Emergency Medical Service
Peer Support Team
MANUAL

Reference and Resource Manual
Edition 2.1

Serve - Care - Support - Surpass

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Emergency Medical Services Peer Support Team Manual

The EMS Peer Support Team Manual is an extrapolation and modification of the Law Enforcement Peer Support Team Manual.

Also by Jack A. Digliani:

Contemporary Issues in Police Psychology
Reflections of a Police Psychologist (2nd ed)
Stress Inoculation: The Police
Law Enforcement Peer Support Team Manual
Law Enforcement Critical Incident Handbook
Law Enforcement Marriage and Relationship Guidebook
Firefighter Peer Support Team Manual
Civilian Peer Support Team Manual
Peer Support Team Utilization and Outcome Survey

For more information and to download free copies of the Emergency Medical Services Peer Support Team Manual and other documents visit *www.jackdigliani.com*

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To order *Contemporary Issues in Police Psychology* or *Reflections of a Police Psychologist (2nd ed)* visit www.Amazon.com.

Manual Information and Suggestions for Use

The use of the designations *EMS, EMT,* and *medic* are intended to include Emergency Medical Technicians (EMT), Emergency Medical Technician Intermediates (EMT-I), Advanced EMTs (A-EMT), Paramedics, Flight or Critical Care Paramedics, First Responders, physicians, and others in the emergency medical service including both paid and volunteer personnel working either inside or outside a hospital setting.

The *EMS 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, and 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 *EMS Peer Support Team Training* program.

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 (2nd ed)* and *Contemporary Issues in Police Psychology*. Much of the information included in Reflections and Contemporary Issues is applicable to the emergency medical service and EMS personnel.

The author wishes to thank EMT Joe Silva and Paramedic Sharon Lowry of the UCHealth system for their counsel, advice, and contributions to this Manual.

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 binding that 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…" Jack A. Digliani

EMS Peer Support Team Manual

Contents

Introduction

EMS personnel have supported one another since the inception of EMS. In the early years when EMS personnel 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, EMS workers now have several alternatives for assistance when dealing with stress-related difficulties. In many contemporary EMS agencies, these alternatives include the option of working with members of the department's peer support team.

EMS peer support teams are proving their worth and are demonstrating their effectiveness. They are establishing their place in the EMS mentality and are becoming an integral part of many EMS agencies.

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

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

If you are reading this as a member of an EMS 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 EMS agency.

This manual is dedicated to the men and women that give much of themselves to comprise our EMS 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, clinical supervision, and their training.
- Attend regularly scheduled peer support team meetings and in-service training.
- Develop and maintain enhanced knowledge and skill. This includes skills in recognizing stress reactions to critical incidents and the unavoidable stressors of EMS and non-work environments.
- Remain in communication with the peer support team psychologist. They 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 a non-professional interpersonal interaction that is based upon a common experience or history. In this way, peer support differs from counseling and psychotherapy. In counseling and psychotherapy, a common experience or history is not necessary. There are two levels of peer support: *Level I* peer support consists of the support found in the everyday 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:

- clarify whether an interaction is peer support, and if confirmed, specify the PST member role and the parameters of peer support interactions.
- advise and explain the limits of confidentiality of peer support team members in peer support interactions prior to engaging in peer support.
- function within the parameters of statute, departmental policy, operational guidelines, and peer support training.

EMS 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: Level I and Level II – EMS Primary/Secondary Danger

Level I peer support: 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 that have some peer status. Nearly everyone, at one time or another, has been the provider and the recipient of this type of peer support. Level I peer support has a long history and can be thought of as "traditional" peer support. Level II peer support is similar to Level I, but Level II peer support includes several important components that are not present, or not necessarily present, in Level I. This makes Level II peer support interactions different from the Level I support that can come from "friends talking."

Level II peer support: (1) Level II peer support is provided by members of a department-recognized peer support team functioning within state statute and/or department policy and operational guidelines, (2) Level II peer support is provided by persons trained in peer support, (3) Level II peer support interactions are characterized by elements of functional relationships which encourage exploration, empowerment, and positive change, (4) Advice giving is avoided in Level II peer support - independent decision making is encouraged, (5) Level II peer support is guided by ethical and conceptual parameters – this makes it different than just "friends talking," (6) Level II peer support has positive outcomes as its goal – this is not always the case in Level I peer support interactions, (7) Peer support team members are clinically advised or supervised by a licensed mental health professional - this provides a "ladder of escalation" if consultation or referral is needed. A structured ladder of escalation is not available in Level I interactions, and (8) Level II peer support, while non-judgmental, includes a safety assessment – it has an evaluative component. If a peer support team member assesses that the recipient of peer support is dealing with an issue that exceeds the parameters of peer support or if it is assessed that the recipient is or may be overly stressed, depressed, or suicidal, the peer support team member is trained to act upon the assessment. This is accomplished by providing information about available resources, making appropriate referrals, moving up the ladder of escalation, or initiating emergency intervention.

Peer support team members capable of providing Level II peer support may continue to provide Level I peer support. Level I peer support occurs when peer support team members are not acting in their peer support team member role. However, when peer support team members are not acting in their peer support team role, the confidentiality privileges afforded to peer support team members during peer support interactions do not apply.

Level II peer support, like Level I, may consist of a one-time contact or ongoing meetings.

Some EMS personnel and EMS administrators are unclear about the role of a peer support team, especially considering that most modern-day EMS departments provide counseling services through health insurance plans and Employee Assistance Programs (EAP). It is not surprising that some EMS administrators ask, "With employee insurance coverage and an EAP, why do we need a peer support team?" The answer is simple - peer support teams occupy a support niche that cannot be readily filled by either health plan counseling provisions or an EAP. This is because well-trained and highly

functioning peer support teams provide support that is qualitatively different than that provided by health insurance therapists or EAP counselors. The difference? The difference is the *power of the peer*. The power of the peer is the factor that is a constant in the support provided by peer support team members. It is the factor that is not, and cannot, be present in any other support modality. Therefore, if an EMS department wants to do the best it can to support its personnel, a peer support team is necessary. Peer support can be initiated early in a medic's career - it can be made available to recruits during basic training as well as incorporated into EMS in-service training programs.

EMS Physical/Psychological Primary Danger and EMS Secondary Danger

The primary danger of EMS has two components: (1) physical primary danger and (2) psychological primary danger.

Physical primary danger. The *physical primary danger* of EMS is comprised of the inherent, potentially life-threatening risks of the job, such as working in toxic environments, confronting infectious disease, working in motor vehicle traffic, emergency vehicle operation, and dealing with violent patients.

Psychological primary danger. The *psychological primary danger* of EMS is related to, but distinguishable from the physical primary danger of EMS. The psychological primary danger of EMS is represented in the increased probability that due to the nature of EMS, medics will be exposed to critical incidents, work-related cumulative stress, and human tragedy. This higher probability of exposure results in an increased likelihood that medics will suffer psychological traumatization and stressor-related disorders. It is the increased likelihood of psychological traumatization and the increased likelihood of experiencing stressor-related disorders that comprises the psychological primary danger of EMS. Another way of saying this is that the physical primary danger of EMS constitutes a work environment that generates the psychological primary danger of EMS.

Secondary danger. There is also an insidious and lesser known *secondary danger* of EMS. The secondary danger of EMS is often unspecified and seldom discussed. It is an artifact of the EMS culture and is frequently reinforced by medics themselves. It is the idea that equates "asking for help" with "personal and professional weakness." Secondary danger has been implicated in perhaps the most startling of all EMS fatality statistics, the frequency of medic suicide. How dangerous is the secondary danger of EMS? So dangerous that some medics choose suicide over asking for help.

The Make it Safe EMS Initiative is designed to reduce the secondary danger of EMS. (Appendix C)

Peer Support: Stage Model of Peer Support

Peer support interactions often involve contacts that provide 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 your current behavior is helping you. In fact, it seems that 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 statute, departmental PST policy, PST operational guidelines, and 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, "*Don't lay your trip on the person you're trying to help"*.

Digliani, J.A. 2015. *Reflections of a Police Psychologist*, 2nd 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?

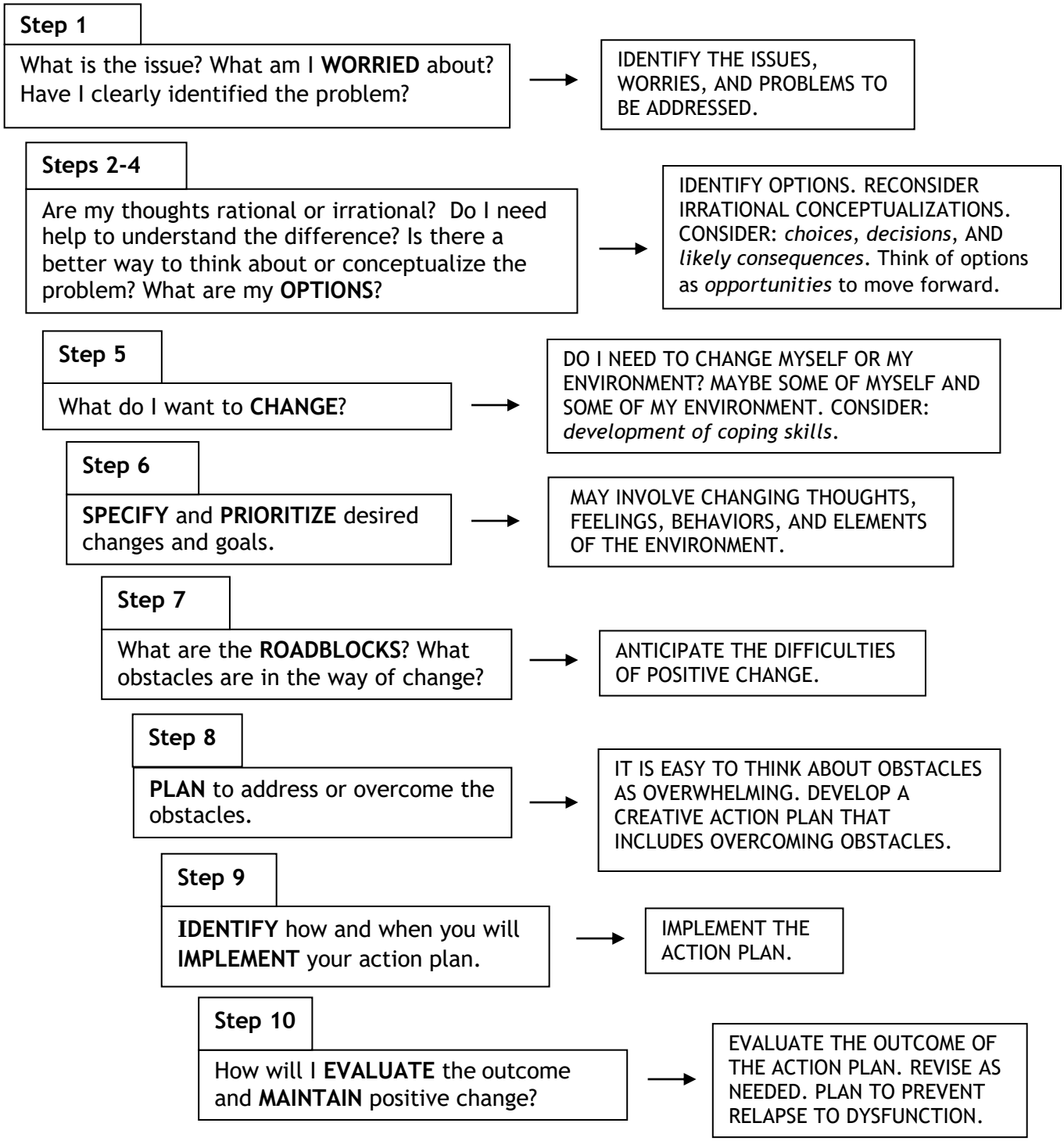
Step 10: How will I evaluate the outcome and maintain positive change? How will I prevent a relapse to dysfunction?

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*.



Joanne Rupert & Jack A. Digliani

Peer Support Team: Helpful Phrases

The following sentences and phrases may be helpful during peer support interactions. Consider circumstances, immediate context, and the emotional state of others when engaging in peer support. A statement of support or exploratory inquiry that is appropriate in one circumstance may not be appropriate in others.

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:
Tell me more.
Would you like to talk about what happened?
Did something stressful happen recently?
Bring me up to date on…
Let's take some time to go over this…
Can you help me to 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)?

> Generally, it is beneficial to avoid asking, "How does that make you feel?" and saying things like "What I hear you saying is…" when engaged in peer support exploration. These statements have too much potential to be regarded as cliché, mechanical, and sterile. They often diminish the perceived authenticity and genuineness of the peer support interaction. This is because it is not the manner in which most people speak to their peers in everyday conversations.

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, feelings, or experiences which are strange or unusual for you? Have you had thoughts of suicide or hurting yourself? Are you thinking about harming someone else?

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 as appropriate
- 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
- Schedule another time to meet if needed (follow up)
- 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. (2015) *Reflections of a Police Psychologist*, 2nd ed .

Peer Support Team: Questions and Answers

As a Colorado EMS peer support team member with a clinical supervisor…

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) and whether you are a mandatory reporter of actual or suspected child abuse or neglect, or abuse or exploitation of at-risk elders. 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 EMS position and act accordingly.
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*. 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 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 and does so, 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 agency's policy and operational guidelines if I am 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…". 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 organizations 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. Failing to bring a peer support interaction under supervision when it is required by PST guidelines leaves the interaction outside of the protection provided by C.R.S. 13-90-107(m) and 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 boundaries 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, first responder peer support team (PST) confidentiality is specified in C.R.S. 13-90-107(m) and department policy. Upon inquiry from investigators, some information discussed in peer support 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 trained and officially designated peer support team members are functioning in their official capacity as a PST member and within written agency PST guidelines.

Policy-based peer support team confidentiality is superseded by U.S. Code and statute-based administrative regulations. The administrative regulations that affect peer support team confidentiality often pertain to mandatory reporting requirements of supervisors. PST members that are supervisors must know and disclose any limits of confidentiality imposed by administrative regulations.

Limits of Confidentiality - C.R.S. 13-90-107(m): The privilege of confidentiality for peer support team members specified in C.R.S. 13-90-107(m) does not include:

1. Circumstances wherein the PST member is a witness or party to an incident which prompted the delivery of peer support (C.R.S. 13-90-107(m)).
2. Information involving actual or suspected child abuse or neglect (C.R.S. 19-3-304), or crimes against at-risk elders (C.R.S. 18-6.5-103, C.R.S. 18-6.5-108).
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. 27-81-111, C.R.S. 27-82-107).
4. Information relating to mental illness where there is an imminent danger to self or others, or a person is gravely disabled (C.R.S. 27-65-105).
5. Information indicative of any criminal conduct (C.R.S. 13-90-107(m)).

Information discussed in peer support interactions is shared with the peer support team clinical supervisor when clinical supervision is specified in PST Operational Guidelines.

Duty to Report or Take Action: Medical personnel are mandatory reporters under C.R.S. 19-3-304 and C.R.S. 18-6.5-108 and have a duty to report:

1. Actual or suspected child abuse or neglect (C.R.S. 19-3-304, C.R.S. 13-90-107).
2. Abuse or exploitation of at-risk elders (C.R.S. 18-6.5-103, C.R.S. 18-6.5-108).

Licensed mental health professionals are also mandatory reporters under these statutes. Therefore, even when a PST member is not required by law to report these circumstances, when PST members bring such information under clinical supervision, they will be reported. *This makes all PST members de facto mandatory reporters*. In such cases, PST members that are not mandatory reporters should contact their clinical supervisor immediately.

PST members are subject to all disclosures mandated by law.

Limits of PST confidentiality must be disclosed prior to peer support interactions.

For additional information see “Peer Support Team Confidentiality Complexities” (page 18) and “Information Regarding Peer Support and CRS 13-90-107(m) (2017)” at www.jackdigliani.com .

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. C.R.S. 13-90-107(m) was amended to include "emergency medical service provider or rescue unit peer support team member" in 2013. In 2017, it was again amended to remove the "individual interactions" provision.

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 subsection (1) (m) (III) of this section; nor shall a recipient of 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 subsection (1) (m) (III) of this section; nor shall a recipient of 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 subsection (1) (m) shall apply only to communications made during 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 subsection (1) (m) does 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, actual or suspected child neglect, as described in section 19-3-102, or actual or suspected crimes against at-risk persons, as described in section 18-6.5-103;
(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
State of Colorado

The protection against testifying without consent afforded to those specified in C.R.S. 13-90-107 applies to testimony within the State of Colorado court system. For first responder peer support teams, this protection is outlined in paragraph (m).

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

Federal code and state statute supersede department policy and guidelines. Therefore, PST policy/guidelines that provide confidentiality for PST members in administrative investigations and debriefings may be limited or overridden in circumstances involving U.S. code or statute-based administrative regulations, such as those that require supervisors to report incidents of sexual and other harassment and work-related employee injury.

PST confidentiality protections under C.R.S. 13-90-107(m) apply only when trained peer support team members are functioning in their official capacity as a PST member and within the written agency PST guidelines.

The prohibition against testifying without consent as specified in C.R.S. 13-90-107 (m) may not apply or may not always apply within the federal court system. This is because there is presently no federal confidentiality privilege for peer support team members and state standards of privileged communication are not necessarily binding on federal courts. In a federal court proceeding, the information exchanged in peer support interactions may be subject to disclosure under Federal Rules of Evidence - Rule 501, *Privilege in General,* depending upon the "rule of decision" and the issues involved in any particular case.

Limits of PST confidentiality must be disclosed prior to PST interactions.

In matters involving peer support confidentiality, peer support team members must exercise judgement and discretion based upon their knowledge of statutory provisions, agency policy and operational guidelines, and their peer support training.

Any questions or uncertainties about peer support confidentiality during or following peer support interactions should be brought to the peer support team clinical supervisor immediately.

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).

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 EMS, 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 person’s 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 –

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, EMS, 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 "bodywork": 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, occupational stress, and stress management see *Some Things to Remember* and Chapter 3 of *Reflections of a Police Psychologist (2nd ed)*.

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 involved patient, patient and/or others behavior, accompanied by other EMS personnel at time of incident, other EMS personnel 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 discernible 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. EMS personnel should never be returned to full duty while they are working through any overwhelming impact of a traumatic incident. EMS agencies should have policy directives which provide for administrative or other appropriate leave until an experienced EMS psychologist evaluates and clears the EMS personnel 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*.

Posttraumatic Stress (PTS) - 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 distress or impairment is absent in PTS.

Posttraumatic Stress Disorder (PTSD) - a constellation of clinical symptoms which meet the specific criteria for the PTSD diagnosis (including clinically significant distress or 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

EMS personnel who have experienced a traumatizing critical event want to place the incident behind them and move on. The difficulty for many EMS workers 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 EMS 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, EMS critical incidents happen because you are an EMS professional 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. Reach out. 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. Sometimes all it takes is sharing your experience with others who care.

This section adapts and includes information from the Colorado Law Enforcement Academy Handbook.

Positive Side of Critical Incidents

There is a positive side to critical incidents, a side that is seldom discussed. It has to do with becoming "stronger and smarter" following a critical incident. Becoming stronger and smarter following a critical incident involves several variables including (1) finding something positive in the experience and (2) placing the event into psychological history.

This aspect of critical incident survivorship was well-expressed by a British police officer (the process would be similar for a medic) that was involved in an incident several years ago wherein he was compelled to shoot a suspect that had taken a hostage. The suspect was killed. He knew he did was what necessary to protect the hostage but like many police officers, it took him some time to psychologically and emotionally process the event. He described part of his experience this way:

"…I am also aware how having come through both the incident and the aftermath, that I changed in a positive way too. I believe that dealing with the incident made me more resilient, able to cope better with problems and difficulties (based on a mind-set that goes something like "If I can deal with all of that, I can deal with anything that life throws at me"). The incident also reinforced my personal levels of professionalism (and my expectations of it in others). Over time these positives have, I believe, come to the fore, whilst the negative reactions have faded." (May 19, 2015)

Positive outcomes can result from critical experiences. We do not have to focus on the undesirable or challenging responses which are sometimes generated out of unpleasant or unwanted experiences. We have an ability to examine the other side of such experiences. We have an ability to achieve a better mental balance. To the degree this can be accomplished, we can move forward, through any aftermath of any critical incident. In this way, we become stronger and smarter.

Resiliency

"Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences. Research has shown that resilience is ordinary, not extraordinary. People commonly demonstrate resilience.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone." (From http://www.apa.org)

Stressor Related Disorders – DSM

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

Do not self-diagnose. Medics should contact an experienced licensed clinician 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

Additional DSM information can be found online at: www.psychiatry.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, MACE, 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**) and consider **Make a Contact Everyday (MACE)**. SPA and MACE activities include shift-briefing presentations, follow-up contacts, and new reach-outs.
- EMS personnel make decisions everyday that are based upon limited and sometimes faulty information. This information is interpreted through many filters including EMS training, work and other experience, current circumstances, and personal history. This *decision-making within limited and sometimes faulty information* is often a major factor in post-traumatic incident *second guessing*.

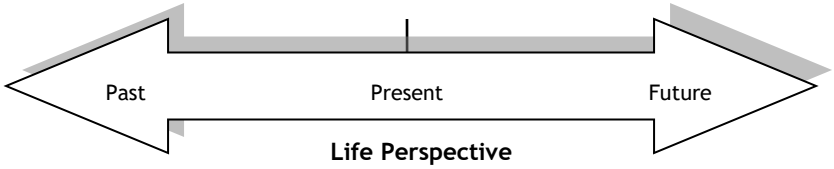
Life Management: Life by Default – Life by Design

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 and 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 EMS 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 medical or personal safety measures
- Increased citizen and family complaints
- Increased problems with coworkers and supervisors

Some Signs and Symptoms of EMS 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 EMTs, boreout can occur after the challenge of learning how to be an EMT diminishes, when they feel underemployed or underutilized, or upon being reassigned, transferred, or promoted (some EMTs will be overwhelmed by the demands of being reassigned, etc, others will not be challenged or have enough to do). To address boreout, EMTs 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 EMS Burnout and Boreout

1. Withdraw – for a short time, take a break from the job
2. Rediscover – the values that first brought you to EMS
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 EMS 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 – Information

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?

<u>Some Information About Alcohol</u>

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

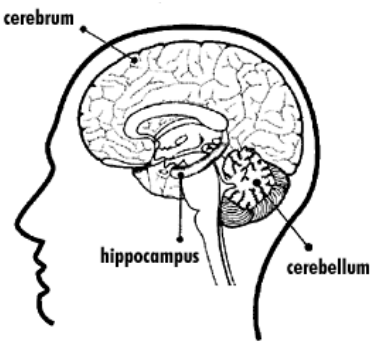
Biological (genetic) and psychosocial factors combine with environmental factors, such as the availability of alcohol, to increase the risk for developing drinking problems.

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

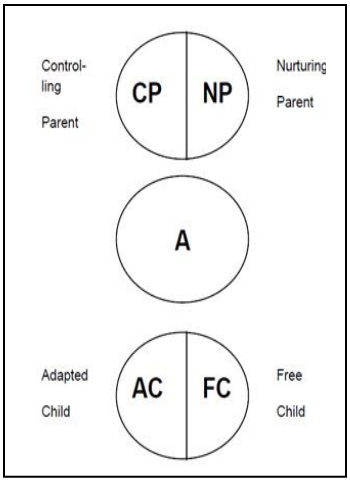
Ego state – a system of feelings accompanied by a related set of behavior patterns
Psychic energy – the theoretical force that energizes the various ego states
Executive power – the ego state with the most psychic energy has executive power
Stroke – the fundamental unit of social action (may be positive 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 50)
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*.

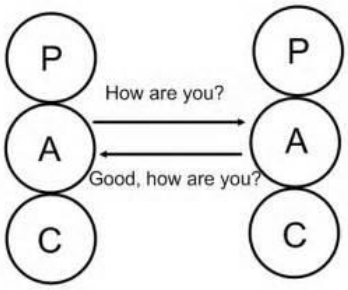


The ego states of TA

(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.

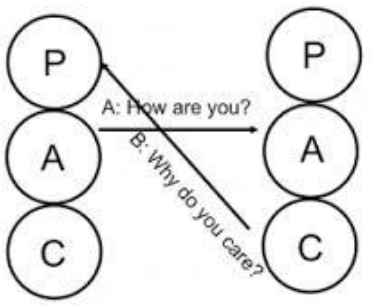
Complementary: In a complementary transaction, a person receives a stimulus in the ego state intended by the sender of the stimulus, ("How are you?" sent from Adult to Adult) and responds from this ego state to the originating ego state of the sender ("Good, how are you?" sent from Adult to Adult).



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).

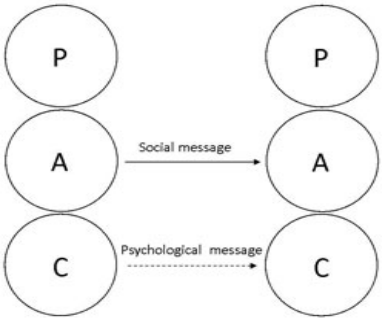


Adult-Child Crossed Transaction

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 – Drama Triangle

There are three rules of communication in Transactional Analysis:

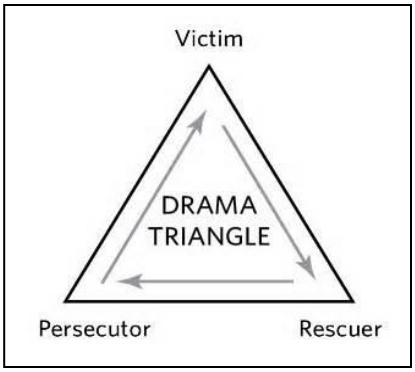
(1) So long as the transactions remain *complementary*, communication may continue indefinitely.
(2) Whenever the transaction is *crossed*, a breakdown (sometimes only a brief, temporary one) in communication results and something different is likely to follow.
(3) The outcome of transactions will be 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 Rowe, New York, 1967.

Peer Support Team and Critical Incidents

Peer Support Team

EMS department peer support teams are part of the department's comprehensive response to a fire service critical incident.

The peer support team is comprised of personnel trained in peer support and functions under the supervision of the department's licensed mental health professional (LMHP).

The goal of the peer support team is to minimize the likelihood of traumatization to medics and their families.

Peer support interactions are confidential within the limits prescribed by department policy and state statutes.

Responsibilities

The peer support team has the following responsibilities:

- Respond to the location where peer support is needed. This may be at the incident scene or another location (such as a staging area, holding area, etc).
- Assist medics by providing support to address any identified or perceived emotional, psychological, or physical need.
- Help medics to appropriately dissipate any heightened emotional and physical arousal. This may be accomplished by assisting them to process the intense emotional and physical reactions that are sometimes associated with critical incidents. Consider the "walk and talk."
- Identify any signs of a complicated stress response which might indicate a need for intervention beyond peer support.
- Facilitate family notification or other contact as requested by EMS personnel. Meet the needs of involved personnel families as necessary.
- Minimize the likelihood of secondary trauma.
- Mentally prepare the medic for any investigative process that may originate out of the actual circumstances of the incident or the medic's participation in the incident.
- Assist medics in any other way consistent with the mission and goals and of peer support and the peer support team.
- Assist the department LMHP as needed.

Information

- Peer support serves a supportive function and does not interfere with on-going scene management, medical intervention, or any necessary investigative process.

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

- Peer support team members, when functioning in their peer support role should not be assigned any medical responsibilities *unless absolutely necessary*. If placed in an alternative assignment, the peer support team member should not function simultaneously in a peer support role.

- The department LMHP or a peer support team member designated by the department LMHP should coordinate the timing, strategy, and format of any critical incident group or resiliency debriefing.

- EMS peer support teams function within the parameters of law, department-specific policy, and PST operational guidelines.

Critical Incidents and Single-exposure Learning: Single-exposure learning is a type of the classical conditioning made famous by Russian physiologist Ivan Pavlov (1849-1936). Simply stated, Pavlov demonstrated that an *unconditioned stimulus* could produce an *unconditioned response*. He showed this by administering meat powder to the mouth of dogs and measuring their salivation. Theoretically, the salivation upon the introduction of the meat powder did not represent learning. Salivation occurred as a natural response to the meat powder. In classical conditioning terms, the meat powder was the unconditioned stimulus, the salivation the unconditioned response. When Pavlov paired the introduction of meat powder with the sound of a metronome, the meat powder continued to produce salivation in the dogs. After a series of meat powder/metronome pairings, the sound of the metronome alone produced salivation. The sound of the metronome had become a *conditioned stimulus,* and the following salivation the *conditioned response*. The dogs had learned to salivate upon the sound of the metronome. Notice that the unconditioned response and the conditioned response are identical - salivation. The difference between the two responses is the stimulus that produced it.

Single-exposure learning is similar to the conditioning process observed in Pavlov's dogs with one significant difference - a series of parings is not necessary to produce learning. Instead, a single exposure to a particularly intense unconditioned stimulus can bring about a lifetime conditioned response. Often, the response is dysfunctional and unwanted. For example, consider the case of Mary G, a woman who was assaulted by a man with a beard. During the assault she experienced an overwhelming fear that she would be killed. She survived the assault and recovered from her injuries. The perpetrator was arrested, convicted, and imprisoned. However, from the night of the assault onward, Mary experienced intense fear whenever she saw a man with a beard. Mary's fear response (unconditioned at the time of the assault) had become conditioned to the previously neutral stimulus, *man-with-a-beard*. Men with beards had become a conditioned stimulus. Men wearing facial hair that approximated a beard produced varying intensities of fear for Mary; the actual response being dependent upon the degree of approximation. This is a process known as *generalization of conditioned stimuli*.

For medical personnel, single-exposure or "one-shot" learning works much the same. Following exposure to a critical incident, medics can become conditioned to nearly anything, including the sight of uniforms, emergency vehicles, certain odors, and the sound of radio traffic.

Conditioned fear or anxiety responses must be neutralized prior to a medic being returned to duty. Unfortunately, historically, medics that suffered from undesirable conditioned responses managed them with alcohol, false bravado, or by simply gutting it out. Today, enlightened medical services engage psychologists and other mental health professionals to assist medics to disconnect dysfunctional conditioned responses from the conditioned stimuli resulting from critical incidents.

Adapted from: Digliani, J.A. (2015). Reflections of a Police Psychologist (2nd ed) 80-81. Bloomington, Xlibris.

Peer Support Team Limits of Confidentiality - Debriefing

Recommended *Peer Support Team Debriefing Statement* for Colorado first responder peer support team members that are trained to facilitate peer support debriefings. Provide a printed copy to each participant if appropriate. Comments for peer support team facilitators are included in [ ] brackets.

Read the following paragraphs aloud to the group prior to the start of the debriefing.

1. Participants in a peer support debriefing have a primary ethical obligation to respect one another and the information disclosed during the course of the debriefing.

2. Recipients of peer support cannot be compelled to testify without their consent except as exempted by C.R.S. 13-90-107(m)(I) and (I.5) and mandated by law.

3. Information communicated in peer support team interactions is not subject to disclosure in administrative inquiries or investigations [if in agency policy].

4. Peer support team members do not disclose, and cannot be compelled to testify, about any information presented during the debriefing without the consent of the person to whom the information relates except as exempted by C.R.S. 13-90-105(m) and mandated by law. These circumstances are:

- Mandatory reporting. Medical personnel, as well as many other professionals are required to report actual or suspected child abuse or neglect (C.R.S. 19-3-304) and abuse and exploitation of at-risk persons (C.R.S. 18-6.5-108). [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 must be reported.]
- Emergency situations involving intoxication and/or mental illness.
- Information indicative of criminal conduct.

5. Peer Support Team members have an obligation to brief our Peer Support Team clinical supervisor. [name your clinical supervisor and the reasons for clinical supervision if necessary]

6. [Specify any mandatory reporting requirements imposed on supervisors by administrative regulations – most often incidents of harassment and work-related employee injury. Identify any PST member supervisors in the group.]

7. [Read the following if there are peace officers in the group] Peace officers that determine 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, peace officers must take action under such circumstances if disclosed during the debriefing (C.R.S. 18-6-803.6).

8. If you have any legal questions or concerns, the Peer Support Team recommends that you not discuss it here. Instead, you should consult with a legal professional.

Guidelines for Facilitating an EMS 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 "you"* in **General Debriefing Information** – page 60)

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 support person tends to suppress the group process and inhibit open discussion. This is especially true for EMS chiefs and other high-ranking officers. In most circumstances it is helpful for the chief to provide an in-person, ***brief*** statement of support to the group just prior to the start of a debriefing. However, this is no substitute for uninvolved persons, supervisors, and administrators to contact involved persons independently and outside the debriefing process to demonstrate their support.
9. *Clinical debriefings* are those that are facilitated by licensed mental health professionals. They are deemed confidential within the limits prescribed by law. Colorado *peer support team debriefings* also involve a confidentiality privilege. Know what confidentiality limitations apply and state them clearly. (See “PST Limits of Confidentiality - Debriefing, page 46). 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.

EMS 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 46
Incident and Debriefing Information (participant handout) – page 54
How to Recover from Traumatic Stress – page 27
Some Things to Remember – page 39

Optional additional debriefing handout information:
Critical Incident Information – page 24
Traumatic Stress: Shock, Impact, and Recovery-PTS/PTSD – page 25
Trauma: Chronological History and Psychological History – page 26

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. They should be offered peer support from non-involved peer support team members.

Peer support team members as gatekeeper: If the "gatekeeper" support intervention procedure is implemented – 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 personnel/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's licensed mental health professional (LMHP) or a PST member designated by the LMHP should coordinate the timing of any critical incident group debriefing with criminal investigators (if applicable) so that the efficacy of the debriefing and integrity of incident 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 (if applicable):

(1) Coordinate efforts with the peer support team and PST LMHP.
(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 LMHP or PST 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 incident investigators and the peer support team are:

(1) to meet the highest standards of incident investigation and
(2) enhance the welfare of involved personnel/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 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 – loss of income
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 – feelings of helplessness
Loss of meaningfulness – no point to living

Greater risk of suicide if:

History of suicide attempts – easy access to firearms
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

Veterans more prone to commit suicide

An analysis of suicide data released in September (2017) by the Department of Veterans Affairs shows the risk for suicide is 22% higher for veterans compared to non-veterans.

The risk was 19% higher among male veterans compared to adult non-veteran men, and the risk for female veterans was 2.5 times higher than for non-veteran adult women. Firearms were used in about 2/3 of veteran suicides.

Veterans in crisis or considering suicide: call the Veteran Crisis Line: 800.273.8755 or visit VeteransCrisisLine.Net/Chat

From: *The National Psychologist*, Nov/Dec, 2017

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 "sworn to secrecy" do not 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 person'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.
- Diagnosis or 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

EMS Suicide Risk Factors

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

EMS suicide risk factors:

Diagnosis of depression, anxiety, or other mood disorder.
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; failed resuscitation.
Frustration or embarrassment by some work-related event.
Internal or criminal investigations; allegations of wrongdoing; criminal charges.
Assaults on an member'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 most of 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.
Unwillingness to seek help because of perceived stigma.
Sudden sense of calm while circumstances have not changed.

EMS members should not avoid other EMTs they think might be suicidal.

Peer Support Team: If you observe any of the behavior associated with suicide risk in another person, 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 person is imminently suicidal, do not leave the person alone. Contact your clinical supervisor immediately. Together, with your clinical supervisor, arrange for the appropriate intervention. If the person is not imminently suicidal, spend some time with him/her. Listen closely and provide emotional support. Contact your clinical supervisor. Provide information about available support resources, including the department psychologist (if applicable), EMS 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 useful 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. 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." Be yourself.
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. Maintain your personal boundaries.
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 of suicide if necessary. Control potentially lethal prescribed medications or street drugs 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 the fact 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: (1) from the suicidal person; ask the person to cooperate with you and your efforts to assist, (2) from others if warranted; ask appropriate others to assist you in your efforts to help the suicidal person.
16) If the person is not imminently suicidal, spend some time talking, "provide an ear," and offer emotional support. Depending on the circumstances and your relationship, encourage, assist, or insist that the person 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 person-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. Do this even if the person objects. 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, even if requested to do so. If necessary, gently explain that you must share the information provided to you and that you must contact appropriate others.
20) Follow up as appropriate. Factors influencing appropriate follow up include the degree of suicidality, 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

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 – Death Imprint

The exposure to the death of others can evoke various emotional responses in EMS personnel. There are many factors that influence an emotional response to death. Among these are the actual circumstances of death, the age of the deceased, the number of those that have died, the relationship of the deceased to the provider, the maturity and personality of the provider, their world view, and whether they feel that they 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 EMS, death is a more-than-usual topic for thought. For one thing, EMT training directly or indirectly encourages trainees to think about death; this normally produces thoughts their own death as well as the death of others.

EMS personnel are also encouraged to think about death by the very nature of their work. Medical intervention exposes them to death in various ways, including treating victims of crime, natural deaths, and deadly traffic accidents.

Every person in EMS is taught or soon learns that there are those in our society that would look to intentionally harm or kill others. This is the reason for the professional emphasis on EMS safety. EMT's must always be prepared to defend themselves. This is why EMTs live in a world of *assumption of possible threat* (although this assumption may not reach the level of that experienced by police officers). This is different from those in most non-emergency service occupations. Most others live in an occupational world of *assumption of safety*. As part of their careers, many EMTs have had to defend themselves against a person intent on harming them.

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 EMS's personal commitment to duty, recognizes human limitation, and more accurately describes the human condition. This is accomplished by following operational procedures, conscientiously practicing EMS procedure, exercising due diligence, and so on. In summary, the degree of death exposure for EMS 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 death-coping abilities. In turn, this allows EMTs to work in their assignments without a great deal of death anxiety or distress. However, no

matter how EMTs conceptualize death or how well they cope with death exposure, there is always the risk of *death imprint*.

Death Imprint

When people in EMS 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 those 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 EMT'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, make appropriate referrals, or support the person to seek professional help.

Recognizing Mental Disorders – Field 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 EMS personnel.

Persons in EMS must be skilled in making mental illness *field assessments*. At minimum, EMTs must be able to (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 incapable of caring for themselves, are endangered by this incapability, and require immediate intervention to avoid unintentional self-harm.

Signs (observable) and symptoms (information reported by the person) are the primary components of EMS field assessments. Observations of reliable other persons can also be used in field assessments.

When conducting a field assessment, a person's behavior must be evaluated within context. Several 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 disability* (formerly called *mental retardation*).

When EMTs 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 an imminent danger to self/others or gravely disabled, the person should not be left alone. Intervention is necessary. If the person does voluntarily consent to intervention and transport, involuntary detention is essential. EMTs should contact the police in cases wherein involuntary detention for evaluation and treatment as authorized under C.R.S. 27-65-105, *Emergency procedure,* is required.

Recognizing *Intellectual Disability*

Intellectual Disability (also called *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 other measures of intelligence.

As defined today, Intellectual Disability "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, p.31).

Persons with an Intellectual Disability:

- 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 EMS 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 911.
- may be fascinated by the EMS 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 EMS commands.

Intellectual Disability and Mental Illness

It is possible for a person to be diagnosed with an Intellectual Disability 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 EMS.
   - 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 EMTs 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 de-emphasize EMS 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 EMTs 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 to treat other conditions)

Abilify *aripiprazole*
Adapin, Sinequan *doxepin*
Anafranil *clomipramine*
Asendin *amoxapine*
Celexa *citalopram*
Cymbalta *duloxetine*
Desyrel *trazodone*
Effexor *venlafaxine*
Elavil, Endep *amitriptyline*
Fetzima *levomilnacipran*
Lamictal *lamtrigine*
Latuda *lurasidone*
Lexapro *escitalopram*
Limbitrol (Librium/Elavil)

Ludiomil *maprotiline*
Luvox *fluovaxamine*
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)
Trintellix *vortioxetine*
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)

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

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

Medications to Reverse Opioid Overdose

Narcan, Evzio *naloxone*

Antipsychotic Medications

Aristada *aripiprazole*
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 *donepzil*
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 EMS members 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 Tips* the *Foundation Building Blocks of Functional Relationships* provide an excellent framework for those wishing to improve their marriage and other personal relationships.

Gottman's 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.

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., 2015. *Reflections of a Police Psychologist 2nd ed,* 166).

<u>There are three general categories of extramarital affairs</u>:

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.

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 - spouses should directly confront poor treatment)

Can an affair be good for a marriage? Although an affair may focus a couple on improving their marriage, affairs are seldom "good" for a marriage. Can an affair be overcome in a marriage? Yes, to varying degrees, in some marriages.

What about multiple spouses and "open" marriage? Culturally, there are several types of marriage that include multiple spouses (i.e. polygyny, polyandry, & group marriage). In an open marriage there is a single spouse and an agreement that permits one or both spouses to see others. Those in open marriages report varying degrees of happiness and satisfaction. Some open marriages "close" after a period of time.

<u>Affairs and addiction to sex</u>: current diagnostic information – DSM
Nymphomania and *satyriasis* (excessive sexual drive) ICD-10-CM
Process addictions - *Soft* addictions

<u>Peer Support</u>: 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 EMS after many years of service represents a major life transition. Many people 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 EMS, members need to prepare. Although having sufficient funds is important, this preparation should go beyond financial considerations. EMTs need to prepare psychologically. This is best accomplished by life-by-design considerations and should begin years before actual departure.

To help EMTs to better decide when they should retire and to help them psychologically prepare for the transition out of EMS, 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 EMS?

5. Are you still connected to EMS 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 EMS career as a ROD (Retired on Duty) EMT*.

6. Are you prepared to lose the prestige associated with being in EMS?

7. Have you thought about who you are without the EMS? What will be your personal identification after retirement? Will "retiree" or "retired from EMS" work for you? What will you put in its place? For some, being retired from EMS 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 games. Many EMTs 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; maybe not significant boredom, but at least some experience of having more uncommitted time. Most will deny this. They say things like "I'm busier now than when I was working." It is seldom true. It is uncertain why it is so difficult for retired EMTs 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 EMTs. It is likely that some retired EMTs are busier retired than when working. But for most of them, things slow down. Newly retired members of EMS 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 EMS). The stress reduction experienced by most of those in EMS 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 EMS 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. How will you spend your uncommitted time?

11. How will you continue to contribute to your community? After a career of public service, many of those from EMS 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.

EMS Retirement and Emotional Abandonment

Upon retirement, some people talk about feeling emotionally abandoned by the department and former coworkers. Retired EMS personnel 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 personnel that have had close ties with a now retired EMT 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 EMT 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 EMS.
- 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*.

Stay connected to your clinical supervisor or advisor. 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 Occupational Imperative

Do not forget *why* you do *what* you do.

The Relationship Imperative

Make it safe!

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

Proactive Annual Check-in

Elements of the Proactive Annual Check-in:

1. **Annual visit with the department mental health professional 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**

Make Your PAC Appointment Today

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EMS Physical and Psychological Primary Danger and Secondary Danger

The primary danger of EMS (physical and psychological) is comprised of the inherent risks of the job, such as working in motor vehicle traffic, confronting violent persons, and increased probability of exposure to critical incidents. Sadly, there is an insidious and lesser known *secondary danger* in EMS. This danger is often unspecified and seldom discussed. It is an artifact of the EMS culture and is frequently reinforced by EMTs themselves. It is the idea that equates "asking for help" with "personal and professional weakness", and in one sense is the number one killer of EMS. For more information about primary and secondary danger see *Contemporary Issues in Police Psychology* (Digliani, J.A., 2015). The EMS Make It Safe Initiative is an extrapolation and modification of the Make It Safe Police Officer Initiative.

The Make it Safe EMS Initiative

Make it safe for members of EMS to ask for psychological support

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

The Make it Safe EMS Initiative seeks to:

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

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

(3) change organizational climates that discourage EMS 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 EMS culture that generally views asking for psychological help as a personal or professional weakness.

(5) improve the career-long psychological wellness of EMS by encouraging EMS agencies to adopt long-term and comprehensive support strategies.

How serious is EMS secondary danger?
So serious that some of those in EMS will choose suicide over asking for help.

Twelve primary elements of the Make it Safe EMS Initiative

The Make it Safe EMS Initiative encourages:

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

(2) every EMT to seek psychological support when confronting potentially overwhelming difficulties (EMS does not have to "go it alone").

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

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

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

(6) EMS administrators to issue a departmental memo encouraging personnel 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, EMS 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 support interventions (for example, proactive annual check in, “early warning” policies designed to support those displaying signs of stress, and regularly scheduled stress inoculation and critical incident stressor management training).

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

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

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

(12) EMTs 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 EMS wishes to do the best for themselves, it’s time to make a change.
It's time to make a difference.

www.jackdigliani.com

Implementing the Make it Safe EMS Initiative

Implementing the Make it Safe EMS Initiative is not difficult. The elements of the Initiative are easily implemented by initiating processes, strategies, and programs already well known to the emergency medical service.

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 EMS Initiative* work for you.

Considerations and recommendations for implementing the elements of the Make it Safe EMS Initiative

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

Implementation: Many in EMS are pretty good at picking up signs of distress in others. But, 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 EMTs know when they are experiencing stress or trauma-related difficulty. However, knowing you are having difficulty is not enough. You must also know what to do about it and be willing to take action. One of the things that you can do about it is to talk to someone. Allow yourself to seek appropriate support and assistance.

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

Implementation: Why limit yourself to personal stress management ideas and strategies? 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. Many times just talking it out will help you to see things differently and help you to feel better, The next time you feel stressed, take a chance. Talk to someone you trust. You may be pleasantly surprised at the outcome.

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

Implementation: Even if an EMT 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, EMTs will shy away from others in distress for a variety of reasons, including not knowing what to say or do. But think about this – during my years of psychological practice I have had many persons time after time talk

about how an unanticipated kind word from a peer 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.

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

Implementation: Veteran EMTs are in a unique position to influence the EMS culture generally and organizational climate specifically. They can do this for better or for worse. If you are a veteran or ranking person of EMS, 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 EMTs seeking or engaging psychological support, and talking about the acceptability of seeking psychological support when confronting stressful circumstances.

(5) The Initiative encourages: EMS 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 EMS primary and secondary danger is relatively new. EMS administrators should think through the notions of EMS primary and secondary danger, take the lead, and consider ways to reduce secondary danger within their agencies.

(6) The Initiative encourages: EMS administrators to issue a departmental memo encouraging personnel 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. All it takes is an understanding of what support services are available, learning about the limits of confidentiality, and a commitment to write and distribute such information in a departmental memo. If you are an EMS 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. A memo from the chief that identifies support services and encourages their use expresses a caring attitude and lets those know that it is ok to seek support. This element alone has significant potential to help EMTs in distress.

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

Implementation: In nearly every jurisdiction there are qualified persons that are willing to train EMTs 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 members of EMS already within the department. Training in these areas should begin in recruit academy and continue throughout an EMT's career.

(8) The Initiative encourages: the development of programs that engage pre-emptive, early-warning, and periodic department-wide EMS support interventions (for example, proactive annual check in, "early warning" policies designed to support EMS 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 EMS agencies. Many departments offer stress management refresher training periodically and have early warning EMT-assist policies and programs already in place. These programs are designed to help those cope with everyday stress and the potentially overwhelming stress of EMS before it becomes an issue.

(9) The Initiative encourages: EMS agencies to initiate incident-specific protocols to support their EMS crews and their families when EMTs 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 critical incidents. The protocol can define "critical incident" and "EMS-involved" to best fit departmental standards. It can also specify when the protocol should be engaged. Critical incident protocols not only help to standardize incident management, but can also be designed to reduce second injury, secondary trauma, and secondary danger. Incident protocols can be developed by and applied to individual EMS agencies or they can be developed by and be applied to 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. Agencies with an EMS critical incident protocol have used a committee from EMS and other professionals to develop it. Such committees have included EMS personnel, investigators, supervisors, administrators, district attorneys, peer support team members, and EMS psychologists.

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

Implementation: The efficacy of EMS peer support teams is well understood by EMS psychologists and many EMS administrators. To be most effective, EMS 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." Several states have enacted legislation which provides members of EMS (and other) peer support teams with a degree of statutory confidentiality.

(11) The Initiative encourages: EMS agencies to provide easy and confidential access to counseling and specialized EMS 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 EMTs are to view them as viable resources.

(12) The Initiative encourages: EMS members 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: EMS must remain aware that even seemingly innocuous verbal exchanges and unintentional nonverbal gestures can contribute to EMS secondary danger. To avoid this, EMTs of all ranks must act conscientiously, proactively, and consistently to reduce EMS secondary danger. This requires increased personal awareness and may require a significant shift in thinking for some EMTs . In this way, EMT's can positively affect their agency's organizational climate and thereby, the EMS culture.

The effects of the Make it Safe EMS Initiative are cumulative:
the more elements implemented,
the greater the effect.

Peer Support Team Code of Ethical Conduct

As a member of an agency peer support team I am committed to the highest standards of peer support. I knowingly accept the responsibility associated with being a member of a peer support team.

Peer support team members:

1. engage in peer support within the parameters of their peer support training.
2. specify when they are functioning in their peer support role, and if uncertain whether an interaction is peer support, they inquire to clarify.
3. keep themselves current in all matters of peer support confidentially.
4. disclose peer support information only with appropriate consent, except in cases where allowed or mandated by law; and if uncertain whether disclosure is appropriate, consult with their clinical supervisor prior to disclosing information.
5. clearly specify the limits of peer support confidentiality prior to engaging in peer support.
6. remain aware of potential role conflicts and are especially vigilant to avoid role conflict if in a supervisory position.
7. make a reasonable effort to attend scheduled team meetings and programs of in-service training.
8. make referrals to other peer support team members, their clinical supervisor, and others when appropriate.
9. are careful providing peer support for persons with whom they have a troubled history. If the history cannot be overcome, they provide appropriate referral.
10. comply with peer support team statutes, policies, and operational guidelines.
11. do not utilize their peer support role for personal gain or advantage.
12. do not engage in inappropriate behaviors with those for whom they are providing peer support.
13. contact their clinical supervisor immediately with any perceived role conflict, ethical issue, or possible conflict of interest arising out of peer support.
14. seek immediate clinical supervision and consultation in any circumstance that reasonably exceeds the assessment and parameters of peer support.
15. reach out to others they know or suspect may benefit from peer support.
16. make reasonable effort to respond to individual requests for peer support and to respond to critical incidents as needed.
17. seek support from other peer support team members, their clinical supervisor, or other support personnel when stressed or otherwise in need of support.
18. are committed to helping other peer support persons to become better skilled. They do this by readily sharing their knowledge and experience when it does not conflict with the standards of peer support confidentiality.
19. endeavor to maintain a positive relationship with their clinical supervisor and other peer support team members, and make an effort to resolve any issues of conflict that may arise in these relationships.
20. understand that they are perceived as role models and that their actions reflect upon the entire team.
21. utilize self-enhancement peer support concepts in their personal lives.

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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 also served as the police psychologist for the Loveland Police Department and Larimer County Sheriff's Office (Colorado). During his service 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 first-responder peer support teams.

Dr. Digliani is the author of *Contemporary Issues in Police Psychology*, *Reflections of a Police Psychologist*, *Law Enforcement Peer Support Team Manual*, *Firefighter Peer Support Team Manual*, *Law Enforcement Critical Incident Handbook*, and *Law Enforcement Marriage and Relationship Guidebook*. 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 principal author of the peer support section of the *Officer-Involved Incident Protocol* of the Eighth 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.

Dr. Digliani developed the Freezeframe method of critical incident debriefing. Through his work, he advanced the conceptualizations of Option funnel versus Threat funnel, Level I and Level II peer support, Life-by-Design, the 2-and-2, and the *Comprehensive Model for Police Advanced Strategic Support* (COMPASS). COMPASS is a career-long psychological health and wellness strategy for police officers. COMPASS was adapted for firefighters in the *Comprehensive Model for Peer Advanced Strategic Support*.

In 2013, Dr. Digliani developed the conceptions of primary and secondary danger. He then created the Make it Safe Police Officer Initiative, a 12-element strategy designed to reduce the secondary danger of policing. The Initiative was later extended to firefighters and EMS in the Make it Safe Firefighter and EMS Initiatives. In 2015, Dr. Digliani crafted the *Peer Support Team Code of Ethical Conduct*. He created the *Peer Support Team Utilization and Outcome Survey* in 2017, a survey specifically designed to assess the use and efficacy of agency peer support.

Emergency Medical Services

Peer Support Team Manual