Emergency Services Dispatch
Support Information

Reference and Resource Handbook
Edition 1.1

Emergency Services Call Takers and Dispatchers Supporting One Another

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Emergency Services Dispatch Support Information

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Introduction

As first-responders, emergency services call takers and dispatchers (CT&D) confront many of the same stressors as those they dispatch. Additionally, they confront several stressors unique to working in dispatch.

One of the unique stressors confronted by CT&Ds is the idea that because CT&Ds are not on scene, they are not, or should not, be affected by the work they do. This somewhat longstanding idea is likely the reason why stress management training, critical incident protocols, and trauma intervention programs for dispatch have lagged behind those created for field personnel.

While CT&Ds have traditionally turned to each other for emotional and psychological support, many call takers and dispatchers now have additional support options. These include jurisdiction-wide Employee Assistance Programs, insurance provided counseling services, community support resources, and agency peer support teams.

The *Emergency Services Dispatch Support Information: Reference and Resource Handbook* is intended to supplement existing dispatch support programs.

Note: references to "dispatchers" are meant to include call takers and all other dispatch personnel. When used alone, the word "dispatcher" is applied solely for brevity of text and ease of reading.

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The *Emergency Services Dispatch Support Information* handbook contains information included in or adapted from the written works of Jack A. Digliani.

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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 dispatch, interacting with highly emotional, injured, and 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).

The Dispatch Culture

Call takers and dispatchers (CT&D) are frequently told
"it's not your emergency, you are not there, it shouldn't affect you"
Katie Barrett, Airport Emergency Dispatch

In modern-day emergency services dispatching, several organizational structures exist. Many first-responder agencies have call takers and dispatchers. Some agencies combine these duties. Within agencies that combine call taking and dispatching, the person that answers the 911 call and/or non-emergency calls is also responsible for dispatching field units. Some agencies have a separate police, fire, and emergency medical services (EMS) dispatch, while others combine the various dispatch positions. Some dispatch personnel are responsible for dispatching a single first-responder agency while others may dispatch multiple agencies. Some dispatch centers are equipped with the latest communication technology, while others await tech upgrades. Regardless of the actual tech and structure of any dispatch center, each center is a workplace that includes some shared and some unique occupational stressors. Of the newer occupational stressors that many dispatch personnel confront is the NG911. This technology will give a face to the voice on the other end of the phone and in some cases provide a live streaming video.

Call Takers and Dispatchers

Emergency services call takers and dispatchers come from a variety of backgrounds. They are former teachers, stay at home parents, former police, fire, military and EMS workers, wait staff, telemarketers and just about everything in between.

Most agencies are able to train and prepare CT&D candidates through uniform and standardized training programs. These training programs are normally focused on the technological aspects of the job. This is beneficial in most cases and it trains the CT&D how to do the job. But within many dispatch training programs there is a critical lack of discussion about the potential mental health and trauma difficulties that are possible in emergency services call taking and dispatching. In many CT&D training programs there is little time spent, if any at all, discussing the unavoidable stressors of CT&D and ways in which to better manage them. There is little or no attempt to prepare CT&D candidates for the inevitable psychological and emotional challenges to come.

Most first-responders "on the streets" are made aware of the "fight or flight" response and are provided at least some training in stress management. Additionally, on calls that street first-responders handle, they often achieve some form of closure or known resolution pertaining to any particular call and usually have some time to decompress between calls. However, CT&Ds too frequently receive no or woefully inadequate training about fight or flight and stress management. They often move from one dispatch event to another with little or no time between calls. There is no time to decompress. CT&Ds also receive little information about call resolution and have little opportunity to seek call follow up. This results in a continuous stream of "open-ended" work events. This causes CT&Ds to remain in a heightened state of alert as they do not get the same type of closure, resolution, or time-break normally experienced by street crews.

Persons that contact dispatch include those that have been hurt in accidents, have been injured at the hands of others, have attempted or are considering suicide, and so on. Some of these calls involve children. Some of these calls are highly stressful, involve life-risk, and are nearly emotionally overwhelming.

Whether or not a particular call feels nearly overwhelming, we now know that the cumulative exposure to calls involving human tragedy takes a psychological and emotional toll. Despite this, many call takers and dispatchers are told over and over "it's not your emergency, you are not there, it shouldn't affect you." As uninformed and harmful as this is, it may get worse. How are these words and reactions going to affect CT&Ds with the development of NG911 when there is no longer anonymity on the other end of the line, when live video calls or pictures are coming in simultaneously?

Occupational World

Imagine for a moment the occupational world in which call takers and dispatchers live. A person telephones, tells you they are injured and is screaming for help. He or she is begging you, as the person on the other end of the line, for help. Now imagine that you do your job and help arrives. Did the person survive? Are they now ok? You never get to know because the minute you disconnect from that call, another call drops in. This time the caller is saying "I can't do it anymore, I think I want to kill myself."

This rapid succession of callers, presenting situations that vary from the mundane to life-threating circumstances, again and again, for 8, 10, 12, 14+ hours a day with few breaks of a few minutes for food or bathroom pushes stress levels to the maximum. This happens because most agencies do not have the staffing to allow for sufficient breaks during shift. A bathroom break may be the only "downtime" available, and even that depends upon call volume. Healthy eating during shift is also impaired. Foods tend to be "inhaled" or eaten cold due to constant radio traffic and call volume. Fast food is often the only option available because healthy meal prepping often takes too much time. Even using a microwave is a luxury when busy.

During staffing shortages overtime is sometimes ordered. Mandatory overtime may compel CT&Ds to work double shifts or at minimum, extended hours in an already stressful environment. There is often seemingly little appreciation for these efforts.

This is the occupational world of emergency service call takers and dispatchers.

Dispatching

Dispatchers go from officers needing criminal information on subjects, to foot chases, to vehicle chases, to fighting with individuals, and a few asking for lunch here and there. In combined centers, there are also the demands of the fire and ambulance services.

Why would anyone in their right mind want to have their mind racing all the time, their adrenaline fluctuating constantly, while being tied to a desk or console? The answer is simple: community service.

Community Service

Serving the community as a call taker or dispatcher takes a special kind of person. Not everyone can "take the call" and perform calmly and consistently as the job requires. Being a call taker or dispatcher can be thankless and incredibly stressful. So why do it? While being a call taker or dispatcher can be thankless and incredibly stressful, it can also be incredibly rewarding.

Although CT&Ds do not provide the hands-on interventions of field first-responders, they assist others in distress and *save lives worldwide* every day. All CT&Ds should take pride in the work they do as an essential part of the emergency services system. They should not forget *why* they do *what* they do.

Dispatch Culture

Although there may be notable exceptions, the overall CT&D culture is one that provides little to no support to those that do the job. There is often little or no support from police officers, firefighters, emergency medical personnel, or even from one another. As a culture, many centers are doing their best to change this. However there is a long way to go.

It is now clear that the unavoidable stressors of dispatch can have a deleterious effect on those that do the job. CT&Ds can be traumatized by cumulative call exposure, by a single critical event, or by a combination of these factors. CT&D traumatization, including the development of symptoms that comprise posttraumatic stress disorder, can be generated out of the dispatch work environment.

In an attempt to address some of the stressors inherent in emergency call taking and dispatching, stress management is now being taught within some of the more enlightened CT&D training programs, but this is still relatively new. For many of those outside of the dispatch center, and for some *inside* the dispatch center, the attitude and constant nagging of "you are not on scene why would it affect you" remains.

Many dispatch centers have been taken under the wing of their public safety partners. They are either part of the agency or are afforded the support services available within the agencies they dispatch. However, this is not true for all dispatch centers. And even in dispatch centers that have access to agency or jurisdiction-wide support services, most support services and organizational interventions still seem geared toward street responders…police, fire, and more recently EMS.

What is needed is a greater cross-understanding among first-responders. This could easily be accomplished by including a dispatch "sit-a-long" segment within police, fire, and EMS training. Correspondingly, part of CT&D training could include a "ride-a-long" with field personnel. While there is a history of CT&Ds riding with field units as part of their training, it is less common for field personnel to sit in dispatch as part of their training. It is time to make "sit-a-long in dispatch" a mandatory part of police, fire, and EMS basic training.

Call Taker and Dispatcher Stressors

Emergency services call takers and dispatchers confront some stressors that other first-responders do not. Many other first-responders fail to recognize this and misunderstand or do not fully comprehend how emergency telephone calls and radio transmissions actually affect a CT&D. Many other first-responders, including some that comprise police, fire, and EMS peer support teams, maintain the idea expressed previously, "you aren't there, it shouldn't affect you."

A director of a large emergency public safety answering point (PSAP) was quoted in a news report as saying that turnover is so high in the CT&D profession because we "eat our own young." This statement sparked anger and controversy in several dispatch centers, primarily because it was true. Too many CT&Ds are taught by their police, fire, and EMS partners that if you get upset or have feelings about the work you do, you are weak and not cut out for this type of work.

Show No Weakness – Asking for Help

For dispatch personnel, like many other first-responders, the fear of showing a perceived "weakness" to others, especially one another, may be a factor in asking or not asking for help. The fear of showing weakness relates to the fear of being seen as defective, unable to take it, and not measuring up. It is founded upon the idea that "if you can't take the heat, get out of the kitchen." Ultimately, it involves the fear of being rejected or ostracized. It is associated with the need to appear strong and capable. This is why some CT&Ds will not ask for help…even as their personal and professional lives are falling apart.

There is some good news. The good news is that with some minor changes in perspective, any perceived stigma involved in asking for help can be reduced.

Like police, fire, and EMS, there are at least two changes that can positively affect the dispatch culture: behavioral health training and peer support programs. These two, in conjunction, function to educate CT&Ds on how to (1) communicate effectively, (2) recognize signs and symptoms of stress and traumatization, (3) recognize the warning signs and risks of suicide, and (4) trust one another so that it is easier to speak about troubling emotional experiences and responses, and ask for help when needed.

1) *Behavioral Health Training*: When there is a deficiency in a certain skill or knowledge area we address it directly in hope that we will be better prepared in the future. Unfortunately, the dispatch services have fallen behind this ethic when it comes to understanding how stress, emotional needs, and repeated exposure to traumatic events affect dispatch personnel. The need to look for and recognize the signs and symptoms of occupational stress, and what to do about it must be addressed.

2) *Peer Support Program*: Appropriately trained CT&Ds can play a vital role in the effort to positively change the dispatch culture. This is especially true when the desired change involves making it acceptable for CT&Ds to seek assistance with job or personal stressors. The "peer support CT&D" is not a trained counselor but has received specialized training in the principles of peer

support. Peer support CT&Ds are trained to recognize signs of emotional distress and take appropriate action. This can range from a single peer support interaction to making recommendations for resources to further assist and support dispatch personnel.

When added by dispatch centers, these key components help to address the stressful attributes of the dispatch culture.

CT&Ds have performed well for many years. This tradition continues but must now incorporate an improved dispatch self-care culture change. CT&Ds must release some of the ideas of the past. This includes the belief that if you ask for help you are showing weakness.

Agency and dispatch administrators must also step up. They must recognize that dispatch stressors have the potential to harm those that do the job. They must create programs and protocols that positively address workplace stressors. One such program is the "Make it Safe Initiative." Although initially designed for police officers, it has been successfully utilized by fire and EMS agencies, and is readily adapted to dispatch (see "The Twelve Elements of the Make it Safe Initiative" included in this Handbook).

Some of the stressors involved in dispatch are unavoidable. Some are avoidable. The lack of stress management programs and critical incident protocols are avoidable. Stress management programs and critical incident protocols can be created and implemented.

Making it difficult for dispatch personnel to ask for help when experiencing stress is avoidable. This requires a culture change. The job is difficult enough. Does it really need to be made more difficult by viewing "asking for help" as a weakness, and maintaining the idea that "you are not there, why would it affect you?"

Communication Technology and Training – The Future

As previously mentioned, communication technology continues to advance. Video phones are becoming more available and soon more CT&Ds will be dealing with real world video of crime and injuries in progress. The challenges:

1. How can we better prepare CT&D candidates for seeing and hearing situations that they cannot physically affect?

   Video trainings and discussion with experienced CT&Ds that have utilized video call-taking and dispatching can be included in CT&D training. Video trainings and discussions with experienced dispatch personnel help to prepare CT&Ds candidates for what they may soon be experiencing. Discussions should include the ways in which experienced CT&Ds manage this and other work stressors. Discussion can also include ways in which experienced CT&Ds balance work, family, and personal stress.

2. How can CT&Ds relay important information that is being heard and seen to street first-responders while protecting their mental and emotional health?

   Unfortunately hands on experience on how to steady your voice while witnessing something terrible is not something that can adequately be trained in simulations. However simulation training can be beneficial - watching a video of a scene and role playing how to type or air what you are seeing would be a start. To protect mental health - practice "Some things to remember" (included in this Handbook).

3. How do you prepare someone to hear a person commit suicide?

   Interacting with a suicidal caller is stressful. Most suicidal callers do not kill themselves while talking to dispatch but it does happen. To date, training in this area has consisted mainly of replaying real calls of a call taker talking to a person who seems calm, makes a statement such as "I can't do it anymore tell my family I love them" followed by the sound of a gunshot...then silence on an open line. After the call replay, there is class discussion. Such training is useful to a certain extent but there is a significant difference. Hearing a call, even an actual call, from the past does not connect the call taker with the caller in the same way it does when talking directly to the person. Therefore, responses can vary widely. At times, CT&Ds are on the line with a suicidal caller for a significant amount of time before field responders are even available to be assigned. This leads to the call taker asking questions and learning about the person. The call taker and caller are building a temporary bond and trust. If the caller then commits suicide, it can be devastating to the call taker. What should be done if the caller commits suicide while on the line with the call taker? If a caller commits suicide while on the line, it is recommended that the call taker be provided some time away from their position to decompress and process the call. Policies should be put in place to assure this off-console respite, to assure that mental health and support resources are available, and to assure that agency support personnel check in with the call taker as soon as practical and periodically over the next several days and weeks.

4. How can training prepare CT&Ds to experience a mass shooting over live video?

   The technology of live streaming already exists. News media and persons on scene frequently stream mass shootings and other tragic events as they are unfolding. In dispatch, if a call taker or dispatcher is experiencing difficulty with event images, providing a break is something that can be done if staffing is available. If this is not possible, providing support as the incident unfolds may be helpful. Following the incident, as soon as practical, making sure that the involved CT&Ds get a break from dispatching duties, whether or not they feel it necessary, often proves beneficial. All involved personnel should then be part of a policy-established aftercare protocol which may include a personal and/or group debriefing, meeting with a member of the peer support team, or visiting with the agency mental health professional.

5. How do you prepare CT&Ds for hearing their favorite officer beg for help and assistance while they are laying injured in the street or fighting for their lives? What plans can we immediately put into place to address these and other stressful situations?

   "This one is definitely hard, and my blanket answer is providing relief and resources ASAP. Hearing an officer scream is something that stays with you. I think being honest and upfront is the best way to handle preparing someone for something they will never be prepared to hear" (Katie Barrett).

6. How do you help manage stress in a 24/7 center focused on emergency phone and radio calls?

   Making sure there is adequate staffing and resources available goes a long way to help manage dispatch stress. Peer support has been a positive addition, as well as meeting and talking with field crews. Talking with field crews helps CT&Ds to dissipate call-related stress and provides a degree of closure. While it is recognized that certain field situations are sensitive and there is sometimes a need to restrict information, providing incident information to involved CT&Ds to the degree possible helps to positively process and manage the stress of the event.

Katie Barrett, Airport Emergency Dispatch, ACE, CTO, Denver International Airport and Jack A. Digliani

Dispatch Stressors and Stress Management

Dispatching, like all professions, includes unavoidable stressors. Many of these stressors are also present in other occupations. Some are unique to dispatching.

Some dispatch stressors:

Department politics
Stress from the first-responder culture: *show no weakness*
Inadequate equipment and/or training
Inadequate salary or compensation
Coworker relationships and team personality conflicts
Perceived lack of support from chain of command
Working on traditional holidays
Shift hours: absence from family for long shift hours
Lack of sleep during changing shift hours/mandatory overtime
Exposure to death – death imprint
Exposure to highly emotional callers
Assisting injured callers and callers suffering from a health crisis
EMD and failed attempts at EMD
Medical emergencies – dealing with human suffering
Uncooperative, threatening, or violent callers
Exposure to others grief responses
Police, fire, and EMS personnel screaming for assistance
Dealing with the injury or death of those dispatched (police, fire, EMS personnel)
Family issues: including conflicts that arise out of “department vs. family” loyalty

Stress Management

Most of our lives are filled with family, work, and community obligations, and at some point we feel as though we are "running on empty." Here are eight immediate stress busters to help "fill up the tank!" So take a deep relaxing breath and read on.

1. Watch for the next instance in which you find yourself becoming annoyed or angry at something trivial or unimportant. Then practice letting go, making a conscious choice not to become angry or upset. Do not allow yourself to waste thought and energy where it isn't deserved. Effective anger management is a tried-and-true stress reducer.

2. Breathe slowly and deeply. Before reacting to the next stressful occurrence, take three deep breaths and release them slowly. If you have a few minutes, try out a relaxation technique such as meditation or guided imagery.

3. Whenever you feel overwhelmed by stress, practice speaking more slowly than usual. You'll find that you think more clearly and react more reasonably to stressful situations. Stressed people tend to speak fast and breathlessly; by slowing down your speech you'll also appear less anxious and more in control of any situation.

4. Jump-start an effective time management strategy. Choose one simple thing you have been putting off (e.g., returning a phone call, making a doctor's appointment), and do it immediately. Just taking care of one nagging responsibility can be energizing and can improve your attitude.

5. Get outdoors for a brief break. Our grandparents were right about the healing power of fresh air. Don't be deterred by foul weather or a full schedule. Even five minutes on a balcony or terrace can be rejuvenating.

6. Drink plenty of water and eat small, nutritious snacks. Hunger and dehydration, even before you're aware of them, can provoke aggressiveness and exacerbate feelings of anxiety and stress.

7. Do a quick posture check. Hold your head and shoulders upright and avoid stooping or slumping. Bad posture can lead to muscle tension, pain, and increased stress. If you're stuck at a desk most of the day, avoid repetitive strain injuries and sore muscles by making sure your workstation reflects good ergonomic design principles. There is information about ergonomics and healthy workstations to assure your station is more ergonomically safe.

8. Plan something rewarding for the end of your stressful day, even if only a relaxing bath or half an hour with a good book. Put aside work, housekeeping or family concerns for a brief period before bedtime and allow yourself to fully relax. Don't spend this time planning tomorrow's schedule or doing chores you didn't get around to during the day. Remember that you need time to recharge and energize yourself. You'll be much better prepared to face another stressful day.

Melissa Conrad Stoppler, MD. (Jay W. Marks, MD, Editor)
http://www.medicinenet.com/stress_management_techniques/article.htm

The American Heart Association recommends the following 10 positive healthy habits to combat stress:

1. Talk with family and friends daily to share your feelings, hopes, and joys.
2. Make time every day for physical activity to relieve mental and physical tension.
3. Accept the things you cannot change.
4. Remember to laugh daily.
5. Give up your bad habits such as too much alcohol, cigarettes, or caffeine.
6. Slow down and pace yourself.
7. Get six to eight hours of sleep each night.
8. Get organized and make “to do” lists.
9. Practice giving back by volunteering your time to help others.
10. Try not to worry.

Signs of Excessive Stress

Impaired judgment and mental confusion
Uncharacteristic indecisiveness
Aggression – temper tantrums and "short fuse"
Continually argumentative – increased family discord
Increased irritability and anxiety
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 333
Indigestion/nausea/ulcers/constipation or diarrhea
Unintended weight loss or gain - changes in appetite
Abnormally cold or sweaty palms
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.

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/hallucination
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, self-performance assessment, perception of alternative options, coping abilities, degree and result of stress management and stress inoculation training.

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

Traumatic Stress: Shock, Impact, and Recovery

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

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

Impact—after the passage of some time, the amount of time differs for different people, there is impact. Impact normally involves the realization that “People died” “People were injured” or “This was a grave tragedy.” These thoughts and the feelings that accompany them can be overwhelming. Dispatchers should never be returned to full duty while they are working through any overwhelming impact of a traumatic incident. Departments should have policy directives which provide for administrative or other appropriate leave until an experienced trauma psychologist evaluates and clears the dispatcher 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

Most call takers and dispatchers who have experienced a critical or traumatic event want to place the incident behind them and move on.

The difficulty for many CT&Ds 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 critical or 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:

<u>REBT Irrational Idea Number 9</u>: *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 stress recovery 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 (police, administrative investigation, the press, etc) in perspective.

Remember, critical incidents involve circumstances beyond your control.

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

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

Getting Help

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

This page adapts and includes information from the Colorado Law Enforcement Academy Handbook and *Reflections of a Police Psychologist, 2nd ed.* (Digliani, J.A., 2015).

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 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 – o*rdinary, not extraordinary*

“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)

Suggestions for Supporting Dispatchers Involved in Critical Incidents

1. Initiate contact in the form of a phone call, text, email, or note. *Do not fall into the trap that "others will do it, so I don't have to." Your expression of support will be appreciated. Avoid becoming overly persistent or intrusive.*

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

3. Let the traumatized dispatcher decide how much contact he/she wants to have with you. They may be overwhelmed with phone calls and it may take a while for them to return your call. Also, they and their family may want some "down time" with minimal interruptions. *Avoid being intrusive, even if your actions are well-intentioned.*

4. Don't ask for an account of the incident, but let the traumatized dispatcher know you are willing to listen to whatever he or she wants to talk about. Be mindful that there is usually no legally privileged confidentiality for peer discussions. *A privileged communication relationship does exist between dispatchers and certain others including psychologists, attorneys, licensed or ordained clergy members, spouses, physicians, and other licensed or supervised mental health professionals. In Colorado, members of a department peer support team (PST) are protected from testifying without consent under the provisions of C.R.S. 13-90-107(m), however this protection is limited and does not apply to "information indicative of any criminal conduct." PST member confidentiality under C.R.S. 13-90-107(m) does not include protection against being compelled to testify in federal courts. PST members are ethically responsible for specifying the limits of confidentiality protections prior to engaging in any peer support interactions.*

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

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

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

8. Don't say, "I understand how you feel" unless you have been through the same experience. Do feel free to offer a BRIEF sharing of a similar experience you might have had to help them know they are not alone in how they feel. However, this is not

the time to work on your own trauma issues with this person. If your friend's event triggers some of your own emotions, find someone else to talk to who can offer support to you. *It's worthwhile to keep in mind that individual dispatchers will frequently perceive a critical incident in a somewhat unique way. However, there is enough overlap in human experience to allow others to relate to some degree to the experience of the involved dispatcher. A good rule to follow: If the involved dispatcher asks you a question about an experience that you have had or how you handled a past incident, respond fully to the question, then re-focus on the dispatcher. If additional questions are asked, respond in a similar fashion...they are requesting more information from you. Your responses are likely to normalize their current feelings, thoughts, and behaviors - which in many cases are new to them or are perceived as strange. Keep your responses concise and talk in plain language. Do not get stuck in your own unresolved issues. The last thing a dispatcher who has experienced a critical incident needs is to become your therapist.*

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

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

11. You are likely to find yourself second-guessing the actions of the involved personnel, but keep your comments to yourself. Critical comments have a way of coming back to the persons directly involved and it only does harm to them. They are probably second-guessing themselves and struggling to recover. Besides, most of the second-guessing is wrong anyway. *Keep in mind that the best anyone can do is to make reasonable decisions based upon perceptions and the information available at the time. No one really knows what it was like for a particular dispatcher to be involved in a particular incident. Saying such things as "I would have done…" or "He (or she) should have done…" is almost always damaging. Remember that <u>every dispatcher, every day</u> makes decisions based on limited and sometimes inaccurate information.*

12. Encourage the dispatchers to take care of themselves. Show support for such things as taking as much time off as they need to recover. Also encourage the dispatchers to participate in department support services. *Dispatchers involved in critical incidents are engaged in peer support, debriefings, and counseling as specified by department policy.*

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

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

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

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

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

Adapted from "Suggestions for Supporting Officers Involved in Shootings and Other Trauma" written by Alexis Artwohl and published in her book, *DEADLY FORCE ENCOUNTERS*, co-authored by Loren Christensen (1997) (Alterations in original text made with permission).

Thoughts and comments of Jack A. Digliani are represented in italics (added with permission).

Suggestions for Spouses of Dispatchers Involved in a Critical Incident

1. Express caring feelings. Saying something like, "I love you, I'm here for you" reinforces your emotional bond and lets your spouse know where you stand. In some relationships this might be communicating something that is often said, in others it may represent the first time in a while that such emotions have been expressed. Either way, it makes a difference.

2. Be patient. Critical incidents can cause some undesirable emotional changes. These changes are normally temporary and subside over time. If this happens in your relationship, keep communication open and try to remain supportive. It is also possible that positive change can occur. Positive change should be reinforced.

3. Be emotionally available to your spouse. Listening is important. Stay connected without being intrusive. After a critical incident some dispatchers need to immediately talk about the incident, others will "open up" gradually and only after a period of time. Some may "bottle up" or suppress their emotions long term. Bottling up or suppressing emotions following a critical incident is a defense mechanism that keeps the person from experiencing unwanted feelings.

4. Be gentile in your communication, verbal and non-verbal. The period immediately following a critical incident is not the time to discuss pre-existing sensitive topics.

5. Touching is important. Caring touch without overstimulation is a significant expression of love and support. Following a critical incident, some dispatchers will want to be touched often, others not so, even by their spouses.

6. Anticipate "internal processing." This often leads to some degree of physical or emotional isolation (shutting down) as the incident replays itself over and over in the dispatcher's mind. This mental preoccupation with the incident is normal and usually subsides within a few weeks. If internal processing does not mitigate after a reasonable period of time, suggesting support intervention is appropriate.

7. Anticipate some change in mood. It does not occur in every instance, but for some dispatchers their mood "flattens" following a critical incident. This means that he or she will seem to have little expression of happiness or sadness, and may appear uninvolved, disengaged, or simply neutral. Another possibility is that the person will appear energized and almost giddy. Again, these reactions normally moderate over a few weeks.

8. The desire and ability to engage in sexual activities may vary with mood. This can range from no desire to heightened desire for sex. Remain aware that the mood can vary with changing thoughts of the incident.

9. Sleep can be fitful for a time. Changes in sleep patterns are often observed following a critical incident. For dispatchers that have experienced a critical incident, sleep usually returns to normal within a month. Mild exercise and staying within the limits of regular consumption of caffeine during the day is helpful in restoring normal sleep patterns.

10. Gently encourage appropriate couples or family activities.

11. Do not encourage alcohol or other drugs as a primary means to cope with the emotional and psychological aftermath of a critical incident. While there is a place for a glass of wine or a beer at dinner, using alcohol to numb feelings resulting from a critical incident is not the best way to work through issues, for you or your spouse.

12. If the dispatcher exhibits any behavior that concerns you, talk to him or her about it. Talk in a caring manner. Describe the behavior first, then communicate your concerns.

13. Occasionally, dispatchers will become depressed after a critical incident. If you observe behaviors associated with depression, talk to your spouse. If necessary, arrange for proper assessment, treatment, and support interventions. Do this together, as a team.

14. Call for help immediately if you think that your spouse is or is becoming suicidal. Know the warning signs of suicide (included in this handbook).

15. Help your spouse but also help yourself. Remain aware of vicarious traumatization and moderate your involvement to remain within healthy boundaries. Use available resources if you become *incident-info saturated:* this circumstance arises when the dispatcher's need to talk about the incident exceeds your capacity to listen. Your capacity may be overwhelmed by the nature of the incident or the sheer number of times that you have heard the story. <u>Dispatcher</u>: if your spouse becomes incident-info saturated, limit further discussion of the incident with him/her and initiate or continue to process the incident with alternative support resources. <u>Spouse</u>: if not already started, consider that it may be helpful for you to engage support services.

16. Monitor and try to mitigate outside stressors. Life demands do not stop following a critical incident. Ask for help with everyday chores and responsibilities if necessary. If you find it difficult to ask for help, think about this: You would be happy to assist those you care about if they were experiencing stressful times. It is likely that they feel the same way about you. Why not give them a chance to help?

17. If you have children, talk to them with your spouse. Talk to them about the incident in an age-appropriate manner. Answer any questions with age-appropriate honesty. Reassure them that they are safe, that you are ok, and that you are there for them.

18. Work as a team to address any particular stressors arising out of the incident.

19. Seek support early from available resources. Many agencies maintain employee assistance programs, peer support teams, and psychologists or counselors. Stay in touch with supportive friends and trusted others.

20. Seek support even if everything looks ok. Although it is not unusual for dispatchers to do well after a critical incident, engaging support services is a good idea. Some departments have specific support protocols which are automatically initiated following a critical incident. Many do not. If the dispatcher's agency does not have a protocol or support services, ask for what you need. Most agencies respond favorably to requests for support from dispatchers and their spouses.

Do not become a critical incident statistic. Seek appropriate professional assistance if you, your spouse, or your relationship becomes troubled following involvement in a critical incident.

Stress Reactions

Stress reactions take five general forms:

- Subjective experience of distress (feeling tense, anxious, worried, harassed)
- Physical symptoms in response to stress (such as raised blood pressure tension headaches, upset stomach)
- Responding to stress with unhealthy habits (smoking, overeating, and overdrinking)
- Suffering a decline in performance
- Increased conflicts with people, or decreased satisfaction in personal relationships

To reduce stress, you must be able to:

- Be aware of initial signs of stress reaction
- Develop basic stress management skills
- Be able to apply the stress management skills in real life

Stress management skills include:

- **Relaxation** through deep breathing techniques, relaxation imagery, tension-relaxation contrasts, cue-controlled relaxation, and biofeedback
- **Cognitive techniques**: Review your attitudes and values, restructure your thinking, set goals, use positive imagery, rehearse mentally, schedule
- **Behavioral changes** to better manage interpersonal situations and distress--Check your assumptions, share your expectations with others, be assertive, exercise, consume sensibly
- **Relationship review**: Review past hurts, forgive, communicate feelings, listen, reward

https://my.clevelandclinic.org/health/articles/6409-stress-management-and-emotional-health

Tips for Recovering From Disasters and Other Traumatic Events

Disasters and other traumatic events are often unexpected, sudden and overwhelming. In some cases, there are no outwardly visible signs of physical injury, but there is nonetheless a serious emotional toll. It is common for people who have experienced traumatic situations to have very strong emotional reactions. Understanding normal responses to these abnormal events can aid you in coping effectively with your feelings, thoughts, and behaviors, and help you along the path to recovery.

What happens to people after a disaster or other traumatic event?

Shock and denial are typical responses to terrorism, disasters and other kinds of trauma, especially shortly after the event. Both shock and denial are normal protective reactions.

Shock is a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed. Denial involves your not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. You may temporarily feel numb or disconnected from life.

As the initial shock subsides, reactions vary from one person to another. The following, however, are normal responses to a traumatic event:

- Feelings become intense and sometimes are unpredictable. You may become more irritable than usual, and your mood may change back and forth dramatically. You might be especially anxious or nervous, or even become depressed.
- Thoughts and behavior patterns are affected by the trauma. You might have repeated and vivid memories of the event. These flashbacks may occur for no apparent reason and may lead to physical reactions such as rapid heartbeat or sweating. You may find it difficult to concentrate or make decisions, or become more easily confused. Sleep and eating patterns also may be disrupted.
- Recurring emotional reactions are common. Anniversaries of the event, such as at one month or one year, as well as reminders such as aftershocks from earthquakes or the sounds of sirens, can trigger upsetting memories of the traumatic experience. These 'triggers' may be accompanied by fears that the stressful event will be repeated.
- Interpersonal relationships often become strained. Greater conflict, such as more frequent arguments with family members and coworkers, is common. On the other hand, you might become withdrawn and isolated and avoid your usual activities.
- Physical symptoms may accompany the extreme stress. For example, headaches, nausea and chest pain may result and may require medical attention. Pre-existing medical conditions may worsen due to the stress.

How do people respond differently over time?

It is important for you to realize that there is not one 'standard' pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions - sometimes months or even

years later. Some have adverse effects for a long period of time, while others recover rather quickly. And reactions can change over time. Some who have suffered from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed. A number of factors tend to affect the length of time required for recovery, including:

The degree of intensity and loss. Events that last longer and pose a greater threat, and where loss of life or substantial loss of property is involved, often take longer to resolve.

- A person's general ability to cope with emotionally challenging situations. Individuals who have handled other difficult, stressful circumstances well may find it easier to cope with the trauma.
- Other stressful events preceding the traumatic experience. Individuals faced with other emotionally challenging situations, such as serious health problems or family-related difficulties, may have more intense reactions to the new stressful event and need more time to recover.

How should I help myself and my family?

There are a number of steps you can take to help restore emotional well being and a sense of control following a terrorist act, a disaster or other traumatic experience, including the following:

- Give yourself time to heal. Anticipate that this will be a difficult time in your life. Allow yourself to mourn the losses you have experienced. Try to be patient with changes in your emotional state.
- Ask for support from people who care about you and who will listen and empathize with your situation. But keep in mind that your typical support system may be weakened if those who are close to you also have experienced or witnessed the trauma.
- Communicate your experience in whatever ways feel comfortable to you - such as by talking with family or close friends, or keeping a diary.
- Find out about local support groups that often are available such as for those who have suffered from natural disasters, or for women who are victims of rape. These can be especially helpful for people with limited personal support systems.
- Try to find groups led by appropriately trained and experienced professionals. Group discussion can help people realize that other individuals in the same circumstances often have similar reactions and emotions.
- Engage in healthy behaviors to enhance your ability to cope with excessive stress. Eat well-balanced meals and get plenty of rest. If you experience ongoing difficulties with sleep, you may be able to find some relief through relaxation techniques. Avoid alcohol and drugs.
- Establish or reestablish routines such as eating meals at regular times and following an exercise program. Take some time off from the demands of daily life by pursuing hobbies or other enjoyable activities.
- Avoid major life decisions such as switching careers or jobs if possible because these activities tend to be highly stressful.
- Become knowledgeable about what to expect as a result of trauma.

How do I take care of children's special needs?

The intense anxiety and fear that often follow a disaster or other traumatic event can be especially troubling for children. Some may regress and demonstrate younger behaviors such as thumb sucking or bed wetting. Children may be more prone to nightmares and fear of sleeping alone. Performance in school may suffer. Other changes in behavior patterns may include throwing tantrums more frequently, or withdrawing and becoming more solitary.

There are several things parents and others who care for children can do to help alleviate the emotional consequences of trauma, including the following:

- Spend more time with children and let them be more dependent on you during the months following the trauma - for example, allowing your child to cling to you more often than usual. Physical affection is very comforting to children who have experienced trauma.
- Provide play experiences to help relieve tension. Younger children in particular may find it easier to share their ideas and feelings about the event through non-verbal activities such as drawing.
- Encourage older children to speak with you, and with one another, about their thoughts and feelings. This helps reduce their confusion and anxiety related to the trauma. Respond to questions in terms they can comprehend. Reassure them repeatedly that you care about them and that you understand their fears and concerns.
- Keep regular schedules for activities such as eating, playing and going to bed to help restore a sense of security and normalcy.

When should I seek professional help?

Some people are able to cope effectively with the emotional and physical demands brought about by a natural disaster or other traumatic experience by using their own support systems. It is not unusual, however, to find that serious problems persist and continue to interfere with daily living. For example, some may feel overwhelming nervousness or lingering sadness that adversely affects job performance and interpersonal relationships.

Individuals with prolonged reactions that disrupt their daily functioning should consult with a trained and experienced mental health professional. Psychologists and other appropriate mental health providers help educate people about normal responses to extreme stress. These professionals work with individuals affected by trauma to help them find constructive ways of dealing with the emotional impact.

With children, continual and aggressive emotional outbursts, serious problems at school, preoccupation with the traumatic event, continued and extreme withdrawal, and other signs of intense anxiety or emotional difficulties all point to the need for professional assistance. A qualified mental health professional can help such children and their parents understand and deal with thoughts, feelings and behaviors that result from trauma.

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Recovering from Traumatic Stress

Recovering from traumatic exposure takes time. The most difficult challenge for action-oriented first-responders is to be patient in recovery. If you are exposed to a traumatic event, accept your feelings, even if the intensity surprises you. Many dispatchers have reported crying following shootings and other critical incidents. They describe this experience as *having lost it*. They are talking about feeling as if they lost control—control of their emotions.

In fact, they have not lost anything. Instead, they have *found* something. They have found the emotion that underlies their experience. When strong feelings surface, let them in, let them fade. Experience and explore the emotion. It is a natural part of recovery. Imagine intense emotion as an ocean wave. It will come, and it will go. Although it may feel overwhelming for a brief time, you can manage it. You know what it is: it is the healthy expression of strong emotion. You know what to do about it: you breathe through it.

Keep in mind that physical symptoms sometime accompany strong emotion. These will normally subside as recovery continues. Additionally, remember that family members may not fully understand your experiences. Try not to become angry or frustrated. They cannot know what it is like for you. Be patient with yourself and with your family. Maintain your family connections. Keep your lines of communication open.

For spouse of dispatcher: Understanding the likely responses of your dispatcher-spouse will help you to provide appropriate support. Keep in mind that you will also respond to the incident in some way and that you may also need to process your feelings.

For the dispatcher: *What if I develop posttraumatic stress disorder after a critical incident and my symptoms persist? Can I be disabled by posttraumatic stress disorder?*

Unfortunately, yes. If you develop PTSD after a critical incident, and the symptoms are severe and enduring, you can become *totally* or *occupationally* disabled.

Total disability occurs when the severity of symptoms renders a person incapable of engaging in any employment. Occupational disability occurs when a person experiences disabling symptoms in a particular work policing environment, but remains relatively symptom free in other work environments. This renders the person incapable of returning to their previous work environment, but able to work in other environments. Occupational disability can occur following a critical incident because traumatic experiences have the power to “split” environments. That is, whereas first-responders are normally symptom free in their work environment prior to the critical incident, following the incident their work environment transacts to produce significant PTSD symptoms. In such cases, the person cannot safely return to the work environment that produced the traumatic event. In essence, work environments have been split into symptom and non-symptom producing work environments.

Fortunately, most dispatchers and other first-responders do not develop PTSD after a critical incident, and many of those that do are successfully treated. They are then able to return to work and continue their career without significant difficulty.

Incident Debriefing Information

It is possible to feel ok following a critical incident, participate in the incident debriefing, and come out of the debriefing feeling a bit unsettled. This is not overly concerning unless the feeling is uncomfortably intense. The unsettled feeling that can be generated by a debriefing is often related to the mild-to-moderate anxiety caused by psychologically revisiting the incident. This feeling usually diminishes within a few hours or days following the debriefing.

Information - Following a critical 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 or incident debriefing.

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.

* note that many of the possible debriefing responses are identical to the possible responses following the incident itself.

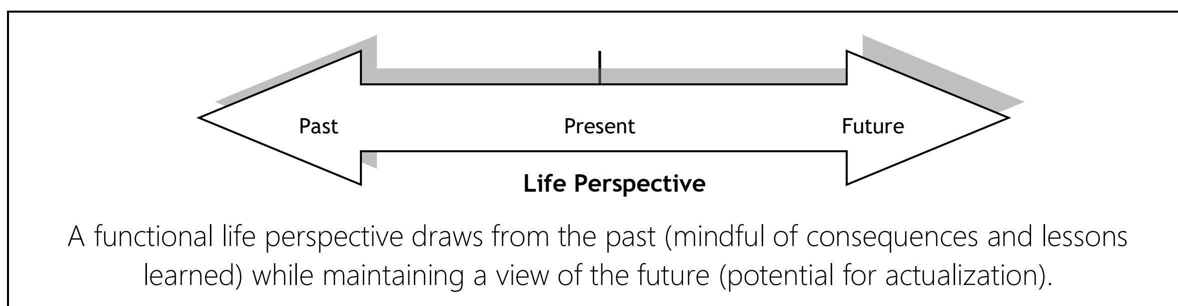
Life Management: Life by Default – Life by Design

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 and evaluate them from their now-adult perspective. They 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 of it. 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. Are you flexible? Consider couples and group goals. If you agree to participate in a couples or group activity that is not your personal preference, you accept the responsibility to support it, or at 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* 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. Do not overdo it.

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 say?* (implies that previous comments have not been sensible and invalidates the person).

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. Change is often considered when the *uncomfortable* becomes the *intolerable*.
- Bringing about enduring change requires two "efforts" – an effort to bring about the change and a continuing effort to maintain the change.
- 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 (and vice versa).
- 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*.

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

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?

Some Information About Alcohol

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

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

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

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

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

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

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

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

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

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

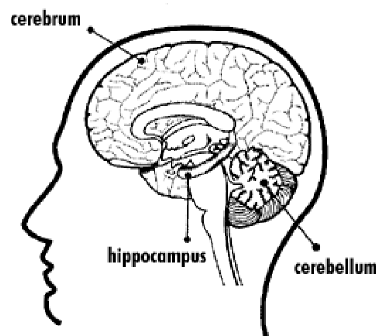
Biological (genetic) and psychosocial factors combine with environmental factors, such as the availability of alcohol, to increase the risk for developing drinking problems.

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

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

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

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



Regions of the brain affected by alcohol

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

Some Things to Remember

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

Some Things to Remember

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

* The notion that “things are never so bad that they can’t get worse” is intended as an aid to help keep things in perspective. It is not intended to minimize the difficulty of any stressful circumstance. At its best, this idea encourages toleration, increases motivation for change, and enhances positive life management. Understanding that “things could be worse” may or may not mitigate the experienced intensity of current stressors.

Suicide Risk and Protective Factors

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

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

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

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

Some Types of Suicide

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

Dispatch Suicide Risk Factors

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

Suicide risk factors:

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

Dispatchers should not avoid other dispatchers they think might be suicidal.

If you observe any of the behavior associated with suicide risk in another dispatcher, 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.*

If you feel that the person is imminently suicidal, do not leave the person alone. Contact the police or a support resource immediately, even if “sworn” to secrecy. *Do not keep a deadly secret.* Follow through.

If the person is not imminently suicidal, spend some time with him/her. Listen closely and provide emotional support. Provide information about available resources, including agency psychologist, department 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.*

Suicidal Callers

Call takers and dispatchers are frequently called upon to assist persons that have become suicidal. For dispatch, these calls, sometimes referred to as "suicidal person" calls are stressful and a positive outcome is far from assured.

In a significant majority of these cases, emergency first-responders, from dispatch to police, fire and EMS, are successful in their efforts to prevent suicidal persons from killing themselves. However, not all "suicidal person" calls end this way.

Some callers kill themselves while on the line with dispatch. When this occurs, the experience can trigger a cascade of emotions for dispatch personnel. These emotions range from calm indifference to intense anger or feelings of guilt and sorrow. Strong emotional reactions are more likely if the call taker or dispatcher has become acquainted with the caller or formed a trust or bond over the phone (this is possible even in a very short period time). This connection is especially felt if CT&Ds have had multiple contacts with the caller or remained on the line for an extended amount of time. This is because the CT&D has learned details about the person during the time spent trying to keep the person from killing himself or herself. All this occurs within the context of supportive interpersonal communication and asking questions while trying to avoid any "trigger" topics until field units arrive and make contact.

Some factors in emotional response to witnessing a suicide: (Yes, *hearing* a person kill himself or herself is witnessing a suicide. Being on-scene or having a visual is not necessary to witness a suicide.)

- Second guessing - "Did I do or say something that I shouldn't have, did I not do or say something that I should have?" (This type of second guessing can lead to unjustified feelings of guilt or inadequacy. Remember, y*ou are not responsible for the person's behavior*).
- Age of the person.
- Proximity to the person.
- Instrument or means of death.
- Body damage, gore, blood, and death scene.
- Efforts at resuscitation - failed rescue attempts.
- Perceived personal danger.
- Content of person interaction.
- Actual circumstance of the incident.
- Interaction with the person's family.
- Actions of others, including co-workers. Your family members, friends, etc.
- Your personal and family history. (For example – If there has been a suicide in your family or if you lost a close friend to suicide, the incident may reactivate feelings of grief associated with your loss and the past event.)

If you have witnessed a suicide:

Accept your feelings. It is stressful and often traumatic to witness (either auditory and/or visually) the death of another person.

Do not blame yourself. It was the person who made the decision. We are all limited in our ability to make others act as we desire, regardless of effort.

Do not forget that there is no perfect way to interact with a person considering suicide. All you can do is manage the interaction based upon current perceptions and interpreted circumstances.

Understand that you did what you thought was best to help the person.

Take a break. Get off the console if at all possible. Take some time to process the event before returning to duty.

You will likely experience some degree of *posttraumatic stress*. This does not mean that you will develop *posttraumatic stress disorder*.

Manage posttraumatic stress as suggested in *Recovering from Traumatic Stress* (included in this Handbook).

Avoid alcohol or other drugs as a primary way to manage your feelings.

Seek support: Talk to a trusted peer, supervisor, friend, or family member about your experience and feelings. Initiate contact with your department's psychologist, chaplain, peer support team, or other available support resource.

Loveland Police Peer Support Team, Tim Brown, Katie Barrett, and Jack A. Digliani
Edited for Dispatch Handbook 7/2020

For assistance contact

Helping a Person that is Suicidal

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

- Take all suicidal comments and behaviors seriously.
- Initiate a conversation. Express your concern. Inform the person that you are there to help. Express caring. Establish rapport. Be yourself. Your support is demonstrated through a genuine caring relationship.
- Listen closely without being judgmental. Be mindful of what you say because the person may be overly sensitive to your remarks. *Be prepared*: the person may become quite emotional when communicating with you. *Remain calm*: strong emotion dissipates naturally and can provide a sense of relief.
- Bring the issue of suicide into the open. Ask about the person's current circumstances, thoughts, and feelings. Acknowledge the person's difficulties.
- Ask about past and recent self-harm thoughts and behavior.
- Ask about the availability of lethal means for suicide – many persons in the United States have ready access to firearms, which are the leading means of suicide in the U.S. Remove firearms and other lethal means if necessary.
- Determine if there is a suicidal plan – the more detailed and complete the plan, the greater the suicidal risk.
- It is ok to talk to the person about their suicidal thoughts. Let him or her know that such thoughts are often the result of depression and that depression can be effectively treated. Assure the person that with appropriate treatment suicidal thoughts and the feeling of wanting to die will diminish. Help to provide *realistic hope*.
- Do not hesitate to ask for help from the suicidal person and others. (1) Ask the person to help you to help him/her. (2) Others: interacting with a suicidal person is stressful. Professional assessment and intervention is often required.
- If you feel that the person is imminently suicidal do not leave him or her alone. If you are a peer support team member contact your clinical supervisor immediately. Together arrange for appropriate intervention. If you are not a member of a peer support team, contact a peer support team member or other appropriate resource person immediately. Keep in mind that emergency intervention may be necessary, including involuntary hospitalization.
- If the person is not imminently suicidal, spend some time with him or her, "provide an ear" and other emotional support.
- Avoid providing problem solutions. Instead, (1) focus on listening and supporting the person. Let the person know that he or she is important to you. (2) Work to have the person contact or become involved with professional counseling services. Provide information about available support services.
- If you are unsure about whether the person is or is not imminently suicidal or you do not feel competent to assess his or her level of self-danger, do not leave the person alone. Contact an available assessment and support resource immediately. The resource will make the assessment. Do this even if the person objects. This is the best way to keep the person safe.
- Do not keep a "suicidal secret". Gently explain that you must contact others.
- Arrange for the person to be with others 24/7 for continued support and to add an additional level of safety if needed.
- Follow up as appropriate.

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
1-800-273-TALK (1-800-273-8255)
Three digit number for National Suicide Hotline: 988

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.

Effects of Exposure to Death – Death Imprint

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

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

For FRs, death is a more-than-usual topic for thought. This is due to the inherent demands of all FR work environments.

First-responders are the most likely to be exposed to death. This is because of the *funnel effect*, wherein the cases involving death get funneled to first-responders.

Some FRs learn to effectively manage death exposure; they must do so if they are to continue in their work. To others, FRs can sometimes appear "cold" or "callous" in their response to death. This can be a healthy response to the knowledge that everyone dies and some degree of calm is necessary to do the job. It can also be an unhealthy suppression of emotion, emotion that has a tendency to surface at some point in a FR's life.

"Nobody dies on my watch!" - FRs can perform their duties in an exemplary manner and still be unable to prevent anyone from dying on their watch. In spite of effective policies and procedures, exemplary personal performance, and all due diligence, FRs cannot control their work environment to the degree necessary to prevent the possibility of death.

No one in any environment can prevent the possibility of death. This exposes the notion that "Nobody dies on my watch!" for the fantasy that it is. It should be replaced by the more realistic "I will do my best to prevent anyone from dying on my watch!" This statement acknowledges a FRs personal commitment to duty, recognizes human limitation, and more accurately describes the human condition. The best that any FR can do is to influence the *probability* of death. This is accomplished by following first responder operational procedures, conscientiously practicing FR safety, exercising due diligence, and so on.

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

Death Imprint

When FRs 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, frequency, and duration of anxiety.

No one is immune from being emotionally overwhelmed by exposure to death. Feeling overwhelmed by exposure to death can occur (1) gradually over time, (2) due to the circumstances of a particular case, or (3) when a particular case causes a *tipping point* in a FR's ability to manage death anxiety. Regardless of the cause of death anxiety, this type of overwhelming emotional decompensation is called *death imprint*.

Death imprint becomes possible when the best of our coping defenses fail and the anxiety or depression associated with the conception of death reaches some degree of expression.

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 Support

Coping with death imprint is enhanced by appropriate support. Talking to a trusted person that understands what it is like to be exposed to death on an all-to-often basis can help a FR to process thoughts and feelings. It can be a valuable asset to those experiencing and coping with death imprint.

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*)

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.

It is a sad fact that some persons talk and interact more politely and less contentiously with coworkers and strangers than they do with their spouse, family members, and other loved ones.

Issues in Interpersonal Relationships and Family Systems

- Rules
- 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.

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The Communication Imperative

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

The Relationship Imperative

Make it safe!

The Occupational Imperative

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

Digliani, J.A.(2010) (2015) (2022) *Reflections of a Police Psychologist*, 3RD-R Ed.

The Twelve Elements of the "Make it Safe" Initiative

The Initiative encourages:

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

(2) every CT&D to seek psychological support when confronting potentially overwhelming difficulties (you do not have to "go it alone").

(3) every CT&D to diminish the sometimes deadly effects of secondary danger by reaching out to other officers known to be facing difficult circumstances. (*Secondary danger* is the danger of equating "asking for help" with "personal and professional weakness")

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

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

(6) agency and dispatch administrators to issue a departmental memo encouraging CT&Ds to engage psychological support services when confronting potentially overwhelming stress (the memo should include information about confidentiality and available support resources).

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

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

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

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

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

(12) CT&Ds 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 call takers and dispatchers wish to do the best for themselves and others, it's time to make a change. It's time to make a difference.

(adapted for dispatch from the "Make it Safe" Police Officer Initiative, Digliani, J.A., 2013)

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 has received several commendations from various law enforcement agencies 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 *Reflections of a Police Psychologist, Contemporary Issues in Police Psychology*, *Law Enforcement Peer Support Team Manual*, *Firefighter Peer Support Team Manual*, *Law Enforcement Critical Incident Handbook*, *Law Enforcement Marriage and Relationship Guidebook,* and several other publications. He is a contributor-writer of Colorado Revised Statute (CRS) 13-90-107(m) *Who may not testify without consent*, the statute and subsection which grants law enforcement, firefighter, and other peer support team members with specified confidentiality protection during peer support interactions. He is also the principal author of the peer support section of the *Critical Incident Protocol* of the Eighth Judicial District of Colorado. Portions of his Trauma Intervention Program have been incorporated into CRS 16-2.5-403, *Peace officer-involved shooting or fatal use of force policy* (2019).

In 1990, he 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.

Dr. Digliani developed the Freezeframe method of critical incident debriefing. He also advanced the conceptualizations of the "2-and-2", Option Funnel versus Threat Funnel, Level I and Level II peer support, Life-by-Default/Life-by-Design, and the *Comprehensive Model for Police Advanced Strategic Support* (COMPASS). COMPASS is a career-long psychological health and wellness strategy for police officers. For more information visit www.jackdigliani.com

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. In 2015, he 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. Dr. Digliani is a guest lecturer in forensic and police psychology at Colorado State University.