators to better educate themselves about the nature of secondary danger and to take the lead in secondary danger reduction.

Implementation: The conceptual distinction between police primary and secondary danger is relatively new. Police administrators should think through the notions of police primary and secondary danger, and consider ways to reduce secondary danger within their agencies.

The Initiative encourages: (6) law enforcement administrators to issue a departmental memo encouraging officers to engage psychological support services when confronting potentially overwhelming stress (the memo should include information about confidentiality and available support resources).

Implementation: This is easily accomplished by administrators that support the Initiative. All it takes is an understanding what support services are available, learning about the limits of confidentiality, and a commitment to write and distribute this information in a departmental memo. If you are a police administrator, whether or not you support the entire Initiative, implementing this element would clarify your position, help to define your philosophy, contribute to a supportive organizational climate, and help to reduce secondary danger. This step alone has the potential to help officers in distress.

The Initiative encourages: (7) basic training in stress management, stress inoculation, critical incidents, posttraumatic stress, police family dynamics, substance use and addiction, and the warning signs of suicide.

Implementation: In nearly every jurisdiction, there are qualified persons that are willing to train officers in the specified areas. Resources for this training include local or regional mental health facilities, community psychologists and counselors, area community colleges, local universities, academy cadre, and specially trained officers already within the department. Training in these areas should begin in recruit academy and continue throughout an officer's career.

The Initiative encourages: (8) the development of programs that engage pre-emptive, early warning, and periodic department-wide officer support interventions (for example, proactive annual check in, ‘early warning’ policies designed to support officers displaying signs of stress, and regularly scheduled stress inoculation and critical incident stressor management training).

Implementation: Initiating pre-emptive, early-warning, and periodic support programs is nothing new for law enforcement agencies. Many departments offer stress management

refresher training periodically and have early warning officer-assist policies and programs already in place. These programs are designed to help officers cope with everyday stress and potentially overwhelming stress before it becomes an issue.

The Initiative encourages: (9) agencies to initiate incident-specific protocols to support officers and their families when officers are involved in critical incidents.

Implementation: It takes some work, but it is possible for an agency to develop a standardized protocol for dealing with a critical incident. Such protocols not only help to standardize incident investigation, but can also be designed to reduce second injury, secondary trauma, and secondary danger. Incident protocols can be developed by individual law enforcement agencies or encompass multiple jurisdictions. To implement this element of the Initiative, it takes someone to introduce the concept, secure administrative support, develop the protocol and have it approved, then put it into effect.

The Initiative encourages: (10) agencies to create appropriately structured, properly trained, and clinically supervised peer support teams.

Implementation: The efficacy of police peer support teams is well understood by police psychologists. To be most effective, police peer support teams must be formally established in policy and function under departmental written guidelines. Peer support team members should be trained by qualified personnel and receive ongoing training and clinical supervision. Clinical supervision provides a "ladder of escalation" and "support for the supporters" (see Chapter 5, "Police Peer Support Teams" in *Reflections of a Police Psychologis*t for more information). Several states have enacted legislation which provides members of police (and some other) peer support teams with a degree of statutory confidentiality.

The Initiative encourages: (11) agencies to provide easy and confidential access to counseling and specialized police psychological support services.

Implementation: Most departments provide insurance coverage for private psychologists and counselors, and many have developed Employee Assistance Programs. Some agencies also provide in-house psychological services. Regardless of the services provided, they must be easily accessible and remain confidential within the limits prescribed by law if officers are to view them as viable resources.

The Initiative encourages: (12) officers at all levels of the organization to enhance the agency climate so that others are encouraged to ask for help when experiencing psychological or emotional difficulties instead of keeping and acting out a deadly secret.

Implementation: Police officers must remain aware that even seemingly innocuous verbal exchanges and unintentional nonverbal gestures can contribute to police secondary danger. To avoid this, officers must act conscientiously, proactively, and consistently to reduce police secondary danger.

Questions about the Make it Safe Police Officer Initiative or Initiative implementation?

Contact Jack A. Digliani at
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Initiative Implementation Action Plan Checklist:

- V Read and comprehend
- V Bring to the attention of administrators
- V Become an advocate
- V Implement the elements
- V Move methodically
- V Contact if you get stuck

About the Author

Jack A. Digliani, PhD, EdD is a licensed psychologist and a former deputy sheriff, police officer, and detective. He served as a law enforcement officer for the Laramie County, Wyoming Sheriff's Office, the Cheyenne, Wyoming Police Department, and the Fort Collins, Colorado Police Services (FCPS). He was the FCPS Director of Human Services and police psychologist for the last 11 years of his FCPS police career. While in this position he provided psychological services to employees and their family, and clinically supervised the FCPS Peer Support Team. He received the FCPS Medal of Merit for his work in police psychology.

Dr. Digliani has served as the police psychologist for the Loveland Police Department and Larimer County Sheriff's Office (Colorado) for the past several years. During this period, he provided psychological counseling services to department members and their families. He was also the clinical supervisor of the agencies' Peer Support Teams. He has worked with numerous municipal, county, state, and federal law enforcement agencies. He specializes in police and trauma psychology, group interventions, and the development of police, fire, and other emergency worker peer support teams.

Dr. Digliani is the author of *Reflections of a Police Psychologist, Police and Sheriff Peer Support Team Manual*, *Firefighter Peer Support Team Manual*, *Law Enforcement Critical Incident Handbook, Law Enforcement Marriage and Relationship Guidebook*, and *Stress Inoculation Training: The Police*. He is a contributor-writer of Colorado Revised Statute 13-90-107(m) *Who may not testify without consent*, the statute and paragraph which grants law enforcement, firefighter, and medical/rescue peer support team members specified confidentiality protection during peer support interactions. He is also the primary author of the peer support section of the *Officer-Involved Incident Protocol* of the 8th Judicial District of Colorado.

In 1990, Dr. Digliani created the *Psychologist And Training/Recruit Officer Liaison* (PATROL) program, a program designed to support police officer recruits and their families during academy and field training. This concept was later extended to the fire service. The *Firefighter Recruit Support* (FIRST) program supports firefighters and their families during recruit training. Through his work, he developed the *Comprehensive Model for Police Advanced Strategic Support* for police officers and the *Comprehensive Model for Peer Advanced Strategic Support* for firefighters (COMPASS). COMPASS is a career-long psychological health and wellness strategy for police officers and firefighters. In 2013, Dr. Digliani developed the conceptions of primary and secondary danger, and created the "Make it Safe" Police Officer Initiative. The Initiative is designed to reduce the secondary danger of policing.

To learn more about the Make it Safe Police Officer Initiative, and to download free copies of the Police and Sheriff Peer Support Team Manual, the Law Enforcement Critical Incident Handbook, and the Law Enforcement Marriage and Relationship Guidebook visit www.jackdigliani.com

Police and Sheriff

Peer Support Team Manual