Jack A. Digliani, PhD, EdD
Police Psychologist

Police Peer Support Team Training Program
Enhanced Outline - 2024*

The 40-hour *Police Peer Support Team Training* (PPSTT) program is designed to prepare police personnel to function as members of a law enforcement agency peer support team (PST). While the PPSTT is presented in terms of police personnel and law enforcement, it is applicable and/or readily adapted to the training of any agency peer support team.

Peer support team training

PST training beyond the PPSTT program is recommended. This is accomplished through ongoing monthly in-service training and annual advanced programs. Monthly PST training and annual advanced programs are designed to enhance and extend the knowledge and skills of peer support team members.

Monthly in-service training

Monthly peer support in-service training addresses two important aspects of ongoing instruction: (1) periodic review of core topics, such as confidentiality and stage peer support, and (2) a discussion of new and timely topics.

Periodic review of core topics is necessary because providing peer support is not the primary role of most peer support team members. Therefore, essential peer support knowledge and the appropriate engagement of peer support interventions naturally fade from memory. Review of core topics is designed to refresh memory and to cognitively reinforce the central principles of Level II peer support.

When not reviewing core topics, monthly training can focus on new and timely topics. These include topics selected by the clinical supervisor as well as those suggested by peer support team members.

One way to structure new-topic monthly training is to consider incorporating issues that have surfaced during group supervision. Another way is to address current circumstances within the department, other jurisdictions, and the world. Regardless of the topic or how it is generated, monthly training of new and timely topics should be presented and discussed in a manner relevant to peer support.

Although monthly training is the responsibility of the clinical supervisor, peer support team members may also assume a team training role. Team members that have special skills or that have recently attended specialized training can present instructional information within the monthly training schedule. Involving peer support team members as team trainers is an excellent idea. It engages members in team activities, helps them to solidify their knowledge, shares information with other team members, brings outside information to the team, and alters the less-than-desirable routine of consistently having the clinical supervisor as the monthly in-service training instructor. Monthly training is normally presented in a one to two-hour block.

Annual advanced programs

Annual advanced training is characteristically different than monthly training. It seeks to add to the knowledge and skill foundation of PST members in a significant way, and is the forum

through which advanced peer support programs are presented. For example, past advanced peer support training topics included motivational interviewing and transactional analysis (TA). Transactional analysis training proved so successful that it was added to the core areas of the PPSTT. However, new PST trainers, if unfamiliar with TA, should consider excluding it from the PPSTT program. This is because the principles of TA, like those comprising all of the PPSTT core areas, must be made relevant to peer support. This is nearly impossible to accomplish for trainers that are not well-versed in the theory and practice of TA. In any event, peer support team TA training should not advance beyond second-order analysis. Experience has shown that for peer support purposes, training beyond second-order analysis is unnecessary and tends to be confusing.

Advanced peer support team annual training is normally presented in a day-long, two 4-hour block (morning and afternoon) format and may include more than one topic discussed by more than one presenter. Brief instructional programs provided by local experts, followed by classroom or panel discussion of the presented topics have also proved to be a successful formula for PST annual advanced training.

Peer support team retreat

In addition to monthly and annual training, some peer support teams opt for an annual peer support team retreat. PST retreats bring peer support team members together in a relaxed and mutually supportive atmosphere. Retreats also allow team members that work various shifts to spend some time together. Although PST retreats provide an opportunity to discuss team administrative issues and often include a training component (usually provided by the PST clinical supervisor, a member of the peer support team, or guest presenter), the primary objectives of the retreat are stress decompression, team building, and just having some fun.

The Police Peer Support Team Training program

The PPSTT program is presented here in enhanced outline. It not only specifies PPSTT core topics, but also outlines what is presented within each topic. The PPSTT enhanced outline includes well-developed topic information that requires summary, as well as brief outline descriptors that require elaboration. Much of the information that requires summary is presented in the appendices of *Contemporary Issues of Police Psychology* (CIPP) (Digliani, 2015). The use of appendices in CIPP is necessary to avoid outline information saturation. Descriptors that are in need of elaboration rely upon information included in the various chapters of CIPP, the Law Enforcement Peer Support Team Manual (available at no cost at www.jackdigliani.com), *Reflections of a Police Psychologist, Third Edition-R* (Digliani, 2022), and the pre-existing knowledge of qualified police peer support team trainers.

While it is not possible to recreate a dynamic multi-day training program in writing, the enhanced outline provides an idea of the content of the PPSTT program. Hopefully, this will assist those that train or are preparing to train police (and other) peer support teams. However, as the normal flow of instructional information and trainer/class interaction cannot be duplicated here, some readers may find the sequence of the outline or the transition from one topic to another lacking in continuity. This is unavoidable. It is the responsibility of trainers utilizing the outline to transform it into a fluid, interactive, and easily understood program. It is imperative that trainers remember that the enhanced outline is a condensed, abbreviated, and dormant representation of the PPSTT. Peer support team trainers must bring the PPSTT enhanced outline to life.

The PPSTT program may be utilized to train fire, medical, legal, patient, student, and all other peer support teams. The provisions of CRS 13-90-107(m) apply only to specified peer support teams that meet statutory requirements.

Information for peer support team trainers

Trainers should consider the PPSTT enhanced outline a descriptive guide. As a guide, it should be edited, altered, and adjusted as deemed appropriate. Similarly, qualified trainers should modify the PPSTT presentation to fit their clinical orientation, professional experiences, teaching practices, and personal training style. The PPSTT works best when trainers add, delete, select from, and alter their presentation to best meet their training objectives.

Trainers of the PPSTT must also be prepared to go to where the class guides them, so long as class interests do not stray too far from the primary PPSTT program objectives. Exploring class interests and incorporating them into the PPSTT presentation is a great way to keep the class engaged and to enhance the adult learning experience.

Although the PPSTT program may be presented utilizing powerpoint, it is not dependent upon any technological delivery system. However, if powerpoint or a similar technology is used in the presentation of the PPSTT, the trainer(s) assume the responsibility to engage class participants and make the presentation interesting. Experienced users of powerpoint know that simply reading from a series of text-only projected slides quickly disengages class participants. This is especially true for lengthy programs like the PPSTT. If powerpoint or a similar technology is used, the slides must be colorful, visually interesting, and topic-symbolic to achieve the best training result.

The acquisition of knowledge and the development of skills necessary to become an exemplary Level II peer support person are the specific training goals of the PPSTT. The acquisition of knowledge serves as the foundation from which skill-based behavior is generated. As class participants become more adept at peer support, they move beyond "good" or "satisfactory" to become exemplary. Exemplary does not mean perfect. It means being conscientious when engaged in peer support. This distinction should be presented and discussed during training.

PPSTT program participants

Throughout the PPSTT there is an emphasis on learner self-enhancement. As class participants advance through the program, they are encouraged to implement program concepts that might improve their lives. In this way, they work toward self-enhancement, experience the benefit of positive re-conceptualization, prove to themselves that change is possible, experience the benefit of classroom peer support, and acquire the skills necessary to support others.

Philosophy, perspective, and experience

The PPSTT program, the police peer support team structure models presented in CIPP, and the model peer support team policy and organizational guidelines (www.jackdigliani.com) are representative of the author's philosophy, perspective, and experience. Other viable philosophies and perspectives exist and are hereby acknowledged.

Suggestions and comments

Suggestions and comments for trainers are presented in brackets { }.

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The Police Peer Support Team Training Program Enhanced Outline

The twenty-four core areas of the Police Peer Support Team Training program are:

1. Peer support
2. Peer support teams
3. Stressors and stress
4. Interpersonal communication
5. Conceptualization
6. Burnout and boreout
7. Family dynamics and issues
8. Mental health, mental disorders, diagnoses, and intellectual disability
9. Critical incidents, traumatic incidents, posttraumatic stress, and posttraumatic stress disorder
10. Concepts in critical incident exposure
11. Peer support team confidentiality
12. Confidentiality, clinical supervision and oversight
13. Foundations of peer support and intervention strategies
14. Model for peer support
15. Peer support tips
16. Alcohol, drugs, and addictions
17. Depression and suicide
18. Police officer suicide
19. Suicide by cop and officer witness to suicide
20. The police culture, police primary and secondary danger, and the "Make it Safe" Police Officer Initiative
21. Grief and mourning
22. Critical incident group debriefing
23. Keeping yourself healthy
24. Transactional analysis for peer support (optional)

A pre-program Introduction and the material included within each of the core areas is described below. Trainers must assess and determine how much time to spend within each of the core areas. This is readily decided by considering several variables including (1) the topic, (2) the type of information presented, (3) a "reading" of class comprehension, (4) class interest and participation, and (5) the goals of topic presentation. Each core area must be made relevant to peer support.

Introduction

At the beginning of the PPSTT program, trainer and class participant introductions are completed, the Law Enforcement Peer Support Team Manual is distributed, and the core training areas are identified. Following the Introduction, discussion begins with the core area of Peer Support and continues throughout the program until all core topics are presented. {The LE PST Manual is not a PPSTT program workbook. While the Manual includes much of the information presented in the PPSTT program, it is independently structured. Trainers may refer to the Manual, have class participants view specific pages, or coordinate their training with Manual information as deemed appropriate.}

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1. Peer support

<u>Peer support, counseling, and psychotherapy</u>. Counseling - a professional relationship and activity in which a professional person endeavors to help another to understand and resolve psychological and other life difficulties. Psychotherapy - psychotherapy is a form of counseling that is used as a treatment for mental disorders. It is the treatment of mental and emotional disorders through the use of psychological assessment, theory, strategy, and technique with the goal being relief of symptoms or personality alteration. There is much overlap between counseling and psychotherapy – and some view the processes of each as nearly identical.

<u>What is peer support</u>? Peer support is a non-professional interpersonal interaction wherein a person attempts to assist another person with past or current psychological, emotional, or otherwise stressful circumstances and with whom they have some common background, experience, or history. These and other commonalities provide the "power of the peer" in peer support interactions. Positive peer support is best reflected in interactions wherein a peer has (1) successfully resolved similar issues or (2) is successfully managing similar issues.

<u>Brief history of peer support</u>. Organized peer support in America can be traced to the 19th century: Drunkard's Club 1870's, United Order of Ex-boozers 1914, and Alcoholics Anonymous 1935. Helper principle – the idea that one is helped by helping others.

<u>Level I and Level II peer support interactions</u>. Present and discuss Level I and Level II peer support (see www.jackdigliani.com). {*all concepts mentioned but not elucidated in the PPSTT enhanced outline are presented and explained at* www.jackdigliani.com}.

<u>How does functional peer support help?</u>

Particularly when confronting difficulties or challenges:
- There is something inherently helpful in talking to another person, especially if that person shares some peer status and/or is experiencing or has experienced the confronting issue
- Normalizes experiences and helps to process experiences
- Helps persons to realize they are not alone & don't have to go it alone
- Provides a model for coping, moving forward, and survivorship
- Provides realistic hope that they will get through it (it will pass)
- Reduces fear, isolation, and loneliness
- Avenue for contact – always somewhere to go
- Provides a non-judgmental safe space – offers acceptance
- Resource for coping with likely periodic anxiety/depression

<u>Why peer support</u>? Employee Assistance Programs and community mental health providers are significant resources but appear insufficient to provide the totality of support services which best serve those in law enforcement.

<u>When peer support</u>? Peer support is best initiated early in an officer's career. It begins in the Psychologist and Training/Recruit Officer Liaison (PATROL) program. {discuss PATROL and its "seeking support" stigma-reducing effect}

Peer support…listening, being available, being patient. Emphasis to class: "you already have the skills necessary to engage in positive peer support." {due to: aptitude, interest, commitment, credibility, and the support and communication skills that made them eligible for the PST}

<u>Key points</u>: definition of peer support, Level I and Level II peer support, PATROL, initiation of peer support, power of the peer, class participants already possess significant peer support skills.

<u>Training objective</u>: acquaint class participants with the concept of peer support.

2. Peer support teams

Peer support team structure and function. Peer support teams can be structured and designed to function in a multitude of ways. Most police peer support teams are trained to provide peer support (1) to personnel dealing with challenging work stressors and stressors of everyday living and (2) immediately after identifiable high-intensity events (critical incidents). Critical incident intervention for PST members frequently involves on-scene support, ongoing support, and involvement in individual and/or group debriefing (group debriefing only if warranted). Peer support for the stressors of everyday living may involve PST members in a wide range of issues {trainer and class participants identify some possible issues}. The actual scope of support offered by any PST is determined by applicable statutes, department policy, and the department's PST operational guidelines.

<u>Model for peer support teams</u>: {discuss the following topics}

1. Team structure - coordinator, advisor, supervisor model
2. Agency PST policy and written operational guidelines
3. Criteria for selected peer support team members -
      aptitude, interest, commitment, and credibility
4. Specified confidentiality – statute, policy, operational guidelines
5. Clinical advisor or supervisor relationship
6. Ladder of escalation - support for the supporters
7. Monthly peer support training
8. Monthly group supervision – also as immediately needed
9. Consultation or availability of supervisor/advisor - 24/7
10. Peer support team as part of proactive support programs
11. Peer support team involved in police psychologist counseling program when appropriate
12. Peer support within specified team member policy boundaries {different from personal boundaries which are discussed later in the program} {amount of time spent on discussing PST structure depends upon whether training a new team or new members of an existing pre-structured team}

<u>Good to know</u>: (I) The efficacy of police peer support teams is in large part dependent upon the support of department administrators and supervisors. There is no "us vs. them" between department supervisors/administrators and the PST. We all have a job to do and a role to play. (II) Peer support team members are not union representatives. A clear boundary between the functions of PST members and union advocates must be maintained. (III) In order to remain in compliance with peer support statutes, department policy, and operational guidelines, PST members must know and periodically review these documents. PST members are held accountable to know and function within these documents.

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Discussion of department PST policy, PST operational guidelines, and PST clinical supervision:

(1) Review of department PST and other relevant policy. If there are personnel in the class from multiple agencies, emphasis is placed upon class participants knowing and understanding their agency policy.
(2) PST operational guidelines are discussed. Section titles of the Model Operational Guidelines are presented.

- Peer support parameters
- Clinical supervision
- Team coordinator
- Primary obligations (professional supervision, confidentiality, PST scheduled meetings)
- Duty to take action
- Clarification of role
- Availability and call out
- Compensation
- Debriefing
- Media
- Attorneys
- Outside agencies
- Team actions
- Referral
- Reach out
- Leave of absence
- Resignation from the team
- Removal from the team
- Compliance with guidelines

The rationale for the guidelines is discussed (rationale for the guidelines: to provide information about PST structure and function, to define expectations and responsibilities, to help PST members remain in compliance with statute and policy, to provide parameters for peer support, to assist PST members maintain a high quality of peer support, to outline confidentially and limitations, and so on).

(3) PST clinical advisor or supervisor. Following a discussion of the actual PST model being utilized, trainers present information pertaining to professional supervision and oversight, the ladder of escalation (ladder of escalation - the option of PST members to immediately contact their clinical advisor/supervisor with issues deemed critical and beyond peer support - the issue is moved up a "rung" in the support intervention ladder), and the availability of less-than-critical consultation (no need for immediate contact) when necessary. PST advisors/supervisors are also responsible for ongoing and advanced PST training, referral services, and providing support for PST members (supporting the supporters) as provided for in job description or contract.

Critical incident protocol: Presentation of relevant police-employee incident protocols involving the peer support team (if applicable). Many jurisdictions have developed specific police-employee critical incident protocols to be initiated under specified circumstances. These protocols frequently involve the agency peer support team. {if there is no established protocol, discuss how the department manages police-employee involved critical incidents and role of peer support team}

Reach out: {discuss the following in a brief narrative} High-functioning peer support teams do not rely solely upon the initiative of others to engage members of the peer support team. History has demonstrated that many employees confronting known stressors are open to peer support but will not initiate a peer support contact. There are several reasons for this, ranging from lack of knowledge about the peer support team to an exaggerated sense of self-reliance. Recognizing this, peer support teams should include in their operational guidelines a reach-out provision. This feature permits peer support team members to take the initiative in cases where it is suspected that proactive peer support would be beneficial. *Reach-outs must not be intrusive, embarrassing, or be conducted in such a manner that they create or exacerbate a problem*.

Reach out and PST confidentiality - reaching out is not confidential within the confines of the peer support team. Peer support team members may inform other PST members that they plan or have completed a reach out. This is necessary to prevent other PST members from unnecessarily contacting the same person. As one frustrated recipient of several well-intentioned PST reach outs exclaimed, "I have already been contacted by two other peer support people. I told them I'm ok. You guys should get your act together." However, if a person *engages* a PST member in a peer support interaction that was initiated through a reach out, that interaction and any following peer support interactions would fall under established PST confidentiality parameters.

Self-initiated Peer Support Activity (SPA) and Make a Contact Everyday (MACE): If PST members find themselves not being utilized or feel underutilized, self-initiated peer support activity (SPA) and make a contact everyday (MACE) should be considered. PST members can readily implement SPA or MACE without becoming a nuisance because most departments handle calls every day which would warrant some form of PST contact. SPA and MACE contacts can be quite casual and must be non-intrusive. MACE may include short shift-briefing presentations. While SPA and MACE are types of reach out, they differ from a more formal reach out in that they may be engaged in the absence of a known or suspected stressor. When engaging SPA or MACE, keep it relaxed and informal, and don't overdo it!

Peer support team mission and responsibility: The peer support team functions as a support and debriefing resource for employees and their families. The peer support team provides support to personnel experiencing personal and work-related stress. It also provides support during and following critical incidents resulting from performance of duty.

Tools available for PST members. There is an array of training, references, resources, and materials available to PST members.

- Basic PST training
- PST philosophy and mission
- Department policy
- PST Operational Guidelines
- Peer Support Team Manual
- Peer Support Team Code of Ethical Conduct
- LE Critical Incident Handbook
- LE Marriage and Relationship Guidebook
- State statute (where applicable)
- Monthly meetings and training
- Annual advanced training
- Clinical supervisor/advisor and clinical supervision
- Support from the PST coordinator

- Support from and discussion with other PST members
- Support from family and others
- Critical Incident Protocol (where applicable)
- Outside training, support, and information resources

Peer Support Team Code of Ethical Conduct

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

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

<u>The future of police peer support teams</u>:

- Integrated into more police agencies
- Statutory confidentiality protections
- Standardized foundation training
- Standardized ethical parameters
- Clinical advisement or supervision
- Ladder of escalation
- Regularly scheduled team meetings
- Ongoing monthly training
- Advanced annual training
- Brochures, newsletters, posters, and retreats
- Shift briefing presentations

<u>A bit about memory</u>: (for class information and information retention)

1) Sensory memory: retains sensory information even after stimulus ends. Very short duration – less than a second to a few seconds depending upon sensory input.
2) Short-term or "working" memory: 5 to 9 (7+-2) holds items for 15-30 seconds (w/o rehearsal).
3) Long-term memory: can last lifetime, unlimited capacity. Various types and subtypes (*implicit* (unconscious) and includes procedural memory (tasks), *explicit* or declarative memory (conscious), episodic (events) / semantic (facts). Subtypes can morph into one another.

Proactive Interference – an older memory interferes with remembering a newer memory.
Retroactive Interference – a newer memory interferes with remembering an older memory.

The process of transferring sensory information to short-term memory is known as *attention*.
The process of moving information from short-term memory to long-term memory is called *encoding*.

Factors which facilitate encoding are:
1. Review, repetition, rehearsal
2. Organization
3. Meaningfulness
4. Imagery

"Forgetting" or "memory" curve - without reinforcement or connection to prior knowledge, most information is quickly forgotten: roughly 56 percent in one hour, 66 percent after a day, and over 75 percent after six days (Ebbinghaus, H., 1859-1909).

<u>Key points</u>. Structure and function of peer support teams, department policy, operational guidelines, clinical supervision, support for the supporters, reach out, SPA, MACE, PST mission, available PST tools, PST Code of Ethical Conduct, future of police peer support teams, memory.

<u>Training objective</u>: provide PST information and outline PST member responsibilities and ethical conduct.

3. Stressors and stress

The development of peer support skills begins with an understanding 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. {discuss the following in brief narrative}

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." In this conception of stress, stress equals demand. 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 problem is influenced by many factors. Among these are: type and intensity of the stressor, stressor appraisal, perceived ability 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*. {fight or flight has evolved into *fight, flight, freeze, fawn responses*}

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 (experienced stressor effects) may 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.*

The relationship between stress and performance. Stress increases performance up to a point. Once an optimal level of stress-for-performance is reached, any additional increases in stress will cause performance to degrade. Excessive amounts of stress will bring performance to a standstill.

The physiology of stress. The physiology of the stress response is characterized by increases in heart rate, blood pressure, respiration, blood sugar, and blood flow to the skeletal muscles. Additionally, pupils dilate, blood flow to extremities is decreased, and intestinal muscles relax. In general, the stress response "revs up" a person in preparation for action.

The person x event transactional relationship. The intensity of the stress response varies with the perceived intensity of the stressor; the perceived intensity of the stressor is influenced by one's perceived ability to cope with it. Therefore, persons can confront stressors that represent real dangers, such as a vicious dog, without any significant stress response if the dog is perceived to be friendly. Correspondingly, persons will experience a significant stress response to a dog they believe is vicious even though it is actually friendly. The intensity of the stress response in both of these "vicious dog" examples will vary with a person's perceived ability to deal with the dog. It is in this way that the stress response is said to be *transactional* (person X event).

The fact that we respond to our interpretations of our environment (internal and external) and our assessed ability to deal with particular stressors is a fundamental element of human experience. The best we can do is to perceive, interpret, assess, respond, and reassess. It is a fundamental limitation of what we can know and how we transact with the world.

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 persons 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.*

Types of stressors. Stressors can be categorized in terms of intensity and duration. This simplified method of categorization can aid in the creation of appropriate stressor management strategies. Stressors can be thought of as:

- Low intensity – short duration (unwanted call from a phone solicitor)
- Low intensity – long duration (unfulfilling marriage or job)
- High intensity – short duration (most police shootings)
- High-intensity – long duration (prolonged torture or hostile captivity)

Frequency is also a variable for all stressors. Therefore, stressors vary along the dimensions of intensity, duration, and frequency. Remember, stressors can be internal or external {present and discuss examples of the various types of stressors}

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

Items for discussion. What are some of the unavoidable stressors of life? (examples: need for water, food, clothing, shelter) What are some of the unavoidable stressors of policing? (examples: confrontation, shift-work, working on holidays, coping with a chain of command, duty to protect others) What are some of the unavoidable stressors of your assignment? How do occupational and personal stressors transact? (for the most part they are cumulative – but work can also offer relief from home stressors and vice versa) Stressor management is really life management. Diet, exercise, and self-awareness are sometimes considered the big 3 of stress (life) management.

Two primary stress management strategies. (1) Change your environment (change for positive) and (2) change yourself (the way you think/feel about yourself, the way you think/feel about your environment, and the way you behave.) Changing yourself includes developing new skills to enhance your coping abilities. The first strategy acknowledges the ability to alter one's circumstances. The second strategy recognizes the internal and external transactional nature of human experience

Primary buffers against stress. Primary physical buffer against stress – exercise. Primary psychological buffer against occupational stress – the Occupational Imperative: *do not forget why you do what you do.*

Discussion. What coping skills are needed for police officers? *How to do the job.* Knowing how to do the job is necessary but insufficient for a healthy career. You must also know *how to keep yourself healthy* in your career and how to keep occupational stressors from negatively impacting your family.

Bio-psycho-social approach to peer support. Clinicians often think in terms of biological, psychological, and social issues when assessing and considering how to best assist a person. {identify and discuss some of the biological, psychological, and social aspects of life and lifestyle} How are these relevant to peer support? {solicit thoughts and experiences from class participants}.

Mindfulness

Mindfulness is a state of active, open attention on the present. When you're mindful, you carefully observe your thoughts and feelings without judging them good or bad. Instead of letting your life pass you by, mindfulness means living in the moment and awakening to your current experience, rather than dwelling on the past or anticipating the future.
www.psychologytoday.com/us/basics/mindfulness

Resiliency

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences. Research has shown that resilience is ordinary, not extraordinary. People commonly demonstrate resilience. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models and offer encouragement and reassurance help bolster a person's resilience.
American Psychological Association

> Do you see yourself as resilient?
> Do you have a primary strategy to manage stressors/disappointments? Mental/physical?
> What helps you to "bounce back" after a difficult experience?

Some things to remember: When confronting change and managing stress there are things that you can do that help – {those having special significance are in italics}

- *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* {discuss the difference between self-care and being selfish}
- Keep yourself physically active, not too much too soon
- Utilize positive and appropriate coping statements
- *Anxiety: influence one part of your brain with another part of your brain* {by using self-talk and breathing exercises, reduce anxiety}
- 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* {a pocket response is a response that you keep in your mental pocket. They are useful when you're asked about something that you rather not talk about to the person asking. Simply use the pocket response instead of having to come up with an "on the spot" reply. Example: question -"What did you do out there?" Pocket response – "That was quite a call. I did my best. Thanks for asking. Sorry, got to run." "Got to run" is an oblique follow-up.}
- Apply thought stopping/blocking to negative thoughts

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- Identify and confront internal and external "false messages"
- Confront negative thinking with positive counter-thoughts
- *Break stressors into manageable units; deal with one unit 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*
- *Things do not have to be perfect to be ok*
- Stressor strategies: confrontation, withdrawal, compromise (combination)
- Remember: transactions and choice points = different outcomes
- Relationship imperative: *Make it safe*!
- *Work*: do not forget why you do what you do {occupational imperative}
- Utilize your physical and psychological buffers
- *Healing involves changes in stressor intensity, frequency, and duration*
- Use your psychological shield when appropriate
- Create positive micro-environments in 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"*
- *"Stronger and smarter"* (in combination with "Trigger anxiety" = the "2 and 2")
- *Walk off and talk out your anxiety, fears, and problems* (walk and talk)
- *Being vulnerable does not equal being helpless*
- Develop and practice relapse prevention strategies
- Develop and utilize a sense of humor, learn how to smile
- *Things are never so bad that they can't get worse* [1]
- *Do not forget that life often involves selecting from imperfect options*
- Time perspective: past, present, future (positive – negative) (Zimbardo, et al)
- Access your power: the power of confidence, coping, and management
- *Stay grounded in what you know to be true*
- Utilize the proactive annual check in and other proactive programs
- Keep things in perspective: keep little things little, manage the big things

[1] The notion that "Things are never so bad that they can't get worse" is not intended to minimize the experience of any particular stressor. It is intended only as an aid to help keep things in a perspective which encourages improved toleration, motivation for change, and positive life management.

Proactive Annual Check In (PAC) {proactive stress management}

1. Annual visit with the police psychologist, a member of the peer support team, or other support resource
2. Confidential meeting that does not initiate a record
3. No evaluation - It's a check- in, not a check-up
4. There does not need to be a problem
5. It's a discussion of what's happening in your life
6. Participation is voluntary and encouraged {some agencies offer incentives for voluntary participation, while others may mandate PAC meetings. Some police departments now offer incentives to attend more than one check-in meeting per year}

Key points: stress and stressors, transactional nature of stress, life stress, occupational stress, unavoidable and avoidable stressors, occupational imperative, primary stress management strategies, primary buffers, and bio-psycho-social, some things to remember, proactive annual check in.

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Training objective: provide an understanding of stressors, stress, and stress management; introduce proactive programs.

4. Interpersonal communication

Theories of interpersonal communication can be complex. A simple and useful way to think about verbal interpersonal communication is: Content, Message, and 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 can alter the message of the content. For example, how you say "have a nice day" might imply that you wish the person to have a nice day. However, if said sarcastically, it might mean the opposite. Many police officers have received citizen complaints wherein the person reported, "it's not what he said, it's how he said it." Nonverbal behavior during in-person interactions, including gestures and interpersonal distance (spacing proximics), can also alter the message of spoken content. {discuss significance of nonverbal communication}

All communication is relative to culture, era, and context. Cultural influences can define and/or alter the meaning of verbal and nonverbal communication. {discuss cultural differences in communication and introduce notion of cultural differences in general}

Communication Imperative - *a person will respond to the message received, not necessarily the message you intended to send.* {provide examples of how the same content can communicate different messages by altering the delivery, and how different content can send the same message}

Ten functional communication tips

1. Hearing is not listening. Be a good listener. This will help you to better understand others.
2. Remain relaxed. Pressured communication often results in misunderstanding.
3. Be mindful of content, message, and delivery. Use feedback loops when you're uncertain that your intended message was received and properly understood.
4. Remember that eye contact, facial expressions, and body posture communicate volumes. Issues: *validation* and *invalidation* of others.
5. Ask appropriate questions in an appropriate manner. This is a good way to show you are interested in the transaction. Avoid over-questioning and becoming intrusive - don't interrogate.
6. Try to understand other points of view. You do not need to change your beliefs or opinions in order to understand the views of others.
7. Avoid dominating or being a wallflower during the conversation. Seek a "participation exchange balance" in your interpersonal communication.
8. Don't immediately respond to something someone has just said by interrupting and then telling your story. For example, "We had a great vacation in Europe. We were able to see…" "Oh yeah. When I was in Europe it was great, I saw…" {this is "hijacking the conversation"}
9. Learn from your communication experiences. If a conversation didn't go well, change some things and try again.

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10. Keep what works for you. Experiment with new strategies. Good communication is a skill to be learned.

Human complexity. Human beings are complex. Human beings are so psychologically complex that we have an ongoing relationship with ourselves (internal communication – self-talk). We also have a secret life. There are some things we know about ourselves that no one else knows. What concept do these factors involve? (self-concept) {discuss self-concept, internal communication, secret life, and "inner world"}

Key points: verbal and nonverbal communication, content-message-delivery, cultural influences on communication, validation-invalidation, Communication Imperative, communication tips, ongoing relationship with self.

Training objective: specify a working communication theory and improve understanding of interpersonal communication. {later to be related to peer support}

5. Beliefs and Conceptualizations

Importance of conceptualization. Conceptualizations are thoughts, beliefs, views, perspectives, etc. There are many ways to conceptualize. Most of our conceptualizations originate in childhood and come from significant childhood figures (this is why if you are religious, you are likely the same religion as your parents). Conceptualizations are important because they determine how we interpret "reality." This is the reason that a particularly colorful sunset is seen by some as nothing more than an atmospheric feature of an uncaring mechanical universe, while others view it as evidence of a beneficent Creator.

Beliefs are very powerful. So powerful that persons will kill and die in the name of their beliefs. New beliefs and conceptualizations can be developed and former conceptualizations may be abandoned or altered throughout life.

Some conceptualizations appear to be more functional than others. {discuss meaning of "functionality"}. There are also conceptualizations acquired in childhood that sometimes cause difficulties in adulthood. For example, being told by your parents that "you're stupid and you'll never amount to anything" can affect self-concept, self-image, and self-esteem in adulthood {provide additional examples}. The functionality of conceptualizations is measured against other conceptualizations (conceptualizations are relative). Conceptualizations represent the basic values of persons and what they believe to be true. Such conceptualizations are known as *core beliefs*. Core beliefs and other significant conceptualizations frequently drive behavior.

Sometimes we think about (conceptualize) difficulties in ways that create little opportunity for resolution. Example, "Life is bad…there is nothing I can do about it." Problematic issues must be conceptualized in a way that makes resolution or some improvement possible. ("Life is bad…I have to try something different or ask for help")

Cognitive psychology and self-concept. Self-talk, self-esteem, self-concept, values, irrational vs rational self-talk, thoughts and their effect on perception and behavior, core beliefs and their effect on perception and behavior. {discuss these concepts with class participants – solicit class opinions and comments}

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Conceptualization and behavior. Model the behavior you wish from others. "You must be the change you wish to see in the world" (Mahatma Gandhi). Must be tempered with a moral code.

Attitude. What is attitude? (pre-conceived notions, perspective, personality traits, core beliefs, cognitive schema). How does attitude relate to conceptualization and life perspective? {discuss}

Life perspective. A functional life perspective draws from the past - mindful of consequences and lessons learned, while maintaining a view of the future potentialities and "eye on the prize" (what is desired).

Life management - life-by-design and life-by-default. 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 theoretical continuum along which a person engages 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. 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. The life-by-design philosophy is characterized by "*taking life by the horns.*" Life-by-design does not mean that you will get everything you want. It means only that you feel you can effectively influence the direction of your life and that you are willing to act within your value system to bring about what is desired. Therefore, a person living life-by-design feels some ability (power) to make things different when desired. Remember, life-by-default is what you get if you do not practice life by design {it's worth repeating}.

Consequence and "prosequence". Consequences – results following behavior. Sometimes consequences of behavior are not well thought out…"why didn't I think before I did X." *Prosequence* – an idea in decision-making that encourages imagining that the likely consequence(s) of potential behavior have actually occurred and now must be confronted. *Prosequence* is thinking about what it would be like to have to deal with likely or eventual consequences of a decision. The idea of *prosequence* is useful in the effort to make decisions that result in more desirable outcomes. (example: imagining having to cope with the consequences of having an affair before you initiate one) {"prosequence" (before consequence) is a coined word to help persons consider the likely or eventual consequences *before* they occur}

Key points: conceptualization, many ways to conceptualize, cognitive psychology, life perspective, life-by-design/life-by-default, consequence-prosequence.

Training objective: comprehension of the significance of conceptualization in human experience and personal perspective.

6. Burnout and boreout

Signs of police occupational burnout (many apply to burnout in all areas of life)

- A sense of dread, "nervous" stomach before shift

- Fatigue – feeling tired most of the time, no energy
- Easy to anger, irritability, lack of tolerance, lack of interest
- Low self-esteem, feelings of low mood/depression
- Negative outlook on life, life and/or job meaninglessness
- A sense of being trapped without options, "boxed in"
- Increased anxiety at work, in other environments
- Tension headaches, increased migraines, muscle aches
- Loss of appetite, stomach upset, eating disturbances
- Increased use of alcohol, nicotine, or other drugs
- Sleep disturbances, anxiety dreams/nightmares
- Sexual dysfunction: hyposexuality - hypersexuality
- Uncharacteristic behavior or "acting out"
- *Lack of concern for behavior consequences*
- Increased problems with coworkers/supervisors
- Increased family problems
- Increased citizen complaints

Good to know: for most of us, our job has components that are more desirable than others. Job burnout can result from too much focus on what you don't like, and not enough emphasis on what you do. The answer to job burnout is reclaiming your career. Consider what first attracted you to policing. Can you re-engage the thoughts and behaviors that were once rewarding? Find what you previously enjoyed about policing and re-engage those activities. Everyone needs to recharge their occupational batteries. Be creative to rediscover meaning in your work. Look for balance.

Boreout. Police officers, like those in other occupations, may also experience *boreout.* Boreout is a term first used by Swiss management consultants, Philippe Rothlin and Peter Werder (2008). They describe it as the opposite of burnout. Although deprivational stress is a part of boreout, being bored out encompasses more than just not having enough to do. It includes feeling underused and unchallenged.

Officers confronting boreout need to reevaluate their position, rewrite job descriptions, initiate new programs, develop new job functions, take on rewarding challenges, communicate with supervisors to address assignment parameters, expand job responsibilities, and similar to burnout - reclaim their careers. PST members must help others understand boreout. The answer to boreout (and burnout) is creativity.

The three-step answer to burnout and boreout:

- Reconceptualization - Cognitive alteration (occupational imperative)
- Creativity - Develop a plan or strategy (workable components)
- Reclamation - Behavior: engage plan (reassess and reengage as needed)

Key points: warning signs of burnout and boreout, getting back to basics, reclamation of career, use of creativity for improvement.

Training objective: relate the concepts of burnout and boreout to that of stressors and stress.

7. Family dynamics and issues

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Marriage and relationships: two perspectives when approaching marriage. (1) There is nothing that we cannot work out, (2) if this doesn't work out, I can always get divorced. Which perspective is more predictive of marital success? Non-traditional marriages? {significance of conceptualization}

What are the stressors of policing that impact the family of police officers?
What can you do to help family members cope with the stressors of your job? (communication is important) {class input and discussion - family issues often emerge in peer support interactions}

Functional Relationships. Fundamental Building Blocks of Functional Relationships

1. Emotional connection
2. Trust
3. Honesty
4. Assumption of honesty
5. Respect
6. Tolerance
7. Responsiveness
8. Flexibility
9. Communication
10. Commitment   (visit www.jackdigliani.com for more "Blocks" information)

Spouses as "special status" persons {present and discuss the Fundamental Building Blocks of Functional Relationships and the idea of spouses as special status persons}

Intimacy, behavior, and sex. Intimacy is not sex – sex is not intimacy. Intimacy is an emotion and is characterized by a feeling of closeness and connectedness. Sex is a behavior. You can have either without the other. Fortunate people have sex with intimacy.

Behaviors within any relationship can enhance intimacy or create intimacy distance. Behaviors that enhance intimacy bring persons closer together emotionally. Intimacy distancing behaviors result in emotional drifting (loss of a feeling of connectedness) and disaffection. In highly functional relationships persons frequently engage intimacy enhancing behaviors (like writing love notes) and avoid intimacy distancing behaviors (like an extended silent treatment). {provide additional examples}

Intentional and unintentional harm. Some couples will intentionally harm one another. They do this psychologically, emotionally, and physically. One pattern of intentional harm involves playing the *relationship card*. The relationship card is played when a spouse implies or threatens to leave the relationship unless the other person does what is desired. This is different than being dissatisfied with the relationship and honestly discussing the possibility of separation. Playing the relationship card is inherently manipulative and dysfunctional. It is intended to hurt, punish, dominate, and control. It is intimacy distancing and risks the relationship. It has several variations including, "If you don't do this, I'll leave" "If you don't like it, there's the door" "I'm not sure I'm coming home" and "Don't let the door hit you on the way out." The use of the relationship card is one level below the threatened use of violence, which is one level below actual violence, in the hierarchy of dysfunctional behaviors used to obtain what is desired in a relationship.

There are many relationship patterns and motivations capable of producing harm. Fortunately, most couples would not intentionally harm one another. Even if they become angry, frustrated, or

disappointed with their spouses, most persons would not look to harm them in any real way. This is an important characteristic of most marriages. It has clinical significance for couples in counseling. If a couple would not intentionally harm one another, then it makes sense to think that any harm experienced must be unintentional. This realization can move a couple forward not only in professional counseling, but also in peer support and everyday life.

When considering unintentional harm, two points should always be kept in mind: (1) you do not have to intend harm to do harm (this is the very definition of unintentional harm), and (2) if you feel harmed in any meaningful way (there is a place for just letting minor transgressions pass without confrontation – after all, no one is perfect), you should talk to your spouse about it. Do not let the feeling of being harmed, even unintentionally, build resentment or lead you to unfounded conclusions.

For the Fundamental Building Blocks of Functional Relationships: two *foundation reinforcing rods*: (1) assume good faith in your spouse and (2) trust in the "lack of intentional harm."

Types of families. There are at least three types of families: family of origin (the family within which you grew up), immediate family (your family now, spouse and any children), and extended family (all family members including grandparents, aunts, uncles, cousins, etc). Concepts within family systems:

- Rules
- Myths
- Generational boundaries
- Alliances and coalitions
- Function vs dysfunction
- Homeostasis
- "Underflow" (the psychological undercurrents of the family system) {discuss and provide examples of these concepts}

Social interaction: Persons have differential desires and preferences (needs?) for various levels of social interaction: solo (alone time), couples (couple only), family (children, other relatives, etc), social/public (work, school, etc). Many persons do not get enough time within a particular level of social interaction. It can be challenging if one partner is significantly different than the other (example, one person in the couple desires much solo time while the other desires a great deal of social/public interaction) as illustrated below.

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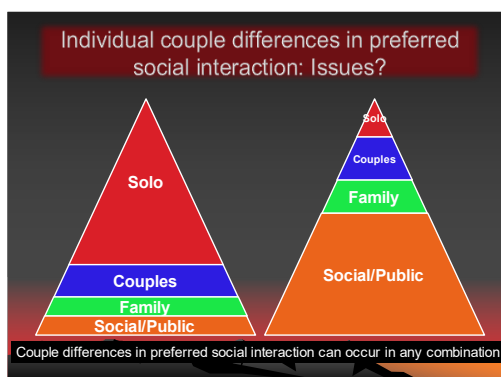
Relationship Imperative: Make it Safe. When it comes to positive social interaction in relationships, especially couples and family, remember the Relationship Imperative – Make it Safe. Spouses (and others) should feel safe to approach one another without undesirable consequences. {make it safe - cornerstone of the "Make it Safe" Police Officer Initiative}

Making it safer. How you start conversations has a huge impact on how you interact. Take a look at these two statements:

Statement 1: "I can't believe you didn't mow the lawn before my parents arrived. You always do this. Why are you so lazy?"
Statement 2: "I felt embarrassed that the lawn wasn't mowed before my parents visited. Could we talk about how to prepare before guests visit in the future?"

Can you spot the key differences between these two conversation start-ups? (criticism vs complaint) If you start an argument harshly, you will end up with at least as much tension as you began with, if not more. In comparison, using a softened start-up is crucial to resolving conflict before it begins. It's a proven way to bring up a legitimate disagreement, concern, issue, complaint, or need without blaming your partner or judging their character. Quoted from: The Gottman Institute, www.Gottman.com.

Couples counseling. In couples counseling, it takes effort from both persons to obtain the most relationship improvement, but only one of the couple to put the relationship on a separation course.

Available for peer support team members to use and for referral - Marriage and Couples Exercise, included in the *Law Enforcement Marriage and Relationship Guidebook.*

Key points: Fundamental Building Blocks of Functional Relationships, intimacy enhancing-intimacy distancing, intentional-unintentional harm, reinforcing rods, types of families, family systems theory, special status, levels of social interaction, Relationship Imperative, criticism vs complaint, Marriage and Couples Exercise - LE Marriage and Relationship Guidebook.

Training objective: familiarize class participants with relationship and family dynamics; introduce the idea of family systems; relate family dynamics and issues to peer support.

8. Mental health, mental disorders, diagnoses, and intellectual disability

To further understand stress and trauma - examine the concept of mental illness.

Concepts of mental illness, mental health, mental diagnosis, and mental disorder are presented and discussed. {the goal is to explain the current and historical conceptualizations of mental disorder. This is necessary for improved field assessments and a better understanding of the responses sometimes seen following critical incidents}

Diagnostic and Statistical Manual of Mental Disorders (DSM)

- *Brief* discussion of the history of the DSM and diagnostic manuals (first DSM: 1952)
- The DSM is based on diagnostic criteria and not upon any theory or notion of cause
- Due to the complexity of the human organism and possible multiple disorders, proper diagnosis can be difficult

- Most mental illnesses are brain illnesses
- There are effective treatments for many of the major mental illnesses – but much work has yet to be done in the area of treatment
- Societal prejudice remains a significant problem for those persons experiencing mental illness
- The concept of insanity (not a clinical diagnosis - legal term pertaining to culpability)

Understanding mental illness. Provide a working definition of mental illness. Each state has a statutory definition of a person with mental disorder {review statutory definition of mental disorder}

What is a mental disorder diagnosis? Generally, a diagnosis represents a particular cluster of *signs* (observable behaviors) and *symptoms* (as reported by a person), often involves a "level of impairment" or distress, a period of duration and/or onset, and positive and/or negative symptoms. Brief review of the current major categories of mental disorders.

Some treatments for mental illness/disorders Review some historical treatments and control methods: chaining and confinement, spinning chair, ice baths, caging, strait jackets, pre-frontal lobotomy, etc.

Current treatments: Psychopharmacology (medications), psychotherapy – many different orientations and strategies, electroconvulsive therapy and other electroceuticals (deep brain stimulation, transcranial direct current stimulation), psychosurgery, new age interventions, transcranial magnetic stimulation, others. {only brief familiarization is recommended}

Understanding psychopharmacology. Many advancements have been made in the medications used to treat mental disorders (main effects). Medications have side effects – many undesirable. Some illnesses get much worse when the person stops medication. Knowing something about psychoactive medications can aid peer support interactions. Alcohol as a "medication" (complex diagnosis involving substance addiction and mental illness) {discuss main effects and side effects of medication – reasons for medication discontinuation}

Intellectual developmental disorder. The former diagnosis of "mental retardation" was replaced by "intellectual developmental disorder" also called "intellectual disability." The essential feature of IDD is significantly subaverage general intellectual functioning accompanied by significant limitations in several skill areas. *Degrees of severity*: mild, moderate, severe, profound. The degrees of severity are rated on adaptive functioning. It is possible for a person to be diagnosed with intellectual developmental disorder and other mental disorders.

Key points: mental health, mental illness, DSM, diagnoses, insanity, treatments for mental disorders, psychopharmacology and effects, intellectual developmental disorder.

Training objective: comprehension of concepts associated with mental health, mental disorder, and treatment of mental disorder.

9. Critical incidents, traumatic incidents, posttraumatic stress, and posttraumatic stress disorder

Ever wonder why psychologists are so interested in your eating habits, how you sleep, and your sex life? (these are the systems most likely to be effected by stress and responses to critical incidents)

History of trauma conception. Traumatic reactions recorded since ancient times.

The influence of military psychology:

- American Civil War - irritable heart
- World War I - shell shock
- World War II - combat fatigue
- Korean War - zombie reaction
- Post-Vietnam War - posttraumatic stress disorder (PTSD) – Stressor(s) and symptoms meet specific criteria. PTSD is one of several stressor-related clinical disorders. {post-Vietnam because PTSD was not an official diagnosis until 1980}

Good to know: There are references to a condition that would currently be diagnosed as posttraumatic stress disorder included in the Iliad (Homer), believed to have been written around 800 BCE.

"…it is strange to think how to this very day I cannot sleep a night without great terrors of the fire; and this very night could not sleep to almost two in the morning through thoughts of the fire." Samuel Pepys (1633-1703) after the London fire of 1666.

Critical incidents: Critical incidents are characteristically different from the stressors of everyday life. While the circumstances of everyday life can be stressful, critical incidents are those that lie outside the norm of common experience. Critical incidents are often unexpected, high in intensity, and have the potential to overwhelm normal coping mechanisms. They often represent a threat to the safety and welfare of self or others. They may involve injury, death, or near death. The nature of a critical incident has the potential to traumatize those involved.

Summary of critical incident characteristics -

- Often sudden, unexpected, and high intensity
- Involves loss or threat of loss of life to self or others
- Disrupts core beliefs or the conception of "how the world works"
- Potentially overwhelming for normal ego defense mechanisms - can strip personal defense mechanisms
- Commonly involves *in-progress* altered perceptual phenomenon
- "One-shot" learning (classical conditioning associations that do not require repeated pairings – effect is due to the intensity of the stressor or event)
- Can cause lifetime physiological dysregulation
- Can turn the *person-in-the-world* upside down
- Can be comprised of repeated and cumulative exposures

Perceptual Distortions Reported Experienced During a Critical Incident.

1. Slow motion
2. Fast motion
3. Muted/diminished sounds
4. Amplified sounds
5. Slowing of time
6. Accelerated time
7. Dissociation

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8. Tunnel vision
9. Heightened visual clarity
10. Vivid images
11. "Automatic pilot"
12. Memory loss for part of event
13. Memory loss for part of your actions
14. False memory
15. Temporary paralysis (Christensen & Artwohl, 1997 & Digliani, 2015)

Common Responses Following a Traumatic Incident

heightened sense of danger - fear and anxiety
splitting of environments (work/non-work)
anger, frustration, and blaming
super-conditioned learning (surface lesson/depth lesson)
isolation, withdrawal, and alienation
sleep difficulties - insomnia or hypersomnia, dreams and nightmares
intrusive thoughts - obsessive thinking, preoccupation with incident, endless video phenomenon
emotional numbing - avoidance/withdrawal
depression/guilt
desire difficulties - sexual, eating appetite
second guessing
interpersonal difficulties - family and friends, work and authority figures
alcohol and drug abuse - self-medication, prescription/street drugs
grief and mourning – uncomplicated / complicated bereavement

Factors Affecting Magnitude of Response.

Person Variables
1. History
2. Personality
3. View of reality
4. Beliefs and aforethought
5. Assessment of threat
6. Assessment of performance
7. Assessment of options
8. Stress training and coping abilities

Incident Variables
1. Proximity
2. Sudden or planned
3. Blood and gore
4. Age of others
5. Personal history of suspect
6. Suspect or others behavior
7. Alone or with other officers
8. Circumstances of the event

Critical incident considerations: levels of decompensation
1. *possible*: no or very little reaction

2. *likely*: some degree of decompensation
3. *most decompensated*: psychotic reactions, severe posttraumatic stress disorder

<u>Ultimate Survivor video (optional)</u>: Case of Steve Chaney (available through Caliber Press) {presentation of officer-involved critical incident dated from the 1970s – while dated, this video remains timely and appropriate. May be presented elsewhere within this block at discretion of trainer}

<u>Critical incidents and trauma</u>. Involvement in a critical incident can cause varying degrees of psychological trauma. This is because the actual outcome for a person who has been involved in a critical event is determined by the complex transaction of event circumstances, personal characteristics, and the perceived elements of the incident.

<u>Critical incidents and traumatic incidents</u>. Some incidents that appear critical when viewed from the outside (like an officer involved injury or shooting) may cause no or little psychological trauma to those involved. Conversely, some incidents that appear non-critical may cause significant psychological trauma. Another way of thinking about this is that "critical" is a feature of the incident, while "trauma" is a concept associated with human (and other organism) experience. This is why two officers involved in the same critical incident in very similar ways can experience different degrees of individual trauma. Simply stated, any incident, whether or not it appears "critical" to an outside observer, may traumatize one or all of those involved. This is because the concept of "critical" is relative and dynamic.

The degree of traumatization following a critical incident can range from no or insignificant distress to a constellation of physiological, psychological, and sociological symptoms and impairment collectively diagnosed as posttraumatic stress disorder (PTSD) or other stressor-related disorder. This is the difference between critical incidents and traumatic incidents – the same critical incident may become a traumatic incident for some of those involved and not for others.

<u>Bessel Van Der Kolk, MD on Trauma</u>

(1) Trauma is "extremely common."
- The mainstream system of psychiatry, psychology is that there is something wrong with you and I need to fix you. That's a very different attitude than dealing with trauma.
- The nature of trauma is that an experience enters into your ears, into your skin, into your eyes, and it goes down into a very primitive part of your brain that automatically interprets what's going on ("cockroach brain").
- And most people actually are barely aware or not aware at all that their reactions that they're having right now are actually rooted in experiences they've had before. That event itself is over, but you continue to react to things as if you're in danger.

(2) Some traumatized persons that feel out of control and unable to stop unwanted experiences…

- Will stop eating
- Will not stop eating or will binge eat
- Will cut or otherwise harm themselves
- Will become aggressive / act out in some way

- Will numb themselves with alcohol / drugs in their attempt to gain some control or cope with what they are experiencing…*these behaviors are often reported to offer some relief.* Problem?

(3) What was very clear is that being in a relationship where people can hear you, where you can talk about how badly you feel, where you can talk about your guilt, and where you can start opening up to particular things that happened to you, that was actually quite helpful because you need to really develop a deep sense of, "This is what happened to me. This is what I'm dealing with and I need to take care of the wounds that I'm carrying inside of myself." This issue of self-compassion and really knowing that your reactions are understandable and are rooted in you getting stuck in the past, is a terribly important part of beginning to recover from trauma. (Yoga, theater, movement, activity.)

<u>Posttraumatic stress and posttraumatic stress disorder</u>. *Posttraumatic stress* (PTS) - expected and predictable responses to a critical incident. Normally resolves within a month through the person's resources and outside psychological support. In PTS, there is no clinically significant distress or impairment. *Posttraumatic stress disorder* - a constellation of clinical symptoms which meet specific criteria for the PTSD diagnosis, including clinically significant distress or impairment. PTSD is best addressed with professional treatment. The symptoms of PTSD may last months or years. Lifetime PTSD and other incident-initiated mental disorders, such as depression and anxiety disorders, are also possible.

PTS and PTSD may include atypical visual hallucinations. {not as uncommon as previously thought – such phenomena are subject to various interpretations by those that experience them – influence of personal conceptualizations and core beliefs}

<u>Posttraumatic stress disorder</u> {PTSD diagnostic criteria is presented}

<u>Summary of PTSD criteria (2023)</u>:

- Exposure: stressor(s)
- Intrusion
- Avoidance
- Negative alterations in cognitions and mood
- Alterations in arousal and reactivity
- Duration: more than one month
- Distress or impairment
- Not caused by substance or medical condition

Specifiers: *with dissociative symptom*s (depersonalization, derealization), *with delayed expression* (full diagnostic criteria after at least 6 months from event)

<u>Complex (CPTSD) posttraumatic stress disorder</u>

CPTSD: results more from chronic repetitive stress from which there is little chance of escape, for example, captivity. PTSD can result from a single event or short-term exposure to extreme stress or trauma. It is this loss of a coherent sense of self and the ensuing symptom profile that most pointedly differentiates CPTSD from PTSD (Herman, J. 1992).

CPTSD is not a diagnosis in DSM-5-TR (2022). It is a diagnosis in the ICD-11.

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PTSD treatment issues.

- Potentially overwhelming emotion
- PTSD symptoms – spectrum (symptoms can vary in number and intensity)
- Atypical symptoms – visual hallucination
- Symptoms - intensity, frequency, duration
- Not psychotic, not "crazy"
- Coping strategy - discomfort is not danger
- Calming skills, grounding skills, etc.
- Healthy lifestyle skills
- Manage "triggers" – UCS/CS/CR
- The "2 and 2" for anxiety management
- Use of medication
- Treatment modalities
- CPTSD and traumatic grief
- Co-morbid substance use
- Other mental disorders
- Conception of mental injury as opposed to mental disorder
- Treatment considerations: individual support counseling, freezeframe processing, in the work setting or out, support network, peer support team, 24/7 contact support persons, formal group debriefing, resiliency

There are several stressor-related disorders and diagnoses in addition to PTSD (DSM). {briefly present the various stressor-related disorders}

- Brief psychotic disorder
- Functional neurological symptom disorder (Conversion disorder)
- Adjustment disorder
- Acute stress disorder
- Posttraumatic stress disorder
- Specified and unspecified trauma and stressor related disorders
- Various mood and anxiety disorders

Some clinical presentations do not seem to fit in any of the current diagnostic categories.

Primary symptoms of psychotic disorders {review primary psychotic symptoms – necessary because peer support team members must be able to recognize a brief psychotic disorder}

- hallucinations – disorder of perception (auditory most common but can involve all of the senses).
- delusions – disorder of thinking (tend to be persecutory or bizarre). Typical delusions are reference, influence, and thought insertion. Often, disturbing thoughts.
- emotional disturbance - often "negative" symptoms, impulse control issues, and emotional lability.
- loose associations - disorganized thinking, often reflected in disorganized speech (word salad).
- odd, unusual, or inappropriate behavior - inappropriate for context, bizarre speech, acting out, posturing, behavior consistent with responding to internal voices, etc.

Some PTSD and other disorder treatment modalities. Can be used in combination. {briefly discuss or review}

- Psychoanalysis
- Behavioral (reinforcement)
- Person-centered
- Cognitive-behavioral therapy
- Rational-emotive behavioral therapy
- Humanistic and existential
- Biofeedback
- EMDR / Yoga / MDMA and psychedelic agent therapies
- Imagery rehearsal therapy
- Dialectical behavior therapy
- Thought field therapy
- Hypnosis and altered states
- Time perspective therapy
- Exposure therapies – prolonged exposure, virtual exposure

Trauma intervention program (TIP). Sequence of support interventions for assisting officers involved in critical incidents - from on-scene support to return to duty and beyond (critical incident management).

Precursor training – basic skills academy stress inoculation training and PATROL. Following critical incident:

- on-scene and *ongoing* support – PST and others (important: contact from chief or sheriff)
- initiation into a counseling program
- assessment and appropriate intervention
- psychological visit to the incident location
- firing range and processing
- reintroduction to equipment
- TIP officer wellness assessment
- graded re-entry to duty
- appropriate follow-up

PST on scene support

- timely arrival
- initial contact – *do not touch involved officers* (although we might be inclined to shake hands, pat on the back, or hug those that have experienced a critical incident as a gesture of support, *do not touch an involved-officer in any manner* unless cleared to do so. (The officer, uniform, and police equipment may be evidence. Do not contaminate.)
- clarify PST role and limits of confidentiality
- remove involved officer from immediate area when and as appropriate
- assess officer's status and well-being
- assist in meeting officer's immediate needs
- "walk and talk" if necessary and possible
- assist officer with variables which may be specific to incident *(not incident specifics!)*
- do not discuss the incident

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- consideration: personal "Peer Support" identification so as not to be assigned other duties or responsibilities – can be ID card, vest, cap, etc. PST not assigned other duties, except in exigent circumstances, should be established in policy
- follow your officer-involved incident protocol for peer support (if applicable)

PST scene coordination

- obtain available incident information from on scene supervisor – considerations?
- arrange for an adequate PST response (at possible multiple locations)
- assign PST members as necessary
- remember Dispatch and other pertinent personnel – deploy PST members
- as support unfolds, assess who needs *what* and *when*
- keep your PST coordinator informed
- make timely contact with your clinical supervisor
- request PST clinical supervisor to respond if part of protocol

FYI - There are on-scene assessments and interventions for severely traumatized persons that are beyond the scope of peer support. Contact your clinical supervisor immediately if you feel that someone has been severely traumatized.

Psychologist and the TIP: immediately following the incident, involved officers are engaged in a support program with the agency psychologist. This is necessary to initiate the confidentiality protections afforded to psychologists and their clients under most state statutes. When all prior components of the TIP are completed, the psychologist conducts an officer wellness assessment and designs a return-to-duty protocol.

Officer Wellness Assessment and Return-to-duty protocol.

- The Officer Wellness Assessment (OWA) is not a fitness-for-duty evaluation. The OWA is an assessment to determine (1) if the incident generated a stressor-related disorder that would prevent the officer from safely returning to duty, (2) if the incident exacerbated a pre-existing condition that would prevent the officer from safely returning to duty, and (3) the optimal timing for initiation of the return-to duty protocol (RTD).
- Sequence of events - the OWA is the last in a series of events which must take place prior to initiation of the return-to-duty protocol. Department policy determines whether an officer can be returned to duty before the officer is cleared by the DA's office and internal administrative investigation.
- The RTD is an individualized graded-reentry to duty – individualized for each officer - even if more than one officer is involved in the same incident. Many officers involved in the same incident do not return to duty at the same time through the TIP. Graded reentry involves being accompanied by "buddy officers" in specified ways.
- Why graded reentry? Because prior assessment is insufficient to ensure lack of difficulty returning to work. Graded reentry eases the officer's return to the environment within which the critical incident occurred. It also provides a support person (buddy officer) during the transition. {RTD's consisting of 35 hours have proven sufficient in most cases. To view an actual 35-hour RTD see www.jackdigliani.com. Past RTDs have ranged from 15 hours to several weeks}
- Support continues for at least one year (psychologist and peer support) - "year of firsts" - first Christmas since the incident, first birthday since the incident, etc. Officer selects a peer support team member for a year of periodic check-in.

Law Enforcement Critical Incident Handbook

Present information about the Law Enforcement Critical Incident Handbook - available without cost from www.jackdigliani.com {PST members can download the Handbook at their convenience and make it available to incident-involved officers – some agencies distribute the Handbook to new officers during the basic in-service skills academy}

Included in the Law Enforcement Critical Incident Handbook: *Suggestions for Supporting Officers Involved in Shootings and Other Trauma* and *25 Suggestions and Considerations for Officers Involved in a Critical Incident* {the amount of time utilized to present or review these documents, which comprise practical PST member guidelines for peer support and intervention, is left to the discretion of PPSTT instructors. Remain mindful of time restrictions}

Goal of peer support and other support interventions – positive survivor - stronger and smarter - placing the incident into psychological history. The goal of peer support and other support interventions following a critical incident is to have involved officers become positive survivors, to become *stronger and smarter*. The alternative is unacceptable (after surviving a critical incident, would "weaker and traumatized" suffice?). Many officers become positive survivors and stronger and smarter following a critical incident. They know they did their best, learn from the experience, gain a new confidence, and place the incident into psychological history. A British police officer expressed this feature of positive survivorship this way…years after he defended a hostage by shooting and killing the suspect:

"…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)

Key points: history of trauma conception, critical incidents, perceptual distortions, common reactions during and following a critical incident, factors affecting magnitude of response, critical incident-traumatic incident, PTS and PTSD, treatment issues, Trauma Intervention Program, Law Enforcement Critical Incident Handbook, positive survivorship, stronger and smarter, positive outcomes.

Training objective: provide information related to critical and traumatic incidents; prepare class participants for critical incident peer support.

10. Concepts in critical incident exposure

Shock, impact, and recovery

Shock Phase: Various responses and reactions are possible in the shock phase. *Impact Phase*: Various thoughts and feelings characterize the impact phase. *Recovery Phase*: That period following the impact phase wherein the experience is slowly integrated into the person's life. For recovery: *You must find something positive in the experience* (at minimum, you survived) {describe possible responses and characteristics of each phase}

<u>Concepts to consider and useful perspectives in police peer support</u>

- The idea of 2nd injury
- Vicarious or "secondary" trauma
- Splitting of environments
- Fear vs helplessness vs vulnerability
- Role of reinforcement/conditioning
- Second-guessing paradigm - *X1 - time/more information* - X2 (decision made at X1 but later self-evaluated after more timer and information from X2 perspective). When helping a person consistently second guessing - "What would you say to a friend in similar circumstances?"

"<u>When someone shares a trauma</u>" Quoted from Rebecca Matteo, https://news.va.gov/104501/ptsd-when-someone-shares-a-trauma/

When people share their experiences and feelings with someone they trust – or disclose their trauma – it can be an important part of the healing process. Your loved one may not share everything at once, so your response can help lead to future conversations and support them getting treatment. Here are some tips.

Believe them. It may be hard to imagine some of the things you are hearing, yet it's important to show that you believe what they are saying and feeling.

- Start with an affirming statement like, "I believe you and I'm here for you."
- When people go through a trauma, they may not remember the details. You don't need to push them to fill in the gaps.

Connect and affirm their feelings

You do not need to "fix" the problems or "take away" their pain. Most people are looking for support and connection. Giving your loved one space to share and show their feelings is valuable.

- Connect with statements like, "I'm sad that you went through this."
- Communicate that their feelings are not wrong. You can say something like, "I support you and won't judge you."

Listen

Even if it is uncomfortable or they appear to be in pain, do not change the topic.

- Respect the decision if someone is not ready to share everything. Try saying, "I'll sit with you as long as you need me."

Be aware of your reactions

You may wonder why they haven't shared the trauma story before with you. Or you may be angry to learn that someone harmed your loved one or feel guilt that you could not prevent this or protect them. While your feelings are understandable, it is important to focus on your loved one in this moment.

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- Do not assume that you know how they are feeling. It's ok to just ask.
- It is possible that their disclosure also triggers something in you.
- People who experienced trauma are often highly sensitive to nonverbal cues, like facial expressions or eye contact. Be open to explaining your personal reactions. For example, say, "I'm upset to learn that you are struggling," rather than looking away.

Offer reassurance.

- Affirm that they are not alone.
- Explain that you do not see them differently.
- They may be worried about how you are impacted and want to protect you. Reassure them that you are willing to be present and able to cope. Find supports for yourself if needed.
- Thank them for trusting you and encourage them to consider treatment if struggling.

Try to avoid unhelpful responses.

- "It's in the past," or "you need to get over it," minimize the impact of a trauma.
- Blame or implying they could have prevented the trauma will not build trust.
- Comparing their trauma to your own can backfire. Saying things like, "that's not so bad, you should hear what I went though" is not supportive, even if you are trying to connect. (end of quoted article by Rebecca Matteo)

Second injury - also known as secondary injury - is the harm that can be caused to officers when they are poorly treated following involvement in a critical incident.

- The way an officer is treated following a critical incident such as a shooting is not benign.
- One way to virtually insure second injury following a police critical incident is to treat the involved officers as suspects without cause to do so.
- The smallest and seemingly innocuous insensitive statements, comments, or even thoughtless non-verbal glances or gestures may cause or contribute to an officer's second injury…but you don't have to walk on eggshells. Be professional – be yourself.

To avoid second injury: peers, investigators, supervisors, and command staff must keep in mind that the officers…

1. may have just survived a fight for their lives
2. may have had to use lethal force to protect another
3. may be variously impacted by various aspects of the incident
4. may be experiencing psychological denial and shock
5. may be experiencing reactions not easily observed by others
6. may have been physically injured

…and act accordingly. According to what? According to policy and procedure, trauma intervention programs, involved-officer protocols, peer support guidelines, basic functional and compassionate human interaction practices, etc.

Secondary trauma — also known as vicarious trauma — refers to the indirect traumatization that can occur when a person is exposed to others who have been directly traumatized. Secondary trauma is a real concern for the spouses and family members of officers that have been involved

in a critical incident, as well as previously non-traumatized officers and others participating in agency critical incident debriefings.

<u>Good to know</u>

- Everyone has a private life and some ability to look one way and feel another.

  This component of human experience was aptly stated by Edwin Arlington Robinson (1869-1935) in his poem, *Richard Cory*, first published in 1923. {read as a commentary on how outward appearance and perception of others may differ significantly from a person's internal experience}

  > Whenever Richard Cory went downtown,
  > We people on the pavement looked at him:
  > He was a gentleman from sole to crown,
  > Clean-favored, and imperially slim.
  > And he was always quietly arrayed,
  > And he was always human when he talked;
  > But still he fluttered pulses when he said,
  > "Good morning," and he glittered when he walked.
  > And he was rich – yes, richer than a king –
  > And admirably schooled in every grace:
  > In fine, we thought that he was everything
  > To make us wish that we were in his place.
  > So on we worked, and waited for the light,
  > And went without the meat, and cursed the bread;
  > And Richard Cory, one calm summer night,
  > Went home and put a bullet through his head.

- Possible choices and decisions can lead to many possible consequences. <u>Kurt Lewin</u>: Human conflicts: approach-avoidance, approach-approach, avoidance-avoidance, and double approach-avoidance (1943, 1997).
- What to do? Tell me what to do…What should I do…What's the right thing to do…What would you do… (Is there really one right thing to do? There are several people in our lives who would be willing to tell us what to do. How helpful has it been?).
- Most often, life involves selecting from imperfect options.
- Some life circumstances cannot be improved or escaped emotionally unscathed.
- Think and feel through issues.
- Tunnel thinking & tunnel feeling. State of mind can drive behavior.
- You can't always get what you want.
- There are things you can learn that no one can teach. Can follow traumatic exposure.
- Some things won't stop until you stop them. Some things won't start until you start them. Some things won't change until you change them.
- Life space, macro, and micro environments.
- Responsibility absorption. Responsibility absorption can be a theme in a person's life.
- "Red flags". Many flags are not red until you evaluate them from some future perspective. Are there "reds flags" that can be observed in the present and be used to construct an action plan? (yes) {discuss}
- You cannot not do your job. Implications for burnout, boreout, boundaries, career development, and your mental health. {provide examples}
- The other guy. It's not always the other guy, sometimes it's you. And even when it is the other guy, it's not the other guy to the other guy!

- Some things can be completely or partially controlled. Some things cannot be controlled. It is better to focus on things that can be controlled, which includes your response to things that cannot be controlled. Some things that cannot be controlled can be influenced. In reference to long held ideas or interaction patterns: "Do you control it, or does it control you?" "How long will you let it control you?" What are we talking about? {initiate class discussion}

<u>Anger</u>. Everyone gets mad sometimes, but how does anger relate to stress and trauma?

- Chronic anger vs. situational anger vs. stress or trauma generated anger
- Anger as the only emotion to penetrate the defense mechanism *emotional insulation*
- Anger as more acceptable for some persons than other emotions (like feeling hurt)
- Anger as a learned response, reinforced by results.
- Consequences of anger {discuss common consequences of anger and angry acting out}

<u>Personal Boundary</u>. A personal boundary is an understanding that there is only so much you can do for another person. This is why there is an emphasis in peer support on empowering others. You must maintain a reasonable personal boundary when providing peer support so that the person's problems do not become your problems. You compromise your personal boundary at the risk of your psychological and physical well-being. Considerations:

1. Limit of how responsible one person can be for another person
2. Limit of what one person can do for another person
3. The border where one person "ends" and another person "begins"
4. Supporting independence vs. fostering dependence
5. Focus on empowerment
6. Related to secondary trauma and personal well-being
7. Personal boundaries are critical for support team members

<u>Peer support issues and strategies</u>. {some have been presented previously but they are worth repeating. Especially important strategies are in bold type}

- **walk and talk** to dissipate the stress response after a critical incident
- **surface lesson/deep lesson** - the surface lesson is the more obvious conclusion to be generated by some experience, while the deep lesson is the deeper meaning personally attached to the experience. The deep lesson is often irrational, tends create anxiety, and can cause life difficulties. Example: "My ex cheated on me, he cannot be trusted (rational surface lesson). No one is trustworthy" (irrational deep lesson)
- **options vs. threat funnel** (as police officer options for interaction diminish, the personal threat level to the officer increases – at the bottom of the option funnel lies self-defense)
- **the 2 and 2** - "I know what this is, I know what to do about it" and "stronger and smarter"
- survivorship vs. victimization
- stay grounded in what you know to be true (use strategy to help buffer officers against unfair or untrue criticism)
- having the right vs. is it right (legal vs moral – a conflict sometimes observed in officers following a work-related shooting. Can occur even in circumstances where the officer would likely have been killed had not lethal force been used in defense)
- selecting from imperfect options
- I'm in trouble vs. I'm alive

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- **intervention as the 2nd best option** (time machine = the best option). "With a time machine we could go back with what we now know and prevent a critical or undesirable incident. Being that the best option is not available, we must work together to do the best we can to move forward." (this simple cognitive presentation often helps officers to diminish the wishful thinking that is sometimes present following a critical incident. It helps officers move past wishing that the incident did not happen. It helps officers to focus on the "here and now" and eventual recovery - While traveling back in time is not possible, we can, with peer and other support resources if necessary, psychologically return to the time of a distressing incident/circumstance and reprocess, redefine, and reinterpret elements and recollections of the event. What about rediscovering or reconnecting with positive emotions of safety, closeness, and wellbeing? Rob Seals, PhD and Jack A. Digliani, PhD, EdD
- police authority in America is intentionally limited
- American society accepts a margin of risk for law enforcement officers, as do officers themselves

Internal investigations and the peer support team.

Officers involved in critical incidents such as an officer-involved shooting, will become involved in two types of investigations: criminal (right to remain silent) (Miranda v. Arizona, 1966) and administrative (no right to remain silent) (Garrity v. New Jersey, 1967) {briefly discuss these types of investigations and how they relate to each other – flow of information} Several departments now include a psychologist and peer support statement within the document that advises officers they are the subject of an administrative (internal) investigation: "you may contact the department psychologist or any uninvolved member of the peer support team."

Key points: shock-impact-recovery, second injury, secondary trauma, second guessing, selecting from imperfect options, tunnel thinking and feeling, micro environments, not always the other guy, anger, personal boundaries, red flags, walk and talk, surface lesson/deep lesson, options vs. threat funnel, the 2 and 2, time machine, risk for police officers, types of investigations.

Training objective: acquaint class participants with issues involved in critical incident exposure and critical incident peer support.

11. Peer support team confidentiality

Comprehensive presentation and discussion of PST statutory confidentiality protections (if applicable), department PST policy, and PST operational guidelines.

In Colorado, C.R.S. 13-90-107 (m) *Who may not testify without consent*. For federal LE peer support teams: Confidentiality Opportunities for Peer Support (COPS) Counseling Act (2021). The COPS Act does not provide confidentiality privileges for non-federal PSTs in the federal court system. {importance of this core topic is emphasized}

PST limits of confidentiality

How important is it for PST members to specify the limits of peer support team member confidentiality? (*extremely important* – recipients of peer support must be advised of the conditions under which PST-interaction information might be or must be disclosed before engaging in peer support) Unless advised of confidentiality limitations, recipients of peer support may falsely believe that all information discussed in peer support interactions is confidential. {the

development of peer support "limits of confidentiality" pocket cards is encouraged – if you have them, distribute to class participants. Pocket cards may be read and provided to those seeking peer support}

If PST members find advising awkward, consider something like this, "I want to do the best I can for you – let's take a minute to talk about peer support team member confidentiality…" Use the pocket card if needed.

What if the person decides not to engage peer support after PST confidentiality limits are discussed? (PST members support them to seek other and possibly more confidential resources. If warranted, assess for suicidality and other-person safety)

Good to know: information discussed within peer support interactions may be disclosed by recipients of peer support. *A recipient of peer support does not need your permission to talk about your peer support interaction.* This means that the person can disclose any or all information discussed, including what you did and what you said without your consent. Bottom line: stay professional.

PST members, critical incident-involved officers, and attorneys

PST members should avoid being present when an involved employee is discussing a critical incident with their attorney. Why? Because even in states which provide some statutory confidentiality protections for PST members, there is limited protection. Also, in some states, the attorney-client confidentiality privilege may not extend to third parties, or it may be compromised in the presence of a non-client third party. Best and safest option – do not become involved in officer-attorney discussions.

- What if the employee insists you remain? (advise the employee of your confidentiality limitations and that you will remain close by but it is best you not participate. The attorney will almost certainly support this position – return when attorney consultation is completed)

PST waiver of confidentiality

- How does a person waive confidentiality? (by signing or providing a confidentiality waiver)
- What is your responsibility when persons you have been providing peer support waives their peer support privilege of confidentiality? (discuss pertinent information with those identified in the waiver if requested)
- Should confidentiality waivers be in writing? (yes, but there is a common practice for verbal waivers in everyday peer support interactions when circumstances require – personal judgment is imperative here. Always best to obtain a written waiver)
- Where do I get an *"Authorization for the Release of Information"* form? (Law Enforcement Peer Support Team Manual)

Duty to warn. Refers to the responsibility of clinicians to inform authorities and others if a client poses a threat to identified individuals. Advising authorities is insufficient. Persons that have been threatened must also be notified. Legally established in the case of Tarasoff v. Regents of the University of California (1976). Police were notified of threats but this notification was determined to be insufficient. Tatiana Tarasoff was subsequently murdered by Prosenjit Poddar. Extended in Jablonski by Pahls v. United States (1983) for cases involving risk assessment (must review historical records). Melinda Kimball was murdered by the man she was living with, Phillip

Jablonski. {discuss duty-to-warn issues, police officer involvement and police action, and expectations for members of police peer support teams}

Criminal confessions and information. Information pertaining to criminal activity is not protected in states that currently have a police peer support team member confidentiality statute. The same is true for members of federal peer support teams.

1. In the event that a person begins to communicate "information indicative of any criminal conduct" (from: Colorado Revised Statutes 13-90-107m), immediately stop the peer support discussion *in this area*. Do not stop peer support.
2. Remind the person that such information is not protected and it's best to stop this area of discussion. (you should have already mentioned this in your "limits of confidentiality" disclosure prior to engaging in peer support)
3. If persons insist on talking to you about criminal activity (self-involved or otherwise) after a reminder of non-confidentiality, it may be that they intend to report this information to you or the police department and is requesting your support. Clarify their intentions. Provide peer support as requested.
4. *Do not leave them alone*, especially if they are police officers.
5. Contact your clinical supervisor *immediately*. Together, devise a plan of action, which may include contacting a department investigator. Stay with the person and continue peer support until otherwise directed by your clinical supervisor.
6. Some circumstances must be reported. Some circumstances require that other action be taken. In some circumstances, some discretion is possible depending upon the kind of information presented and statutory requirements. What are some examples of these cases? {discuss examples – avoid making examples unreasonably complex}
7. Peer support team members are committed to helping others, however *police peer support team members are not required to, and do not jeopardize themselves professionally or ethically by concealing ongoing or past criminal activity.*

Important: Stopping a peer support conversation when a person begins to discuss information indicative of any criminal conduct is not an effort to assist the person to conceal or cover-up past or ongoing criminal behavior. Quite the contrary, peer support interactions encourage honesty and the assumption of personal responsibility. Instead, stopping the conversation and following up as indicated recognizes the fact that you can better assist the person if you are not placed in a position where you might become a witness in a possible prosecution. As it is, you may be required to take action and/or testify based upon the information already presented.

If a person that has been advised of the limits of peer support team confidentiality insists on talking to you about information that is not protected, you must act upon the information as you would if you were not a member of the peer support team. This is especially true for sworn police officer and other "mandatory reporter" members of the peer support team.

If you have any concerns or questions about any information provided to you in a peer support interaction, contact your clinical supervisor immediately. You do not have to interpret or sort out ambiguous peer support confidentiality circumstances on your own.

Key points: confidentiality statute, policy, organizational guidelines, limits of confidentiality, confidentiality waivers, recipients do not need your consent to discuss peer support interactions. duty-to-warn, officer-attorney discussions, criminal activity information and peer support.

Jack A. Digliani, PhD, EdD

Training objective: comprehension of peer support team confidentiality standards and the complexity of particular peer support interactions.

12. Confidentiality, clinical supervision, and oversight

Supervisor/advisor- PST member confidentiality. The PST Supervisor/Advisor and peer support team member "confidentiality highway" is a one-way street. As specified in policy and/or organizational guidelines, information can move from PST member to clinical supervisor without a waiver. However, information provided to the clinical supervisor by a person in a counseling setting cannot move to a PST member without a waiver. This is because the counseling relationship between psychologist and client is independent of peer support. {this one-way arrangement is necessary to provide clinical oversight of peer support interactions while providing confidentiality in the professional counseling setting. The fact that peer support information will be shared with the PST clinical supervisor, if required in policy, must be included in the peer support "limits of confidentiality" disclosure}

Definition of "bring under supervision." To bring a peer support interaction under supervision is to inform your clinical supervisor (or advisor) of whom you are working with and the primary issues you are addressing (clinical supervisors, in some peer support interactions, may not require the identity of the peer support recipient). Your supervisor may ask questions or make recommendations for your peer support interactions so that the quality of your peer support is enhanced.

Bringing your peer support interactions under supervision. Some peer support interactions must be brought under supervision immediately (like suicidal ideation and criminal activity information). Some clinical supervision can take place in the group setting (usually involving reach-outs, information that is already public or department-wide knowledge, waived confidentiality for the PST, etc). Some information discussed within peer support interactions should be brought under supervision privately (information pertaining to medical conditions and personal relationships are good examples of what should be brought under supervision privately, unless there is expressed consent to share the information with other members of the peer support team). General rule - if you have any doubt about whether supervision should be done in the group setting or privately, *do it privately*.

Supervisors as members of the peer support team. Most jurisdictions have administrative regulations that require supervisors to report incidents of sexual and other harassment. In such cases, statutory PST confidentiality may not apply. This is because agencies within a jurisdiction cannot "opt out" of jurisdiction-wide administrative regulations. Also, department PST confidentiality policy cannot and does not override an administrative regulation based in federal law. Therefore, PST members that are supervisors must report previously unreported incidents of harassment as required, even if the information comes to them within a peer support interaction. PST members that are supervisors must include this exemption in their peer support "limits of confidentiality" disclosure prior to engaging in peer support. Non-supervisor members of the peer support team are not required to report such incidents because they are not included in the mandatory reporting requirements that apply to supervisors.

PST member confidentiality issues – summary and review.

- Unless you have a waiver of confidentiality, you cannot talk to other peer support team members, including the PST coordinator, about specific peer support interactions.

Persons that seek peer support do not automatically consent to having their information shared with other members of the peer support team.

- In the real world, peer support confidentiality waivers often consist of a casual verbal statement, something like "you can talk to Victor (another PST member) about this. I have already spoken to him about it." In such cases, a formal written waiver of confidentiality is seldom completed. However, if the issue is serious or likely to result in a court proceeding, a written confidentiality waiver should be obtained. Remember, while cumbersome, it is always best to require a written waiver. Who keeps the waiver? The PST member or as otherwise specified in PST operational guidelines.
- When clinical supervision is required in PST policy or operational guidelines, you do not need a waiver to talk to your clinical supervisor, but this must be disclosed in your "limits of confidentiality" prior to engaging in peer support.
- Peer support team members can seek peer support from other peer support team members about issues in their own lives. In such cases, all the responsibilities of peer support team members and all of the confidentiality protections provided to recipients of peer support apply.

Class activity. Peer support team member presentation: selected experienced PST member(s) present actual *types* of cases (not actual cases) that have involved peer support. Also discussed are (1) peer support strategies, (2) how clinical supervision was utilized, and (3) general outcomes, if known. Then, question and answer period.

Referral to professional services. When to refer? Issues beyond peer support, suicidal ideation, troubled previous history with persons seeking peer support, degradation of an existing peer support relationship, etc. {discuss circumstances that indicate referral is desirable or necessary}

Referral resources. (Who can you refer to?)

- other peer support team members
- clinical supervisor
- employee assistance program (most EAPs include financial and legal assistance)
- community mental health professionals
- medical professionals
- legal professionals
- clergy and department chaplain (if applicable)
- military veteran services (VA, etc)
- any other appropriate and available support persons or organizations.

Referral does not mean peer support needs to stop. Peer support may continue in conjunction with the engagement of referral support or counseling resources when appropriate.

PST member helpful information:

Stay in contact with your clinical supervisor.
Stay in compliance with the clinical supervision provisions of your operational guidelines.
If a peer support interaction is not under clinical supervision as outlined in your guidelines and training, it is not Level II peer support. Therefore, (in Colorado) that particular interaction would not be protected under department policy or C.R.S. 13-90-107(m). Why? Because your interaction is not in compliance with the department's written guidelines as required by Colorado statute.

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Key points: relationship of clinical supervisor and PST members, one-way information highway, supervision and oversight, class activity, referral.

Training objective: further develop the understanding of PST confidentiality and its relationship to clinical supervision and oversight; identify factors involved in referral.

13. Foundations of peer support and intervention strategies

Brief review of the major schools of psychology: psychoanalysis, behaviorism, cognitive-behavioral, and humanistic-existential {presented to provide class participants with a brief history of psychological conceptualization and intervention theory. This helps to develop a conceptual foundation. Keep it brief - avoid making the presentation an introductory psychology class}

Psychoanalysis: id-ego-superego, brief discussion of developmental theory and perspective of pathology (Freud)

Behaviorism: learning and reinforcement theory, brief discussion of primary principles (Pavlov and Skinner)

- Classical conditioning – UCS/UCR, CS/CR
- Positive reinforcement - the presentation of a reward. The reward increases the probability that the behavior which occurred just prior to the reward will be repeated. Thus, that particular behavior is strengthened (reinforced).
- Negative reinforcement – the termination of an unpleasant stimulus upon the performance of some behavior. The behavior which is associated with the cessation of the unpleasant stimulus is thereby strengthened and likely to be repeated (not to be confused with punishment).
- Punishment - is not a reinforcer because it does not strengthen a response or behavior. Punishment is the presentation of an unpleasant stimulus and tends to suppress and decrease the probability of the behavior which occurred just prior to its presentation. Punishment does not provide information about more acceptable alternatives. Punishment also often elicits emotional reactions such as anger or fear. Normally, the more severe the punishment, the more intense the reaction. Positive punishment: presentation of an unpleasant stimulus (spanking). Negative punishment: removal of a desired object or circumstance (taking away a favorite toy).
- Shaping - the rewarding of successive approximations to the desired behavior.
- Extinction - the cessation of a behavior following the cessation of reward.

Schedules of reinforcement

- Continuous reinforcement - the reinforcement of a response each time it occurs. Works best when first learning something new. Produces the fastest learning.
- Partial reinforcement - the intermittent reinforcement of a response. Intermittent reinforcement may occur in several ways:
  1. Fixed ratio schedule: reinforces a response after it occurs a set number of times ($5.00 for every 10 items made - piecework method of compensation).
  2. Variable ratio schedule: reinforces a response after it occurs varying number of times (slot machine). Most resistant to extinction.
  3. Fixed interval schedule: reinforces responses after a set period of time (paycheck every two weeks).

4. Variable interval schedule: reinforces responses after varying periods of time (some contract arrangements).
- Primary reinforcers - involve rewards that aid biological survival (food, water, sleep, etc.)
- Secondary reinforcers – rewards that strengthen responses which do not aid biological survival (verbal praise, non-verbal winks, nods, thumbs up, etc.) {discuss how these principles might be observed and be applied in peer support}

Cognitive-behavioral: discussion of cognitive-behavioral theory/therapy.

Cognitive-behavioral therapy (CBT) is based on the idea that thoughts create and cause our feelings and drive our behavior…not external things, like people, situations, and events. The benefit of this perspective is that we can change the way we think so that we feel and act differently even if the situation does not change (From: National Association of Cognitive-Behavioral Therapists)

Varied and broad application of CBT.

- Cognitive mediation - *influencing or controlling one part of the brain with another part of the brain*: most often – influencing or controlling undesired *emotional* responses with *thinking* (cognitive) coping strategies
- To the degree that this can be accomplished, dysfunctional thoughts and behavior can be mitigated
- CBT is a useful perspective when applied to oneself and considered in peer support

Two of the most powerful thoughts for change:

1. what has been, does not have to be
2. the person you were, does not have to be the person you are

Implications for the experience of guilt and other feelings, self-esteem, self-empowerment, and *cognitive distortion*.

Some common cognitive distortions:
- Emotional reasoning
- Disqualifying the positive
- Mind reading / Filtering
- Overgeneralizing / Labeling
- All-or-nothing thinking / Either-or thinking
- Magnification, minimization, catastrophizing
- Maintaining rigid perspectives or beliefs that cannot be altered by objective evidence

Suggestions to limit cognitive distortion

- Avoid "never" "always" "everybody" etc.
- Keep an open mind
- Think critically – ask questions
- Objectively evaluate evidence
- Separate facts from opinion
- Do not take everything personally
- Learn to recognize self and other's assumptions

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- Be mindful – practice self-examination
- Monitor self-talk (Tim Brown, LPC and Jack A. Digliani, PhD,, EdD)

Humanistic-existential: person-centered and existence perspective (Rogers)

"This process of the good life is not, I am convinced, a life for the faint-hearted. It involves the stretching and growing, of becoming more and more of one's potentialities. It involves the courage to be. It means launching oneself fully into the stream of life." (Rogers, C. 1961).

Rogers regarded every one as a "potentially competent individual" who could benefit greatly from his form of therapy. The purpose of Roger's humanistic therapy is to increase a person's feelings of self-worth, reduce the level of incongruence between the ideal and actual self, and help a person become more of a fully functioning person. Person-centered therapy operates according to three basic principles that reflect the attitude of the therapist to the person:

- The therapist is congruent with the person.
- The therapist provides the person with unconditional positive regard.
- The therapist shows empathetic understanding to the person. (McLeod, S. A., 2008.) {discuss these principles in easily understandable terms}

Existential – issues of existence. {briefly discuss historical and current existential perspectives}

Key points: psychoanalysis, behaviorism, schedules of reinforcement, cognitive-behavioral therapy, influencing one part of the brain with another part of the brain, humanistic-existential perspectives.

Training objective: provide foundation information pertaining to counseling theory and helping perspectives; build foundation for concepts utilized in peer support.

14. Model for peer support

Police peer support: Three stage model (Egan, G., 2009)

- Stage I   *Exploration*
- Stage II   *Person Objective Understanding*
- Stage III *Action Programs*

Stage I: Exploration

1. Attending	7. Transparency
2. Effective (active) listening	8. Reflection
3. Genuineness	9. Respect
4. Empathy	10. Trust
5. Concreteness	11. Summary
6. Non-judgmental	12. Assessment

{explain and discuss each of the components of Stage I}

Counseling continuum: directive /non-directive {explain difference, pros and cons of each}

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Good to know:

- People can change. People do not change easily.
- Dysfunctional behavior is frequently reinforced in some way…it serves some need or purpose.
- Habitual dysfunctional behaviors lead to dysfunctional behavioral patterns.
- Meet the need being served by a dysfunctional pattern in a more functional way and the dysfunctional pattern will diminish.
- To help initiate and maintain desired change…talk to yourself. Talk to yourself in a way that those supporting your efforts would talk to you. Use self-talk to alter behavior for yourself and to help others.

Stage II: Person objective understanding (finding new perspectives)

1. Self-disclosure
2. Confrontation
3. Advanced accurate empathy
4. Immediacy

(1) Self-disclosure - involves sharing your thoughts, feelings, experiences, and reactions. Normally increases intimacy or "depth" of relationship. Can normalize the person's experiences or feelings. Can encourage the person to talk more about previously avoided topics. Can change the person's opinion of you. Share only what is comfortable for you. Can be overdone – do not make it about you. Avoid "enabling" through self-disclosure. *Do not make the person seeking peer support your therapist*.

(2) Confrontation – (for peer support) do not confront another person if you do not intend to increase your involvement. Confront only if you experience feelings of caring or some sense of connection. Avoid confronting when angry. Confront only if the relationship has gone beyond the initial stages of development or if basic trust has been clearly established.

- If the conditions above are present and the person is not ready to deal with the information non-defensively, then you have two basic options: avoid confrontation or help the person become ready to use the information once it is presented.

How to confront constructively

- Present the data on which the inferences are based before stating the inference.
- Distinguish between observations and inferences and make that distinction verbally clear in the message to the person.
- State inferences tentatively.
- Use "I messages" throughout the confrontation.

(3) Advanced accurate empathy - advanced accurate empathy goes beyond another's verbal and non-verbal expressions. When accurate, it represents a deeper understanding, a degree of insight, and a summation of what another person is thinking and feeling. What happens if your empathy is inaccurate? (most persons will correct you – accept their feedback and continue peer support)

(4) Immediacy - what's happening now. Immediacy involves moving the focus of the discussion from whatever is being presented to what is happening right now (immediately) between you and the other person.

Stage III - Action programs.
Characteristics of good action programs:

1. Concrete workable goals
2. Set priorities
3. Check behaviors
4. Make it effective
5. Move from less serious to more serious when possible
6. Consider the person's values
7. Develop relapse-prevention strategies
8. Appropriate follow-up

Peer support team 10-Step CBT-based action program:

Step 1: Have I clearly identified the problem.
Step 2: How am I thinking about the problem?
Step 3: Are my thoughts rational or irrational? (seek help if you do not know)
Step 4: Is there a better way to re-think or conceptualize the problem?
Step 5: What do I wish to change?
Step 6: What behaviors do I wish to change?
Step 7: What are the possible obstacles to my desired changes?
Step 8: How will I overcome these obstacles?
Step 9: How and when will I implement my plan?
Step 10: How will I evaluate the outcome and maintain positive change? How will I prevent a relapse to dysfunction?

Action plans are most helpful when they are written. To improve the effectiveness of an action plan you can provide the person with a copy of the *Peer Support Team Action Plan Worksheet.* The person can also design a personal action plan. Action plans may be used in conjunction with peer support or may be independent of peer support. {the Peer Support Team Action Plan Worksheet is included in Law Enforcement Peer Support Team Manual}

Supporting positive change in peer support: Support the person to make a positive change even if it seems small -

• Psychological change
• Cognitive change
• Emotional change
• Behavior change

Sometimes changing a behavior is easier than changing anything else. Even small, accomplished changes in behavior can motivate a person to continue effort. Changing behavior is a great place to start.

Good to know – information and summary

- a common mistake in peer support is trying to move from Stage I to Stage III too fast - in fact, you can consistently support a person by remaining in Stage I, Exploration
- avoid imposing your world view
- remain within the parameters of the PST program and your training
- contact your team coordinator or clinical supervisor if questions arise
- peer support team members have a commitment to enhance the independence of those they are supporting – avoid fostering dependency
- use care if working with people you dislike - refer to other PST members if you cannot remain professional (much depends on how much dislike there is – a peer support team member should not begin peer support with a person for whom there exists a great deal of animosity)
- if *you* have unfinished psychological or emotional business, seek appropriate support or counseling
- do not become the client of the person you are trying to help
- in the words of the 1960's, "*Don't lay your trip on the person you're trying to help*"

Peer support information:

- *Blinded by the principle* (cognitive rigidity that drives dysfunctional behavior) Example: "Real men win every argument"
- Seeing things from other perspectives is a skill to be learned
- Seeing things from another's perspective, also a skill to be learned
- Working within another's thought and value system

Peer support skills: reflective listening, paraphrasing, and summarization {define and discuss these peer support skills}

Video presentations: reflective listening, paraphrasing, and summarization (can be found online) {use to demonstrate concepts, then discuss pros and cons of this particular presentation}

Discussion of the following and how they relate to peer support:

- "learned helplessness" as a component of depression (Navy – torture resistance) (Positive Psychology) (Martin Seligman)
- cognitive restructuring
- rational-emotive behavioral therapy (REBT) (Albert Ellis) A-B-C-D *adversity-belief-consequence-dispute.* REBT Basic Philosophies - unconditional self-acceptance USA, unconditional other-acceptance UOA, unconditional life-acceptance ULA. The 12 REBT irrational ideas that cause and sustain neurosis (Appendix K). Ellis's most frequent advice — "deal with it"

Video presentation: Albert Ellis – on REBT {available on internet}

REBT irrational idea number 9 – "The idea that because something once strongly affected our life, it should indefinitely affect it - instead of the idea that we can learn from our past experiences but not be overly-attached to or prejudiced by them" (application for police critical incidents, PTS, and PTSD? What do you think? {class discussion}

Key points: stage model for peer support, action plan, supporting positive change, concepts in peer support, REBT.

Training objective: development of basic peer support skills by applying the stage model of counseling; familiarization with practical peer support concepts.

15. Peer support tips

Peer support tips – a summary collection of easily recalled practical factors and useful things to remember when providing peer support. As a summary, the peer support tips necessarily include some previously presented information: {excellent for reinforcement of appropriate peer support behaviors}

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

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- Set a future time to meet again if warranted
- Bring your interactions under clinical supervision
- Refer to available professional resources when appropriate
  (Meier, S.T. & Davis, S.R., 2011 and Digliani, J.A., 2015)

<u>Video presentation</u> – Counselling skills: knock three times (Barton, R., 2011, online).

<u>Peer Support</u>: re-frame, re-interpret, re-conceptualize. Frame the problem so that there can be some resolution or improvement. Reframe prior unsuccessful efforts as contributing to "the value of experience." Establish a safety net. Can include a "ring down" list of persons to call if things get tough. Safety net is a concept in peer support and in the proactive PATROL and RTD programs.

<u>Education</u>: Officers must assume greater responsibility for their psychological health and learn to ask for help when feeling stressed or overwhelmed. {part of the upcoming Make it Safe Police Officer Initiative discussion}

<u>New PST member assets</u>: the biggest assets for new PST members are: (1) the PST Manual, (2) your clinical supervisor, and (3) experienced PST members.

New PST members should not be reluctant to engage in Level II peer support. Trust yourself and trust your training. When it comes to peer support, NIKE had it right: Just do it. Remember, *inexperience is not inability*.

<u>Class activity - practical exercise role play</u>: peer support with emphasis on Stage I (Exploration). "Create groups of three. Form a group with persons not well known to you (if possible). Each person will assume one of three roles - a PST member, a person seeking peer support, and an observer. Each person will eventually assume each role." {Each person spends 10-12 minutes in each role.} Some fictional scenarios for this activity are presented below:

- a supervisor that "plays favorites"
- an officer-spouse that is stressed by the hours of shift work
- a child that is misbehaving at school
- personal difficulty sleeping & feeling tired much of the time
- officer not sure of desire to continue in law enforcement
- civilian police department employee not feeling part of the "police family"

{fictional issues, even though they mimic real issues, are used because this is not the forum for processing actual issues. Once each person in each group has had the opportunity to assume each role, the activity is ended. Each group then discusses their experiences with the class and receives feedback from other class members. The trainer utilizes the information presented to advance knowledge, to provide feedback, and to reinforce positive participant skills. The trainer notes that role playing peer support is often more difficult than actual peer support. The activity and following discussion usually requires 60 to 90 minutes, depending upon the size of the class. Although many officers cringe at the idea of role-play, this activity has proven to be instructional, experiential, and a welcome change from lecture. The trainer should endeavor to make this exercise non-threatening, educational, and even fun}

<u>Key points</u>: peer support tips, peer support role-play, discussion of role-play experience.

Training objective: provide practical "how to" peer support information; experience brief Level II peer support role-play.

16. Alcohol, drugs, and addictions

• Neurobiological perspective: addiction as a disease of the reward centers of the brain
• Most experts agree that although drug abuse begins as a voluntary behavior, at some point a critical point is crossed and it becomes a brain disease
• Each drug manipulates the reward circuitry in a bit different way, but all substances of abuse activate the same pleasure pathway in the brain
• Pleasure pathway: *nucleus accumbens*, the "universal site of addiction" (including nicotine and alcohol)
• The brain is tricked into acting as if it needs the substance to survive
• These substances change the molecular structure of the brain
• In experiments, rats will press a lever for cocaine until it kills them

Substance information:

• alcohol: *dose dependent* - many effects in the brain (behavioral disinhibitor to toxic)
• natural "opiates": naturally present in the brain. Serve to lift mood, motivate behavior, moderate pain. Opium based drugs are much more potent than naturally occurring brain chemicals
• methamphetamine - creates a "dopamine dump"
• cocaine – stimulant, appetite suppressant, triple reuptake inhibitor (dopamine, serotonin, norepinephrine), some medical uses, second most abused drug in US (behind MJ)
• marijuana - active ingredient - THC (delta-9-tetrahydrocannabinol), most commonly abused illicit drug in the United States. Medical MJ? Recreational MJ? One or both now legal in many states
• caffeine, nicotine, sex, food? Can you become addicted? What are behavioral addictions (formerly called "process" addictions)? {discuss known facts and various views}

Alcohol use disorder – DSM-5-TR

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Alcohol is often taken in larger amounts or over a longer period than was intended
2. There is a persistent desire or unsuccessful effort to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
4. Craving, or a strong desire or urge to use alcohol
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Recurrent alcohol use in situations in which it is physically hazardous
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
10. Tolerance, as defined by either or both of the following:

a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
b. Markedly diminished effect with continued use of the same amount of the substance
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal)
   b. The same (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms {extrapolate to other substance use disorders}

25 warning signs of alcoholism

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. Has 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 or criticisms of others?
15. Do you ever forget what you did while you were drinking?
16. Stockpiling alcohol.
17. Hiding alcohol.
18. Planning your activities to insure that alcohol is available.
19. For women - Have you continued drinking while pregnant? (even small amounts)
20. For women - Have you continued drinking while breastfeeding? (even if only between feedings or in small amounts)
21. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
22. Have you ever had to take a drink while at work to feel better?
23. Do you feel shaky, unsettled, or sick if you do not have a drink for a few days?
24. Do you look for occasions to justify drinking?
25. Alcohol becomes number one in your life.

Alcoholism: disease or choice? Perspectives: (1) Substance addiction is a complex but treatable brain disease. It is characterized by compulsive drug craving, drug seeking, and use that persist even in the face of severe adverse consequences. (2) Substance addiction is not a disease, but a choice in lifestyle. {briefly discuss}

Alcoholism and the ADA: briefly discuss the alcohol addiction provisions of the Americans with Disabilities Act as it relates to protection of employment when an employee seeks voluntary treatment. {at minimum, PST members should be able to provide basic information about alcohol and other substance use. They must be able to appropriately refer a person who comes to them for help with an alcohol or other substance use or addiction concern}

Some treatment programs

- residential & non-residential programs
- counseling and psychotherapy (individual and group)
- lifestyle counseling and life skills
- CBT – "think about what you're thinking"
- AA , NA, GA and other 12-step programs
- Non-12 step programs (SMART, CRAFT, etc)

The 12 steps of Alcoholics Anonymous (AA) {many officers have heard of 12-step programs but are unfamiliar with the actual steps – most 12-step programs are spiritually based. Regardless of a trainer's personal views, class participants should be familiar with these steps and some non-12 step programs – may be slight variations in 12-step text from various sources}

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Success and AA. "…figures compiled by Alcoholics Anonymous, probably the world's most high-profile treatment program, reveal that 64% of their members drop out in the first year. They also reveal that 84% of AA members do not exclusively rely on the AA's *12-Step Program* promoted in its group sessions, but supplement this with outside help from various sources. In fact, 31% of AA members have been referred to AA by other treatment centers. The many people who have been cured of their alcohol addiction through AA tend to be zealous in their support for the organization, but this cannot mask the fact that, for most people, it has not worked - According to a 2014 AA membership survey, 27% of members have been sober less than a year. After more than 20 years, 22% have remained sober." (Retrieved 2015/2024 from: http://alcoholrehab.com) {discuss support and criticism of AA and 12-step models, and the apparently poor success rates for substance addiction treatment generally}

Substance treatment.

Traditional concepts: "intervention", "confrontation", "rock bottom", "enabling", "one drink away" "disease" etc.

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CRAFT – *Community Reinforcement and Family Training*
- Non-confrontive
- Positive reinforcement, positive alternatives
- Role playing & training for family members
- Natural consequences (Retrieved 2015 from http://www.robertjmeyersphd.com)

SMART - *Self Management for Addiction Recovery*
- Teaches self-empowerment and self-reliance.
- Provides meetings that are educational, supportive and include open discussions.
- Encourages individuals to recover from addiction and alcohol abuse and live satisfying lives.
- Teaches techniques for self-directed change.
- Supports the scientifically informed use of psychological treatments and legally prescribed psychiatric and addiction medication.
- Works on substance abuse, alcohol abuse, addiction and drug abuse as complex maladaptive behaviors with possible physiological factors.
- Evolves as scientific knowledge in addiction recovery evolves.
- Differs from Alcoholics Anonymous, Narcotics Anonymous and other 12-step programs. (Retrieved 2015 from http://www.smartrecovery.org)

Motivated interview: *Four General Principles - e*xpress empathy, develop discrepancy, roll with resistance, support self-efficacy. (Miller, W.R. and Rollnick, S., 1991)

Aversion therapy: pairing of an aversive stimulus with the behavior that is targeted for change. Can be used in combination with other forms of therapy (example – use of disulfiram)

Drug treatments for substance use. Medications: Treat withdrawal/craving (best when used in combination with support programs)

- Anabuse (disulfiram) alcohol antagonist
- ReVia (naltrexone) block effect, alcohol craving
- Campral (acamprosate) alcohol craving
- Topomax (topirimate) alcohol
- Librium, Valium, etc. (benzodiazepines) (alcohol, etc)
- Parlodel (bromocriptine) craving (especially cocaine)
- Opiate replacement therapy: Methadone, Suboxone (buprenorphine & naloxone), LAAM (Levo-alpha acetyl methadol) (Opiate replacement therapy targets the symptoms of narcotics craving and withdrawal)
- Addiction vs physical dependence
- Concepts of "harm reduction" and "brain healing" following addiction

What can you do as a police peer support team member if (1) a person comes to you for help with an alcohol or substance use problem or (2) you know about or suspect that an officer has an alcohol or substance use problem? {discuss options – the ever-present viable option is to contact your clinical supervisor and develop a plan for contact, peer support, intervention, and referral} Often, there are officers who are recovering alcoholics or alcohol-addiction sponsors within the department. They may be viable referral resources.

Alcohol and depression: link between depression and alcohol. Introduce discussion about depression and suicide.

Key points: substance use, alcohol use disorder, warning signs, substance effects and treatment, ADA, appropriate peer support for problematic substance use, alcohol and depression.

Training objective: acquaint class participants with a general view of substance use and substance use disorder; introduce several substance-related treatment modalities; discuss appropriate PST member action if substance use becomes an issue in a peer support interaction.

17. Depression and suicide

Depression: what is normal?

"It's perfectly natural for you to respond to the ups and downs we all experience with elation or fear. It's normal and expected for you to feel grief at the loss of a loved one, or a job, or a precious possession. It's common, and occasionally even helpful, for you to react to life's stresses, challenges, and dangers with anxiety.

- *What's NOT perfectly natural* is when those feelings persist long after the event or condition that triggered them.
- *What's NOT normal and expected* is when those feelings seem to come at you from nowhere, appearing even in the absence of obvious external triggers.
- *What's certainly NOT helpful* is feeling the weight of your emotions so heavily that they interfere with sleep, prevent you from performing daily activities, or arouse concern in the people who care about you.
- In its milder forms, depression or anxiety can make it difficult to even get yourself out of bed each morning and to go through the motions of your daily activities. Fatigue, inertia, feelings of sadness and recurring fears can hover like a rain cloud over your life.

In its more severe forms, a depression or an anxiety disorder can immobilize you, sabotage your relationships, trigger feelings of helplessness and self-destructive behavior, and perhaps even turn your thoughts to suicide". (Swartz, K. L., 2014. Retrieved 2015 from http://www.hopkinsmedicine.org)

PET image: PET scans of the brain of a depressed and not depressed person - shows activity levels in various parts of the brain {utilize a PET scan image to demonstrate the brain-activity difference in depressed and non-depressed persons - easily obtained online}

SIG-E-CAPSS: mnemonic for areas of life affected by depression.

- Sleep
- Interest
- Guilt
- Energy
- Concentration
- Appetite
- Psychomotor retardation
- Suicidal ideation
- Sexual dysfunction

<u>Depression and mania</u>: depressive, manic, and mood disorders

Depression -
Disruptive mood dysregulation disorder
Major depressive disorder
Persistent depressive disorder (formerly: dysthymia)

Bipolar - major depressive episode and mania/hypomania in bipolar disorder (formerly: manic-depressive disorder)
       Bipolar I (depressive episode - mania)
       Bipolar II (depressive episode - hypomania)

Cyclothymic disorder

Depressive episode - sleep disturbances, sadness, hopelessness, loss of life's meaning, appetite disturbances, lethargy, loss of interest in previously enjoyable activities (anhedonia) including sex, poor concentration, memory, "flat affect", associated suicide risk, possible psychotic features. Specify: mild, moderate, severe, with psychotic features.

Manic episode - increased energy, disorganized thinking & loose speech, loss of need or ability to sleep normally, logorrhea, may be angry or euphoric & expansive, spends money impulsively, increased interest in sex, grandiose delusions, loss of judgment, episodic - will remit w/o treatment in most cases, overall, the person appears "revved up" "hyper," likely a genetic and biochemical component. Specify: mild, moderate, severe, with psychotic features

<u>Suicide</u>

In the world, a person completes suicide about every 40 seconds. In the United States, about 125 Americans complete suicide each day, about 1 every 11 minutes on average (estimates by the CDC and World Health Organization, http://www.who.int).

In the U.S., the Centers for Disease Control and Prevention reports:

- Overall, suicide is the eleventh leading cause of death for all Americans, and is the third leading cause of death for people 15-24 years of age.
- Although suicide is a serious problem among the young and adults, death rates continue to be highest among older adults aged 65 years and over.
- Males are four times more likely to die from suicide than are females. Females are more likely than males to attempt suicide (http://www.befrienders.org/suicide-statistics).

<u>Best and common estimates</u>: validity difficult to establish

1) About 80% of people who are suicidal when intoxicated are not when sober.
2) About 80% of suicidal people give some warning of their thoughts/intentions.
3) In the U.S. annually, suicides consistently outnumber homicides (about 2:1).
4) Most people who become suicidal do not remain suicidal.
Question - What are some ways in which a suicidal person may communicate their thoughts/intentions (warning signs)? {discuss ways}

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Suicide: The *intentional* act of self-killing. Many philosophical issues and differences exist around the conception of suicide. Suicidal ideation is more prevalent in some mental disorders than others (depression and other mood disorders). Not all suicidal persons are mentally ill {provide examples}

- Suicide is frequently an act of desperation. The person often feels alone, lost, abandoned, or cannot think of viable alternatives.
- Most suicides are *not* about dying.
- Most suicides are about *stopping the pain*.
- A retreat into unconsciousness.

Accidental self-inflicted death (*not suicide* - intention vs. means, autoerotic behavior *fail-safe* fails, etc)

Some types of suicide:

1) blaze of glory (to be remembered, make a statement)
2) fate suicide (let another or circumstances decide)
3) suicide by cop (suicide by homicide)
4) protest suicide (political, social)
5) cause suicide (political or military objective)
6) psychotic suicide (delusion-command hallucination)
7) health issue suicide (terminal illness, health issues)
8) hopelessness suicide (mood, depression, loss)
9) revenge suicide ("get even" with or punish someone)
10) punishment suicide (punish self or others)
11) honor suicide (to avoid or in response to disgrace)
12) shame suicide (exposure of secret activity, arrest, embarrassment)
13) guilt suicide (sense of responsibility)
14) anger suicide (anger at self or others)
15) hate suicide (self-hatred)
16) life change suicide (incarceration, divorce)

There can be combined motivations for suicide. Although suicidal behavior may not appear rational to outside observers, most persons that are suicidal have a *rationale* for suicidal behavior.

Suicide prone persons:

1) particular disposition to overestimate the magnitude and insolubility of problems. Little problems seem big, big problems seems overwhelming.
2) significant lack of confidence in their own resources for solving problems.
3) tend to project a resulting picture of doom into the future.
4) the suicide-prone person has somehow incorporated the notion of the acceptability or desirability of solving problems through death.
5) death is viewed as relief (as mentioned, a retreat into unconsciousness) .
6) psychological buffers against suicide have begun to fail. There are several predominant psychological buffers against suicide including: (1) the ability to experience pleasure - many people that are "tired of living" report that they do not attempt suicide because they continue to experience pleasure in at least some part of their lives; (2) some meaning in life – there is something to live for; (3) concerns about family – worry about how their suicide would affect

family members; and (4) religious/philosophical beliefs – suicide is prohibited by religious or philosophical beliefs.

7) hopeless and helpless perspective, loss of sense of meaning, existential meaninglessness "There's no point to life or living." (unknown author and Digliani, J.A.)

Suicidal thoughts are more common than most people believe. Such thoughts can be active or passive. They may or may not co-vary with environmental events. In those prone to suicidal thinking, suicidal thoughts often vary in intensity, frequency, and duration. Suicidal thoughts which are put into action become suicidal behavior (acting out).

Depressed and suicidal persons do not always act in ways that might be expected. If you have any concerns about a person being suicidal, ask the person about it in a caring, non-judgmental manner.

Increased levels of agitation and anxiety, and severe insomnia often precede serious suicide attempts (Fawcett, J. 2006. Retrieved 2014 from http://www.psychweekly.com)

Suicide assessment is composed of three tasks:

A sound suicide assessment is comprised of 3 components:

- • Gathering information related to risk factors, protective factors, and warning signs of suicide.
- • Collecting information related to the patient's suicidal ideation, planning, behaviors, desire, and intent.
- • Making a clinical formulation of risk based on these sources of data. (Shea, S. C. Retrieved 2009 from http://suicideassessment.com) {Errors can occur in any of these three tasks}

Suicide plan:

- • may be brief or elaborate.
- • how does a suicide plan correlate with the likelihood of suicide? (more developed, higher likelihood of suicide)
- • do suicides or suicide attempts occur in the absence of a suicide plan? (yes, impulsive)
- • what can a peer support team member do to determine if a person has a suicide plan or thoughts of suicide? (ask in a caring manner)
- • the contract against suicide. (effective in many cases) {discuss each item}

Peer support team members: *Always* follow up on…

- • They'll see something tomorrow…
- • Things will change soon…
- • Don't worry, everything will be ok…
- • I can't take this much longer…
- • I want you to have this…
- • Will you give this to…
- • I know what I have to do…
- • I'm at peace with myself…
and similar statements.

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Emergency mental health hold - involuntary mental health treatment and evaluation. No officer wants to go against the wishes of another officer, however in emergency situations where an officer is a danger to self and you cannot obtain voluntary compliance, you may need to use the statutory provisions for involuntary mental health treatment and evaluation. As difficult as this is, when warranted, it may save a life.

Emergency commitment: intoxication - involuntary alcohol and drug treatment and evaluation. {same concerns and issues as specified for mental health}

QPR (Question-Persuade-Refer) strategy for intervention

The four cornerstones supporting the QPR approach is derived are:
- Those who most need help in a suicidal crisis are the least likely to ask for it. Thus, we must find our at-risk citizens and go to them with help without requiring that they ask for it first.
- The person most likely to prevent you from dying by suicide is someone you already know. - Thus, those around us must know what to do if we become suicidal.
- Prior to making a suicide attempt, those in a suicidal crisis are likely to send warning signs of their distress and suicidal intent to those around them. Thus, learning these warning signs and taking quick, bold action during these windows of opportunity can save lives.
- When we solve the problems people kill themselves to solve, the reasons for suicide disappear. Thus, crisis intervention, problem resolution and treatment save lives.
(Quinnett, P. Retrieved 2010 from http://www.qprinstitute.com/)

Helping a person that is suicidal {review}

Key points: depression, bipolar disorder, suicide, suicide risk factors, suicide buffers, some types of suicide, suicide prevention, QPR, helping a person that is suicidal.

Training objective: increase comprehension of suicidal behavior; identify suicide risk factors; introduce suicide intervention strategies.

18. Police officer suicide

Police officer suicide:

- Specialized studies conducted throughout the past several years concluded that there were *141* police suicides in 2008, *143* police suicides in 2009, and *126* in 2012 (Violanti, J., et al. 2011). Update to include recent reasonably reliable police suicide vs line-of-duty deaths statistics. Check www.bluehelp.org and FBI annual reports for updated statistics.
- Although every suicide is a tragedy, and police officer suicide is especially painful to those in policing, these numbers are significantly lower than previous estimates. Some research: police officer suicide rate is higher than the general population: 18 per 100,000 for police officers, 11 per 100,000 for general population (Ibid. 2011).
- Some research suggests that when certain variables such as the state of residence, age, gender, race, and marital status are taken into consideration, suicide rates for police officers may be as much as 26 percent lower than that of the general population (Aamodt & Werlick, 2001). If this is accurate, the fact that most police officer candidates are psychologically assessed for emotional stability prior to being hired may prove to be a factor. This is in contrast to research suggests that the police officer suicide rate is higher

than that of the general population (Violanti & Steege, 2020). The diverse conclusions of past police-suicide research highlight the difficulty inherent in conducting research on suicide. A major problem is data collection.

- Historically, there was no governmental agency or private organization responsible for recording the number of police suicides. Therefore, researchers had to rely upon various sources for data, including police organization websites, news reports, social media systems, individual police agencies, and police officers themselves. To address this issue, Congress passed the Law Enforcement Suicide Data Collection Act (LESDCA), signed into law on June 16, 2020. The LESDCA established a data collection program for law enforcement agencies to report officer-suicides and officer suicide attempts. "According to the LESDCA, the FBI must collect, at minimum, the following information for each officer who died by or attempted to commit suicide:

  (1) The circumstances and events that occurred before the act or attempt
  (2) The general location where the act occurred
  (3) The demographic information of the officer
  (4) The occupational category of the officer
  (5) The method used in each suicide instance or attempt" (Perine, 2021, 1)

  The LESDCA further allows for the submission of information relating to the officer's employment status, known contributing stressors, whether mental health services were available through the agency, and whether the officer reported or the agency observed any mental health-related warning signs prior to the incident (ibid). While submission of data to the LESDCA database is voluntary, it represents a significant step forward in the effort to better understand police officer suicide

Video presentation: "Police Suicides: How many?" (National Surveillance of Police Suicides) (video available online) {dated but remains useful to illustrate current issues}

Police suicide as a line-of-duty death? Should an officer suicide that is linked to traumatization due to an on-the-job incident or cumulative stress be considered a line-of-duty death? {classroom discussion}

As part of increased awareness of the psychological toll of traumatic events on first responders, the U.S. Congress passed the Public Safety Officer Support Act. The Act was signed into law on August 18, 2022. It expanded eligibility for death and disability benefits to public safety officers and their beneficiaries. The Public Safety Officer Support Act:
• Allows public safety officers to seek disability benefits for PTSD linked to severe trauma by directing the Public Safety Officers' Benefits Program (PSOB) to designate work-related PTSD and acute stress disorders as a line of duty injury for eligible officers, as well as those who are permanently disabled as a result of attempted suicide.
• Allows families of public safety officers who die by trauma-linked suicide to apply for death benefits by directing the PSOB to presume that suicides are a result of job duties in certain traumatic circumstances where there is evidence that PTSD or acute stress disorder would be the cause of the injury (Reschenthaler, 2022).

Within the Act, Congress recognized the physical and psychological primary dangers of policing, "Every day, public safety officers, including police officers, firefighters, emergency medical technicians, and others, work to maintain the safety, health, and well-being of the communities they serve…This work not only puts public safety officers at-risk for experiencing harm, serious

injury, and cumulative and acute trauma, but also places them at up to 25.6 times higher risk for developing post-traumatic stress disorder when compared to individuals without such experiences...Psychological evidence indicates that law enforcement officers experience significant job- related stressors and exposures that may confer increased risk for mental health morbidities (such as posttraumatic stress disorder and suicidal thoughts, ideation, intents, and behaviors) and hastened mortality" (ibid).

While the Act is a major step forward, there are concerns. The primary concern is related to suicide buffer #3 - worry about how their suicide would affect family members. This buffer fails when thoughts change from "I cannot kill myself because it would devastate my family" to "My family would be better off without me." Within the midst of depression, will family compensation become a factor for some suicidal officers? Will the number of officer suicides increase due to the knowledge that their family will be compensated and thereby "better off" by their suicide? Time will tell.

Police officer suicide risk factors: a risk factor increases the likelihood of suicide. Risk factors are cumulative, but not necessarily causes. Many apply to all persons regardless of occupation.

- Diagnosis of depression, bipolar, anxiety, or psychotic disorder.
- Veiled or outright threats of suicide.
- Development of a suicidal plan.
- Marital, money, and/or family problems.
- Recent or pending discipline, including possible termination.
- Over-developed sense of responsibility. Responsibility absorption.
- Frustration or embarrassment by some work-related event.
- Internal or criminal investigations.
- Allegations of wrongdoing; criminal charges; pending incarceration.
- Assaults on an officer's integrity, reputation, or professionalism.
- Recent loss, such as divorce, relationship breakup, financial, etc.
- Little or no social support system.
- Uncharacteristic dramatic mood changes. Angry much of the time.
- Increased aggression toward the public. Citizen complaints.
- Feeling "down" or "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 other involuntary loss of job.
- Self-isolation: withdrawing from family, friends, and social events.
- Giving away treasured items.
- Saying "goodbye" in unusual manner.
- Easy access to firearms (a constant for police officers).
- Sudden sense of calm while circumstances have not changed.
- Unwillingness to seek help because of perceived stigma.

Officer spouse and other family members: Do not hesitate to contact police support personnel if you suspect that your officer-spouse is suicidal. Call for help.

Occupation may not be a significant factor in suicide. Research in the area of occupation and suicide is often inconclusive and sometimes contradictory. Several past studies did not include law enforcement in the top five occupations that experience the highest rates of suicide. Instead of occupation, the following were among the top predictors for suicide:

1) diagnosable mental illness, especially mood disorder
2) co-morbid substance abuse-dependence
3) no or loss of social support
4) easy access to firearms

Suicide protective factors:

• 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 (Catholicism – prohibition of suicide).

Video presentation – "Code 9 - officer needs assistance" (accounts of officer suicide and related commentary) (available at http//www.youtube.com)

Peer support team philosophy – suicide prevention

• the peer support team is proactive. PST members reach out to officers believed to be suicidal or otherwise experiencing difficulty.
• the PST makes an active effort to prevent police officer suicide by reducing the "seconds" of policing.
• peer support team members encourage "eyes and ears" beyond the peer support team and act conscientiously upon any relevant information received from others.
• peer support team members act independently to prevent officer suicide by presenting shift briefing programs on officer suicide risk factors and suicide prevention, and making themselves available for open discussion of issues related to suicide.

Preventing police suicide – strategic summary

• "Make it Safe"F Police Officer Initiative
• Organizational environment and COMPASS - the peer support team is an essential component of the Comprehensive Model for Police Advanced Strategic Support (COMPASS). COMPASS starts early and continues beyond retirement.
• Proactive Annual Check-in
• Available support services – including PST
• Knowledge of risk factors
    – In service training
    – Shift briefing training
    – Informational posters
• Peer environment – peer relationships "eyes and ears" beyond PST

- Officer and officer-family education
- Plan of action: *all officers* - reach out - know what to do

<u>Peer support suicidal-officer action plan</u>: What do you do if an officer to whom you are providing peer support (1) tells you that he is suicidal or (2) you suspect is suicidal?

1. Assess whether there is an imminent suicidal danger – if yes, take immediate action to assure the officer's safety – in extreme cases, this may include requesting that the officer surrender his firearm(s) for safekeeping
2. Do not leave the officer alone
3. Contact your clinical supervisor immediately - together, develop an intervention plan (may range from ongoing peer support to hospitalization)
4. Be prepared to take any action necessary to assure the officer's safety – including involuntary evaluation and treatment
5. Contact family members and other support persons as needed
6. Do not leave the officer until approved to do so by your clinical supervisor
7. Provide reassurance and caring support - provide realistic hope
8. Assist the officer to make any necessary communications with department personnel
9. Accompany the officer to any office or facility deemed appropriate for further evaluation and treatment
10. Follow up as appropriate or as directed by your clinical supervisor

The peer support team not only attempts to reduce police officer suicide by providing support services, it also becomes involved in cases of *suicide by cop* and *officer witness to suicide*.

<u>Key points</u>**:** police suicide, officer suicide risk factors, buffers against suicide, officer suicide prevention, "eyes and ears" beyond the peer support team, peer support suicidal-officer action plan.

<u>Training objective</u>: present information relative to police officer suicide; develop strategies for police officer suicidal behavior intervention; officer suicide prevention.

19. Suicide by cop and officer witness to suicide

Suicide by cop (SbC) involves a person who seeks death by acting in a threatening manner toward police officers with the intent of provoking officers to shoot.

<u>Case of Moshe Pergament and SbC</u>

On November 15, 1997, nineteen-year-old Moshe Pergament, known as Moe to his friends, was intentionally driving recklessly on the Long Island Expressway, planning to be contacted by police. He sideswiped several cars. It was not long before his dangerous driving was reported. A short time after the reports, he was located and stopped by police. Once stopped, Moe exited his car. He pulled out a handgun. Officers ordered him to drop the weapon. He did not comply. He began to walk toward officers with his gun pointed at them. When Moe again failed to comply with the officers' orders, they fired, killing him. In Moe's vehicle, investigators found ten notes. Nine were addressed to family members and friends. One was addressed "To the officer that shot me." It read…

"Officer, It was a plan. I'm sorry to get you involved. I just needed to die. Please send my letters and break the news slowly to my family and let them know I had to do this. And that I love them very much. I'm sorry for getting you involved. Please remember that this was all my doing. You had no way of knowing. Moe Pergament." Pergament was holding a realistic-looking plastic replica of a silver .38 caliber revolver that he had purchased earlier the same day.

Some characteristics of persons seeking SbC:

- lower socioeconomic class male
- aggressive life-style
- violence to solve problems
- poor self-concept
- mood disorder - depression
- need to punish society or self
- need to be seen as a victim of society
- may use any means to accomplish goal including killing a hostage, police officers, etc. {discuss other possible characteristics –solicit class input}

SbC information

Researchers studied 707 cases of officer-involved shootings in North America from 1998 to 2006. Results showed that SbC occurs at extremely high rates, with 36% of all shootings being categorized as SbC (Mohandie K., et al. 2009). (Several older studies found incidents of SbC ranged from 10% to 26%)

Some persons seeking to be killed by the police: (1) do not possess a weapon but act as if they are armed (2) do not possess real, functional, or loaded firearms but act as if they are armed (3) are in possession of functional and loaded firearms.

Question: Why would persons in possession of a functional firearm force a law enforcement officer to kill them? Several factors:

- Social influences: Suicide remains a social taboo.
- SbC is a way of dying while *not* killing yourself.
- Fear: inability to follow through with suicide
- Religious prohibitions against suicide (SbC as a religious "loophole"?)
- Concern over insurance policy payoff
- Psychological inability to kill oneself

SbC considerations for police officers

- available lethal means for person
- officer's perception of threat
- time (can you buy time?)
- distance (can you increase distance?)
- functional verbal communication
- nonverbal behavior and posture
- cover (can you find cover?)
- back up

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- officer safety
- self-defense (when other options are not available)
- officer as victim (being manipulated into shooting – having to cope with aftermath)

<u>SbC – critical incident, peer support, possible traumatization, and interventions for officers involved in SbC</u>

Discuss SbC as a critical incident, potential for officer-traumatization, peer support team involvement, and the application of the Trauma Intervention Program.

<u>Officer witness to suicide</u>

Police officers are frequently called upon to assist persons that have become suicidal. In a significant majority of these cases officers are successful in gaining the person's cooperation and the person receives appropriate professional intervention. However, not all "suicidal person" calls end this way.

Some persons will kill themselves in the presence of police officers. When officers witness a suicide, the experience can trigger a cascade of emotions. These emotions range from intense anger to feelings of guilt and sorrow. This is especially true if the officer is acquainted with the person or the officer has come to know the person during the time spent trying to keep the person from killing himself.

Some factors in the police officer emotional response to witnessing a suicide:

- Developed relationship
- Second guessing - "Did I do something that I shouldn't have, did I not do something that I should have?" This type of second guessing can lead to unjustified feelings of guilt. Remember: *You are not responsible for the person's behavior*.
- 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 officer/person interaction
- Actual circumstance of the incident
- Interaction with the person's family
- Actions of other officers
- Officer's 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 often traumatic to witness 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 in the best way you can.
- Understand that you did what you thought was best to help the person.

- Take some time to process the incident before returning to shift duties.
- You will likely experience some degree of *posttraumatic stress.*
- Manage posttraumatic stress as suggested in "25 Suggestions and Considerations for Officers Involved in a Critical Incident" and "Recovering from Traumatic Stress" (Law Enforcement Critical Incident Handbook).
- Avoid alcohol or other drugs as a primary way to manage your feelings.
- Seek support: talk to a trusted peer, supervisor, friend, or appropriate family member about your experience and feelings.
- Initiate contact with your department's psychologist, peer support team, chaplain, or other available support resource.
- Become stronger and smarter

Key points: issues involved in suicide by cop, some persons seeking to be killed by police will kill others to accomplish their goal, witness to suicide, Law Enforcement Critical Incident Handbook.

Training objective: familiarize class participants with factors involved in suicide by cop and witness to suicide; present information included in the Law Enforcement Critical Incident Handbook.

20. The police culture, primary and secondary danger, and the "Make it Safe" Police Officer Initiative

Present the notions of police primary and secondary danger, police organizational climate, and police culture. Train the 12 elements and implementation of the Make it Safe Police Officer Initiative (information available at www.jackdigliani.com).

Key points: police primary and secondary danger, police culture, organizational climate, Make it Safe Police Officer Initiative, Make it Safe Police Officer Initiative implementation.

Training objective: introduce the concepts of police primary and secondary danger; comprehension of the Make it Safe Police Officer Initiative; understand the difference between police organizational climate and police culture.

21. Grief and mourning

Grief – personal, emotional responses to loss.

Mourning – public, culture-specific ways of expressing and honoring the deceased.

- There are many and varied responses to loss
- There are varying lengths of time necessary to process grief
- The "role" of guilt – implications for everyday interactions
- It may be difficult to understand the grief experience of another person

Tasks of grieving

1. Accept the reality of loss
2. Experience the pain of grief
3. Adjust to the environment in which the deceased is missing

4. Withdraw emotional investment in the deceased and recover the ability to re-invest in other relationships (Worden, J.W., 2008) {although academic in composition, the "tasks of grieving" have application in instructional settings – useful for peer support training}

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 emotional attachment, spiritual views, the age of the deceased, how the person died, the similarity of the deceased to the living loved ones, 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 single correct way to grieve. People deal with loss in different ways for different periods of time.

4. *Coping with loss*. It is common to experience powerful emotions. Confront emotions openly. Strong emotion may feel overwhelming at times, but it will naturally diminish. Let it in, let it fade (like an ocean wave). Breathe through it. Talk it out. Over time, you will be able to share pleasant memories.

5. S*pecific 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, 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 deal with 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 (their legacy to you). From here, you can further honor the person by reengaging life. {for more information see chapter 8 of *Reflections of a Police Psychologist*}

It is important to remember that similar feelings can follow the death or loss of pets, non-pet animals, and even plants & inanimate objects that have acquired some special meaning.

Responses to death: Implications – how you choose to live your life (life by design), interactions with others, and honoring legacy of the deceased. {discuss responses to death and the implications for life}

Relate grief and loss to peer support: caring support without becoming intrusive. Sometimes just being there is enough.

Key points: grief, mourning, tasks of grieving, issues of survivorship, legacy, responses to death, implications for life, peer support during grief.

Training objective: acquaint class with cognitive and emotional aspects of death, grief, mourning, survivorship, and loss.

22. Critical incident group debriefing {descriptive presentation – not intended to train group debriefing skills}

The process of debriefing should be utilized only under selected critical incident circumstances. There are several other support interventions which may be used in cases where debriefing is deemed less than ideal.

Peer support team debriefings and clinical debriefings: Peer support teams may or may not become involved in the facilitation of critical incident debriefings. Possible: (1) peer support team debriefing – facilitated by peer support team members. Implemented when officers are not directly involved in the incident (for example, officers exposed to a particularly gruesome suicide) (2) clinical debriefing – facilitated by a licensed clinician. Implemented when officers are directly involved in the incident (for example, an officer defends himself with lethal force). These examples represent a general guideline. In many cases, clinical judgment must be exercised to determine if debriefing is appropriate and if so, what type of debriefing should be utilized. Peer support team members participate in and contribute to debriefings facilitated by licensed clinicians.

Incidents being considered for debriefing should be evaluated by an experienced licensed clinician to determine if a debriefing is warranted. If yes, the clinician approves the debriefing and determines what type of debriefing should be utilized.

Models for debriefing

1. Phase Model
2. Freezeframe Model

Phase model (the incident is processed in some variation of the following phases)

- Introductory Phase
- Fact Phase
- Feeling Phase
- Response Phase
- Information Phase
- Reorganization Phase (Critical Incident Stress Debriefing – CISD) (Mitchell, J.T. 1983: Mitchell J.T. and Everly, G.S., 1996)

Freezeframe model (the incident is processed through time frames)

The incident is -　　1) organized into "frames"
　　　　　　　　　　2) processed within frames
　　　　　　　　　　3) all elements are processed
　　　　　　　　　　4) process until frame is "completed"
　　　　　　　　　　5) the group guides the frame process
　　　　　　　　　　6) the facilitator "freezes" frames as appropriate
　　　　　　　　　　7) education, strength, and resiliency are part of frame processing
　　　　　　　　　　8) need for follow up is assessed (Digliani, J.A., 1992)

Recent concerns of debriefings – (1) disrupting the normal psychological trauma integration process of participants, (2) the retraumatization of individual debriefing participants, and (3) the vicarious traumatization of a previously non-traumatized involved participant or support person.

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

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

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

Resilience - ordinary, 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. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models and offer encouragement and reassurance help bolster a person's resilience" (Retrieved 2011 from http//www.apa.org).

Keys to successful debriefings: relax, stay attentive, and trust the group process.

Key points: peer support team debriefing, clinical debriefing, phase and freezeframe debriefing, concerns about debriefing, resiliency debriefing.

Training objective: introduce types of debriefing, debriefing concerns, and debriefing dynamics.

23. Keeping yourself healthy

Peer support: keeping yourself healthy and self-care. Self-care - appropriate assertiveness, proper personal boundaries, balancing life stressors, etc. (self-care is not selfishness – being selfish is getting what you want regardless of effect on others).

Review elements of self-care:

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

Key points: difference between self-care and selfishness, factors for self-care.

Training objective: enhance personal philosophy of self-care within and without the role of peer support.

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24. Transactional analysis for peer support (optional) {present only if well-versed in TA and time allows – keep it brief, emphasize useful aspects, avoid trying to create TA therapists}

Transactional Analysis (TA) (Eric Berne, 1910-1970) is a theory which operates as each of the following:

- a theory of personality
- a model of communication
- a study of repetitive patterns of behavior

<u>Primary concepts in TA</u>

- Ego states, Exclusion, & Contamination
- Structure & Function
- Psychic energy & Executive
- Flow of cathexis
- Ego boundaries
- Strokes
- Transactions
- Games, Scripts, & Rackets
- Time structuring
- Contracts

<u>The three ego states</u>:

- Parent
- Adult
- Child

Ego states can be thought of as parts of our personality. Each ego state is made up of thoughts, feelings and behaviors that belong together.

Parent - The Parent ego state includes the thoughts, feelings and behaviors we have copied from our parents and other significant people in our lives.

The Parent Ego State is split into two categories:

- The Critical or Controlling Parent provides norms, rules, rewards, and punishment
- The Nurturing Parent loves, cares for, provides for, and protects
- The Parent is the domain of the "Taught"

Adult - The Adult is the domain of the "Reflexive" or the "Thought". Our Adult is our capacity to determine our actions on the sole basis of the received information. The Adult forms in us in the neighborhood of 10 months. It is what allows us to keep the control of the ego-state "Parent" or of the ego-state "Child".

This ego-state is often compared with a "computer" or a "regulator". It concentrates on the reality, handling as well the external information ("it is three o'clock in the afternoon", "I need more data")

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as the internal information resulting from the ego-states (the Child, e.g.: "I suffer, it is not fair" or the Parent, e.g.: "I am responsible").

Child - The Child ego state includes the thoughts feelings and behaviors that we developed in the past. For the most part this is developed in our childhood to enable us to thrive (cope/survive) in the world we live in.

The Child ego state is split into two categories:

- The Adapted Child composed of thoughts, feelings and behaviors learned, developed in response to other people.
- The Free or Natural Child is composed of uncontrolled, uninhibited thoughts, feelings and behaviors. A state in which people behave, feel, and think similarly to how they did in childhood.

The Child is the source of emotions, creation, recreation, spontaneity and intimacy. The Child is the domain of the "Felt". (Retrieved 2012 from http://www.transactional-analysis. info/menuglossaire.html)

The Child decides what goes into the Parent using three criteria:

1. Vulnerability of the self
2. Power of the parent figure
3. Believability of the parent figure

Concepts in ego state transactions.

Executive power and psychic energy
Ego boundaries and permeability
Exclusion
Contamination
Shifts in ego states
Lability – Sluggish cathexis

This more modern conception of TA established Controlling and Nurturing aspects of the Parent mode, each with positive and negative aspects, and the Adapted and Free aspects of the Child mode, again each with positive and negative aspects.

Transactions under analysis

Strokes are the recognition, attention, or responsiveness that one person gives another. Strokes can be positive (nicknamed "warm fuzzies") or negative ("cold pricklies") *and* conditional or unconditional. A key idea in TA is that people hunger for recognition, and that lacking positive strokes, they will seek whatever kind they can, even if it is a negative kind recognition.

Transactions may be complementary, crossed, or ulterior

A complementary transaction is characterized by a response being sent from the ego state which received the stimulus, and sent to the ego state from which the stimulus originated.

A crossed transaction results when the response is directed at an ego state other than the one from which the stimulus was generated

Ulterior transactions contain a social message as well as a psychological message: For example: A: "I need you to stay late at the office with me." (Adult words), body language indicates sexual intent (flirtatious Child). B: "Of course." (Adult response to Adult statement), winking or grinning (Child accepts the hidden motive).

Three rules of transactions in TA communication:

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

What events and people trigger your Parent and Child state?

- Do you assign responsibility equally?
- Do you have to be in control?
- Do you feel forced into taking control?
- Do you have a hard time making decisions and try to get others to make them for you?
- Do you feel fundamentally you're not as good as others?
- What might these issues bring out in other people, in reaction to you?
  (From: Theramin Trees, TA training)

Games In TA

"A game is an ongoing series of complementary ulterior transactions progressing to a well-defined, predictable outcome. Descriptively, it is a recurring set of transactions…with a concealed motivation… or gimmick."

"Because there is so little opportunity for intimacy in daily life, and because some forms of intimacy (especially if intense) are psychologically impossible for most people, the bulk of the time in serious social life is taken up with playing games. Hence games are both necessary and desirable …" (Berne, E. 1964).

- Purpose of games: *To promote the life script.*
- Will go on as long as someone is willing to be victimized.
- The drama triangle: On each end are roles that we play in life. One is the persecutor, another is the victim and the last is the rescuer.
- If anyone in this triangle changes roles, the other two roles change as well. (Retrieved 2012 from http://karpmandramatriangle.com/)

PERSECUTOR - "It's All Your Fault" VICTIM - "Poor Me" RESCUER - "Let Me Help You" (Steiner, C., 1990) (James, M. & Jongeward, D., 1978)

Steiner on the drama triangle... "the Victim is not really as helpless as he feels, the Rescuer is not really helping, and the Persecutor does not really have a valid complaint."

- Withdrawal
- Ritual
- Activity
- Pastimes
- Games (and scripts)
- Intimacy

Transactional Analysis Life Positions

I'm ok, you're ok
I'm ok, you're not ok
I'm not ok, you're ok
I'm not ok, you're not ok (Harris, T.A., 1969)
How might you apply TA in peer support? {solicit class input}

Application of TA in peer support

- If you apply TA in your life, it will help you to help others
- Helps to keep you focused in desired ego state
- Conceptual model: provides a "way to think" in your life and a way to support others…but it is not the only way
- Not offensive – does not pathologize
- Normally does not invoke defensiveness
- Provides a framework for discussion of patterns of behavior
- Assists with plans of action and desired change
- Lends itself well to "Immediacy"
  {to the class} Can you think of other applications for TA in peer support?

TA class activity

- Groups of three: PST member, person seeking peer support, observer. Exchange roles upon instruction.
- Begin Child-Child complementary transaction.
- Move to Adult-Adult complementary transaction.
- Observer: notice transactions and determine if a transaction was crossed. Prepare to report and discuss observations to class group.

Key points: principles of transactional analysis, ego states, ego state transactions, rules of TA communication, drama triangle. Limit to second-order analysis.

Training objective: explain transactional analysis in terms that make it possible for class participants to utilize the concepts in peer support.