Placer County Law Enforcement Chaplaincy

(PCLEC) A Non-Profit 501(3)(C) Organization

Proudly serving the community of Placer County and the following agencies…

Auburn Police Department

California Highway Patrol

Lincoln Police Department

Placer County Sheriff Department

Rocklin Police Department

Roseville Police Department

State Parks and Recreation Patrol

FBI Sacramento Office

Office of Emergency Services

Placer County Probation

Placer County District Attorney

Training Manual

September 2007

A Word from our Supporters

Placer County Law Enforcement Chaplaincy is a nonprofit 503(c) organization serving law enforcement in Placer County. Our diverse organization is called upon to meet the diverse needs of the citizens of Placer County. Without the support and endorsements of the agencies and citizens we serve, we would have to humbly consider the motivations and impact of this Chaplaincy. Always strive to meet the higher calling and never take for granted the relationships built between a Chaplaincy and the Agency it serves.

"The Law Enforcement Chaplaincy of Placer County has been an invaluable ally in our mission of service to the community. Because of the very nature of our "business", we are daily in contact with individuals suffering the most stressful of situations. In existence since 1986, the Chaplaincy has proven to be one of our greatest assets.

The Department and the citizens of Placer County are fortunate indeed to be able to rely on the dedicated members of the Chaplaincy."

Sheriff Edward Bonner
Placer County Sheriff-Coroner-Marshal

"I consider the Placer County Law Enforcement Chaplaincy to be an integral part of our entire community.

The Chaplains unwavering devotion exemplifies their commitment to law enforcement and our citizens. Having the Chaplains available as a source of support for our office, and various law enforcement agencies, lending their assistance in times of need is a valuable asset to the people of Placer County.

Over the past several years, the Placer County Law Enforcement Chaplaincy has worked closely with the District Attorney Victim Services program and has directly aided many victims of all type of crime, such as domestic violence, sexual assault, child abuse, elder abuse, drunk driving, robbery and survivors of homicide. We truly appreciate their efforts which have greatly contributed to our county's public safety and security."

Bradford R. Fenocchio
Placer County District Attorney

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"On behalf of the Gold Fields District of California State Parks, I wanted to give my full support to the Placer County Law Enforcement Chaplaincy. [The Chaplains] have been very supportive to our park visitors and employees throughout the years.

The Placer County Law Enforcement Chaplaincy has been at the scene of numerous critical incidents that have occurred in the State Parks located within Placer County. I have personally witnessed Chaplains compassionately assisting and comforting families and friends whose loved ones have been involved in a traumatic incident. We recently lost a State Park Ranger to a sudden unexpected death and the Chaplaincy has been there offering support and assistance for our employees and the Ranger's family.

It is comforting to know that the Placer County Law Enforcement Chaplaincy is available to respond to critical incidents within our State Parks where they are available to offer support to friends and family of the victim(s) as well as to our employees."

Scott S. Nakaji
Superintendent, Gold Fields District
Department of Parks and Recreation

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"Dear Chaplain,

On behalf of the fine men and women of the Lincoln Police Department, I would like to thank you and the Placer County Law Enforcement Chaplaincy for your service and dedication to our community. The care and compassion extended by the chaplaincy to families in need or who are experiencing a life altering tragedy is an invaluable service.

Sometimes we forget that when a community member goes through a difficult time or suffers a loss, more often than not, one of our officers are there sharing that experience with them. The Officers typically put on the brave face and say it is part of the job and they try to deal with it on their own. If an officer is experiencing such an incident on a personal level then the internal stress and emotions they endure are magnified even greater.

We count on the Chaplaincy to be there for us and the community, to walk along side of us during these times of need and leading us along the path of emotional survival. We can not thank each and every chaplain enough for always being there and allowing us to count on them to help us through the troubled times. Just as important to us is the fact the chaplaincy is always there to share our joy, our accomplishments and help us celebrate our successes.

Once again I would like to thank you and the Placer County Law Enforcement Chaplaincy for your friendship, service and support for the members of the Lincoln Police Department and the community we serve."

Brian M. Vizzusi
Chief of Police (former)
Lincoln Police Department

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"We at the Roseville Police Department truly value the services the chaplaincy has provided to the police department, our employees, and the community.

The chaplains have helped the police department by responding to critical call outs, attending officer briefings and joining the officers on ride a alongs in patrol cars, assisting at DUI checkpoints, and providing in-service training for police employees. The chaplains responded to emergency callouts in Roseville 109 times in 2006. The chaplains provide an invaluable service to the department and community during these callouts. They provide support to affected family members or neighbors, provide food and other necessary supplies for police personnel or affected citizens, and provide ongoing support to those affected in addition to responding during the actual crisis.

The chaplains assisted our police employees individually by assisting with stress management counseling, just being a friendly ear to listen, and providing nationally renowned speakers who talked about the stresses of police work on employees and their families. It is difficult to measure the value the services provided by the chaplaincy have on our employees, however, I can attest it is substantial.

Lastly, the chaplains are a tremendous resource for our community. They assist officers during tragic circumstances such as death notifications and suicide incidents. The help they provide to grieving family members is immeasurable. This is something the police employees are not fully trained in or have the time to provide the ongoing support that the chaplaincy can provide. As an example, in 2006, the chaplains responded to the fatal plane crash that occurred in Roseville. The chaplains provided many hours of support to the affected neighbors and the family of the young man who was killed.

... The chaplains respond 24 hours a day, 365 days a year whenever we request their help. Their service touches the lives of the police employees and members of the community."

Joel A. Neves
Chief of Police
Roseville Police Department

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We "…understand the hard work and personal sacrifices that each Chaplain makes on a daily basis as they provide support to public safety personnel throughout Placer County. Additionally, the efforts by your members to give spiritual support to the law enforcement community and those citizens devastated by criminal activity, serious accidents, or the loss of a loved one deserves recognition for their service and call to duty.

Valerie Harris
Chief of Police
Auburn Police Department

Table of Contents

Chapter 3: Confidentiality

Keeping Secrets
Statutory Conditions For the Privilege
Exceptions to the Privilege
A Duty to Warn?
Minimizing Problems
Excerpt from the California Evidence Code
Chaplaincy Validated
ICPC (International Conference of Police Chaplains) – A Case of Confidentiality

Chapter 4: Critical Incident Stress Management

Critical Incident Stress Debriefing / Powerful Event Group Support
What is a Critical Incident?
Symptoms of Critical Incident Stress
Critical Incident Stress Management (CISM)
Formal Critical Incident Stress Debriefing (CISD)
Who serves on a CISD Team?
Conducting a CISD
CISD Structure
CISD Functions During an Incident
Post Traumatic Stress Disorder
Survival Guilt
Formal Counseling

Chapter 5: Crisis Reaction

Trauma Recovery Guidelines
Expected Emotional Reactions
Self-Help Techniques
Things to Try
Crisis Reaction – A Normal Response to an Abnormal Situation
Common Signs and Signals of a Stress Reaction
Family
Helping Children Respond to Trauma
Working with Schools
Profile of Someone in Crisis
Working with Mentally and Emotional Disturbed People
Types of Mental Disorders
Levels of Mental Disorders
Common Symptoms of a Mental Disorder
Support the Officer Dealing with an Emotionally Disturbed Person

Chapter 6: Death Notifications – The Most Difficult Task

Three Stages of Grief: Impact, Recoil, Recovery
Death
Loss
Grief / Mourning
The Psychological Autopsy
Transference

Impact on Survivors
Most Common Reactions
Three Rules to Live By
Duration of Distress
Support that Helps
Overcoming Grief
Death Notifications (In Person Only)
Epilogue Clichés – Things people despise hearing
Greif Interventions
Article: Grief Knowledge
Article: Straight Talk About Grief Intervention – Suicide
Article: Handling Difficult Grief Crises
Sudden Infant Death Syndrome
SIDS Legislation in California
Definition of Sudden Infant Death Syndrome
Description of the typical baby that dies of SIDS
Risks and Non-Risk Factors of SIDS
Physical Signs of SIDS
Facts surrounding the Incident
Differentiating SIDS from Child Abuse/Neglect
The Grieving Process for SIDS related deaths
When SIDS Happens
Support of Parents/Caregivers – Communication Techniques
Facts Surrounding the Incident
Referral Agencies
Line-of-Duty Deaths
Article: Survivor and Department Responses
Notifications Dealing with Trauma
Management of Relatives
Give to the Future: Support Organ Donation
The Clergy's Role
What good comes from organ donation?
Article: How do I ask?

Chapter 7: Suicide and Alcoholism

Suicide, Let's Talk About It
Suicidal Myths
A Cry for Help
Prevention of Suicide
Clues for Preventing Suicide
What to do for a suicidal person
Where to look for help
How can Chaplains help
Lethality Assessment Scale for Suicide Potential
Working With Suicide Bereavement
Common Misconceptions About Suicide
Stages of Suicide
Signs of Depression & Suicide Risk
Befriending Suicidal or Despairing People
Article: Suicide affects the lives of so many

Article: Police Suicide

Officer Suicide
Causes of Suicide Among Police Officers
Suicidal Symptoms in Police Officers
Teenage Suicides
What Kids are at Risk for Suicide
Suicide Signs
Suicide Hotlines
Survivors of Suicide
Unique Aspects That Survivors Have
Alcoholism
Support Groups
The Twelve Steps of Alcoholics Anonymous

Chapter 8: Stress

How Does Stress Affect Us?
Exhaustion – Stress without an outlet
Avoiding Stress
Common Sense for Stress Management
Stress is the Product of an Entire Life Style, not just an isolate incident
Gaining Control Over Stress
Stress Response Syndromes
Signs of Excessive Stress
Law Enforcement Stress
Article: Officer Down Needs Assistance
Article: Peer Counseling
Suggested Stress Management Class Outline
Critical Incident Stress vs. Cumulative Stress
Three relaxation techniques
Why is stress so bad?
How does stress affect us?
How Vulnerable Are You To Stress?
Murphy's Law of Police Work
Serotonin, Noradrenalin, and Dopamine
Symptoms of being overstressed
Avoiding Stress
Reducing Stress / Getting back to Normal
Relieving Stress
Red Flags of Emotional Exhaustion
Stress Rating Scale

Chapter 9: Listening / Communication Skills

Rules of Communication
Levels of Listening
Impairments to Listening
Communicating in a traumatic situation
Listening and Responding styles
12 Roadblocks to Communication
When the Chaplain hears the worst
Cultural Issues in Communication
Communications within the Chaplaincy

APPENDIX

Appendix A: Sample PCLEC Application
Appendix B: Sample PCLEC Commitment Letter
Appendix C: Sample PCLEC Emergency Call Out Form
Appendix D: Sample PCLEC Monthly Report
Appendix E: Handouts on Stress
- Handout 1: How does Stress affect us?
- Handout 2: How Vulnerable Are You to Stress?
- Handout 3: Murphy's Laws of Police Work

Supplemental Articles
- Article: What You Should Expect from a Chaplain
- Article: A Chaplain's Call
- Article: A Day in the Life of a Senior Chaplain
- Article: Special Article: The Chaplaincy
- Article: Breaching the Blue Wall
- Article: Police Chaplain Programs and the Constitution
- Article: A Guide to Grief
- Article: Death Notification: Some Recommendations
- Article: I'm Sorry to Inform You…
- Article: Protect Yourself from the Dead
- Article: Apnea, Sudden Infant Death Syndrome, and Home Monitors: Psycho-Social Issues
- Article: Informing the Family of Sudden Death
- Article: Commonly Asked Questions about SIDS: A Doctor's response.
- Article: Fact Sheet: SIDS Information of the EMT
- Article: Chaplain's Corner
- Article: Men and Grieving

Chapter 1
THE CHAPLAINCY

PURPOSE

The purpose of the Chaplaincy Program will be:

1. To provide spiritual guidance and counseling to all members of the Law Enforcement agencies located in Placer County, both sworn and civilian, and their families in time of need.
    A. The services of the Chaplains are available on the basis of need and desire. They are an optional service available by request.
    B. They are not intended, nor do they wish to replace an individual's clergy, or faith.
    C. Every effort shall be made to provide for the religious preferences of the person(s) being served. If a particular religion or denomination is requested, we will honor that request and attempt to contact the particular religious practitioner of their choice.

2. To assist Law Enforcement officers and the people of the community through a field service ministry.

3. To provide guidance, counseling and comfort in times of crisis. The Chaplain should be able to put people in contact with the appropriate agency or agencies to help them.

DEFINITIONS

Chaplaincy: A ministry to the people of the community in the area of field service crisis counseling to and through Law Enforcement agencies or other first responders.

Service: The Chaplaincy will provide the services of a Chaplain on a twenty four hour, seven day a week basis. At the request of a Law Enforcement agency, or their employees, the Chaplain will seek to bring comfort and consolation to persons involved in accidents, natural catastrophes or confronted with death.

Responsibilities: 1) The Chaplaincy is *Reactive;* it responds to crisis situations when an event occurs requiring crisis intervention or a Chaplain's support. 2) The Chaplaincy is *Proactive;* we work along side those in the community we serve in day-to-day activities and special events. 3) Lastly, the Chaplaincy has *an Administrative responsibility which prepares* the organization to respond to the various requests and maintain a healthy organization and team of well-trained Chaplains. These responsibilities are further defined in the Tables to follow:

Responsibilities Defined

Reactive	Definition
Crisis Response	Emergency call outs for employees on duty and off duty, their families, and the community.
Critical Incident Team	Negotiations, SWAT, and SET emergencies.
Crisis Intervention	CISM, suicide interventions and prevention, horrific crime scenes and trauma locales, both citizen and officers.
Death Notifications	For employee and in cooperation with the Coroners office to the community.
Follow-Up	Injuries, sickness, or deaths of employees or immediate family, active or retired.
Funeral / Memorial Services	Employee or family and community members.
Weddings	Performed for employees and their family members, and community members.
Counseling	Job-related stress reduction, marriage, and family.

Proactive	Definition
Briefings	Attendance at various watches and duty sections.
Ride-Alongs	Patrol and detectives.
Visitations	Homes and hospitals, employees and families.
Informal Counseling	On-site recognition, referrals (leads) by supervisors or peers.
Community Involvement	Department representative at various functions (Public Relations).
Weddings	Pre-marital counseling and wedding planning
Official Functions	Award Ceremonies, Academy visits, promotions, and swearing in.
Training Seminars	CISM, Line of Duty Death Funeral Preparation, Stress Management, etc.
Volunteer Chaplaincy Corp.	Establishing and training volunteer Chaplains for service.
Back-Up Resources	Establishing a network of available resources to assist employees and families, i.e. referrals.

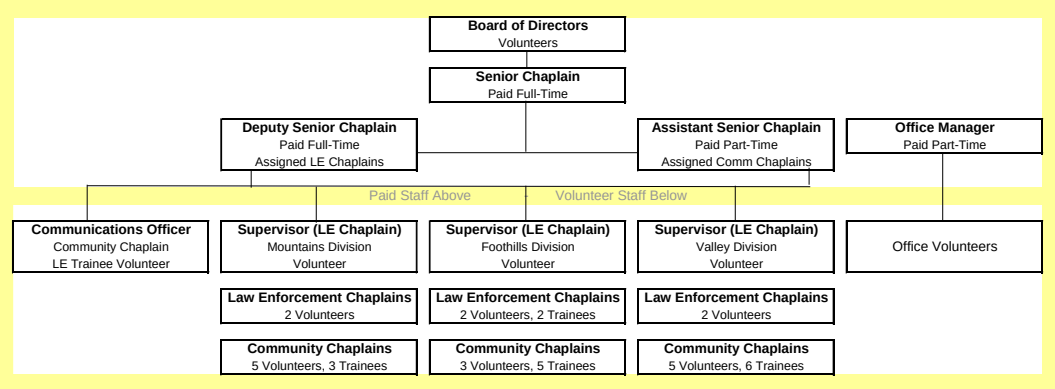
Administrative	Definition
L.E.C Administration	Administering Chaplaincy programs, planning, organizing and directing; liaison for Chaplaincy.
Training and Seminars	Training of volunteer Chaplains and support staff.
Presentation of L.E.C.	To community and other law enforcement agencies.
Fundraising Programs	Churches, businesses, community, United Way, payroll deductions, etc.
Pulpit Filling	Various churches in the community.
Public Relations	Information, media, community, brochures, video, newsletter, department employees.
L.E.C. Board Meetings	Planning and fiscal budgets, programs, generic "reports".
Reporting	Chaplaincy statistics to Law Enforcement agencies.

SCOPE

The Placer County Law Enforcement Chaplaincy, located in Placer County California is a 501(c) (3) Non Profit Incorporated Ministry established in 1986.

It is governed by a Board of Directors consisting of 9 members including Corporate Officers acting as President, Vice President, Secretary and Treasurer. Board members are from local law enforcement management; business leaders, and members of the clergy.

At the time of the revising of this manual in 2007, the Chaplaincy Staff consists of the following:



Honorary K-9 Chaplain, Max. Max has four legs, one tail and a big heart. He is a big Golden Retriever mix, who works with one of our Chaplains who has physical disabilities that require the use of a service dog. "Chaplain Max" has a lot of extra training in working with children and is used in grief and crisis situations. Max is a "natural" as her partner working with kids. They love him, and he is a great tool in getting (especially young) kids to open up to the Chaplain.

Law Enforcement Chaplains assist with calls involving officers and their families. They do ride-alongs and agency visits. They are ordained or licensed ministers, with the ability to legally invoke confidentiality. Community Chaplains may or may not be licensed or ordained ministers that serve the community. All Chaplains respond to emergency call-outs involving deaths or critical incidents in the community but typically do not work directly with officers or their families, deferring to the Law Enforcement Chaplains for work with the Law Enforcement community.

The Chaplaincy and its staff work as reactive responders on call, or as pro-actively involved with or to the agencies and citizens of Placer County.

LAW ENFORCEMENT CHAPLAINS – Minimum Requirements

- Formal ordination or licensing by a recognized church or denomination of churches, and be a member in good standing and endorsed for the Chaplaincy by a recognized religious denomination. We encourage the ordination or licensing of women; as some situations a woman may be more effective than a man and her serviced should be obtained
- Three years of formal graduate or post-graduate theological training in a recognized school or seminary.[1]
- Five years of ministerial experience, preferably pastoral, under the supervision of a properly constituted church.
- Formal endorsement for law enforcement chaplaincy from a properly constituted church or religious body attesting to the moral and ethical character of the applicant and their willingness to oversee that person's life and conduct.
- Adherence to the rules of confidentiality as set forth by the State of California.
- Be tactful and considerate in his/her approach to all people, regardless of race, creed or religion.
- A Commitment to serve as a Community Chaplain (CCRT) for a minimum of one year (12 months) prior to becoming a Law Enforcement Chaplain.[2]
- Upon becoming a Law Enforcement Chaplain; fulfill the basic service requirements of: being on-call to provide emergency crisis response for a minimum of one 24 hour period per month; doing a minimum of one ride-

[1] Requirement may be waved with fulfillment of a minimum of 1 year of service as a Community Chaplain at the discretion of the Senior Chaplain, and approval of the Board of Directors.

[2] May be waved at discretion of Senior Chaplain and approval of the Board of Directors if the applicant has recent Law Enforcement Chaplain experience.

along per month at an assigned agency; attending a mandatory monthly in-service training; and completing and timely submitting a monthly statistical activity report.
- Must possess a valid California Driver's License and proof of insurance.
- Must have a current health insurance policy in effect.

A Chaplain must possess all the above and be willing to be screened before appointment. Screening consists of an application, endorsement, background check, resume and interview.

COMMUNITY CHAPLAINS – Minimum Requirements

- Active member in good standing with their church. Formal endorsement for Community Chaplain (CC) from a properly constituted church or religious body attesting to the moral and ethical character of the applicant and their willingness to oversee that person's life and conduct.
- Demonstrated ministerial leadership in their church. This could include but is not limited to such things as Men's or Women's ministry, teaching Sunday School, Deacon/Elder/Board leadership, worship team, etc.
- Prior to assignment of duties as a Community Chaplain, each CC must complete specialized training by Placer County Law Enforcement Chaplaincy (PCLEC) and pass an FBI/Law Enforcement Agency background check.
- A period of field training will be undertaken after the class room instruction. During that time, the recruit will be on probation, and will be required to "shadow" an experienced ("seasoned") Chaplain until such time as they meet the field training requirements of PCLEC.
- Upon completion of class room and field training, the CC recruit will be asked to sign a commitment to serve as a Community Chaplain (CC) for a one year (12 months) assignment. Annual commitments may be renewed, provided satisfactory performance reviews and Board approval is granted at the beginning of the next fiscal year.
- Upon becoming a CC; each Community Chaplain must fulfill at a minimum the basic service requirements of: ① Being on-call (and responding) during one 24-hour period each month, ② Providing timely emergency crisis response, ③ Attending a mandatory monthly in-service training, ④ Completing Monthly Activity Reports, and ⑤ Making at least one visitation to a dispatch center, substation, first responder (other than Law Enforcement) per month as assigned by PCLEC management.
- Must possess a valid California Driver's License and proof of automobile insurance.
- Must have a current health insurance policy in effect.

A Chaplain recruit must possess all the above and be willing to be screened before appointment. Screening consists of an application, endorsement, background check, resume and interview.

Note that pursuant to Labor Code Section 3352I, all volunteer workers of PCLEC (both Chaplains and support "staff") are not entitled to Workers Compensation Benefits.

UNDERSTANDING REGULATIONS AND PROCEDURES

The Chaplain should have a basic knowledge of the duties of Law Enforcement officers and seek to keep abreast of new procedures, and be willing to attend training sessions and programs at the agencies.

The Chaplain shall conform to all Law Enforcement procedures insofar as applicable.

The Chaplain on duty should be available to the dispatcher or Emergency Call-Out Chaplain (ECO), at all times either by pager or cell phone. If the Chaplain is on vacation or out of town, he/she will designate Chaplains to act in their absence.

The Chaplain shall not publicly criticize the action of any Law Enforcement officer, department official, fellow Chaplain or department policy or action. Don't fall into the trap of criticizing management. Remember, you are the Chaplain for the entire department, which includes management and line officers.

The Chaplain shall not release any information to the news media or insurance agencies or attorneys regarding cases in which he is involved. All information should be held in strict confidence and used only for the benefit of the person or officers involved.

In the field of religious guidance, he/she is an advisor to the Law Enforcement agency administrators in all matters pertaining to the moral, spiritual and religious welfare of law enforcement personnel.

Show your concern for officers. Nothing says you care more than sincerely asking an officer if he/she is okay after a critical incident.

DEVELOPING THE CHAPLAIN'S ROLE

Availability: Part of the Law Enforcement Team

A Chaplain's duties are similar to those of a military chaplain – the person who is always there when the officers and their families need them. Just as a pastor cannot serve his people unless he is one of them, neither can the Law Enforcement Chaplain serve the Department unless he/she is a part of the Law Enforcement Team. Officers cannot wait for the Chaplain to come to them. The Chaplain must go to them! They must meet those who need his/ her services wherever they may be; at the station house or in a patrol car; at the scene of a disturbance or disaster; in the hallway, office or at social functions; as well as their homes.

Remember that Law Enforcement officers spend most of their time in a squad car. Their car is in affect their office. It is vitally important that the Chaplain do regular ride-alongs. The officer is most comfortable in his or her own "office" and will be most likely to open up to the Chaplain there.

Counseling of Law Enforcement Officers

Counseling is an important part of the Chaplain's work. More and more Law Enforcement Officers and their families seek out the counseling services of the Chaplain. The Chaplains needs to be able to provide counseling and consultation, at a basic level, for law enforcement personnel and their families in areas such personal concerns, marital, family, job-related and other problems.

Unique Demands

There have been drastic changes in Law Enforcement Service over the years. Today, more than ever, the Law Enforcement profession is unique in its demands. According to Clarence M. Kelly, former Director of the Federal Bureau of Investigation, "The time has come for Americans to understand and appreciate - the humanitarian nature of the Law Enforcement profession - in more than thirty years in the Law Enforcement profession, I have known thousands of officers - they are human. They have emotions." (FBI Law Enforcement Bulletin - December 1, 1973).

High stress occupation

Law Enforcement officers are subject to the same kinds of feelings and tensions as other people. They are also subjected to stressors and tensions not experienced in other professions. Law Enforcement work is considered a high stress occupation that involves considerable provocation on a day-to-day basis. The many pressures of the job create an added burden on the officer which may affect his physical, emotional and personal well-being. Law Enforcement work is an occupation requiring a high level of emotional stability.

Family or job-related problems are likely to interfere with optimum performance on the job. It is important that counseling services be made available to Officers and their families, particularly those with stress-related problems.

Confidentiality - Privileged Communication

The Law Enforcement Officer who comes to the Chaplain for counseling should clearly understand that this is an "off-the-record" and "privileged" communication. Anything said in the patrol car stays in the patrol car. It will not be reported to their Superior or have any bearing on his or her job status. This element of confidentiality is very important to the over-all effectiveness of the Chaplain and his/her rapport with the men and women of the agencies they serve. If confidentiality is ever broken, it will damage the reputation of the Chaplain and the Chaplaincy program. Once that trust is broken, it is extremely difficult to ever get it back.

Referral to Other Professional Resources

The role of the Chaplain is generally short term. The Chaplain will most likely be able to offer only a brief, short- term, crisis-oriented type of counseling in most cases. If it is determined a long-term counseling program is desirable for a particular officer or family member, a referral may be made to an appropriate

community agency or to a marriage counselor. However, the Law Enforcement Chaplain must keep in mind that serious crisis-oriented problems can arise in a law enforcement officer's life and he should be available to offer immediate help with the understanding that other professional help may be recommended when the crisis passes.

Cooperation With Other Law Enforcement Chaplains

The Law Enforcement Chaplain needs to stay in touch with other chaplains, not only in their own area, but throughout the country. The question has often been asked, “Who does the Chaplain turn to for help?” The Chaplain should become involved by attending meetings, conferences, and workshops in order to find out what other departments and chaplains are doing. Networking of chaplains throughout the country is vital to the success of the local Chaplaincy efforts. We encourage our Chaplains to become involved with a good national Chaplain Organization.

There may be times when a call crosses city or county boundaries which may require you to cooperate with the Chaplain from another department. An example would be an officer who lives in one city, or county, but works for an agency in another. If something happens to the officer while at home, the other Chaplaincy may hold jurisdiction. By building relationships before something like this happens there can be mutual aid and/or a smooth transition to the call out.

VOLUNTEER CHAPLAINCY

It is the responsibility of the Senior Chaplain and Supervisory Chaplains to organize train and supervise a corps of Chaplain Volunteers. This Corps shall be composed of duly ordained or licensed clergy who desire to serve the Law Enforcement community. A Corps of Community Chaplains is also a great asset to any Chaplaincy program. (See minimum requirements for Law Enforcement and Community Chaplains)

The purpose of the Chaplain Corps is to assist the Senior Chaplain in ministering to the agencies and community. The Senior Chaplain is responsible for the Proactive and Reactive outreach ministries and Administrative duties of the Chaplaincy.

Nomination and Appointment

People interested in serving with the Chaplaincy must complete an Application Form (see Appendix A) setting forth personal information, their experience, education, and willingness to actively participate.

The Senior Chaplain and Supervisory Chaplains shall review and give careful and prayerful consideration to each application submitted, considering the effect on the overall Chaplaincy Program.

Chaplains will be approved on a year-to-year basis and must sign a new *Annual* Commitment *Letter* agreeing to the terms of the Chaplaincy (See Appendix B).

ORGANIZATIONAL STRUCTURE AND DESCRIPTION OF THE CHAPLAINCY

Board of Directors

Specific duties, terms and limitations are referred to in the Chaplaincy Articles of Incorporation and By-Laws.

The Board is generally comprised of law enforcement officers representing various agencies within Placer County, business professionals, and clergy.

The board has officers holding positions of president, vice-president, treasurer and secretary.

In general, the Chaplaincy Board is to set and review Chaplaincy policy; act as personnel Board for the Chaplaincy; hold regularly scheduled Board meetings; review Chaplaincy reports issued by the Senior Chaplain and designated personnel; offer support and suggestions to programs and ministry; assist in maintaining the integrity of the ministry; be stewards of Chaplaincy funds.

Various Staff Positions

Senior Chaplain**:** Reports to the Chaplaincy Board of Directors and is responsible for all matters pertaining to Chaplaincy Program operations. He/She is also responsible for Administering and Supervising the Chaplaincy Program and overseeing the Pro-active and Reactive outreaches of the supervisory and Associate Volunteer Chaplains. This is a paid, full-time position.

Deputy Senior Chaplain: Assists the Senior Chaplain, and acts in his or her stead in their absence. He/She manages special units (i.e. Law Enforcement Chaplains) under the direction of the Senior Chaplain. The Deputy Senior Chaplain is second in rank only to the Senior Chaplain, and is similar in role to a Captain, or Undersheriff and a member of the Executive Team. This is a paid, full-time position.

Assistant Senior Chaplain: Assists the Senior Chaplain and Deputy Senior Chaplain in carrying out the administrative duties and general responsibilities of the Chaplaincy program. He/She manages special units (i.e. Community Chaplains and Chaplaincy Support personnel) under the direction of the Senior Chaplain. The Assistant Deputy Senior Chaplin is third in rank and is similar to the role of lieutenant, or Assistant Sheriff and a member of the Executive Team. This is a paid, part-time position.

Supervisor Chaplains: Carry out the directives and the Executive Team and supervise the day to day activities of the Associate Volunteer Chaplains. The Supervisor Chaplains are responsible for dispatching Emergency Call-Out (ECO) responses and other Chaplaincy activities that take place in their region. They

help to insure that the quality of activity response is maintained. The Supervisor Chaplains work under the direction of the Senior Chaplain and are considered part of the Chaplaincy staff.

Supervisory Law Enforcement Chaplains are required to keep close contacts with the Law Enforcement Agencies in the County and Patrol Sergeants through weekly visits and walk-throughs. They are required to attend monthly Briefings and Ride-Alongs, and formally or informally meet quarterly with each Chief or Agency Commander for coffee/lunch, etc.

They communicate regularly with the Associate Chaplains and assist with the Volunteer Associate Chaplain training. They collect and summarize monthly activity reports of all Chaplains reporting to them the Executive Team during regularly scheduled staff meetings. This is a volunteer position.

Field Training Officer-Chaplains (FTOs): Works with Supervisor Chaplains to help with the training of new volunteer Chaplains. He/She should have experience as a Chaplain, and demonstrate leadership ability among their peers. Field Training Chaplains report back on the progress of new Chaplains, and encourage and instruct them as mentors in the field. This is a volunteer position.

Communications Chaplain: Acts as the liaison between the Senior Chaplain's office and all of the volunteer Chaplains. He/She must have strong verbal and written communication skills and effective leadership skills. The Communications Chaplain will regularly communicate information to all Chaplains and make sure no one is "left out of the loop". This may be accomplished through e-mail, phone calls, etc. This is a volunteer position.

ORIENTATION AND TRAINING OF THE VOLUNTEER CHAPLAIN

Law Enforcement Chaplains

Upon completion of the application process and acceptance to the program, each volunteer Law Enforcement (LE) Chaplain will be required to begin a training program which consists of the following:

- Personal Interview with the Senior Chaplain Staff
- Completion of Law Enforcement Chaplain Academy
- Ride-Alongs
    - Orientation ride-along with the Senior Chaplain Staff
    - Ride-Alongs with Training Sergeants from a Placer County Agencies
- Final interview with Senior Chaplain Staff

The LE Chaplain candidate will be issued a Chaplaincy picture ID card during the initial training period. A Chaplaincy badge, wallet and ID number will be issued upon completion of the initial training period.

Community Chaplains

Upon completion of the application process acceptance to the program, each volunteer Community Chaplain will be required to attend a training program which consists of the following:

- Completion of BASIC training
- Completion of the Advanced Academy
- Personal interview with the Senior Chaplain Staff
- Completion of 30 Shadow Hours in Emergency Call-Out situations

The Community Chaplain (CC) will be issued a Temporary Trainee Card after graduation from the Advanced Academy. A Chaplaincy picture ID card will be issued upon the completion of the initial training period.

Uniform Requirements

Each Chaplain will be required to wear the appropriate Chaplaincy uniform while on ride-alongs, visits to law enforcement agencies, or on calls for service. The basic Chaplaincy uniform consists of:

Law Enforcement Chaplain Uniform	Community Chaplain Uniform
Black shoes and black socks	Black shoes and black socks
Black slacks with black belt	Black pants with black belt
LE issued logo shirt (royal blue)	CC issued logo shirt – burgundy
LE trainee shirt (gray w/logo)	CC trainee shirt (white w/logo)
Black Logo Jacket	Burgundy Logo Jacket
Visible Photo ID badge & pocket badge	Visible Photo ID badge

Both Law Enforcement Chaplains and Community Chaplains should carry a Fanny Pack or a Chaplain's Bag with the following contents:

- Small Bible
- 3x5 Cards
- Rubber Gloves (for Universal Precautions)
- Reflective vest or arm bands
- Flash light and extra batteries
- Black Ink Pen
- Ten Codes
- Business Cards
- Hand Cuff Key (LE Chaplains)

Monthly Commitments

Each Chaplain must be able to accomplish the following on a monthly basis:

- Agency Visit
  - LE Chaplain: One ride-along in assigned agency
  - LE Chaplain: One office visit/walk through starting with the Chief's office, going through dispatch and briefing in assigned beat.
  - CC: One agency visit (Dispatch, first responders, fire departments)
- Attend Chaplaincy Monthly Training
- Be available for crisis or emergency response a minimum of one 24-hour period per month, or three 12-hour periods per month, or five 8-hour periods per month.
- Complete Emergency Call-Out Report (ECO) for every emergency call out; reporting information should include contact information for the person(s) assisted, type of call, Agency/Department requesting the call out, etc.
- Complete Monthly Activity Reports and submit no later than the 7th of the next month.

The Chaplain's Role Defined

The Chaplain is not a law enforcement officer, but a representative of God, duly ordained or licensed and approved, an experienced representative of their denomination. Their responsibility is to assist all Officers, upon request, on matters within the Chaplain's realm. He/She shall not, in any way, interfere with an Officer in the performance of his/her duties, but be subject to the authority of the officer on duty.

The Chaplain is authorized to visit the Law Enforcement Agencies within Placer County and the offices of law enforcement personnel. They may have access to all buildings and scenes where the presence of Law Enforcement Officers indicates their requirement of need for the~~ir~~ services of a Chaplain. The Chaplain shall carry on their person the Identification Card issued by the Chaplaincy and wear the appropriate Chaplaincy attire or uniform. The Chaplain, when on duty, shall properly identify themselves, be courteous, and conduct themselves in a manner becoming their role and ministry. For this Purpose, the Chaplain may

converse with any member of the department whenever the need for Chaplain services arise.

The Chaplain's Aspiration

Believing that God is the answer to man's dilemma, the Chaplain stands ready to bear witness to the forgiving love and redeeming power of God, through Jesus Christ, to all people, especially to those in crisis. They pray that God will guide their thoughts, words, and actions. They seek to be a channel of God's love. They desire to serve as a source of support and counsel to the Law Enforcement Community.

Duties and Responsibilities

As part of their official duties with the Chaplaincy, Chaplains are expected to respond and react to such duties that may be requested of them by the Law Enforcement Agencies. Some of these duties include, but not limited to:

- Death notifications
- Suicide threats, attempts and completions
- Deaths of children
- Fatal accidents
- SWAT operations
- Violent crimes against people
- Sex crimes
- When an officer is seriously injured or has died on duty, respond to the hospital emergency room, on request, and identify themselves to the hospital staff and the hospital chaplain and work with both according to common ethical courtesies. They shall be part of the death notification team to the officer's family.
- Counsel Officers and families with personal problems, marriage and family, stress, etc., according to your authorized level of training.
- Be on call and on the street during any major demonstration in the city or any public function requiring the presence of a large number of Law Enforcement personnel.
- Visit sick and injured Law Enforcement personnel at home or in the hospital.
- Attend and participate in funerals of active as well as retired members of the Agency or Department.
- Conduct memorial services.
- Assist department officials in making notifications to families of law enforcement personnel who are injured or killed.
- Participate in "in-service" training classes, as attendees or instructors.
- Be willing to enter into training courses to enhance his/her effectiveness
- Periodically attend roll calls or briefings.
- Do regular ride-alongs with Patrol officers.
- Attend Departmental graduations, promotions, award ceremonies, dinners, social events, and offer invocations and benedictions.
- Officially represent the Department, as requested.

- Be responsible for the organization and development of the spiritual organizations in the Department.
- Public relations efforts.
- The Senior Chaplain will recruit, train, deploy, supervise and evaluate a team of volunteer Chaplains to assist in performing the ministry. Each volunteer will report in writing to the Supervising Chaplain regarding services rendered (See Appendix C). Privileged information will not be included in the report.

Agencies We Service

Auburn Police Department
California State Parks and Recreation Police
California Highway Patrol – including local offices within in Placer County
Lincoln Police Department
Office of Emergency Services
Placer County Sheriff's Office – PCSO (including sub-stations within the county)
Placer County District Attorney
Placer County Probation
Rocklin Police Department
Roseville Police Department
Sacramento Division of the Federal Bureau of Investigations (FBI)

WHAT MAKES A GOOD CHAPLAIN

1. Desire To Minister
2. Desire To Know
    A. The Law Enforcement Chaplaincy Training Manual
    B. The purpose and reasoning behind its creation
3. Who We Respond to
    A. All Law Enforcement Agencies
    B. Every emergency called to
    C. The Officers and their families
    D. The Community
    E. With Confidentiality
    F. With Credibility
4. The Ride-Along
    A. Things to Remember
        i. We earn the right to ride in the right-hand seat.
        ii. We have a ministry of Presence.
        iii. We must be an asset not a liability.
        iv. We must be prepared to help the Police Officer in ANY Situation.
    B. Things to Know on Ride Alongs:
        i. 10 and 11 Codes
        ii. How to operate: Radio, Shot Gun Release, Sirens, Spot Lights, and Scanner
        iii. Ask for spare patrol car key while riding

5. Weapons Training
    A. Willingness to protect their own life and to save and protect the life of the officer they are with.
    B. Know the shot gun: firing loading, and releasing
    C. Know the different kinds of hand guns used by officers.
6. Critical Incident Stress Debriefing
    A. Procedures used and reasoning for
    B. Post Traumatic Stress Syndrome
7. Crisis Reaction
    A. A normal response to an abnormal situation
    B. Profile of Crisis
    C. 5150 – Mental Case, Self Endangerment
8. Death Notification
    A. Dealing with Grief
    B. Stages of Grief
    C. SIDS
9. Suicide
    A. Threat
    B. Attempt
    C. Completion
    D. Survivor of
    E. Don't be afraid to talk about Suicide
10. Stress
    A. Chaplains
    B. Chaplains Families
    C. Officers
    D. Officers Families
    E. Civilians
    F. Understanding Stress Management
    G. Understanding Burnout
    H. Having a good referral system
11. Listening
12. Post Shooting Trauma
13. Referral References
14. Crisis Information

LE CHAPLAINS GUIDELINES FOR EFFECTIVE SERVICE

<u>The DO's:</u>

1. Have approval/backing of your local church (governing bodies).
2. Learn to Ride – listen, observe, etc.
3. Ride to Learn – earn privilege to ask questions
4. Remember, patience is a virtue.
5. Take time to develop trust.
6. As Hawkeye told Dr. Frank Burns in a MASH episode – "Remember your hypocritical oath" …Confidentially help that person.
7. Remember - police function in a para-military system…learn it.
8. Learn to appreciate fellowship of `team' members.
9. Develop an understanding of the "fraternity" of law enforcement officers.

10. Develop "sensitivity" to the uniqueness of Law Enforcement Officer's needs.
11. Learn to tolerate teasing.
12. Ride with the officers; visit roll call sites (post, stations, as these are good places and times to get acquainted and to learn things about the officers.
13. Attend social functions.
14. Get to know the minister, pastor, priest or rabbi of the officer.
15. Develop a basic knowledge of the officer's work responsibilities.
16. Learn the lingo; the basic radio code signals, legal jargon peculiar to the respective department.
17. Develop a working knowledge of the organizational structure of the department.
18. Be able to identify the various rank insignias within the respective departments.
19. Congratulate personnel on birthdays, weddings, anniversaries, promotions, positions, etc., as is appropriate.
20. Be Visible, Available, Adaptable and maintain Credibility.
21. Volunteer to assist.
22. Listen to radio and/or scanner if available.
23. Go in on runs - but don't interfere.
24. Be loyal to the officer and his superior, serving as a bridge or link between them.
25. Respect the officer's religious views or lack of them.
26. Earn the officer's personal respect and confidence.
27. Be contagiously honest.
28. Identify with the person-problem – Come up with viable options
29. Be positive and optimistic.
30. Be a good stroker – always be courteous and sincere.
31. Be aware of community agencies for referral purposes.
32. Be "Real" - Remember actions speak louder than words.
33. Maintain confidentiality.
34. Be a good listener – there are at least two sides to every story.
35. Be trustworthy – be a team member and be a play-maker.
36. Be neat and clean in appearance.
37. Keep informed.
38. Be the spiritual leader - primarily be an example.
39. Do carry an easy, confident manner balanced with humility
40. Remember: if you lose your credibility, you have nothing to offer.

The DON'Ts

1. Don't be priestly or preachy.
2. Don't get involved in police department politics or inter-department politics.
3. Don't promise more than you can deliver.
4. Don't try to be one of the boys' - swearing, drinking, dirty jokes, etc.
5. Don't think you have `license' to evangelize.
6. Don't appear to have all the answers or think you have to have "all" the answers (you won't even know the right questions for some time).
7. Don't cut law enforcement agents short, a veteran officer will understand 'people' (dynamics of inter-personal relations don't come from a book).
8. Don't get in the officers way while he is performing his duty.
9. Don't assume acceptance by officers.

10. Don't forget you are chaplains to all officers.
11. Do not over identify with the situation; remain objective.
12. Do not interfere with management operations (setting policy, arranging transfers, etc.)
13. Do not confuse the role of the Chaplain with that of the officer.
14. Do not try to throw your weight around; status must be earned.
15. Do not get your exercise by jumping to conclusions.

Police Officers Deal with…

The Extremes of Life: Is what a Cop sees everyday on the job. They regularly see the very worst that society has to offer. They deal with the career criminals, dead children, and constantly being lied to by people in the community.

The Lack of Accomplishment: They Don't See The Finished Product of their Work. A carpenter sees a building they built that may last long after they have died. A cop arrests a criminal, and sees him back on the street before he has even finished the paperwork in some cases.

Paranoia: Cops say to their wife, "Don't tell anyone that I am a Cop." Over time, they may develop an attitude that they can trust no one but themselves and their partner – and they are not sure about their partner!

Ingrouping: Having only Cops friends. They begin to get an “Us versus Them” mentality.

WHAT IS A CHAPLAIN

The following outline was taken from an International Police Chaplain Conference (ICPC) held in Des Moines, Iowa 1992. Speaking about the volunteer and part-time Chaplain, instructor Bruno Kemp offered the following insight to the role of the volunteer/part-time Chaplain. Reprinted here by permission.

1. We are Chaplains

A. Our role is not to Proselytize
B. Chaplaincy is a Ministry of Presence
C. Suicide: The answers to the why questions are not always important, rather. “I am here and my faith will help carry these people to some degree.”
D. Do they have a Pastor? If not, I am here.
E. Crisis Situation – being able to step outside of our denomination as a Chaplain and help people where they are at.
F. See a need and meet it.
G. Sometimes being out there is an uncomfortable place to be.
H. Being out there though, verbalizes through our actions and our presence that “God is still alive.”

I. Know your own limitations – get in touch with your own feelings about what we do.
J. How you feel will control how you act and react to each situation.
K. How do you feel about: Alcoholics, Suicide, Tragic Deaths, Death of Children, Murder, Rape, and Abuse?
L. Don't forget your own families and your congregation along the way.
M. There are no simple solutions.
N. Don't lose sight of your own Physical, Emotional, and Spiritual Health.
O. Teach by example – you can always say "No"

2. We are Police Chaplains

A. Police Officers – Get to know them.
B. Ride as often as you can.
C. 75% of all counseling is done in the Patrol Car.
D. In the car, the Officer is in control.
E. They think that nobody understands a Cop except another Cop – unless you ride with them.
F. Don't lose sight of who you are.
G. These people we are ministering to – aren't so weird, they even have to arrest Ministers and Priests, for things that we can't explain very well. Like a drunk Priest, for example.
H. Never forget that we are living in a very real world.
I. Know going into the Chaplaincy, Police Officers will test you….raunchy jokes, etc.
J. If you are honest with them, don't be afraid to challenge them – but not in front of other cops….example, "Did you have to use that much force or night stick?"
K. Talk about it, but don't embarrass the Officer.
L. We must first earn the right to ask.
M. As a Policy Chaplain, let them get to know you.
N. Cops won't call us unless they know how we operate.
O. We must know the Rules and Procedures for incidents – Swat, Traffic, Suicide, and Disaster.
P. We don't need loose cannons out there.
Q. If a Cop says, "How about riding with me sometime?" It usually means "RIGHT NOW" I want to talk.
R. Make time to ride with him/her. Take the time to learn their language.
S. Don't go from the briefing room to the Captains Office.
T. Don't abuse the system.
U. Don't use your badge or ID to talk your self out of a ticket. If you do, you will lose because you become one of "them"!
V. We are Ministers of the Gospel – we are an example.
W. Live what you preach.

3. People we work with, the man behind the badge

Personality Traits of Officers

A. Obsessive-Compulsive Personality
B. It makes them good at details.
C. Flip Side – Perfectionist
D. Don't take criticism well
E. Cynicism can set in

Histrionic: People in the middle of tragedy and not affected at the time of the tragedy.

A. Aggressive
B. Domineering
C. Confronting

Control People: Trained to take control

A. People call a Cop when they are out of control. We learn that we can't control everything in our life.
B. Know the 3 Step 12 Step Plan:
    i. I Can't
    ii. God can
    iii. Let Him!!
    iv. Cops Are Action Oriented
    v. Use hands, not minds
    vi. They look for immediate gratification
    vii. They have a strong need to be needed
    viii. Strong and ethical values, but maybe not our values.
    ix. They like things to be Black and White
    x. Good guys or bad guys
    xi. Often disillusioned by what they see.
    xii. Team Players who have strong loyalties
    xiii. They adopt the image to be one of the boys.

Physiologically Immature Emotionally

A. They have immature relationships
B. 70% of Cops after 3 years are in divorce or in their third marriage.
C. They don't talk to their wife, so their wife buys a scanner to know what they are doing. They need to ask their wife if she wants to hear about their day. If she says no, at least they have communicated.
D. Cops make lousy partners, but good caretakers.

Ask: Why did you become a Cop?

A. 65% to 70% of adult children of alcoholics go into service organizations. Cops and Chaplains are service organizations.
B. Their Answer:
    i. I want to help people.
    ii. I want to solve the crime and catch the crook. (If this is their answer, they become very suspicious of people and treat their family with suspicion.)
    iii. I want to become somebody. (Then only cops are somebody and everyone else is nobody.)

iv. I need a job because I have a wife and 2 kids to support. (This is the healthiest perspective.)

Our perception of any given situation controls the stress level.

A. Stress is how I perceive the situation.
B. They see situations as them against us.
C. We can help them change their perceptions, if we care enough to be out there with them.
D. They need to have a strong support system and we are it.
E. Develop team work - Look out for Your Partner
F. Establish your credibility!
G. Don't Underestimate the Value of Riding in the Right Hand Seat!

TEN COMMANDMENTS FOR LE CHAPLAINS (Source unknown)

1. Thou shalt love the Lord thy God with all thy being, realizing that the depth and quality of that love is constantly scrutinized.

2. Thou shalt love thy Law Enforcement Department and all its personnel, even as thou dost love thyself.

3. Thou shalt perform they Chaplain's duties at all times in a professional and godly manner.

4. Thou shalt be faithful to all thy appointments, schedules, commitments, and engagements, punctually fulfilling all of them.

5. Thou shalt show partiality to no one, whether he be the chief of police or the newest rookie, but shalt seek to love and serve all alike.

6. Thou shalt never use thy privileged place as a position from which to proselytize or to grind thine own private ax.

7. Thou shalt guard thy tongue at all times, so as never to divulge or violate a confidence.

8. When thou rides with a Law Enforcement Officer, thou shalt remember that thou art a guest; therefore, be courteous and warm.

9. Thou shalt never grumble or complain because of what is expected of thee, but shalt remember thy servant’s role.

10. Thou shalt maintain a humble spirit at all times, remembering that though thou art a religious specialist; not all wisdom and knowledge concerning God shall die with thy demise.

PUBLIC PRAYER IN A PLURALISTIC SOCIETY

Guidelines for Civic Occasions

Spoken prayer is common on many civic occasions such as club meetings, legislative sessions, graduations, political rallies, testimonial dinners and community forums. Prayer in settings which are primarily secular should bind a group together in a common concern. However, it can become divisive, even if not intended, when forms or language exclude some persons.

Individuals who lead the general community in prayer have a responsibility to be clear about the purpose as well as the nature of the occasion. Prayer on behalf of the general community should be general prayer. General prayer is inclusive, non sectarian and carefully planned to avoid embarrassments and misunderstandings. Those who are reluctant to offer general prayer should be given the option of declining an invitation.

General public prayer on civic occasions is authentic prayer that also enables people to recognize the pluralism of American society.

Prayer of any kind may be inappropriate on some civic occasions. Decisions should show respect both for public diversity and for the serious nature of prayer.

General Public Prayer

- Seeks the highest common denominator without compromise of conscience.
- Calls upon God on behalf of the particular public gathered; avoids individual petitions.
- Uses forms and vocabulary that allow persons of different faiths to give assent to what is said.
- Uses universal, inclusive terms for deity rather than particular proper names for divine manifestations. Some opening ascriptions are "Mighty God," "Our Maker," "Source of all Being" or "Creator and Sustainer." Possible closing words are "Hear Our Prayer," "In Thy Name," "May Goodness Flourish," or, simply, "Amen."
- Uses the language most widely understood in the audience, unless one purpose of the event is to express ethnic/cultural diversity, in which case multiple languages can be effective.
- Consider other creative alternatives, including a moment of silence.
- Remains faithful to the purposes of acknowledging divine presence and seeking blessing, not as opportunity to preach, argue or testify.
- These guidelines for inclusiveness and sensitivity on prayer should also apply to the content of meditations or addresses on civic occasions, and to the selection and performance of music.

Prayers That Hurt

The following, are several testimonials of how prayer can be used to exclude and hurt others whose faith may differ from the chaplain offering the general prayer. These words express more powerfully any words we could offer on the topic.

Public Prayer in Interfaith Settings
Source Unknown

In the Mekong Delta, it was a Protestant chaplain - Les Westling - who helped me grow as a Jew, and who helped me decide to become a rabbi. With his help, I discovered the love within Judaism; because of his help, I discovered love within Christianity.

After the terrorist truck bomb attack in Beirut, when my skullcap, my Kippa, was lost in the rubble and misery, it was a Catholic chaplain - George "Pooch" Pucciarelli - who cut a circle of cloth from his own Marine camouflage cap to take its place. For others, the Kippa was a symbol of Judaism; for me, his action made this one a symbol of Christianity.

The Talmud tells the story of a Jew who bought a camel from an Arab, only to discover a precious gem hidden in the saddle, of which neither the seller nor the buyer had been aware. When the Jew returned it, the Arab's reaction was one of respect and appreciation for the Jewish faith, for it must be praiseworthy, he said, to teach a man such honest ways.

Colleagues like Les and Pooch helped me to understand the lesson of this Talmudic story; it does not take words to witness for one's faith. It takes love.

Knowing What Hurts
Sources Unknown

A story from rabbinical tradition tells of two long-time friends:

"Do you love me?" (One friend asks the other)

"Of course."

"Do you know what hurts me?"

"No, what hurts?"

"How can you say you love me if you don't know what hurts me?"

When my father died two years ago, a fellow chaplain wrote to me with the prayer that I would accept the resurrection of Jesus.

> *'Without that acceptance', he wrote, 'it must*
> *seem truly hopeless to bear the death of a loved one.'*

Many other notes from chaplains brought me comfort during that time of grief; this letter brought me pain.

At the 1980 Navy Chaplain Corps Worship, a chaplain began by stressing the need for us to work together as a team during the decade which was about to begin. Inviting us to join together for a moment of prayer, he ended the prayer in the name of the Trinity. I could not add my Amen. Hadn't I been invited to pray with the group? I felt out of place. I wanted to be a part of this prayer, as we faced the future together-and it hurt me that I could not.

Few chaplains would write to me to tell me that there can be no basis for comfort within Judaism, but there are many who let me know that there can be no basis for prayer. We may work together, but we cannot face God together, as servants or as children, not even for a moment. There are times, of course, when the slight is unintentional, and the chaplain simply does not realize that inviting me to join in prayer and then using words which I cannot say is the same as inviting me for dinner and serving food I cannot eat. But there are other chaplains who understand that there are words and expressions which exclude non-Christians, but they see the question of public prayer on an academic plane.

For me, it is not an intellectual question, nor even one of "interfaith relations," a phrase which brings to mind meeting of religious bodies, rather than actions between human beings. When I raise the issue, as I do in this article, it is an attempt to share feelings among friends. It is an effort to let others know what hurts.

Article ~

PUBLIC PRAYER

By Chaplain Resnicoff
Permission granted to reprint his article originally
appearing in the Military Chaplains Review. Date unknown.

A fundamental question for some chaplains has to do with whether it is appropriate for chaplains to participate in "civil ceremonies" at all. For some chaplains prayers made appropriate to civil occasions "water down" the true faith and open up the dangers of "civil religion."

My feeling is that such a danger is overshadowed by the far greater danger of the secular world, that it will be a place of no religion at all. A word of prayer at a civil or secular occasion can be a reminder that faith is not relegated to the synagogue or church. My concern is not simply that our people do not pray in the best way possible; it is that they do not pray at all - they have no relationship to prayer.

Our participation in public events can be a beginning. The danger of encroaching civil religion - and the fear of "watered-down" concern is not that most people do not pray in the best way possible; it is that they do not pray at all. If we fear the specter of "civil religion," we should fear the nearer danger of secularism even more; a world where religion is relegated to the confines of the church or synagogue, kept entirely away from the "real world." Our participation in public events can be a reminder of God's presence, a reminder of something holy - even a reminder of the idea of the holy - for those who have forgotten how to pray or how to dream.

Within our own faith groups we emphasize our particular beliefs and approaches to God. Before men and women of all faiths, we stress the ties that bind through a moment of awareness of the Presence of something larger than ourselves.

We need not begin with the founders of America to understand that there are times to speak of God in general terms. Millennia before the founding fathers celebrated this truth, it was a Biblical prophet Malachi who saw the cruelty of fighting in his time and cried out, "Have we not all one Father? Did not one God create us all?" (Malachi 2:10). His fear was not that he might water down God's word or forget the different cultic responsibilities of Jews and non-Jews. His concern was to remind the world of God's existence and the way that God's care binds all humanity together. In today's world, still torn by strife, it is no "danger" to share this prophetic message and no "cop-out" to follow this example. Instead, it is a challenge worthy of all our faiths.

From any newspaper we can see religion abused so as to tear people apart. Through a moment of prayer we can remind a cynical world that faith can and must be used to bring them together. When entire faith groups are excluded from our prayers, then a chance to face God together is lost. An opportunity to touch men and women of all faiths has become an occasion to relate to our faith group alone. Without prayer which includes all, an opportunity to teach that despite differences we must work together for common good remains a reminder of how separate we stand.

Each of us wears the cross or tablets which identify us as Christian or Jew. In public prayer we have the opportunity to say that our religion, Christianity and Judaism, teaches us to care for others, regardless of their origin. Whatever a public prayer should be, it should not be cruel or uncaring.

One of the most "general" prayers in the Bible is Psalm 117, the Bible's shortest chapter:

> *O praise the Lord, all you nations;*
> *Praise Him all you peoples;*
> *For His love for us is great;*
> *And the truth of the Lord endures forever.*
> *Hallelujah.*

Would such a prayer water down our faith?

Rights and Responsibilities

Does not each of us have the right to pray as he or she pleases? We can never be denied the right, or the ability, to pray. As has been written regarding the question of prayer in public schools, there will always be students praying so long as there are teachers handing out tests. In America, of course, we enjoy religious freedom as groups within our houses of worship, speaking to those who share our faiths.

It is the gray area of public prayer before interfaith groups, a modern phenomenon, that the question of the right of the speaker as over against the right of the listeners comes to the fore. For me it is helpful to remember a basic difference between the "law of the land", at least in the West, and the "law of the Bible." The former considers a situation from the point of view of rights, while the latter is more concerned with responsibilities.

When we accept the invitation or the assignment to participate in a public ceremony by offering a word of prayer, we understand that we are making a contract of sorts. Analogously we do not agree to participate in a wedding and then use the ceremony as the occasion to speak against the union. It seems to me, if there is a right involved, it is not the right to word the prayers as we please, but a right to be exercised much before the occasion: the right to decline to participate. It is the right of the chaplain who cannot offer a "general" prayer to decline, in the same way that we may choose not to participate in baptisms, weddings, or funerals.

If we accept the invitation, however, we have a responsibility to understand that we have been asked to add a reminder of the holy and challenged to touch and inspire those present through a moment of shared prayer. We have not been asked to preach nor to confess our faith. We have a responsibility to our conscience and our faith, but we also have a responsibility to those before whom we stand. Neither can be ignored.

Practical Consideration

At the most practical level, it is well for us to remember that participation in a civil ceremony may be only a small part of our ministry, but it often lays the groundwork for much of what follows.

There is a story of a young sailor who hesitated to speak to the chaplain when he saw that the chaplain's faith was different from his own. "Chaplain" he stammered, "I hope you won't try to change my faith." Don't worry, friend," the chaplain answered, "but together perhaps we can understand how our faith can change us."

Parents still send their children off to the military with the reminder that if problems arise they are to go "see the chaplain." What a wonderful basis for ministry. Because we are "religious," our people believe we must care about others. Often our civilian counterparts do not enjoy such good publicity. We learn from the prophets, religion includes a demand for justice-and so it is appropriate that chaplains are sought out when the military system seems unfair. We are men and women of faith, and so we are approached when others feel loneliness or pain or seek reason for hope.

When we offer public prayer, we are often being "sized up" by men and women who may one day need us. When our prayers disappoint the listeners, they may give us another chance - or even come to us for advice! But when our prayers hurt those who hear us, we may simply never hear from them. In my line-officer days I know that I would never approach a chaplain whose prayer denied my existence. When I try to teach Jewish sailors that they should approach "their" ship's chaplain for help, I often know they will not. "He doesn't care about me," they tell me. "You should hear his evening prayer..."

On the other hand, we should not underestimate the impact of inclusive prayers. We might think it is a neutral act to offer a general prayer, but it is not. It is understood, at least by many, as a positive action: a careful and inclusive word of prayer is an act of love.

Christian Theological Considerations

For many Christians, the New Testament gives a scriptural basis for "general" prayers. They point to Jesus' prayer as an example. When asked how to pray, Jesus began, "Our Father, who art in heaven... " (Matthew 6:9 and Luke 11:2). For another illustration of "general" prayers, they point to the words of Stephen recorded in Acts 7:60, "Lord, lay not this sin to their charge." Or "God, be merciful to me, a sinner," written in Luke 18:13.

Many of the New Testament epistles end with prayers offered in the name of Jesus, but in the Epistle to the Hebrews there is a simple prayer we might emulate today when ending an invocation or benediction, "Grace be with you all, Amen." (Hebrews 22:25)

There are verses in the New Testament, however, which some Christians understand to teach that the Christian faith requires prayer to be offered in Jesus' name. "Whatsoever you shall ask of the Father in my name, He will give it to

you." (John 16:23-26). This verse is sometimes translated a different way: "Whatsoever you shall ask of the Father, in my name He will give it to you." This rendering seems to teach something quite different, but keeping the first reading, how does this verse apply to the subject at hand?

For some Christians, the idea of praying with a phrase as "In His Name," "In Your Name," or In the name of the Lord," allows them to remain true to the verse and yet open enough to allow others to accept the prayer as well. Others accept the Trinitarian understanding that where one person of the trinity is present, all are present. A prayer to the Father, or to God's Holy Spirit, invokes Jesus as well. And for still other Christians, any prayer rooted in the love and faith of Christianity is in fact a prayer asked "in Jesus' name," regardless of what words are used. The word, name, in this context means more than a title, it means being or essence. Praying in His name means praying as His representative, praying as a person filled with His Love.

Finally for those who would interpret the verse most strictly, I offer a "Rabbinical" answer in terms of the struggle we share - the challenge to remain true to our faiths and yet offer something which can bring us together in faith, even for a moment. If the verse means that prayers asking for something must be offered in the name of Jesus, is it not acceptable to offer prayers which are not petitions in a different manner?

Can we not touch or inspire persons of all faiths through a word or prayer of praise? ("Whoever offers praise glorifies me." Psalms 50:23) Can we not offer a word of thanksgiving? ("This is the day the Lord has made; we will rejoice and be glad in it" Psalms 118:23) Christians can heed Paul's advice in Colossians 3:16 and Ephesians 5:19 to offer psalms and hymns, or drawing from the Roman Catholic Bible, Christians can follow the example of Ben Sirach and bear witness to God's presence through the glory of His world: "Behold the rainbow, then bless its maker." (Ecclesiastics 43:11)

For some Christians sharing the proclamation that "Jesus is Lord" becomes the proof of faith. "No one can say Jesus is Lord except by the Holy Spirit." (I Corinthians 12:3) Speaking these words becomes a way of invoking the presence of the Holy Spirit and therefore an important part of Christian prayer. But if we see the opportunity to offer prayer in a public setting, before men and women of all faiths, as a challenge or privilege and not a right, then the struggle must be to find other ways to proclaim our faith and other ways to make the moment holy.

My contention is that there are other ways for us all. We can search for other verses in the New Testament: "When we cry Abba! Father!" It is the Spirit Himself bearing witness with our spirit that we are children of God." (Romans 7:15f) But with or without specific verses we know we witness for our faith when it fills us with love enough to care about each other.

If it is a choice between an imperfect prayer or an action which will divide us at the very moment given to bring us together, then let us opt for the caring word and trust that God will understand. "The Spirit helps us in our weakness; for we do not know how to pray as we ought; but the Spirit himself intercedes for us with

sighs to deep for words." (Romans 8:26) From the thirteenth chapter of I Corinthians, we learn that love is better than prayer...even better than prophecy.

Jewish Theological Considerations

In some ways it may be easier for a Jewish Chaplain who is invited to participate in public prayer to offer an inclusive or general prayer. There are many verses in the Hebrew Scriptures which seem to assure us that there is no special formula for prayer. From the shortest prayer in the Bible (Numbers 12:13-five Hebrew words) to the longest (Deuteronomy 9:25- one that lasted forty days and forty nights), we understand prayer as a cry from the heart. "The Lord is near to all who call upon Him," Psalms 145), and so the exact words are less important than the act of prayer itself. After all, God hears us even when we do not use words at all. He hears and heeds the pain of slaves (Genesis 3:7) and the sighs of prisoners (Psalms 79:11).

In a beautiful discussion in the Talmud, the rabbis offer the story of the woodcutter who, lost in the woods, knows he will not make it to the congregation in time for evening prayers. "Lord," he prays, "I am not an educated man. I do not know the prayers by heart. But, I know the alphabet, and I will recite it. Please rearrange the letters to form the prayers you know exist in my heart.

This is not to say that the wording of public prayer is not a problem or challenge for the Jewish chaplain. Many of the prayers I regularly offer within Jewish settings would simply be inappropriate for interfaith groups. A widespread myth has it that Jewish Chaplains are not asked to change their prayers and so it is "unfair" to expect such action on the part of Christians. The fact is that Rabbis, like the Christian clergy with who we serve, must choose words carefully in interfaith groups. If the prayers offered by Jewish Chaplains seem "acceptable" then perhaps we tread more softly, for we, like other minorities, know the pain of being ignored.

Although I pray in the synagogue that we not lose faith in the coming of the Messiah - in all the millennia of our yearning he has not yet arrived - I would not offer these words in a non-Jewish setting. If I pray for strength to reject false messiahs - false in Jewish terms - I would not do so before an interfaith group. Words which refer to the horrors of the holocaust, or the hopes of Zionism, or the State of Israel come as naturally to my lips during synagogue prayer as a reference to the Trinity might come to those of a Christian colleague, but references to the Holocaust, Zionism, or the State of Israel are seldom appropriate in non-Jewish settings, at least not without extra words to explain their relevance or to show sensitivity to the needs and cares of all those present.

Some rabbis believe we cannot compose our own prayers in public, but that we are restricted to those handed down to us from the past. When these rabbis are asked to offer public prayer, they often choose to read lessons instead of prayer.

Today it is also important for us to recognize that there are other questions of sensitivity which challenge us to be sensitive to the feelings of those gathered for prayer. An immediate example is language which does not recognize racial integrity or which excludes or hurts women.

Language that Hurts

The intention of the prayer is basic and some maintain that the intention is all that is important, not the impact on the hearers. If the intention is not to hurt then it is not important that we do for the problem, if there is one is in the minds of the hearers.

Neither life nor prayer is that simple. Once we know that an action or a word hurts a neighbor, it is not a question of right and wrong alone. It is a question of causing pain or trying not to do so. Because male gender was once used in a neutral sense does not mean that it is still so used today. If it seems awkward to find words which do not exclude women, perhaps we are saying that we do not feel their feelings are worth our effort. When someone explains to me that an offense is the "Christian" thing to do, it is the same as a white man offending a black and then offering the weak apology that he had done the "white" thing.

Certainly we sometimes misuse language innocently. Following the initial advertising of the manufacturer, I always used the phrase "flesh colored Band-Aids," until a Black friend pointed out that the Band-Aids were not the color of his flesh. Language changes. Once we know what hurts, we must change as well.

Finding a Way

The faith and the conscience of some Chaplains allow them to choose words for public prayers that easily touch us all. Other Chaplains, who are unwilling or unable to change the exclusivity of their prayers, choose not to participate in an interfaith prayer setting. For those of us who struggle with this problem, feeling that there is a tension between the responsibilities of one's faith and the responsibility to those we serve, the following ideas are offered as suggestions.

In Your Name. Phrases such as "For you name's sake." and "For the glory of your name," are found throughout the Bible Psalm 79 uses both. Another simple, scriptural ending for prayers can be taken from Psalm 72: "Blessed be His glorious name forever."
Silent Ending. Psalm 19 speaks of prayer as "the words of my mouth, and the meditation of my heart." God hears both. Could we not offer prayer aloud, and when the petitions are finished, conclude in silence offering our particular endings as we choose?

Invitational Ending. As a variation of the silent ending, I have sometimes offered a prayer and ended with the invitation for all persons present to complete the prayer using the words of their faith and of their tradition.

Shared Images. When Abraham prayed with Melchizedek (Genesis 14) this non-Jewish priest offered a prayer to "the most high God, the possessor of heaven and earth." One modern rabbinical commentary points out that this may be the first example of persons of different faiths searching for a "shared image" in order to join together in prayer.

The story may be an appropriate basis for our prayer, "in the Lord's name," which allow both Christians and Jews to say amen, even if the words take on different meanings within the different traditions. The Bible offers many shared images. So we may pray together to God as savior, redeemer, shepherd, creator, and king. Even the image of the Holy Spirit has a Jewish meaning. It comes from the Jewish idea of ruah ha-kodesh.

Is the Lord's Prayer appropriate for interfaith expression? Although it is based on Jewish prayers, this prayer has become the Christian prayer par excellence. In the past Jewish scholars have generally taught that Jews should not recite it. Perhaps today we Jews should re-examine the situation. If this prayer were offered by someone attempting to find common ground for prayer, should we Jews not respond by participation?

Biblical Readings. We may simply offer appropriate words form the Bible as our contribution to the public ceremony. As a benediction, the priestly blessing recorded in Numbers 6 is often used in this way.

Parables. Some rabbis offer a teaching, a d'var Torah, a Word of Torah, rather than a prayer. Could we not offer a parable or story which shares a biblical image or scriptural hope? When using the holy books of the Jewish and Christian traditions, my feeling is that we should not restrict ourselves to those we have in common. Many Christians have led devotions based on Christian New Testament readings which have included me completely. "From this story in the New Testament, which is a part of the Christian Bible, we can all learn an important message..."

Interfaith Endings. Although somewhat awkward, it is possible to use an ending which is both particular and universal. For example, "We who are Christians offer this prayer in the name of Jesus; but all of us-regardless of our individual religions - offer it in the name of the Almighty God, Creator of Heaven and Earth.

Personal Prayers. While most of this article deals with public prayer offered aloud - a prayer to which each listener can add a personal amen - there is one additional alternative. The possibility exists for a Chaplain to see his or her participation as an opportunity to offer a simple, personal prayer, perhaps asking others to do the same, in silence. I should think that such a prayer would require an introduction: "I thank you for the opportunity to offer a personal prayer from my tradition: It is my hope that something I say may touch you so that you may pray for a moment as well."

One final alternative, linked to this idea, comes from my experience with a Christian Chaplain who struggled with the matter for months. He made two small but significant changes in his way of offering public prayer. When he began, he no longer said, "Let us pray." When he ended, he did not say, "In Christ's name we pray." Instead he said, "In Christ's name I pray." Perhaps few noticed the changes, and perhaps that is a weakness of this approach. But I know that I appreciated the sensitivity.

Praying Together

The word, amen, means "it is true," or "may it be so." According to Jewish tradition, adopted by Christianity, saying amen is the equivalent of reciting the entire prayer. (Talmud, Berakhot 53b) Because of this, the Talmud cautions Jews not to say amen to prayers of non-Jews, unless they have heard the entire prayer. (Berakhot 51b) Prayer is taken seriously, and we must be able to make it our own before saying amen.

At the same time, the idea of joining another human being in prayer was seen as an action filled with power and hope. Setting aside our differences and praying together "opens the gates of Paradise." (Talmud Shabbat 119b) Through a play on words, the Talmud sees hidden meaning in a Biblical verse, Isaiah 26:2. Although it is ordinarily read as, "open ye the gates (of paradise) that the righteous nation which keepeth truth may enter in," a slight change in the vowel marks of the Hebrew renders it, "Open ye the gates of righteousness, that the righteous nation which says amen may enter it!"

In 1984 a civilian minister served as one of the visiting scholars at the annual Navy Chaplain Corps Professional Development Conference. He led us in prayer as part of his presentation, but his prayer was worded in such a way as not to include me. One of my colleagues, a Christian Chaplain, approached him after the session, and told the speaker that he was unable to pray because of the anguish he had felt for me. His thoughts were on me because he sensed that I was excluded.

During the next session of the conference, the speaker related the conversation to the group. He told us he had learned to think of prayer in a different light and that he was deeply touched that there could be such love among ministers of different faiths. Not just words of love, but love.

"The Christian Chaplain does love me," I thought to myself. "He knows what hurts, and he cares."

Thank you to Chaplain Greg Kammann, Portland Oregon, PD who spotted this article and passed it along to our Chaplaincy. Chaplain Resnicoff graciously agreed to our reprinting it. It originally appeared in Military Chaplains Review. Chaplain Resnicoff added this postscript to the article:

"I have received many beautiful responses to this article. But the most touching came from a minister who told me that he now uses the verse from Psalms which I quoted, "The words of my mouth and the meditations of my heart." "Now, he says, when someone asks why he did not close a prayer "in Jesus' name", he answers them: "I did. I ended it in Jesus name because I love Him. I ended it silently because I love my neighbor, as well."

Chapter 2
CHAPLAINCY RESPONSES

CHAPLAIN BASICS

Chaplain "On-Call" Assignment Information

The Law Enforcement Officer is sworn in and, by law, is an officer 24/7/365. The Chaplaincy is a 24/7/365 service as well. Therefore, the Chaplain should always be ready to respond.

PCLEC requires that every chaplain serve one 24-hour shift per month as part of the annual Chaplain commitment. However, it should be understood that even if you are not officially "on-call" (any of the other days in the month), you may be called upon anytime law enforcement or PCLEC needs a chaplain...this is our ministry, *The Ministry of Presence.*

It should also be understood, by every chaplain and their families, that maintaining a successfully responsive team, will require a sacrifice. This may be in the form of late-night calls (a lack of sleep), skipped meals (long hours on a call), changed plans (God's appointments take priority over ours), and possibly rescheduled work-related appointments (when the Chaplain takes the call over previously scheduled work commitments).

The On-Call Chaplain should be in uniform and have all materials and equipment within hand in order to respond to the call within minutes of the initial dispatched call. PCLEC chaplains are a type of first responder as we are often called to the scene and go with the deputy to make any notifications. PCLEC has a response time goal of 20 minutes (from Dispatch's initial call to the incident arrival time) so it is imperative that the On-Call Chaplain be prepared to go immediately upon call out.

For some chaplains, because of positions held within PCLEC, availability for call-outs, and/or physical location within the county, they are considered always "On-Call". Some conditions (mass disasters) will be considered a "Full Response"; this is when we have a large event, such as a plane crash or any event involving a highly visible public impact. Just as we depend on our Law Enforcement and first responders to be there for us, regardless of the inconveniences, we need to do the same. The Law Enforcement, all other first responders, the community and the country depend on their chaplains to be there in the hour of need and it is our honor and duty to fulfill that role to our very best.

Emergency Call-Out Process

In an emergency call-out / crisis response, the agency (local police department, sheriff, etc.) will generally follow the procedures identified here:

1. The agency involved will have their dispatch center call our 24-hour answering service. The Chaplaincy Answering Service (530-889-5824) will call the On-Call Supervisor Chaplain.
    2. The Emergency Call Out Dispatcher (ECO) will call the dispatching agency, obtain the information available, decide what level of support may be required for the event, and decide which chaplain(s) to dispatch to the scene/event.
        A. On-Call Chaplains closest to the area or those who will have the best response time will be called first.
        B. If there is no On-Call Chaplain in the area, the ECO dispatcher will contact any chaplains they deem appropriate to handle the specific call.
    3. The ECO dispatcher will give the chaplain(s) the available information. (Note, Information during the emergency call out, is often very limited, incomplete or possibly incorrect. It is the responsibility of the responding chaplain to investigate as they proceed in the event. Verifications, corrections, and/or changes in the event information should be relayed to the ECO dispatcher.
    4. At the scene or meeting place, the responding chaplain should:
        A. Check in with the Incident Commander (IC), the Officer in Charge (OIC), or the first chaplain on scene.
        B. Confirm the information and plans for this event. If needed, call the ECO dispatcher for any additional help.
        C. Follow instructions
            i. Be an asset: comfort as God directs
            ii. Before clearing the call, leave needed and appropriate information packets and business cards.
            iii. Inform appropriate parties of your departure.
    5. The responding Chaplain(s) will call the ECO dispatcher when leaving the scene.
            i. Report activities in which you were involved.
            ii. Obtain event number
            iii. Confirm time event is to be cleared.
    6. Complete an Emergency Call-Out Report (Appendix C)
    7. Log hours on the Monthly Activity Report (Appendix D)

As a Chaplain, we are trained to use “emotional armor” to survive the critical incidents we are called out to help with. The nature of these calls can sometimes lead to transference, or can so affect us that our emotional armor is unexpectedly lowered. You may experience a call out or group of call outs that seem to impact you. If you feel your emotions are not what they normally are or if you feel out of

sorts, etc., contact the ECO dispatcher, a supervisor, or another Chaplain. Don't just let it go, or think it will get better without help.

Ride-Alongs (LE Chaplains)

Things to know and do on your ride-along with any Police Unit:

1. Give Officer your 1 Charles Number.
2. Ask and know how to operate the equipment inside the Police Unit.
   A. Radio
   B. Shotgun Release & Shotgun
   C. Sirens
   D. Spot Lights
   E. Scanner
3. Don't talk when the radio is broadcasting.
4. Know your location.
5. Listen to the scanner to know what's happening around you.
6. Watch for on coming traffic or citizens approaching
7. Know your 10 codes.
8. Be prepared to help the Police Officer in ANY situation.

Agencies Visits / Briefings (LE Chaplains)

1. Be in uniform including your photo ID
2. Visiting is import part of your ministry but, be courteous of their time.
3. Leave business cards when appropriate
4. Visit from Top rank first then others. If done the other way around it will appear that you are going to superiors with what you have heard.

Agencies Dispatch Visits (CC and LE Chaplains)

1. Be in uniform with your photo ID
2. Visiting is import part of your ministry but, be courteous of their time.
3. Leave business cards when appropriate
4. Visit from Mangers/Supervisors first then others. If done the other way around it will appear that you are going to superiors with what you hear.

Responding to Officer-in-Charge (OIC) and the Incident Commander (IC)

1. Be in uniform with your photo ID

2. When approaching be patience let an officer or the IC himself that you are present and the IC will talk you at the proper time. Most times the IC will acknowledge and talk to at present.
3. The IC will convey the issues at hand and how you and the Chaplains can help.
4. 1144, 1144n, 1146 Crime Scene. See sections on Death Notifications, Suicides.
5. 1199 or "Officer Down" –An officer down call is a time of extreme stress. It is considered "All hands on Deck". It is imperative that all available Chaplains respond.

Officer's Funerals

1. The week after an officer's death is a very intense in grief and will need chaplains to help with *CISMs*, Ride a longs, planning and many other tasks.
2. At the funeral Chaplains will be in their Class A or a dark suit (preferably blue or black).
3. Chaplain's will be assigned to the following:
   A. Family
   B. Agency
   C. Church
   D. Reception
   E. Honor guard unit

DUI Checkpoint Instructions

1. Report to the host law enforcement department for briefing.
2. Report to the Chaplain in charge.
3. Call the ECO dispatcher and ask them for an event number for the DUI checkpoint.
4. ***Safety Note***: DUI check points can be dangerous! Follow all safety precautions.
   A. Help set up food and refreshments, etc. (Be available to help officers during the set-up portion and throughout the night.)
   B. One function of the chaplains at DUI checkpoints is to transport passengers to their homes when the car they were riding in has been impounded, if needed (and the Chaplain feels the situation is safe).
      i. The officer or deputy will ask you to take a person home. (Don't be afraid to ask the officer if the person has been patted down. If there is a second chaplain available, feel free to ask a second chaplain to help with the escort; two is always better than one.)
      ii. Ask this person for name and address. If the person is a juvenile also ask his or her age.
      iii. Call the appropriate dispatch to identify yourself.
      iv. Tell them you are transporting a person to (give address). If it is a female say, "I am transporting a female to" and give address. Or, "I am transporting a juvenile to" and give address.
      v. Give your starting mileage to the dispatcher and the dispatcher will give you your start time.

vi. At your destination, Call the dispatch back and identify yourself
vii. Give your ending mileage to the dispatcher and they will give you the end time.
viii. Return to the DUI checkpoint.

Chapter 3
CONFIDENTIALITY

KEEPING SECRETS

If you can't trust your pastor to keep a secret, who can you trust?

Suppose you went to your pastor and confessed a continuing problem of shoplifting or adultery. You sought his prayers and counsel. You prayed with him for God's forgiveness and strength to renew you life. But alas, the problem continued; you tired of the pastor's confrontation and spoke no further with him about it. Then suppose you found out he had told the deacons about your problem. Or imagine he told you that unless you changed your conduct, he would "tell it to the church." What would your reaction be?

What if you were the pastor? What would you do? Would you advise other church leaders and follow step two of Matthew 18? Would you eventually "tell it to the church"? Or is the information confidential?

Or suppose the counseling ministry of your church is ministering to a church member who acknowledges a drug problem that is affecting her marriage and work, and has been nominated by the church for a position of leadership. As a counselor, what should you do with this information – morally, biblically, legally?

Such situations pose difficult ethical, pastoral, and legal problems because of the issue of confidentiality.

Most of us expect that if we acknowledge a transgression or identify a problem to our pastor it is personal and not intended to be shared with others. Indeed, most of us would be quite surprised and angry to hear our "story" become the sermon illustration on Sunday or used as a church discipline "case" for the elders. When we seek spiritual help with a problem we do not expect it to become public information. Yet when we seek spiritual help with a problem we do not expect it to become public information. Yet when the counseling is proving ineffective and the ongoing conduct is serious and destructive, there are biblical expectations that seem to run against absolute secrecy. From a purely spiritual perspective, what we wish to keep hidden and secret may need to be brought into the light.

Church discipline "cases" frequently raise claims that the church discipline process violated an expectation of confidentiality when the information revealed in counseling or confession was then divulged to church leaders.

Charles Roberson in his suit against the Evangelical Orthodox Church alleged that the revelations to the defendant Weldon Hardenbrook were "a penitential communication" made "as a penitent to his clergyman." He claimed he asked the pastor and others "to keep his communication confidential," but that in spite of this the defendants "told numerous other persons." These acts were the complaint alleged, a "breach of fiduciary duty" - a duty to "the highest standard of trust, confidence and fair dealing."

Similarly, in John Kelly's suit against the Christian Community Church and Dr. Donald Phillips, the complaint alleged that Kelly had secured Phillips's services as a counselor and "in the course of treatment (Kelly) disclosed confidential. Details of his sexual and marital life" and that Dr. Phillips then "released confidential information" to the church board of elders. These acts of Phillips were, it is argued, "negligent, careless, reckless and/or in derogation of his professional duties."

To some extent these claims sound very much like the "invasion of privacy" issue, but though the concern about revealing "private" facts is the same and legal basis is different. Here the allegation is not an invasion of privacy, but a claim that the pastor or counselor was negligent. The negligence arises from an implied agreement between the parties, based on their relationship, that this information would not be shared, that it was an agreement to keep matters confidential. It is further argued that the role of pastor or counselor carries with it a professional duty to keep such communications confidential.

The legal argument is that the recipient of the communication (the pastor, for example) was under a legal duty not to disclose what he had been told in confidence. When he reveals the information, he violates a trust, breaching his duty to preserve the confidences of the counseling, there must be strong elements of trust and reliance that the information shared will be held in confidence. If there is no expectation of confidentiality, few will venture to reveal embarrassing personal facts or acknowledge their shortcomings. People seek counseling not for publicity but for help.

Yet it is in such pastoral conversation, whether in formal counseling or not, that pastors and counselors may obtain information about conduct that, if not changed, would call for further church efforts to encourage repentance and restoration. These efforts could include discipline. How can these seemingly contradictory expectations be dealt with?

Of course, there is no conflict when the confiding party is genuinely repentant and seeking God's renewal, even if in a stumbling, slow, and often inadequate way. Here the confidence is respected in keeping with biblical principles as well as any personal or professional expectations.

But what if the sin becomes increasingly prominent, destructive of spiritual life and the ministry of the parishioner? What if the person persists and compounds his or her sin? What ought to be the pastoral response? What will the law say if the minister tells? What about the pastor's duty to the church versus his spiritual duty to the unrepentant counselee?

The kind of confidentiality claimed in these church discipline cases should not be confused with a related but somewhat different legal right often referred to as "clergy confidentiality. This refers to the right of a clergyman to remain silent and refuse to testify in court as to communications with a "penitent." In law this is often called the "clergy-penitent privilege."

We have already noted the concept of a "privilege" that creates some exception from a duty or requirement. The clergy-penitent privilege is the right of persons who

have communicated certain confidential information to the clergy in the context of pastoral ministry to prevent testimony in court regarding such communications. Such testimony is thus said to be "inadmissible." In some states the privilege is also held by the clergy who may refuse to testify even with a penitent's permission regarding such matters.

Like most privileges it exists not because there is some doubt about the relevance of the testimony or its reliability but because of a social policy of encouraging rather than discouraging persons form confession or seeking pastoral counsel. The Minnesota Supreme Court noted the reason:

"The fundamental thought is that one may safely consult his spiritual adviser. The purpose of the statute is one of a large public policy, based in part on the idea that the human being does sometimes have need of a place of penitence and confession and spiritual discipline. When any person enters that secret chamber, this statute closes the door upon him and civil authority turns away its ear."

Besides the social policy behind the privilege, the fact it is known that many clergymen would refuse to testify in any event may encourage the protection. As Ponder, writing in Liberty magazine, noted: "Generally ministers will not testify, regardless of what the trial judge says or does to them. The Catholic priest, for example, would be subject to excommunication for breaking the seal of confessional. From his viewpoint, the court's penalty is to be preferred to the church's penalty."
The origin of this privilege can be traced to those traditions, primarily Catholic, in which there is a requirement that members confess regularly to their priest and where the priests are under an absolute religious duty not to reveal these secrets.

In England the privilege has not been recognized since the Restoration in 1660, and, thus, was not a part of the common law influencing American law. In the United States, however, the privilege has been more favorably received. In 1813 perhaps the earliest case, a New York court held largely on free exercise grounds that a Catholic priest should not be compelled to reveal what he had heard under the Sacrament of Penance. The court declared:

"It is essential to the free exercise of religion, that its ordinances should not be administered - that ceremonies as well as its essentials should be protected. Secrecy is the essence of penance. The sinner will not confess, nor will the priest receive his confession if the veil of secrecy is removed."

Interestingly, some early courts declined to give the same privilege to Protestants since the secrecy of the confessional did not constitute a central religious tenet. A New Your case applying such a distinction, People v. Smith, led in part to the adoption by the New York legislature of the first statute dealing with such a privilege.

Today at least forty-six states provide for the clergy-penitent privilege by statute, encompassing minister, rabbis, and other religious leaders who perform similar roles.

Often the distinctions among statutes and the specific language lead to interesting cases raising such questions as, who is a clergyman entitled to the privilege? Does it extend to non-ordained persons acting on behalf on the church such as elders and deacons? And what about those groups that claim all their members are clergy?

Statutory Conditions For The Privilege

Not all conversations are privileged, and the statutes usually identify the limits. First, statutes typically provide that the person must be a clergyman or at least one acting in such a capacity. Usually a reasonable belief on the part of the penitent that the other person is a clergyman will suffice.

Second, the privileged communications must be to a clergyman who is acting in his professional capacity. Random conversations with the clergy will not necessarily be protected.

Third, in some instances courts have held that the communication must be "penitential" in nature; that is, it must be a confession. The New York Court of appeals declared that the priest-penitent privilege arises not because statements are made to a clergyman. Rather something more is needed..."It is only confidential communications made to a clergyman in his spiritual capacity that the law endeavors to protect." Generally, however, the tendency has been to broaden the privilege to include other situations besides traditional confession. The significant role of pastors in general counseling, specifically in marriage counseling, has resulted in revision of statutes or court interpretations that have included these non-confessional communications; but not all courts have extended the privilege to these contexts. As to whether it applies in the context of marriage counseling, a California court indicated that marital counseling communications were not privileged, while a New York court held they were.

Some state statutes specifically include marriage counseling. For example, Alabama protects communications when one approaches a clergyman "to enlist help or advice in connection with a marital problem." Fourth, a number of state statutes have a requirement that the communication be pursuant to a "discipline enjoined by the rules of the church." That is, confession must be in response to a religious duty set forth by the doctrine of the church mandating such confession. Such a requirement reflects a more narrow view of the privilege and roots it not in a general policy of protecting spiritual counsel but in the First Amendment protection against government interference in religious duties. A restrictive view of such language might limit the privilege to Catholic clergy. In Simrin v. Simrin, for example, the court noted that the communications in the marriage counseling context were not "a discipline enjoyed by the church" and that the statute limited the privilege to such communications. In an Arkansas case the privilege was held not to exist without evidence that the church to which the pastor and penitent belonged made confession a duty. On the other hand many courts read such statutory provisions broadly. In one widely cited case, In re Swenson, the Minnesota Supreme Court read "discipline enjoined" to broadly mean the practice of confession:

We are of the opinion that the "confession" contemplated by the statute has reference to a penitential acknowledgment to a clergyman of actual or supposed wrongdoing while seeking religious or spiritual advice, aid or comfort, and that it applies to a voluntary "confession" as well as to one made under a mandate of the church. The clergyman's door should always be open; he should hear all who come regardless of their church affiliation.

Exceptions To the Privilege

Few privileges are absolute, but especially lately; this general protection of confidentiality and privilege is under some challenge. In a 984 story, Time reporter Richard Ostling noted the controversy when the legal principle of confidentiality competes with a strong social policy, such as stemming the rising tide of child abuse. Widespread attention was drawn to the case; of a Florida pastor, John Mellish, to whom Earl Sands, accused of sexually molesting a six-year-old-girl, had surrendered. The prosecutor called Mellish to testify regarding conversation he had with the accused, and Mellish invoked a right of confidentiality. The court rejected the claim, and when Mellish continued to refuse to testify he was sentenced to sixty days for contempt of court.

At least twenty states have now abolished the clergy-penitent privilege in cases of child abuse. By 1974 all fifty states had mandatory reporting laws often noted as "child protection" statutes. The statutes vary: some involve only medical personnel, but the tendency has been to broaden the group of persons under a duty to report suspected child abuse. Some states have statutory clauses including "any other person." In at least twenty states all privileged communication protection are withdrawn except the attorney-client privilege. Mississippi, for example, specifically indicates that the act of reporting is "not a breach of confidence" and thirty-three states provide a criminal penalty for failure to report such crimes.

These policies clearly clash with the privilege, but some rulings protect the privilege even in child abuse cases. In a 1958 decision, Mullen v. United States, the United States Court of Appeals reviewed the conviction of a mother for abuse and willful mistreatment of her children. The decision was reversed on other grounds, but two of the tree justices also concurred in an opinion that the admission of the testimony of a Lutheran minister regarding what the woman had told him in preparation for receiving communion was erroneously admitted. "Sound policy-reason and experience-concedes to religious liberty a rule of evidence that a clergymen shall not disclose on a trial the secrets of a penitent's confidential confession..." Circuit Judge Edgerton in a separate concurring opinion went perhaps even further:

> *I think a communication made in the reasonable confidence that it will not be disclosed, and in such circumstances that disclosed, and in such circumstances that disclosure is shocking to the moral sense of the community, should not be disclosed in a judicial proceeding...*

Other recent cases have also pressed the issue of the clergy-penitent privilege. In Arizona a Pentecostal pastor, David Crumbaugh, was given a six-month sentence and one thousand dollar fine for refusing to testify about what the wife of a convicted child killer told him while he counseled them both during the murder trial.

And in one state, pastors publicly announced they would disobey a new statute requiring them to report suspected child abuse.

As Ostling noted, regardless of what the courts say, most clergymen continue to invoke the privilege and the "question is whether they will be jailed for doing so." The "privilege" in regard to court "testimony" is not really the same concept as the kind of confidentiality raised by the church discipline cases, nor is it the primary type expected by the counselee. The counselee does not merely expect that the pastor won't testify in a court or call the cops but that he won't "blab" at all.

In the context of church discipline, the critical aspect of confidentiality is whether there is a relationship creating a legitimate and binding expectation of confidentiality so that its breach is a kind of clergy malpractice, a negligence created by the breach of the pastor's duty to keep secrets.

As churches are increasingly involved in ministries of pastoral counseling, there is a tendency to uncritically adopt a secular counseling style including all the assumptions about confidentiality that properly prevail in secular counseling. And certainly the general concept that persons seeking pastoral care are not going to have their shared secrets made public is reasonable.

But we have noted the conflict between the biblical admonitions about pastoral and church care and any notions of absolute secrecy. In Matthew 18 it is clear that if "counseling" fails, the church is to further its discipline even to the point of public rebuke and expulsion. The secret is to be made known, brought to light that it might be made manifest. As Robert Illman noted writing in the Presbyterian Journal, "We have too often been guilty of encouraging an expectation of confidentiality that is inconsistent with our biblical responsibilities.

The more a church counseling program, whether separately staffed or simply part of the pastoral ministry of the staff, takes on the style and character of a secular counseling operation, the more reasonable it is for counselees to assume that secrecy is a guarantee. Such an expectation may be directly encouraged by many pastoral counselors.

The question has not only legal dimensions but pastoral ones as well. The pastoral ministry of the church does depend on a sense of trust that secrets are not revealed. It is important for pastors who become possessors of powerful secrets about others to be scrupulous. If word gets out that a pastor can't be trusted, few will confide in him. But there are limits, and those biblical limits are not simply the legal limits of physical harm to other persons.

Unless the church through its teaching and counseling makes clear that while confidentiality is an aspect of the church counseling ministry it is not absolute, church discipline based on facts that emerge from counseling settings will continue to be legally troublesome.

There is no problem with pursuing church discipline when facts are obtained from independent and clearly non-confidential sources. But where the only source is pastoral counseling settings, the courts may well apply a test of asking whether or

not the counselee-parishioner had a reasonable belief that the communications would be held in confidence.

Where courts find there was an expectation of confidentiality that has been breached, the counselor may be vulnerable to actions for "negligence" or breach of a fiduciary duty. Of course, even where confidentiality is properly presumed, there may be limits as we have already noted in the case of child abuse reporting statutes. Recent cases raise other exceptions where the secret may be revealed in spit of expectations of confidentiality. One exception that may affect church ministries is the situation where the confidence not only may be revealed, but there may be a duty to disclose it.

A Duty To Warn?

The protective privilege ends where the public peril begins. When is information obtained in a situation of expected confidentiality so vital that one not only may but must reveal it? One guideline is whether the revealed information has to do with past acts, or whether it deals in part with future acts. Lawyers, for example, have a privilege not to reveal confidences from their clients regarding past acts, even heinous crimes, but the privilege does not cover contemplated future criminal acts.

Another factor is whether or not there is a real physical danger to third persons. Public policy interests will certainly be greater where there is ongoing danger to other people. A case that raised both of these dimensions was Tarasoff v. Regents. In 1968 a student at the University of California at Berkeley became distraught over his rejection by a girlfriend. He sought professional counseling and in the process of conversations with a psychologist threatened to kill Tanya, the former girlfriend. Later the agitated lover murdered Tanya. Her parents sued the psychologist and others for negligence because they failed to warn Tanya of the threats. The California Supreme Court in reviewing the case held that; when a therapist realizes a third person is in danger, there is a duty to warn that person.

The Court noted a "duty to exercise reasonable care to protect the foreseeable victim." The Court concluded that "in our risk-infected society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal."

The duty to warn has been included in some codes of conduct for mental health professionals, but there is no such uniformly accepted guide for clergy. When is there a "right" to reveal, and when might there even be a "duty"?

Minimizing Problems

Given both legal and ethical considerations, how ought churches and pastor to treat "confidential" information? What policies are appropriate or even mandated?

The most critical legal issue today regarding traditional protection of clergy confidentiality in regard to "testimony" is balancing the interest in protecting such communication {for reason of both public policy and religious liberty} against concern for protecting third persons (e.g., abuse children). This may well create severe tensions for clergy to whom abusive parents come for help. If the clergyman

promises help but advises he must first call the police, the number of such person seeking help will surely diminish. On the other hand, failure to take action may result in tragedies for children.

It may be critical for pastors to distinguish between situations where the acts for which one seeks help are in the past and where the conduct is likely to continue. Where one comes to confess past acts that are highly unlikely to continue, it is understandable that many clergy will not report such instances for reasons of spiritual duty or prudence. Where there is a continuing risk of harm to others, some action would seem to be legally and morally required, though there may be alternatives to notifying state authorities. When parents seek help they may consent to various reasonable and adequate interim remedies, such as placing the threatened children with relatives while the parents commit themselves to intensive counseling. Of course, clergy who take such steps may be liable under the law not only for failure to report, but should their remedies turn out to be inadequate to protect the children, they may well bear enormous legal liability and moral responsibility.

In regard to church discipline and counseling areas where there is a reasonable expectation of confidentiality, courts may well hold clergy liable if they reveal confidences to others such as church elders or boards. Unless the commonly held expectation of privacy and confidentiality is somehow negated, the pastor may be obliged not to reveal such information.

While this expectation of confidentiality may be overcome by specific statements (disclaimers) and by clearly established principles taught in the church, these may prove inadequate. Much pastoral counseling is simply not done formally but in the process of normal conversation where one does not begin with disclaimers, and in any event the use of such may will serve to shut off counseling. The clarity of disclaiming confidentiality may require it to be so prominent that it would create an erroneous impression of no confidentiality when in fact the church might want to indicate only that there are limits imposed by biblical principles and that communications would be held as confidential as possible within these limits.

If the only source of information is one where there is a reasonable expectation of confidentiality, clergy and counselor may be obliged to respect that confidence. In such a situation, it may be appropriate not to reveal the information even if it seems relevant to the church's ministry and church discipline. That does not bar efforts to encourage the counselees to "own up" to their conduct, to advise them to remove themselves from positions of leadership inconsistent with their continuing conduct, to suggest to appropriate committees that certain persons might not be best to serve in given positions, or in certain circumstances to remove persons from leadership positions. And, as noted, one may proceed with church discipline if the information has come to the attention of the church through other, non-confidential means. As in Guinn, where there is no secret about what is going on, there is no confidence to respect at least as to the basic facts.

On the other hand if information has been obtained in confidence, and whether or not there is potential legal liability, the pastor or church leaders may choose to disclose limited information both in terms of the scope of the audience and the extent of information revealed. "Tell it to the church" is not a license for gossip or a

refuge for moral Peeping Toms. There are good reasons for respecting confidences, and even church discipline does not require that the guilty be paraded before the church.

What is important for purposes of church discipline is to carefully assess:

1. the church's counseling practices
2. the likely expectations of parishioners and counselees
3. whether the church wishes to overcome any expectations it believes are inconsistent with its doctrines
4. in specific instances, whether or not there is a potential breach of criminal proceeding, confidence if information is provided others
5. whether or not possible disclosure requires a change in the manner which the church will proceed

The issue of confidentiality is a mine field not only of legal claims but of troublesome church policy and potentially surprised penitents. "The clergy-penitent privilege is a "rule of evidence"; that is, a rule relating to what kind of evidence of testimony is admissible in a civil. The legal issue is, who holds the privilege? In general the view is that the penitent holds the privilege and may waive the right to claim it. Normally, however, the clergy may assert it on behalf of a penitent absent any indication the penitent has deliberately chosen to waive the privilege. In some states the language would seem to indicate that the clergy also have a privilege independent of that of the penitent, e.g., California Evid. Code. 1034(West): "A clergyman, whether or not a party, has a privilege to refuse to disclose a penitential communication if he claims the privilege."

In re Swenson, 237 N.W. 589, 591 (1931), citing in part Reuckemeier v. Nolte, 179 Iowa 342, 161 N.W. 290, 293 (1917). Ponder, "Will Your Pastor Tell?" Liberty, May-June 1978, 3. Church policy itself varies. The Lutheran Church bylaws provide an exception to confidentiality, "in order to prevent the commission of crimes." The Catholic Church, however, provides no exception, noting that "no cause, however great, whatever the circumstances, will justify its violation. The seal is inviolable. . . ." See the New Catholic Encyclopedia, cited by Yellin, 147.

See twenty-first canon of the Lateran Council, 1215. There is some debate about whether English courts formally recognized the privilege in law in the pre-Reformation period. Certainly it was not absolute. In Garnets Case in 1606, Father Garnet had been the spiritual advisor to Guy Fawkes and others allegedly involved in the attempt to assassinate James I. The plot failed, and Garnet was called to testify on any conversations with the defendants. He refused and was tried and found guilty of "having knowledge of a treasonous plot." He is now considered a martyr of the "seal of the confession."

If there was any legal privilege before the Reformation, it was clearly not a part of English law after the Reformation and the Restoration in 1660. While confessions remained a central part of the life of the Anglican community, it was no longer compulsory. (Canon 113, Anglican Canons of 1603.) The Sacrament of Confession is held inviolable, but an exception is made where one's knowledge of a crime would subject him to capital punishment if he did not reveal it. Blackstone makes no mention of it in his famous Commentaries, and a long line of English cases deny the privilege. In Normanshaw v. Normanshaw, an action for divorce, the Vicar had

refused to disclose the substance of an admission made to him. The Court declared that "it was not to be supposed for a single moment that a clergyman had any right to withhold information from a court of law." Cited by 8 J. Wigmore. Wigmore on Evidence, 2394 at 869, 70 n.4 (McNaughten rev. 1961).

See a report of this case in "Privileged Communications to Clergyman." - Catholic Lawyer (1955), 207. Keeenan v. GiganteKeeenan v. Gigante, 47 N.Y.2d 160, 167, 390 N.E.2d 1151, 1154, 417 N.Y.2d 226, 229 (1979). Simrin v. Simrin, 233 Cal. App. 2d 90, 43 Cal. Rptr. 376 (1965). Kruglikov v. Kruglikov, 29 Misc. 2d 17, 217 N.Y.S.2d 845 (1961), appeal dismissed, 16 A.D.2nd 735, 226 N.Y.S. 931 (1962). Sherman v. State 170 Ark. 148, 279 S.W. 363 (1926). In re SwensonIn re Swenson, 183 Minn. 602, 604-05, 237 N.W. 589, 591 (1931). Richard Ostling, "Confidence in the Clergy," Time. 1 Oct 1984, 66. Mullen v. United States 263 F.2d 275 (D.C. Cir. 1958). 263 F.2d at 281 (Edgerton, J., concurring).

"This alleged type of clergy malpractice should be distinguished from the type alleged in the well-publicized California case Nally v. Grace Community Church of the Valley, No. NCC 18668-B (L.A. County Super. Ct. filed Mar. 31, 1980). A suit was brought by the parents of Ken Nally alleging that the Grace Community Church and its pastor, John MacArthur, were negligent in failing to refer a suicidal counselee to "professionals," and in training, selecting, and hiring "lay counselors." Of course, in such cases, establishing the nature of the "duty" is extremely difficult because there are no accepted standards of spiritual counseling, and many commentators have expressed concern that the courts not impose a secular model of counseling on the church. See Ericsson, "Clergy Malpractice: Ramifications of a New Theory," 16 Val. U.L. Rev. 163 (Fall 1981). Robert S. Illman, "Confidentiality and the Law: The Church's Right to Discipline." Presbyterian Journal, 26 Dec 1984, 9. In all negligence claims, the basic nature of the legal action is the allegation that there was a duty (here it is a duty of confidentiality), a breach of that duty (the disclosure) that has been the cause of damage (pecuniary or other). Tarasoff v. Regents, 17 Cal. 3d 425, 442, 551 P.2d 334, 349, 131 Cal. Rptr. 14, 27(1976) Tarasoff v. Regents, 551 P.2d at 347, 348 (1976). In another California case a court rejected a claim that a psychiatrist had a duty to reveal to parents disclosures of their daughter about the conditions that might lead her to commit suicide, holding that that duty arose only in regard to risks of assault on third persons, not where the danger is self-inflicted. Bellah v. Greeeson, 81 Cal. App. 3d 614; 146 Cal. Rep. 535 (1978).

Excerpt from the CALIFORNIA EVIDENCE CODE:

California Evidence Code Section 1033-1034, 1030-1032, 917, 912

Privilege of Penitent Privilege of Penitent (Sec. 1033)
"Subject to Section 912, a penitent, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a penitential communication if he claims the privilege." Privilege of the Clergyman (Sec 1033) "Subject to Section 912, a clergyman, whether or not a party, has a privilege to refuse to disclose a penitential communication if he claims the privilege."

"Clergyman" "Clergyman" (Sec. 1030)

"As used in this article, "clergyman" mean a priest, minister, religious practitioner, or similar functionary of a church or of a religious denomination or religious organization."

"Penitent" "Penitent" (Sec. 1031)
"As used in this article, "penitent" means a person who has made a penitential communication to a clergyman."

"Penitential Communication" (Sec. 1032)
"As used in this article, "penitential communication" means a communication made in confidence, in the presence of no third person so far as the penitent is aware, to a clergyman who, in the course of the discipline or practice of his church, denomination, or organization, is authorized or accustomed to hear such communications and, under the discipline or tenets of his church, denomination, or organization, has a duty to keep such communications secret."

Presumption That Certain Communications Are Confidential (Sec. 917)
"Whenever a privilege is claimed on the ground that the matter sought to be disclosed is a communication made in confidence in the course of the lawyer-client, physician-patient, psychologist-patient, clergyman-penitent, or husband-wife relationship, the communication is presumed to have been made in confidence. . . "

Chaplaincy Validated

The U.S. Supreme Court has rejected an attempt to bar public hospitals from keeping chaplains on their payrolls. This was the essence of the March decision when the Court declined to grant a hearing to a Court of Appeals decision. Three atheists had challenged a paid chaplain's position maintained by Polk County's Broadlawns Medical Center in Des Moines, Iowa. The Court, without comment, turned away arguments that spending taxpayers' money for a hospital chaplain's job violates the constitutionally required separation of church and state. While cases of military chaplaincy have previously reached the Supreme Court, this may be the first case involving the use of tax revenue to support chaplaincy in a civilian setting. The opinion of the U.S. Court of Appeals of the 8th circuit in the case of Carter vs. Broadlawns Medical Center et. al does place certain limitations on the use of tax dollars. It also explains the court's current thinking about chaplaincy. The purpose of the chaplaincy cannot be exclusively religious in nature. It must also have secular purpose. Chaplains cannot proselytize (no direct advancement of religion). Counseling of staff (in the hospital setting) that is non-religious in nature is permitted. Permitted are necessary accouterments of chaplaincy and such things as wearing name tags, reserved parking spaces for chaplains, holding optional religious services, storing supplies for optional religious services, etc. The implications for law enforcement chaplaincy are obvious.

Article ~

International Conference of Police Chaplains

A Case of Confidentiality

(The Following is a true case study involving privilege communication and a chaplain. Because of the sensitive nature, names have been omitted.)

> *The Chaplain's Background: A sworn full-time police officer for 26 years, sixteen years as a Sergeant. Ordained as a Roman Catholic Clergyman, has served the department as chaplain for seven years. In the department, has two roles: Training Coordinator (paid) and Chaplain (volunteer, not paid).*

THE INCIDENT:

"On the 14th of February at 12:45 a.m. I was called at my home by the Watch Commander to report to 39 Livingstone Ave., on a report of a possible suicide. This call came from the Captain of Detectives who knew that I knew the family from prior problems involving both the Captain and me. I was attired as follows: I wore a green parka, a black cap with the ICPC logo, a dark blue clerical shirt and collar, and light blue dress jeans with brown shoes.

"I reported to the Captain. He said, "This may not be suicide, do you have a problem with that ? I responded, "No." I entered the rear bedroom and blessed the body of the 15 year old girl. I prayed and counseled the 14 year old sister, the father and the mother, collectively and individually as they were being interviewed, while I was seated on the sofa. The officers present at this time were: 1 Captain, 1 Detective, 1 Sergeant and 3 Patrolmen from my department; 2 State Police Detectives and finally 4 State Police Lab Technicians.

"After the lab boys were done, and at the request of the family, I called their youth minister ...he knew both the girls very well. So he took the mother and the 14 year old to a friend's house. The father stayed with me and we decided to clean the house, because the family would be returning later in the day. (This was a shotgun blast to the abdomen, which destroyed the liver, etc. The girl had bled to death; we estimate that she lived 15 minutes after the shot...so you can picture the mess...) "As we began, the pastor of the 2nd Church, colleague of the youth minister, arrived and he ministered to the father. I started the clean up and was pretty much done when they joined in. The house was secured at 6 a.m.

"On the 16th, two days later, the mother of the dead girl asked the Nursing Supervisor of the ICU unit where she had been hospitalized for an overdose to call me. She wanted to see "the Police Chaplain." I responded in uniform. We had a privileged conversation. "On the 17th I received a call from the youth minister who stated that the mother wanted to see him and me (as a clergyman). This was the morning of the funeral. In the bedroom of her friend's house the mother spoke to both of us, again in what I call a privileged communication. "At no time did I reveal this to the Detectives from my department or the State. One month later, through their investigation they found out that I was involved. They got very upset and demanded a formal statement. So I did tell them that I had met and had conversation with the mother, but did not say what. I told them it was confidential. The only reason that I had kept quiet was so their investigation would be

independent of my information. And I believe that they have a very strong case based on circumstantial evidence, and some physical evidence.

"This, however, drew the ire of the District Attorney, who stated that I cannot be a Police Officer and a Clergy man at the same time. I am one or the other. So they investigated my "ordained" status in the Roman Catholic Church, through the chancery office. I am an "Ordained Deacon", a "Rev. Mr.," an Ordained Priest... The D.A., who is not of the Christian faith, started his own investigation and consulted the attorneys for the Archdiocese to ascertain if I am a "Clergyman" and if the State law on "Privileged Communication" applies. The attorneys replied in the affirmative and also told the D.A. they would represent me in all proceedings. Next the D.A. attacked my status as "Chaplain", asking who made me chaplain. When? How I was appointed, rules, regulations, i.e. the whole ball of wax. And if that wasn't enough they started in on me with the "Mandated Reporter" law. In this state, being a cop or a clergyman you are by law a mandated reporter, and so must report all matters of "child abuse", etc. I declined to file such a report. The next step, by State Law, is for a judge to serve as the final arbiter to determine if, in fact, the information you have is "privileged". So the D.A. has scheduled an inquest and I am under summons the week of the 23rd through 27th."

<u>CHAPLAIN'S COMMENTS ON THE CASE</u>: "There is great anger in the community. This popular 15 year old cheerleader is dead. Everyone on the streets, because of their personal knowledge about the family, etc. knows or believes that the mother killed her daughter. The police have probable cause from day one, but not enough evidence for a conviction, so the D.A. won't touch this with a ten foot pole. All the anger of the community, and of the D.A., is being directed at the police investigators. And their frustration is being directed at me. At least Rev. (the youth) minister is in his "Christian environ" being supported and uplifted. I am living in the Lion's Den. Some of the arguments being posited:

1. *"You were a cop first, where is your loyalty?"*
2. *"You are a police chaplain, not hers."*
3. *"As a cop, you are a mandated reporter you are not doing your duty."*
4. *"When I told you that it might not be a suicide that night, I told you to go in as a police officer."*

"The positive: the Archdiocese will defend the "clergy role". I have hired the attorneys that work for the [State] Police Association, in case I am suspended for malfeasance or misfeasance, or anything else that they can conjure up.

<u>THE PAIN</u>: All the good that I have tried to accomplish in my 7 years may go down the tubes. I am prepared to go to jail if I am held in Contempt of Court for not testifying to the privileged communication. "The police case is deadened and I am the scapegoat.

<u>MY DEFENSE</u>:

1. *My attire that night speaks for itself. Dressed as a clergyman, I could not possibly have assumed the role of police officer.*
2. *They had 8 officers there already and 4 more on the way. They didn't need me.*
3. *They did not pay me overtime, as required in our contract, for the 7 hours. So obviously I was a chaplain, not a cop.*

4. *This case is unique - 1 in a 10 - because in my mind and in her mind we had a prior pastoral relationship. Had this been any other family, this would not have happened."*

FURTHER CHAPLAIN'S REFLECTIONS LESSONS TO BE LEARNED:

1. *"The misunderstanding or miscommunication at the scene: The Captain wants to cover himself with the Chief and D.A. and now what he remembers is not exactly as I recall it."*
2. *"No matter how many times the role of Chaplain is explained, or how the statutes on [privileged] communication are understood, problems like this one will come up. And the chaplain had better be on solid ground."*
3. *"State laws differ on Privileged Communication but there is a common denominator - ONE MUST BE ORDAINED OR LICENSED - to be protected. To be anything else could be very expensive and traumatizing, not to mention the possible loss of everything in a civil suit."*

THE OUTCOME: The judge ruled in favor of the chaplain and privileged communication. The foundation for deciding the chaplain was an ordained clergyman was based on a Federal Court case. Buttecali vs. United States, Circuit Court of Appeals, Fifth District, July 9, 1942. This States: "Generally, a duly ordained minister" is one who has followed a prescribed course of study of religious principles, has been consecrated to the service of living and teaching that religion through on ordination ceremony under the auspices of an established church, has been commissioned by that church as its minister in the service of God, and generally is subject to control or discipline by council of the church."

THREE FURTHER CONSIDERATIONS:

1. *Be sure you know EXACTLY your state's law on privileged communication. Get a copy of it. Your Police Department should have a full and complete set of the state laws. Library or County Courthouse are other sources.*
2. *If you are not ordained or licensed, discuss this with a lawyer NOW. You are probably NOT covered under the privileged communication law and could be required to testify in court. You can still function as a chaplain, but must warn anyone that you do not have the "seal of the confessional".*
3. *Many states have mandated reporter laws. Are you included in yours as a clergy person or chaplain? CHECK IT OUT. There's a very thorny problem here if you have privileged communication and yet are a mandated reporter. [Editor]*

Chapter 4
CRITICAL INCIDENT STRESS DEBRIEFING
(Powerful Event Group Support)

At the time this Training Guide was rewritten, the International Critical Incident Stress Foundation (ICISF) had recently been endorsed by the United Nations and asked to develop common international language which will be used for previously known tools used in Critical Incident Stress Management (CISM). Two changes to the terminology include Powerful Event Group Support (PEGS) which replaces what was commonly and formerly referred to as CISD (Critical Incident Stress Debriefing) and Immediate Small Group Support (ISGS) which replaces what was commonly and formerly referred to as Defusing. This manual will be updated for these changes during the next rewrite, however, it should be noted that it will likely take several years for this change to be realized at the local levels where CISM defusings and debriefings are currently being conducted.

Debriefing is a specific technique designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with the incident to process the event and reflect on its impact.

> *"Caught off guard and "numb" from the impact of a critical incident, individuals and communities are often ill-equipped to handle the chaos of such a catastrophic situation. Consequently, survivors often struggle to regain control of their lives as friends, family, and loved ones may be unaccounted for or are found critically injured, lay dying or are already dead. Additionally, the countless others who have been traumatized by the critical event may eventually need professional attention and care for weeks, months and possibly years to come. The final extent of any traumatic situation may never be known or realistically estimated in terms of trauma, loss and grief. In the aftermath of any critical incident, psychological reactions are quite common and are fairly predictable. Critical Incident Stress Debriefing (CISD) can be a valuable tool following a traumatic event."*[3]

WHAT IS A CRITICAL INCIDENT?

[3] Joseph A. Davis, Ph.D., *Providing Critical Incident Stress Debriefing (CISD) to Individuals and Communities.* © 1998 by The American Academy of Experts in Traumatic Stress, Inc. Used by permission.

A "critical incident" is any event that has significant emotional power to overwhelm usual coping methods. These include a sudden death in the line of duty, serious injury from a shooting, a physical or psychological threat to the safety or well being of an individual or community regardless of the type of incident. Moreover, a critical incident can involve any situation or events faced by emergency or public safety personnel (responders) or individual that causes a distressing, dramatic or profound change or disruption in their physical (physiological) or psychological functioning. There are oftentimes, unusually strong emotions attached to the event which have the potential to interfere with that person's ability to function either at the crisis scene or away from it

Symptoms of Critical Incident Stress

Critical incidents produce characteristic sets of psychological and physiological reactions or symptoms (thus the term syndrome) in all people, including emergency service personnel. Typical symptoms of Critical Incident Stress include:

- Restlessness
- Irritability
- Excessive Fatigue
- Sleep Disturbances
- Anxiety
- Startle Reactions
- Depression
- Moodiness
- Muscle Tremors
- Difficulties Concentrating
- Nightmares
- Vomiting
- Diarrhea
- Suspiciousness

The physical and emotional symptoms, which develop as part of a stress response, are normal but have the potential to become dangerous to the responder if symptoms become prolonged. Researchers have also concluded that future incidents (even those that are more "normal") can be enough to trigger a stress response. Prolonged stress saps energy and leaves the person vulnerable to illness. Under certain conditions, they may have the potential for life-long after effects. They are especially destructive when a person denies their presence or misinterprets the stress responses as something going wrong with him.

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

Critical Incident Stress Management (CISM) is a comprehensive, integrated, systematic, and multi-component approach to managing traumatic events.[4] Four group tools used in CISM are identified by the chart on the following page.

The following is a brief description of the four tools used in group CISM:

1. Demobilization – a one time (end of shift/end of deployment), large group information process usually used for emergency services, military or other operational staff who have been exposed to a significant traumatic event such as a disaster or terrorist event.
2. Crisis Management Briefings – this is a structured "town meeting" style focusing on large community or organizational groups. It is designed to provide information about the incident, control rumors, educate abut symptoms of distress, inform about basic stress management, and identify resources available for continued support, if desired. This may be especially useful in response to community violence / terrorism and can be tailed to smaller group applications.
3. Defusing – is a shortened version of the debriefing (3 phases) focused on small homogeneous groups within 8 hours of the conclusion of an event. If a delay beyond 8 hours occurs, it is best not to defuse but plan for a debriefing. It is best to provide separate defusing for each homogeneous group involved in the event.
4. Debriefing – a structured GROUP discussion concerning the critical incident which follows a CISD structure of 7 phases. Common ground rules of a CISD include:
   A. Voluntary participation

[4] Mitchell, PhD, Jeffrey T. *Critical Incident Stress Management (CISM) Group Crisis Intervention.* 4th Edition. © 2006 by the International Critical Incident Stress Foundation, Inc. Note: The information presented on CISM in this training guide is taken from several sources written by Jeffrey T. Mitchell, PhD, including *When Disaster Strikes* and *Critical Incident Stress Management (CISM), Group Intervention.* Reprinted here by permission.

Caution must be given to individuals who have never been formally trained in CISM. It is important to note that the information presented in this manual is for the purpose of introducing/educating the reader at a very minimal level. We encourage any reader who is working with first responders, or the local community, affected by a traumatic event, to obtain formalized training in CISM. Good intentions of untrained individuals can cause more harm than if you were to simply comfort them and do nothing else.

B. No note taking or recording devises
C. Not used as an operational critique or investigation of events
D. Not a “blame” session

Type	Demobilization	Crisis Mgmt Briefing (CMB)	Defusing	Debriefing (CISD)
When	After Shift	Anytime post-crisis	Within 12 hours	24 hours – 10 days*
Who	Large number of responders	Organizations, Communities, Schools	Small Groups	Small Groups
Format	Passive – Information and rest if the focus	Semi-Active – Info plus short Q&A, Resources	Active, Loosely guided. Three stages	Very Active – Structured team, guided discussion through seven stages
Leader	Peer, Chaplain, or Mental Health Professional	Peer, Chaplain, and/or Mental Health Professional	Peer, Chaplain, or Mental Health Professional	Trained Leader and one Mental Health Professional
Length	½ hour	1 – 1 ½ hour	20-45 minutes	1 ½ - 3 hours
Follow-Up**	CISD	Assess need for CISD	Assess need for CISD	Closure or referral

*Debriefings for disasters may not be appropriate until 2-4 weeks (and sometimes longer) following the disaster.

**During any CISM, the team members should be watching for individuals who might need 1:1 follow-up or referral for additional support.

Formal Critical Incident Stress Debriefing (CISD)

The formal Debriefing is a psychological and educational Support Group discussion that utilizes specially trained individuals, mental-health professionals, and peer support personnel. The main objectives of a debriefing is to mitigate the impact of a critical incident and assist the personnel involved in returning to routine functions after the incident. Events that require a Critical Incident Stress Debriefing include:

- Line of Duty Deaths (LODD)
- Serious Line of Duty injuries
- Emergency workers suicide
- Disasters
- Unusually tragic deaths of children
- Significant events where the victims are relatives or friends of emergency personnel.
- Events that attract excessive medial attention.
- Events that seriously threaten the lives of the responders
- Any event that has significant emotional power to overwhelm usual coping mechanisms.

Because overuse of CISDs dilutes their effectiveness, they are reserved for only those events that overwhelm the usual coping methods of emergency personnel. Before a debriefing is held, all of the coordination associated with the debriefing is done, including the announcement to those involved and the setup of the room.

In the majority of cases, a formal CISD is generally not organized for the first 24 hours because the responders are still too worked up to be able to deal appropriately with an in-depth group discussion of the incident, especially as it relates to their inner feelings. They are trained to suppress emotional reactions during and for a brief time after an incident. Natural feelings of denial and avoidance predominate during the first 24 hours. However, the one-day time limit is only a guide. In some situations it may be desirable to conduct a formal CISD earlier than 24 hours.

Often emergency personnel attempt to intellectualize about the incident, and they run it through their minds over and over as they try to make sure that they handled their part correctly. Several hours after the incident their cognitive activities decrease and fairly intense feelings may then come to the surface. This is the time for a CISD.

Ideally, the formal CISD should be mandatory for all personnel involved in the scene. At times a joint debriefing between police, fire and EMS personnel is extremely beneficial. The tone must be positive and understanding. Everyone has feelings which need to be shared and accepted. The main rules are - no one critiques or criticizes another participant and all listen to what was, or is, going on inside each other.

Research on the effectiveness of applied critical incident debriefing techniques has demonstrated that individuals who are provided CISD within a 24-72 hour period

after the initial critical incident experience less short-term and long-term crisis reactions or psychological trauma. Subsequently, emergency service workers, rescue workers, police and fire personnel as well as the trauma survivors themselves who do not receive CISD, are at greater risk of developing many of the clinical symptoms mentioned in this chapter.

Who serves on a CISD Team?

During the past two decades, mental-health professionals have gradually become aware of the stresses that negatively affect emergency personnel. As a result of this increased awareness, several *general classifications* of mental-health professionals have developed interests in emergency workers. For example:

The "entrepreneurs" who see emergency personnel as just another business deal. They generally have little understanding of the population they serve and make no special provisions for the emergency worker. A main concern is to cultivate a positive impression with administrators so they have the best potential to develop a lucrative contract.

The "glory seekers" they are nowhere to be found unless an event that attracts the media occurs. They suddenly appear as "experts" and lap up as much exposure as possible during the incident, then quickly fade away when the excitement dies down.

The "number crunchers" that do not see genuine research as a tool to help emergency service workers, but instead as a way to complete a degree, get published or draw attention to themselves. They usually appear suddenly, demand a lot of survey data from emergency workers, and disappear without a trace of feedback to those who have spent their time working on the surveys.

The "well-meaning but unknowing" who have not taken time to learn that emergency personnel are normal people reacting to abnormal events. They use non-directive or "psychiatric" interventions on emergency people which will not work. They are generally clumsy in their approach to emergency response personnel and unable to establish a connection because they failed to learn about their special personalities and needs.

The "dedicated and trained" professional who understands the unique personalities of emergency personnel and the special jobs they perform. **They take the time to go through special training**, read about emergency personnel and ride along with

them on calls. They keep a low profile, are not primarily motivated by money and perform careful research that aims at bettering emergency workers. Most emergency personnel have encountered these types of mental-health professionals in the course of their career. They will agree that the dedicated and trained type is the very best for service on a critical incident stress debriefing (CISD) team and that the wrong type of mental-health professional is usually worse than no help at all!

It is important to note that the Chaplain's role is not that of a mental health professional. When a CISD team is put together, it is always advisable to request a mental-health professional trained in CISM to serve on the team. Chaplains fill a much needed role assisting responders of traumatic events, however no Chaplain should advise or counsel in the area of mental health unless they are trained/qualified counselors (formal training recognized by the state in which they operate) but should refer the individual(s) to their Employee Assistance Program (EAP), Peer Support Group or a Mental Health Professional trained in CISM.

Conducting a CISD

The following outline bullet points the important things to think about as you prepare for a formal debriefing. This section is not intended to be a "teaching" chapter, as only trained individuals should initiate a CISD. The goal of a debriefing is to help normal people deal with abnormal situations. Untrained individuals, though well-intended, can cause more harm then good if they do not understand the reasons behind the methods and steps involved in a Critical Incident Stress Debriefing.

<u>Preliminary/Prep Work</u>

1. Facilitator
   A. Someone trained in CISM.
   B. Good people skills, ability to read the room and know how to keep the process moving forward.
   C. More skilled facilitators may be required for incidents that are particularly intense.
2. Time Frame
   A. Optimally within 24-48 hours
   B. Effectiveness diminishes when the time between the incident and CISD is offered. There is minimal effectiveness after six weeks.
3. Ground Rules
   A. Absolute confidentiality

B. Only people impacted by the traumatic event. No management or supervisory staff should be present. If a supervisory person was part of the traumatic event, consideration should be given to conducting an individual CISD as oppose to a group CISD. In some cases, they might be included – but this should be the exception, not the norm. (my wording and perception stated here)
C. No comments or criticisms regarding other's feelings or reactions (this is not the time to assess performance – its about what did happen and how they felt about it)
D. Positive, supportive, understanding atmosphere, based on concern
E. Active listening
F. Providing Structure

4. Establish Guidelines for expected of all participants
   A. Clarify reason for the Debriefing (if you are the Facilitator)
   B. Identify the event or time period the group will be discussing. Example, if PCLEC conducted a debriefing with the first responders on the Roseville helicopter accident, the facilitator would instruct that the debriefing would focus on the first phase of the event (for example) – not on day two or day three of the event. Therefore only those who had responded within the first phase would be present at the debriefing. For group debriefings, assure the group that each person involved will have an opportunity to "tell their story". Reassure the group that each person's viewpoint and contribution is important.
      i. Each person speaks for them selves, no "I heard so-and-so say, "bla, bla, bla". Keep things in the first person.
      ii. Important that each person talk about the crisis event.
   C. Location
      i. Private
      ii. Comfortable
   D. Systematic Approach (as outlined in the formal CISM training)

The CISD Structure

Once the debriefing begins, it follows a carefully designed structure that progresses through seven phases and provides important stress-reduction information. While participants are not required to speak, they are encouraged to discuss various aspects of the incident that distressed them. The whole process usually takes two to three hours to complete.

During the debriefing, personnel should not be required to respond to calls; others in the system need to fill in for them. Also, only those involved in the incident should attend, including command officers. If the critical incident affected various types of emergency personnel at the scene, a joint multi-agency debriefing is often held. It is important then to pick peer-support personnel from each of the agencies for the CISD team. If an incident involves only law enforcement personnel, it is important to choose law enforcement peers since law enforcement are more likely to trust fellow officers. The same concept holds true for other agency personnel.

Phase 1: Introduction Phase

The CISD begins with an introduction from the CISD team members at which point they state that the material to be discussed is strictly confidential. It should also be emphasized that the CISD is not an operation critique. Attendees are then told what to expect during the debriefing and assured that the major concern of the CISD team is to restore people to their routine lives as soon as possible with minimal personal damage to the individual. The basic rules of the debriefing are explained before the team members move into the next phase.

Phase 2: Fact Phase

The second phase of the CISD is the fact phase in which people are asked to describe what happened at the scene. This is a relatively easy phase for law enforcement and emergency personnel who are used to talking about the operational aspects of an incident. Once the incident is described, the debriefing team leader will lead the discussion into the thought phase of the process.

Phase 3: Thought Phase

The usual question asked in this phase is, "Can you recall your first thought once you stopped functioning in an automatic mode at the scene?" This helps people to "personalize" their experiences. The events are no longer a collection of facts but an individual, meaningful recollection of how they personally experienced the incident.

Phase 4: Reaction Phase

The fourth phase of a debriefing is the reaction phase, the point at which people can describe the worst part of the event for them and why it bothered them. If a critical incident has any significant emotional content attached to it, it will usually be discussed during this phase. It can occasionally become a heavy emotional phase of the debriefing but is not necessarily intense.

It is not the objective of a CISD team to promote emotional behavior but, instead, to foster discussion so that recovery is as rapid as possible. The reaction phase allows people to discuss the worst parts of an incident in a controlled environment that enhances venting thoughts and feelings associated with the event and prepare them for useful stress reduction information.

Phase 5: Symptom Phase

The fifth phase of the CISD process is the symptom phase. The group is asked to describe stress symptoms felt at three different times: The first being those symptoms experienced during the incident; the second are those that appeared three to five days after the incident; and the last being symptoms that might still remain at the time of the debriefing. Changes, increases and decreases of symptoms are good indicators for the mental-health person of the need for additional help for some attendees.

Phase 6: Teaching Phase

The next phase of the CISD process is the teaching phase. The CISD team members furnish a great deal of useful stress-reduction information to the group. They also incorporate other information, such as the grief process, promoting communication with spouses and suggesting how to help one another through the stress.

Phase 7: Re-Entry Phase

The seventh phase of the debriefing process is called the re-entry phase, when personnel may ask whatever questions they have. A summary is given by the team and the CISD is concluded.

After the debriefing, the CISD team remains at the debriefing center to talk with those needing additional individual assistance. Referrals are made for counseling if necessary. Finally, the CISD team holds a post debriefing meeting to quickly review the debriefing and discuss ways to improve their functions for future debriefings. However, the main reason for meeting is to make sure that everyone on the team is okay before going home – hearing the pain that others experience may bring about some pain for the debriefers.

CISD FUNCTIONS DURING AN INCIDENT

On-scene support services

During an incident, a debriefing team may be involved with providing on-scene support services that assist obviously distressed personnel. The team advises and counsels responders and gives direct and indirect support to the victims and agencies present.

Defusings are shorter, unstructured debriefings that encourage a brief discussion of the events which can reduce acute stress. Defusings can be done anywhere from one to three hours following the incident, often at the station, and generally last from 30 minutes to an hour. Only those crews most affected are involved; not all workers from the scene attend, as would be the case in debriefings.

If the defusing is not accomplished within 12 hours, a full formal debriefing is what should occur next. A well-run defusing can often eliminate the need for full formal debriefing. If both are necessary, a debriefing should be held three to seven days after the defusing.

Establishing a Critical Incident Stress Debriefing Team

Some regional CISM teams have been established and may be available if a local CISD team cannot be pulled together. Formalized CISM teams are made up of personnel who have met nationally recognized requirements and are usually registered with the agency or locale in which they serve.

Utilizing a regional CISM team is not always an option, nor is it always desirable. The Placer County Law Enforcement Chaplaincy has a list of qualified personnel

who have met the training requirements to serve on a Critical Incident Stress Debriefing Team. This list identifies personnel by training, experience, profession, and "normal" availability. Since there is generally one day to pull together a team, the more preliminary information available to the facilitator will assist in the rapid deployment of the team.

When pulling a team together, keep the following things in mind:

- Mental Health professionals who possess the diagnostic skills to help recognize issues more serious than stress alone.
- Peer professionals who understand the day-to-day stresses of the responders.
- Support personnel (Chaplains) who have on-going relationships with the first responders and can observe behavior change which could lead to a referral to a mental health professional (something most first responders are less likely to do).

To obtain formalized training in Critical Incident Stress Debriefing, check the courses offered through any of the reputable organizations specializing in Critical Incident Stress Management.

The simplicity of the critical incident stress debriefing should not cause one to underestimate its value. Well-executed CISDs have an enormous potential to alleviate overwhelming emotional feelings and potentially dangerous physical symptoms. When used properly, they can extend the careers of personnel, thus saving great outlays of resources to replace perfectly good men and women who have seen too many broken bodies and too much human misery.

POST TRAUMATIC STRESS DISORDER

Recognizing It, Treating It

Post Traumatic Stress Disorder ("PTSD") is the usual diagnosis that Mental Health Professionals apply to persons who have suffered severe trauma in their lives and develop certain symptoms as a result of that traumatic event.

PTSD is characterized by psychologically re-experiencing the event through nightmares, daydreams, flashbacks and/or intense distress when reminded of the original event. There may be symptoms of avoiding things that remind one of the traumas, social isolation, a feeling of being different from other people and a general lack of interest in the world. Other symptoms include tension and anxiety,

such as difficulty falling asleep, irritability, and outbursts of anger, trouble concentrating or being exceptionally jumpy.

Any individual who has experienced trauma may suffer from these symptoms. Being in crisis, however, doesn't mean the individual will develop Post Traumatic Stress Disorder. PTSD may occur if the victim hasn't had the opportunity to work through their crisis.

There are three distinct phases of acute post-trauma reactions: the shock phase, the impact phase and the recovery phase. Following, is a short description of each phase:

1. The Shock Phase
   A. Can last a few days or several weeks
   B. Common emotional responses
      i. Immobilization – confusion, disorganization, and inability to perform simple, routine tasks. (Example, during an armed robbery, the store clerk may have difficulty following the direction to open the cash register – almost feeling like everything is happening in slow motion. Tunnel vision, which causes the victim to focus on one area of the trauma, is also not uncommon. In the store clerk example, the clerk may focus on the weapon to the point that they do not know what the robber looked like or anything else going on in the store.
      ii. Denial – refusing to believe that the trauma <u>is</u> actually happening.
   C. Not all victims experience the shock phase. People trained to deal with trauma on a regular basis, such as police, military, medical emergency workers, may initially bypass the shock phase, though elements of the shock phase may be evident.
2. The Impact Phase
   A. Anger and/or extreme anxiety
      i. Trembling
      ii. Crying
      iii. Subjective feelings of tension
      iv. Anxiety
      v. Outrage
      vi. Displacement (Store clerk example – may become extremely angry with the store owner or the police as oppose to the perpetrator).
   B. “What-if-and-maybe” stage
      i. Self Doubt
         a. Invents different scenarios – ignoring the actual fact and outcome of the trauma.
         b. “If only I’d been five minutes earlier”

c. "If only I had reacted more quickly"

ii. Self Blame (Common in police and ambulance crews)

d. Guilt can last indefinitely if not dealt with

C. Depression
   i. Irritable
   ii. Misunderstood
   iii. Helpless
   iv. Isolation which leads to a loss of hope for the future
   v. Prevailing attitude: "Leave me alone, there's nothing wrong with me."

D. "Mad/Sad" Cycle. If the victim fails to face the trauma at this point, they will continue in an anger/anxiety and depression cycle and will be unable to progress to the recovery phase. PTSD becomes chronic.

3. The Recovery Phase

A. If the trauma is dealt with right away, the chances of getting stuck in the Impact Stage are slim. If a victim sees a crisis counselor at the scene or soon afterward, and the counselor explains what they're experiencing, why they are experiencing it, and what to expect next, the victim will feel reassured that what they are feeling is "normal".

B. Once the person resolves the guilt and returns to a relatively symptom-free mode of functioning, they may remain there for sometime. A new disturbance or a reminder of the original trauma can cause recurring symptoms.

C. Similarly, an accumulation of the stresses of daily life, such as financial problems, employment difficulties, or ill health, may also cause the trauma survivor to regress.

With effective treatment, survivors can learn to control many of the symptoms of anxiety and depression which will allow them to function more productively. Victims who haven't worked through their trauma and don't understand what they are experiencing may become trapped in the anxiety / depression cycle.

Those subject to constant high levels of stress, such as police or emergency response workers, are often unable to remain in a symptom-free mode because of constant immersion in trauma. It is important that first responders continually work through their trauma by taking advantage of programs offered through their agencies like, peer counseling, formal debriefings, the Employee Assistance Program (EAP) or the Chaplaincy.

People experiencing the anxiety / depression cycle tend to self-medicate in an attempt to alleviate their symptoms; with alcohol and drugs being the "drug of choice" abuse in these areas can become a severe problem.

A less obvious form of self-medication is sensation seeking is to get symptom relief through an adrenaline rush. Some people suffering chronic post traumatic stress disorder take a sudden interest in high risk activities like sky diving, motorcycles riding or rock climbing. Some will also seek out excitement through numerous sexual encounters.

Survival Guilt

When a victim suffering PTSD becomes trapped in the anxiety/depression cycle, their guilt overwhelms them. They feel guilty for surviving and responsible for the fate of others or for the event having happened in the first place.

Existential Guilt

Existential guilt is characterized by the survivor's confusion over having lived and the meaning of this survival. For instance, if the trauma includes death of other individuals we sometimes see variations on this theme: the survivor wishes to change places with the person who died, and the guilt is expressed as "I should have died, and they should have lived." Because their own lives have been so chaotic since the trauma, they feel that the person who died would have had a better life with more to live for, failing to recognize that it's likely this person would be struggling with similar emotions.

After hearing about the trauma during an interview, counselors may ask, "How come you lived through that?" A common response is, "I don't know, I ask myself that question all the time," or, on a more positive note, the victim may see a new purpose for their life after facing the probability of death.

Content Guilt

Content guilt, as opposed to existential guilt, is a result of a person's having done something to ensure their survival, such as hiding under a table during a shooting. This is a much easier form of survivor guilt to recover from because there are actual behaviors to talk about and understand.

Because survivor guilt has both emotional and intellectual components, a major goal in counseling is to separate the feeling and thinking elements. The survivor must learn that it is okay to feel sad about someone's having died or been injured in a traumatic situation, but it is neither rational nor appropriate to feel totally

responsible for the person's death. The situation or perpetrator should be blamed, not the survivor.

Formal Counseling

To keep the victim accessible to counseling, however, the counselor cannot say "You have nothing to feel guilty about," because victims often cling to their guilt for comfort. The counselor should attack the guilt through the issue or responsibility. Getting survivors to share responsibility for what happened starts with pointing out other factors involved in the incident. One of the factors may be time and space; they may have been in the wrong place at the wrong time. They may have been the victim of a random act.

Survivors of trauma tend to remember the traumatic situation in an unchanged way; their initial perception of the event is the way they continue to view it, as if the traumatic event were frozen in their memories. The healing process involves looking at and discussing those memories realistically. Because the memories have a negative focus, the goal of re-thinking is simply to look at the original trauma in a different light.

Sometimes when victims have intrusive thoughts about the traumatic incident, the original thought may be followed by a host of “what-if” and “maybe” versions of the event. To help victims stop this negative thought process, the victim might find it helpful to physically rebuke the thought. Simply shaking their head and saying “no” or “no, this is what happened”, has the effect of training themselves to separate the intellectual from the emotional and deal only with the reality of the situation.
They may also set a time limit, allowing themselves a certain amount of time to think about the incident (maybe five minutes) Then, at the end of the five minutes, they can tell themselves, “Okay, that is all”.

It is important to know that a victim may become confused when they begin to ponder the facts of the traumatic event. This confusion is a positive sign that indicates they are beginning to question their original perception. There is usually a realization that the traumatic event had other facets that may have been overlooked, ignored, forgotten, or devalued. Finally, if the victim has religious beliefs, those beliefs may need to be addressed. It is not uncommon for someone’s beliefs to either be strengthened or weakened by their experience. It is recommended that trauma counselors be in contact with the clergy in their community, as talking to clergy can do much to alleviate individual guilt.

Chapter 5
CRISIS REACTION

TRAUMA RECOVERY GUIDELINES

It is important to educate family members and close friends of the common reactions and signs of stress when working with someone who has experienced a traumatic event. Family/friends who are not traumatized often want to help but don't know how to help.

As a chaplain, if you give basic information about trauma reactions and self-help techniques to the family/friends, they have an opportunity to understand the emotional reactions be experienced and possibly impacting their relationship with the victim. An acknowledgement and understanding of these emotional reactions helps to shorten the recover time and prevent complications through the natural healing process.

Expected Emotional Reactions (Experienced for days/weeks/months)

- Sense that life is out of balance
- Disbelief
- Flashbacks
- Sleep disturbance
- Sadness
- Diminished sexual drive
- Minimization of the critical incident
- Anger/irritability
- Forgetfulness
- Cold-like symptoms
- Survivor guilt
- Increased substance use.
- Social withdrawal
- Emotional numbing
- Feelings of being "Out of control"
- Fears of "Going Crazy"
- Loss of feeling secure in the world
- Self doubt - as parent and provider
- Omens
- Mood swings - high and low
- Fear

Self-Help Techniques

- Don't push thoughts and memories of the event away, it is critical to talk about them.
- Don't feel embarrassed about a repetitious need to talk to people.
- Keep life in balance.

- Diet/sleep/exercise
- Balance your work with rest
- Avoid new major projects in life
- Keep a familiar routine with familiar people and surroundings.

Things to Try

Within the First 24-48 Hours

- Periods of strenuous physical exercise, alternated with relaxation will alleviate some of the physical reactions
- Structured time - keep busy
- Remind them they are normal and having normal reactions – tell them not to label themselves crazy
- Talk to people - talk is the most healing medicine
- Be aware of numbing the pain with overuse of drugs or alcohol, you don't need to complicate this with a substance abuse problem
- Reach out - people do care
- Maintain as normal a schedule as possible
- Spend time with others
- Help your co-workers as much as possible by sharing feelings and checking out how they're doing
- Give yourself permission to feel rotten and share your feelings with others
- Keep a journal, write your way through those sleepless hours
- Do things that feel good to you
- Realize those around you are under stress
- Don't make any big life changes
- Do make as many daily decisions as possible which will give you a feeling of control over your life (i.e., if someone asks you what you want to eat--answer them even if you're not sure)
- Get plenty of rest
- Recurring thoughts, dreams or flashbacks are normal - don't try to fight them - they'll decrease over time and become less painful
- Eat well-balanced and regular meals (even if you don't feel like it)

Solicit Support from Supervisor, Friends and Family

- Speak with senior Chaplaincy personnel about the possibility of conducting a Critical Incident Stress Debriefing
- Offer suggestions to Co-Workers, Supervisor, Family and Friends
  - Listen carefully, even if they have not asked for help
  - Spend time with the traumatized person
  - Reassure them they are safe
  - Help them with everyday tasks like cleaning, cooking, caring for the family, minding children, etc.
  - Give them some private time
  - Don’t take their anger or other feelings personally
  - Don’t tell them they are “lucky it wasn’t worse”. (People are not consoled by those kinds of statements.)

- Give them “permission” to let the normal healing process unfold (this takes time). If gradual reduction in symptoms does not occur, suggest/encourage them to seek further assistance.

Crisis Reaction – A Normal Response to an Abnormal Situation

All of the feelings and reactions are normal and natural, even though they may seem unusual and though some are very different from others. We are all unique individuals who respond in our own unique way. Although there are “common” reactions, each individual reaction is unique to that person. Our memories are a part of our lives and a traumatic incident cannot be erased. Everyone will move at their own pace through the stages of crisis and healing. The internal clock ticks differently for each person and each person may have other things going on in their lives which contribute to the healing process.

Below are common signs and signals of a stress reaction. This list is not intended to be used to “diagnose” individuals, rather something to refer back to in order to help someone navigate through the ‘mind-fields’ which can trip people up when we over analyze our situations. Don’t allow people to “Monday-Morning Quarterback” by thinking about what we or others could have done differently.

Encourage the victim to take care of themselves physically (balanced diet, rest, exercise, and maintain a daily routine). Avoid the use of drugs and alcohol, including over-the-counter medications. Medications should be taken sparingly and only under the supervision of a physician. Substances may be addictive and interfere with the healing process.

Help them to talk about what happened and about their feelings. If they need more information or want to talk in the future, have them call the Chaplaincy at (916) 663-2427. An easy way to remember the number is (916) One-Chas (which stands for 1-Charles …the Chaplaincy Call Number).

Common Signs and Signals of a Stress Reaction[5]

Physical*	Cognitive	Emotional	Behavioral
Chills	Confusion	Fear	Withdrawal
Thirst	Nightmares	Guilt	Antisocial acts
Fatigue	Uncertainty	Grief	Inability to rest
Nausea	Hyper-vigilance	Panic	Intensified pacing
Fainting	Suspiciousness	Denial	Erratic movements
Twitches	Intrusive images	Anxiety	Change in social activity
Vomiting	Blaming someone	Agitation	Change in speed patterns
Dizziness	Poor problem solving	Irritability	Loss or increase of appetite
Weakness	Poor abstract thinking	Depression	Hyper-alert to environment
Chest Pain	Poor attention/decisions	Intense anger	Increased alcohol consumption
Headaches	Poor concentration/ memory	Apprehension	Change in usual communications
Elevated BP	Disorientation of time, place, or person	Emotional shock	
Rapid heart rate	Difficulty identifying objects or people	Emotional outbursts	
Muscle tremors	Heightened or lowered alertness	Feeling overwhelmed	
Shock symptoms	Increased or decreased awareness of surroundings	Loss of emotional control	
Grinding of teeth		Inappropriate emotional response	
Visual difficulties			
Profuse sweating			
Difficulty breathing			

**Any of these symptoms may indicate the need for medical evaluation. When in doubt, contact a physician.*

FAMILY

The following section on Family and Helping Children Respond to Trauma may be administered to children in the family as "First Aid". This information can be reproduced and sent home with students or mailed to the homes of families dealing with trauma. Give children special and directed support by keeping things fairly structured and adjusting for fears, especially at bedtime.

1. Help re-establish a sense of safety by assuring that the house is locked and that the child knows the parents' whereabouts at all times. This may mean transporting to and from school for awhile.
2. Offer reassurance when traumatic reminders intrude on thinking, feeling or behavior.
3. Validate the expression of all feelings by tolerating them and not dismissing them.

[5] Mitchell, PhD, Jeffrey T. *Critical Incident Stress Management (CISM) Group Crisis Intervention.* 4th Edition. © 2006 by the International Critical Incident Stress Foundation, Inc.

Helping Children Respond to Trauma

Response to Trauma: Preschool – 2nd Grade

- Helpless and passivity
- Generalized fear
- Cognitive confusion (e.g., do not understand that the danger is over)
- Difficulty identifying what is bothering them
- Lack of verbalizations - selective mutism, repetitive nonverbal traumatic play, unvoiced questions
- Attributing magical qualities to traumatic reminders
- Sleep disturbances (night terrors and nightmares, fear of going to sleep, fear of being alone--especially at night)
- Anxious attachment (e.g., clinging to parents)
- Regressive symptoms (thumb sucking, enuresis, regressive speech)
- Anxieties related to incomplete understanding about death; fantasies of "fixing up" the dead, expectations that a dead person will return

First Aid

- Provide support, rest, comfort, food, opportunity to play or draw
- Re-establish adult protective shield
- Give repeated, concrete clarifications
- Provide emotional labels for common reactions
- Help to verbalize general feelings and complaints
- Separate what happens from physical reminders such as the place where the trauma occurred.
- Encourage them to let their parents know
- Provide consistent patterns (e.g., assurance of being picked up from school)
- Tolerate regressive symptoms in a time-limited manner
- Give explanations about the physical reality of death

Response to Trauma: 3rd – 5th Grade

- Preoccupations with their own actions during the event
- Specific fears--triggered by reminders
- Retelling and replaying of the event (traumatic play)
- Fear of being overwhelmed by their feelings (of crying, of being angry)
- Impaired concentration and learning
- Sleep disturbances (bad dreams, sleeping alone)
- Concerns about their own and others' safely
- Altered and inconsistent behavior (e.g., unusually aggressive or reckless behavior, inhibitions)
- Somatic complaints
- Hesitation to disturb parent with own anxieties
- Concern for other victims and their families
- Feeling disturbed, confused and frightened by their grief; fear of ghosts

First Aid

- Help to express their secretive imaginings about event--issues of responsibility and guilt
- Help to identify and articulate traumatic reminders

- Permit them to talk and act it out; address distortions and acknowledge normality of feelings and reactions
- Encourage expression of fear, anger, sadness, in your supportive presence
- Encourage to let teachers know when thoughts and feelings interfere with learning
- Support them in reporting dreams--fear of providing information about why we have dreams
- Help to share worries; reassure with realistic information
- Help to cope with the challenge to their own impulse control (e.g., acknowledge "It must by hard to feel so angry")
- Help identify the physical sensations they felt during the event and link when possible
- Offer to meet with children and parent(s), to help children let parents know how they are feeling
- Encourage constructive activities on and behalf of the injured or deceased
- Help to retain positive memories as they work through the more intrusive traumatic memories

Response to Trauma: 6th Grade and Up - Adolescents

- Detachment, shame and guilt.
- Self-consciousness about their fears, about sense of vulnerability--fear of being labeled abnormal
- Post traumatic acting out (e.g., drug use, delinquent behavior, sexual acting out, etc.) as effort to numb their responses to the event
- Life threatening reenactment, self destructive or accident-prone behavior
- Abrupt shifts in interpersonal relationships
- Desires and plans to take revenge
- Radical changes in life attitudes which influence identity formation
- Premature entrance into adulthood (e.g., leaving school, getting married) or reluctance to leave home

First Aid

- Encourage discussion of the event, feelings about it and realistic expectations of what could have been done.
- Help them understand the adult nature of these feelings--encourage peer understanding and support
- Help to understand the behavior--voice their anger over the event
- Address the impulse toward reckless behavior in the acute aftermath; link it to the challenge to imply control associated with violence
- Discuss the expectable strain on relationships with family and peers
- Elicit their actual plans of revenge--address the realistic consequences of these actions encourage constructive alternatives that lessen the traumatic sense of helplessness
- Link attitude changes to the event's impact
- Encourage postponing radical decisions in order to allow time to work through to their responses to the event and to grieve

Working with Schools

Preparation for handling deaths at school, before a trauma happens, is beneficial. Chaplains or mental health professionals can be engaged to teach small group techniques to teachers who may be quickly called upon to organize with skilled leaders if a tragedy occurs. In-Service training programs for teachers on topics related to grief and loss can help school officials maintain the psychological sanctity of the school. By making a choice to learn about grief and loss, teachers are not forced out of necessity to react to a situation but can use art, musical expression, poetry and storytelling as expressive outlets.

Profile of Someone in Crisis

- Sense of bewilderment
  ("I never felt this way before.")
- Sense of danger
  ("I feel so nervous and scared--something terrible is going to happen.")
- Sense of confusion
  ("I can't think clearly, my mind isn't working right.")
- Sense of impasse
  ("I feel stuck, nothing I do seems to help.")
- Sense of desperation
  ("I've got to do something - don't seem to know what though.")
- Sense of apathy
  ("Nothing can help me. I'm in a hopeless situation.")
- Sense of helplessness
  ("I can't manage this myself, I need help.")
- Sense of urgency
  ("I need help now.")
- Sense of discomfort
  ("I feel miserable, so restless and uncomfortable.")

WORKING WITH MENTALLY AND EMOTIONAL DISTURBED PEOPLE

How to handle a 5150.

Mental illness is becoming increasingly common and afflicts all age groups levels of society, and all ethnic groups. A police officer should be prepared to encounter disturbed persons at any time. When mental illness is dealt with in a competent, professional manner, they rarely cause trouble. However, distraught people sometimes behave in eccentric ways and tactfully handling the person could avoid confrontation that might exaggerate their behavior, draw a crowd, or require the officer to take measures that could have been avoided.

Types of Mental Disorders

Organic disorders: physical damage to the brain has been caused by such things as head injuries, alcohol, drugs, disease, or old age.

Functional disorders: brain refuses to work properly although there is no sign of actual injury.

Levels of Mental Disorders

Neuroses: affects sufferer's happiness but permits them to work and maintain ordinary social contacts. A neurotic person is usually treated on an outpatient basis. Modern methods of therapy are beneficial.

Psychoses: condition is severe enough to make the victims unfit for normal living. A psychotic person ordinarily requires treatment in a mental institution. Modern methods of therapy are beneficial.

Common Symptoms of a Mental Disorder

- Irrational behavior which does not fit the situation
- Sudden changes in behavior, such as a shift from cautious to reckless
- Severe loss of memory (amnesia)
- Unwarranted or prolonged depression
- Delusions of grandeur or persecution
- Hallucinations
- Alcoholics and narcotics users often reveal physical evidence of their condition. This includes shaky movements, a grayish complexion, liquor on the breath, sores from injection of sniffing drugs, and abnormally dilated or constricted pupils. Many addicts also carry supplies and equipment.
- The borderlines between eccentricity and mental illness are not always clear. Sufferers may show several symptoms at once, or their symptoms may vary from minute to minute. Many physical ailments create symptoms like those of mental disorders.
- When the situation is not urgent, try to learn something about the sufferers before you approach them.
- Adopt a relaxed, friendly attitude as far as this is consistent with the necessity of staying alert for any sudden changes in subjects' behavior.

Supporting the Officer Dealing with an Emotionally Disturbed Person

A backup officer is highly desirable to handle any needed communications and also to deal with relatives and onlookers. A Law Enforcement Chaplain on a ride along often takes on the role of the backup officer – being an extra set of eyes and offering support to the officer. If you can, try to have relatives or friends of subjects present when you talk with them.

- Deny any suggestion of a threat. Sit down beside sufferers when this is practical.
- Begin by asking simple questions that they can easily answer, and then offer to help. Use a calm, confident tone of voice.
- Adopt sufferers' viewpoints as far as possible. Argument almost never convinces them.
- Be careful not to let subjects get you personally involved with their problems.

- If you deceive disturbed persons, even on trivial matters, you may make them lose faith in everyone including their doctors. This can seriously retard their recovery.
- In rare cases when physical restraint becomes necessary, two officers are required. Avoid devices, such as handcuffs, that may injure sufferers if they struggle against them.
- After subjects are under control, try to get expert advice on the disposition of their case. If such advice is not available, it is usually wise to take the sufferers into custody.
- When sufferers must be held in regular detention facilities, remove anything with which they may harm themselves, place them in a separate cell, and keep them under close surveillance.
- Offenders arrested on routine charges sometimes show symptoms of mental disorder. In such cases, take special precautions for their safety.

Chapter 6
DEATH NOTIFICATIONS
The Most Difficult Task

Three Stages of Grief: Impact, Recoil, and Recovery

1st Stage: IMPACT - Understanding grief and grief response

The initial reaction to death is that of the Impact stage. This phase is characterized by numbed, stunned and shocked feelings. The person is unable to come to grips with what has happened; he feels suspended from life. Usually the bereaved experience a restricted field of attention and are indifferent to their immediate needs. Often there is denial and a refusal to believe that the deceased is gone. Generally the person is not in touch with his own emotions. There is often somatic distress such as choking, shortness of breath, sighing, weakness and poor digestion.

The impact stage has often been described as feeling like you have just been slugged in the stomach. It is a period of maximum stress, where normal coping mechanisms don't seem to work. Our bodies and minds often attempt to deal with this overwhelming event by shutting down. It is almost as if our mind creates a wall or a cushion to allow time to deal with the blow. The time orientation of the bereaved is the immediate present. The victim is temporarily cut off from both his past and his future and can only deal with the present. This stage varies in length from a few minutes to a few hours. On rare occasions, this stage may last a month or even 6 months or more.

2nd Stage: RECOIL – Anger, protest, bitterness, feelings of guilt

One thing that marks the beginning of the Recoil Stage is an acceptance of the fact that the person is gone. Whereas during the Impact Stage the victim often will express denial, during the Recoil Stage, their language will change. They will begin talking about their loved one in a past tense rather than a present tense (i.e., they will say such things as “Johnny used to love…”, or “Mary would talk about…” instead of “Johnny love to…” or “Mary talks about…”).

When the initial shock and numbness of the impact phase begins to lift, the person experiences the first awareness of what has happened. Now the loss is felt most acutely and the bereaved feels restless, tense, and in turmoil. Now the first overt expression of emotion occurs. Anger, protest, restless irritability, irrational feelings, sometimes bitterness both toward others and at one's self. Guilt may also be expressed. There is usually also a need to talk and ventilate. During this stage there will be acute periods of loneliness and often times a childlike attitude of dependency, wanting to be cared for and looked after.

This is the time when there is an intense yearning and urges to recover the deceased. This manifests itself in many ways: preoccupation with thoughts of the deceased, a clear visual memory of the deceased, a sense of the presence of the

deceased, calling and crying for the lost person, and even a conscious recognition of this urge to search for the deceased by going to his/her grave or places where he/she had been. Usually during this phase the bereaved will need to be with others and to have a stable, supporting environment. However, they are reluctant to request other's help. Therefore, the initiative to have people near them will usually have to be on the part of others. It is very easy to remain at the recoil stage, to become fixated here. Furthermore, this is a very crucial period and the response of other persons is of critical significance for the bereaved person's future.

The time orientation or perspective now includes the past, present and future. This phase usually begins a month to a year after the death, and can last for the remainder of the bereaved person's life. It is not uncommon for the Recovery State to start as last as five years after a loss. It is helpful for the Chaplain to share with the victim that they will never get back to the same as before the death of their loved one. They will eventually get a "new normal". You can also share that there is no time limit on grieving. Just because there is a funeral, this does not mean they now have closure; they are not "just over it" Remember, grieving is a process.

Indicators of the Recoil Stage:

- If I could, I would
- Loneliness
- How will I go on?
- Assist survivor with a need to go on
- They will have a yearning for deceased not to be dead
- You cannot recover from grief until you are in a past tense process: called closure: He was; instead of he is.
- Could be preoccupation of the person calling the deceased
- Searching for deceased will happen
- Desire to be with others, relatives, friends, neighbors
- How we react is how the survivor will react!
- Be positive, in a negative response
- Shift from present tense to past tense

3rd Stage: RECOVERY – I have to go on!

This phase of the grief response entails getting back to normal in so far as that is possible. The person begins to feel the stress is passed and has come to face the matters of everyday living in the new environment without the deceased. The permanence and fact of the loss are accepted, and the attempts to recover the deceased are given up. The bereaved now has to develop a new set of functioning roles which involves letting go of the past and the building of a new life.

Some of the tasks included in building this new life are as follows:

A. Learning to be alone.
B. Finding a meaningful social and emotional life.
C. Being the head of the household, breadwinner, both mother and father to the children and learning the role of the single parent.
D. Facing the issue of remarriage.

Often times the bereaved will be in need of both vocational counseling and advice as to financial management. There may also be feelings of temporary anxiety, fatigue, and or depressive reactions.
The time orientation or perspective now includes the past, present and future. This phase may begin within three months to a year after the death, and last for the remainder of the bereaved person's life.

Indicators or Statements of someone in the Recovery Stage:

- I now must develop a new set of functioning rolls
- Realizes that life will go on
- Set up new social life
- Be both father & mother
- Facing issues that I am going to be alone the rest of my life
- May need: counseling- psychological, financial, and spiritual
- Anxiety; fatigue; stress
- Pulling together the past, present, and future
- No more denial is evident

Death

Death is the end of life, but death cannot sever the bond established between the living and the dead. Love still exists. Precious memories and cherished experiences can never be taken from us. Ask the grieving what the deceased meant to them, or ask them to share some memories they have of the deceased. Whether the deceased is a long-time friend or a recent acquaintance, the emotions are the same.

Loss

Experiencing death is a realization that there is something beyond yourself and your own life. We experience loss, and loss hurts. Because people tend to want to "fix" things or "make things better", they say things that are more hurtful than helpful. Don't ever say, "I know how you feel." Even if you have experienced death, you don't know EXACTLY how they feel. If you don't know their feelings, don't say you do. We can empathize with their pain – we can say we know pain and pain hurts.

Ask them to share their feelings with you. Emptiness and loneliness can overwhelm someone who loses a close friend or family member. That loss may invoke feelings of fear or fright. The relationship is gone, it is over. The loss in death is permanent.

Grief / Mourning

Grief is the pain of loss. It can be overwhelming. It cannot be contained and can tear us apart. Grief is a collection of emotions which include anger, disbelief, sadness, and loss. Grief is the single most powerful emotion we will ever face.

Grief shared is grief relief. When grief is bottled up, it can cause ulcers or other stress-related conditions. Grief is also the realization that we all will die. Refusing to accept what is inevitable is not uncommon for someone who is grieving

Crying helps us mend and caring for someone or something else helps us mend. There is a close connection for people who have pets and the healing process. The life expectancy of a pet is often short and this loss can help someone work through death.

Mourning is a process of healing. It lasts until you get your sense back about yourself. It cannot be rushed, healing takes time and mourning helps sooth the pain.

Everyone who dies has a relationship with someone that affects someone else. Those who make death notifications will be affected.

The Psychological Autopsy (What do we do with it? Where do we file it?)

All deaths fit into one of four categories: Natural, Accident, Suicide, and Homicide.

Imputed Lethality
How much of a role did the deceased have in his own death?

High Lethality:	He planned it.
Moderate Lethality:	He was in a position to die. (Motorcycle going to fast, jumping on a train, driving a car too fast without seat belts, careless and risky.)
Low Lethality:	Forgot safety factors. A mistake, stupid, caused his own death.
Absent Lethality:	Person really wanted to live. Failure on inside that caused his death. Failure on the outside that caused his death.
Additional factors:	Age, Sex, Family Status. Example: 79 year old smoker, kids live across Town, natural death, Coroners case, 911 *Versus* 11 year old girl, assaulted and murdered, 911. We have different feelings for the girl than we did for the old man. (Natural vs. Homicide) Absent Lethality

Example: 21 year old man/boy, motorcycle 130 mph, crash into car, 911. We deal differently with this type of death. (Accidental) Moderate Lethality

Example: 19 year old girl takes pills after loss of boyfriend. (Suicide) High Lethality

We pigeon hole death notifications. By performing a psychological autopsy we file it away and react to the death differently based on the level of lethality.

Transference

Scenario: 33 year old dead female. Who is the woman?
Scenario: 18 month old dead baby. Who is the baby?

Transference makes the scenario belong to the Chaplain. They (Chaplain) take ownership of the emotions and grief. The victim's loss becomes the Chaplain's loss. Without a support system that allows the Chaplain to defuse or debrief after a death notification, transference becomes more likely. Purging the scenario through defusing or debriefing lowers the impact of transference on the Chaplain. Without an outlet to defuse/debrief, the impact of transference on a Chaplain, just like an officer, will lead the person down the path towards cynicism. Cynicism can be the result of a career involving too much transference.

Impact on Survivors

Is anyone ready? Never!

The impact of a death on the survivors can be influenced by several contributing factors. These include how the notification was handled, what kind of support system is in place for the family member, and what information was made available at the time of notification. However, even in the "best" of scenarios where there is little lethality, the notification is handled "picture perfect" and the survivor is surrounded with caring support – none of this can truly prepare someone for the loss of a loved one. As a Chaplain, how we feel, think, and act can help or hinder the survivor's reaction.

As a Chaplain, be on the lookout for the signs of Acute Critical Incident Stress. This might be things like: agitation, denial, feeling numb, repetitive or intrusive thoughts, sleep disturbance (can't go to sleep, wake up in the middle of the night, violent nightmares), graphic remembrances of the event, emotional flat line, fear of losing control, guilt, quick to anger, compulsive behavior, etc. Acute Critical Incident Stress (ACIS) if not adequately handled will often lead to Post Traumatic Stress Disorder (PTSD).

MOST COMMON REACTIONS

Reactions fall into one of three areas, Cognitive, Emotional, or Physical. A person can react in any one of these areas or a combination of them. Common reactions include:

- Having trouble concentrating or making decisions
- Confusion
- Anger
- Hostility
- Feeling alone: uncomfortable in social places
- Flash backs: intrusive thoughts
- Fearing familiar things
- Wondering, how will I survive?
- Numbness: a lack of interest to go on
- Guilty: I wish I had...
- No one understands
- Lowered energy: causing a slow down
- Irritated, annoyed
- Tense, keyed-up
- Easily hurt
- Over Imagining
- Closure, understanding it is real, reality settles in
- Mind racing, repeating and thinking that same thought
- Emotionally empty, going through the motions
- Wishing others would take care of you
- Sleeplessness
- A feeling ob being taken advantage of
- Vulnerable
- Over thinking decisions
- Transference: anniversaries, birthdays, holidays – It is a well known fact that anniversaries, birthdays, holidays, etc. bring back the loss in vivid detail. This is especially true of the first and second years after a death (often times the second year is actually worse than the first year). Transference can refer to the emotions that are attached to each of these anniversaries or holidays, so for example, they can no longer enjoy Christmas because it reminds them of their loss.
- Angry for not accomplishing more, why didn't I do...
- Displacement

Three Rules to Live By

A. If you can't improve on silence, don't!
B. If you can't improve the conditions in the home when you get there, then don't go in. (If you cannot bring peace and comfort to a chaotic situation because you are emotionally charged up, you will make the situation worse. We have often seen where we have a situation calmed down and an emotional person arrives – and blows everything up.)
C. Use soft words in your vocabulary: splendid, lovely, wonderful, beautiful. Soft words can draw a person into seeing things differently. Especially when

working with officers who see the negatives of society; they don't tend to see the beauty in things because they are often looking for the negative.

Duration of Distress

In the United States, we have a tendency to avoid topics like death and dying. This inability to talk about death in a "healthy" way increases the stress level of those around a survivor. The survivor's level of *distress* and the amount of time the survivor feels distressed, is greatly reduced when they have contact with others close to them, whether they are family or close friends. This support system may include the survivor's spouse, mother, father, sister, brother, grandparent, or other close relative. If a person does not have family or friends close by, it will be important for them to get connected with a local support group or bereavement group.

Be careful not to say, "You will heal in time", or other sentiments. Time is NOT a healer, although it helps. Encourage the survivor to return to "pre-event" behavior, assisting them in doing things they did before the death.

Routines are helpful in establishing a sense of order or control in a situation which is completely out of their control. Examples of this include: Taking a daily nap (at the same time each day), or taking the dog out for a walk (could be every morning at 9:00 and every afternoon at 4:30).

SUPPORT THAT HELPS

When working with victims who show strong signs of "being in control", several practices or support policies are often helpful. This is especially true if the loss is in a law enforcement family. These support practices include:

- Action Oriented Assistance: Officers tend to be action orientated. Is there something they can do to help? Give them tasks to do.
- "Need to Know" actually means, "Help me do what is next".
- Psychological and emotional support assistance: CISM, Chaplain Service, professional counseling, etc.
- Conformation Information: Means giving everyone the same information. This is especially important in a line of duty death. There should be a phone tree to all off duty officers to make sure they have all the current information as to the death and what is going on.
- Command Level Contact: Means the Chief is in briefings, with the family, and generally showing his support. This is very important at such times as a line of duty death.
- Pastor, mortuary: Make sure those involved (Pastor, Mortuary, Caterer, etc.) know and understand the details with regards to services and upcoming "events".

OVERCOMING GRIEF

A. Take time to accept death, we can't deny it.
B. Take time to let go: Letting go indicates that we are not in control of life.
C. Take time to make decisions.
D. Take time to share
    1. Loss of parents, grieve for our past.
    2. Loss of spouse, grieve for our present.
    3. Loss of a child, grieve for our future.
E. Take time to believe: There is a difference between fact and faith. Faith works because it is totally illogical. (It is 28 – 0 in the last of the fourth quarter. Faith says “we can win”. Facts would say “it is impossible”.
F. Take time to FORGIVE: Non-forgiveness is a bitterness. It traps people in their past. Forgiveness is not pardon but it helps in looking at things differently.
G. Take time to feel good about your self.
H. Take time to laugh: laughter in humor is medicine. A merry heart makes like a medicine.
I. Take time to meet new friends.
J. Take time to give your time, energy, or effort. Getting involved makes life go on.

DEATH NOTIFICATIONS (IN PERSON ONLY)

(Suggestions/Recommendations)

Pre-Notification

- Correct Information: Verify deceased and family information. Who, what, when, how it happened, Next of kin or family information. Make sure information is correct.
- Pre-event conditions of family (stability, if known): health, kids, neighbors/friends.
- Two person detail / Parking / Time of Day: Always go in with an officer to do the notification. NEVER go by yourself. The officer is your protection. Remember, no situation is “typical”. Park down the road or street, not right in front of the residence. Regardless of the time of day or night, never park right in front.
- Determine, before you go in the house, who will be giving the notification. If comfortable, offer to give the notification. If the officer would prefer to give it, be there as his/her support. It is their call – we are their support. If they are non-committal or ask you if you are willing – take the hint. They’d probably rather have you give the notification.

The Notification

- Knock and introduce yourself and the officer. Get in! Do not give notification at the door or outside. Access the room conditions.
- Get into a soft room: living room, family room, somewhere with soft chairs. Steer the person to a chair where their knees are above their hips – this prevents them from jumping up when the notification is given. It is not uncommon for a person to jump up and start swinging as a reaction to receiving very bad news.

- Ask if there are other people in the home – so you can tell everyone in the house at the same time.
- Use direct words that are understandable, dead, killed, died, etc. Do not use words like fatality, fatal accident, tragic accident – too much is left for interpretation and you don't want to explain yourself a second time. Say things like, "We are here to tell you that Phillip is dead", or "Phillip was killed in an auto accident on Highway 65".
- Expect the un-expectable – reactions are not predictable.
- Offer limited facts only. ABSOLUTELY NO OPINIONS. Avoid saying, "I don't know". Rather say, "I will find out" or "an investigation is taking place, they'll know more later". Absolute honesty is not always the best way to handle things. There are some things they just don't need to know.
- Be Specific, but tactful. This is not the time for jargon. Use soft, simple, and clear language.
- Offer empathy (ability to share in their feelings), not sympathy (often perceived as pity when coming from a stranger). Unless you know them, people do not want sympathy from strangers.
- Do not give reason for false hopes – that is actually cruel.
- Help move them towards closure. "What <u>did</u> he/she like to do?" – help them think in past tense, but don't force it.
- Quiet moment? Don't try to fill the quiet moments. When you cannot improve on silence, don't!

Next Steps

- Don't be in a hurry to get out of there. If you have other commitments, ask the ECO DISPATCHER to send a back-up.
- Make phone calls, get someone else there to help. Don't leave them alone – even if they request it.
- What types of support systems are available to them? (Pastor/Priest/ Rabbi, relative/children, neighbors)
- What else can you do?
- Have you shared with them the burial process? Do they know what the deceased would have wanted, burial or cremation?
- Inform them that they don't have to make immediate decisions about the funeral, etc. It is usually best to make these decisions with the help of a close fried or relative. If no one is available, a Chaplain may be able to help with making arrangements, including going to the mortuary as a support person.

Epilogue Clichés – Things people despise hearing:

- Be strong for your children.
- You've got to get a hold of yourself.
- It's natures way or God's will.
- Buck up.
- You're young; you'll make a life for yourself.
- Time will heal all this.
- Look around you're not the only one going through this.
- You need to stop reliving the past.
- Only the good die young.

- You need to count your blessings.
- Think of your precious memories.
- God needed Him more than you did.
- He's happy now that he's with God.
- I know how you feel.
- If there's anything you need just call.
- What you don't know won't hurt you.
- Well you have 2 other children.
- You can have more children.

GRIEF INTERVENTIONS

The process of grief, as identified by Kubler-Ross, includes five stages: Denial, Anger, Bargaining, Depression and Acceptance. When dealing with those in grief, our intervention should include allowing the expression of feelings, responding with empathy, and prayer, if desired by griever(s). If prayer is desired, offer to pray with them at that moment. Be careful not to force yourself to be a theological "expert".

Effective grief intervention is understanding there are a variety of reactions to grief and recognition of the importance of grief work (and it is work). If appropriate, arrange for follow-up with the person or refer them to resources that can assist them as they work through their grief. Most importantly, remember this is a ministry of presence.

Article~

Grief Knowledge

No amount of knowledge can prepare us for bereavement. Grief is the most intense and enduring emotion we can experience. No quick fix. No short cut. An ancient African saying is, "There is no way out of the desert except through it." Knowledge of the grief process gives us a very generalized map of the terrain we have to cover. Each of us will take a different route. Each will choose his own landmarks. He will travel at his own unique speed and will navigate using the tools provided by his culture, experience, and faith. In the end, he will be forever changed by his journey.

Knowledge helps us avoid the major pitfalls of grief. A knowledge of what is known of grief assures us that we have not lost all sense of sanity. When we find ourselves feeling befuddled in a mist shrouded swamp we can say "It's okay. This too is a part of my journey. Others have gone this way before me and I will survive. I am human".

The following is an excerpt from an article by Reverend Howard R. Gorle, M.Div from Hospice.Net. *(www.hospicenet.org/htm/knowledge.html)*

Article~

STRAIGHT TALK ABOUT GRIEF INTERVENTION
Suicide – Last year my father killed himself with a handgun.

When you spoke of how "invasive" your presence seems to a family, I remembered wanting to strike the officer who barred my way into my father's room. I immediately hated him, and resented his presence. One of my sisters used language (to an officer) I'd never heard come out of her mouth before! We actually laughed about it later, but at the time, the violent feelings brought on by fear and shock was over-whelming!

Not long after, I saw one of the officers at a restaurant. It may have been purely coincidence, but at the moment of recognition, it seemed he, either out of respect for my privacy or his (or in fear of my wrath!) moved to another area of the restaurant. I wanted to speak to him, but the lump in my throat prevented me from saying:

- *Thank you for being there.*
- *Thank you for doing your job professionally, sensitively, and with obvious care and concern.*
- *In that long wait for Homicide to arrive, and then do their job, thank you for behaving in a respectful manner.*
- *Thank you for refraining from "small talk" with each other about sports, or cracking jokes to offset your discomfort and awkwardness in the face of our pain.*
- *Thank you for your honesty and patience in answering questions again, and again, and again.*
- *Thank you for your gentleness in handling my father's body. I noticed.*
- *Thank you for pausing to let me touch the wrapped and covered remains of what I knew for a lifetime as flesh of my flesh - my father.*
- *Thank you for cleaning up as much as you could in Dad's room. We could tell that you had made a real effort to make things as easy on us as possible. (We are not allowed as chaplains to clean up blood or other body fluids)*
- *Thank you for treating each of us with respect and concern.*
- *Thank you for not avoiding eye contact with us.*
- *Thank you for seeming to give us private moments as family members arrived, even though I knew you had to observe each one of us.*
- *I remember the Homicide sergeant giving us his telephone number and offering to answer any ongoing questions. He respected my need for detailed answers, which others in my family didn't require. He was gentle and patient, and at the same time direct and painfully honest. He also told me clearly how to get a copy of the police report, how long it would take for the autopsy report to be prepared, and exactly what to expect and how to proceed.*

  As I anticipate the "year-anniversary" of my dad's suicide, I can look back and remember the support I have personally received.

Article~

HANDLING DIFFICULT GRIEF CRISES

Earl Grollman

Each death is different. When a parent dies, one loses the past. When a spouse dies, one loses the present. When a child dies, one loses the future. Even though grief is a common human experience, it is as individual as fingerprints-it shows itself in widely differing ways.

The following are some guidelines for the sorts of death experience that are encountered infrequently-where information may be scant. To be effective as clergy persons, we must be aware of al kinds of loss, the frequent as well as the less common incidences of death: loss of a newborn, sudden infant death, a death that was unanticipated, suicide, and the special feelings of the clergy person-so well acquainted with grief-when a loved one of his own has died. There are sources of help to assist the bereaved in coping with grief and loneliness and provide for continuing reassurance and understanding. People differ more widely in their reactions to death than they do to any other human experience. There is no magical procedure that will comfort all people, either at the time of death or during the period that follows.

The problem is not that the clergy person will not always succeed in grief counseling. The tragedy is that the clergy person may not be well-informed and at least attempt to do his or her best to help people in times of crisis. As Mark Twain said: "It's not what people know that gets them into trouble; but it's what they know that isn't so."

People differ more widely in their reaction to death than they do to any other human experience.

While bereavement and grief are the most universal of all human experience and the most human - they are also the most painful. Information is not adequate if it remains with the clergy person alone. Those insights must be shared in a non-threatening way to help make the agonizing period less stressful and less frightening. Then survivors will not be caught unaware and unprepared for their often bizarre but rarely spoken of sensations, thoughts, and behavioral changes. They need to understand that these changes are normal in the face of the very unusual and traumatic death in their family. And don't forget: just being with the bereaved is often more important than what you say.

LIVING WITH NEWBORN DEATH

How often do newborns die?

Within the first 28 days of life, approximately 35,000 newborn infants die in this country every year. In addition, 33,000 fetal deaths or stillbirths occur after the 20th week of pregnancy. Taken together, these 68.000 deaths add up to one death every seven minutes. The cold statistic translates into an enormous collection of human suffering for surviving parents, siblings, and the greater circle of family and friends. A child's death is no longer in the ordinary order of events. We expect older people to die-but not young babies. It doesn't seem fair before they have had a chance to live.

What about stillbirths?

Stillbirths occur in about one in 80 deliveries. After the birth and death, there is usually a conspiracy of silence. Parents are rarely encouraged to see and touch the dead body. Frequently, the baby is not given a name and the mother is quickly discharged - as if nothing had occurred. Rituals and rite of passage are seldom offered. The funeral (if there is one) is open private, without the mother and sometimes without the father being present. Most health professionals do little or no follow-up. Still birth is a non-event. It is as if the mother never carried her child. As if the father had no hopes and aspirations. There is no communication about the misery, the guilt, the shame, the failure.

What can the clergy person do in this tragic climate?

First, help the family to face reality. The child is dead. And no matter how brief the life, there are deep emotional attachments. The parents desperately need to cope and respond to their loss. How hard it is to grieve the death of a dream! Help the family make their baby-and their loss-more real with something tangible to hold on to-a hospital bracelet, a lock of hair, photographs, birth and death notices. These reminders dramatize the fact that a profound event indeed touched their lives, ever so swiftly. Let parents mourn a reality, not an illusion.

If the parents desire, let them view and touch their dead child. Too often, the infant is rushed from the mother to a special (care) unit, never to be seen again. Many parents who have had the opportunity to hold their child have remarked how therapeutic this touching had been. "Now I know my child lived. I an better able to accept that he died." This is true even when the infant is physically deformed. Beauty is in the eyes of the beholder.

As options are offered to the family, describe in advance the child's appearance, explain that the body is cold. We may offer our support by saying: "If you want, I'll stay with you. Tell me what's best for you." Understand that funerals are not solely for people who have lived a long while. The importance of funeral rituals for infant deaths has been emphasized by Dr. D. Gary Benfield, Director of the Regional Neonatal Intensive Care Unit, Children's Hospital Medical Center of Akron and Jane A. Nichols, Bereavement Consultant. They afford both closure and relief.

SUDDEN INFANT DEATH SYNDROME (CRIB DEATH)

Is there a typical history?

There is no classical case. Both rich and poor, white, black, and yellow are the victims. SIDS is not preventable no predictable. The infant is usually put to bed after a feeding without any suspicion that something is out of the ordinary. Sometime later, a few minutes, several hours or the following morning, whenever the parents next check on the baby, the infant is found lifeless. There is no outcry, no struggle. The infant may be lying face up or face down in the crib. Occasionally, there is a pinkish froth coming form the hose, or a spot of blood on the bed. The face and remainder of the body may bear bluish-purple discolorations which may appear to be bruises. These are normal post-mortem changes and should not be mistaken for injuries.

"What did I do wrong?" "Was it my fault?" "Why didn't I detect that there was something wrong with my child?"

Lola Redford, wife of actor Robert Redford, tells how guilty they both felt after their first born died in his crib. "I had this notion that when you come from strong Mormon stock, you just don't have children who die." She also spoke of not being willing to hire a baby-sitter for her two subsequent children, of spending all her energy "guarding" them. For almost nine years, I gave those children my undivided 100% neurotic attention. I was so afraid they would die."

Some parents believe that they accidentally killed their child by allowing the infant to suffocate in the bedclothes or choke on regurgitated milk. There is no basis to believe this is true.

How about the grandparents?

Grandparents are often unaware of the mysterious, sudden, unexpected death called SIDS. They may believe that the tragedy could have been averted by some action of their children such as a more proper diet or closer observation during a virus. Worst of all, they may believe the baby died because of some omission or neglect. Grand parents need continual reassurances that the cause of the disease remains unknown and that the parents did not cause nor could they have prevented this crashing, bitter disappointment.

Grandparents often take charge of the funeral arrangements. After all, they are older and more experienced in the sad preparations for death. The clergy person might have well to say: "I know that you, too, are going through an ordeal. But you know of course, that your children are the ones who feel the loss most keenly. Perhaps it would be better for your children to come to their own decisions about what is best for them!"

What can the clergy person do to help the family?

Tell them that SIDS occurs in apparently healthy, normal, thriving babies who have received the most skillful and loving care. The death does not reflect in any way on

the ability of the parents to care for their children SIDS is not suffocation or pneumonia. They did nothing to cause death

Should there be an autopsy?

Usually the examination reveals no disease sufficient to account for death. In approximately fifteen percent of the cases, however, post-mortem examination exposes a previously unsuspected abnormality or rapidly fatal infectious disease. This is one of the reasons autopsy on these infants is so important.

Did my child suffer?

Explain to the family that evidence underscores the point that the infant was not in pain. In most cases, death is sudden, almost instantaneous. There are examples when the child "just stopped breathing" in the arms of the parent. The adults report a sense of peacefulness and quietude.

SIDS Questionnaire

In California there is an extensive multi-page questionnaire that the law enforcement officer must complete by talking with the family. You as chaplain will find it helpful to let the family know that the officer needs their help with this task. The extensive questions are not to cast blame on the parents or family but rather to aide in future research to prevent SIDS in the future.

DEATH BY SUICIDE

What is the incidence of suicide?

Once every minute, someone attempts to kill himself or herself with conscious intent. Sixty or seventy times a day these attempts succeed. In America, the problem has reached somewhere between twenty-two and twenty-five thousand annually or one suicide every twenty-six minutes.

Who would dare destroy something so precious as life?

Almost everybody at one time or another contemplates suicide. Death is one of the choices open to human beings. Suicide has been known in all times and committed by all manner of people, from Saul, Sappho, and Seneca to Virginia Woolf, James Forrestall, Marilyn Monroe, and Ernest Hemingway. Every person is a potential suicide.

How is suicide different from other death?

Of course, natural death has its share of emotional overtones: Loneliness, disbelief, heartache, and torment. With self-inflicted death, the emotions are intensified to unbelievable and unbearable proportions. Those left behind experience not only pain of separation but aggravated feelings of guilt, shame, and self-blame.

The act of self-destruction raises the obvious questions, "Why?" and "What could I have done to prevent it?" Suicide is an irrational act and often we cannot understand or find out WHY. Anxious and grief-stricken, the survivors ask, "How can I face my friends? What will they think of me?" Death by suicide is the greatest of all affronts to those who remain. Special counseling skills are needed to cope with the runaway emotions of the bereaved. Suicide stigmatizes not only the victim but the survivors as well.

As a clergy person, can I suggest a public funeral? Wouldn't this run contrary to religious beliefs? Not Necessarily!

Suicide is taboo. Theology and customs are changing. Suicide is an irrational act. Suicide victims were not in there right mind. A loving God loves us unconditionally no matter what we have done. Our Lord offers us his "Amazing Grace" and healing power. Funerals and services of worship are not for the dead, but rather for those who are grieving and who remain. It is still appropriate to celebrate the life of the suicide victim and to affirm or faith in the future.

<u>Shouldn't the funeral be private?</u>

It is understandable that when the survivors hear the shocking news their first impulse is to hold the funeral as quickly as possible. After all, there is an aura of shame and dishonor. As a result, a private service may be contemplated for the immediate family only.

However, no matter how great the humiliation the relatives cannot hide from the bitter truth. No one can run away form pain. A private funeral seems to say that because the family is unable to bear the disgrace they want to keep it "secret." The mourners overlook one important fact: When given the opportunity, friends can be of inestimable value. The funeral, where no one is invited but all may attend, affords a sharing occasion for supportive love at a time when it is so desperately needed. One person is no person. The solitary heart must throb with the caring heart of others.

Many people who themselves have experienced the death of a loved one have developed tremendous gifts of insight. They understand the value of sharing. They may help the bereaved to reach out of their isolation to an important support system. Fellow sufferers often become second families to each other. Some helpful organizations include:

- *Candelighters, 123 c Street, Southeast, Washington, D.C. 20003. This is an international organization of parents whose children have cancer or died form this disease.*
- *Compassionate Friends, P.O. Box 1347, Oak Brook, Illinois 60521. A support group for bereaved parents who "need not walk alone."*
- *Sudden Infant Death Syndrome Foundation, 8240 Professional Place, Landover, MD 20785. The group intervenes on behalf of stricken parents of SIDS or "crib death" with professional counseling services for adults and children.*
- *Widowed-to-Widowed Program. Begun at the Laboratory of Community Psychiatry, Harvard Medical School, 58 Feinwood Rd., Massachusetts 02115.*

There are hundreds of these organizations throughout the United States. They bring together the widow and widower in fellowship and help them find a new way of life.

- *Parents without Partners, 7910 Woodmont Avenue, Washington, D.C. 20014. A nonsectarian organization with a membership of a hundred thousand in over 700 chapters concerned with the welfare of single parents and their children. It assures them that they are not alone. Their motto is "Sharing by Caring." If such an organization does not exist in your area, the clergy person could be instrumental in its formation.*

SUDDEN INFANT DEATH SYNDROME

A call involving a death especially that of a child will be one of the most difficult calls a First Responder may be expected to handle. Completing this task in an efficient and caring manner may save the family from the additional trauma of repeated interviews. ALL suspicious deaths should be treated/ handled as a homicide until proven otherwise. The goal of this section is to point out the difference between SIDS (Sudden Infant Death Syndrome) deaths and those of child abuse and homicides.

This section has taken into account information from the California Penal Code 13519.3, which mandates instruction of this material. (Revised January 1996)

SIDS Legislation in California

Senate Bill 1067 – Training First Responders
Senate Bill 1068 – Training Public Health Nurses
Senate Bill 1069 – Standardizing Autopsy Protocol
Senate Bill 1070 – State SIDS Advisory Council

Definition of Sudden Infant Death Syndrome

The sudden and unexpected death of an apparently healthy child or infant which is unexpected by medical history and which a thorough postmortem examination and Death Scene investigation fail to reveal an adequate cause of death.

SIDS babies generally have no history of serious illness. However, two distinguishing factors are related to SIDS: the age of the baby at the time of death, and the baby dies while sleeping.

Autopsies provide no definite cause of death, as there are negative findings in an autopsy, thus making SIDS an exclusionary diagnosis.

SIDS has been studied for years and many theories have been tested. Unfortunately, we come to the same conclusions – there no definite cause is found even though there are only two pathways to death in this situation: respiratory and cardiac.

In continued attempts to find a cause, and thus possibly preventive measures, recent theories have focused on sleep pattern disorders, nervous system disorders, heart irregularities, chemical imbalances, and the responsiveness to acetylcholine chemical or the inability to respond to high levels of carbon dioxide.

Description of the typical baby that Dies of SIDS

Babies tend to be between the age of two weeks and one year with the most common occurrences happening between two and four months. 90% of the deaths caused by SIDS happen before the baby reaches the age of six months. Rarely do we find a toddler (after the age of two) to have died of SIDS.

The loss of a child is difficult even if there is an explanation for the death. However, with SIDS the added stress that parents put themselves through is wondering what they might have done something, anything differently. But in SIDS, typically there is no recent history of an illness so there was no reason to suspect the child would die. It almost always occurs during sleep, and there is no warning to the parent or child care provider. The only fact we do know is that SIDS is more common (3:2 margin) in boys than in girls. But that margin is not great enough to take any comfort in.

Risks and Non-Risk Factors of SIDS

Studies have discovered several common factors that may contribute to an increased possibility of a SIDS-related death. These include: smoking and/or drug abuse by the mother during pregnancy, multiple births (one of a twin or more), premature birth, and low birth weight.

What we also know is that infant immunizations like DPT and polio vaccines have no correlation to SIDS. Even if a family had a child die of SIDS, the risk factor is no higher for a second child to be more prone to die of SIDS. Race is not an issue nor are periods of apnea.

Physical Signs of SIDS

<u>Facts Surrounding the Incident</u>

When a first responder or law enforcement officer is called to an infant death, they will immediately look for signs of foul play – it is there job. In a SIDS case, however, there are no physical signs to observe, there is no evidence of trauma, the child appears well nourished, and, there is no swelling (edema). There may be blood tinged sputum, they may have had a bowel/bladder movement as part of the terminal event, there may be frothy drainage from the mouth, and diaper rash looks more sever.

Generally, due to the size of the infant, the cooling (rigor mortis) takes place quickly (3 hours) – post mortem lividity. Lastly, first responders and law enforcement will

meet with other siblings to ensure they appear normal and healthy. Again, this is routine in an investigation of SIDS.

Differentiating SIDS from Child Abuse or Neglect

SIDS	CHILD ABUSE / NEGLECT
7,000 – 10,000 deaths annually	1,000 – 4,000 deaths annually
Highest between 2-4 months of age	300 deaths per year in infants
More prevalent in winter (Nov-Mar)	No Seasonal differences
Physical appearance (see above)	Physical appearance – there are distinguishable and visible signs of injury like: Broken bones, bruises, burns, cuts, head trauma, scars, welts, may show signs of obvious malnutrition (thin). Other siblings may show signs/ patterns of injuries commonly seen in child abuse and neglect
Initially suspect SIDS if all the above characteristics are present and the parents state the child was well and healthy when put to bed.	May initially suspect child abuse/neglect if all of the above characteristics and the parent's (child care provider) story does not or cannot account for all the injuries to the infant.

The Grieving Process for SIDS – related deaths

Shock/ Disbelief
- No known reason to suspect death.
- No known cause of death.
- Reactions of parents at the time of death may vary according to each person's coping or managing severe, acute, stressful situations based on prior history and social/cultural norms.
- Most parents' feel there must have been some way to prevent the event from occurring.

Numbness
- Goes through motions of daily living.
- Cannot distract parent from hurt.
- Fear for safety of other family members.

Psychosomatic symptoms of illness may develop with other signs of prolonged stress.

Release of grief and guilt
- May not give into the need to release anger and guilt (through crying, etc.) for weeks or months.
- Parent at this point needs to talk it out.
- Men and women often grieve differently which can lead/cause communication breakdowns between couples.

Dealing with reality and fantasy
- Begin to accept death as being unchangeable.
- Realize only they can pull themselves out of the pit of despair.
- Begin to think about subsequent children, job outside home, or perhaps work with local S.I.D.S. parent group(s).

Dealing with memories
- About a year later, relief periods of not thinking about baby begin to grow longer.
- More able to talk objectively about their personal grief and death of infant.
- Will be moments of relapse.

Becoming a new person
- Suffering strengthens and changes a person.
- Hopefully change is not crippling.
- Not how fast, but how well person mends.

WHEN SIDS HAPPENS

- Baby found non-responsive, not breathing
- Call to 911 by responsible party
- EMS, fire and /or police respond
- Decision is made to institute or continue basic life support resuscitation efforts in accordance with local EMS agency policies.
- Death Scene Investigation
- Decision is made about transporting baby (hospital)
- Baby is pronounced dead by Physician
- Family informed of death
- Chaplain Notified
- Coroner is notified / responds to the hospital

SUPPORT OF PARENTS/CAREGIVERS – COMMUNICATION TECHNIQUES

- Use a calm and directive voice
- Be clear in instructions to those present
- Provide explanations to the parents or caregivers about treatment and transport
- Reassure parents or caregivers that there was nothing they could have done
- Allow a parent or caregiver to accompany the baby, if the situation permits (get approval from deputy/coroner before offering the option)
- Be Sincere
- Be supportive
- Be open minded
- Do not interrogate
- Be a good listener
- Be a good observer
- Allow family to talk
- Do not be afraid to show emotion

FACTS SURROUNDING INCIDENT

The deputy will elicit a brief history at scene, if time permits. The Chaplain should be aware of the procedure but would not be asking questions. When you do have an opportunity to interact with the family, refrain from asking judgmental questions. Focus on non-leading and open-ended questions, which include:

- What happened?
- Who found the infant and where?
- What did he or she do?
- Had the infant been moved?
- What time was the infant last seen alive?
- How was the infant that day?
- Had the infant been sick?

Perform an environmental check and document findings:

- Observe the location of the infant upon arrival, in the crib or bed, floor, etc.
- Observe for the presence of objects in the original area in which the infant was found.
- Observe any unusual conditions such as high room temperature or odors in the environment.
- Observe presence of medications (take all medications to the hospital, if possible).

Document all findings completely and accurately on the patient care record.

Failure to accurately document findings could result in unnecessary investigations or significant emotional stress to the parents or caregiver or emergency medical responders.

Identify Potential Parent/Caregiver Responses to an Infant Death.

- Responses of parents/caregivers to the sudden and unexpected death of an infant are not predictable. The responses may vary and could include: denial, anger, hysteria, withdrawal, intense guilt, or no visible response.
- The parent/caregiver may or may not accept that the infant is dead.
- The parent/caregiver may make demands of the emergency medical responder which could include:
  - Repetitive questions.
  - Request to not initiate care or terminate resuscitation efforts.
  - Request to be alone with the infant.
  - Request for the cause of apparent death.
  - The parent/caregiver may even interfere with appropriate care.

Identify Potential Responses of the Emergency Medical Responder to an Infant Death.

- Response of the emergency medical responder to the sudden and unexpected death of an infant may include the following:
  - Anger, blame and identification with the parent.
  - Withdrawal, avoidance of parent/caregiver.

- Self-doubt, if the baby does not recover.
- Sadness and depression.

- The emergency medical responder may have expectations of how the parent/caregiver should behave and respond:
  - Expecting tearful and hysterical responses and unable to believe that not every parent/caregiver will initiate CPR.
  - Unable to accept a parent who has decided the infant is dead and does not want CPR started.
  - Unfamiliar with the mourning and grief behaviors of different cultures or religious belief.

Identify Ways the Emergency Medical Responders May Prevent, Reduce, or Stop the Critical Incident Stress.

- Acknowledge that stress is an integral part of the job of the emergency medical responder.
- Identify signs and symptoms of stress which may include:
  - Recurring dreams.
  - Anger.
  - Physical illness.
  - Depression.
  - Changes in eating and sleeping patterns.
  - Mood changes.
  - Inability to concentrate.
  - Withdrawal.

  - Identify strategies for decreasing the impact of stress. These may include:
    - Exercise, plan leisure time and limit overtime hours.
    - Get feedback from SIDS parent groups.
    - Request tape reviews and become educated about stress management and SIDS.
    - Talk to field supervisors, get adequate rest, eat a balanced diet, write a personal journal and obtain professional, religious or peer counseling.

  - Request professional assistance if the particular incident produces a profound emotional reaction. Request Critical Incident Stress Debriefing (CISD), if available.

NOTE: The determination of whether the child is or is not a SIDS victim is the responsibility of the medical examiner or medical coroner. It is NOT the responsibility of the Emergency Medical technician.

The responsibilities of the Coroner and the Local Health Department are noted on the following:

Coroner's Responsibilities

- Performs autopsy
- Death Scene Investigation
- Notifies Local Health Department
- Notifies State SIDS program
- Notifies parents of cause of death
- Signs Death Certificate

Local Health Dept Responsibilities

- Provides information and counseling
- Referral information for peer support.
- Provides information to state program.
- Periodic follow-up.
- Community education with peer group.

REFERRAL AGENCIES

California SIDS Program
(800) 369-SIDS

National SIDS Foundation and Guilds for Infant Survival
GIS (800) 221
SIDS (800) 247-4370

National SIDS Foundation
Two Metro Plaza, Suite 205
8240 Professional Place
Landover, MD. 20785

National SIDS Foundation
10500 Little Patuxent Parkway, Suite #240
Columbia, Maryland 21044
(800) 221-SIDS
(800) 369-SIDS

Guild for Infant Survival, Inc. (Orange County)
P.O. Box 17432
Irvine, California 92713-7432
(714) 474-SIDS

California Association of Public Health Nurses
3701 Branch Center Road
Sacramento, California 95827
(916) 366-2345

Bereavement Network Resources of Sacramento
P.O. Box 660365
Sacramento, California, 95866
(916) 363-3092

Valley-Sierra Chapter the SIDS Alliance
564 La Sierra Drive, Box 78
Sacramento, California 95864
(916) 368-SIDS

Placer County Law Enforcement Chaplaincy
P.O Box 1111
Newcastle, CA 95658
(916) 663-2427

Reference Resources

- Bereavement Network, Resources of Sacramento
- Commonly asked Questions about Sudden Infant Death Syndrome, A Doctor's response, Bruce Beckwith, M.D.
- Facts About SIDS, National S.I.D.S. Foundation
- Facts About SIDS. For Police Officers, National SIDS Foundation

Articles/ Books

- Archer, D.N. (1988), "*Sorrow Has Many Faces*", Nursing 88, May issue, pages 43-44.
- Berman, AB. (1979), "*The Sudden Infant Death Syndrome- What Can I Do*", Medical Times, April
- Burrus, W.M. (UNK), "*The Riddle Of Crib Death*"
- Carson, S.H. & Duncan, J.A. (1985), "*The Important Work Of Grieving*", Special care, September, pages 5-7
- Counseling Team, "*Emotional Impact on First Responders and Emergency Personnel in a SIDS Incident*".
- De Frain - Taylor- Ernst, “Coping *With Sudden Infant Death*” Epiro, P.D. (edit) (1984), "*When Sudden Infant Death Strikes*".
- Keens, T.G., MD. (1987), "*Public Health Grand Rounds Presents Sudden Infant Death Syndrome*", State Of California
- Korth, S.K. (1988), "*Behavior Issues: Unexpected Pediatric Deaths in the Emergency Department: Supporting the Family*." Journal of Emergency Nursing, 14:5, pages 302-305
- Krous, H.F., MD (1988), "*Pathological Considerations Of Sudden Infant Death Syndrome*", Pediatrician, 15: pages 231-239
- Guntherroth, R.G., MD (1982), "*Crib Death- Sudden Infant Death Syndrome*"
- Thomas, D.O., (1986), "*Thoughts on Pediatric Arrest*." Journal of Emergency Nursing, 12: pages 406-408.
- Wanz~t~id, J. (unk), "*What to Say and What Not to Say to the Sudden Infant Death Syndrome Parent*."

LINE-OF-DUTY DEATHS

Article~

Survivor and Department Responses

Frances A. Stillman, Ed.D., Research Director,
Concerns of Police Survivors
Introductory comment by James K. Stewart,
Director of the National Institute of Justice

Introduction: Officer Brummett was performing a routine traffic stop when a passing car struck and killed him.. For the first 6 months after the incident, his widow refused to accept the fact that her husband had died. After 6 months, she accepted his death but felt emotionally numb and unable to grieve. She said she needed to be "strong" so she would not upset others.

More than 2 years after the accident, Mrs. Brummett remained distressed by her loss. Plagued by nightmares of her husband, she had trouble controlling her thoughts about his death and her consequent problems. She could not concentrate at work and began to drink heavily. She felt alienated from most of her friends and family.

The National Institute of Justice is proud of its efforts in "protecting the protectors" - reducing the risks police officers face on the job. The most dramatic example is the Institute's role in developing lightweight police body armor, which has been credited with saving the lives of more than 700 police officers nationwide.[6]

But despite these and other efforts, far too many police officers still are killed in carrying out their sworn duty to protect citizens from criminal attack. Line-of-duty deaths, whether felonious or accidental, are a sad and frequent reminder of the danger inherent in police work. While the loss to the department and the community is serious, each police death leaves family, friends, and coworkers with the emotional trauma of a devastating loss.

There is a bond joining those in the "police family" that is formed by the shared experiences they have faced. A police death hits hard within that family, as others are reminded of their own vulnerability.

Many mistakenly believe that the spouses, children, and parents who survive police deaths are somehow more prepared for their losses than are other people. But knowing that the job can be dangerous does not prepare an individual for the actual

[6] Updated statistic: Between 1975 and 1999, 1,800 law enforcement officers have been killed in the line of duty. Since that same time, 2,400 officer's lives have been saved due to the use of police body armor. That is an average of 72 law enforcement officers killed annually and 96 saved due solely to the use of body armor. Statistic taken from Video entitled, *Surviving a Shooting, Your Guide to Personal Body Armor*. Justice Technology Information Network, National Law Enforcement and Corrections Technology Center. National Institute of Justice. http://www.justnet.org/videos/justnet.html#surviving..

experience of losing a loved one. Police survivors often endure prolonged psychological stress because they do not seek help. They are hurt by the misconception that, because they are part of the police community, they should somehow be stronger emotionally and better prepared for such a tragedy.

To learn more about the problems faced by survivors of police deaths, and how police departments can help, the National Institute of Justice sponsored this study by Concerns of police survivors. The findings presented in this Research in Brief clearly show the magnitude of distress survivors face.

Too often, when police survivors do seek help, it isn't available. As this Research in Brief indicates, police departments can do much more to help survivors cope with their loss. Many departments have no formal procedures for completing required paperwork and assisting family members with funeral plans and requests for benefits. Most departments do not consider the emotional and psychological needs of survivors to be a part of their responsibility.

When police departments establish systematic policies for dealing with a departmental death, they are better able to respond to the needs of survivors. Effective procedures allow a police department to respond in a prompt, organized manner and remain sensitive to the profound human emotions they must confront. The immediate and continuing response of police departments when an officer is killed has a definite impact on the well being of survivors.

Departments with no formalized policies can learn form those that have developed clear and caring procedures for dealing with line-of-duty deaths. The information form this study can help departments begin to meet this great unfulfilled need.

To some, Mrs. Brummett's reaction to her husband's death may seem extreme. It is not. In fact, it is typical of the intense, long-lasting reactions experienced by the majority of adult police "survivors" - that is, the spouses, parents, siblings, friends, and coworkers of police officers killed in the course of their work. (While children also are survivors, their reactions were not studied in the research on which this report is bases.)

Reactions of police survivors are often so profound as to be diagnosed as Post-Traumatic Stress Disorder (PTSD), a psychological disorder associated with traumatic events that are generally outside the range of usual human experience. Common PTSD symptoms include recurring recollections of the traumatic event, feelings of detachment or estrangement from others, hyper alertness, sleep disturbances, guilt about surviving, memory impairment, and difficulty with concentrating.

Many people and police departments are unaware of the devastating impact of an officer's death on survivors. Many mistakenly believe that police survivors are somehow more prepared for their losses than civilian survivors.

In fact, surviving family members of public safety officers may be more at risk than other survivors after their loss. Relatives of slain police officers often endure psychological distress for long periods of time and do not seek help or discuss their problems because they feel embarrassed or wish to avoid seeming weak. They

may refuse existing community services because they believe that only other members of the "police culture" can understand their problems.

A survivor's level of distress is affected by the police department's response to the tragedy. Elements of the department's response that should be considered include:

- *The way survivors are notified of the death.*
- *The emotional support provided by the department.*
- *The information the department gives concerning insurance and benefits.*

How these elements are handled has an influence on whether or not the survivor will develop a clinical psychological disorder such as PTSD.

However, most police departments lack formal policies for handling the aftermath when an officer is killed on duty. Some departments have provided policies concerning only felonious on-duty deaths, thus excluding accidental deaths, thus excluding accidental deaths. Others deal only with such tangible issues as notification procedures and funeral arrangements but neglect important intangibles such as counseling and emotional support.

To learn more about the impact of a law enforcement officer's death on adult survivors and on the steps a police department can take to help survivor, the National Institute of Justice sponsored a study on the psychological, emotional, financial, and practical problems faced by survivors of police deaths.

The study was conducted by Concerns of Police Survivors (COPS), a nonprofit organization that offers emotional and moral support to spouses, parents, children, siblings, other family members, and others who are affected by police line-of-duty deaths. The study examined the reactions of 126 survivors to their losses and the ways that 188 police departments responded to their problems.

This report discusses the study findings and provides recommendations that will assist police departments in developing workable, sensitive policies that help bereaved spouses and families.

Methodology of the Study

Data for this project were gathered from two main sources: Surviving adult family members of police officers killed in the line of duty; and Police departments that had lost an officer feloniously or accidentally.

The sample of spouses and of police departments for this research was drawn primarily from the U.S. Department of Justice, Public Safety Office, and Benefits Office data base. The office which provides financial benefits to eligible survivors, maintains records on officers killed in the line of duty whose departments file an application for the death benefit.

Most of the spouses included in the study were survivors of officers who died between November 1982 and February 1986 and whose applications for benefits had been received by the Office. Police departments surveyed were those that had

submitted a claim for Federal death benefits through the Office between 1983 and 1985.

Participating survivors responded to a questionnaire; some also participated in personal interviews. Police departments responded to a mailed questionnaire. Responding departments, located throughout the Nation, ranged in size from less than 10 sworn officers to more than 5,000 and represented Federal, State, and local jurisdictions.

Impact of the Loss on Survivors

This study found that when police officers die in action, surviving spouses, parents, and siblings are not more prepared for the death just because they are part of a law enforcement family. Knowing that the job could be dangerous does not prepare an individual for the actual experience of having a loved one die.

According to the COPS study, the following are common police survivors' reactions to their loss:

- *Having difficulty concentrating and making decisions, feeling confused, having one's mind go blank.*
- *Feeling hostile.*
- *Feeling different from others, feeling alone, being uncomfortable in social situations.*
- *Fearing people, places, and things, and being anxious of one's ability to survive.*
- *Re-experiencing the traumatic incident through flashbacks, dreams, or thoughts.*
- *Feeling emotionally numb, having less interest in previously enjoyed activities, or being unable to return to prior employment.*
- *Having less ability to express positive and negative emotions.*
- *Feeling guilty about the way one acted toward the deceased or as if one could have prevented the death.*

These reactions are indicated by specific symptoms. Table 1 presents the most prevalent and acute symptoms identified by survivors as occurring at levels that clinically indicate serious distress.

The study also found that 59 percent of the surviving spouses of police officers killed in the line of duty met the criteria for having PTSD. This psychological disorder is common among victims of physical assault, rape, and natural disasters, prisoners of war, and persons taken hostage.

Factors that were found to intensify distress reactions among spouses include the way they are notified of the death and the length of time they had been married. Spouses who are not notified in person experience additional trauma, as evidenced by increased levels of hostility and guilt. Younger women, especially if married for 10 years or less, were found to have a ;more severe reaction to the death of a spouse than older women married for a longer period of time.

Duration of Distress

It has commonly been assumed that survivor grief reactions are "acute, time-limited phenomena." Survivors are often encouraged and even pressured to return to pre-trauma behaviors and activities. For some, this is an impossibility. For others, it is possible only after an extended period of healing.

- *This study confirmed recent research that indicates that the grief response after an accidental traumatic loss may add to long-term emotional distress.*
- *Survivors were found to have clinical levels of psycho-pathology in a number of areas and evidence of PTSD even 2 years after the traumatic death occurred.*

Most Prevalent and Acute Symptoms Identified by Survivors	
Reported Symptom	**Percent**
Feeling Lonely	75.2%
Feeling Unhappy or Sad	70.4%
Feeling low in energy or slowed down	68.3%
Feeling easily annoyed or irritated	67.5%
Feeling tense or keyed up	66.7%
Easily hurt feelings	64.3%
Trouble concentrating	56.3
Repeated images that won't leave your mind	53.9%
Thinking about the same thing repeatedly	52.8%
Trouble remembering things	52.4%
Feeling emotionally numb or empty	52.4%
Feeling angry	51.6%
Wishing others would care for you	51.2%
Difficulty falling asleep	50.8
Feeling uncomfortable in social situations	50.8%
Feeling people will take advantage of you	50.8%
Difficulty making decisions	47.6%
Having to think carefully to make correct decisions	46.8%
Being angry at yourself for not accomplishing more	49.6%

Table 1

The assumption that time heals all wounds is not valid in the case of police survivors since people who hold this assumption may be deterred from providing the support and intervention that survivors need to recover emotionally and psychologically from a personal crisis and to return to a pre-trauma level of functioning.

Felonious vs. Accidental Death

Responding police departments reported a total of 298 line-of-duty deaths during the time period studied. Of these, 158 resulted from accidental causes and 140 from felonious causes.

Deaths due to homicide traditionally have been perceived by society as more serious and threatening events than deaths due to accidents. Thus, it was believed that surviving family members of an officer who died feloniously experienced a more severe reaction than survivors of one killed accidentally.

This study indicates this assumption is not valid for surviving spouses. Spouses of officers killed accidentally and spouses of homicide victims experience the same level of distress.

Significant differences were noted, however, between parents of officers killed accidentally and parents of officers killed feloniously. The latter were found to be more traumatized, hostile, and depressed after the death.

Survivors reported that the type of death makes a difference in the response they receive from the police department, with homicides receiving more or preferential attention than accidents. The difference in police department response can add considerable pain to an already traumatized family - especially when the family expected a different type of treatment.

In addition, if the suspect accused of killing the officer is apprehended, the survivors may experience additional trauma as a result of the trial.

Benefits and Compensation

Ninety-one percent of the police departments surveyed reported that they provide explanations of their health benefits to officers and 89 percent said they provide explanations of death benefits. However, the departments were not questioned about how the explanations were carried out and whether the officers actually understood or were aware of the importance of the information. Some departments indicated this instruction was accomplished in a brief description, or by handing officers a booklet to read. Very few departments fully explain all benefits, options, and compensation and their implications for the officer and family.

Survivors may be excluded from the police department's group medical coverage within days of the officer's death. In such cases, a letter informing survivors of this separation is sent in the mail, forcing the survivor - still in a state of shock - to find health coverage for the family. In such cases, departments seem to fail to differentiate between a planned termination from police service and an unexpected line-of-duty death.

While survivors generally reported satisfaction with the treatment they received from police departments, they did report certain specific problems regarding compensation and benefits. Most survivors are not prepared for the delays that occur in processing benefit and compensation requests. Some survivors found that departments are uninformed about benefits.

Psychological Counseling

Of the police departments surveyed, 58 percent have a psychological unit but only 31 percent offer access to a staff psychologist. Only 5.4 percent of the departments offer peer counseling and police-family response services; 43 percent make counseling referrals; and 19 percent pay for outside counseling.

Survivors reported a lack of psychological counseling for family members. In addition, most believed that if such services were needed as a result of the death, the police department should pay for them.

Survivors also reported they felt abandoned by the police departments. The spouses wanted some type of formal and informal contact to continue. Most reported that contact ended soon after the funeral.

Police Department Policy

In addition to its impact on the family, the death of an officer can be a tremendous shock for members of the police department. For smaller departments that lack financial and personnel resources, the loss of an officer creates significant disruption. And, for police officers in departments of all sizes, the death of an officer can be a demoralizing reminder of their own vulnerability.

Yet 67 percent of departments surveyed lack formal policies concerning the death of an officer. Often no one is designated or prepared to deal with the legal and financial paperwork and to assist the surviving family members in planning for the funeral, with requesting benefits, or in preparing for the emotional and financial strain that may accompany the death.

In addition, most existing policies reflect an action-oriented, task-oriented, time-limited philosophy toward survivors. Most departments tend not to consider the emotional or psychological needs of survivors to be part of their responsibility.

Notification. Notification practices varied greatly among departments. Of the policy statements submitted to COPS (60 percent of the departments with formal policies submitted them), 50 percent dealt with notification. Some dealt only with chain-of-command notification procedures, but most specified the need to notify the family quickly.

Most departments do not have designated officers or teams for notification. Often any available officer or a group of officers is asked to notify survivors.

Maintenance of records. Accurate records of next of kin are essential to notification procedures. Yet records - in cases where they are kept - are not consistently verified and updated by most police agencies.

While almost 80 percent of the police agencies surveyed keep records of spouses, more than two-thirds lack records on parents of officers. Some 40 percent of the agencies update spouses' records periodically, about 27 percent never do, and

another 23 percent do so only on change of duty. Agencies that maintain records on parents of officers update then infrequently.

Action-oriented assistance. Funeral and burial procedures appeared in 53 percent of the policies COPS received; information on amount of compensation varied greatly among departments. In 67 percent of the departments surveyed, the family pays for funeral and burial expenses.

Information and emotional services provided. Of the departments surveyed, 5.3 percent provide information on will preparation; 44 percent offer instruction on stress management; 92 percent provide transportation to the hospital after the incident; 92 percent provide assistance with the media; 97 percent provide assistance with benefits; and 32 percent provide financial counseling.

Policy suggestions for police departments. The results of this study suggest that more than half of the surviving spouses of police officers killed in the line of duty may need support and assistance from the police department. Recovery from such trauma may be a very long, involved process quite different from the recovery process after a death due to a terminal illness or other anticipated event.

Police departments can help family members, as well as their own officers, to cope with the loss of an officer by establishing and implementing both general and specific policies on how to proceed in the event of a death. By designing clear-cut policies concerning notification procedures, psychological services, emotional support, and benefits and compensation for survivors, police departments will be better prepared to respond to survivors in an organized and humane fashion.

However, being organized is not enough. Survivors and police personnel need to be aware that the death of a loved one of a good friend, of a partner, or of a coworker, is a stressor of the highest magnitude. Avoiding discussion of the possibility of injury or death, of possible plans of action, and of prescribing policies protects no one from death. But it means that if death does occur, the crisis management skills needed to help survivors will not have been planned and thus will not be readily available.

NOTIFICATIONS DEALING WITH TRAUMA

The following information is taken from an article by C.A.J. McLauchlan entitled, *Handling Distressed Relatives and Breaking Bad News". Publication and Date Unknown*

Common problems associated with breaking bad news in cases of trauma stem from the fact that death or severe injury is sudden and unexpected. Often the victim is young and the prognosis is unsure. First Responders, Emergency Personnel and Hospital staff are often very busy causing the notification to the family to be done in an unskilled manner. Lastly, when alcohol intoxication is suspected as being a contributing factor – this raises another series of questions and concerns.

Coping with major trauma is stressful for both staff and the relatives. Handling distressed relatives is an under emphasized part of the work, and medical staff may have had no training and little experience of it. It is a time that the relative will always remember and, if handled badly, will leave lasting scars.

Major trauma does not always end in death. Other various outcomes of major trauma include: serious head injury, multiple injuries, spinal injury, major burns, loss of limb, and loss of sight.

Giving bad news is never easy, but it can be especially difficult in cases of major trauma. The nature of the patient's problem and the bad news can be very varied. The management of the relatives may begin before they arrive at hospital and carry on until well after death or discharge of the patient. The principles of management apply to the accident and emergency department as well as the intensive treatment unit or admitting ward. Providing genuine understanding and support for relatives is the key to their management.

Initial contact

When a victim of major trauma arrives in the emergency room the priority is immediate resuscitation. Once the victim has been identified the closest relatives or friends should be notified.

Handling the initial contact with relatives

It may be preferable for a police officer and law enforcement Chaplain to make contact in person. Information on the telephone should be given by an experienced nurse or doctor. Relatives should not drive to hospital alone
The full severity of injuries or death may be best explained at the hospital

Communication with the emergency services is very important. The ambulance crew and police, as well as giving information on the incident, may have already seen the relatives or know their whereabouts. It is usually better for a sympathetic law enforcement chaplain and police officer to make the initial contact in person rather than for a telephone call to be made from the hospital. The police may also be able to help with transport.

If the telephone is used, information should be given by an experienced nurse or doctor and a lone relative advised strongly against driving to hospital alone. Mentioning that the victim is unconscious often helps to impart a certain severity to the lay person, although the full severity or death is usually best explained in person at the hospital. If relatives are not told of the victim's death, however, they may blame themselves for not arriving at the hospital in time to be with their loved one at death. It is important to dispel any self recrimination by giving the relatives the exact information, including the time of death. If the relatives have to travel great distances or from overseas the full details, including death, may have to be explained over the telephone. Find out if the relative is alone and, if so, suggest that he or she seeks support locally. Offer to telephone for support.

Anxious relatives should be met by a nurse and not be kept waiting around at reception for the department's or ward's communications to be established.

Therefore, it is important that the nursing sister coordinates the information so that the staff, in particular those at reception, know that potentially distressed relatives are expected. They should be welcomed and not made to feel in the way. Staff should remember that it is not only the victim's relatives who may be distress; in some instances close friends may be severely distressed and should be handled in the same way as the relatives.

There should be a private room or office where relatives and friends can wait and be seen. Ideally this room should be solely for relatives and friends and be suitably furnished.

Breaking the news

When setting up the relative's room for notification of the trauma, you will want to make sure the room is private, has a telephone, hand basin and mirror, cups and water, tissues and advice/information leaflets. The informational leaflets should be kept out of sight and brought out when appropriate. Make sure the décor and furniture is appropriate – soft furniture and low lighting is helpful.

Remember to ask relatives for the medical history of the patient. This history may be vital if the patient is receiving certain drugs such as steroids or anticoagulants, and an idea of the quality of life may be useful in elderly victims or those with disease. Providing a history can also make relatives feel less helpless and that they are doing something.

During attempted resuscitation relatives should at least be given early warning if the condition is critical. Regular updates by the same person (usually a nurse) are also appreciated and may help to break the bad news in stages. It also allows relationships to form, which will help in providing the support that may be needed later.

The contact nurse should introduce a doctor, preferably a senior one to the relatives as soon as possible to provide further information. Relatives expect to see a doctor for medical information and an idea of the prognosis: "Will he be all right, doctor?"

Advice for the doctor

Breaking bad news has to be tailored to the situation and the particular relatives, but the following principles generally apply:

- On leaving the resuscitation area or theater you may be stressed, so take a moment to compose yourself and think about what you are going to say. Also remove evidence of blood stains, etc., so that you are physically and mentally prepared.
- Take an experienced nurse with you. A nurse can be a great support and can carry on where you leave off.
- Confirm that you have the correct relatives and who's who. Ascertain what information they already have.
- Enter the relatives' room, introduce yourself, and sit down near the patient's closest relative. Do not stand holding the door handle like a bus conductor

ready to jump out. Giving the impression that you have time to talk and listen is important.

- In general look at who your are talking to, be honest and direct, and keep it simple. Be prepared to emphasize the main points. Avoid too much technical information at this stage (although with patients with multiple injuries there may be much going on). If death is probable say so; do not beat about the bush.
- After breaking bad news allow time and some moments of silence while the facts sink in.
- Be prepared for a variety of emotional responses or reactions. Some people may stick at one reaction whereas others go through several reactions.
- Allow and encourage reactions such as crying. Provide tissues and facilities for relatives to make themselves presentable to the world again.
- Although it is upsetting, close relatives appreciate the truth and your honest empathy.
- At this stage there is no substitute for genuine understanding and support. A sensitive nurse is a great asset.
- During the interview it is a helpful and natural comfort for staff to touch or hold the hand of the relative. Various social and cultural factors may influence the appropriateness of touching, but generally if it comes naturally then it is probably right.
- Likewise, during the interview it may be natural for the staff to have sad feelings, and these need not be completely hidden. Some sign of emotion may help distressed or bereaved people to release that the staff do have some understanding and it is not just another case.
- Avoid platitudes - for example, after a death comments such as "you've still got your other son, etc.," which are not helpful as it is the dead person whom the relatives want back. Also avoid false sympathy as in "I know what it's like," but rather empathize, as in: "It must be hard for you...." or "It must feel very unreal...," etc., reflecting back their emotions.
- Encourage and be prepared for questions to be asked during the interview. These may disclose any misunderstandings and present a chance to re-emphasis the message. The question of pain and suffering is common and should be discussed routinely, with reassurance as appropriate. The prognosis may be unknown initially, and you should say so. If death or serious disability is possible, however, then it is only fair to be honest and warn the relatives. It will be worse shock later if they have been protected from this knowledge. Do not be afraid to answer that you do not know the answers to medical or philosophical questions such as "Why me?" Other difficult questions ;may arise from feelings of guilt or when a relative was involved in but not injured in the same accident. Special problems may arise if the relative feels responsible directly - for example, as the driver in an accident. Other complications may include a recent squabble before the accident with subsequent self recrimination. The "If only..." rumination can be a type of guilt response that is fruitless and should be understood but discouraged at the outset.

If death has already occurred the same principles as discussed above apply. It is important to use the word "death" or "dead" early and avoid euphemisms such as "passes on." The news is usually hard to accept and so it must be as clear as possible, abrupt as it may seem. People usually need an explanation to the cause of death of a loved one. It may be helpful to explain the inevitability in the light of

known injuries and that "everything possible was done." Worries about their own first aid at the scene of the accident may need talking through.

Children should not be excluded form the proceedings in the mistaken belief that they need protection. They will be afraid and may have fantasies and feelings of guilt and need information.

Management of Relatives

Seeing the patient

Depending on urgency of further treatment it should usually be possible for close relatives briefly to see the patient before he or she is rushed off to the theater, the intensive treatment unity, or even another hospital. Although distressing, reality is usually preferable to fantasy. Also, sometimes this may be the last time that they will see their lives one alive. In addition, this contact may be beneficial to the conscious patient. Relatives may ask to enter or remain in the resuscitation area during emergency treatment, especially of infants and children. This is not yet generally accepted, but it seems that it can be beneficial provided that they are supported by an advocate such as a sensitive member of staff. Hospital staff may, however, be apprehensive about the presence of relatives, and their feelings must be considered.

Seeing the body after death

The opportunity to see the body after death should always be offered and gently encouraged if there is any doubt. Well meaning friends may try and discourage this act, which is an important part of accepting reality.

The imagination is usually far worse than reality, and cruel fantasies about the victim being disfigured or squashed flat can be dispelled. The actions and words of staff when relatives are with the body should give "permission" for relatives to touch, hold, kiss, or say good-bye to the loved one. Nurses will often carefully prepare a body before viewing in the clinical are or chapel. The relative may also like to be left alone with the body.

Checklist of actions in the event of death

- Notify the general practitioner, other relatives and friends, and the coroner's officer
- Ensure that the minister or chaplain has been called if the relatives wish
- Give an information or help leaflet to the relatives
- Notify the social worker if he or she is available
- Give useful telephone numbers and contact addresses to the relatives (including your number)

Other actions

Although they are stunned by events, it is often the small touches of care that relatives appreciate and remember, such as being given a lock of hair from their dead child by a thoughtful nurse.

Always ask if there is anyone else whom the relatives would like to be contacted - for example, a close friend or minister. The hospital chaplains can be a source of great support to both relatives and busy staff.

If a mechanism of counseling and follow up exists locally consider borrowing their expertise in appropriate cases of trauma.

Follow up

Long term management and bereavement counseling is not within the scope of this article, but arrangements for follow up may need initiating on day one. If the nurse or doctor concerned in the emergency department feels able they can offer to see the relative again. Some departments have a social worker who can provide some practical help as well as coordinate follow up. If death occurs it is helpful to have a routine checklist.

An up to date leaflet explaining official procedures slipped into a relative's pocket is useful for later perusal. Participation by the coroner's officer, who may be a policeman, should be explained. Warning relatives of the possibility of them developing symptoms of post-traumatic stress disorder is appropriate in certain cases. (An explanatory leaflet that includes ways to get help would be useful in busy departments.) Such symptoms include depression, anxiety, and flashbacks, with a wide range of severity. Also, it may be necessary in follow up to warn them of possible avoiding or unhelpful actions by neighbors. Details of any local organizations, from which help and practical advice can be obtained from trained counselors, should also be given.

Staff's reaction

Lastly, do not forget the caregivers. There are many different reactions, the commonest of which are sadness, anger, and guilt. Staff may identify with particular people or situations. For example, a child being killed will be particularly upsetting, especially for staff with children of the same age. Part of the debriefing on major trauma must include an opportunity for members of staff to express their feelings. Hiding behind a defense of excessive concern with composure or tasks should be avoided.

Because of its suddenness and severity major trauma is especially difficult for relatives and staff to cope with. However bad the news is relatives need direct, honest information along with genuine understanding and support. Many doctors find this important part of their work difficult. Reasons have been suggested for this. Awareness may help the situation and lead to a greater emphasis in training.

In short, the principles of dealing with the distressed relative can be remembered as follows:

- Empathize. Sit and listen to and reflect back relatives' reactions rather than make assumptions or categorize them.
- Enable relatives to accept reality and to experience the pain.
- Encourage, as in "you will be able to cope" (with help if needed)
- Encounter your own feelings and express them later, perhaps as part of a debriefing.

GIVE TO THE FUTURE: SUPPORT ORGAN DONATION

The Clergy's Role

In the course of performing clerical duties in a hospital setting, you may be requested to offer spiritual counsel to families who are considering donation of the organs of a loved one. This is a sensitive role for a counselor, whether you have had one or one hundred experiences with such a call.

The Uniform Anatomical Gift Act governs organ do nation in the United States. This Act allows individuals to will their organs. Also, relatives of the deceased can make the donation as long as there is no indication of the decedent's wishes to the contrary. Advances in medical science have made it possible to transplant as many as 25 human tissues and organs including the kidneys, corneas, heart, liver, pancreas, skin, and bone. While it is recognized that all are important, this brochure specifically addresses kidney donation and transplantation.

Kidney Failure and Treatment Options

Irreversible kidney failure affects many lives. There are now more than 60,000 Americans suffering from permanent kidney failure. When the normal function of both kidneys stops and cannot be restored, medical intervention is necessary to prevent death. Persons with end stage renal disease (ESRD) have two life-saving treatments available to them: dialysis and transplantation.

Dialysis

Dialysis is an expensive process of removing toxic materials from a patient's bloodstream. Patients on dialysis must devote many hours per week to this therapy. This schedule alone places great demands on patients and their families. Also, the dialysis process, while life-saving, rarely allows patients to feel as vigorous or health as they did prior to their illness.

Transplantation

Patients suffering from irreversible kidney failure often prefer kidney transplantation because of the less restricted life-style that is possible. Also, success rates for kidney transplants are impressive and are improving. Even through a cure for this disease has yet to be discovered, a kidney transplant offers the possibility for return to work and daily activities.

Kidneys for transplantation come from two sources: living related donors and cadaveric donor. For a number of reasons, it is not always possible for a family member to donate a kidney. The majority (nearly 75%) of transplants are made possible by cadaveric donations. If a sufficient number of cadaveric kidneys were donated, many more patients could receive kidney transplants. Although about 9,000 kidney transplants are performed in the United States each year, another 13,500 Americans remain on waiting lists because not enough kidneys are available. Obviously, donated kidneys are desperately needed.

The Option of Donation

When a family is faced with the loss of a loved one, the suggestion of organ donation can be overwhelming. The decision may not be an easy one, especially if the family has never discussed the issue. Your role, then, is one of offering support and answering questions as objectively as possible.

Working as a Team

While experienced health care professionals will already be on hand to respond to the physical, medical, and some psychological aspects, you have a fundamental role in offering support and religious guidance. Although you may not be the person who first presents the option of organ donation to the family (usually the request is made by a medical team member), you are often one of the key individuals to whom a family will turn to help with the decision. Good communications with health care team members is imperative to effective counseling. Two requests for donation may be as disconcerting to a family as no request at all, and family denials must be respected. In the event that family consent is given, all future arrangements for the organ donation are the responsibility of the health care team, but communications should be maintained if on-gong pastoral counseling is taking place.

Frequently Asked Questions

The specific questions family members ask are as varied as the individuals themselves. The concerns listed below are among those most frequently expressed about organ donation.

Is there any possible conflict between saving life and using organs for transplantation?

Many safeguards exist to prohibit such conflict. Organ donation occurs only after all efforts to save life have been exhausted and death is legally certified. The doctor who certifies death is not the one who removes the organs.

How are the donated organs used?

Sophisticated, modern communications can rapidly locate those patients with kidney failure who are waiting for compatible kidneys. Usually, donation of kidneys allows two patients the opportunity for transplantation, since a person can function adequately with one kidney.

What happens after the organs are removed?

The body becomes the responsibility of the family or next of kin. There is nothing involved in organ donation that should alter funeral arrangements.

Will the identities of the donor and recipient be kept confidential?

Because of respect for the privacy of both donors and recipients, names are considered confidential information and are rarely released to either party.

Why must this decision be made immediately?

A request for a decision in this hour of grief may seem insensitive, yet timely kidney removal is necessary in order to give life to others. This immediacy does not change the fact that the decision should be carefully considered and acceptable to family members.

Are there financial considerations?

There is no cost to the donor family for organ donation. These costs are wholly the responsibility of the organ acquisition facility. Costs for funeral arrangements, burial, etc., remain the responsibility of the family whether or not an organ donation has been made.

Is it a sin to desecrate the body? Will donation affect salvation?

Just as there are a wide variety of religious practices in our society, so are there many views on death and salvation. Common themes of sacrificial giving, sharing, and healing are found in numerous religious writings. Such themes represent the universality of the highest humanitarian and spiritual ideals.

Does organ donation conflict with religious beliefs of the family?

Religious leaders all over the world support organ donation which is essential to the lives of others. Specifically, some religious denominations have expressed their attitudes in the following faith statements.

A Lutheran tradition: "The decisions concerning replacement therapy have to be made in a responsiveness and responsibility toe the whole web of mankind." "By such a donation the very fact of death may be changed from a total physical loss for one to a second chance of a better life for another.

A Catholic tradition: "The public must be educated. It must be explained with intelligence and respect that to consent explicitly or tacitly to serious damage to the integrity of the corpse in the interest of those who are suffering, is no violation of the reverence due to the dead.

A Jewish tradition: "...there can be no greater Kevod Hamet [honor to the dead] than to bring healing to the living."

What good comes from organ donation"

Organ donation is an opportunity to make a positive, valuable contribution out of a tragic death. It is a considerable comfort for families to realize that they have helped others to live and to lead healthier, happier lives.

Summary

It is sincerely hoped that you, as the spiritual counselor, may share in the values of organ donation and transplantation. By supporting the concept of organ donation, you can offer those you counsel an opportunity to feel that something valuable was salvaged from their misfortune. Also, you can join in the concerted effort to enrich life for thousands of persons suffering from irreversible kidney failure.

Article~

" HOW DO I ASK?"
Requesting Tissue or Organ Donations From Bereaved Families
By Sheila Howard, RN, BSN

Brian was pale and out of breath as he ran into the private lounge where his parents and I were waiting for him. The grief on his parents' faces told him what he least wanted to hear. I reached out to grab him as he fell into a nearby chair; his body shook with retching sobs.

No words were needed: Brian had just lost his bride of 4 months. A driver with a suspended license had run a red light, plowing into Claire's car and killing her instantly. She was 25 years old.

You could feel the pain and outrage in the room. WHY? WHY? WHY?

I had no answer. Who could?

As a transplant coordinator for a tissue bank, however, I did know of one possible thread of consolation. These tragedies are, in fact, the very basis of my job. If the patient meets the eligibility criteria, I approach the grieving family members, console them, and offer them the option of tissue or organ donation.

You might be taking on this responsibility, too: A federal law passed in 1986 requires hospitals to set up protocols to encourage donations for tissue or organ transplants. The hope is that form the devastating sorrow of people like Brian, some good may come for others.

How then, should you ask? How do you talk to families about donation when they've just had their lives turned upside down? And when? To do it immediately doesn't seem right. Yet that's when the donation is usually needed.

Though approaching a family about donation is never easy, two common barriers make it harder. Both our own anxiety and helplessness in dealing with the grieving family or a scanty knowledge of the donation process can stop us.

In-service education can bridge the information gap. But getting ourselves to feel more comfortable about asking is more difficult. My advice is to first acknowledge your feelings of inadequacy. Examining some of the fears, myths, and misconceptions that surround donation can also help.

Overwhelmingly accepted

One common myth is that asking for a donation as quickly as we must is insensitive to the family's grief, even offensive, because most people don't want to donate anyway. That simply isn't true.

Nationwide, the concept of tissue or organ donation is overwhelmingly accepted. In recent Gallup polls, for instance, up to 85% of the people surveyed said they'd be willing to donate the tissues and organs of their loved ones.

If so, then why aren't more donating? Well, acceptance of the concept apparently becomes more tentative when the reality hits home. People don't dislike donation; they dislike thinking about their own mortality.

Another reason is that many families who might donate aren't being offered the option at the time of loss.

If someone wanted to donate, you might ask, wouldn't he carry a donor care? Not necessarily. Best estimates show that perhaps on 2% or 3% of the adult population care donor cards. Again, people are reluctant to plan for death, even though donor cards can ease the burden of the donation decision for their families.

Donor cards don't lift that burden entirely, however; the family still must approve the donation. Although donor cards are legal in all 50 states, ;most hospitals also obtain consent from the legal next of kin. Enforcing the legality of the donor card over the family members' objections would only intensify their grief, so their right to refuse is typically respected.

As you approach the family, the, remember that most people are willing to at least consider donation. Their right to refuse ensures that you won't in any way override their feelings.

Talking to the family

Before you discuss donation with the family members, be sure, of course, that they've been informed of the death and that the patient is an appropriate candidate.

Your next step is to assess whether the family members are calm enough to discuss donation. Have they truly accepted the death or, in the case of brain death, do they understand that their loved one is dead - and that the ventilation support is to maintain the vital organs only?

One of the public's misconceptions, by the way, is that a potential donor's care will have been compromised for the sake of the donation. Your thorough explanation of the donation process can reassure the family members on this point; you might also

let them know that the patient's doctor is in no way involved with the tissue or organ procurement.

Then, try to find out whether the patient had a donor card or whether anyone in the family has mentioned donation. Knowing that before hand can help the discussion go more smoothly.

To properly ask for consent, you'll need to identify the legal next of kin and his relationship to the patient. This is usually the spouse; if there's no spouse, an adult son or daughter (over age 18); if there are no adult children, either parent of the patient; and son on. But bear in mind that usually one family member or close friend - not necessarily the legal next of kin - is the main support person and decision maker. Failure to include this person in the consent process may spell failure to get the family's permission.

As you talk to the family members about donation, remember first of all why you're there: to comfort, help, and support them - and to offer them and option that's now available through your hospital.

If they do react with tears or screams of protest, try not to take it personally. This, too, could be part of their grieving, and not necessarily a rejection of your request or even a sign that they think of it as an "intrusion."

Perhaps the best way to demonstrate how donation can help console bereaved families is to tell you how I approached Brian, the young man whose wife was killed in a car accident.

As Brian moved his hands away from his face, he softly moaned, "Claire, Claire," I placed my hand on his shoulder and stooped down so he could see me clearly. "Brian, my name is Sheila Howard. I'm the transplant coordinator here. I'm so sorry about Claire.... Can I do anything for you? Would you like something to drink - coffee? A soda? Water?

Maintaining eye contact with Brian (without invading his space) helped clam him. Besides trying to give him something to focus on. I wanted him to know that I cared. Even the few minutes I spent getting Brian and his family sodas helped them regain some control of their emotions. They could then start thinking about the necessary calls and arrangements.

You may not always be sure of the exact moment to ask for the donation. Just remember, your first priority is to care for the family members during their bereavement. And the option you're offering can give them some comfort.

"Brian, would you like ;me to call someone for you? Can I answer any questions for you?" His eyes, flooded with tears, never left mine. I added, "Would you like to talk about Claire?"

Yes, he would: "How did this happen?" "Where?" And then, the hardest question: "Did she suffer?"

These questions are universal. Sometimes simply letting the family members talk about their loved one will open the door for more communication. The family needs to know who, why, how, could the death have been prevented? As part of their normal grieving, later, they'll probably want to review the death to see if they could have done anything to prevent it.

Most likely, despite your assurances that there was nothing they could have done, they'll feel anger, guilt, and sadness. Yet the answers you give them now can help they resolve some of these feelings afterward.

I answered Brian's questions as truthfully and completely as I could, avoiding clichés such as, "It must have been God's will," "There must be a reason," or " at least she didn't suffer." When I was sure I'd answered all his questions about the accident, I explained my role.

"Brian, losing Claire must be terrible for you. I'm very sorry: I'd like to be able to help. When facing a tragedy like this, many people get a lot of comfort from donating tissue or organs. Our hospital can provide this option for you. Did you know that Claire carried a donor care?"

He nodded. "Yes - anything you can use. Claire and I talked about this once. It's what we both wanted."

What if Claire hadn't carried a donor card? Knowing that the concept of donation is widely accepted, I would have gone on to ask Brian if he'd like to consider the option. He probably wouldn't have thought about it unless someone mentioned it to him.

I'd never start the discussion by asking if the patient carried a donor card. In most cases, the reply would be no, and I wouldn't want to have the door closed on the subject before I could start.

Although Brian had given a resounding yes, I couldn't simply get his signed consent and leave. I had to give him the specific information he needed, such as which organs or tissues could be donated, which blood tests would be needed beforehand, when and how the surgery would be done and who would perform it, how long it would take, what effect the donation process would have on Claire's body and on the funeral arrangements, and what costs would be involved and who would pay them. (The costs of evaluating donor eligibility and the entire donation process are covered by the procurement agency involved.)

I also explained the potential benefits of transplantation. Success wasn't guaranteed, I told him, but important research would progress even if an organ or tissue proved unacceptable for transplantation.

Most important, I made sure Brian realized that he had the right to refuse donation and that his decision wouldn't be held against him in any way.

Only after I'd finished this explanation did I ask Brian to sign the consent form.

As I stood up to leave, I said, "Brian, I know this is hard for you, but many families say it helps to receive some information later about their donation. Would you like to know how many people Claire was able to help? I can't tell you their names, of course, but I'll be able to tell you how she helped them." He smiled slightly.

"Yes, I'd like to know. Yes. It's a way for Claire to live on, isn't it?"

The Who, What, and How of Donation

A recently deceased person can donate either tissue or organs, sometimes both. The two types of donation have important differences.

Organ donation includes vital organs such as the heart, lungs, liver, kidneys, and pancreas. These organs can be donated only by those who have suffered brain-death and whose vital functions have been maintained by a life-support system. The age limit for donating vital organs is 60 or under - for heart donations, much younger.

Once brain-death has been documented and the family's consent for donation obtained, the patient is usually placed on ventilator support to ensure maximum viability of the organs until the actual procurement occurs. Vital organs must be transplanted relatively quickly after being removed from the donor: heart and lung, within 2 hours; heart, within 3 to 4 hours; liver, within 8 to 12 hours; pancreas, within 24 hours; and kidney, within 72 hours.

Tissue donation includes the long bones of the arms and legs, the iliac crests, vertebrae, ribs, facial lata, dura mater, arteries, veins, heart valves, cartilage and ligaments, skin, and corneas.

Tissue donation can be accepted up to 24 hours after the cessation of circulation. Because the patient needn't have been sustained on a life-support system and the maximum age limits aren't as strict, more deceased patients can donate tissue than organs.

Every year in the United States, more than 500,000 operations require bone products for transplantation. Bone is perhaps the most versatile tissue transplanted because it can be cut and shaped as needed.

Some common uses of bone? Reinforcement for areas where bone tumors and cysts have been removed, spinal fusions, and reconstructive surgery. Advantages to the recipient include faster healing, shorter hospital stays, reduced costs, and less discomfort.

In bone and soft tissue donation, a surgical team removes the tissue, which is then sent to a tissue bank to be either freeze-dried or fresh frozen. The tissue may be stored up to 5 years for later transplantation.

Chapter 7
SUICIDE AND ALCOHOLISM

SUICIDE - LET'S TALK ABOUT IT

Suicide is an increasingly serious problem – in our communities, our families, and our police forces. Suicide is more common than most of us realize. It now ranks among the ten leading causes of death in North America. As reported by the Center for Disease Control (CDC), suicide took the lives of 30,622 people in 2001. In 2002, 132,353 individuals were hospitalized following a suicide attempt and 116,639 were treated in emergency departments and released.[7] Since many suicides are not reported as such, experts believe the true number is considerably higher. For every successful suicide there are several unsuccessful attempts.

- Suicide rates are generally higher than the national average in the western United States and lower in the eastern and Midwestern United States (CDC 1997)
- In 2001, 55% of suicides were committed with a firearm[8]

In 2001, 55% of suicides were committed with a firearm (Anderson and Smith 2003).

Who tries to commit suicide? Why? What are the danger signals? How can we help? Despite the seriousness of the problem, surprisingly little research has been carried out. However, a number of facts are now known; a number of myths can be laid to rest.

Suicidal Myths

True or False — *People who talk about suicide rarely commit suicide within the six months preceding the suicide.*
False: Talk of suicide may be a clue or warning. Out of ten people who kill themselves, eight have given definite clues about their intentions. Suicide threats MUST be taken seriously.

True or False — *The suicidal person really wants to die.*
False: Most suicidal people are ambivalent and want help. They are undecided about living or dying. They "gamble with death", leaving it to others to save them. Almost no one commits suicide without letting others know how they feel. Often this "cry for help" is given in code.

[7] Department of Health and Human Services, Center for Disease Control and Prevention (CDC), 2004. For Additional information, visit CDC's website at www.cdc.gov/ncipc/ factsheets/suifacts.htm.
[8] Anderson RN, Smith BL. Deaths: leading causes for 2001. National Vital Statistics Report 2003; 52(9):1-86.

True or False *There is no correlation between alcoholism and suicide.*
False: A person who commits suicide is often also an alcoholic.

True or False *Once someone attempts suicide they will always be suicidal.*
False: Happily, individuals who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead productive lives. New ways of coping with stress can be learned.

True or False *Asking directly about suicide could encourage an attempt.*
False: Asking directly can minimize anxiety and act as a deterrent.

True or False *A person who tries to kill him/herself is mentally ill; suicide always the act of a psychotic or crazy person.*
False: Stories of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, they are not necessarily mentally ill. Their overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.

True or False *Improvement following a suicidal crisis means that the suicidal risk is over.*
False: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put their morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.

True or False *Suicide strikes more often among the rich, or conversely, occurs more frequently among the poor.*
False: Suicide is neither a rich man's disease nor a poor man's curse. It is common through all levels of society.

True or False: *Suicide is inherited and "runs in a family".*
False: Suicide does NOT run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

A Cry for Help

Someone who is seriously thinking of suicide is undergoing a crisis in which they are not their normal self. They need help just as surely as if they were fighting a severe physical illness.

Even a "mild" suicide attempt indicates a desperate need for sympathy and understanding. If help isn't forthcoming, a more serious attempt may follow. Every effort should be made to get at the cause of the unhappiness, and the individual should be watched carefully for at least 90 days after the suicidal period.

Prevention of Suicide

A question sometimes thoughtlessly asked is, "If a person finds life so intolerable that they want to commit suicide, why not let them?" Evidence shows that if a person is prevented from committing suicide, they are very thankful afterwards.

Every human life is precious. Our culture's humanitarian and religious beliefs place a high value on human life. This is reflected in the great effort we put into the control of disease, accident prevention, rescue operations, etc.

Suicide leaves a trail of tragedy. Sorrow over a death is always difficult to bear, but suicide places an unusually heavy burden on the survivors. Our society attaches a stigma to suicide which the victim's family must bear. This can be particularly difficult for children.

Then, too, those left behind may identify with the victim and become preoccupied with the fear that they too may resort to suicide if life becomes very difficult.

Clues for Preventing a Suicide

Very often a suicide could have been prevented if the family had been able to recognize clues in the victim's behavior shortly before death. Here are some of the more common clues:

- Repeated talk of death or suicide threats.

- The following remarks were made by people who later killed themselves:
  - Bullet and indent
  - "My whole family would be better off without me."
  - "I'm going to end it all; I can't stand it any more."
  - "I won't be around much longer for you to put up with me."
  - "I don't want to be a burden."
  - "This is the last straw; this is all I needed."
  - "I can't stand it any longer. I want to die."

- It's a mistake to take such remarks lightly. If a person has been ill, unhappy or depressed for some time, it's important to seek prompt professional help.

- Planning for death or absence
  - Many suicides are carefully planned so that affairs will be left in order for surviving family members. Making a will, discussing insurance policies and organizing affairs can be warning signs if these actions are accompanied by suicidal talk and general unhappiness. Of course it is foolish to think that anyone who makes a will or discusses insurance is suicidal.

<u>Other clues</u>

Other warning signs are important if they occur along with any of the above symptoms. These may include chronic sleeplessness, loss of weight (through loss

of appetite), withdrawal from social contacts, loss of sexual desire, and loss of interest in hobbies. In short, any change in behavior which makes a person seem quite different.

What to Do For the Suicidal Person

Family, loved ones and friends are in the best position to give emergency assistance. The first step is frank recognition that the person - no matter how healthy or stable he has been in the past - is now very unhappy and potentially suicidal.

It is a dangerous mistake to play "ostrich" or to delay in the hope that "things will get better". There is no substitute for professional assistance in the treatment of a suicidal crisis. If in doubt, call in expert help.

Where to Look For Help

The Family Doctor. In most communities, the first source of emergency help is the family physician. If there is no family doctor, the local medical society may be called for suggestions and help. In larger centers, the general hospital usually maintains an emergency out-patient service.

Crisis Intervention Distress Center. There are now telephone distress centers across the United States and Canada; they have proven themselves to be a reliable suicide prevention resource.

The name given to this method is "Befriending". In many cases the telephone lines are open 24 hours a day with trained lay people working in shifts. Most of the callers respond positively to a friendly voice at the other end of the line, and the workers have been trained to cope with referral or emergency situation.

The Psychiatrist. A psychiatrist is a medical doctor who has specialized in treating mental and emotional illnesses. Suicidal behavior is usually considered to be a symptom of pathological disturbance of emotions - in other words a mental illness.

Psychiatric Facilities. In addition to the family doctor and the practicing psychiatrist, there may be special mental health clinics and treatment facilities available in the community. These can be called on for special help, in many cities the general hospital provides 24-hour psychiatric emergency services.

Religious Counselors. Surveys have shown that people concerned with personal or health problems go first to their minister, priest or rabbi - even more frequently than to their family doctor. Today many clergymen have had professional training as counselors, so they're able to assist with problems or at least locate other sources of help.

Social Agencies. In most communities there is a network of family case workers and social welfare agencies. They can be found in the telephone directory under such listings as United Way, Social Planning Council, Community Information Center, and Social Service Organizations.

Remember, that "Cry for Help" should always be taken seriously. The best response is fast, professional help. Keep the following things in mind if you hear a “cry for help” that indicates a person might be suicidal:

- How to Assist the Person – Suicide Prevention
  - Ask them open ended questions
    - What are you feeling now?
    - What’s going on in your life? Look for these commonalities:
      - Unbearable Physical Pain
      - Desire to cease pain
      - Tunnel Thinking
      - Unfulfilled Needs
      - Hopelessness
      - Trying to Communicate, Intent
      - Unsolved Problems
      - Ambivalence
      - Difficulty with Coping Pattern
    - Are you depressed?
    - What are your goals (dreams)?
    - Are you thinking about killing yourself? *(This can be very “releasing” to the person)*
    - Have you ever tried suicide before or given it serious thought?
    - Has anyone in your family ever committed died by suicide?
    - Are you on any medication?
    - Are you under a doctor’s care? (medical, physical, or psychological)
    - How do you want to do it?
    - Do you have the means to do it? How? (Available Now!)
    - Look for the following clues in their answers to the above
      - Previous suicide attempts (family or self)
      - Recent Losses (relationships, job, etc.)
      - Loss of face among peers (rejected)
      - Isolation
      - Appetite loss
      - Verbal Cues
      - Behavioral Clues (giving things away)
      - Philosophy on Death
      - Failures (i.e., school)
      - Intolerance for Crisis
      - Moving
      - Moodiness – Changes
      - Alcohol / Drugs
      - Poor Physical Health
      - Stress
      - Lack of Resources
      - Low Communication
      - Apathy
      - Disturbed Family Structure

- Look for clues…do they have a DESIRE to live
- Look for Self Revealing Techniques. " A person who is suicidal will drop verbal clues that say "I really want to talk". These clues are an invitation for the helping person to probe deeper and ask more questions. Some clues might be: I don't know what's happening with me!" , "I'm confused."
- Keep them in the RIGHT NOW!
- It's between you and them.
- Be aware of your surroundings and what's going on around you. Sometimes a suicidal person may decide to take someone with them, or do something spontaneous such as jump off a bridge. Remove anything that may prove to be a danger to you or to the person you are helping.
- Be Warm – Be Direct – Be Confrontive

How can Chaplains Help?

Chaplains are a buffer between the survivors and the police. If it is appropriate, Chaplains will often be used to assist the survivor in seeing the victim. Assist the survivors in obtaining the facts and direct them towards support group information when the timing is appropriate. This referral, if acted upon, may be one of the most important things they will do after the event.

Other areas where a Chaplain may find him/herself asked to assist include working with the family and mortuary/chapel as a liaison for funeral preparations. Of all the victim/survivor scene events, police tend to get over protective for survivors in suicide-related deaths. This is especially true when the person is a law enforcement victim. Just keep in mind, "If you can't improve on silence, don't".

What should a Chaplain bring to a suicide attempt? Bring yours "best" self. Offer hope and honesty. Have and show a caring attitude through touch and being touched. Have patience and be empathetic to the conditions. Keep these in mind:

DO

- Listen – Establish a relationship (obtain information)
- Identify and clarify the problem – talk about it.
- Share hope
- An extended family (significant others) – Reach out to them as well
- Talk about suicide
- Speak slowly but softly (be calm)
- Take your time
- Know your limits
- Clarify concept of death
- Reassurance in a positive way
- Alternatives – what else can be done (formulate a plan)

DON'T

- Promote guilt
- Physically reveal a weapon
- Promise confidentiality
- Argue
- Give choices they can't make
- Leave them alone
- Get over involved
- Be shocked at anytime

SUICIDE LETHALITY SCALE

Risk Level	Details	Mental Health	Precipitating Event	Person's Disposition	Action
Low	▪ Person states he/she is feeling suicidal ▪ No suicide plan ▪ Person not in immediate danger (e.g. the means to carry out the plan are not present, intent is not immediate.)	▪ May or may not have received counseling in the past ▪ May or may not have received mental illness diagnosis/ treatment.	▪ Recent crisis or string of crises.	▪ Primary need seems to be someone to talk to who will listen ▪ Person is open to and active in developing a positive plan of action. ▪ Person has a basic support system available.	▪ Explore primary issues. ▪ Discuss short and long term plans of actions. ▪ Contract with person to fulfill positive plan of action. ▪ Contract with person to reach out for help again if the suicidal feelings return.
Medium	▪ Person states s/he is feeing suicidal. ▪ They have a plan. ▪ Means to carry out the plan are readily accessible ▪ Means are available but not immediately lethal. ▪ Intent is not immediate.	▪ May have family history of suicide and/or mental illness. ▪ May have chronic mental illness diagnosis.	▪ Likely feels that negative life events have been ongoing for years. ▪ May resist idea of "here and now"	▪ Person may seem uncertain about prospect of future happiness/ wellness. ▪ Person still willing to reach for help and develop a positive action plan.	▪ Explore primary issue. ▪ Discuss short and long term plans of action, including the possibility of mental health assessment. ▪ Contract with person to fulfill a positive plan of action. ▪ Contract with person to reach out for help again if the suicidal feelings return.
High	▪ Person states s/he is feeling suicidal. ▪ Plan developed. ▪ Intent is immediate or within near future ▪ Means are lethal and accessible. ▪ Likely to have attempted before and has probably felt suicidal for a long period of time.	▪ Presence of chronic mental illness is likely, whether or not it's been diagnosed. ▪ Likely has family history of mental illness/suicide.	▪ Recent crisis likely in addition to ongoing crisis/distress.	▪ Person stated intent to die. ▪ Resistance to open communication/ alternatives. ▪ Disillusioned with helping system, strong feelings of hopelessness and diminished fear in the face of death. ▪ You believe the person will harm themselves.	▪ If suicide is in progress, call 9-1-1 to dispatch emergency services. ▪ Contract with person to seek immediate ▪ Assistance from a mental health professional – follow up to make sure this was done. ▪ Contract with person to reach out for help again if suicidal feelings return.

Table 3: www.crisiscallcenter.org/crisisweb/suicide_lethality_scale.htm

LETHALITY ASSESSMENT SCALE FOR SUICIDE POTENTIAL

How likely is it that this person will be dead in 2 hours? From the above table, you can see that many factors contribute to the suicide lethality scale. When dealing with the assessment of whether or not someone has a high potential for suicide or not, the following facts should be taken into account:

1. Age and Gender
    a. Females attempt suicide most often
    b. Males accomplish suicide the most
    c. Young men and men over the age of 60 are higher risks then males of other age groups.
    d. Race is not a critical factor
2. Self Destructive Behavior
    a. Is this the first time they have felt suicidal tendencies versus feeling suicidal feelings a number of times.
    b. First feelings are "scored" as a low lethality where multiple feelings are "scored" as a high lethality.
3. Method and Availability
    a. The less violent the method, the lower the lethality. Pills are an example of a low lethality.
    b. The more violent the method, the higher the lethality. Guns are an example of a high lethality. So too, is hanging or jumping.
4. Major Losses:
    a. Have they lost someone/something close to them?
        i. A friend moved away
        ii. Loss of a pet
        iii. Something minor, like they broke something or "spilled the milk"
        iv. The degree of loss depends on their perspective not ours. We will never know what their perspective is unless we ask.
5. Medical Conditions tend to be high on the lethality scale.
    a. Have they been battling ill health or serious medical conditions?
    b. Do they have psychological conditions or depression?
    c. What is the "last straw" for them?
6. Resources
    a. If they have a supportive family, feel needed at their job or enjoy their job, if they have an "okay" home life, if people listen to them – their lethality level is low.
    b. If they have been sloughed-off by people who have dealt with their previous attempts, have missed their "cries for help", or they have "worn out" the people around them – their lethality level is high.
7. Communication Quality
    a. If you can engage them in meaningful conversation and they can express their feelings – low lethality
    b. If they are isolated, are having trouble communicating, or holding things in – high lethality
8. Self Worth (Self Worth used instead of "Personality Status")
    a. Does the person have any self worth? Do they have a family status? Do other people depend on them (in a positive way)?

b. Low self worth and family status – higher lethality.

When a person has a high lethality score, they may be admitted to an observation ward for safe keeping. Under a 5150, the physician can keep a person under observation for 24 hours. If the person is not a threat to themselves, you can apologize the next day for your concern. If the physician or professional feels the person has a moderate level of lethality, they will work with the person on their mixed or conflicting feelings and help them work out any ambivalent feelings they have. If the person has a low level of lethality, the basic assessment will most likely recommend that the person work out their issues with the guidance of a licensed counselor.

If you are dealing with a person that appears to be low to moderate on the lethality scale, ask them to make a “contract” with you – not to do anything in the next 24 hours. Ask them to meet with you again – and force them, if you have to, for a decision on where to meet and at what time. Think about where God fits in all this?

WORKING WITH SUICIDE BEREAVEMENT

Be Honest. No one is comfortable with the facts and feelings that surround a suicide. However, the temptation to be dishonest to avoid facing some of these facts or feelings should be avoided. Any attempt will undermine your effectiveness with the bereaved.

Be Willing to Hear and Accept Feelings. Grief brings a variety of feelings to a person. The grief that follows a suicide can bring so many conflicting feelings that the bereaved feels unable to accept them. Often, this takes the form of guilt over the various feelings being experienced. They need to know that it is "OK" and even "normal" to experience conflicting and confusing feelings.

Take a Non Judgmental Stance. It is not our place to judge the deceased or the bereaved. We need to be very cautious about any judgmental messages that might inadvertently come across. This is true even when the bereaved seeks a judgment from you.

Recognize Their Need for Acceptance. The person who has lost a loved one to suicide has experienced the ultimate rejection. In their mind, their loved one chose death over life with them. This can lead to the feeling that they themselves are unlovable and unacceptable. As a person representing God, the church, and the community, your willingness to accept them as people carries great meaning.

Disregard Taboos. Each culture has its own taboos regarding suicide, such as "Don't talk about it," "Don't say anything negative about the dead," and so on. The bereaved needs help understanding what is acceptable and what is not. Any "taboo" about suicide that stands in the way of the bereaved person's pain being healed should be ignored or consciously denied.

Lead the Bereaved to Forgiveness. The bereaved may have legitimate reason for feeling guilty. If so, they should be recognized and the bereaved should be helped to find forgiveness.

Remember Who You Are. When you go to a bereaved person, you represent God and humanity. Your actions will in some ways illustrate for the bereaved what the reality of life is. If you teach that God forgives, yet they sense that you don't, they will not believe what you have said about God.

Make Appropriate Referrals. Often you will only be able to help with the immediate crisis. If you are not going to be offering ongoing assistance, or if you feel the bereaved needs help you cannot provide, help them to someone who can.

COMMON MISCONCEPTIONS ABOUT SUICIDE

False Statements	**True Facts**
1. People who talk about suicide rarely commit suicide.	1. People who commit suicide have given some clue or warning of intent. Suicide threats and attempts must be taken seriously.
2. The tendency toward suicide is inherited and passed on from one generation to another.	2. Suicide does not “run in families”. It has no characteristic genetic quality.
3. The suicidal person wants to die and feels there is no turning back.	3. Suicidal persons most often reveal ambivalence about living versus dying and frequently call for help immediately following the suicide attempt.
4. Everyone who commits suicide is depressed.	4. Although depression is often associated with suicidal feelings, not all people who kill themselves are obviously depressed. Some are anxious, agitated, psychotic, organically impaired or wish to escape their life situation.
5. There is very little correlation between alcoholism and suicide.	5. Alcoholism and suicide often go hand in hand; that is, a person who commits suicide is often also an alcoholic.
6. A person who commits suicide is mentally ill.	6. Although persons who commit suicide were often distraught, upset or depressed, many of them would not have been medically diagnosed as mentally ill.

7. A suicide attempt means that the attempter will always entertain suicide.	7. Often a suicide attempt is made during a particularly stressful period. If thoughts during the remainder of the period can be appropriately managed, then the attempter can do on with life.
8. If you ask a client directly, "Do you feel like killing yourself?" This will lead them to make a suicide attempt.	8. Asking a client directly about suicidal intent to kill often minimizes the anxiety surrounding the feeling and acts as a deterrent to the suicidal behavior.
9. Suicide is more common among lower socioeconomic groups than anywhere in our society.	9. Suicide crosses all the socio-economic groups and no one group is more susceptible than another.
10. Suicidal persons rarely seek medical help.	10. In retrospective studies of committed suicide, more than half had sought medical help within the six months preceding the suicide.

STAGES OF SUICIDE

Behavioral Clues

1. Stressful Events: A series of upsetting situations may lead persons to considering suicide. These situations may include things such as:

    - Loss of job
    - Breakup of a relationship
    - Death of a loved one
    - Rape or assault
    - Illness
    - Other significant changes in lifestyle

    What you can do:

    - Encourage them to talk about feelings.
    - Be willing to listen without passing judgment.
    - Suggest finding supportive help that will offer new ways of coping with stress.
    - Encourage them to call the local Suicide Prevention center and speak with a counselor.

2. Suicidal Thoughts: Sometimes these thoughts may be expressed silently through behaviors such as alcohol or drug abuse, depression or sadness. Sometimes they are expressed in words like:

    - "No one understands."
    - "You'd be better off without me."
    - "There's no hope; it'll always be this way."

What you can do

- Recommend that they get help for specific issues of concern.
- Encourage them to reduce stress through physical exercise, eating regularly, getting adequate sleep, and avoiding coffee and alcohol.
- Don't be afraid to ask, "Are you thinking about suicide?"
- Call the Suicide Prevention center to discuss your concerns.

3. Suicidal Plan: Look for unexpected changes in behavior or disruption in sleeping or eating patterns. The person may also begin getting ready by:

   - Buying a gun
   - Collecting pills
   - Giving away valued possessions
   - Making or changing a will
   - Saying "good-byes"

   What you can do:
   - Strongly encourage them to seek professional help.
   - Ask directly about suicidal feelings and find out about specific plans.
   - Take away pills or gun
   - Help them to see other alternatives.
   - Get them to agree not to attempt anything without first consulting a professional counselor.

4. Suicidal Action: Persons who up until now have been agitated and upset often appear unusually calm or emotionally withdrawn just before a suicide attempt. Plans may be acted out by:

   - Driving reckless
   - Going off to be alone
   - Taking dangerous chances

   What you can do:

   - This is a Life and Death situation. Take whatever action is necessary to save a life.
   - Contact the police, sheriff or Suicide Prevention center.
   - Let the person know you are worried and that you care.
   - Enlist the help of family members and close friends.

5. After An Attempt: The first three months after a suicide attempt is a critical period of adjustment. People often feel embarrassed, ashamed or angry, and they may be gathering strength for another attempt. They may view their unsuccessful suicide attempt as just another personal failure.

   What you can do:

   - Be honest and open about your concerns.
   - Let them know that their survival matters and that you have confidence in their ability to work things out.

- Encourage them to get professional help to find betters ways of dealing with crisis.

Remember: Ultimately you cannot stop someone who is intent on suicide but you can encourage them to seek professional help.

SIGNS OF DEPRESSION AND SUICIDE RISK

- Sad, withdrawn
- Lack of interest in activities previously enjoyed
- Apathy and fatigue
- Pessimistic, irritable
- Loss of appetite and weight
- Loss of sexual interest (married relationships)
- Sleep disturbance -- insomnia, sometime early waking nightmares
- Difficulty in making conversation and carrying out routine tasks
- Sense of futility
- Indecisiveness
- Feeling worthless
- Loss of religious faith
- Feelings of guilt and self-blame
- Preoccupation with illness, real or imaginary
- Financial worries
- Drug or alcohol dependence
- Preoccupation with or talk about suicide
- A definite plan for committing suicide
- Suicidal impulses
- Previous suicide attempts
- Social isolation
- Recent loss
- No hope for future
- Unsympathetic relatives, feeling that "nobody cares"
- Tidying up affairs, giving away possessions
- Suicides in the family or among close friends
- Fear of losing control, going crazy, harming self or others
- Feeling of helplessness
- Low energy
- Anxiety
- Stress

Many times people are most at risk when they seem to be improving. Sometimes when a person has carried around with them for a long time the idea of suicide, even a seemingly trivial mental stress can set off a tragedy.

If a person seems depressed, do not be afraid to ask "Do you feel bad enough to kill yourself?" It can be a great relief to them if you bring up the subject and let then talk freely about their suicidal thoughts, feelings, impulses, plans and/or fantasies. Talking about it to someone who accepts them, without showing shock or disapproval, can clear the air and reduce the tension. Nearly everyone can be helped to overcome almost any kind of situation which might destroy their

self-confidence; if they have someone who will listen to them, take them seriously, and show that they care about them.

BEFRIENDING SUICIDAL OR DESPAIRING PEOPLE

1. All befriending is played by ear. There are no formulas, just some safe guidelines.

2. You must be yourself. Anything else feels phony and won't be natural to you or the person who is talking with you.

3. Your job is to make a relationship with the other person so that they feel they can trust you enough to tell you what is really on their mind. You want them to be able to level with you as they would to their friend.

4. What you say or don't say is not as important as how you say it. If you can't find the right words, but feel genuinely concerned, your voice and manner will convey this.

5. Deal with the person; not just the problem. Talk as an equal; if you try to act as a counselor or an expert, or try to solve problems, it will probably be resented.

6. Give your full attention. Listen for feeling as well as facts and for what is not said as well as what is said. Allow the person to unburden without interruption.

7. Don't feel you have to say something every time there is a pause. Silence gives you each time to think.

8. Show interest, and invite the person to continue without giving him the third degree. Simple, direct questions ("What happened?" or "What's the matter?") are less threatening than complicated, probing ones.

9. Steer toward the pain, not away from it. The person wants to tell you about the private, painful things that most other people don't want to hear. Sometimes you have to provide an opening, and give them permission to begin talking. ("You sound depressed. What's the matter?")

10. Try to see and feel things from the other person's point of view. Be on their side; don't side with the people they may be hurting or the people who are hurting them.

11. Let the person find their own answers, even if you think you see an obvious solution.

12. Many times there are no answers and your role is to bear witness, to listen, to be with the person in his pain. Giving your time, attention, and concern may not seem like "doing enough". People in distress, in seemingly hopeless situations can make you feel helpless and inadequate. Happily, you do not

have to come up with solutions or change people's lives, or even save their lives. They will save themselves, make their own changes, etc. Trust them.

When you don't know what to say, say nothing!

Article~

Suicide affects the lives of so many
By: Penne Usher, The Journal (Gold Country Media – Auburn, CA)
Wednesday, June 28, 2006 11:07 PM PDT

I cried Tuesday for a young man I never met.

As six deputies carried the body of a man who fell to his death from the 730-foot Foresthill Bridge Tuesday afternoon, they looked like uniformed pallbearers. It was at that moment when I thought in just a few days well-dressed friends and family members of the young victim will be carrying his casket to its final resting place.

For reasons no one will ever know, this man made a decision to end his life. I cannot fathom what pushed him to the brink where he felt death was his only option.

I've covered many tragic stories involving deaths, but this one hit me - hard.

On my way home from work I thought about the latest victim of the bridge. I thought about his family and that they were about to receive a knock at the door.

A uniformed officer and a chaplain would be standing on the other side.

A mother, a father, would hear the horrific news that their son had died.

I learned Wednesday that the young man had not yet been identified. He was found without identification. There was no vehicle in the area that could be traced to the victim. No one has come forward looking for him. No one has missed him yet.

Seeing his body lying on the Clementine Trail is an image I cannot erase from my mind. I spoke to my friend, Officer Dale Hutchins of the Auburn Police Department. He understood what I was feeling.

Hutchins told me I needed to talk to someone. I thought that's what I was doing.

I spoke Wednesday to the Senior Chaplain of Placer County Law Enforcement Chaplaincy. As my emotions bubbled at the surface we recounted what had occurred on the banks of the American River.

As we sat in his office, I went through what he called Critical Incident Debriefing. He said that what I saw was abnormal, but what I was feeling was normal.

Author Victor Frankle once wrote, "An abnormal reaction to an abnormal situation is normal behavior."

The Chaplain and I talked. I cried.

The Center for Disease Control and Prevention reports that suicide is the third leading cause of death among young people age 15 to 24.

Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools and communities. Such feelings can overwhelm young people and lead them to consider suicide as a "solution," the CDC reports.

Coping with the tragic and sudden loss of a loved one is something many have endured - myself included.

At 6:15 a.m. on April 1, 2004, I received a phone call from my mother. She told me my 41-year-old brother had drowned. I fell to my knees, cried and kept denying her words. He left behind a wife, and two daughters.

In the two years since his death, I have come to terms with the loss. My brother, Dale, taught me in his death, to be a more compassionate writer.

There's a lesson in this latest tragedy as well. I just don't know what it is yet.

As I drove home Wednesday I prayed for the family the young man left behind.

The Journal's Penne Usher can be reached at penneu@goldcountrymedia.com.

Article~

POLICE SUICIDE
by Gilles Sussant
Psychologist, Institute de police du Quebec, Nicolet, Quebec

Fiction:Suicidal people are fully intent on dying.
Fact:
Most suicidal people are undecided about living or dying, leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. Often this "cry for help" is given in code.

Fiction:Suicide strikes more often among the rich,
or conversely, occurs more frequently among the poor.
Fact
Suicide is neither a rich man's disease nor a poor man's curse.
It is common through all levels of society.

Fiction:Suicide is inherited and "runs in a family".

Fact

Suicide does not run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

Fiction:All suicidal individuals are mentally ill,
and suicide always is the act of a psychotic person.
Fact:

Although extremely unhappy, he is not necessarily mentally ill. His overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.

Fiction:People who talk about suicide don't do it.
Fact:

Out of 10 people who kill themselves, 8 have given definite clues to their intentions. Suicide threats must be taken seriously.

Fiction:Once a person is suicidal he is suicidal forever.
Fact:

Happily, individuals who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead useful lives.

Fiction:Suicide happens without warning.
Fact:

Research shows that the suicidal person gives many clues and warnings. Recognize these cries for help can save a life.

Fiction:Improvement following a suicidal crisis
means that the suicidal risk is over.
Fact

Most suicides occur within 3 months following the beginning of "improvement" - when the individual has the energy to put his morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.

PORTRAIT OF A SUICIDAL INDIVIDUAL

Psychologist Jean-Louis Campagna, founder of the Quebec Suicide Prevention Center, claims that we cannot stereotype suicidal individuals; however, they do share certain characteristics. In his opinion, a distinction must be made between two categories; those who have chronic suicidal tendencies and those who contemplate suicide because of a given situation.

One specialist, Marie-Josee Filtear, describes these two categories in a short document entitled "Suicidal people and how to deal with them". Her document

also deals with topics such as: the warning signs of suicide, people's reaction to someone threatening suicide and, finally, how to assist the person in distress.

1. People with chronic suicidal tendencies:

Serious lack of affection during childhood, battered or sexually abused during childhood, academic failure, dropout, inter-personal relations almost always fail, intense and chronic depression, inability to keep a job, alcoholic, addicted to drugs, repeated tries to commit suicide before making a clear and resolute decision to go through with it.

At one point, they choose to die and decide when, how and where they will do it. They might draw up a will and settle their affairs, or make peace with those around them. Even at this moment, all is not lost - there is still a chance that the person will be able to find a glimmer of hope, a new reason for carrying on with life. This is what we must help them discover.

2. People contemplating suicide because of a given situation:

This applies to a person who has led a normal life until the day they suffer a major loss. This could be the loss of a loved one through death or divorce, the loss of prestige or social status, the loss of a job, a financial loss or a loss of self respect.

For a variety of reasons, the loss may upset the person's psychological balance and cause a crisis. No longer able to think as before, they become increasingly depressed and negative towards others and themselves. This is when their thoughts turn to suicide. The time between the thought and the act may be very short and therefore, prompt action is imperative.

It is therefore extremely important to know and recognize the warning signs of suicide, so that immediate intervention is possible. What are these signs? A tendency to withdraw, settle their affairs, take an interest in medication, talk about a trip. There may be psychosomatic changes such as: loss of appetite, insomnia, headaches, a tendency to give away things that they value, etc.

Attention: Care must be taken because certain signs may be deceptive. Often the individual with chronic suicidal tendencies may appear to be at peace with themselves once they have made an irrevocable decision to commit suicide. They will appear to be relaxed, happy, and even euphoric. It might therefore be easier for those around them to mistakenly believe that things are going better, that the crisis has passed.

It must be remembered that sudden fluctuations in mood from deep depression to happiness may be a sign that the person is contemplating suicide. In case of doubt, it is better to talk to the person directly and see how they react.

THE CLOSED WORLD OF THE POLICE OFFICER

Not much research has been done on police officers, as their domain is relatively inaccessible to those who are not part of a police organization or a legal institution.

In 1978, in his article entitled "Suicide in police officers", David Lester criticized the lack of recent research into suicide in police officers. He attributed this fact to the desire of police forces to protect the image of the police officer.

He argued that this attitude was unfortunate, because this image was being protected at the expense of police officers whose suicides could be prevented, if enough data were available. Lester did, however, do some valuable work in this area, which we will now investigate.

HEIMAN'S STUDY

In his article "The police suicide" Heiman explores a few of the psychological aspects likely to explain the high rate of suicide amongst police officers. He comments on the suicides that have taken place in both the New York and London police departments.

In his opinion, it is the relatively infrequent use of guns in London and the public's acceptance of the police officers' role in their city that explains the low rate of police suicide in London compared with New York. The police here are under less stress, at least as far as their morale is concerned, and this facilitates their social integration.

Heiman also points out that police officers often suffer from anxiety and an inability to confide in their colleagues. He suggests that greater use should be made of psychological services and techniques, to protect the mental health of the police officers.

Listed below are the psychological and sociological hypotheses of various experts as related by Heiman.

1. *Friedman: Suicide represents the displacement of a drive to kill, turned against oneself. Friedman's hypothesis is inspired by Stekel: no one would ever kill himself, if he had never wished to kill someone else, or desired someone else's death. The subconscious convicts the self under the lex talionis: and eye for an eye, a tooth for a tooth. He finds himself guilty of the wish to kill and so condemns himself to death. Police work involves "legitimate" aggressive behavior, but this behavior must be controlled. Such behavior is not always well accepted, leading to tension in the police officer.*

2. *Hendin: Suicide can be viewed as:*
    a. *an act of desertion (vengeance)*
    b. *a way of exercising power, omnipotent mastery*
    c. *a homicide directed at oneself*
    d. *a meeting*

e. *a rebirth*
f. *a punishment*
g. *a process with an emotional purpose, i.e. the individual sees himself as already dead (cancer)*

3. *Menninger: Basing himself on Freud's "desire to live", the author elaborates on the following three desires: desire to kill, desire to be killed, desire to die (these desires are unique to man).*

4. *Nelson and Smith: According to these two authors, the suicide rate is high when the following two characteristics are weak: social integration and social regulation. A study conducted in Wyoming revealed that the following six factors could serve to explain the situation:*
   a. *Police work is a male-dominated profession, and men have the higher suicide rate.*
   b. *The fact that police officers are familiar with guns and know how to use them may explain the small number of unsuccessful suicide attempts.*
   c. *Constant exposure to death has psychological repercussions.*
   d. *The long and irregular hours of work strain family relations and do not encourage police officers to strengthen friendships.*
   e. *They are always exposed to public criticism and hostility.*
   f. *Contradictions by judges, irregularities and illogical decisions tend to negate the value of police work.*

5. *Henry and Short: These authors claim that aggressive behavior results not so much from the individual's internal drives as from social frustrations. Suicide is a manifestation of this phenomenon.*

6. *Gibbs and Martin: The suicide rate of a population is inversely proportional to its "status integration". The authors try to relate the degree of social integration to the durability and stability of social relations and to the absence of conflict in the individual.*

GASKA'S RESEARCH

According to research done by Cass Gaska, a police instructor at the Henry Ford College in Dearborn, Michigan, the suicide rate amongst retired police officers is ten times greater than the national average. This study concentrated on the deaths of 4.000 retired police officers between 1944 and 1978.

Gaska was a Southfield police lieutenant. He affirmed that, out of these 4.000 police officers, those who had committed suicide had held positions with high stress levels or had been forced to retire while still young because of physical or emotional problems.

Another reason why the suicide rate is so high amongst police officers is that a police officer almost never misses, because of his familiarity with guns. Two-

thirds of these suicides had been reported as accidental or natural deaths, so as not to traumatize the families.

FURTHER RESEARCH BY DANTO

While doing further research on the Detroit police, psychiatrist Bruce Danto focused on twelve active police officers who had committed suicide between 1968 and 1976. It was reported that these officers had been caught in a major "police-family" dilemma, and that they had chosen suicide as the final solution.

They had all been relatively young, with little seniority, and they had had marital problems.

POLICE OFFICER'S SUICIDE

Stress is taking its toll on police officers throughout the nation. It is a problem that many departments do not want to talk about, according to an article written by Claude Lewis of the Philadelphia Inquirer.

It is difficult to confront the situation when various departments in our United States refuse to talk about the problem. Everyone knows this is a serious business. It needs to be addressed and people need to deal with it.

Most officers will not admit they have a problem and often decline into depression from which they are unable to help themselves. Often they turn to suicidal thoughts.

A recent study revealed that New York City officers kill themselves at a rate of 29 per 100,000 a year. The rate of suicide in the general population is 12 per 100,000. Most of the victims are young with no history of having problems that shoot themselves while off duty.

Nationally, twice as many cops – about 300 annually-- commit suicide as are killed in the line of duty. This is according to a study by the National Association of Police Chiefs.

It is difficult to determine just why an officer will take his or her life. There are many factors to be considered because of a state's confidentiality law and possibly the police will not admit to keeping such statistics.

Michael Broader, a clinical psychologist, has been working with the EPA since July of this year. He states that "The dynamics of the job" sometimes lead officers to take their own lives. One must keep in mind they always have a weapon with them, on or off the clock.

Captain Gus Carre, the commanding officer at EAP, did say stress among police officers is not unusual. "It's a difficult job made by more difficult by the individuals that officers must deal with on a daily basis." Many officers are on a steady diet of bad situations dealing with the undesirable sides of life which most people rarely see.

Many officers all over the country refuse to seek needed assistance because the fear it will result in them being labeled as "weak". They also fear that their careers will be destroyed if their supervisors find out. There may be an occasion where an individual will feel betrayed by those fellow officers and the officer may commit suicide because he or she may feel abandoned. They often make the mistake of trying to solve their own problems quietly which often leads to alcohol or substance abuse. There may also be some departments that place a different label on an officer who committed suicide, such as "an accidental discharge of a weapon." It may be anything but accidental. Many departments do not want to share with the public when an officer commits suicide. They feel this is a personal matter that should not be divulged to the public.

The California High Way Patrol is developing a training program for suicide awareness and prevention after eight troopers killed themselves in eight months last year, for a total of thirteen since September 2003 as stated by John Ritter, USA TODAY. The CHP is "the largest cluster I've seen for a department that size," says Robert Douglas, executive director of the National Police Suicide Foundation.

The International Association of Chiefs of Police is circulating a proposal to make suicide prevention tools available to all of the nations nearly 18,000 state and local police agencies. Current police culture tends to be avoidant of the issue leaving suicidal officers with "no place to turn.", a draft of the proposal says.

The suicide foundation says it has verified an average of 450 law enforcement suicides in each of the last three years, compared with about 150 officers who died annually in the line of duty, it is believed there are no more than 2% of the nations law enforcement agencies that have prevention programs.

Most large departments across the nation have comprehensive programs which include, tapes, videos, brochures, posters, training classes, peer-support, and coaching about warning signs of a possible suicide potential. The Los Angeles sheriff's program started in 2001. Since 2002 the force has had two suicides among 9,000 officers. The personnel are receptive to getting assistance when they need it.

People are to remember that police bear the same stress from work, and family illness that civilians do. What is different is the stress of the street. It is a different kind of stress and it is an every day occurrence dealing with a negative environment continually. Remember, the street officer has to wear a bullet proof vest to work.

OFFICER SUICIDE

The following section is information taken from an article entitled "Every Police Department's Nightmare: Officer Suicide", by Sgt. Monroe Dugdale. It was originally published on 1 August 1999 (source unknown) and reprinted here by permission.

There were more than twice as many police officers committing suicide than were killed in the line of duty in 1994 [ourworld.compuservu,1999]. The growing problem is not only in the United States, but also places like France who experienced 50 per cent more than the average rate of suicide for the last decade. Paris had a rate in 1995 of almost twice the rate for New York City Police Department [Simons, 1996].

There are many preconceived ideas of what goes on with a police officer, such as the pain and suffering police experience and witness as a direct result of their job. Police suicides, corruption, and misconduct, high rates of alcoholism, divorce and mental breakdowns among officers offer a grim conformation that police work is grueling and stressful. How can policemen be happy when they must deal with more emergencies, tragedies and criminals in a violent society than ever before, while vowing to serve and protect? In a study of 1995 reports a rate of 29 suicides per 100,000 for the New York Police Department, versus 12 per 100,000 for the general population [McNamara, 1996].

The nation's largest organization, the Fraternal Order of Police, studied suicides among 38,800 of its 270,000 members in 1995 by looking at insurance records in 92 local chapters in 24 states. They found a suicide rate of 22 deaths per 100,000 officers [Fields and Jones, 1999].

Robert Douglas, executive director of the National P.O.L.I.C.E. Suicide Foundation states, "We are losing about 300 officers a Year to suicide." Forensic psychologists are now paying more attention to police suicide and to what is referred to as a hidden epidemic [Loh, 1994]. One forensic psychologist in New York profiles a typical suicide potential as being 35 years old abusing alcohol, separated or seeking a divorce, experiencing a recent loss or disappointment. Typically domestic abuse is involved. [Loh, 1994] Cops are generally controlling individuals. When the officer loses control in their own home, they can not handle it. When that point is reached, they may be suicidal for at least the next 24 to 36 hours.

Drugs, alcohol, and relationships continue to surface among officers suicides. Suicides among officers rise when they bring their job home. Many deny such and offer excuses to compensate for their actions. Most officers witness some most horrific scenes and get catapulted into moments of terror and danger and close-ups of human degradation and death "[McNamara, 1996]. These things could trigger stress which can be labeled as Post Traumatic Stress Disorder [PTSD].

Departments must stop ignoring the problem before the problem becomes a nightmare. Many police officers have ended their life needlessly when perhaps help is just a phone call away.

CAUSES OF SUICIDE AMONG POLICE OFFICERS

Generally speaking, the authors and researchers who deal with the field of police work agree that several factors contribute to the suicide of a police officer:

1. Firstly, the stressing agents inherent in police work
2. Physical or emotional inadequacies
3. Marital problems
4. 4. Conflicts between police and family
5. Abuse of alcohol
6. Use of tranquilizers
7. Use of drugs
8. Certain difficult political situations
9. Certain environments that are hostile to the police
10. Badly organized police department
11. Poor partner
12. Poor team (negative) (bad elements)
13. Personal financial problems
14. Inadequate training (resulting in professional shortcomings)
15. Poor selection (the individual is not at home in the police and does not demonstrate the qualities, aptitudes or attitudes required for the job)

SUICIDAL SYMPTOMS IN POLICE OFFICERS

Early Warning Signs

Previous studies refer to several symptoms detected (after the fact) in police officers who had committed suicide. A psychological autopsy of the suicides almost always pointed to the following behavioral signs:

1. A clear and obvious threat to commit suicide (which must always be taken very seriously)
2. Cries for help, but not necessarily clearly expressed, verbal pleas; sometimes distress signals were simply in the form of indications of impotence, despair, implicit and camouflaged pleas for help
3. Abrupt changes in behavior unexplained, weird behavior
4. Bad mood, aggression, irritability, violent temper
5. Confusion, illogical speech
6. Morbid fear
7. Feelings of persecution
8. Anxiety
9. Insomnia, loss of appetite, shaky hands
10. Isolation, an attempt to withdraw or seek solitude, introversion
11. Friendships dropped
12. Appearance neglected
13. Lethargy
14. Sudden preoccupation with death and what happens after
15. Tendency to give away property, particularly things of value

Pay close attention to someone who appears to get his energy back after going through a period of depression or withdrawal, or after simply talking about suicide. The change in behavior might be due to the fact that the decision to commit suicide has been made.

Symptoms or Early Warning Signs of Suicide

Pay close attention to severe psychiatric, psychological or physical problems: 13 had lengthy psychiatric and/or psychological files; 7 had voluminous medical files.

Hence we can see that we must be very careful with such cases. It is not a question of discrimination; on the contrary, we should ensure that these people receive preventive care and follow-up tailored to their needs. For the sake of their own welfare, we must not be afraid to take away their guns and take them off the job, if necessary. We must ensure that they are psychologically ready before they assume their former duties, or assign them to new duties better suited to them.

Let us now take a look at the 28 symptoms or early warning signs that the 27 police officers showed, which we will now use to help others: these signs are visible to superiors, peers or colleagues, subordinates, family members (spouses, children) and, most often, to their partners. (See Table 2)

Early Warning Signs (listed in order of importance)	**% of signs**
1. For some time or for a few days, they have been depressed, not themselves; they do not have any energy, "pep" or motivation. [19/27]	70%
2. They are no longer involved in sports and pay no attention to their physical fitness. [14/27]	52%
3. They are introverted, withdrawn, solitary, shy and even awkward; they do not say much any more, or say nothing at all, they do not confide in anyone [13/27]	48%
4. They are an alcoholic or are turning more and more to alcohol. [10/27]	37%
5. They are given to having accidents with their personal car and their service vehicle (one, two, or more accidents) [10/27]	37%
6. They are anxious, anguished. [9/27]	33%
7. They look very tired or are suffering from overwork [9/27]	33%
8. They have told others about their thoughts of suicide [8/28]	30%
9. They use tranquilizers [8/27]	30%
10. They are emotionally unstable [7/27]	26%
11. They are having trouble concentrating and often hurt themselves (unlucky) [7/27]	26%
12. They have a discipline file (often very lengthy) [7/27]	26%
13. They are arrogant, aggressive, impulsive, violent [7/27]	26%
14. They are very proud and unable to deal with frustration [7/27]	26%
15. They often cry [6/27]	22%
16. They are nervous, or more nervous than before [6/27]	22%
17. They have talked about killing somebody. Under influence of alcohol or on an empty stomach. They have talked about using a gun. They have started to take out their gun (for no reason) [5/27]	19%
18. They are an insomniac [5/27]	19%
19. They appear to be very pensive [5/27]	19%

20. They have complexes (physical or other) 5/27]	19%
21. They are jealous [5/27]	19%
22. They are disillusioned [4/27]	15%
23. They suffer from high blood pressure [4/27]	15%
24. They have tried to commit suicide [3/27]	11%
25. They use tranquilizers combined with alcohol (very dangerous) [3/27]	11%
26. They have written one or more strange letters to those close to them, in which they talked about life, death, the purpose of life, or they have made their last wishes known, in case something were to happen to them on of these days. [3/27]	11%
27. They have written or rewritten their will and talked about it in a weird and unusual way. [2/27]	7%
28. They have let it be known, in a mysterious way, that they had something important to do (or something like that) [2/27]	7%
	Table 2

Here we have a list of the 28 symptoms, warning signs or signals that constitute a major police suicide syndrome.

It goes without saying, however, that the appearance of one of these symptoms does not automatically mean that a police officer is contemplating suicide!

However, it should be noted that, if the manifestation of one of these signs is sufficiently severe, or if several of these symptoms are evident in the same police officer, his family, social or professional milieu should take note, so that competent, trained specialists can intervene.

Preventing Police Suicides

Jerry Dash and Martin Riser, in an article entitled "Suicide among police urban law enforcement agencies", explain why the suicide rate in the Los Angeles Police Department is low in comparison with other police forces.

The authors claim that it is the result of the rigorous screening and evolution of police personnel. Even their emotional stability is examined. Aspiring police officers who do not pass the psychological, physical, written and oral tests are eliminated.

The low suicide rate over the past few years is also attributed to the fact that a general program has been implemented to prevent mental health problems. Psychologists involved in the program provide training, organize group meetings and seminars and do personal and family counseling.

Los Angeles' example appears to answer the question of how to prevent police suicides. To be sure, if someone is dealing with the causes and symptoms mentioned previously, the prevention of suicide is almost automatically ensured.

Such prevention is beneficial not only to the suicidal police officers, but also to the police department, family and society as a whole.

This is why we strongly encourage the creation of a psychological services section of police officers by ensuring that applicants have the necessary psychological profile. Also, prevention counseling and treatment could be provided.

Thought should also be given to creating a special police suicide prevention service; a department that would be independent of police organizations and therefore absolutely impartial. This department should be run by competent individuals who are familiar with the police environment and related problems. We are therefore looking at a skilled and highly confidential service, a provincial service available to all police officers, whenever necessary.

Helping a Suicidal Person

It is recommended that the following steps be taken:

1. Establish an atmosphere of confidentiality.

2. Try to understand what the person is going through (the easiest way to do this is to simply ask the person directly) and have them talk about the problem; in other words, what hurts them so much that they want to stop living.

3. Assess the risk of the person committing suicide in the near future: talk to them about their desire for death; ask them when and them how they plan to kill themselves. If the method they have chosen is easily accessible at any time, the danger of their carrying out their plan is greater.

4. Try to find the best approach to talk with the person: should you be direct, tread lightly or be calm? Should you be authoritarian, tell them what to do or simply provide advice?

5. Avoid sermonizing: do not tell them to banish all thoughts of death from their mind; rather, talk about the issue, so that they realize all of the implications of their act. Do not tell them that committing suicide would be bad or that they are crazy. Such comments serve no purpose and will not help them.

6. Do not give your recipes for happiness to the suicidal person, because everyone has their own way of living and being happy depending on their background, personality, etc. Instead, try to see what they think would make them happy, try to find other solutions (aside from suicide) that would enable them to get through their crisis.

7. Try to pinpoint what activity the person likes or liked before things started deteriorating. Encourage them to pursue activities, to meet people, but at a rate that is in keeping with their current abilities.

8. Do not try to help the suicidal person by doing everything for them. They will then think that they are no longer able to take action, that you no longer trust them.

9. Explain to the individual that they do not have to make threats or attempt to commit suicide to make sure that you will understand how they feel and be willing to help. This is sometimes how a suicidal person expresses their despair. Explain that it is not necessary to resort to these techniques, that you are there, you understand and want to help.

10. Once again, if you fear that the person is really going to commit suicide, put the question to them directly, finding out when and how they plan to do it. In an emergency, contact your nearest suicide prevention center.

11. Do not forget to respect your limitations in what you can and cannot do as far as helping the suicidal person is concerned.

12. Remember that you are not responsible for what they do. They are the one who decides to kill themselves, not you, regardless of what they may say.

These notions apply to any suicidal person in general and, therefore, to the police officer in particular. I am not advocating that you assume the role of a trained specialist, but I am saying that everyone can do something.

TEENAGE SUICIDES IN THE UNITED STATES

According to the National Institute of Mental Health, scientific evidence has shown that almost all people between the ages of 15 and 24 years old that suicide has become the subject of much recent focus. In 1999, U.S. Surgeon General David Satcher recently announced his call to action to prevent suicide, an initiative intended to increase awareness, promote intervention strategies, and enhance research. Suicide among our nation's youth has drawn the attention across our country. Teenage suicide seems to be most tragic – lives lost before they have really started. The question is, "Why must we lose so many lives unnecessarily?"

<u>Some Basic Facts</u>

- Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this age group.[9]
- Of the total number of suicides among ages 15 to 24 in 2001, 86% (n=3,409) were male and 14% (n=562) were female.[10]
- American Indian and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group.[11]
- In 2001, firearms were used in 54% of youth suicides. (Anderson and Smith 2003).

[9] Anderson RN, Smith BL. Deaths: Leading causes for 2001. National Vital Statistics Report 2003; 52(9):1-86
[10] Anderson and Smith, 2003
[11] Center for Disease Control, 2004.

What Kids Are At Risk For Suicide? *(KidsHealth.org)*
Teenage years are a time where they get caught up in that gray area between childhood and becoming an adult. It is a time of responsibilities which can become a period of confusion and anxiety. There are the pressures of fitting into society, to perform academically, and act responsibly. Then there is the awakening of sexual feelings, self-identity, and a need for autonomy which conflicts with the rules and expectations set by others.

Teens with adequate support of friends, family, religious affiliations, peer groups or extracurricular activities may have an outlet to deal with their frustrations. If they do not have that support, they may feel disconnected and isolated from family and friends. These teens are at an increased risk for suicide.

Factors that increase the risk of teenage suicide:
- The presence of a psychological disorder, depression, bipolar disorder, and alcohol and substance use. [Approximately 95 per cent of people die by suicide have a psychological disorder at the time of death.]
- Feelings of distress, irritability, or agitation
- Feelings of hopelessness and worthlessness that often accompany depression
- Previous suicide attempt
- Having suffered physical abuse or sexual abuse
- Lack of support network, poor relationships with peers or parents, or hostile school environment

Suicide Signs *(National Alliance on Mental Health, 2007)*

There are many behavioral indicators that can help parents and friends to recognize the threat of suicide of a loved one. Many of the clues to watch for include:

- Extreme personality changes
- Loss of interest in activities that use to be enjoyable
- Significant loss or gain in appetite
- Difficulty falling asleep or wanting to sleep all day
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Withdrawal from family or friends
- Neglect of personal appearance or hygiene
- Sadness, irritability or indifference
- Having trouble concentrating
- Extreme anxiety or panic
- Drug or alcohol use or abuse
- Aggressive, destructive or defiant behavior
- Poor school performance
- Hallucinations or unusual beliefs
- Rejection from peers

Many times these signs go unnoticed while the person suffers from one off these symptoms. It is always best to communicate openly with a person who has one

or more of these behaviors when they are unusual for that person. Watch and listen to those who are having concerns as they are expressing themselves and what is going on inside as they try to deal with their understandings and emotions. What may not be a big deal to a parent or friend, it is to the person expressing them self. Don't be afraid of asking questions, especially the question about if they are thinking of committing suicide. GET THEM HELP!

SUICIDE HOT LINES

National Suicide Hot Line	800-273-TALK
Auburn, CA	530-885-2300
Lincoln, CA	916-645-8866
Roseville, CA	916-773-3111
Sacramento, CA	916-368-3111

SURVIVORS OF SUICIDE

This is not dealing with victims of suicide, because they are already dead. This deals with the survivors, the families of a suicide victim, those who have suffered a death.

In talking to these families we must remember to remove them to a safe place because the media and officer activity can distract and keep them in a state of unsettledness.

Follow-up is necessary in the actual dealing with these families. If possible, a chaplain could be assigned to the family to carry them through the funeral if they do not have a minister available.

Suicide is epidemic. It is the eighth cause of death. In ages 15-20 it is the third cause. One-third of homicides involve suicide.

Find the prevention center closest to you and work with them if possible. To have it in place is extremely important before the fact.

Helping to recognize signs is also important. Learn all we can about it. Coordinate with other agencies. The caregivers must be trained. The training, however, is general enough to work with all ages. Caregivers are those who may be turned to in times of crisis from bus drivers at school to ministers, to teachers, to cops. We don't have to be professionals to take this intervention training. It is a model that can be carried with us in memory which may be able to save lives.

> *JACK CLAYTON is with the California Highway Patrol. His son died by suicide on May 12, 1984. He was asked, "How does suicide affect your life and those around you?" The following is his story (source unknown):*
>
> *His son died by suicide May 12, 1984. Saturday morning his son came in to the store distraught. He had wrecked the truck. He wasn't satisfied that*

they could fix the truck. Jack was working and went to the back room where the son said, "I must talk to you." Jack didn't have time to talk at that moment so he went on to the front to deal with customers. The son left the store, got into the truck and drove off.

About 15 minutes later, the daughter called and asked, "What is the matter with Brad? He walked in, slammed the door, and I heard a bang. The door is locked and I can't get in." The mom went home and found her son in the room dead with a gunshot wound. 911 was called and they responded. Jack went home and was met in the yard by an officer who said, "Mr. Clayton, your son blew his brains out and it is all over the room." (Even today, five years later, the event is so tragic that Jack cannot talk without breaking up.)

People who experience a suicide have gone through something very traumatic and they need sensitivity and caring. It hurts as bad today as it did then. The problems were that they took the body to the Medical Examiner who sent it to the funeral home. The family went to see the body. The director would not let them see the boy because of the wound. Being an officer, he had seen mangled bodies and forced the mortician to allow him to see the son. The director refused in spite of all the insistence. Jack still has doubts as all of the furniture, even the personal effects, in the room were removed. It is like he has just vanished from the face of the earth. The worse cycle of grief is almost never-ending. The events continue to return in vivid memory

Prior to the event, Jack's memory was keen and effective. He had no trouble in memory but today there are total lapses of memory. This event drastically changes the individual. The feelings and loses are tremendous.

When asked, during a question/answer period, Jack was gracious to talk about his experience. The following are his answers to several questions raised:

Question: In this period of time, what has given you the most help?

Answer: "My faith in God #1." The final step taken by the suicide is FINAL. There is no turning back. There are many who are insensitive to suicide. Neighbors may still believe that suicide is a mortal sin. The families don't need that type of thing because there is no scriptural basis for it.

Question: "Are you in some way feeling responsible for the death?"

Answer: "Yes, I didn't stop to talk to him when he needed help. It may not have made any difference, but the gnawing guilt is there."

Question: "Were there signs leading to this?"

Answer: "Yes, he stared off into space a lot. Became disoriented and paid little attention to the details of business. His customers noticed it as well as the family, but they didn't do anything that would help him." He didn't give away personal items, he didn't say good-bye. This was more of a spontaneous event rather than a planned event.

Brad had a girlfriend who married and came back and attempted to contact him but he refused her advances. He did leave a note that said "I love you all. Pray for me. Brad."

When a certain wife killed herself, insensitive people asked the husband, "Did you cheat on her, or she on you? Is that what caused this ?" They were not able to accept the failure of anyone who would take their lives. On the other hand there is a train of thought that says "They did it, I can do it and be free of these problems."

Friends quite often pull back from the families of suicide. This is where the chaplains can come into play with such a tremendous part of aid and help and caring. Getting people to listen to the facts of survivors and suicide is difficult because they feel if you talk about it they will do it. Lots of questions are usually discovered in open discussions about suicides.

Marilyn Koenig of Friends for Survival, Inc.

1977 there were no signs that her son, 18, was going to kill himself. He was one of seven children, obedient, and about to graduate high school. Their friends were supportive through their tragedy. The church gave great help and support. He had a girl friend and things seemed well. *It is scary because you feel like there will not be the support.*

Most of the time the person who kills themselves doesn't want to die, they just want to stop the pain. They feel their only option is suicide. There are alternatives of which we must make them aware.

Grief can last as much as 10 years, even normal people grieve 5 years. It takes so long to overcome this type of death. The trauma is extensive. It may not be public grieving, but the personal hurt is when the darkness is thickest.

Life must go on so the human spirit carries on. The truth is, however, there may be lasting symptoms. Even 12 years later, my memory is not what it used to be prior to the event.

People who have been affected by suicide may not function very well. To expect them to function as they used to function is unrealistic.

Every year, more police officers die by suicide than are killed by criminals. Their families are particularly affected. There are more suicides in the nation than there are homicides. If we can get people to admit they have had a suicidal thought then they can be helped. Without saying the word, they can't be helped.

Unique aspects of survivors

The Shock that is There

Disbelief, denial, questions like could it be an accident, or even murder. There are usually months that pass before the family can accept that this is a suicide. They need something to blame.

Searching for Why is the Ultimate Goal

The bottom line is when they come to the point that no matter the "Why" they accept the fact that it is the decision of the one killed, not anyone else's fault. There are always options and even the most professional of situations cannot prevent someone who makes up their mind to kill themselves. 8 to 9% of the time there are subtle signs. Families need to know the signs.

Honesty Helps

Teach kids to be up front about their feelings. They must be honest as to how they got through bad times.

Anger Builds Up in Survivors

This person leaves you without so much as an explanation. They may then feel guilty because the problem child is now gone. We can never feel good as anger builds up.

They Face the Stigma of Being involved in Suicide

There are many reasons, but fear, ignorance, immaturity...all cause withdrawal of friends, even churches. Many families feel that they should have been the ones to be affected and guilt builds up so they withdraw rather than face their guilt. Being uncomfortable is often the reason friends don't come around anymore. It is best to deal with survivors as if they had been victims of someone dying with a heart attack or cancer. We must program our minds to think this is like an accident. The loss is real, regardless of circumstances.

Depression will often Follow the Suicide

This is natural and normal and a good help is for them to realize this is normal.

Survivors will Spend Time Assessing Responsibility

Survivors will spend time assessing their own responsibility and the responsibility of others; school, civic, churches, etc. They want to blame others but they will not do it verbally. We can help them do this verbally. They can blame other family members. Some subtle remark is made that kids catch on that means nothing to adults. Those kids then have great guilt heaped upon them and they will never verbalize that guilt. It festers, they then become candidates for suicide.

We may say: "No one is to blame. That person made that decision themselves. You could not have helped."

Suicide is often Considered by the Survivors Themselves

They fail to realize the added burden it may add to the family. Some get into a cycle where there are a series of suicides in the same family group.

Recovery Takes Time!

Often longer time is required than is published. Productivity can be resumed but some of the pain may last forever.

Non-Judgmental Attitudes are Helpful

Survivors need places where they can go to where others have been through suicide and can tell them that it is normal to feel they way they do.

Scripture and Pious Platitudes Usually Fail!

Discovered revelation is better than proclaimed revelation from some "well-meaning" clergy. You can't heal them, you can't fix them. That is the task of the Holy Spirit and if they don't have that resource then you may be able to impart it to them in time. "If only..." is a futile statement.

Marilyn Never Goes to the Cemetery: "I don't have time." (I try to go since it is part of the follow-up – Assigning chaplains to these families would preclude complete follow-up).

Jack: There are some strange things that have happened. Son used .3030 deer rifle. They could not find the bullet. They finally discovered it in the closet where it had ricocheted off the son's head. Jack then walked in one day many weeks later and noticed the closet opened a bit. No one could have opened it. Strange thing. They closed the door, and about two weeks later the door was opened again. No one could explain how the door was opened, or who opened it.

Wife was folding clothes one day and felt a hand touch her on the shoulder. There was nothing there. Daughter and husband moved to Monterey and one Saturday walked in the house and into the family room where pictures were hanging of both kids. She walked to Brad's picture and noticed that the picture had something wrong with it. The bullet was in the forehead.

(My observations of the picture are eerie. The photograph showed a red hue around the hair line of the boy. It did simulate blood running down the head. Also, there was a spot just under the hairline that represented a bullet hole. No conclusion drawn, just observation.)

Many strange things happen and other folks think they are crazy. The picture had red streaks all over the face. Almost an outline. The people are not craze. Some things happen that cannot be explained.

Having Friends Who will Assure and Not Blame are Important

Circumstances will run every moment in the minds of the families. Their thoughts cannot be changed, they can respond, however.

The Families may be Suicidal and Need to Talk about those Feelings

There are organizations which can help if they are approached. This must be something that is done. Over 1000 people in 7 years called Marilyn. Talking can be effective, one doesn't have to be a therapist from a formal agency to assist (do know your boundaries). Just simple caring referrals will help.

> QUESTION: How would you define "Survivors"?
>
> ANSWER: Anyone who has been affected by the suicide death of another. This includes many other groups or organizations, not simply family.

Teach folks coping skills. They must find alternatives to dealing with the pain. They cannot take a permanent solution to temporary problems.

There are other options to suicide. There are no perfect people and no perfect solutions, but there are helping people and alternatives. Each must be explored and those ideas must be revealed.

Bill Blackburn wrote a book, "What you should know about suicide". He talks about a family contract against suicide. In our family suicide is not the answer to the problem. We must share with each other and talk about all the options with each other. Then the family is in on the solutions and there is an instant support group.

ALCOHOLISM

According to the United States National Library of Medicine and the National Institutes of Health (www.lms.nih.gov/medlineplus/ency/article/000944.htm) alcoholism is defined as:

> An illness marked by drinking alcoholic beverages at a level that interferes with physical health, mental health, and social, family, or occupational responsibilities.

There are those who can not deal with every day life situations and believe they must depend upon some substance for support. This often becomes alcohol abuse. Alcoholism is an illness by drinking alcoholic beverages at a level that interferes with physical health, mental health, and social, family, or occupational responsibilities.

Alcoholism is divided into categories: dependence and abuse.

People with alcohol dependence, the most severe alcohol disorder, usually experience tolerance and withdrawal. Tolerance is a need for increased amounts of alcohol to achieve intoxication or the desired effect. Withdrawal occurs when alcohol is discontinued or the intake is decreased. Alcohol dependents spend a great deal of time drinking alcohol, and obtaining it. Those with dependence have more severe problems and a greater compulsion to drink.

Alcohol abusers may experience legal problems such as drinking and driving. They could also have other problems such as binge drinking [drinking 6 or more drinks at one sitting].

Alcohol is an addictive type of drug. There is both physical and psychological dependence with this addiction. The physical evidence reveals itself by withdrawal symptoms when the intake is interrupted. Alcohol affects the central nervous system as a depressant, resulting in a decrease of activities, anxiety, tension, and inhibitions. A few drinks can result in behavioral changes, slowing down motor skills, and decrease the ability to think clearly. Concentration and judgment become impaired

Alcohol also affects other body systems. Irritation of the gastrointestinal tract can occur with erosion of the lining of the esophagus and stomach causing nausea and vomiting, and possibly bleeding. Other things can happen such as vitamins are not absorbed properly, which can lead to nutritional deficiencies with long term use of alcohol. Liver diseases may also develop and can cause cirrhosis. The heart muscle may be affected. Sexual dysfunction may also occur causing problems for both male and female.

Alcohol can also affect the nervous system and can result in nerve damage and severe memory loss. Chronic alcohol use also increases the risk of cancer of the larynx, esophagus, liver, and colon. Alcohol intake during pregnancy can cause birth defects. The most serious defect is fetal alcohol syndrome which could result in mental retardation and behavioral problems. A milder form of the condition could result in a lifelong impairment called fetal alcohol affects.

The development of dependence on alcohol may take several years following a consistent pattern. A tolerance of alcohol develops, then black-outs may occur relating to the drinking, people may lose control of their drinking and will find it difficult or impossible to stop. The most severe drinking problem includes prolonged binges of drinking with associated mental or physical complications.

Withdrawal occurs because the brain has physically adapted to the presence of alcohol and cannot function without the drug. Symptoms of withdrawal may include elevated temperature, increased blood pressure, rapid heart rate, anxiety, psychosis, seizures, and can cause death.

There is no common cause of alcoholism, but there are some factors which may play a role in its development. People who have or had alcoholic parents, genes

may have an influence, unresolved conflict with relationships, low self-esteem, a need for anxiety relief, peer pressure, and a stressful lifestyle.

Symptoms

Men who consume 15 or more drinks a week, women who consume 12 or more drinks a week, or anyone who consumes 5 or more drinks per occasion at least a week are all at risk for developing alcoholism. [One drink is defined as a 12-ounce bottle of beer, a 5-ounce glass of wine, or a 1 1/2-ounce of liquor.]

The above information was taken from the United States National Library of Medicine (NLM) and the National Institutes of Health (NIH). For more information, please refer to the NLM/NIH website at (www.lms.nih.gov/ medlineplus/ency/article/000944.htm) Medline Encyclopedia, 2007.

SUPPORT GROUPS - Websites / Contact Numbers

FamilyDoctor.org

Alcoholics Anonymous (Sacramento) 916-454-1100
One of most popular support groups, with members available 24/7 – support is through peer groups, learning to participate in social functions without drinking; given a model of recovery.

AL-Anon/Alateen (for those who live with someone who drinks) 800-344-2666

Adult Children of Alcoholics 310-534-1815

Celebrate Recovery 916-791-1244
Jeff Redmond
email contact: jeffr@baysideonline.com

Center for Abuse Treatment 800-662-HELP

Women for Sobriety 800-333-1606

SMART RECOVERY 440-951-5357

Alcohol Anonymous (National Number) 212-870-3400

National Association for Children of Alcoholics www.nacoa.org

National Institute on Alcohol Abuse and Alcoholism 301-443-3860

National Clearinghouse for Alcohol and Drug Information 800-729-6686

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

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 whenever 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 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 the result of these steps, we tried to carry the message to alcoholics, and to practice these principles in all our affairs.

Chapter 8
STRESS

HOW DOES STRESS AFFECT US?

Alarm – The body's natural response to danger

This first stage is the mobilization of the body's defenses. Messages from the nervous system reach the hypothalamus gland which notifies the pituitary gland and adrenal glands. The pituitary-adrenal system pumps hormones into the blood-stream. These hormones have the effect of speeding the heart rate, increasing respiration and stopping digestive activity. The body is ready for a fight!

In animals or primitive man this alarm system triggers physical action (fight) or running away (flight) thus tension is released. If there is neither fight nor flight, then there is no release for all the preparedness. Such a situation can lead to ulcers, headaches, backaches, palpitations, rashes, and various other ailments.

Resistance and Adaptation – the natural defense system

In this stage the invader is fought off or some adjustment is made. If tired, one sleeps. If hungry, one eats. if a large number of microbes are in a wound, inflammation seals off the site from the rest of the body. This defense system works so well that most of the time, we are not even aware of it. We are all bombarded by hostile forces - but we are not all sick; it is only when defense systems break down that illness results.

Exhaustion – Stress without an outlet

A body cannot be under stress all the time; release must occur. Some people believe that illness is the result to stress. The interaction of a hostile condition with stress could be the cause of colds, allergies, asthma, headaches, ulcers, colitis, heart decease, arthritis and other illnesses.

Avoiding Stress

1. Get up 15 minutes earlier. Morning mishaps are less stressful and also less likely when you have time to spare.

2. Prepare for morning the night before. Start the breakfast table, get the coffee pot ready to plug in, make lunches for those who take them. And check to see if the clothes you plan to wear need pressing or mending.

3. Never wear ill-fitting clothes. If shoes pinch, panty hose creep down or a waistband binds, even a stroll to the mailbox can be stressful.
4. Set appointments ahead. If you're always waiting for others, tell them to meet you 10 minutes earlier than you plan to arrive. "When I give a dinner party,"

one hostess admitted, "I give different times to different guests, depending on whether they're usually prompt or chronically late.

5. Don't rely on your memory. Write down addresses, directions and phone numbers and take them with you to unfamiliar places. Leave notes on your mirror, refrigerator or car door to remind you of important dates and errands.

6. Practice preventive maintenance. You'll have fewer breakdowns of automobiles, heaters, air conditioners, washers and other necessary machines if they're cleaned and serviced regularly.

7. Make duplicates of all keys. Exchange house keys with a trusted neighbor, hide car keys in your garage, keep extras for luggage, storage closets and strongboxes in a safe convenient place.

8. Rearrange work hours, if possible. A thirty-minute change in arrival or departure times can make a big difference in traffic, crowds and other stress producers.

9. Say "No" more often, it's amazing how much stress can be eliminated by giving up unrewarding activities, refusing inappropriate requests and turning down invitations from people you don't enjoy.

10. Never shop for clothes with critical teenagers, skinny friends or those who look terrific in everything. We all have imperfections: why call attention to them?

11. Take advantage of off hours for banking and shopping. And shop by mail or by phone whenever possible. Why put up with crowded stores, long lines and impatient clerks if you don't have to?

12. Rearrange mealtimes. If it's a hassle to get dinner ready on time, try postponing it. Your family won't starve if they eat and hour later.

13. Feed the children separately. It's nice to get the whole family together for meals but not if you have to endure spilled milk, sibling squabbles and cranky remarks about the food. You deserve to eat in peace.

14. Keep an emergency supply of necessities soap, toilet paper, toothpaste, and dip into it only in emergencies.

15. Walk everywhere you can. Exercise has a soothing effect especially when it permits you to avoid traffic jams, crowded buses and costly taxis.

16. Make copies of all important papers and keep the originals in a safe place. Never let go of an original deed, birth certificate, will or important receipt send copies instead. When originals are required (such as securities, passports, insurance policies) send them by registered mail.

17. Anticipate your needs. Make sure you have plenty of coins for toll collectors and vending machines, batteries for children's toys, pens and pencils that still

write, and panty hose without runs. And always stop for gas before you really need it --especially at night and on holidays.

18. Don't put up with anything that doesn't work properly. No one needs the aggravation of malfunctioning alarm clocks, key rings that lose keys, radios that buzz and squeak or appliances that smoke. "My mood improved remarkably," one woman told us, "when I treated myself to a new coin purse that doesn't pop open all the time."

19. Make advance reservation at hotels, restaurants and theaters: reconfirm time, location and other details before you go.

20. Allow extra time. If it usually takes 30 minutes to get to the airport, allow an hour. It's better to arrive well ahead of schedule than to fret over every stoplight or traffic tie up along the way.

21. Be prepared to wait. A long line at the post office or a delay at the dentist's office is almost pleasant when you have a good book with you.

22. Never arrange a meeting place that has no telephone. An unavoidable delay can be a nightmare when there is no way to make contact. It is impossible to meet at a place where you can both call of something goes awry.

23. Find the humor it. Every disaster has something funny about it if you look for it. Seeking a taxi in the rain, for example, used to put us out of sorts. But now we remember the passerby who told us, "New York taxis are water soluble," and hardly mind at all.

24. Keep a "busy kit" handy when you travel. Transportation snafus are easy to ignore when you have a portable tape deck, a favorite magazine or a needlework project with you. "I learned to speak French," one mother told us," by playing the tapes whenever I chauffeured my three kids around."

25. Relax your standards. Doing everything perfectly is not only unnecessary, it's boring. Life is a lot easier if you ignore a little dirt, take more shortcuts in the kitchen and let the sheets go a few more days between laundering.

26. Get help with the jobs you hate. If you find that certain chores always make you tense, such as paying bills, defrosting the refrigerator or scrubbing bathtubs, get someone else to do them. Beg, barter or pay for help it you have to; it's worth it.

27. Establish a serene place of your own, even, if it's just a comfortable chair in a quiet corner. if the sound of your teenager's stereo, your husband's ball game or the neighbor's barking dog still penetrates, wear earplugs.

28. Change your perspective. Instead of worrying about what will happen "if," try asking yourself, "So what?" So what if your mother's birthday gift is a few days late? So what if you can't get your best dress dry-cleaned before that party? So what if you actually miss your train or plane? Will it matter next

week, or next year? Even if our worst fears are realized, they often turn out to be not so bad.

29. Count your blessings. No disaster is so bad that it couldn't be worse, and it helps to remember that. After all, you could have burned the entire dinner instead of just the rolls. The doctor could have kept you waiting 2 hours instead of only 20 minutes. And you might have lost a thousand dollar instead of ten.

30. Keep time fillers by the telephone. You won't mind being put on hold if you can spend that time reading mail or writing a letter. And you'll be more sympathetic to a friend who "needs to talk" if you can do your mending or file your nails while you listen.

31. Memorize your favorite scriptures or poems and recite them to yourself whenever you're forced to stand on a crowded bus or get stuck in line or on an elevator.

32. Keep a supply of individually wrapped candies or sugar free gum handy. "Getting one out, unwrapping it and popping it into your mouth," one writer told us, "is a welcome distraction that takes some of the tension out of bad moments."

33. Travel light. The less you have to keep track of when you're away from home, the easier it is. If you never take more than you can comfortably carry onto an airplane, you can avoid lost luggage, long waits at luggage claim counters and frustration searches for porters.

34. Be prepared for rain. Don't try to outguess the weather man. Stock your handbag, work place and car with rain hats, plastic rain capes, umbrellas, shoe protectors.

35. Ask questions. You're less likely to make mistakes or get lost if you make sure to get detailed instructions first.

36. Take advantage of your body rhythms. If you're at your best early in the morning, that's the time to schedule complicated tasks that require concentration. If you don't reach your peak until later in the day, start with easier things that don't require much thought. it doesn't matter when your peaks and valleys come as long as you plan accordingly.

37. Make contingency plans. A rained out picnic, or sold out theater or a closed restaurant is disappointing, of course, but it won't spoil your day if you've made alternate plans "just in case."

38. Unclutter your life. Get rid of clothes you never wear, objects that just collect dust, furniture you hate, articles you don't enjoy. Anything you can do to simplify your life helps reduce stress.

39. Avoid reliance on chemical aids. Alcohol, tranquilizers and sleeping pills may release stress momentarily, but regular use increases stress in the long run.

40. Get in touch. Hold hands, stroke a pet, hug a loved one, make love. Physical contact is the best stress reliever of all.

41. Take time out to breath deeply, stretch your muscles, nap, meditate or do a few tension relieving exercises. If you can't arrange a brisk walk, try raising your shoulders in a high shrug, hold 10 seconds, release and repeat.

42. Find enjoyable ways to exercise. Experts agree on the benefits of aerobic exercise; the kind that raises your heart rate and makes you breathe hard. But if you hate to jog or jump rope, you'll create as much stress as you relieve. Try swimming, cycling, aerobic dancing, racquet ball or a few fast sets of tennis instead.

43. Get if off your chest. Bottling up feelings just increases stress. If you buy defective merchandise or receive bad service, write a letter of complaint. If a friend lets you down, express your disappointment. If your husband hurts your feelings, tell him. You'll feel a lot better afterward.

44. Talk to a loving friend or relative. A sympathetic listener is always helpful. "When I have a bad day," one young woman said, "I always call my grandmother. To her, I can do nothing wrong."

45. Reward yourself after stressful activities. Stop for a special lunch or snack after shopping in crowded stores. Relax with a favorite television show or book after cleaning house.

46. Take leisurely baths. Showers are more efficient, but a long soak in a hot, fragrant bath is more relaxing (Just unplug or turn off the phone first.)

47. Schedule more fun. Don't give up seeing friends and doing things you enjoy because you "have too much to do." Pleasurable activities are important. And work goes faster and produces less stress when fun comes first.

48. Take a break from the children. Baby-sitters are not just for emergencies or special occasions. You also need time to yourself to listen to music, pursue a hobby or have a heart to heart talk with a friend. If you can't afford to hire a baby sitter, trade child care time with another mother.

49. Have a massage. Tension just melts away under the touch of experienced fingers. But a talented amateur, a friend for whom you perform the same or an equivalent favor, perhaps, can do almost as well. Massage therapists can be found in chiropractic offices and some insurance company cover massages.

50. Unwind before bedtime. Do some stretching exercises to get the kinks out then read, listen to music, do needlework or some other relaxing activity. It helps you sleep better, and that's a great stress reliever.

Common Sense for Stress Management

1. Eat three meals a day, including breakfast.
2. Avoid sugar, salt, animal fat, and processed white flour.
3. Pursue regular program of physical exercise or other leisure pastime.
4. Nurture and maintain friendships.
5. Get enough sleep (6 to 8 hours).
6. Practice abdominal breathing and relaxation.
7. Schedule time and activities alone, and with others to maintain a well-rounded life style.
8. Stop smoking.
9. No alcohol and limit caffeine intake.
10. Pace yourself and allow for an even flow of demands.
11. Identify and accept emotional needs.
12. Recognize early warnings.
13. Allocate time and energy to allow for stimulation.
14. Take appropriate supplements, if needed, for proper nutrition.
15. Avoid self-medication.
16. Take one thing at a time.
17. Give in once in a while.
18. Talk out your worries.
19. Make yourself available.
20. Learn to accept the things you cannot change.

STRESS IS THE PRODUCT OF AN ENTIRE LIFE STYLE, NOT JUST AN ISOLATED INCIDENT

Goals of Stress Management:

- Realize potential for self-direction.

- Assume self-responsibility as a major factor in health and sickness.
- Minimize detrimental effects of stress.
- Restore sense of harmony with the environment.
- Achieve and maintain a high level of health.

Gaining Control Over Stress

- Identify stresses: What's bothering me?
- Appraising and Developing Commitment: What am I willing to do?
- Become More Aware of Behavior Patterns: How an I handling it?
- Develop A Plan of Action: What am I gong to do about it?
- Try Out The Plan: Put your plan into action.
- What Are The Results: Evaluate your progress.

Stress Response Syndromes

Psychological and Emotional
Anxiety, irritability, restlessness, hyper excitability, feelings of depression, moodiness, periods of crying, anger, blaming, feelings of apathy, diminished interest in usual activities, feelings of isolation, detachment, estrangement, feelings of guilt about surviving, denial or constriction of feelings "flashbacks" or intrusive memories of event, recurrent dreams of the event or other trauma , other sleep problems.

Physical
Headaches , feeling weakness in parts of the body, nausea, upset stomach, other gastrointestinal problems, soreness in muscles, hot or cold spells, sweating or chills,
lower back pain, faintness or dizziness, numbness or tingling in parts of the body, heavy feeling in arms or legs, feeling a "lump in the throat", pains in chest, trouble getting breath, exaggerated startled reaction, tremors , fatigue, increase in allergies, colds, flu.

Thought
Poor concentration , mental confusion, slowness of thinking, loss of objectivity, forgetfulness, inability to make judgments and decisions, loss of ability to conceptualize alternatives or prioritized tasks

Behavioral
Hyperactivity, outbursts of anger or frequent arguments, inability to express self verbally or in writing, withdrawal, social isolation, "distancing", increases use of alcohol, tobacco, other drugs, avoidance of activities or places that arouse recollection of traumatic event.

SIGNS OF EXCESSIVE STRESS

Psychological Impact	Physical Strain
Apathy	Backache
Anger	Chronic Fatigue
Denial	Clenching Jaw
Futility	Cold Sweaty Palms
Impaired Judgment	Eyestrain
Inadequacy	Headaches
Indecisiveness	Heart Palpitations
Insecurity	Hypertension
Irritability	Increase in smoking, drinking or drug use
Loss of Objectivity	Indigestion/Nausea
Low self-esteem	Insomnia
Mental Confusion	Lethargy
Reduced Confidence	Loss of Appetite
Strained Relationships	Muscle Tightness
Threat	Nervousness/Jittery
Under utilization of skills	Sexual Dysfunction
	Tics
	Ulcers

LAW ENFORCEMENT STRESS

OFFICER DOWN NEEDS ASSISTANCE
Source Unknown

Dave is a detective for a major city police department in the sunbelt. Like many of his colleagues, Dave feels the stress of combining marriage, family life, and police work. "I was doing fine until the new sergeant took command. Now I take antacid pills, yell at the family, and drink too much beer. This guy is always on my back - the tension is unbearable," he laments.

Tina is a police dispatcher for a small sheriff's department in the northeast. As a college graduate she feels overqualified, underutilized, and over stressed. "Every day I hear about things I can do nothing about; I feel like just another secretary at

times," she says. But living expenses cause Tina to feel trapped in her job. Distressed, angry, and depressed, she goes from doctor to doctor and begins to overuse prescription medication. Soon she cannot function without tranquilizers, antidepressants, and sleeping pills. Tina becomes so shaky, tearful, and sick that she cannot work or care for herself. The prescription merry-go-round begins to spin faster and faster - too fast for Tina to get off.

These cases illustrate a well-established fact: A career in criminal justice may be hazardous to one's health. Job burnout is probably the greatest life hazard for today's law enforcement personnel. Police officers suffering from burnout are more likely to commit suicide than be killed on the job. Due to stress and its concomitant health problems, police officers have only a ten-year life expectancy after retirement, which typically takes place around 45 years of age.

Identifying Burnout

What is burnout? According to experts on clinical stress and addiction, burnout is a debilitating state of mind, body, and spirit. The causes: unrelieved career stress and career-related stress at home. The symptoms: (1) poor job performance; (2) changes in eating and exercise patterns; (3) extreme risk-taking; (4) personality changes; (5) abuse of alcohol or other drugs; (6) family problems; (7) financial difficulties; (8) physical illness; (9) depression, mood swings, and insomnia; and (10) sexual problems.

Law enforcement personnel are particularly vulnerable to burnout, and they often unknowingly contribute to their own burnout by attempting to live out the myths that surround police work. Among these are the "John Wayne," the "control" and the "lonely at the top" myths.

The "John Wayne" myth. This myth is familiar to most people who work in the criminal justice field. The expectation is that police officers personify the "rugged individualists" portrayed in the movies by actor John Wayne. These larger-than-life characters were always in control, never complained about physical or emotional hardship, and always came out on top. In the most stressful situations, these movie heroes maintained equanimity, triumphed over the bad guys, and rode off into the sunset.

The "control" myth. Both peers and the public have unrealistically high expectations of police officers. They are expected to always be in complete control of themselves, their families, and whatever situations they find themselves in. The officer's desire for control often carries over at home, but spouses and children sometimes rebel when they perceive dad as using too heavy a hand. A vicious cycle begins in which job stress causes increased home stress, which increases job stress, and so on, until burnout reaches a crisis level.

The "lonely at the top" myth. When a veteran officer who was "one of the boys" is promoted to an administrative or leadership position, he or she may suddenly become part of the "them" in confrontations that arise between administration ("them") and line officers ("us"). He or she must now enforce rules and regulations that may be unpopular. Friends do not call, and social invitations drip

to zero. Communications channels with friends on the job seem to shut down as stress and tension begin to mount

Stress/burnout as masquerader. One reason stress. burnout is so insidious and dangerous is that it is a slow process which may not be recognized, or it may masquerade as many other problems. Employee assistance program (EAP) professionals should be aware of the signs of job stress and burnout among law enforcement personnel. The following are just a few of the signs that may when considered together, indicate stress/burnout: increased civilian complaints, changes in appearance, lateness, defensiveness. accidents, decreased efficiency, fatigue, violence, staring into space, calling in sick after days off, nervous habits, taking unnecessary chances, family problems and medical problems.

Safety Valves

There are several safety valves that police officers may tap to help alleviate stress before it reaches a critical stage:

Learning to shift gears. The ability to shift from the work mode to home life and leisure-time pursuits is critical. officers often set themselves up for burnout by their inability to switch gears when they leave work. Police and correctional personnel see the dark side of humanity. But officers who carry their tough, suspicious mind-set from work to home ;may find their families in rebellion. The daily exposure to women and children who are victims of crime makes police officers suspicious and, at the same time, overprotective of their own families. Wives and children are "interrogated" and eventually be come another set of "suspects" to be dealt with accordingly. Curiously enough, family members eventually begin to behave like suspects.

Family stress can have devastating consequences - such as chemical dependence, divorce, and suicide - for both the officer and family members. If an officer cannot shift gears on his or her own, professional help is needed!

Getting the proper amount of exercise. Exercise is one of the best strategies for releasing the tension brought about by the "fight or flight" response. Unfortunately, many law enforcement officers do not get the exercise necessary to relieve tension. Instead many get caught up in destructive behaviors such as alcohol or other drug abuse, overeating, oversleeping, and even fighting.

One interesting story is told of a deputy who was suffering from burnout. He became depressed and decided to commit suicide in a most ingenious way. The deputy began jogging and tried to run himself to death; he ran until he dropped, then got up and ran some more. Having reached the point of exhaustion, the deputy could not run any longer. But curiously enough, he felt better. The next day he attempted the same thing and experience the same results. Within a month, the deputy was running several miles a day, feeling much better, and no longer thinking of suicide.

Maintaining a balanced diet. Proper nutrition is essential for alleviating the effects of stress and burnout, but at the same time improper eating habits are common

among people who are suffering from stress and burnout. Among the poor eating habits are overeating, periods of not eating at all followed by overeating, bingeing and purging, cutting out nutritious foods in favor of junk food, increasing salt and fat intake, and consuming too much sugar and starch. Overindulging in chocolate and other sweets can cause many of the same physiological changes that result from abusing alcohol or other drugs. Actually, alcoholic beverages are composed primarily of sugar. "Fast-food syndrome" is rampant among police officers. "Help, I need a cop -- call Dunkin' Donuts" is more than a popular joke within the law enforcement community.

Acquiring hobbies and interests. Getting involved in an interesting, enjoyable activity outside of work is often helpful in alleviating stress. This is especially true of those who are bored, rather than over stimulated, on the job. For example, Jim, a correctional officer, often found himself performing seemingly endless tower and dispatching duties. The long, monotonous hours were creating great stress. By chance, a fellow officer introduced Jim to chess, and he immediately liked the game. Breaks and downtime were no longer the pessimistic gripe sessions they once were; rather they became a challenging contest between players in a game both had grown to love. There is nothing like a new, pleasurable challenge to relieve the stress that leads to burnout.

The Search for Solutions

Stress-relief valves may be helpful in the early stages of the stress/burnout process. However, ongoing stress, leading to burnout, must be addressed by measures other than self-reliance. There are several approaches that have helped criminal justice officers cope with serious stress/burnout.

EAP services. EAP services in a criminal justice setting may take a variety of forms. All are subject to federal confidentiality regulations and to the impaired officer regulations and policies of each department. The optimal system for fostering utilization by officers is a contracted EAP located off department premises, run by persons who are not seen as part of the "department premises, run by persons who are not seen a part of the "department system."

Peer counseling. Many large police departments have staff members who are available for counseling distressed officers. Often, the counselors are themselves officers or retirees. The services are almost always confidential, so information divulged in counseling sessions cannot be obtained by the department.

Some police departments have confidential "stress units" that utilize an officer-to officer day treatment approach, based on the theory that many officers have trouble trusting non officers. Modeled after Eddie Donovan's Boston Police Department Stress Unit, the police stress unit is a self-help model that utilized the 12-step principles of AA

Police impatient units. This novel, progressive approach is based on the principle that police officers need a program designed especially for them. Such programs are responsive to the fact that law enforcement officers distrust "outsiders" by providing clients with the services of clinically trained counselors who have personally experienced the stress of law enforcement. Police impatient units

may provide complete medical evaluation, treatment for alcoholism and other drug abuse. stress management training, biofeedback, nutritional counseling, education about stress and its psychological and physical symptoms, trauma groups, death and bereavement groups, depression groups, post traumatic stress disorder groups, family groups, referral for financial counseling, parent effectiveness training, and recreation and exercise therapy. Clients are self-referred or can be referred by a supervisor, union member, peer counselor, police psychologist, family member, friend, physician, or chaplain.

Conclusion

The needs of the criminal justice officer underscore and further all of the traditional arguments for implementation and utilization of an effective EAP. Few members of society have more power to do harm or good than the men and women who patrol the streets and guard the cell blocks. It is an irony that those who have the courage to face high-speed chase and shoot-outs may find that seeking help for themselves is the toughest battle of all. The criminal justice EAP, when properly constructed, can guide those who protect and serve others in protecting and serving themselves as well.

PEER COUNSELING
Source Unknown

The Los Angeles Police Department (LAPD), like many large city departments, has full-time psychologists on staff, in addition to several of the employee assistance programs discussed above. They have also taken the lead in the initiation of a program of peer assistance or peer counseling. The LAPD is the first department in the country to develop and implement an integrated and fully department-supported peer counseling program using regularly employed officers and civilians on a large scale. It defines peer counseling as "a group of employees who have been to a three day school and have volunteered to give direct, simple support to people who are hurting." There program began during the summer of 1981 in response to the major psychological trauma suffered by 2 LAPD officers as a result of their involvement in shooting incidents. It is important to note, however, that the program goes far beyond providing assistance to officers involved in shootings. Monthly statistics indicate that the majority of counseling time - 70 % - is spent on issues involving personal relationships, discipline, and career problems.

<u>Program Goals</u>

1. *To help fellow employees through the temporary crisis situations that are a common part of our lives;*

2. *To develop a readily accessible network of employees trained and willing to be of service to their fellow employees who have expressed a need for assistance;*

3. *To develop an awareness among employees that they are not alone, that people are willing to listen to them, and that others care about them and their problems;*

4. *To develop among employees an awareness of the self-help alternatives that are available to them;*

5. *To develop a system of referrals which can provide, in ;more serious cases, appropriate professional care; and*

6. *To increase the availability of employees, thereby increasing organizational efficiency, through a program of intervention which can assist in defusing problems before they reach a point of crisis and result in the loss of work time.*

Officer Reaction

Professional in-house psychological services have been available at LAPD and other larger law enforcement agencies for years. However, many police officers who experience psychological problems do not consider obtaining professional help. This is seen by some to be a reflection of the officer's stereotypical belief that people who seek professional help are seriously ill, out of control, unmanly, or unfit for work. because police organizations tend generally to be close-knit, officers experiencing personal problems often feel more comfortable discussing these matters with a fellow officer rather than a mental health professional.

Peer Counsel Training

It is often believed that the counseling process requires extensive training and can only be conducted by specialists with advanced degrees. The opposite, however, appears to be true. Professional mental health training does not appear to be a necessary prerequisite. Paraprofessionals are rated by the studies reviewed at least as effective as and often better than professionals.

LAPD's training program for peer counselors is conducted over a 24-hour period by a team consisting of a licensed psychologist, an experienced peer counselor, several guest speakers, and role players. Topics include reflective listening, general assessment skills for distinguishing chronic from short-term problems, problem solving skills, alcohol and drug abuse problems, the issue of death, dying and relationship termination, suicide risk assessment and management, and when and how to refer. New counselors are given instruction in crisis counseling with maximum emphasis on the practical application of a simple but effective model designed to assist the employee in solving his own problems. During training sessions, now counselors assume alternately the roles of counselor and employee, first with classmates and later with trained, experienced peer counselors who take the role of an employee in need of help. By participating in these work counseling situations, the new counselor is able to see his own strengths and weaknesses, and with coaching, improve his skills.

Problem-solving Model

A three-phase crisis counseling model is presented to the new counselors. In the first and most important phase, the hurting employee is given as much time as is necessary to express his feelings. The counselor is taught to provide a non judgmental, emotionally supportive atmosphere using simple, positive listening skills to facilitate the employee's full discussion of the problem. In the second phase of this model, the counselor assesses the problem presented by the employee and verbally summarizes the points he has heard. This ensures that the counselor has fully heard the employee and that they are in agreement on all of the issues. In the last phase, options are discussed. In most cases, these options are selected by the employee who also makes his own decision concerning which option seems to be best.

Role of Management

The role of supervisors and administrators in this program is extremely important. they should be aware of how the program operates and must believe it to be beneficial to both their subordinates and the organization. Employees involved in counseling will need support and sometimes guidance from supervisory personnel, making it imperative that management at all levels be familiar and supportive of the program. it is also crucial that managers recognize that this program belongs to employees. Its success at LAPD is, in part, due to the fact that it was organized at the "grass roots level" by employees for employees and is not a management tool used to control employees or a conduit for information to be passed to management. In an interview, Chief Gates addressed the issue, saying, "I must tell you I'm kind of letting this thing grow on its own. I haven't reached down and tried to direct it because I think I could very quickly ruin the whole program just by saying, 'Okay, now I'm going to take control over it and we're gong to do it my way.' I may not have the intention but it might appear that way. I've let it develop on its own."

Confidentiality Issue.

Peer counselors have no legally protected privilege of patient confidentiality as do most members of the mental health profession. Even without this legally recognized privilege, a high degree of confidentiality in a program of this type is necessary for its success. The regulations that govern the operation of the LAPD's Peer Counseling Program state that counselors have a responsibility to insure the confidentiality of their communications with employees, with the exception of situations involving criminal acts or violations of departmental regulations. This limited confidentiality is considered central to the effectiveness of the program.

Conclusion

The time between when an employee begins to experience the minor problems caused by the daily stresses of life and those problems developing to the point where the employee must seek help from a mental health professional is vast. During this period, the employee experiences pain and may make many bad decisions. It is also during this period that a network of peer counselors, acting

as paraprofessionals, can step in to give early aid in assisting the employee in resolving his problem, or in severe cases, refer the employee to appropriate professional assistance.

Many acts committed by employees that require a disciplinary response from management are "cries for help." These acts may include shoplifting, drug abuse, alcoholism, or other equally undesirable activities. While peer counselors would be expected to refer these more complicated problems to full-time professionals, they are in a position to detect them early. Early detection and referral has the obvious benefit of preventing major problems later on.

Alcoholism programs involving peer counseling focus on one major issue - alcoholism. With a peer counseling program of the type the LAPD instituted, the focus is expanded to include a wider range of employee problems. These programs can increase productivity, reduce absenteeism, reduce grievances and the need of the disciplinary action, and improve employee morale. Improved employee morale is considered by many to be the most important benefit derived from such programs. A peer counseling program gives concrete evidence to employees that management does care.

Informal peer counseling is common among employees in law enforcement as well as other professions. Employees discuss their problems with their peers, from the most insignificant daily insures to the major life traumas. A study of officers involved in shootings indicates that "a significant phenomenon is that every police officer interviewed was, within 48 hours, back at the station to speak with his fellow officers." Without proper training, however, the results of these peer contacts can be less than desirable. A Salt Lake City study showed that officers involved in shootings talk with their fellows 85% of the time. Results show that fellow officers without proper training were reported to be of assistance in 59% of the cases, and in 41% of the cases surveyed, other officers were reported to be major source of aggravation.

Employees who experience short term crises need to be heard, need to have the opportunity to feel understood, and need to receive peer recognition of the extent of the problems they face. Peer counseling offers a means of effectively providing this support to employees who are under stress. With careful planning and implementation, an organization can provide a workable support network of peer counselors at a low cost to support fellow employees and the organization as a whole in resolving significant problems with a resulting increase in organizational efficiency and employee well-being.

Suggested Stress Management Class Outline

Which of these is stress?

- You receive a promotion at work.
- You get in trouble at work or even fired
- Your car has a flat tire.
- You get engaged the man/woman of your dreams
- You have serious marital problems and are getting divorced

- You go to a fun party that lasts till 2:00 a.m.
- Your dog gets sick all over the house.
- Your new furniture is being delivered.
- Your best friend from high school and his wife come to stay at your house for a week.
- You get a bad case of hay fever.
- You win the lottery
- All of the above.

Different kinds of stress:

- Eu-stress
- Distress
- Critical Incident Stress
- Emotional Stress
- Argument with your spouse or a good friend
- Allergic Stress
- Allergic reactions cause physical changes in our bodies that cause our bodies stress
- Cumulative Stress
- Any kind of change in our physical bodies, or our surroundings can be considered stress. Imagined change, or worry, can be just as damaging as actual change. The “What ifs…”

Critical Incident Stress vs. Cumulative Stress

Here is an example of a traumatic event which is known as Critical Incident Stress: “A great white shark will kill and eat you in one gulp. At the other spectrum, is an example of cumulative stress: Little ducks walking down a path toward you begin to nibble away at you. It may take a lot longer for little ducks to nibble you to death, but the final result is still the same.

An example of cumulative stress: Bad day, spill coffee, late for work, boss is mad – three days in a row, etc.

Stress is like walking down the street when someone walks up and shoves you in the back. Your body and mind will react instantly to try to regain your balance. If you are shoved hard enough, your arms will go out to try to break your fall and protect your face. Your whole body reacts to the attack. The same thing happens with stress, it impacts the entire body.

Three relaxation techniques

Combat Breathing

Breathing is both automatic, and can be controlled. By controlling breathing, you can slow down your heart beat, lower blood pressure, etc. In a "Fight or Flight" situation, adrenaline will be dumped into your system, and your stress level will dramatically increase causing your heart beat to race, and your blood pressure to increase. The result of the increased heart rate and blood pressure is that your

fine dexterity ability will decrease. Some common professions this technique is used:

- Used and taught by military
- Used by athletes – basketball player getting ready for a free throw

Muscle Tensing

Tensing and un-tensing muscle groups – including and finishing with your face.

- Used by athletes
- Used by business professionals

Visualization

This is an exercise you would use somewhere private. Sitting in a comfortable chair, sit straight up with your hands on your knees. Close your eyes, and your imagination. Visualize all of your energy oozing out through your eyelids. Start with the feet and slowly move up the body, imagining all of the energy in the feet and moving up the body oozing out through the eyelids, until the whole body is totally relaxed.

- Used by actors
- Used by motivational speakers
- Used by teachers

Why is stress so bad?

The body responds to stress on two levels – physically (starvation, auto accident, enduring severe weather) and psychologically (emotional, mental stressors like loss of a loved one, inability to solve a problem, difficult day at work). Our bodies, however, can not distinguish between stressors and natural reactions and may physically react the same way to joy as it may to fear.

The term General Adaptation Syndrome[12] describes the body's short-term and long-term reactions to stress and follows a three-stage response to stress: the alarm reaction (AR), the stage of resistance (SR), and the stage of exhaustion (SE).

Stage 1: The Alarm Reaction (AR)

The first stage of General Adaptation Syndrome (GAS) is the immediate reaction to a stressor. This has often been referred to as the "fight or flight" response stage. This stage prepares the body for physical activity; however, this phase can also decrease the effectiveness of the immune system, making a person more susceptible to illness.

Stage 2: The Stage of Resistance (SR)

The second phase is also referred to as the adaptation stage. If stress is continuous, the body may adapt to the stressors and changes will take place in

[12]Originally described by Dr. Hans Selve (190701982), an Austrian-born physician who immigrated to Canada in 1939.

order to reduce the effect of the stressor. An example is starvation; an active person may loose the desire for physical activity due to the body's need to conserve energy and maximize the absorption of nutrients from food.

Stage 3: The Stage of Exhaustion (SE)

In the third phase, the stress has continued for some time and the body's resistance to stress may be reduced or may collapse quickly. This means that the body's immune system (ability to resist disease) may almost be eliminated. Patients who have experienced long-term stress may find increased possibilities of heart attacks or severe infection due to reduced immunity. An example is a person with a stressful job; If long-term stress of the job is not controlled the person might develop high blood pressure and eventually a heart attack.

All Stress is not Negative.

It should be noted that Dr. Hans Selye did not regard stress as solely negative. "Stress is not even necessarily bad for you; it is also the spice of life, for any emotion, any activity causes stress." Some later researches coined the term "eustress" or pleasant stress. Eustress refers to positive experiences such as a desired job promotion, completing a degree or training program, marriage, travel, and many more events which are also stressful. Dr. Selve also pointed out that human perception and responses to stress is highly individualized. A job that one person finds anxiety-provoking or exhausting might be quite appealing and enjoyable to another person. Observing one's responses to specific stressors can contribute to better understanding of that person's particular physical, emotional, and mental resources and limits.

The three stages of the General Adaptation Syndrome may be summarized as follows:

How Does Stress Affect Us? (See Appendix E - Handout 1)

Stage 1: "Flight or Fright" Response

a. Body: This is the alarm phase. When the body senses a threat – allergy, emotional, fear, all are a threat – the body is energized to either fight or run.
b. Mind: The mind is presented with a situation (stressor) that is not familiar and reacts with surprise and anxiety.

Stage 2: Resistance Phase

a. Body: Continues to resist and provide energy until either the threat is gone, or all of the energy has been depleted.
b. Mind: Learns to cope with the task effectively

Stage 3: Exhaustion

a. Body: If the demands continue over a period of time, and all of the energies are depleted, the body becomes physically and psychologically exhausted. At this point, a person is very susceptible to illness, and if not checked may actually die from exhaustion.

b. Mind: You come to a state of emotional fatigue.

How Vulnerable Are You To Stress?

Take the Stress Test and find out your "Stress Score". (See Appendix E - Handout 2).

Flying Squirrel Story

Two boys went on a camping trip with their dad up in the Canadian wilderness. Boys went to gather fire wood. Took an axe to an old dead tree. The first boy swung at the trunk of the old hollow tree while the other boy watched. A little furry face popped out of a hole in the tree. A flying squirrel popped out, to their delight, and jumped out to glide to a far away branch. The little squirrel misjudged the distance however, because he didn't have time to get his pre-flight calculations. He fell to the ground and was slightly dazed.

One of the boys quickly snatched up the little flying squirrel. He was nervous about being bit, so he held on to the soft, furry little creature very tight in his hand to keep it from moving, as he rushed over to show his brother. The little flying squirrel was terrified, and paralyzed from fear. After a few moments, the squirrel simply went limp and lifeless.

The boy wasn't sure what happened. The little flying squirrel appeared to be dead. Did he do something to harm it when he snatched it up? Or was it hurt from its fall?

What the boys didn't realize was that flying squirrels are very gentle and friendly little creatures, and would probably not bite even if it was given a chance. Because they are so fragile and shy, excessive pressure or fright will cause them to terror stricken and paralyzed with fear. The flying squirrel doesn't have the ability to cope with excessive pressure. Instead of fighting to escape, the gentle creature will simply give up. Its paralyzing fear will cause it to go into shock and die.

We are not flying squirrels, but we do have a limit to how much stress we can take before we are overwhelmed by it.

Being overstressed will make a person sick. It is like running your car engine past the red line, or leaving your toaster stuck in the on position. Eventually something will break down, or burn up.

Murphy's Law Of Police Work (See Appendix D – Handout 3)

Break Out in Groups and discuss the following questions:

1. What are some of the signs that you are being overstressed?
2. What are some of the things that cause you to feel stressed?

This summary is from a recent article in a scientific paper about a primitive cave used by Native Americans for what is estimated to be several thousand years. In studying the archeology of the place, they could see each technological advance, and estimate the time between these advances. They could see where the Native Americans began using mostly basic tools. Over about a period of a thousand years, they saw the revolutionary change of using a spear for hunting. The next revolution, of again about a thousand years, showed the use of a sling shot. A thousand years after this, they developed and began using the bow and arrow….It took a thousand years for this tribal group to change their tools or make an advance. How many advances have been made, just in your life time? Microwave, CDs, VCR, DVDs, personal computer, cell phones – to name just a few.

Serotonin, Noradrenalin, and Dopamine

There are three chemicals in our bodies that help us keep functioning, and when any of the three are out of whack, can cause us problems:

Serotonin – What allows us to sleep. Causes changes in our body that make us sleepy, and allow us to fall to sleep. Serotonin sets are body clock. If Serotonin is not doing its job, you will not be able to fall asleep no matter how you try.

Serotonin helps to re-set your body clock, adjusts your body temperature (cooler when you are sleeping), stress fighting hormones, and your sleep cycle.

Noradrenalin – Gives you energy. A cousin to adrenalin. People who do not have the right level of Noradrenalin will be sluggish and lethargic. They don't have energy to do anything. It is like running a car with a bad alternator. It will drain the battery until the car dies.

Dopamine – Sets your pleasure and pain threshold. Dopamine is linked to Endorphins. When Dopamine is not functioning properly it causes the bodies natural pain killer to shut down, causing achiness especially in the chest, neck, shoulders and back areas. Dopamine is also the body's pleasure center, which allows us to feel pleasure. With a low Dopamine level, our bodies will feel achy, and we will not be pleasant to be around.

Symptoms of being overstressed:

1. First your body clock will stop working. You will have a hard time falling asleep, or waking up depending on where your body clock is stuck. You will wake up not feeling rested at all.
2. You will have a notable lack of energy.
3. Aches and pains
4. Lack of enjoyment in life and in things you once enjoyed.
5. You may feel anxious, or think maybe you are having a heart attack. You may even fall into a sense of panic. Shortness of breath, feeling light headed, stomach upset, diarrhea, ulcers, etc.

Avoiding Stress

1. Get up 15 minutes earlier.
2. Prepare for morning the night before.
3. Never wear ill-fitting clothes.
4. Set appointments ahead.
5. Don't rely on your memory.
6. Practice preventative maintenance.
7. Make duplicates of all keys.
8. Rearrange work hours.
9. Say "no" more often.
10. Never shop for clothes with critical teenagers, skinny friends, or those who look terrific in everything.
11. Take advantage of off hours for banking and shopping.
12. Rearrange mealtimes.
13. Feed the children separately.
14. Keep an emergency supply of necessities.
15. Walk everywhere you can .
16. Park your car further from the store entrance and return the store cart to the proper area (you will feel good about helping out the store clerk and you benefit from the additional walking).
17. Make copies of all important papers and keep the originals in a safe place.
18. Anticipate your needs.
19. Don't put up with anything that doesn't work properly.
20. Make advance reservations.
21. Allow for extra time.

Reducing Stress / Getting back to Normal

Here are a few tips for reducing stress:

1. Be prepared to wait
2. Never arrange a meeting place that has no telephone
3. Find the humor in it.
4. Keep a "busy kit" handy when you travel.
5. Relax your standards.
6. Get help with the jobs you hate.
7. Establish a serene place of your own.
8. Change your perspective.
9. Count your blessings.
10. Keep time fillers by the phone.
11. Memorize your favorite poems.
12. Keep a supply of individually wrapped candies or sugar-free gum handy.
13. Avoid pick-me-ups such as caffeine or sugar. It will actually cause more stress on the body and prolong the problem.
14. Travel light.
15. Be prepared for rain.
16. Ask questions.
17. Take advantage of your body rhythms.
18. Make contingency plans.
19. Un-clutter your life.

20. Avoid reliance on chemical aids.
21. Set your schedule like “clock Work”. Go to bed at the same time every night, even if you don’t want to.
22. Every morning make a list of things you want to get done today, then cut off the bottom half of the list.
23. Lighten your social calendar – delegate – or if unable to delegate say NO more often.
24. Postpone making changes in your living environment – don’t move, remodel, etc at this time.
25. Cut back your number of hours at work or school.
26. Eat a balanced diet with proper amounts of minerals and vitamins.
27. Exercise.
28. Don’t take sleeping pills or self medicate (see a doctor before stopping or starting any medications).
29. Work on your self talk. Don’t think ‘I have to get this done’, or ‘something terrible will happen if…’. Change that kind of thinking.

Group Exercise: Break into groups and discuss the following:

What are unique stressors to Law Enforcement Personnel?
What are signs and symptoms to watch for that a cop is over stressed?
What can we as Chaplains do to help?

Relieving Stress

Some things to do to relieve stress include:

- Get in touch with friends/family who bring you joy
- Take time off
- Find enjoyable ways to exercise
- Talk to someone you trust – “Get it off your chest”
- Reward yourself after stressful activities
- Take leisurely baths
- Schedule more fun
- Take a break from the children
- Have a massage
- Unwind before bedtime

Challenges:
How to help
Changes in personality
Irritability
Sleepless or Sleeping much more than usual
Loss of appetite or unusually large appetite over a period of time
Crying

RED FLAGS OF EMOTIONAL EXHAUSTION

How can you tell when your energy level is slipping to dangerous levels? What signals emotional and physical exhaustion? Here are a few significant pointers.

Answer the questions below as you consider the last two or three weeks of your life. Give yourself a score for each:

2 if your answer is "often" 1 if it is "sometimes" 0 if it is "rarely"

Question	Often	Sometimes	Rarely
Are you spending an unusual amount of time by yourself, withdrawing from friends, family and work acquaintances?			
Are you becoming more negative, pessimistic, critical, or cynical about yourself and others?			
Are you forgetting appointments, deadlines, or activities and not feeling concerned about it?			
Are you more irritable, hostile, aggressive, angry, or frustrated than usual?			
Are you sleeping either much more than usual or significantly less?			
Do you suffer from gastrointestinal problems (indigestion, stomach discomfort, diarrhea, or colitis)?			
Are you waking up feeling tired or fatigued?			
Are you spending a lot of time thinking or worrying about your work, people, the future, or the past?			
Do you have an overwhelming feeling of being overloaded, that too many demands are being imposed on you?			
Do you find yourself focusing on relatively petty things or persevering with nonproductive or ineffective actions?			
Do you feel that nothing you do is effective in coping with your life, or that you are helpless to control the outcome of anything?			
Are you experiencing headaches, muscle tension, or stiffness in your shoulders and neck, or increased pain anywhere in the body?			
Does your heart thump or race, or do you get irregular heartbeats when you lie down to rest?			
Do you get dizzy or lightheaded (especially when you are under pressure)?			
Have you become aware of increased anxiety, worry, fidgeting, and restlessness?			
Column Totals			
Total Score			

Interpretation – Scoring the results

The fifteen items of this test cover the most significant, subtle signs of overwork, such as repeatedly waking up tired in the morning. Other symptoms include withdrawal, negative thinking, forgetfulness, and irritability, as well as an assortment of hysterical problems, such as stomach discomfort, headaches, and lightheadedness.

Although this simple self-test is not intended to yield conclusive results, your score might caution you to take a second look at the stressors most recently influencing your life.

Score	Possible Stress Level
25-30	Your stress level is dangerously high. You are probably experiencing distress in your nervous system, cardiovascular system, muscular system – just about every major physical and emotional system of your life – even if you don't recognize it. It would be advisable to consult a physician right away and seek some good stress-management counseling.
17-24	Your stress level is high and you are more than likely showing severe signs of distress. This would be a good time to change your life style or make some drastic changes to reduce your stress level. Seeking help from a professional might be beneficial.
11-16	Your stress level is at a moderate level and may simply be from too many things happening at once. If you can ease up a bit, or do activities that will reduce the physiological effects of stress (exercise, rest, enjoyable activities).
6-10	Your stress level is showing mild signs of distress. It might be helpful to ease up a bit.
0-5	You are living a relatively stress-free life and appear to be coping well with the pressures of daily living.

STRESS RATING SCALE

Think of what has happened to you in the past year as you read through this test. Jot down the point values for events that apply to you in the column at the right, then add up your score. If your total for the year is under 150, you probably will not have any adverse reaction. A score of 150-199 indicates a "mild" problem, with a 37% chance you will feel the impact of stress with physical symptoms. A score of 200-299, you qualify as having a "moderate" problem with 51% chance of experiencing a change in your health. And a score of over 300 could really threaten your well-being.

Rank Life Event	Stress Rating Score	Your Stress Score
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Jail Term	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired from job	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sex Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different kind of work	36	
Change in number or arguments with spouse	35	
Mortgage over $80,000	31	
Foreclosure of mortgage or loan	30	
Wife begins/stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision of personal habit	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in school	20	
Change in recreation	19	
Change in social activities	18	
Mortgage or loan less than $80,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas	12	
Minor violations of the law	11	
	Total:	

Chapter 9
COMMUNICATIONS / LISTENING

RULES OF COMMUNICATION

“The words we speak are very powerful. The perception of many people is that the chaplain speaks for God”.

- Learn to listen.
- Be open and honest.
- Be tactful, considerate, and courteous.
- Be clear and specific.
- Be realistic and reasonable.
- Do not preach or lecture.
- Do not use excuses and do not fall for excuses.
- Recognize that each event can be seen from different points of view.
- Do not allow discussions to turn into destructive arguments.
- Let the effect, not the intention, of your communications be your guide.
- Accept all feelings and try to be understanding of them.
- Know when to use humor and when to be serious.

LEVELS OF LISTENING

Level Three~~3~~: Listening in spurts.

This is the "tune in - tune out" type of listening, only hearing bits and pieces of what is being said. We "must" pay attention to the person seeking help from us.

Level Two~~2~~: Quiet/Passive Listening.

With this type of listening there is not a great deal of body language in the listener. Typical of this type of listening is that the eyes glaze over and/or the head nods but the "listener" is not really listening but instead is drifting off and distracted. The person speaking begins to perceive that they are not being heard.

The antidote for either one of these levels of listening is honesty. Tell the person what you were doing and apologize for drifting away. Tell them why you are apologizing, "I really want to hear what you have to say".

Level One~~1~~: Active Listening.

At this level of listening you are observing body language. You are evaluating the underlying feelings beneath what is being said. You are not just hearing the words but you are listening for the content, the sub-text of what is being said, and reading the emotions.

> When you enter the scene the FIRST thing you will see is their body language. Watch for signs of physical distress such as shock, grabbing the

chest, rubbing the chest (are they having chest pains), excessive perspiration, color either pale or ruddy, respirations such as gasping or hyperventilating. Pay attention to what they are doing with their hands, watch for clenched fists or a working jaw which indicates anger.

Part of reading their body language is reading their needs. Make them more comfortable. Bring them water, get them into the shade, have them sit down or whatever will bring them comfort.

Allow expressions of emotion, sometimes the person will be better able to continue after having expressed their emotions. Listen without judging or making assumptions.

Mirror back what has been said, repeat back what you have just heard. Be sure you understand by asking simple, clear questions.

Listen, don't let the mind wander, don't rehearse thoughts or the next thing to say. You don't have to agree with the person, don't use that disagreement as an excuse to keep you from listening. Don't criticize, just listen, you can say, "please help me understand."

Avoid interrupting, as the saying goes, "if you can't improve on silence, don't". This is a "ministry of presence" which means that if we cannot fix the situation we can at least "be" there with the person to help them through it. However, too much silence can make the person feel as if you are not interested in what is happening to them. People in crisis need someone to provide structure for them, this is where sensitive listening and mirroring back can help.

Remember, the person communicating to us has a message to convey.

We should ask ourselves, when and with whom do I actively listen?", and bring that level of listening to the person who is in front of us at the moment and needs our help.

Keep practicing your listening skills!

IMPAIRMENTS TO LISTENING

Some of the impairments to listening are fatigue, hunger, dehydration*, and illnesses. Know your limitations and know when to ask for help. (*Dehydration causes the liver to work harder thereby placing more stress upon the body)

COMMUNICATING IN TRAUMATIC SITUATIONS

Perception is reality, it is not what you "said" but what they "heard".

The following is a good model when communicating in a traumatic situation, or any situation for that matter. SOLAR (square-on, one-on-one, level, attentive and range) is an easy acronym to remember and is defined as follows:

(S) Square-On: Give them "full face" listening. If possible, get them to a quieter place. Keep a relaxed posture as much as possible. If you are calm that will be transmitted to the person you are listening to and it may help them to calm down.

(O) One-on-One: Males don't usually stand square on, as it makes them uncomfortable but you can face the female square on. When sitting try to sit slightly to the left of the person you are listening to while still facing them.

(L) Level: Get on the same level as the person being listened to with no obstacles between you. This will help you to pick up on their body language more easily. Pay attention to eye contact, tone of voice, posture, and emotional tone. Crossed arms may indicate defensiveness or "I'm not listening and I don't want to listen." (Learn to discern between defensiveness and a comfortable body posture.)

(A) Attentive: This is level one active listening. Practice your active listening skills by being attentive to their verbal and non-verbal communication cues. You are in support mode (listen) not advisory role (telling).

(R) Range: Be aware of a person's personal space. In a crisis situation, what used to be their private zone now has strangers in it and they will be sensitive to your invasion of their personal space as well. If a person steps back from you or stiffens in posture or looks away, it may indicate that you have invaded their personal space and they are more comfortable with a little more distance.

Learn to speak softly. Look them in the left eye, if possible. Looking a person in their left eye while gently talking to them will physiologically change their brainwave patterns. This in turn can calm them down.

LISTENING /RESPONDING STYLES

Several years ago noted psychologist Carl Rogers conducted a series of studies on how individuals communicate with each other in face-to-face situations. He determined that communication styles could be broken down into the following categories; evaluative, interpretative, supportive, probing and understanding. He found that 80% of all communications fell into one of these categories with the remaining 20% being incidental communications and of no real importance.

From his observations of individuals in different settings he found that the communication styles were used with the following frequency: 1) evaluative, most used, 2) interpretive, 3) supportive, 4)probing, and 5) understanding, least used. He also determined that if a person used one category of response as much as 40% of the time, then other people see him as always responding that way.

Examples of the response categories:

Evaluating
Judging negatively, disapproving, blaming, name calling, criticizing. ("You shouldn't feel that way," "You aren't thinking straight,")

Supporting
Reassuring, excusing, or sympathizing. ("I know how you feel", "Don't worry", "You have to be strong".)

Interpretive:
Diagnosing, psychoanalyzing, reading-in, offering insights. ("You really don't mean that," What you need is…," I know what you need,")

Probing
Questioning, cross examining, prying, interrogating. ("Why didn't you..", "Who", "What", "Where", "When", "How".)

Understanding
The listener hears the message that the person communicating is attempting to convey and restates that message back to the speaker in fresh words (" are you saying…?"). The speaker is now encouraged to expand upon the ideas, feelings, and attitudes first expressed. Even when the listener has misunderstood the speaker at first, it is when the message is restated to the speaker and subsequently corrected that the communication achieves greater clarity.

It is the "understanding" response that best conveys, to the person being listened to, the interest of the listener and conveys the listener's desire for an accurate understanding of what is being said.

12 Roadblocks to Communication

Comparing
This can be competitive and lead to emotional responses. (Why can't you be like …?" "When I was your age.")

Placating this is pretending that you made a connection with them. ("I know how you feel.") You really don't know how they feel, you are, in reality, lying to them.

Mind Reading
Anticipating what they are going to say. Finishing their sentences.

Rehearsing
Practicing what you are going to say while they are talking to you. (This is a person who does not care what they are saying).

Derailing
Changing the subject, if it is something they do not want to talk about the subject will change suddenly. Be aware of underlying issues when this happens.

Judging
This is negatively criticizing, blaming. ("You brought this on yourself so you have only yourself to blame.")

Filtering
Interpreting what they say, jumping ahead of them (speeding up the conversation). This is somewhat like "comparing" and/or "mind reading".

Identifying
You may have had the same experience. This is somewhat like "filtering" in that you begin to interpret what they say through your own experience and fail to listen to and to acknowledge "their" pain.

Sparring:
Don't be argumentative. ("Do you realize that…?" "You shouldn't feel that way." "Well, the facts are…")

Advising:
Telling them what to do or how to feel. ("Why don't you just do…?" "I think it would be best if you…")

Being right
This is like sparring.

Dreaming
That glazed look to the eyes.

The goal of listening is to let the person express what they need to express; that is the beginning of the healing process for them.

This to Say	**Things Not to Say**
"This has got to be so painful"	"I know how you feel"
"I can't even imagine your pain"	"It could have been worse"
"Is it all right if I help you with…?"	"You have to be strong"
"It is okay to have strong reactions to what has just happened"	"Your anguish won't change things"
"I am honored that you are allowing me to share your tears" (Give them permission to cry)	

We are there to be strong for them. Remember, we are a ministry of presence. If you can't improve on the silence, then don't. Learn to be comfortable in the silence.

When the Chaplain hears the Worst

How does the chaplain handle it when hearing the things that are hard to hear.

For the person who has just seen or been through the horrible or who has been carrying within them the awful, hidden secrets of their lives; the very act of opening up and speaking of those things aloud is like lancing an infected wound. All of the horror and all of the poison comes spilling out.

In cases like this it is good to think in the terms of the "universal precautions" taken by emergency responders.

- Glove up - be prayed up. Cover yourself and that person in prayer. ("God, protect my heart")
- Be aware of your physical reactions. You may feel your heart rate and/or your blood pressure going up. When this happens use "Combat Breathing", taking a deep breath and letting it out slowly, this will calm you down and give you time to pray. Drink water, give water.
- Remember, you are there for them, turn your emotional switch off; don't become emotionally involved.
- Know your limits.

Cultural Issues in Communications

Be aware of the different customs among different cultures regarding non-verbal contact such as eye-contact or leaning forward, distances for interaction or touch. Be aware of some of the customs regarding male-female contact, for example, in Russian or Ukrainian households, a male chaplain should not touch the women who live in that home. Also, a female chaplain should not give a death notification to a Muslim family, only a male chaplain should give that notification.

Communications within the Chaplaincy

The Chaplaincy is a "para-military" organization with various levels of command. However, there is an open door policy maintained within the Chaplaincy because our leaders are in fact shepherds to those under their direction.

The purpose of the command structure is to make sure there are clear channels for communications particularly in times of crisis. Much as fire agencies rely on their system of Incident Command, the Chaplaincy must also have an established structure for moving information within the agency as well as to all the Chaplains involved in any particular incident.

- The chaplain who is first on the scene will be in charge and will be the one to direct any other chaplains, or staff who arrive afterward unless that chaplain relinquishes command to a more senior chaplain.

- In the event of a major incident the Senior Chaplain will most likely be on the scene and will remain in close communication with the Law Enforcement Incident Commander.

- In the regular operation of the Chaplaincy, communications from the field chaplains should be passed up through the Division Supervisors or the Communications Officer to the Senior Staff. This will keep the Division Supervisors aware of the concerns of the field chaplains, as well as identify any needs for prayer and support.

Appendix A
Sample

Placer County Law Enforcement Chaplaincy
APPLICATION

Application For

Community Chaplain (CC) _____ **Chaplaincy Support**_____

Law Enforcement Chaplain *(1 year as CC completed or prior LE Chaplain)* _____

Name: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Email Address: _____

Member of what church? _____ How long?___

Name of Pastor: _____

Address: _____

Describe your *Call* to law enforcement chaplain or caregiver ministry:

Referred by: _____

References: (Other than pastor or ecclesiastical supervisor)

1. Name: _____ Phone Number: _____
   Address: _____
   Relationship: _____

2. Name: _____ Phone Number: _____
   Address: _____
   Relationship: _____

3. Name: _____ Phone Number: _____
   Address: _____
   Relationship: _____

Ministry Education: _____

Ministry Experience: _____
_____

Appendix B
Sample

Placer County Law Enforcement Chaplaincy

Commitment Letter

Thank you for prayerfully committing to work with the Placer County Law Enforcement Chaplaincy (PCLEC) for the fiscal year 2007-2008 (July to June). We are pleased to have you as a member of our outstanding team. PCLEC is a field service ministry to the members of law enforcement, their families, all first responders, and the citizens of Placer County. In order to have a positive impact on PCLEC, Law Enforcement and the Community in which we serve, your signature below a indicates your agreement and support of the following:

1. I will regularly pray for the Placer County Law Enforcement Chaplaincy, my fellow Chaplains, and the support staff. I will regularly pray for the leadership of the Chaplaincy program, and seek God's best for the entire Chaplaincy.

2. I will maintain a personal walk with God, and refrain from such activities in my personal life that would damage or sully my reputation and/or that of the Placer County Law Enforcement Chaplaincy.

3. I agree that it is vital that my skills and training be kept sharp and up to date, in order to respond to emergency dispatches. I will maintain my skills by attending the mandatory monthly training meetings except when excused, in advance, by the Senior Chaplain, or Deputy Senior Chaplain. I understand that missing three meetings in a 12 month period or two consecutive meetings may require me to fulfill additional Shadow Training Hours under the direct supervision of another Chaplain before I can return to an Active Status.

4. I will submit a monthly activity report to the Chaplaincy office by the 7th day of the month so that my hours can be duly recorded and counted.

5. I will maintain reliable communication including a cell phone and/or a pager on a 7/24 basis so that I may be contacted when needed and will respond to pages and phone calls promptly whether or not I am available.

6. I will sign up each month as the primary responding (On-Call) Chaplain for the following:

   On-Call Hours (Pick One)
   _____ One 24-hour period
   _____ Three 12-hour periods (Total of 36 hours)
   _____ Five 8-hour periods (Total of 40 hours)

   Weekday or Weekend On-Call Service (Pick One)
   _____ Weekday On-Call
   _____ Weekend On-Call
   _____ Available Anytime

7. I will maintain the Chaplain uniform issued to me. I will wear this uniform at any time I am representing the Chaplaincy whether this be for an emergency call-out, or any official function of the Placer County Law Enforcement Chaplaincy.

8. In keeping with Homeland Security recommendations, I understand that if I leave the Chaplaincy or take a leave-of-absence in excess of three months, I will be required to return all uniforms until I actively return to service.

9. I will submit to the authority of the Chaplaincy's leadership and to all written policies and protocols.

10. I will maintain personal health and automobile insurance.

I understand that when I wear the uniform of the Placer County Law Enforcement Chaplaincy I am clearly in the public eye. I am representing God, all Chaplains in general, and the Placer County Law Enforcement Chaplaincy in particular. My deeds and actions will be noticed and will influence people's opinions. I will give my position the dignity and respect it deserves and will represent the Placer County Law Enforcement Chaplaincy with integrity.

_____

Chaplain Signature Printed Name Date

I the undersigned act as a witness to the signature of the above signed Chaplain. As a spouse, friend, or significant other, I commit to regularly praying for, exhorting and supporting him/her in their ministry as a Chaplain. I will avail myself to them as a friend and confidant, and be a source of encouragement to them.

_____

Signature *Printed Name* *Date*

Appendix C
Sample

Placer County Law Enforcement Chaplaincy

Emergency Call Out Form

Chaplain Name &
Badge No:

Date	Start Time	End Time	Total Time	Agency	Event Code

Event Address:	
On Scene Contact:	

Primary Victims (Deceased / Injured)

Name	Address	B-Date / Notes

Secondary Victims			
Name	Relationship	Address	Phone

Brief Summary

Follow-Up suggested	Yes	No

Appendix D
Sample

Placer County Law Enforcement Chaplaincy
Monthly Report

Month: June **Chaplain:** Sample

CHAPLAIN MONTHLY REPORT

OC	YR	DAY	EV#	ECO X	TIME IN	TIME OUT	AGENCY				ACTIVITY				1C DISP			CA	Stnd by	ADDRESS / INSTRUCTIONS	HRS
	07	03			6:00	12:30	01	05	02	03	123									APD Motorcycle Event/Manual	6.5
	07	03					04	07	08	11											
	07	03					00														
	07	08			18:15	23:30	00				110									Monthly Training - Rocklin PD	5.3
	07	08			23:30	6:30	00				153								7.0	On Call	
	07	09			6:30	13:30	05				110									SAR Training	7.0
	07	09			13:30	19:22	00				153								6.8	On Call	
1C3	07	09	3	x	19:22	21:15	05	11	12	07	123				1C3			15		House Fire	1.9
	07	09			21:15	0:00	00				153								2.8	On Call	
1C3	07	10	1	x	8:22	12:45	05	00			115				1C3					1144 - Lincoln, CA	4.4
	07	10			14:00	16:08	00				111									ECO Reports, correspondence w/PCLEC	2.1
	07	13			8:00	11:30	03				110									Weapons Training	3.5
	07	14			19:22	22:30	00				110	111								Last night of Basic @ Bayside	3.0
	07	16			8:00	11:30	00				110									Chaplain Communication Workshop	3.5
1C2	07	16	3	x	20:46	0:05	05	11	12		115				1C2			10		1144 - Roseville, CA	3.3

AGENCY TOTALS				
	1	2	3	4
00 PCLEC	8	1		
01 Auburn	1			
02 Rocklin			1	
03 Roseville	1			1
04 Lincoln	1			
05 PCSO	4	1		
06 Tahoe				
07 CHP		1		1
08 Pks/Rec			1	
09 DA/Prob				
10 SIU				
11 Allide Assist		2		1
12 Citizen Assist			2	
13 Jail				
14 Animal Control				
15 Newcastle Fire				
16 Penryn Fire				
17 Lincoln Fire				
TOTAL EVENTS	15	5	4	3
TOTAL HOURS	40.4			
ECO TOTALS	3			
STAND BY HOURS	15			
TOTAL CHAPLAINS DISPTACHED	3			
Citixens Assisted	28			

CODES							
100	Self Generated Response		130	Officer Down-Injury/Death			
101	Home/Hospotal Visit		131	Hazardous Material/Spill			
102	Agency Visit/Briefing		132	Crime Or Crime Scene [Spec]			
103	Ride Along		187	Homicide			
104	Counceling		211	Robbery			
105	Wedding		245	Assult W/Deadly weapon			
106	Funeral		261	Rape			
107	DUI Checkpoint		273	Child Neglect			
108	Chaplaincy Presentation		273.5	Domestic Violence			
109	Official Function		288	Sex Crimes Against Children			
110	Training	5	415	Disturbance			
111	Administration	2	417	Threat With Weapons			
112	OCS Duties		459	Burglary			
113	Ref.From/To Other Chaplains		C10	Bomb Threat			
114	CISM		5150	Disturbed Person/Mental			
115	Coronors Case - 1144	2					
116	Death Notification						
117	1146T						
118	1146A						
119	1146C						
120	Major Injury Accident						
121	Major Injury Accident/W/Fatality						
122	Officer Assist						
123	Agency Assist	2					
124	Citizen's Assist						
125	Fire Assist						
126	Hospital Assist						
127	SET/SWAT						
128	SAR						
129	Officer Involved Shooting						

Appendix E
Handouts on Stress

Handout 1: ***How does STRESS affect us?***

ALARM

This first stage is the mobilization of the body's defenses.

Messages from the Nervous System reach the hypothalamus gland which notifies the pituitary gland and adrenal glands.

The pituitary-adrenal system pumps hormones into the bloodstream. These hormones have the effect of speeding the heart rate, increasing respiration, and stopping digestive activity.

THE BODY IS READY FOR A FIGHT!

In animals or primitive man this alarm system triggers physical action (fight) or running away (flight) thus tension is released.

If there is neither fight, then there is NO RELEASE for all the preparedness. Such a situation can lead to ulcers, headaches, backaches, palpitations, rashes, and various other ailments.

RESISTANCE & ADAPTATION

In this stage the invader is fought off or some adjustment is made.

If tired, one sleeps. If hungry, one eats. If a large number of microbes are in a wound, inflammation seals off the site from the rest of the body.

The defense system works so well that most of the time, we are not even aware of it. We are all bombarded by hostile forces – but we are not all sick.

IT IS ONLY WHEN DEFENSE SYSTEMS HAVE BROKEN DOWN THAT ILLNESS RESULTS.

EXHAUSTION

A body cannot be under stress all the time. RELEASE MUST OCCUR!

Some people believe that illness is the result of STRESS. The interaction of a hostile condition with STRESS could be the cause of colds, allergies, asthma, headaches, ulcers, colitis, heart disease, arthritis, and other illnesses.

Appendix E
Handouts on Stress

Handout 2: ***How Vulnerable Are You To Stress?***

The following test was developed by psychiatrists Lyle H. Miller and Alma Dell Smith of Boston University Medical Center. Score each item from 1 (almost always) to 5 (never) according to how much of the time each statement applies to you.

	1	I eat at least one hot, balanced meal a day.
	2	I get 7 to 8 hours of sleep at least 4 nights a week.
	3	I give and receive affection regularly.
	4	I have at least one relative within 50 miles on whom I can rely.
	5	I exercise to the point of perspiration at least twice a week.
	6	I smoke.
	7	I take fewer than 5 alcoholic drinks a week.
	8	I am the appropriate weight for my height.
	9	I have an income adequate to meet basic expenses.
	10	I get strength from my religious beliefs.
	11	I regularly attend club or social activities.
	12	I have a network of friends and acquaintances.
	13	I have one or more friends to confide in about personal matters.
	14	I am in good health (including eyesight, hearing, and teeth).
	15	I am able to speak openly about my feelings when angry or worried.
	16	I have regular conversations with the people I live with about domestic problems; e.g. chores, money, and daily living issues.
	17	I do something for fun at least once a week.
	18	I am able to organize my time effectively.
	19	I drink fewer than 3 cups of coffee (or tea) a day.
	20	I take quiet time for myself during the day.
	Total	

To get your score, add up the figures and subtract 20. Any number over 30 indicates current vulnerability to stress. If your score is between 50 and 75, you are seriously vulnerable. If you total is over 75, you are extremely vulnerable.

Appendix E
Handouts on Stress

Handout 3: ***Murphy's Laws of Police Work***

1. If the bad guys are in range, so are you.
2. Incoming fire has the right of way.
3. Don't look conspicuous, it draws fire.
4. There is always a way.
5. The easy way is a trap.
6. Try to look unimportant, the bad guys may be low on ammo.
7. Professional criminals are predictable – it's the amateurs that are dangerous.
8. Criminals provoked into attacking on two occasions:
    a. When you're ready for them.
    b. When you're not ready for them.
9. Teamwork is essential – it gives them someone else to shoot at.
10. The small criminal element you have been ignoring is the big drug drop.
11. If your sting is going well, you have walked into an ambush.
12. Never draw fire – it irritates everyone around you.
13. Anything you do can get you shot, including nothing.
14. Never share a squad car with anyone braver than yourself.
15. When you have secured an area, don't forget to tell the criminals.
16. Never forget your weapon is made by the lowest bidder.

Dan Tyler included this as a handout in the workshop, "Keys to Successful Chaplaincy" which he led at the Florida Regional Seminar.

Article ~

WHAT YOU SHOULD EXPECT FROM A CHAPLAIN
by Chaplain David DeRevere
(Military Chaplains Review, month/year unknown)

Chaplains serving law enforcement come in all sizes, shapes, ages and religious persuasions. Most are male, but some are female. No matter, for there are common traits that should be shared by all.

Some of these common traits are listed below and explained:

ACCEPTANCE

A police chaplain cares about all members of a department because they are people. Members don't have to fit any particular mold or measure up to any special standard to be important. They don't even have to go to a church or to a synagogue. They don't have to know the Bible. A chaplain accepts them as they are, just because they are one of God's children. A chaplain doesn't have to agree with or condone whatever an officer does or says, he accepts a person without judgment for they are an important being.

AVAILABILITY

A chaplain should be willing to come whenever he or she is needed--this includes getting out of bed in the middle of the night. Chaplains are committed to responding when needed. Of course there will be times when a chaplain cannot respond immediately, but the complaint most often heard from chaplains is that the department doesn't call them enough.

If someone needs to talk personally with a chaplain, they should be able to get a prompt response. However, don't expect the chaplain to be a mind-reader. He may not realize that when you propose, "why don't you ride with me sometime, chaplain," that what you really want is to talk with him privately. Expect a quick response, however, when you say, "I've got something I would like to talk about with you."

CONFIDENTIALITY

An absolute must for chaplains is to keep what is told to them confidential. A person must be able to discuss almost anything with a chaplain and know that it will never go any further. The only exception is when there is a threat of danger; to either the person being counseled or someone else. A chaplain should make these ground rules known in advance.

Officers are a suspicious group but charges that a chaplain is a snitch for the chief are rarely true. An officer who makes a claim that he told something to the chaplain and now everyone knows about it, usually has overlooked the three or four other officers he also told.

CREDIBILITY

A chaplain must have integrity. A department can expect correct ethical behavior from their chaplain. They can expect a chaplain to stand up for what is right and just, even when it pertains to prisoners. Members of a department should be able to count on the chaplain to do what he says he will do. A chaplain's actions should square with his words. He should not only talk a good game, but live one.

FAITH

A chaplain must be a person of faith. This does not mean that a chaplain will always be preaching or quoting the Bible, but it does mean that his belief shines through in the kind of life that he lives and the things he says.

INTEREST IN YOU

A chaplain is genuinely interested in all the members of a department and their families. What they and their families do, and their successes or failures are important to the chaplain. He will be pleased to share both the joys and sorrows of their lives.

LAW ENFORCEMENT KNOWLEDGE

A chaplain should know what the world of a police officer is like. He should understand the pressures and keep abreast of the developments impacting on such a life. If the chaplain is new, it will take time for him to learn this.

A good chaplain strives to be conversant with everything pertaining to law enforcement--from use of deadly force policies, to union negotiations. He will recognize this is a different world.

A chaplain will not "play cop," for he does not function as a sworn peace officer. While many chaplains feel it is an obligation on their part to be able to defend themselves and not be a liability if they are riding with someone, their function is not to be another officer.

These are some of the basic ingredients of a chaplain. Most chaplains have them, but chaplains do have faults and some will make mistakes. After all, they are human too.

Chaplain David DeRevere is Executive Secretary of the International Conference of Police Chaplains. He was a volunteer chaplain for 19 years.

Article ~

A CHAPLAIN'S CALL
By Chaplain Walton J. Tully

Lucky thing for chaplains that Father Mulcahey of the TV series MASH had a good reputation among his medical unit - he didn't preach at them and he never supposed he was "one of the boys," yet he was always present to them and quietly served whenever and wherever they needed him.

"Chaplain, this is the dispatcher. We have a Code 44 (police officer down) and Unit 31 is in the emergency room.

This type of call sends an immediate chill up the spine. No one is quite sure what had happened or just how badly hurt the officer is. And this type of call usually comes in the middle of the night, rarely during the daylight hours. The chaplain dresses quickly and responds to the hospital to check on the officer, and on the officer's family who also have been called, and to work with the officer's friends who have gathered there as well. The chaplain is the comforting presence, the stabilizing influence in a time of uncertainty and fear.

Thankfully, this type of call is NOT the norm. More often it is the chaplain who regularly visits the station and becomes well acquainted with the department personnel will be approached by an officer who says, "Chaplain, do you have a few minutes? I need to talk about something that has been bothering me."

In many cases it will be a personal problem involving a family matter. It may be that they have received a reprimand from a superior officer and feels it was unjust or unwarranted. Rarely does the officer stop the chaplain to talk "church talk."

Introduction to the Chaplain

Today, more than ever in the history of law enforcement agencies, the need for religious guidance and assistance to law enforcement officers is great and demanding. Each day the police officer is faced with potentially dangerous situations as they come into contact with the baser elements of society. They must make split-second decisions that are just and right, knowing that someone with a lot of time will be analyzing what was done, and how it should have been handled differently- all with the expertise of an armchair quarterback. After careful deliberation of the facts that person will tell the officer whether or not the split-second decision was the right one. Many times after such a situation the officer has the feeling they are coming apart at the seams and need someone trustworthy to "dump on." That person has to be one who fully understands the circumstances surrounding the decisions that were made.

There is a great need to be able to "let it all hang out" with someone who will not be judgmental, but understanding. Someone needs to be there to hear what the officer is up against, yet is detached enough not to become personally involved in the situation.

Often an officer does not feel comfortable taking with the supervisor or even other officers about a problem they are experiencing. They do not want to take the problem home to the spouse or parents as they do not want to alarm them. Where can they go?

The police chaplain needs to be the one who can listen with empathy, advise calmly, and offer assistance when such assistance is appropriate. On call 24 hours a day the chaplain stands ready to respond. The key words are "service" and "presence." The chaplain knows they need to be with the officer whenever and wherever their service is needed.

The Chaplaincy is no place for a person who does not like to have his sleep interrupted. It is not a vocation or avocation for the person who is enamored of a uniform and wishes only to be used on "state occasions." The Chaplaincy must be filled by a person whose primary desire is to be of help to law enforcement personnel wherever and whenever the call may come.

The Chaplain's Qualifications

To be a chaplain, the person should:

- Be an ordained or licensed clergy person in good standing
- Show a God-like compassion, understanding, and a love for others
- Be able to relate easily to all kinds of people
- Maintain high spiritual and moral standards
- Manifest maturity in judgment, emotional stability, and personal flexibility
- Be tactful and considerate with people of every race, creed and religion
- Be willing to become involved in training (such as the basic academy, "in-house" training, seminars, etc.) that will enhance effectiveness in dealing with people and crises.
- Be familiar with the various helping agencies in the community to which referrals can be made.
- Be willing to respond to any and all situations where his presence as a chaplain is indicated
- Never have been convicted of a criminal offense, nor of offenses involving moral turpitude. (Minor traffic offenses are excluded).
- The police chaplain needs to be a person who has a deep concern for the spiritual and emotional well-being of law enforcement personnel. The chaplain may or may not have received the basic law enforcement training given to new officers, although some chaplains have become sworn officers usually serving as reserve or auxiliary officers, and some may carry weapons.

When I started my work as a volunteer police chaplain I found that the personnel were friendly, but would not openly talk about the problems of police work which were the root of their concerns. When I asked the sheriff how I could get closer to them, to get them to respond to me as their chaplain, he said, "Become one of them." After completing the 300 hours of training I began riding with them on patrol, and they did begin to talk. Once they know you are willing to face the street scene with them you will be accepted.

One thing the chaplain must not do is to preach to them when riding with them, or when speaking with them in the office. The chaplain should just be there accepting the officer as he or she is, but not trying to be "one of the guys," using inappropriate language or sharing stories that are "colorful." The chaplain must remember that he is God's representative to a hurting people and act accordingly.

Ways A Chaplain Can Help

There are many areas in which the chaplain can help officers in doing their duty. They include, but are not limited, to:

- Assistance in making notifications to families when there has been a death in the family due to homicide, suicide, accidental or natural causes.
- Help comfort persons seriously injured in an auto or other type accident, or comforting their family members.
- Assists in dealing with attempted or potential suicide victims and their families.
- Helping officers deal with confused and/or emotionally distressed persons.
- Aiding in cases of domestic disputes where families indicate a willingness to accept counseling (on a short-term, emergency basis only). Long term counseling should be referred to the person's own pastor or some other agency.
- Responding when an officer is killed or injured in the line of duty.
- Respond to scenes of major disasters in which law enforcement officers are involved, i.e., bombings, train or plane accidents, explosions, industrial accidents, toxic spills, etc. Be there in the field with the officers.
- Promote and conduct memorial services when appropriate. Observe National Law Enforcement Memorial Day on or about May 15th or each year.
- Attend such occasions as academy graduations, award or promotion ceremonies, dinners, social events, and other public functions as a representative of the department.
- Work in the area of public relations as liaison with other religious leaders in the community.

If there is an officer or a department whose primary concerns are child or spouse abuse or sex crimes, the chaplain can often be the soft shoulder for the officer who is feeling overwhelmed by it all. The department should never overlook the chaplain when it comes to dealing with juvenile delinquents because he may be a guiding influence.

Confidentiality

This becomes one of the touchiest areas in dealing with law enforcement personnel. There has to be an understanding with the chief or sheriff or other head officers of the department, that some things discussed will be highly confidential. Without this agreement there will be no possibility that an officer will completely unburden him/herself to the chaplain. The personnel have to know that this confidence will be maintained.

What happens if what the officer tells you has a direct bearing upon the individual's emotional stability and/or ability to do the job effectively? Now comes the question: Does the officer trust you implicitly? If so, then the two of you can probably work out some sort of an arrangement where he will be willing to talk with another professional counselor if it is out of your area of expertise.

If there is hesitation, a showing of a lack of trust in you, it will be up to you whether or not withholding information from the officer's supervisor will cause harm to the officer, to another officer, or to the general public. It becomes a judgment call, but one which will affect your relationship not only with that officer, but with the other officers in the department as well. Will your actions cause them to distrust you in the future? Will your actions cause "the brass" to lose confidence in you?

There is no easy answer to disclosing something told you in confidence.

The Police Family

The chaplain stands ready to assist the officers and family in the times of distress, crises involving the possibility of separation and divorce and problems in which children are involved.

No one understands the stress, the pressures, the problems, the discouragements that are a part of the officer's daily life except the person who has walked with that officer in good days as well as bad days. There are situations which the officer may not be able to discuss with an outsider due to department regulations, but for which the chaplain has been cleared and is available to respond. The chaplain may even have faced that or a similar problem previously.

Generally the chaplain can be called upon at any time, day or night, seven days a week. However, we do want to state that the chaplain will not, and does not wish to take the place of the officer's own pastor. The chaplain is there to help until the family's pastor can arrive, or to be the pastor if the family has no church affiliation.

The Authority Of The Chaplain

As stated before, the chaplain may or may not be a sworn officer, but he is a person of God with the responsibility to assist all officers on matters that fall within the realm of the Chaplaincy.

The chaplain should report directly to the chief law enforcement officer. It is to be understood, however, that any information of a privileged nature shall not be included in any report made by the chaplain to such head officer.

To be effective in his role as a helper, the chaplain shall be authorized to ride with officers on all shifts, shall be given permission to visit all offices of the department, and be welcomed at the various scenes at which the officers are working. This requires that the chaplain be issued a department identification card and possibly, a uniform so as to readily identify. If possible, the chaplain should have access to radio communications of some sort, and/or a pager in order to be in constant contact with the dispatcher in case of emergencies.

The chaplain shall not release any information to the news media except as authorized by the chief or the sheriff.

Learning In Retrospect

One department with which I became affiliated had an officer killed and one wounded in a shooting in the station parking lot ten months prior to my arrival in the city. I heard much about it and we held a memorial service one year after the death. That all seemed to go well and seemed to be comforting to the family.

A while later the second officer, the one who had been wounded, invited me to have a cup of coffee with him, I sensed that he wanted to talk about what had happened - post-shooting trauma had set in. I sat and listened, but I was too unsure of my relationship with him at the time to press him to reveal just how he felt. The right question probably would have opened the flood gate and healing might have taken place. But I sat there on my hands, doing nothing. And he did nothing and said nothing. A missed opportunity!

Was I wrong in not insisting on talking it out? In retrospect I would have to say, yes, I was wrong. This was a learning experience for me. Now, I would much rather err in pushing the officer to talk about the experience than in allowing him to suffer in silence. If you sense there is something bothering an officer let him know you know something is wrong, and that you want to help. We, as chaplains, must be willing to be vulnerable if we are going to be able to help others. And you officers, if you want to talk and the chaplain seems unsure of what to do - for heavens sake tell him or her.

The Police Chaplain needs to stay in touch with other chaplains, not only locally, but throughout the nation. There is an organization dedicated to keeping chaplains in touch with each other and also to provide continuing education in their specialized field. The International Conference of Police Chaplains (ICPC) exists for the purpose of fellowship, assistance on an international basis, and for providing seminars to help further the knowledge of police chaplains. Seminar leaders are provided by our own people as well as those from the FBI, local and state police agencies.

For more information on the International Conference of Police Chaplains, contact: ICPC, PO Box 5590, Destin, FL, 32540. (850) 654-9736, Fax (850) 654-9742. Website http://www.icpc4cops.org.

Article ~

BREACHING THE BLUE WALL

By Lowell F. Lawson

This article originally appeared
as a Paul Harvey commentary.

I will never forget the sense of frustration that edged his voice as he spoke. "I go to the precinct and I stand and no one ever comes up to talk to me. He was a young police chaplain candidate. He had come to the end of his training period and had decided that he would not seek appointment as a police chaplain. A quiet individual who found it difficult to initiate relationships he had struggled through the most frustrating experience of his life. As a priest he was welcomed by his congregation and strangers smiled at him as he walked the streets. Not so when he went to the precinct as a police chaplain. He had met the BLUE WALL. And the BLUE WALL won.

The BLUE WALL. It is not a physical structure. It is the invisible social and psychological barrier that separates police officers from others. It is not the existence of such a barrier that is unique. Many groups erect such obstacles to relationships, doctors, lawyers, ministers, politicians, housewives, cheerleaders, bag ladies and winos - every distinctive group tends to segregate itself from others at some point. There is something which draws us together with others who share a commonality with us. All of us tend to withdraw behind a wall that keeps out others who lack that commonality.

Although there are many walled groups in society, there is something about the BLUE WALL that sets it apart from all other walls. That something is the intention of the wall. Police officers build the wall and they maintain it. No one breaches it without the approval of the officers.

Why is the BLUE WALL particularly impenetrable? Why is it, of all walls, the most difficult to breach? The answers are found in the nature of law enforcement. Police deal with the negatives of our culture. Their task is to restore a positive balance to situations and circumstances that are biased toward and/or un-inclined to accomplish. They restore domestic peace, recover stolen property, arrest those who commit crimes against citizens – to deal with the unpleasantness of life. It is a difficult job carried out under the bright lights of public scrutiny. Police officers inhabit a world little understood by those outside its boundaries. Little wonder they withdraw into an enclave surrounded by the BLUE WALL.

Police officers place the clergy at the far right end of the bad-good spectrum. Like many persons, police officers view others from a stereotypical frame of reference. They see the minister as naive; incapable of accepting the fact that there are bad people in the world. The minister is seen as one who has never heard the "four-letter words" and would be uncomfortable at a murder scene. The police officer thinks that ministers should seek the safe and quiet places, insulated from the real world of the streets.

An impenetrable wall. A closed society. That is the arena in which the police officer lives and moves and has his being. It is also the place where the chaplain must go if he is to be the chaplain. And so the obvious questions. Can you get there from here? How do you get there? The answer to the first question is "YES". The second answer is a bit more complex.

You can get behind the wall. unless you do you will be a police chaplain in name only. Yours will never be more than an appointed position. Certainly it will not be a ministry.

How do you get there from here? The route is not a short one nor is the journey brief. Rather it is long and winding.

When the chaplain enters the world of the police officer the initial reception may vary from acceptance to rejection. If the chaplain is known to the officers and a relationship has been built based upon previous contacts then entry may be eased somewhat. If the chaplain is unknown he may experience feelings ranging from indifference to ostracism. Hopefully there will be at least passive acceptance and toleration for his presence.

The chaplain must know who he or she is. His or her sense of calling must be clear. If it is then they will be willing to spend the time that it will take to establish their role as chaplain. Otherwise, he may soon become discouraged.

The chaplain must make a serious time commitment. They must visit the officers frequently enough to become a familiar face. They must go to the station often enough that the officers can identify them as a "regular".

The chaplain must assume responsibility for building relationships. They will need to initiate conversations, ask about how things are going, and speak a good word about something positive he has observed.

The chaplain must be a listener. What is happening in the lives of the officers? Who is buying a new home? Whose son is graduating from high school? Was the weekend hunting trip successful? How is the daughter who just had surgery? When is the new baby due...and how many kids will that make at home? The bits and pieces of news that are picked up while riding in the patrol car or waiting for roll call are the basis for conversations. Conversations are the basis on which relationships are built.

The chaplain should be an affirmer. Generally we live in a non-affirming society. Criticism is easy to come by and it is a frequent visitor in the lives of most people. Affirmation comes calling much more infrequently. Criticism is a constant companion of the police officer. The officer seldom arrives as quickly as needed. He uses too little tact and too much force in making an arrest. He forgets to put on his hat when making a traffic stop. The counseling register lists far more disciplinary actions than accolades.

Affirmation helps close the distance between officers and chaplains. When an officer maintains his composure in the face of an irate citizen venting his anger about some matter over which the officer had no control, the chaplain may say,

"You handled that very well." A simple comment. Yet for the officer who seldom hears much approbation it is better than a raise in pay (almost).

The chaplain should acknowledge special events. Birthdays, weddings anniversaries, completion of a college semester, and other significant milestones should be acknowledged. The death of a family member is a time when a visit to the funeral home will communicate boldly that the chaplain cares about the officer and be long remembered. These special remembrances become the foundation on which the chaplain achieves acceptance.

If the chaplain demonstrates sensitivity to the officers as individuals he will need not worry about acceptance. Gradually the word will be shared form officer to officer: "The chaplain is okay"...

No. Acceptance will not come overnight. But it will come. The route behind the BLUE WALL is not short nor is the journey brief. But it is well worth the taking.

WHAT IS A POLICEMAN?

He is a composite of what all men are, a mingling of saint and sinner, dust and deity.

Culled statistics wave the fan over the stinkers, underscore instances of dishonesty and brutality because they are news. What that really means is that they are exceptional, unusual, and not commonplace.

Buried under the froth are the facts. Less than one-half of one percent of police officers misfit the uniform. That's a better average than you will find among clergy.

What is a police officer made of? They, of all people, are at once the most needed and the most unwanted.

They are a strangely nameless creature who is "Sir" or "Ma'am"' to their face and "fuzz" behind their back. They must be such a diplomat that they can settle differences between individuals so that each will think he won.

But...if they are neat, they're conceited; if they're careless, they're a bum.

If they are pleasant, they are a flirt; if not, they're a grouch. They must make, in an instant, decisions which would require months for an attorney.

But...if they hurry, they're careless; if they are deliberate, they're lazy.

They must be first to an accident and infallible with their diagnosis.

They must be able to start breathing, stop bleeding, tie splints and, above all, be sure the victim goes home without a limp, or expect to be sued.

The police officer must know every gun, draw on the run and hit where it doesn't hurt. They must be able to whip two men twice their size and half their age without damaging their uniform and without being "brutal".

If you hit an officer, they're a coward; If they hit you, they're a bully. They must know everything and not tell; Know where the sin is and not partake.

They must, from a single human hair, be able to describe the crime, the weapon, and the criminal and tell you where the criminal is hiding.

But... if they catch the criminal, their lucky; if they don't, they're a dunce.

If they get promoted, they have pull; if not they're a dullard.

They must chase bum leads to a dead-end, stakeout ten nights to tag one witness who saw "it" happen, but refuses to remember.

They run files and write reports until they ache in order to build a case against a felon who will get "dealt out".

They must be a minister, a social worker, a diplomat, a tough guy, and a gentleman/lady, and, of course, they will have to be a genius since they will have to feed a family on a policeman's salary.

Article ~

POLICE CHAPLAIN PROGRAMS AND THE CONSTITUTION
Source Unknown

The first amendment to the constitution of the United States provides the following protection: Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

One court summarized the protection of the first amendment thusly: "The amendment protests freedom of (religious) speech and expression of view. It protects the free exercise of religion. And it insures freedom of religious worship by prohibiting the government from any establishment of religion."

The supreme court articulated a three prong test in 1971 to determine whether a statute or government policy will offend the establishment clause of the first amendment. In Lemon vs. Kurtzman, (403 U.S. 602, (1971), the court said that: "First, the statute must have a secular legislative purpose; second, it's principal or primary effect must be one that neither advances nor inhibits religion; and finally, the statute must not foster an excessive government entanglement with religion."

SECULAR PURPOSE

The government act in question must not have a religious purpose. The supreme court has explained that there can be no "Animus of Religion" in the design or goal of the program. Religious tests for public employment are unconstitutional, per se. But, the court has also made clear that the presence of religious purposes would not doom a law or practice, as long as there was also a secular purpose. "The court has invalidated legislation or governmental action on the ground that a secular purpose was lacking, but only when it has concluded there was no question that the statute or activity was motivated wholly by religious considerations. Even where the benefits to religion were substantial we saw a secular purpose and no conflict with the establishment clause." Id. at p680. accord, Wallace V. Jaffree, Van Zandt V. Thompson, where the 7th Cir. Ct. of appeals held that the prayer room in the state capitol has the secular purpose of promoting meditation: "The resolution (Authorizing the Prayer Room) suggests that (The Legislators) may legislate better for having taken some time to thing quietly";

In Carter V. Broadlawns Medical Center, A case challenging a hospital Chaplaincy program, the 8th Cir. held that the district court plainly erred by focusing almost exclusively on the religious purpose in isolation from the larger context, which reveals a valid secular purpose (To Help The Patients Get Well). Thus, as long as there is a valid overall SECULAR PURPOSE, there may be religious benefits to the program without violating the first prong of the lemon test.

PRIMARY EFFECT TEST

The second prong of the lemon test states that the principal or primary effect of a law or program must be one that neither advances nor inhibits the practice of religion. Just because a program has a "primary" effect to promote some legitimate secular end, nevertheless the program may be further examined to ascertain whether it also has the direct and immediate effect of advancing religion. "Secular objectives no matter how desirable and irrespective of whether judges might possess sufficient sensitive calipers to ascertain whether the secular benefits outweigh the sectarian benefits, cannot serve... to justify... a direct and substantial advancement of religion."

However, the impact on religion must be direct and substantial. Where government action does not directly endorse religion or a particular religious practice, its primary secular effect is not rendered unconstitutional merely because it happens to harmonize with the tenants of religions. The mere fact that a religious organization receives an incidental benefit under a government policy does not violate the privacy effect prong. In Lynch vs. Donnelly, the supreme court stated that their precedents plainly contemplate that on occasion some advancement of religion will result from government action, but not every law that confers an "indirect", "remote", or incidental benefit upon religion is, for that reason alone, constitutionally invalid. However, the court said focus exclusively on the religious component of any activity would inevitably lead to its invalidation under the establishment clause.

In Carter vs. Broadlawns, the hospital Chaplaincy program was challenged on the grounds that it violated the effect test by providing financial aid to enable persons in its care to practice their religions. While the district court concluded that paying a chaplain to provide religious care is an advancement of religion, the 8th Cir. noted that some financial benefit to religion can be tolerated in applying the lemon test. It distinguished the neutrality of employing a counselor with the versatility and training to help persons all along the continuum of religious dispositions from cases where the effect was more direct and selective.

As the court stated in Voswinkel vs. City of Charlotte, supra, "The agreement here (between the city and Providence Baptist Church) necessarily has several obvious, direct, and constitutionally impermissible effects:

1. It provides for a publicly funded position that must, under the terms of the agreement, be filled by a "Minister". To the extent that one's status as a minister depends on some degree of adherence to the creed of, and is subject to control by, the denomination one serves, the agreement necessarily imposes a religious test for eligibility to a publicly funded office.

EXCESSIVE ENTANGLEMENT TEST

The final question under the lemon test is whether the challenged practice gives rise to an excessive government entanglement with religion. Government oversight - determining what material is religious and what is not, inquiries into religious doctrine, detailed monitoring or close administrative contact - is likely to violate the undue entanglement prong of the test. For instance, in 1981 the

supreme court said that a university would risk greater entanglement by attempting to enforce its exclusion of "Religious Worship" and "Religious Speech" than by opening its forum to religious as well as non religious speakers.

Oversight of the chaplains themselves risks undue entanglement. The district court in the Voswinkel case in North Carolina held there was undue entanglement because it was not clear to whom the chaplain must answer, in the last analysis, in the performance of his duties. Supra. thus giving chaplains as much independence as possible in performing their duties is desirable.

AVOIDING FIRST AMENDMENT PROBLEMS

It is evident we must be careful to avoid running afoul of the first amendment's establishment clause. The court in the Voswinkel case, though only a U.S. District Court, has given some guidance that should withstand the scrutiny of the U.S. Supreme Court: "The creation of a counseling position to which any counselor could apply and be considered on religiously neutral grounds in not a government action that could reasonably be said to threaten "An establishment of religion". "The city may, of course, spend money to provide its police officers with the purely secular services described in the agreement (between the city and the church). There is nothing ;unconstitutional in hiring a clergyman to perform those services, so long as the clergyman is selected as the result of a religiously neutral process rather than, as here, pursuant to a contract with a specific church that restricts eligibility to ministers. Indeed, to reject a job applicant because he is a minister would violate the first amendment prohibition against government interference with the "Free Exercise of Religion", as well as statutory prohibitions against religious discrimination in employment. Neutrality in religious matters, not hostility toward religion, is what the constitution requires. The court does on believe that a public employee, hired as a counselor through some neutral selection process, is constitutionally required to refrain from discussing "spiritual" or "moral" matters in the course of his counseling duties. There is nothing unconstitutional, per se, in a church's donating money or property to a governmental entity or in the passage of money from a government entity to a church for some purpose that does not threaten to assist religion or to entangle govt. excessively in religious affairs.

Any Chaplaincy program should have no constitution problems if:

1. The program has a "secular" purpose,
2. Is religiously neutral, and
3. Avoids excessive religious entanglement.
4. It is a long standing program (History)

A GUIDE TO GRIEF

By National Hospice and Palliative Care Organization

Grief is a normal response to loss. It can be the loss of a home, job, marriage or a love one. Often the most painful loss is the death of a person you love, whether from a long illness or from an accident or an act of violence.

This guide will help you understand the grief you and others may feel after a death, whether sudden or anticipated. We hope this guide will help you realize that these feelings are not unusual and things can get better. You are not alone.

The Grieving Process

Grief is painful and at times the pain seems unbearable. It is a combination of many emotions that come and go, sometimes without warning. Grieving is the period during which we actively experience these emotions. How long and how difficult the grieving period is depends on the relationship with the person who dies, the circumstances of the death, and the situation of the survivors. The length of time people grieve can be weeks, months, and even years. One thing is certain: grief does not follow a timetable, but it does ease over time.

Because grief is so painful, some people try to “get over” a loss by denying the pain. Studies show that when people don’t deal with the emotions of grief, the pain does not go away. It remains with them, and can turn up in unrecognizable and sometimes destructive ways. Understanding the emotions of grief and its feeling and symptoms are important steps in healing and in helping others who may be grieving.

The Feelings and Symptoms of Grief

Experts describe the process of grieving and the emotions of grief in various ways The most commonly described reactions are: Shock, Denial, Anger, Guilt, Depression, Acceptance, and Growth. Some people experience the grieving process in this order. Most often, a person feels several of these emotions at the same time, perhaps in different degrees.

Shock

If the death comes suddenly, as in an accident or murder, shock is often the first response people feel. Even if the death is anticipated, there may be disbelief at its finality. A person may be numb, or, like a robot, be able to go through the motions of life while actually feeling little. At the same time, physical symptoms such as confusion and loss of appetite are common.

Denial

Shock and denial are nature’s way of softening the immediate blow of death. Denial can follow soon after the initial shock. People may know their loved one has died, but some part of them can’t yet accept the reality of the death. It is not uncommon to fantasize that the deceased will walk through the door, as if nothing has happened. Some people leave bedrooms unchanged or make future plans as if the loved one will participate, just as in the past.

Anger
Anger is normal. It may be directed at the deceased for leaving and causing a sense of abandonment, or at the doctors and nurses who did not do enough, or at a murderer who killed without remorse. People of faith may feel anger at God, for allowing so much pain and anguish. Anger may also be directed at oneself for not saving the life of the loved one. It can be a mild feeling or a raging irrational emotion. It can test one's faith in religion or even in the goodness of life.

Guilt
Few survivors escape some feeling of guilt and regret. "I should have done more" are words that haunt many people. Were angry words exchanged? Most people are very creative in finding reasons for guilt. So many things could have been done differently "if only I had known."

Sadness
Sadness is the most inevitable emotion of grief. It is normal to feel abandoned, alone and afraid. After the shock and denial have passed and the anger has been exhausted, sadness and even hopelessness may set in. A person may have little energy to do even the simplest daily chores. Crying episodes may seem endless.

Acceptance
Time alone will not heal grief. Acknowledging the loss and experiencing the pain may free the survivor from a yearning to return to the past. Accepting life without the lost loved one may give way to a new perspective about the future. Acceptance does not mean forgetting, but rather using the memories to create a new life without the loved one. Hoping for things to be as they were may be replaced by a search for new relationships and new activities.

Growth
Grief is a chance for personal growth. For many people, it may eventually lead to renewed energy to invest in new activities and new relationships. Some people seek meaning in their loss and get involved in causes or projects that help others.

Some people find a new compassion in themselves as a result of the pain they have suffered. They may become more sensitive to others, thus enabling richer relationships. Others find new strength and independence they never knew they had. After the loss, they find new emotional resources that had not been apparent before.

The Experience of Grief

Grieving people have two choices: they can avoid the pain and all the other emotions associated with their loss and continue on, hoping to forget. This is a risky choice, since experience shows that grief, when ignored, continues to cause pain. The other choice is to recognize grieving and seek healing and growth. Getting over a loss is slow, hard work. In order for growth to be possible, it is essential to allow oneself to feel all the emotions that arise, as painful as they may be, and to treat oneself with patience and kindness.

Feel the Pain
Give into it - even give it precedence over other emotions and activities, because

grief is a pain that will get in the way later if it is ignored. Realize that grief has no timetable; it is cyclical, so expect the emotions to come and go for weeks, months or even years. While a show of strength is admirable, it does not serve the need to express sadness, even when it comes out at unexpected times and places.

Talk About Your Sorrow
Take the time to seek comfort from friends who will listen. Let them know you need to talk about your loss. People will understand, although they may not know how to respond. If they change the subject, explain that you need to share your memories and express your sorrow.

Forgive Yourself
Forgive yourself for all the things you believe you should have said or done. Also forgive yourself for the anger and guilt and embarrassment you may have felt while grieving.

Eat Well and Exercise
Grief is exhausting. To sustain your energy, be sure to maintain a balanced diet. Exercise is also important in sustaining energy. Find a routine that suits you - perhaps walks or bike rides with friends, or in solitude. Clear your mind and refresh your body.

Indulge Yourself
Take naps, read a good book, listen to your favorite music, get a manicure, go to a ball game, rent a movie. Do something that is frivolous, distracting and that you personally find comforting
.
Prepare for Holidays and Anniversaries
Many people feel especially “blue” during these periods, and the anniversary date of the death can be especially painful. Even if you think you’ve progressed, these dates may bring back some of your painful emotions. Make arrangements to be with friends and family members with whom you are comfortable. Plan activities that give you an opportunity to mark the anniversary.

Get Help
Bereavement groups can help you recognize your feelings and put them in perspective. They can also help alleviate the feeling that you are alone. The experience of sharing with others who are in a similar situation can be comforting and reassuring. Sometimes, new friendships group through these groups – even a whole new social network that you did not have before.

There are specialized groups for widowed persons, for parents who have lost a child, for victims of drunken drivers, etc. There are also groups that do not specialize. Check with your local hospice or other bereavement support groups for more information.

If you find that you are in great distress or in long-term depression, individual or group therapy from a counselor who specializes in grief may be advisable. You can ask your doctor for a referral.

Take Active Steps to Create a New Life for Yourself

Give yourself as much time to grieve as you need. Once you find new energy, begin to look for interesting things to do. Take courses, donate time to a cause you support, meet new people, or even find a new job

.

It is often tempting to try to replace the person who has been lost. Whether through adoption, remarriage, or other means; this form of reconciliation often does not work.

Many people discover that there is hope after death. Death takes away, but grief can give back. It is possible to recover from grief with new strengths and a new direction. By acting on our grief, we may eventually find peace and purpose.

Helping Those in Grief

You may know someone who has experienced a loss. Many of us feel awkward when someone dies, and don't know what to say or do. The suggestions below are designed to help your friends, family, and coworkers who are grieving.

Reach Out to the Grieving Person

Show your interest and share your caring feelings. Saying the wrong thing is better than saying nothing at all. At the same time, avoid clichés like, "It was God's will", or "God never give us more than we can bear", or "At least she isn't suffering". Do not say you know how it feels. Do say you are sorry and that you are available to listen. Be prepared for emotional feelings yourself. A death generates questions and fears about our own mortality.

Listen

Your greatest gift to a grieving person can be your willingness to listen. Ask about the deceased. Allowing the person to talk freely without fear of disapproval helps to create healthy memories. It is an important part of healing. While you can't resolve the grief, listening can help.

Ask How You Can Help

Taking over a simple task at home or at work is not only helpful, it also offers reassurance that you care. Be specific in your offer to do something and then follow up with action.

Remember Holidays and Anniversaries

These can be a very difficult time for those who are in grief. Do not allow the person to be isolated. Remember to share your home, yourself, or anything that may be of comfort.

Suggest Activities That You Can Do Together

Walking, biking, or other exercises can be an opportunity to talk, and a good source of energy for a tired body and mind. Help the grieving person find new activities and friends. Include grieving persons in your life. Grieving people may require some encouragement to get back into social situations. Be persistent, but try not to press them to participate before they are ready.

Pay Attention To Danger Signs

Signs that the grieving person is in distress might include weight loss, substance abuse, depression, prolonged sleep disorders, physical problems, talk about suicide, and lack of personal hygiene.

Observing these signs may mean the grieving person needs professional help. If you feel this is the case, a suggestion from you (if you feel close enough to the person), or from a trusted friend or family member may be appropriate. You might also want to point out community resources that may be helpful.

Death can be a painful and permanent loss experience, and one of the hardest from which to recover. Death takes away, but facing it and grieving can result in peace, new strengths and purpose.

Article ~

DEATH NOTIFICATION: SOME RECOMMENDATIONS

By Hubert Looney and Jerry L. Winsor

Without a doubt death is a most unpleasant, yet ever-present, reality for law enforcement officers. Law enforcement is a high-stress occupation for a variety of reasons, and the ubiquitous necessity of dealing with situations surrounding pre-mature death are significant contributing factors to the occupational stress. "Frequently," writes Friedrich Wenz. "line of duty/crisis situations include incidents in which the office must face tragic duties." Such duties he notes:

"...Include situations like telling a mother of her child's death, having to take a dead person to the morgue, or having, to clean up a body after an accident. The police observe death frequently and in a variety of situations, and exposure to death of others must register deeply on the mind of the law officer."

Doubtless the term "death" to a law enforcement officer brings to mind much more than the subtle, yet pervasive, fear of his or her own physical vulnerability. Unfortunately, in our society, few officers are encouraged to discuss death rationally, let alone develop a philosophy useful in facing tragic situations that are job-related. The purpose of this article is to deal practically with one aspect of this law enforcement stressor - death notification.

SOCIAL SERVICE FUNCTION

Many police officers have found death notification to be the hardest thing that they have done. It falls into the department's responsibility when no one else is available to do it. Perhaps the hardest task in all of law enforcement is that of telling a father and mother that their young son or daughter has been killed. Officers are affected most by this kind of death.

Because of its social services nature, death notification training has taken a back burner to other police services. Police organizations traditionally structure their training to contain approximately 80% police-related material and 20% services or social service material. In actual practice, the work turns out to be 80% social service in nature and 20% police related. Communication activities with citizens comprise the bulk of the modern officer's time.

SUGGESTIONS

Some suggestions we believe are helpful in accomplishing the task of death notification. There are no easy answers to a difficult job. We offer following:

1. Never take death information over the police radio. If the radio operator starts to do this, ask him to stop. Have him/her call you on the telephone or vice versa.
2. Obtain as much information as possible: what, when, where, and sometimes if possible, how. Disregard the why of the incident, you should not get into that during the notification (a simple answer to why is "I don't know").

3. Before you break off contact with your source of information make sure you have positive identification of the victim. Nothing is more inept than to be making the notification and have the supposed victim walk into the room, call on the phone, or later contact the grief stricken party. They may be elated at the moment, but later their elation will turn into bitterness for you and your department because of the trauma that you have caused.
4. Operating patrol vehicle emergency lights and flashers is inappropriate if department rules permit, keep a low profile when you park in front of the residence.
5. Never, if possible, carry a personal item of the victim with you. Leave all those items at the hospital or morgue. A simple note pad with the name or description written down will suffice.
6. Try by all means to get inside the residence before you deliver the message. If a medical emergency develops behind a closed door, you'll never know about it.
7. Never make the notification by telephone; the consequences could be too great.
8. Never go alone--a friend (of the victim), preferably a relative, can help break the news more easily. If your agency is fortunate to have an auxiliary chaplain available,, he or she may be of great help. Most people would rather hear the news from a relative than a policeman. Failing this, one officer in civilian clothes can be a help. Where possible, a female and male team of officers may function well in this capacity.
9. Try to asses the stability of the individual to whom the news must be broken. If in the officer's judgment, the person may be so shocked by the death notice that hospital treatment would be required, the officer should attempt to make some arrangement (i.e., one officer recalled an accident in which the child of a pregnant mother had just been killed. The mother was taken to the hospital on the pretext of making an identification of the child, so that the hospital personnel would be able to treat her when she reacted to the news.)
10. Relate the message straight out using a direct approach; i.e., "Your son had been involved in an accident. He has been killed." There is no way to soften the initial blow of this reality. Avoid jargon such as "your daughter was injured fatally." The message should be very clear at first hearing leaving no room for false hope as the word "injured" may allow.
11. If the family breaks down, you try to console the best you can. Almost any behavior is possible---anger, denial, questions, etc.- Physical violence is always a possibility. This possibility underscores the need for two people going on such calls.
12. Beware of the variety of reactions---some pass out, some become hysterical. Assess the situation. Read the non-verbal cues and try to anticipate needs e.g., a place to sit...some water. A "quick read" of the living environment may give you valuable hints to possible reactions.
13. If the person is alone, ask if there is a friend they could call or you could call that could come and be with them for a while. Men are just as emotional sometimes as women and; need the comfort of an understanding friend. If at all possible, stay until someone arrives.
14. It is usually better to be empathetic than sympathetic. The grieving person usually does not want sympathy from strangers. Feeling sorry for, is not as effective as feeling with the person. Some shared feelings may be most

meaningful. In no case should an officer's behavior give cause for false hope.

15. Be specific but tactful and try to avoid police jargon when explaining the situation; i.e., words like "fatality," "vehicular flow." and codes 11-44," etc. are out of place. Use plain language. Do not obscure the message and do not pass the buck. Center on meeting immediate needs. Do not get involved in a discussion of possible future actions.
16. Be prepared to spend a few minutes there. Don't drop the bomb and turn and walk out. Try to access the situation. The family may have a question or two as soon as the initial shock can be handled. If questioned, be as ho nest about the situation as you can. They will let you know verbally or emotionally that they are handling it and will most of the time cue you in some way that they wish to be alone.

CONCLUSION

This is by no means a complete guide on the subject. Every call will be different. We believe that the subject of death notification needs to be included in academy training and in-service workshops, and even then it will still be a difficult job.

Article ~

I'M SORRY TO INFORM YOU . . .

Rev. Randy Sly
Riley County Police Department
Manhattan, KS.

"I don't want to be here," the officer mutters to himself. he stands under the porch light, waiting for the door to open, knowing the news he has will drastically alter the world of those inside.

As the door swings open, a woman stands apprehensively holding her toddler close. The officer swallows hard, for Daddy won't be coming home tonight. Or ever...

Of all the tasks in police work, death notification ranks as one of the most difficult.

Many police departments enlist the help of volunteer chaplains as a part of their notification procedures. Most police chaplains, members of the local clergy, have training or expertise that orients them toward the "people side" of problems. They can form a strong alliance with the assigned officer to become a complementary team who can present the news of a death, deal with the necessary details that need to be exchanged, and still provide person-centered support in the process.

A request for a death notification is a simple, standardized procedure in most departments. Usually the procedure is to order an officer or other representative to make contact with the party and inform them of the situation. Notices are received at all times of the day or night and for a variety of reasons. However, what seems to be a routine assignment may end up more ;complicated when the officer arrives at the person's residence. The outcome of the assignment may affect the party's ability to deal with the news effectively. This emotional jeopardy may seem overstated, yet the first moments of any tragedy stay with individuals for a long time. In addition, wrongful handling can also provide an opportunity for a negative experience in community relations. The following 10 action points are offered in order to maximize the ability of a department to carry out the task of notification effectively and efficiently.

1. ASSIGN A CHAPLAIN OR CLERGY PERSON WITH THE OFFICER.

While many departments use chaplains, they are oftentimes overlooked in their usefulness. A hectic shift might cause a supervisor to just give the assignment to a patrol officer. Contacting the chaplain is seen as an option rather than a necessity and is viewed as a nuisance when everyone is busy.

Utilizing a chaplain frees police officers, many of whom are fully capable to handle such a task, but who may be unprepared, untrained, or unable to handle what can follow. Responses to such news can be as varied as the people being notified. The problem is not so much one of carrying out the task, but in doing it well.

Hospital chaplains are taught to understand the "ministry of presence," meaning that they provide a needed function to an individual just by being there. They are a human extension of care and concern. The same principle holds true for the area

of death notification, where the police chaplain of local clergyman becomes the "presence of compassion" during an extremely stressful time. This does not discredit the officer as a compassionate person, but softens the impact made by the image of someone in uniform.

2. VERIFY THAT CORRECT INFORMATION HAS BEEN RECEIVED.

Very early one morning, an officer and I knocked on a door and proceeded to convey the information as it had been communicated to the department. The woman became extremely distraught because we told her that her father had died, but gave the name of her brother. She wasn't sure who was dead and who was alive. It took several phone calls to clear everything up.

Informing a person of ate death of someone close is serious enough without confusion. While difficult to guarantee absolute accuracy, all those assigned to the task, chaplain, officer, supervisor, and dispatcher, should double-check all information for notification. This includes the name of the deceased, the name of the person to be notified, their addresses, the relationship to the deceased, and as much detail as possible surrounding the death. A follow-up call to the reporting agency may be necessary to re-confirm any ambiguous information.

3. TAKE SEPARATE VEHICLES.

When a chaplain and officer team make a notification call, each should travel in their own vehicle. This allows the chaplain to remain with the person while freeing the officer to return to patrol, etc. This is advantageous in most cases, except out-of-town calls, unusual circumstances or more dangerous settings.

When the team arrives at the location, they have no idea what they will encounter. Sometimes the person will become overly distraught and in need of longer term attention. Other times, he or she will become so disoriented that someone will need to make phone calls to bring friends or family for support. By arriving separately, each is able to stay as long as necessary without encumbering the officer in the process.

4. PLAN THE NOTIFICATION PROCEDURE.

The process should be outlined before the team leaves the station: who is going to do the talking, what is going to be said, how much can be said, etc. A death notification is usually better handled by the chaplain rather than the officer. The reason has less to do with ability than it does with position. A chaplain is traditionally viewed as the one charged with such responsibilities. He brings a sense of comfort into the process. I recommend that officers initiate contact with the person. The conversation might go something like this: "Good evening, are you Joe Taylor? I'm Officer Smith and this is Chaplain Jones from the police department. May we come in?"

The chaplain takes the lead in getting the people comfortable and giving the news. By proceeding this way, the officer provides authority and endorsement for the chaplain to do his work. He can add details and provide whatever support the chaplain may need.

This cooperative effort works to the advantage of the person being informed. One notification involved the tragic death of a little boy. I accompanied a female officer to notify his mother. After the news was given, the woman melted into the arms of the officer who provided exceptional emotional support at a critical time. We had already decided, before entering, that this would be the best way to handle the situation.

Chaplains, especially if they are new or infrequently used might not initiate the planning needed. As a volunteer, they feel somewhat awkward since this is not their domain. Officers should feel free to offer this opportunity to them, and invite them to take the lead.

5. THE TEAM'S PRESENCE ALREADY INDICATES SOMETHING HAS HAPPENED.

Those bearing bad news are tempted to hedge, to begin with small talk and avoid the real reason. The family would be better served by telling them up front what happened. The presence of an officer and chaplain has already alerted them of a problem. They have braced themselves and are not interested in idle chatter.

The actual notification procedure is quite simple. First establish the relationship between the party and the deceased. Next, inform the person of the death, slowly and carefully giving any details available. Then, calmly answer any questions they may have. If you don't know the answer, assure them that one may be found.

6. TRY TO GET PEOPLE INTO A COMFORTABLE SETTING.

We already mentioned giving the information first thing, but a moment will be needed to move into the privacy of the home (or other more secure setting). This will place the person to be in a better position to receive bad news. Since you have no idea how the party will react, ask to go inside rather than give the notification on the doorstep.

Ask the person(s) to be seated, or, at least, find a comfortable position. If other family members are present, they will naturally move to a supportive position, so give them a moment to do that.

When the notification must be made at a place of business, the person's supervisor should be contacted first and asked for assistance in getting the person to a place of privacy. Request that the supervisor remain with the person and have another close friend at the business (if possible) be present as well.

7. BE SENSITIVE TO SURROUNDINGS.

This point is closely related to the previous one. Notifying someone of a death can result in extreme emotional behavior. Often, we forget that there may be little children around or others nearby who may not understand what is taking place. When approaching the location, try to determine the dynamics that must be taken into account.

I once had to notify a mother that her son had been killed in a school bus accident. Upon arrival in the dentist's office where she worked, we found she was the receptionist. We had no opportunity to talk to the supervisor first. We asked the woman to take us to a private room and proceeded to share the news. The officer remained with the woman, while I sought out the woman's supervisor - one of the dentists. He was able to come in and provide additional comfort and support. he also had to deal with another sensitive problem--the woman's cries were very disquieting to the waiting patients.

8. PROVIDE A POLICE DEPARTMENT CONTACT.

Many questions arise in the mind of the person after the officer leaves. Be sure to leave a card with the name and number of the officer, the chaplain, or someone with the police department (victim assistance, community relations, etc.) who can be of further assistance.

Also, people are often in shock after receiving the news of a death and can confuse the facts. This phone number will give them an opportunity to clarify any blurred information and lesson the possibility of a misunderstanding, which later could be blamed on the department.

9. INITIATE A FOLLOW-UP.

Some people might feel abandoned after the initial notification. Some want clarification, others are unsure how they need to respond, still others didn't know what arrangements are necessary. The work of a chaplain can continue until such time as the party has made contact with their own clergyman, counselor, or other appropriate person who can go through the details with them.

One of my hardest assignments involved the murder of a teenager. After notifying his parents, I checked back with them later and even met with the father at the funeral home when he identified the body. Through these contacts, I was able to put the family in touch with the correct people at the police department, victim assistance, etc.

10. ASK IF THERE IS A RELATIVE, FRIEND, OR CLERGY PERSON THE WOULD LIKE TO HAVE CONTACTED.

The officer and/or chaplain provide the first line of support. In order for that care to continue, inquire if there is anyone you can contact for them, thus removing the burden of making a call at a very emotional time. Those I have called really appreciated the call. I then try to remain there until they arrive.

No one likes to deliver death notices, yet departments are regularly called upon to render this service. Communicating this information is a common occurrence, but it must not be treated commonly. The impact of notification can make a big difference in the ability of the informed party to handle the news appropriately. By implementing a person-centered and person-sensitive approach to death notification, departments can serve their communities in a vital and meaningful way.

You may not see your work in this area praised by the press but, be assured, it is acknowledged and appreciated by the people you touch.

Article ~

PROTECT YOURSELF FROM THE DEAD

Chaplain Harold Elliott, Arlington, TX PD

Police officers are constantly being taught street survival, and most of us shudder at the behavior of an unthinking officer who fails to protect himself. There is the ongoing discussion of how large a weapon should be carried and how many spare bullets should be at the officer's immediate disposal. All this is important, but no less important is that the dead will kill you too. It just takes the dead a bit longer to do the job. The living will shoot you, knife you, club you, or run over you. The dead will blow your mind apart and vandalize your emotions until you become a shell of a human being. These are the trappings of death.

Ask any officer to describe the first death scene he worked and he will remember almost every detail. He can recall the position of the body, facial expression, open or closed eyes, location of wounds, and type of clothing worn. No matter how many years ago, he'll still remember… of all the things we forget, it never seems to be a death scene. That being the case, it only stands to reason that an accumulation of such sights eventually takes its toll on an officer, unless he safeguards himself.

There is a social norm among many police officers which says, "Thou shalt have no unexplained reactions to the things which thou hast seen" So, they spend a bulk of their lives trying to convince themselves and others that they are totally unaffected by dealing with the dead.

Lectures on the subject can help, but they don't eliminate the impact of direct, prolonged experience; that can be a killer. I remember an old man who used to stroll the streets of my hometown with a sad face, bland personality, and a walk that resembled a funeral march. I never knew his name, but my mother always referred to him as "that old man who's dead and doesn't know it." The dead may not physically kill you but they can sap your emotional resourcefulness until you are about as useful as they.

How you receive death will make a considerable difference in the effect a corpse will have on you:

Those who equate human and animal death will likely become cynical, and persuade themselves that no scene is too bloody for them to view and remain unaffected. This illusion is generally exposed when the officer loses someone he loves.

Those who view death as the doorway into eternity will normally feel a sense of tender emotion. they may feel stress because of man's inhumanity to man or man's inhumanity to himself.

The job demands that an officer view death scenes. However, it does not demand that each officer view them in the same manner. Whenever I see a body, regardless of the circumstances surrounding the death, I view it as a wax figure in a museum. Some officers see the dead as mannequins. Others may view them as

evidence in the overall investigation. Still another may see the victim as only an object that once was alive and is now only a shell. Whatever image one may concoct, the result is the same: dehumanization of the victim. This isn't wrong, in fact, it is a natural part of our built-in survival kit.

Some officers would rather not show their real emotions at a death scene. Certain feelings are simply natural to human beings, and should not be construed as signs of weakness. For example, when alone in a room with a body, experiencing an eerie feeling; if the victim is child, female, or helpless individual, feeling intense grief; if sexual deviation is involved, feeling repulsion.

Officers also feel angry if death and mutilation are related to drugs or alcohol; if the victim was viewed by a family member, especially children, the officer may be moved to sympathy; and he will feel shock, the same as any other individual, if the victim is known to him personally.

Though most officers will contain themselves at the scene, if the victim reminds him of a loved one, he will probably cry when alone. It isn't uncommon for sickness to affect those who must work an exceedingly violent scene. Nausea is common if the odor is overpowering and the body of the victim is decomposed.

The dead person troubles us, disturbs our peace, gives us the creeps, stirs our fears, and gives us nightmares. Even the policeman's badge isn't thick enough to prevent it, and there isn't enough authority in the book to ward it off.

But we aren't defenseless. Take a look at some safeguards against being overcome:

Talk it out. Talk is good therapy. Some officers choose to talk to other officers. However, there is always the fear of appearing weak in the eyes of a comrade if true emotions are revealed. In departments where a chaplain is present, the officer may feel a freedom to bare his soul with the assurance of strict confidentiality. The officer who shares with his spouse is utilizing a good source of understanding. Every blood and guts detail need not be divulged to relate the story and get relief.

Crying is OK. Obviously there is a time and place for everything, but it should not be forgotten that crying makes us no less professional. Tears are terrific for washing away hurt. Some officers have wept at the scene and there is certainly no reason for apology, but whenever possible the officer will normally do this when alone.

Humor. Although humor should never be crude, and great precaution must be taken to avoid its use in the presence of family members or persons outside the police department, it should be recognized that well-placed humor is great release. It isn't necessarily disrespectful to use some humor at a death scene. Humor is a real salvation to those who use it wisely and at the appropriate place and time.

Take a break. Though it is necessary to view the victim, photograph the entire scene, and sometimes handle the body, it isn't necessary to stare at it over a prolonged period of time without a break. Take time out to regroup your thoughts,

get a breath of fresh air, and let your mind remove itself from the ugly sight of death.

Be prepared for, and understand something about, post-traumatic stress disorders. Two types of disorders are prevalent. First, the acute disorder has symptoms which occur immediately after or sometime during the event. They are things such as frequent urination, or an uncontrollable desire to just break away and run from it all. After a particularly difficult experience with a tragic death situation one officer said to me, "I hate this fob, I just want to get out of the whole mess." It had only been a few days before that he had sat in my office and related how much he loved police work.

Second, the delayed disorders are those which may occur two days, two weeks, or two years after an event or series of events. They include things such as sleep disorders, flashbacks, isolation and depression. I know one officer, who after working homicide in a major city, requested a transfer to any division in the department which didn't deal with death. Death had stacked up on him until he felt he could not stand it if he had to see another body. The number of gruesome death scenes the officer has experienced in a short time will obviously make him more prone toward post-traumatic stress disorders, especially the inexperienced officer.

The officer who is honest with himself will accept the fact that he is only human, and it is natural for humans to hurt at the sight of needless death, injury and mutilation. Wise is the officer who takes off his superman suit, and allows himself to be just plain Clark Kent.

Officers can't avoid blood in the alley and brains on the ceiling, but they can learn to deal with it in a manner which will preserve their own mental and physical health. If professional help is needed, get it. It is a weak person who thinks of himself as too strong to need support.

How strongly a person reacts to a situation depends on that person as an individual. The officer who continually holds in painful emotions or does not react at all, is a likely candidate for severe emotional problems. The wise officer takes the precaution of watching the living, avoiding needless danger, and not living in a mental graveyard.

Remember, the living can kill you physically, while the dead can kill you emotionally.

Protect Yourself From The Dead originally appeared in the April 1985 issue of Police Product News. Used here by permission.

Article ~

APNEA, SUDDEN INFANT DEATH SYNDROME,
AND HOME MONITORS: PSYCHO-SOCIAL ISSUES

Judy A. Duncan, Ma., MSW.

Since the Sudden Infant Death Syndrome (SIDS) is the most common cause of death during the first year of life in both term and premature infants, the use of home monitoring is rapidly increasing. The psycho-social issues surrounding apnea and SIDS and the impact of home monitoring on the family are discussed.

The most common cause of death in normal infants and graduates of Neonatal Intensive Care units during the first year of life is the Sudden Infant Death Syndrome (SIDS). One of the fastest growing industries in the health care field is providing home monitoring. Subsequent siblings of SIDS victims are at increased risk for SIDS themselves, or are they? What should we do for the child with an apparent life-threatening event? How does all of this relate and how does it apply to perinatal health professionals?

SUDDEN INFANT DEATH SYNDROME

Is not possible to discuss home monitoring and apnea without talking about SIDS. They are regularly linked in the minds of the general public and the health care community as well. It is important to clarify that the relationship of SIDS to apnea is only circumstantial. There is also no conclusive evidence demonstrating that monitors can prevent SIDS.

By definition, SIDS is "the sudden death of any infant that is unexpected by history and in which a thorough postmortem exam fails to demonstrate an adequate cause of death." Therefore, SIDS can only be declared a cause of death after an autopsy. What the pathologist is really saying is that he does not know why the child died.

SIDS is the number one cause of death for all infants between the ages of 1 month and 1 year. The rate is about 2/1000 in the United States and kills about 6000 babies a year. The peak ages for death are from 2 to 4 months, with a sharp decline after 6 months of age. More deaths occur in the winter months. We do not know why there is an age or seasonal variation.

The parent needs to know that SIDS cannot be predicted. The parents are blameless. The first real indication of increased risk for SIDS comes when the parents find the baby already dead. The fear of SIDS exists for all families. We need to be extremely cautious about adding to that fear by exaggerating the incidence of SIDS. We also need to be cautious about leading families to believe that we know what SIDS is and how to prevent it. We clearly do not.

ISSUES OF SIDS IN THE PREMATURE INFANT

In some ways SIDS following a premature birth causes even more anguish for the parents, and certainly hospital staff, than the death of a normal child. This is due to the fact that a premature baby may struggle to survive for weeks and sometimes for months, finally leaving the hospital and going home. For the perinatal health

professional there has been more time to build a relationship with the family during the premature baby's hospitalization. The infant's death comes as a cruel blow to all who have provided care. Sometimes hospital staff members question their clinical judgments regarding discharge. They wonder if they missed something, or left something undone. Sometimes the family places blame on hospital staff. More often, though they share the tragedy.

Prior to discharging a premature infant, the basic work with the family may center on the resolution of acute distress and fear. All families need support and information about the child's condition and likely clinical course. They need the opportunity to explore their feelings about grieving for the healthy, full-term baby they expected, but did not get, and to learn to accept and appreciate the baby they really have.

Throughout the infant's hospitalization, the time is available to assess the family member's strengths, weaknesses, and interpersonal styles, as individuals and as a unit. We can help the family use or build networks. We can assess their ability to problem solve by watching which coping mechanisms they choose, and how well they use them.

Particular areas need special attention. By the time discharge draws near, the parents have usually become familiar with monitors and may be uncomfortable about going home without one. The majority of infants who have not had significant apnea or bradycardia for the week prior to discharge are not in need of home monitors. Infants must be carefully selected for monitoring and the advantages and disadvantages of this option clearly delineated. Once decided, staff should teach the family how to use the home equipment while in the hospital and use it for the remainder of the infant's stay. This plan helps establish an easier transition from hospital to home. It also allows the staff to tailor the learning process to the individual family's needs and gives the family a chance to practice in a safe environment. It also enables the hospital staff to reinforce the concept of competency of the parents as the primary caregivers. It is vital that the apnea program coordinator and nurse work as a team. It is also important that the parents become part of the team caring for the infant and responsibility for the child's well-being can be shifted gradually form staff to parents. Apneic events can be simulated so that parents gain additional experience with problem solving.

SIDS AND THE SUBSEQUENT PREGNANCY

The process of building a relationship with the family following a SIDS death can begin during the subsequent pregnancy, sometimes even during the period between the SIDS death and the next pregnancy. The sooner the process begins the better. The pregnancy following a SIDS death primarily will deal with two basic issues, the SIDS death and safeguarding the expected child. The first step is to confirm that the baby died from SIDS by reviewing the autopsy. We have found several cases where the previous sibling had not died from SIDS. Revealing this to a family and helping then deal with such information requires sensitivity and time. The second step in the counseling process is to determine what needs the family has. There is often much unfinished business related to the grief process, especially if the child has recently died. For some parents this is the first time they have ever talked about the death of their child and the impact of that death on

them separately, as a couple, and as a family. It may also be the first time the parents have openly discussed their feelings, fears, and sense of loss with each other. I feel strongly that the initial session should be with both parents. A separate session can include siblings, grandparents, and other as appropriate.

Sessions can be done jointly by a nurse or a worker, and the physician. Families are more incline to believe the facts about SIDS from a physician. They usually direct medical questions to him or her. It is helpful to have a health team composed of one male and one female interview a couple to decrease issues of power, control, and transference, and enhance modeling and support. Any team member can provide legitimacy and offer generalized statements about grief reactions or SIDS misconceptions.

It is important to assess how other siblings in the family (if any) are dealing with their own sense of loss and their reactions to the subsequent child. Parents may need encouragement or reinforcement to approach such topics with their children. They also may need education about what is age appropriate. Parents and children alike may have been trying to protect one another by not sharing feelings of grief, anger, fear and guilt.

Equally important as the meaning of the loss is the meaning and place of the new child in the family. Is the child thought of as replacement for the dead infant? Or is the child thought of as a child in his or her own right?

Families may have the idea that the subsequent sibling is somehow sick or different that other newborn infants. Parents may experience strong tendencies to be overprotective. Others may find it difficult to approach the baby and begin the process of bonding and attachment. The vast majority of families can successfully accomplish the task of incorporating the new infant into their family structure in constructive ways. What they need is information and support over time. Meeting those needs is certainly not new to perinatal health professionals.

The family concerns for safeguarding the new infant present themselves in a wide variety of ways. Some families will not leave the hospital without a monitor; others will not use the monitor under any circumstances. Some wait to decide until the child is one month old, and some when the new baby reaches the age at which the previous child died. The decision to monitor or not belongs to the family.

Currently there is no testing available, whether simple impedance or full scale sleep studies, that can identify infants at risk for SIDS. Indeed, Southall's prospective study of over 9000 infants demonstrated that two channel impedance recordings were not predictive. Finally, parents and health care professionals need to be clear that monitors cannot guarantee that an infant will not die from SIDS.

The perinatal staff needs to be sensitive to parental fears and anxieties. The usual nursery, postpartum and visitation arrangements may not be appropriate or adequate for these families. Mothers may be afraid to have rooming-in, or afraid to have the baby out of sight. Fathers may need to have longer and easier access to mothers and babies. Older siblings may need to actually see and touch the new baby. Mothers may have problems with breast feeding as a result of tension.

Infants might have to stay in the nursery for observation and testing. Some may have to be transferred to hospitals equipped for such testing.

There is a special category of SIDS sibling, when one infant of a multiple birth dies from crib death. The survivor is at increased risk. Most programs will then automatically evaluate and monitor the survivor. The impact of the death is compounded by the problems associated with home monitoring. These families need especially intense and prolonged support.

INFANTS PRESENTING THROUGH EMERGENCY DEPARTMENTS

Parents are routinely seen in emergency departments with infants who have stopped breathing, turned blue or are limp or unresponsive. All of these complaints need to be taken seriously. If the infant arrives in poor condition, or if paramedic reports confirm the parent's story, then the child is seen and evaluated, even admitted for observation or workup. If the infant arrives in good condition with nothing abnormal on exam and there is no corroboration of the event, many facilities send the family home. Most parents get a clear message that they overreacted.

It may be that the infant experienced "normal" (very brief) apnea, or a physiologic event during sleep. Perhaps the child choked on secretions and could have spontaneously resolved the spell with time. Providing the parents with these explanations for physiologic apnea is a component of quality care. However, the worst scenario would be to send the family home because the baby looked fine, only to have the child return dead because of an undetected etiology.

The burden of proof to document the etiology of the spells resets with the medical staff. The reported event should not be taken lightly regardless of the child's apparent good condition.

If the parents work and the child is brought in by a caregiver, or if one parent saw the episode and the other did not, a more complex situation exists. Those who did not see the episode may not believe it really happened, or that it was a severe as reported. Or there may be anger and blame directed toward the caregiver for not really watching the baby or not responding in an adequate manner to the medical emergency. At the same time the caregiver may be feeling totally responsible for the event and need support for the quality of care he or she provided.

Each family member or caregiver will assign meaning and significance to the event. Most people equate any cessation of breathing, whether awake or asleep, with crib death in the making. Most people fear that there would have been brain damage or death if then had not intervened. Most will still have questions and fears about the possibility of brain damage. Most believe that the spells will recur.

It is important to know if this is the child's first episode, a repeat episode or an episode that has happened during home monitoring. The concerns of the parents may vary. if it is one of many episodes, the family may feel the child is not making progress. They may be angry with the medical staff for not identifying and better managing the child's condition. They may be resigned and feel defeated in their efforts to care for their child, or they may be relieved to have the child hospitalized

and the burden of care removed from them, at least for a while. They may feel vindicated with a repeat episode when the initial episode was not taken seriously.

One of the most frightening things we can do to a family is to label these episodes as "near-miss SIDS" or an "aborted crib death." Can you imagine what you would think if you were the parent? You would fear or expect a real crib death at some future time. What does that notion do to feelings of security, family structure, and the continuation of attachment to the infant?

HOME MONITORING: IMPACT ON FAMILIES

It is not possible to introduce the element of home monitoring in to a family without creating change and the need to accommodate. Not all the changes are negative, not all are positive, but all families change.

There is always the possibility that the monitored child will be seen as ill or different from other newborns or other children in the family. At times the issue of home monitoring is seen as the cause of problems that actually predate the monitor and the child.

The basic explanation for many of the medical problems that result in home monitoring relates to developmental tasks the child must accomplish. Seen in this way, most families can begin to see their child as more normal that sick. This is a key concern for families and has to be addressed. Most often the social worker is the first to appreciate this.

Child abuse potentials exist for parents of monitored children just as they do far any et of parents. There are high levels of fear, frustration, anger, and isolation. Parents may be overwhelmed by the incorporation of the child into the family unit, let alone a child attached to a monitor. Assessing levels of parental expectations and realities is essential.

Practical issues of everyday life are also affected. The caregiver must always be physically close to the child to answer an alarm, as well as being able to hear the alarm. Simple chores like washing dishes or running a lawn mower have to be considered from the standpoint of alarm response time. None of these are impossible to do, but the parents need help altering their perspectives and learning to deal with such issues on their own.

There are many concerns about home monitoring. These notions may be held by the family, friends, relatives, or neighbors. We can provide anticipatory counseling so parents can go home knowing what to expect. Common misconceptions are 1) that the monitor can electrocute the child, 2) the child will be developmentally delayed by reasons of being confined and having movement restricted, 3) the child's condition is contagious, especially if the cause of the apnea is unknown, or if this is a SIDS sibling, and 4) the monitor will prevent death.

In the face of such enormous responsibility, stress, and fear, it is possible that the mother will become totally absorbed in the baby. This preoccupation can be to the exclusion of self -interest, involvement with other siblings, career goals, personal relationships, social activities, and marital relationships. Discord and dysfunction

can occur in any or all of these areas. Sometimes the mother is burdened with the entire responsibility for the care of the infant. This may evolve from a lack of resources for respite. It may be self imposed, imposed on her by other family members (often the father), or because she believe the infant is vulnerable despite the monitor.

Parents can be overwhelmed emotionally by the impact of monitoring. It can be frightening to assume such responsibility. Strong negative feelings toward the child are not uncommon. The parent may feel anger and resentment toward the child. Just as quickly they may feel strong urges to protect and shelter the child. Having a chance to explore the variations in feelings prior to discharge is important. It is also vital to assess those feelings after discharged by phone, home visit, and use of public health nurses and or parent aides.

Parents need help to sort out their feelings related to home monitoring. They need to look at their expectations and make adjustment to their real situation. The implications of CPR need to be addressed. What does it mean to assess you child as lifeless?

It would be ideal for parent s to have time away form their monitored child. This is not always possible for much reason. The parents may be too fearful to leave the child. Family and friends may be unwilling to assume the responsibility. Day care regulations may prohibit accepting children using medical devices. Home care nurses may not be familiar with home monitoring. Costs to the parents may be too high to pay for such care.

In the face of so may negative elements it might be expected that parents would strongly resist monitor, or quickly abandon it once they got home. Yet many studies and my own experience say just the opposite. What seems to make it easier for them is strong psycho-social support, good education, cease explanations of the need for monitoring, continuous access to service people and medical care, established criteria for discontinuation of home monitoring, and help during the process of weaning from the monitor. For the great majority of families at hospital, the levels of stress and anxiety were greatly reduced. Babies were returned to the family structure as safely and as soon as possible. Parents again gained a sense of control and mastery over their lives.

Training for home monitoring can be done by a variety of health care professionals - nurses, respiratory therapists, health care educators, social workers, or physicians. The professional level is not as important as the quality of the educational process in combination with identifying and meeting psycho-social needs.

Article ~

INFORMING THE FAMILY OF SUDDEN DEATH

Mark A. Robinson, M.S.W., U.C. Davis

Physicians are neither trained nor prepared for delivering the news of sudden death. the unique stresses which tax a physician during the medical or surgical emergency can affect the way he delivers the news. There are distinct strategies for preparing and delivering the news of death. An informative, chronologically ordered account of events up to and including the death, delivered after taking time to review all the facts, makes the task less stressful and is less likely to elicit unnecessary confusion and anger in survivors.

In dealing with medical emergencies, the physician is prepared to act quickly and efficiently to sustain life. Despite every effort, some of the patients in serious condition will die, and the physician will have to inform the relatives of the death. Since most physicians have had little formal preparation or training for this difficult task, they may experience anxiety before and during the encounter, and may be troubled by doubts about their style of delivery.

This article discusses the transition from dealing with medical trauma to approaching the family, and suggests ways of delivering the news of death.

PERIOD OF EMERGENCY TREATMENT

Medical emergencies are intense, action-oriented situations posing life-and-death problems that demand immediate identification and rapid attempts toward resolution. Diagnosis and treatment must occur almost simultaneously. This requires a high-quality combination of concentration, manual dexterity under pressure and leadership in applied medical-technical skill. Strong emotional reactions may be elicited by severely injured patients who are very young, who resemble one of the physician's family members or who are victims of criminal acts. These emotions can detract from the clear, objective concentration that is needed for effective performance. Setting aside these normal responses to maintain objectivity cannot be done without great effort and further energy drain.

When a patient dies after intensive efforts to save him, there is sometimes a dramatic change in atmosphere as activity comes to a halt and technicians, aides and nurses walk out to the treatment room. At this point, the physician is likely to be at a mental and emotional low point. When several hours of work and risks have been compressed into one, a person can be left temporarily exhausted. Unfortunately, it is at this time that the physician has to face family members and inform them of their loss. He cannot be certain how they will react to hearing such news; each family is capable of a wide range of feelings and expressions. This adds an immense surprise potential to the situation and may contribute greatly to the physician's anxiety.

The transition from dealing with medical trauma to dealing with family trauma is quick and dramatic. Objectivity must now be tempered by empathic sensitivity; role responses are replaced by interact ional responses, and mechanical manipulation must give way to concerned involvement. it is not surprising that many physicians

develop a defensive maneuver to protect themselves from the stress of their situation. One common maneuver is to avoid thinking about, preparing for as long as possible after the death has re-involving oneself with another patient. Another way the physician may minimize stress and discomfort is to proceed from the medical trauma to the family trauma without hesitation. This decreases the time available for experiencing anxiety about the task to come.

While at first glance these tactics appear to be effective ways for physicians to reduce stress, they may have the opposite effect. By delaying the news, the physician may increase the relatives' anxiety and thus decrease their ability to assimilate, acknowledge and deal with grief. On the other hand, rushing in unprepared increases the likelihood of presenting the news in an awkward manner.

TRANSITION: MEDICAL TO FAMILY TRAUMA

There are other, more effective ways a physician can prepare himself to deal with the patient's family. Some helpful suggestions follow.

Acknowledge Feelings and Limitations

When treatment is finished, identify any strong feelings you are left with. An unusually hectic trauma case that results in death may generate a mood of frustration and resentment. Such feelings should be set aside for later resolution rather than carried into the family situation. Relatives may interpret these residual feelings as being directed to ward them. One family remarked that the physician must have been angry because they had not called the ambulance soon enough.

Remember that your limitations are related to your particular level of capability on any given day. If you are at the end of a particularly busy day, you may be less than able to deliver an objective, reasonable and calm presentation of death to a family. If this should occur, you might ask another physician who was involved in the case to assist you or take over the task entirely.

Review the Case

Before facing the relatives, review and, if necessary, make notes of the major points, symptoms, treatment procedures and patient's responses as they occurred. This will order your thoughts and help identify or anticipate areas which might be difficult to explain. One or two minutes of preparation can prevent unexpected verbal stumbling blocks during an unavoidably stressful situation.

Enlist an Aide – Call the Chaplain

Have someone accompany you, if possible. Choose a person who is willing and able to provide additional support, because it is helpful to share the emotional demands of the encounter with someone.

Obtain Data on the Family

Find out as much as possible about the relatives to be confronted. The main points are who is present, what their relationship is, what they have been told about the onset or treatment and how they have reacted to the situation thus far. Obtaining this kind of basic information lessens the surprise potential and can better enable you to prepare for special problems. These facts may be gathered from any person who has had contact or been involved with the family, such as a registration staff member, a social worker, a nurse, a volunteer, the ambulance driver or a member of the pastoral care staff.

The Rational Approach

The rational approach to informing a family of a death is nothing unique or extraordinary; in fact, it is probably the way most physicians inform relatives of illness or injury situations which do not result in death. Common sense and simple terminology are used to tell the family what problems occurred, what actions were taken and what the patient's response was. This information is given in chronological order. Consider the following example:

"Mr. Smith arrived here at 7:10 p.m. He had collapsed at the grocery store. The ambulance crew found that his breathing was extremely shallow and that his pulse was very weak and irregular, so they began giving him cardiopulmonary resuscitation. That means pushing down on his chest in regular forceful rhythm while forcing in air to breathe for him. when he arrived here, we continued CPR and obtained an ECG tracing of his heart activity. We found ;that his heart had stopped beating altogether, so we immediately gave him several heart medications. Next, we tried to get his heart to copy the rhythm of a temporary pacemaker we inserted, but the heart didn't pick up the device's rhythm. After using the paddles and mild electric chock, we had no other ways available to us. I'm very sorry to tell you that we pronounced him dead as of 7:50 p.m.

Discussion

When presenting this material to physicians, I am often asked two questions. One is: Why describe treatment and response when relatives are in a crisis state and are not likely to hear or understand much of what is said? This assumption is not valid. In a family of five, there are usually at least one or two who will accurately hear, perceive and retain what is said. These people will be able to repeat the facts to those who did not hear and to other relatives who will need an explanation in subsequent hours. Even those who do not full comprehend the specifics of what is being said will be able to recognize the amount of effort expended on the treatment attempt. When given this information, many families are amazed at the actual amount of work involved, much more so than after hearing the more common and vague cliché' "We did all we could."

The other common question I am asked is: What should the physician do if he approaches the family and they immediately demands to know whether the patient is alive or dead? When this happens, it indicates that the family has already considered the possibility of death and that they are going to be told. Relatives are more likely to confront the physician with this question when they have been well prepared with accurate updates on the patient's lack of response to treatment or when the patient has had previous severe exacerbations of some chronic disease,

such as a previous heart attack. One physician responds to this question by saying he would like to explain briefly how things went; he then proceeds if the family finds this acceptable. Most family members will focus intently on every word of the physician's account. Frequently, they will add up the facts as presented, and one will utter the conclusion of death before the physician does.

The gentle and gradual yet factually informative approach facilitates an intellectual acknowledgment of death and a more solid cognitive basis from which to react with normal grief. It is also helpful in providing more accurate data with which to prepare and inform others of the death.

Some physicians add certain information that is not actually necessary to an understanding of how the death came about. Such information may include the likelihood that the ambulance crew's resuscitative efforts were more than adequate and that the patient was oblivious to pain or unaware of his predicament. Without this information, many relatives envision the patient's last minutes as being filled with intense pain amid strange surroundings and with feelings of being abandoned by the family. Some of these notions spring from the survivors' own fears about death, and their impact can be minimized by factual information to the contrary. The following case shows that the importance of these subtle points cannot be overstated.

After a head-on car collision, a three-year-old child was brought to an emergency room. The child's mother, who had not been in the accident, arrived at the hospital an hour or so later and was informed of the death. She was well supported by nursing personnel and physicians until her relatives arrived. During the following year, she had a recurring nightmare of helplessly watching her son screaming for help and suffering form pain while he was pinned in twisted wreckage. After consulting a therapist, she returned to the same emergency room and was fortunate enough to find a physician who had been involved in the case and recalled it vividly. He informed her that the child's particular head injury indicated that he had been rendered totally unconscious immediately on impact. The woman's nightmares ceased.

If only a few people can be spared months of unnecessary anguish, the extra time involved in delivering the news of death in this way is justified.

TECHNIQUES TO AVOID

The Blunt Approach

The physician walks in, shakes his head and says, "I'm not going to pull any punches - he's dead." His blunt, curt announcement increases the likelihood that the patient's relatives will react with anger and confusion. The anger that this delivery elicits probably relates to its basically rude, insensitive tone at such an emotionally vulnerable time.

The Apologetic Approach

The physician walks in, sinks into a chair and sighs heavily. Hesitantly, he says, "This is one of the most difficult things I have to do as a physician..." or "I really hate having to be the one to tell you this but..."

This approach appears to be a sensitive way to approach the family. It may be an honest way to begin, because informing the family of a death probably is one of the most difficult tasks that a physician has to perform. The apologetic approach can be called a plea for mercy because it implies a need for forgiveness and thus may elicit pity and support from the relatives. That, in itself, is not objectionable because the physician has just provided a great deal of intensive work on behalf of the patient, and some expression of gratitude and empathy can be appropriate. The problem is that often a physician will elicit this response, accept the family's supportive attempt and then excuse himself to return to other patients. he is essentially getting more nurturing and support than he is providing, and thus is an additional drain on the family's already taxed resources.

Article ~

COMMONLY ASKED QUESTIONS ABOUT SIDS: A DOCTOR'S RESPONSE

by J. Bruce Beckwith, MD

It is difficult to deal with the conflicting, confusing body of information and misinformation about SIDS that we're all confronted with in the daily and scientific press. We may be disappointed in our physicians because they give us information that conflicts with our physicians because they give us information that conflicts with our own intuition or experience about SIDS, or because they don't seem to know much about it. My assigned topic is "Using Accurate Information." The definition of "accurate information" for each of us who work in this field is information which agrees with our own ideas! The following are my answers to some commonly asked questions.

WHAT IS THE CAUSE OF SIDS?

It is common to read in newspapers that the "cause" for SIDS has been discovered. Some recent examples are elevated T-3, maternal smoking, prematurity, poverty or viral infection. I believe that SIDS is not a disease, but a way of dying. It's an episode which occurs over a very brief span of moments that results in the death of a baby. Things which preceded that episode may or may not be relevant to SIDS. There are lots of so-called predisposing factors such as prematurity, but being a preemie is not the "cause" of SIDS. So many of the "causes" that we read about are really factors which describe a population of SIDS victims, but do not explain the cause of death.

In approaching SIDS, the thing that happened last is most important, namely how did the baby die? In other words, what was the mechanism of death? Perhaps the most significant original observation I've made on SIDS bears on that specific point - how they die. It is my belief, based upon many research findings, that at the end of a breath, as a baby lets out air and is ready to take a new bath during sleep, the airway closes off in the back of the throat. That closure makes it impossible for the baby to take a next breath. As a result, the baby may change position. The face may come to be straight down into the bedding, or might get wedged in a corner of the crib, or a blanket may be pulled over the head. These conditions may suggest the baby suffocated, but in fact, specific research has been done proving that even tucking the blankets on all four sides of the crib mattress does not cause blood oxygen levels to drop. So even when appearances may suggest the baby might have suffocated in its bedding, these appearances are misleading, and are the result of the way they die, not the cause of death.

If there is evidence of airway obstruction, how can we so confidently rule out suffocation? I emphasized earlier that the obstruction occurred at the end of a breath. One of the findings in the examinations of the SIDS babies are little pinpoint hemorrhages (petechiae) found in the chest organs of 87% of the cases. These hemorrhages result from instantaneous and complete closure of the upper respiratory tract at the end of a breath. If I were to go out and attempt to strangle somebody or put a plastic bag over their head, it would be almost impossible to produce the hemorrhages. The findings differ in SIDS and suffocations, with approximately 95% confidence levels.

So what causes SIDS? Again, I believe that SIDS is not a disease, but a way of dying. The mechanism appears to be sudden obstruction of the airway during sleep.

WHY CAN A HEALTHY BABY DIE SO SUDDENLY?

Why would the airway become obstructed during sleep in a healthy and thriving baby? Nobody knows for sure. If one accepts that we understand how they die, the next question is why do they die? A concept that I have found appealing for many years is that this stoppage, or obstruction of the airway is not due to a disease process or an abnormality of the baby, but is a reflection of the fact that babies at this time of life are undergoing an incredibly rapid state of growth and maturation.

Many important changes are occurring at the age when most SIDS occur. The infant is, among other things, coming into an age where he is beginning to sleep through the night. That's not just a simple change in habit pattern, but a change that is very fundamental and has to do ;with control mechanisms in the brain. Centers that are beginning to be active in the baby's brain didn't even exist when that infant was born. Virtually all of brain growth occurs in the first two years of life and the growth rate in the first six months is the most rapid of any time in life. During the time when these important control centers are in a period of transition, abnormal messages might come down to the organs of respiration, one of which is to "close off" rather than "open up." Normally, at the end of a breath, the throat collapses or closes, then opens up prior to a new breath being taken. But if the wrong message comes down from the brain, the throat may stay closed instead of opening. That wrong message isn't necessarily a result of this baby being abnormal, but occurs in a normal baby whose brain is growing at a tremendously rapid pace.

This view of SIDS is certainly one person's view; it's not shared by everybody who works in SIDS. It's a view which I find very reasonable and helpful; the concept is that the baby was normal when it dies, not abnormal. There is no way for anyone to predict that a normal baby is going to have this kind of abnormal event. Many factors may contribute to that event. Minor irritation of the airway may, by increasing the sensory input coming up the nerves form the throat to the brain, increase the likelihood of abnormal messages to come down. Thus, perhaps we have a connection with the minor respiratory infections which are present in many cases.

HOW IS THE SIDS DIAGNOSIS MADE?

In doing a post-mortem examination, we don't see the lethal mechanism directly. After death, muscles relax, so the pathologists don't find the throat muscles clamped shut. There are little things that we find consistently, such as the pinpoint hemorrhages I mentioned earlier, but none of those things account directly for death. They are only clues to the way they die, and helpful to the pathologist in diagnosing the case as SIDS.

The SIDS victim did not die of nothing. The baby died of a very distinctive entity. Any of you who are familiar with sudden infant death will know that the typical case falls into a narrow age range, and seemed to be okay except maybe for a cold, ate his last meal normally, was put to bed and was later found dead. You know when you hear that story what the pathologist is going to say. But when the story is different, then you really want to know what the pathologist found. When there are some unusual features to the case, the post-mortem becomes especially important, as there are many conditions other than SIDS which can kill infants and young children suddenly.

If we take all babies under one year, who have 1) died unexpectedly, 2) during sleep, with 3) no history of alarming symptoms, such as seizures, temperature over 105 degrees, and 4) no external findings to allow one to suspect a cause of death (like a fractured skull or a skin rash), 92% of cases will be diagnosed as SIDS after-autopsy. If the infant is 2 or 3 months old, it would be more like a 95% certainty. In some communities it is not possible to get an autopsy, but one can usually do an x-ray examination to add to these four criteria. With the presence of a normal full body x-ray, the chance the death was due to SIDS goes from 92% to 98.2%.

My baby wasn't a typical SIDS case.

Each of you who have personally experienced SIDS probably feels that your baby in some ways doesn't fit the classical profile. You read about "high risk" babies and it's very easy to confuse the concept of "high risk" with "typical." For example, a "high risk" baby might be born weighing less than three pounds to a disadvantaged family in the winter months. The risk to that baby is perhaps one in 50. If your baby was a full-term, 8-lb. baby who died in the summertime, and was a girl, it doesn't sound typical of the "high risk" baby that you hear about. But, if fact, most SIDS babies are not drawn form the "high risk" population. There are many more babies in our society who are in the "low risk" population, and the majority of SIDS babies are from this "low risk" population. Thus, the 8-lb. baby is a more "typical" SIDS victim than is a 3-lb. preemie. even though that preemie had a higher individual risk of dying. Because there are so many full-term babies, they constitute the majority of SIDS babies. The same principal applies to the other so-called "high risk" factors. Therefore, these things you read about "high risk" SIDS babies often lead to confusion and it is important to understand that "high risk" and "typical" are very different concepts.

Any one case is a single dot on the bell-shaped curve and it could fall anywhere on that curve. The description of a population as a whole does not describe each individual member of that population. That's an idea that's often difficult to get across. I don't know if the totally typical case of SIDS ever has occurred. Every baby that ever died was an individual, and every person who has lost a baby identifies SIDS with that particular individual - the hair color, behavioral patterns, and the medical history of the baby is the profile of SIDS to that parent and family. It's important for families to be able to appreciate that because that baby seemed different than the other children in that family, it doesn't mean that difference was in any way related to the death. My experience has made it very clear that there is no typical pattern of behavior, for example, in babies who later die of SIDS.

My baby cried out during the night he died and I feel so guilty because I didn't respond.

This was a death caused by airway obstruction and babies can't cry when their airway is obstructed. So when that baby was crying, he could not have been dying. He cried, went to sleep, and then died later. Not responding to that cry had nothing to do with the fact that the baby died. Babies do not die from crying.

Since SIDS only occurs during sleep, if I had awakened my baby, would he have died?

My answer has to be "no, he wouldn't have died then." But how in the world could anybody know at what moment it was going to happen? The way to prevent SIDS would be never to let a baby sleep, and that's obviously impossible.

IS SIDS CONTAGIOUS?

Again, the answer is "no." My personal experience with over 1,200 cases includes not one example where a SIDS victim was closely in contact with another SIDS victim (except for three cases of twin SIDS cases). There are times in every community when there are more SIDS than other times. When viral diseases of certain kinds are sweeping through the community, the incidents of SIDS will climb. But there is no "crib death virus."

Will it happen again in my family?

SIDS is not a hereditary disease. There are two widely quoted articles in the research literature that say that it may be familial. Each of those came up with a risk figure that scares everybody - of 1 in 50. Each of those two papers contains some important errors, so that the true figure is more like 1 in 125. Even these figures exaggerate the risk to siblings. There are two reasons for this.

One reason is the familial aggregation of risk factors, such as prematurity. For some mothers prematurity tends to occur repeatedly because of a relaxed cervix or other factors that make it difficult for her body to retain a baby in utero for nine months. Since 20% - 30% of any SIDS series will be preemies, any large SIDS series is going to include lots of subsequent preemies. Therefore, we would expect risk figures somewhat higher risk figures are not shared by the entire population of subsequent siblings, but only by the subsequent preemies.

The other reason is that there are some hereditary diseases that can kill babies suddenly and unexpectedly: heart disease, brain disease and a variety of bio-chemical disease that require some special studies to diagnose. If you take a large population of SIDS cases, it is likely to be contaminated by a few rare examples of these diseases. One of the most common that we know about is something that we now call familial infantile apnea, and that's a strongly hereditary disorder. If in the family background there are a lot of infant deaths, then a genetic disease mimicking SIDS could be a factor of concern. A few families will have genetic disease - most of these will have multiple sudden infant deaths in the family background as a clue to this fact. These few families do have a high recurrence

risk the others do not. In summary, there is no reason to believe that most families who experience the loss of a baby to SIDS are at any increased risk of recurrence.

Article ~

FACT SHEET: SIDS INFORMATION OF THE EMT

Prepared by: Paula Pachon,
Information Specialist National SIDS Clearinghouse

Sudden Infant Death Syndrome (SIDS), the sudden and unexpected death of apparently healthy babies, is the major cause of death of infants between the ages of 1 month and 1 year. In the United States, SIDS, sometimes referred to as crib or cot death, is responsible for the death of approximately 6,500 infants each year. It has been estimated that annually up to two deaths per 1,000 live births will be the result of SIDS.

SIDS deaths produce intense and traumatic reactions among surviving family members, as well as health care providers. Lifelong feelings of guilt, sibling emotional problems, divorce, and even, suicide are all too often the result of this tragic event. It is clear that there are multiple victims of this disease - the dead infant and the surviving family members.

SOME BASIC FACTS ABOUT SIDS

- SIDS is a definite medical entity and is the major cause of death in infants after the first month of life.
- The cause or causes for SIDS are not known.
- Approximately 90% of all SIDS deaths occur annually in the United States.
- Approximately 6,000 to 7,000 SIDS deaths occur annually in the United States.
- SIDS occurs in all socio-economic levels.
- SIDS is at least as old as the old Testament and seems to have occurred at least as frequently in the 16th and 19th centuries as it does now.
- Victims appear to be healthy prior to death.
- At this time, SIDS cannot be predicted or prevented, even by a physician.
- There appears to be no suffering; death occurs very rapidly, usually during periods of sleep.

WHAT SIDS IS NOT

- SIDS is not cause by external suffocation.
- SIDS is not caused by the type of feeding method used.
- SIDS is not caused by vomiting and choking.
- SIDS is not caused by immunizations.
- SIDS is not caused by child abuse or neglect.
- SIDS is not cause by overheating.
- SIDS is not contagious, it is not an infectious disease process.
- SIDS does not cause pain or suffering to the infant.
- SIDS cannot be predicted.
- SIDS is not caused by a lack of love.
- SIDS is not caused by a sleeping parent rolling over onto the baby.

SIDS AND THE ROLE OF THE EMERGENCY MEDICAL TECHNICIAN

The Emergency Medical Technician (EMT) is often the first official person on the scene following the discovery of the infant. The parents or other caretaker of the infant - e.g. grandparents, baby-sitter - cling to the hope that the EMT can do something to save the infant even thought the child may be obviously dead. The role of the EMT in this situation is difficult. he should begin immediate emergency resuscitation efforts and comfort the parents whose reactions may range from numb silence to violent hysteria. By offering sensitive support to the family and gathering accurate information in a non-threatening manner, the EMT helps to alleviate the future emotional burden of the surviving family members.

How the EMT can tell if the infant is a SIDS victim

Only an autopsy can conclusively determine if an infant's death is due to SIDS. The EMT should make no assumptions about the cause of death. The death of an apparently healthy infant, and the general appearance of the infant in his crib may be misleading. There have been cases where SIDS has been mistaken for child abuse. Therefore, it is necessary that the EMT, as the first responder, know some of the identifying features characteristic of the SIDS victim as opposed to the abused child. The table on the reverse of this sheet provides a list of the general physical characteristics of each. This table will help the EMT in observing evidence useful to the medical examiner or coroner in identifying the possible SIDS victim as well as distinguishing this infant from a battered child.

Article ~

CHAPLAIN'S CORNER
By Chaplain Jack Poe

Law enforcement officers are a brave breed of unique men and women. They know up-front the risks that are involved in their line of work, yet they choose to place their lives on the line every single time they put on their uniforms and walk out the door to go to work. Their journey through life often places them in situations seldom seem by the majority of the members of the communities in which they serve. More often than not they encounter the rude and the crude who make their living by taking from others.

Most of the time, what they take are material things that for the most part can be replaced. Sometimes they take that which can never be replaced. Sometimes they take that which can never be replaced, human life. Every 57 hours in the United States, a law enforcement officer's life is taken in the line of duty. Law enforcement officers take an oath of office in which they promise to protect and serve. Providing that protection and service to the community means they live "in the valley of the shadow of death." Chief McBride has often described the world that needs police as being made up of two types of people. The Takers and the Givers.

On the evening of September 29th, one of the Takers took one of the Givers. Our community will never be the same. Officer Delmar Warren Tooman gave his life in the line of duty, faithful to his promise to protect and serve. Warren was a living witness to what he believed. The poem, The Living Sermon, sums up Warren's life nicely. Part of it reads, "I'd rather see a sermon than hear one any day. I'd rather one would walk with men than merely tell the way. The best of all the preachers are the ones who live their creeds. For to see good put in action is what every body needs. I may not understand the high advice you give, but there's no misunderstanding how you act and how you live.

Warren had attached to his rear view mirror this verse of scripture. "And the Lord shall deliver me from every evil work, and will preserve me unto his heavenly kingdom: to whom be glory forever and ever Amen." (II Timothy 4:18)

Even though Delmar Warren Tooman, "lived and walked in the valley of the shadow of death" for him, death had no grip on him.. for he had decided a long time ago who was going to shepherd his life. And if death were to come as we know it, he knew he would be ushered into God's heavenly kingdom.

Delmar Warren Tooman has left behind for us a great legacy of service to his community. In the changing world in which we find ourselves today, two things remain constant: A commitment to service, and: a willingness to do whatever is necessary to keep the peace. Sometimes the price is high. We commit ourselves to upholding the same high tradition. Those famous lines from the poem, "In Flanders Fields" reads, "To you from failing hands

we throw the torch: be yours to hold it high". That is our pledge to our brothers who have fallen and the generations that are yet to come. We can do nothing less.

Post-Script:

Do not grudge your brother his rest, he has at last become free, safe, and immortal, and ranges joyous through boundless heavens: He has left this low-lying region and has soared upwards to that place which receives in its happy bosom the souls set free from the chains of matter.

Your brother has not lost the light of day, but has obtained a more enduring light. He has not left us, but has gone on before. -Seneca-

Article ~

MEN AND GRIEVING
By Charles Collenberger

FOR MALES...After a Death

You, a man, recently learned of the death of someone YOU loved. You may have been told by a police officer, doctor, or other spokesperson... or possibly you discovered it yourself. It really doesn't matter much whether it was murder, a drunk driving homicide, an accident, suicide, or a catastrophic illness. You are starting down a traumatic road which can, if you allow it, destroy your life.

At first, the sudden shock left you numb. You may even have cried a little. But then the little voice inside said, "Men don't cry." You then talked about what needed to be done, called the rest of the family, arranged the funeral, carried on with life.

You may have looked at the women in the family and found them incapacitated with outward displays of grief. Therefore, you decided to pull yourself together even more taking the pain like a "little soldier."

You kept busy so you wouldn't have time to cry. You met people at the door as will as in the funeral home. You supported your family. You might have remembered for a fleeting moment the last argument you had with the dead person, but it was quickly smothered. You couldn't lose a day of work. You had to pay for all of this.

You cram down the all-consuming anger over the way the death happened but have fleeting thoughts that you would rather be hunting down and killing the person who did this than working so hard to maintain control.

You get through the funeral, and then it's back to normal living, back to associating with people who don't know or don't understand. If you show too much emotion - or any at all-you are looked at with suspicion and run the risk of losing your job. You notice that after one "I'm sorry," colleagues look at the other way, seeming to hope you'll go away. They act like what happened to you is catching. So you bury yourself in your job, even though your lived one is in your thoughts nearly all the time. You try to push them aside and work. So, further down go the feelings, deep into the mind to fester.

Just about the time you think you'll survive, if was a murder or other homicide, the trials starts. Each minute detail comes out. Your loved one is attacked by the defense attorney. You realize that the killing is considered a crime against the State rather than against your loved one, and you don't count except as evidence. It takes days for the trauma of a few minutes to be relived. Even if the case is "won" emptiness accompanies it. There can

be no true justice. And, of course, appeals and other efforts to reverse the decision begin immediately and can continue for year.

You may begin to notice that come of the women in the family seem to have cried themselves into a semblance of recovery. They have cried together. They may have joined a therapy or self-help group. Because they seem to be doing a little better, you can't talk to them for fear of appearing weak and maybe sending them back into grief. So you draw away...and feel guilty about it.

You may begin to accept overtime or take on more than you can possibly get done. Extra jobs, which at first helped with burial expenses, continue to be an escape from facing up. You spend less time at home facing the guilt from which you must escape.

Sleeping may have become a problem, and during the day you experience wide mood swings. A well-meaning but foolish doctor may give you some sleeping pills. They help outwardly. They help you forget, so you become dependent on them for day-to-day existence. Perhaps you try more and different kinds.

Evenings are a real problem. You can't talk with your wife anymore, and just sitting watching television doesn't keep the memories from returning. A few drinks might help. Maybe going out with the boys can get rid of the guilt you feel while being with your wife. Maybe your wife is the one who died. You just can't stay home anymore.

WHO CARES?

Everybody does! But they are standing outside the barrier you have thrown up around yourself. Their hearts are broken as they watch you destroy the man they love so dearly. But they can't break down the wall. Only you can break down this impassable, invisible wall.

HERE'S WHAT YOU MUST DO:

FORGET that "men don't cry."
FORGET the silent little soldier.
FORGET to hide your feelings.
FORGET it's not manly to ask for help.

BUT MOST IMPORTANT OF ALL, allow yourself to cry long and loud until you begin to recover. It won't be easy. Years of crippling training have to be undone. It takes tremendous courage to cry...almost as much courage as it did not to cry all these days.

Your life will never again be the same. You will not have your loved one back physically. Your relationship with him or her is changed, and now it is memories that you hold in your heart. No one can take those away. But you can only cherish the good memories if you are healing. And you will only heal when you allow the tears to flow.

Charles Collenberger has survived the murder of a loved one. He says, "I can cry. I am healing. I am surviving."

BRIEF HISTORY OF DEVELOPMENT OF CRISIS INTERVENTION

Post traumatic stress disorder has been around for as long as there has been human conflict. However, crisis intervention is a relatively new field and has been around in a variety of forms since the early part of the 20th century. One of the early support organizations was created in 1906, the National Save-A-Life League, which focused on suicide prevention.

Beginning with World War I and World War II evidence came to light that with early intervention chronic psychiatric morbidity was greatly reduced. Furthermore, it was also noted that the processes of immediacy, proximity and expectancy were identified as important “active ingredients” in effective emergency psychological response.

In 1944 Erick Lindemann’s observations of grief reactions to the Coconut Grove fire started the “modern era” of what we now recognize as crisis intervention. In the late 1950s community based suicide prevention programs began to grow.

From the early 1960s to the early 1970s crisis intervention continued to grow and expand. Crisis intervention was defined by Gerald Caplan as having three tiers of preventive psychiatry implemented within the newly created community mental health system (i.e. primary prevention, secondary prevention and tertiary prevention). It was proven that crisis intervention principles, when applied, reduced the need for hospitalizations of potentially “chronic” populations. This was a time when early work on crisis and stress in first responders began.

The 1980s brought about rapid growth in the crisis intervention field due to the DSM-II recognizing Post Traumatic Stress Disorder (“PTSD”) as threats to long-term mental health and called for examination of crisis and traumatic events. Also, the Air Florida 90 air disaster in Washington D.C. prompted re-examination of psychological impact on emergency personnel. In fact, this was the first time that small group Critical Incident Stress Debriefings (“CISD”), which was originally formulated in 1974, were utilized in a large scale disaster.

The 1980s also began the era of “Violence in the Workplace” when 13 postal employees were killed on the job in 1986. Since that incident, in 1989, the International Critical Incident Stress Foundation (“ICISF”) was formalized. It offers a standardized and comprehensive crisis intervention model which is utilized world wide. Since its formation there are now over 1,000 CISM teams and the ICISF has grown to over 7,000 members in 28 nations.

During the 1990s there have been a number of mass disasters world wide which have impacted CISM and PTSD. In 1992 there was Hurricane Andrew which tested the nationwide disaster mental health capability and the new mental health function of ICISF in the United States. In 1993 there was also the implementation of a nationwide crisis intervention system due to the Kuwait University for post-war Kuwait. Then America experienced one of the first modern-day terrorist attacks in

the form of the first World Trade Center bombing. Once again, the DSM-IV recognized Acute Stress Disorder as a legitimate after-effect of crisis and traumatic events.

In 1996, the Oklahoma City bombing emphasized the need for crisis services for first responders, as well as civilians. The TWA 800 air disaster further emphasized the need for emergency mental health services for families of the victims of traumas and disasters. Out of these tragedies came the OSHA 3148, which recommends comprehensive violence/crisis intervention programs in healthcare and social service agencies, and the Aviation Disaster Family Assistance Act.

Further recognition for the need of crisis intervention came about in the form of AFI 44-153 which mandates the establishment for crisis programs for the United States Air Force bases worldwide. Also, the Gore Commission recommended crisis services for the airline industry. ICISF gained United Nations affiliation. OSHA 33153 established the recommendation for crisis intervention programs for late-night retail stores. COMDINST 1754.3 required the United States Coast Guard to establish a CISM team for each of their regions. The Department of Defense DIRECTIVE 6490.5 established policy and responsibilities for developing Combat Stress Control ("CSC") programs throughout the United States military.

1999 brought in the advent of mass shootings with the Columbine High School in Colorado. This forced ICISF to re-examine the increase in issues of youth and school violence. As a result, ICISF established protocols, procedures in dealing with school crisis response and created a special program for just that purpose.

In 2000 there was an increase in international concern regarding the potential use of nuclear, biological and/or chemical terrorism. This concern also included the planning for mental health consequences which would follow in such an aftermath.

Then on September 11, 2001 the United States was again attacked by terrorist measures from a non-American enemy. Attacks against the World Trade Center in New York City, The Pentagon in Washington, D.C. and United Airlines Flight #93 showed the value of immediate response to crisis events. The mass disaster of the terrorist attacks showed how the enormous and prolonged intervention (approximately 1 ½ years) to victims, families, businesses, communities and first responders mitigated the need for long term counseling and the development of full blown PTSD was significantly reduced.

2002 was a year of growth and challenge. The NIMH published guidelines on Mental Health and Mass Violence, National Institute of Mental Health (2002). Mental Health and Mass Violence, Washington, DC: U.S. Government Printing Office. The EAPA also released guidelines on Disaster Mental Health. Employee Assistance Professionals' Association ("EAPA"), (2002). Report of the disaster preparedness task force, Boston, November, 2002. This was also the start of the liberation of Afghanistan and Iraq. The military struggles with the challenges of CSC among its various branches.

In 2004 mass disasters were seen world wide. First there was the tsunami which hit Indonesia causing massive damage and numerous deaths. Again, Critical

Incident Stress Management Foundation of Australia ("CISMFA"), an affiliate of ICISF, under took the rapid training of crisis responder for South Pacific relief agencies to work with both victims and first responders. Again, the United States was targeted by mother nature in the form of four major hurricanes hitting Florida and the southern United States. Crisis intervention services were challenged by the back-to-back storm and the mass devastation of entire communities throughout Florida and the southern United States.

In 2005 NVOAD released recommendations for disaster mental health intervention and training. Olson, J. (2005). "National Volunteer Organizations Active in Disaster: Successful Strategies for Collaboration During the Historic 204 Hurricane Season." The Dialogue: A Quarterly Technical Assistance Bulletin on Disaster Behavioral Health (SAMHSA), Summer, 16-17. Also, that year was the year of Hurricane Katrina and Hurricane Rita. The southern United States and Florida again suffered massive devastation. Approximately 1,300 dead, many thousands of sick and injured, 33,000 aerial evacuations, and 96,000 square miles of severe damage all causing these storms to become the most devastating and costly natural disasters in United States history. They also provided significant challenges for all response organizations, including those dedicated to crisis intervention services.

As of 2006, fears of pandemic influenza arise and many states and local agencies begin preparations and simulations for the unforeseen. Crisis intervention services are tapped for guidance on dealing with widespread psychological distress.

The above-referenced milestones in the historical development of the field of crisis intervention have served to shape its nature and provide insight into its current status and to look to for growth and development in the future..