LifeNet

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INSIDE:

LifeNet

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ICISF is a non-profit non-governmental organization in special consultative status with the economic and social council of the United Nations.

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ICISF Announces

The Academy of Crisis Intervention

The International Critical Incident Stress Foundation (ICISF) continues to evolve to address the needs of the crisis intervention community. We are pleased to announce the establishment of the ICISF Academy of Crisis Intervention, which aims to promote and maintain standards of training in the specific field of crisis intervention. The Academy will offer our current education and training programs through Regional Trainings, World Congress, Approved Instructor Programs and Speakers Bureau Presentations. Future plans for the Academy of Crisis Intervention include new editions of existing courses, the introduction of new courses, online training, webinars and other educational opportunities geared specifically towards the individuals and communities we serve.

Helping Save the Heroes

By Rick Barton-ICISF Chief Executive Officer

Ask someone to identify a hero, the sort of person who risks his or her well-being to help someone in trouble. They will name people who reach deep into their souls to gather the resolve to deal with fires or medical emergencies, serve in the military, or fight crime. These are examples, and certainly not a complete list. The true question is not, "Who qualifies as a hero?" We must ask who saves the heroes from the consequences of the risks they suffer.

At the International Critical Incident Stress Foundation (ICISF), our mission guides us to help save the heroes from their personal internal struggle. We are not alone in this quest, thus we help save the heroes. This single phrase offers the value of our work; and now we must step up our effort. The ICISF struggled to survive the aftermath of the economic recession of 2008. Many other educational foundations and non-profit organizations withered away. The survival of the ICISF set the stage for specific, positive changes offered in the following paragraphs. Keep reading if you want to know the near and multi-year plans for the ICISF.

My two prior LifeNet articles described the bright future of the ICISF and the four pillars that establish the basis of rebirth of a crisis intervention protocol that works in the real world. The mission remains sound, allowing us the opportunity to build upon nearly 25 years of success. Numerous positive steps lay in our path, and we invite you to join us as we walk into the future.

Four general areas of evolution describe the rebirth of the ICISF. Those include: product improvement, product delivery, marketing, and administrative adjustments. Each

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Regional Conference Calendar

March 4-8, 2015
-Atlanta, GA
GCISF

June 24-28, 2015
-San Francisco, CA
San Mateo CISM Team

August 20-23, 2015
-Denver, CO
Mayflower Crisis Support Team

October 15-18, 2015
-Seattle, WA
Seattle Police & Fire Peer Support Team

November 11-15, 2015
-Baltimore, MD
ICISF

December 3-6, 2015
-San Diego, CA
San Diego CISM Team

Check our Website for updated information on course offerings!

Submit a Letter to the Editor! ICISF welcomes comments from our readers. Please submit your comments to the editor at (lifenet@icisf.org)

Like ICISF on Facebook!

ICISF Regional training

Attend ICISF's Regional Trainings and World Congress for core, specialty and elective courses offered through ICISF's Academy of Crisis Intervention. One-, two- and three-day courses are offered at each location, with ICISF faculty and staff onsite to answer all of your questions regarding crisis intervention. Earn up to 41 CE hours.

Start planning now!
March: Atlanta, GA
May: Baltimore, MD
June: San Francisco, CA
August: Denver, CO
October: Seattle, WA
November: Ellicott City, MD
December: San Diego, CA

For specific dates and course offerings as available, visit ICISF.org.

CISM in the Humanitarian Aid Context

By Johara Boukaa, World Vision International, Netherlands ICISF Member and Approved Instructor

Introducing World Vision International

When you visit our international website, you will read that "World Vision is a global Christian relief, development and advocacy organization, dedicated to working with children, families and communities to overcome poverty and injustice."

Let me expand a little bit on this statement. From the above, it is clear that World Vision works from a Christian philosophy, but this does not mean that we do not assist people who have different faith traditions. When providing relief or development aid, World Vision does not discriminate on the basis of religion, race, ethnicity or gender.

As an organization, we conduct relief operations to assist people who have survived natural or man-made disasters. Think of earthquake or hurricane survivors, or people who have fled war-torn countries. Related activities are, for example, food distribution or provision of temporary shelter. World Vision also provides long-term, sustainable assistance to communities through child sponsorship and area development programs. You can then think of school feeding and community health programs or agriculture projects. Our advocacy work is about speaking out on behalf of those whose voices may otherwise not be heard. We advocate for the most vulnerable.

No matter what our activities are, World Vision always has the well-being of children as a focus, which is emphasized in our vision statement:

"Our vision for every child, life in all its fullness,

Our prayer for every heart, the will to make it so"

CISM as a component of Staff Care

World Vision International (WVI) works in 96 countries worldwide, and has more than 45,000 people employed. With a workforce that large, working in the type of environments that they do, it is inevitable that our staff is vulnerable to critical incident stress, cumulative stress and compassion fatigue.

As an organization WVI has a duty of care which it takes very seriously. The Global Staff Care Unit – manned

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I Read it on the Internet

By Alice Franks-Gray

I have been following discussion groups on social media around CISM. The discussion has been particularly lively at the LinkedIn discussion group sites. For LinkedIn members there are three discussion groups, two of which have new discussion posts every 1-2 weeks:

Critical Incident Stress Caregivers
-1,281 members

EAP Critical Incident Response
-1,279 members

I have noticed that some of the same discussion questions appear at both the "EAP" and "Caregivers" locations; both seem to share some of the same participants. The backgrounds and experiences of those responding to questions and comments posted there are broadly diverse and represent mental health and EAP providers, and uniformed services (both first response and military). A flaw of this form of information is (absent an active moderator) anyone can say anything. Given enough reported letters behind a last name, anyone can present as an 'expert,' and this allows biased individuals to appear as credible resources.

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Deadly Force Encounters - The Individual Debriefing in Law Enforcement

By Kathy Platoni, Psy.D., DAAPM, FAIS, COL (RET), US Army, ICISF Member

In the aftermath of traumatic events that fall far outside the realm of the "normal" range of human experience, the vital importance of downloading and de-escalating from catastrophic events is paramount. To obtain closure and a more palatable perspective regarding events that are characteristically tragic and emotionally laden becomes a primary key to resolution and recovery from the impact of traumatic events. This is the crux of the matter and forms the very basis for crisis management and critical incident stress debriefing models. Deadly force encounters certainly fall within this category and comprise a degree of psychological injury unique to the law enforcement community.

From both personal and professional standpoints, officer-involved shootings can become ruinous to the officers themselves, as well as to family members who can be secondarily or vicariously

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The Impact of Psychological Trauma and PTSD on First Responders

By Raymond B. Flannery, Jr., Ph.D.

First responders are those courageous men and women who run towards critical incidents when everyone else is fleeing. We know that first responders run the risk of physical injury, bodily disability, and line-of–duty death, but what is the psychological impact of these critical incidents on first responders? What do medicine and the behavioral sciences have to teach us about any possible negative psychological effects?

While there are feeling states of anger and depression as noted below, by far, the more common psychological impact is the understandable fear, anxiety, and general distress associated with psychological trauma. Traumatic events occur when first responders experience, witness, or are confronted by an incident that involves actual or

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Share Your Team's Milestone with *LifeNet* Readers

ICISF would like to acknowledge CISM Teams that have reached significant milestones in organizational longevity (i.e. five, ten, fifteen year anniversaries, etc.) in future issues of *LifeNet*. If your team reached such a significant anniversary this year, please contact George Grimm, ICISF CISM Team Coordinator (via email at hotline@icisf.org) and provide the appropriate information so we may proudly list your Team in a future *LifeNet* and provide a Certificate of Appreciation.

"Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity."
- Pema Chodron

From the Hotline Team Coordinator

By Reverend George Grimm

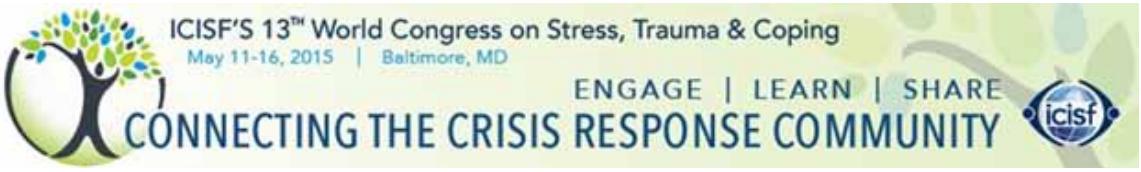
In order for teams to remain on the current team list in our database and on the website, an annual update of information is required. It has been noted that many teams sending in the information do have changes to be made in the contact information, indicating that phone, and email contact information given out by ICISF would have been incorrect and possibly delayed anyone attempting to contact the team.

At times, the email or US Mail reminder sent to the team that this update is due is returned because the contact information we have is incorrect. It is vital that we have the correct information to provide when a request for assistance is made to the ICISF office or Hotline. As of this writing, only 155 of the 809 teams in our database have current information on file. If your team is one of those, you may find the necessary form at http://www.icisf.org/wp-content/uploads/2014/04/0-team-form-05-11-11.doc

Your assistance in keeping our database up to date is greatly appreciated. If you have any questions, please contact me at hotline@icisf.org

Thanks in advance for your help,
George

ICISF's 13th World Congress on Stress Trauma & Coping



ICISF's 13th World Congress on Stress, Trauma & Coping in Baltimore is the place to be May 11-16, 2015. We're planning fresh ideas and plenty of activities at the Baltimore Renaissance Hotel to help you Engage, Learn and Share as you connect with others in the international crisis response community.

Join us for Pre-Congress on Monday, Tuesday and Wednesday for up to 20 options from half-day workshops, full day workshops, ICISF's 2-day Advanced Individual course and ICISF's 3-day Assisting Individuals in Crisis Intervention and Peer Support & Group Crisis Intervention.

The ICISF's World Congress Opening Ceremony on Thursday morning sets the mood with the Fire Brigade Pipes and Drums of Greater Baltimore and representatives from area Honor Guards.

Look forward to:

General Sessions in the morning and afternoon, featuring Keynote Speakers, International Speakers and experts discussing best practices, recent disasters and major incidents.

Educational Sessions- Concurrent workshops, round-table discussions, symposiums– something for everyone, no matter your professional status or expertise.

First-Timers Breakfast- A great way to meet other "newbies" to World Congress and get tips on how to get the most from your experience.

Nightly Networking- We've arranged an array of planned activities so you can explore Baltimore with colleagues and friends.

Taste of Baltimore- Join us for lunch at nearby restaurants to experience local favorites.

Great Way to Start the Day- Like to run, walk, laugh, practice yoga or Tai Chi? Get motivated with others.
Members-Only Reception featuring discussions with authors of new books.

Super Celebration- Saturday night ends the World Congress. Join old and new friends as we close out another year.

Raffles- Prizes galore!

Baltimore City Welcome Desk- Ambassadors of Fun! Where to go, what to eat- get it directly from the locals on the Baltimore City CISM Team.

Look for registration to open in January!

Can't make it for all six days? No worries! Join us on whatever days are available in your schedule!

From the Approved Instructor Department

We would like to welcome the newest Approved Instructors to the ICISF Family. The following individuals recently completed the Individual Crisis Intervention and Peer Support Instructor Program in Chicago, IL, October 22-24.

Brian Bennett
Gary Berryhill
Sue Blechschmidt
Bill Burns Jr.
Patricia Copeland
Denver Drieberg
Dan Drissell
Daniel Gagnon
Dean Grace
Steven Horner
James Hoy
Creston Hulett
Gary Isbell
Luana Kaleikini
Christen Kishel
Melissa Krebs
Rob Lloyd
Kenneth Macgregor
AJ Moore
Nichole Schwerman
Rhonda Seaton
Davina Sentak
Brad Shepherd
Victoria Syren
Elbert Tomai
Janet Tomai
Carol Truesdale

ICISF was very pleased to be able to honor the request made by several European ICISF Instructors to hold yet another Approved Instructor Program in Germany this year. The students below completed the Advanced Group Crisis Intervention Instructor Program in Cologne on September 4-5. Please join us in congratulating them.

Rena Achten
Ollie Barbour
Johara Boukaa
Gerhard Fahnenbruck
Walter Gaber
Inez Laaser
Christoph Lindenstromberg
Claudia Mantke
Jose Ponz Canto
Karl Richstein
Uwe Rieske
Jutta Unruh
Suzanne Wavre

Comments, Questions or Suggestions

Please direct any comments or questions regarding the contents of this issue to the attention of Victor Welzant, PsyD, Editor, at lifenet@icisf.org. Letters to the Editor are also welcome.Have an idea for an article in a future issue of *LifeNet*? Send your suggestions to the attention of Michelle Parks, Content Editor, at lifenet@icisf.org We welcome your input. **Thank you!**

If your article is approved and used in an issue of the LifeNet you will receive a complimentary Level One-1 year ICISF membership ($50.00 value)

Make Sure We're Able to Stay in Touch!

To be sure ICISF emails get through to your inbox, be certain to add ICISF email addresses to your address book. If you have a spam filter, adding ICISF.org to your "white list" of acceptable senders will also help to ensure that our emails get through. Thanks!

Conference Awards and Scholarships

ICISF's Victoria, BC Conference held October 2-5, 2014
ICISF awards Certificates of Appreciation in recognition of outstanding contributions in the field of CISM. Congratulations to **Geoff Spriggs**, **Leigh Blaney**, and **Steve Sorenson** (L-R, with Dr. Jeffery Mitchell) on being chosen for the Certificate of Appreciation Award.

Marlatt Scholarships are offered in remembrance of Erin and Colleen Marlatt to deserving individuals in Fire Services. Recipients are selected by the local host and are acknowledged and presented with awards at the conference Award Ceremony & Town Meeting. Congratulations on being chosen as Marlatt Scholarship recipient:

Diane Blanchette

Clay Armstrong

ICISF's Chicago, IL Conference held October 22-26, 2014
Congratulations on being chosen for the Certificate of Appreciation Award:

Sue Blechschmidt

Shining Star Program

ICISF is proud to announce a new recognition program entitled "Shining Star" in CISM. Current CISM Teams or Liaisons may nominate a local person who has, over seven years or more, shown outstanding leadership/innovation for their efforts in promoting CISM. The Categories and Eligibility for this program are as follows:

Rising Star: Those individuals who have shown seven years of dedication, commitment and enthusiasm towards the mission of ICISF and CISM.

Guiding Star: Those individuals who have, over eight or more years of involvement in CISM, shown dedication and commitment to those in need, mentoring others to become involved in CISM, through training, team building and team support.

Heavenly Star: Those individuals who made significant contributions to the field of CISM and have left us far too soon.

Nominations will be evaluated by a committee comprised of Pete Volkmann from New York, Sandy Scerra from Massachusetts, Dennis Potter from Michigan and Mary Schoenfeldt from Washington State. This committee is independent of the ICISF office.

Announcements will be provided by ICISF on their webpage and in LifeNet Newsletter. This program will recognize the grass-roots efforts and successes of CISM worldwide. The recipient being honored will receive a special pin and a Proclamation from ICISF. Please nominate those rising stars in CISM. We need to know.

Complete the nomination form and forward to Michelle Parks (mparks@icisf.org)

Dear Shining Star Committee,

I received the "Shining Star Award" in the mail at the weekend.

I feel very humble and don't know what to say, nor how to show my gratitude for this acknowledgement. Yes, it's been a long time, sometimes at great cost, but I've done all this in the spirit that so many of you at ICISF share - a dedication to CISM, peers and a better world.

Thank you, and please extend my warmest regards to those who supported my nomination.

Yours sincerely,
John Durkin, PhD

Dear Shining Star Committee,

I can't tell you how surprised and humbled I was to receive your Shining Star Award..... It was presented to me at the end of our staff care / CISM training for our African-based staff, which was recently conducted in Senegal..... I really had no idea what was happening!

Any success we have in staff care in World Vision truly goes to my colleagues - I'm surrounded by people who really make this service happen. This primarily includes my boss, Richard Marshall, his boss, Bessie Vanaris, and my two extraordinary staff care colleagues (and dearest friends), Suzanne Wavre and Johara Boukaa - surround yourself with people who are smarter than you and are patient with your weaknesses and good things will happen.....

Critical Incident Stress Management (CISM) has given World Vision a very practical and powerful set of tools to assist our staff that experience a critical incident or are at risk for experiencing a critical incident. I can't tell you how grateful we are for being part of this very professional crisis care movement. We owe you all so much. Because of the ICISF, and what we have learned from you, we are able to help people in places around the world that you would have never imagined...

Warmest regards, and all the best,
Michael - back in Seattle

ICISF Company Store

ICISF Company Gear is available our website!

Remember! Active members get 20% off the retail price. Call ICISF for the member discount Code!

Keep an eye out for special products available for a limited time through preorder!

Membership Announcement

ICISF is happy to announce an online member site which allows you to update your information, renew your membership, access issues of the LifeNet member newsletter and view the members-only library. If you do not have your username and password, please contact Michelle Parks (mparks@icisf.org).

ICISF Welcomes Our Newest Member to the Team

John Newnan has recently assumed the position of Director of Development with ICISF.

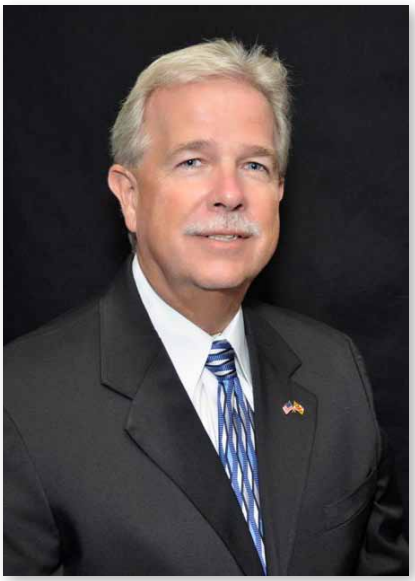
John began his career in public safety as a volunteer firefighter/EMT in 1976, working his way up to a Chief Officer in the Fallston Volunteer Fire & Ambulance Company, where he is a Life Member. John became a police officer in 1978 in Havre de Grace, Maryland, and transferred as a "lateral" police officer to the Howard County Police Department in 1986.

John worked his way through the ranks in the Howard County Police Department, and recently retired as a Captain this past October. Most recently, he was the Commander of the Information and Technology Management Bureau, which included oversight of the 911 Center (fire, EMS & police), Records Management and Computer Operations. John managed this Bureau, with a $15.2 million dollar annual budget and 125 employees, for the past five years. John holds a Bachelor's Degree in Criminal Justice and is a graduate of several senior management and leadership programs.

John has been a volunteer for Special Olympics Maryland for the past 28 years, and was the State Director for all law enforcement volunteerism for the past 15 years in a movement called the Law Enforcement Torch Run. This volunteer movement has generated over $30 million for Special Olympics Maryland through a variety of fundraising events over the past three decades.

John currently is a member of the Board of Directors for Special Olympics Maryland, as well a member of the International Law Enforcement Torch Run Executive Council. John regularly works with law enforcement officers around the world in creating awareness and raising funds for Special Olympics.

John is tremendously excited about joining the team at ICISF and understands the mission of the Foundation, as a past recipient of critical incident stress management resources after being involved in several significant critical incidents early in his career as a law enforcement officer. John believes that, with his life experiences as a public safety professional, as well as his past two decades of experience in working at a high level in the non-profit world, he can help the ICISF in creating more awareness and developing new funding streams to continue to build upon the excellence and further the outreach of the training programs provided by the ICISF.



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area depends upon the success of the others. For example, a meaningful upgrade of products must include modern delivery methods and effective marketing.

The journey begins with the update of ICISF products. This action features the new editions of the core courses of instruction, including both the Individual and Group student manuals. ICISF founders Dr. Jeffrey Mitchell and Dr. George Everly devoted extensive work to complete the new editions. The introduction of both manuals should occur by the end of 2014, setting the stage for many other course updates. Webinars, new instructor manuals, and new slide programs will help transition instructors to the updated courses. The new editions of the manuals no longer include the slide outline, but do include new and updated content.

During 2015, the new manuals will be converted to digital products, available as "eBooks". In fact, the ICISF has begun the transition to an entirely digital process to register for training, including the purchase of materials, and the printing of certificates. The shipment of materials thus becomes as easy as ordering anything online. Digital products also enhance language translation.

Updating of courses and manuals requires renewing the partnership and agreement with various authors and faculty. We intend to make this essentially standard while establishing a clear understanding of the relationship. That sets the stage, so to speak, for the creation of new courses and modified versions of traditional programs.

An important new method of product delivery features the conversion of ICISF training programs into online courses as addition to our array of in-person sessions. The flexibility of this modern approach to training enables participants and instructors to work from anywhere at any time during the day. Courses that have been cancelled due to low enrollment at a specific location are great candidates for online instruction. The potential is unlimited. Challenges include the actual creation of an online version of a course, and the online application of interactive classroom exercises. The potential benefits of this option outweigh the challenges, although this involves considerable work.

Much of our work is now organized within a new ICISF Academy of Crisis Intervention. This package of programs encompasses the Regional Trainings (formerly Regional Conferences), the Approved Instructor program, Speaker's Bureau programs, World Congress, online courses, and other training products. Objectives of this new feature include maintaining standards of training and consistent messages to ensure that the various components complement each other. The Academy of Crisis Intervention essentially symbolizes the rebirth of the ICISF, emphasizing the techniques and time-tested values of critical incident stress management, delivered with new editions and through new methods.

The ICISF has begun the journey to become more of a membership organization. The transition to online membership application and renewal occurred in the summer of 2014. Members will find traditional discounts on regional trainings, along with new benefits, including member discounts for apparel and other products featuring the new "globe" ICISF logo. The website now offers an area exclusive for members that include articles and other information pertinent to the work of crisis intervention. If you care about supporting the work of the ICISF, if you care about helping us perform this essential work, then it is important that you remain a member. Perhaps it is even more important for you to encourage other people to join. As membership grows, the ICISF programs and services shall become stronger.

Alternative revenue through creative development programs is a new department at the ICISF. This includes an organized effort to pursue grants, corporate support, charitable giving, and other donation development. It is important to note two parameters of this new program. First, this support shall never affect the policies and decisions regarding the content of programs and delivery of the products of the ICISF. Second, the development program is a new department, essentially a startup set of objectives that shall evolve over time.

The third area of ICISF evolution involves internal functions, including use of office space, updating a fifteen-year-old phone system, hiring a new registration contractor, pursuing a new email server and file storage, and many other changes. By the end of 2014 we reduced our office space to be more efficient with our rented space. This includes the digital conversion of dozens of boxes of old documents, with the intent of reducing rented space and improving our ability to find records you need. The phone system will enable us to be more responsive to your calls. At present we have difficulty with voice mail and other basic services.

The fourth area of evolution of the ICISF involves marketing. The new logo represents the renewed effort to bring the programs to you, throughout the world. That is just a start. We must work to inform instructors, participants in programs, and people around the world. We must effectively share news about the updated courses, the new student manuals, the availability of online

Helping Save the Heroes (Cont'd)

products and merchandise, details of the Academy programs, member benefits and other pertinent updates. The website, social media, static displays, document appearance, brochures, and many other methods of marketing communication help bring our messages to you.

People may focus on the tagline "Helping Save the Heroes" with various criticism or praise. The point is to say something meaningful about the mission of the ICISF in a few words. That perhaps generates a discussion about the heroes, the role of the ICISF and how we may make that claim. We easily identify heroes in our midst, even though those individuals might shun that identity.

How do we help save them? The programs we manage, delivered via highly skilled faculty and instructors, give people tools to help others live with the burdens they carry each day. They receive a helping hand up from where they may have fallen. It is doing our part to help those who raise them up from an internal struggle. Of course, these tools are not exclusively reserved for heroes.

The coming months remain part of a transition for the ICISF. We survived a period of great struggle and now perform our work in the midst of a renovation of programs and delivery. The vision and mission remain powerful, fueling the motivation to endure the challenge of change. We need your feedback, your participation as a member, as an instructor, as a thoughtful partner. We need you to be part of the effort to help save the heroes, and to bring these programs into the mainstream of our society. Please forward any feedback you may have to lifenet@icisf.org.

I Read it On the Internet

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Unbiased information is needed to make the most informed decisions when navigating the complex issues of critical incident response, particularly for those "in harm's way."

Some background: In 1984 I lived in a rural Wisconsin community where the mentally ill son of two local EMTs stabbed his teenaged sister to death in the family home. His intention was to kill his parents as well, but after slicing into his sister 32 times and leaving her body in a basement closet, he walked to a local church and confessed his act to a priest. The couple returned home, after a social evening with friends, to find their property a crime scene. The deceased young woman was a regular babysitter for the children of local emergency services personnel, was well-known and popular in the community. The aftermath of this incident had a profound impact upon the local emergency services community; 50% of the emergency services personnel in the community had or would leave uniformed service within four years of the murder. There were a number for divorces, substance abuse issues with those who remained and the level of staffing for the ambulance was very thin. This was one catalyst for my involvement in CISM and my continuing education in psychology.

I attended "Emergency Services Stress" training with Dr. Mitchell in Madison Wisconsin, in 1990. I didn't know what CISD was, but I felt there had to be a way to support personnel following a horrible event; based upon the description of the training, this seemed a place to start. Debriefings were discussed as a component of a broader approach to address stress management in emergency services providers, but CISD was not defined as a stand-alone mechanism in the absence of pre-incident education and ongoing support for both front line staff and their families. As a board member of the Wisconsin EMT Association, I was asked to chair a sub-committee looking at stress management within uniformed services. Over the next seven years, hundreds of emergency services peers and mental health professionals were trained by Doctors Mitchell and Everly in Wisconsin. At one point in the mid-to-late-1990s, over 800 CISM-trained peers and providers were formed into a regional CISM team.

Prior to earning a Master's degree in psychology I had served as an emergency medical responder, chief deputy medicolegal death investigator, and as the executive director of a domestic intervention agency— a total of more than 30 years assisting individuals and families in crisis. After receiving the graduate degree, I served as a (Military) Family Programs Analyst with a Department of Defense program; and am now actively immersed in veteran reintegration issues while seeking a PhD program for a terminal degree. For the sake of full disclosure, and acknowledging my potential biases (important to tag my own baggage): I have been a proponent of stress management programs, and particularly psychoeducation (PE) in advance of exposure to trauma, for emergency responders and military personnel for many years and have followed the debate about the efficacy of PE and "debriefings" for these occupations with great interest. I actually selected the topic for my

Master's program capstone/thesis, conducting an extensive literature review on the topic. I made this choice because I served for seven years as the program administrator for the Wisconsin CISM Network, Inc., and during that time I first encountered the statement: "CISD is not helpful and is potentially harmful."

Initially I was informed of the potential harm of CISM by a firefighter, who heard such from a PhD university psychology professor in our state. I was surprised again while attending the Midwestern CISM Conference in Omaha, Nebraska, in 1992, when a presenter, Dr. Richard Gist, spoke negatively about CISD/CISM and instead discussed his approach to stress management for emergency services personnel from his perspective working with the Kansas City Fire Department. This presentation stuck with me as it seemed odd that, at a conference for those utilizing CISM and expanding their understanding of the process, someone would take that opportunity to knock it. At that point in my professional development I knew nothing of empirical research findings or peer-reviewed journals. I didn't have a clue how mental health interventions were tested or found to be helpful or harmful. I certainly felt I wasn't book-learned enough to challenge anything critics of CISM were saying. These people must certainly know something I didn't, as I was just a volunteer EMT in a 100 square mile rural response area! The CISM program had grown within our state because it was filling a need that had been identified and was a reasonable approach for responders. Comments about uselessness or potential harm just didn't square with my experience, but again as an EMS officer just trying to staff the rig 24/7, what did I know?

Beginning the literature review for my master's program in 2009, I fully expected to find volumes of information about the potential harm of CISM dating back to the early 1990s. Such research findings would have solidly supported the critical statements. The most discussed and earliest cited research discussion was the 1997 *British Journal of Psychiatry* article, "Randomized Controlled Trial of Psychological Debriefing for Victims of Acute Burn Trauma" written by J.L Bisson, P.L. Jenkins, J. Alexander, & C. Bannister. The Bisson et al (1997) study focused on the provision of single session debriefings to individual burn patients in a hospital burn unit. The "debriefing" intervention(s) actually provided were single sessions with a single burn victim by one mental health provider or a nurse. Later journal discussions about the 1997 Bisson and colleagues study essentially acknowledge it to have compared apples to oranges, and there is much agreement in literature that the Bisson findings do not support negative commentary around the use of CISD/CISM with uniformed services personnel. The findings did not provide any greater understanding regarding the provision of the Mitchell model critical incident stress debriefing to uniformed services personnel in a group setting or as component of a broader CISM program. Bisson et al (1997) did open a door to the understanding that single-session debriefings should not be co-opted for use for the general public, but failed to prove conclusively that the group CISD or CISM is ineffective when used with those for whom it was originally structured.

By way of another example, a 2006 study did research "group debriefing" but researched the responses (as with Bisson) of non-rescuers. Devilly and Varker measured civilian reaction to a "traumatic video." I am guessing here that we can all agree that seeing a video, no matter how graphic, cannot compare with the sensory experience (lights, sirens, smells, touch, threat, etc…) of emergency scene response or participation in a combat. I remember while attending medicolegal death investigator training in St Louis the entire class ate lunch while viewing a video of a complete autopsy, start to finish. I didn't notice anyone unable to finish their lunch or profoundly traumatized by the experience. We were a room of coroners/medical examiners at various years of experience; this would not have been lunchtime-appropriate for many. So how exactly did the 2006 study prove anything about CISD/CISM? It did not, but it did confirm (as with Bisson) that debriefings were not particularly helpful to the general public. It is correct to say "research indicates group psychological debriefings are not helpful and potentially harmful." BUT the statement is just plain misleading without acknowledging the great majority of the research coming to this conclusion has been conducted with non-rescuers. In spite of the apples-to-oranges comparison issue, studies like these are often cited as the "proof" of the harm caused by CISD/CISM. The Bisson et al paper has been cited in over 250 published papers, and an unknown number of unpublished research papers.

Malcolm et al (2006) support my apples-to-oranges concern with their statement: "There is an extant body of work that accuses debriefings of being ineffective and even harmful to participants (Bisson & Deahl, 1994; Bledsoe, 2004; NIMH, 2002; Wessely et al., 2000). Although controversy fuels empirical integrity, there seems to be a simple answer to this debate

I Read it On the Internet (Cont'd)

about the validity of CISD. Careful review of the articles that indicate a lack of efficacy reveals numerous debriefings conducted in one-on-one settings, with hospital patients, and with ill-defined methods of crisis intervention. These debriefings do not follow the CISD guidelines, the Mitchell Model, or the ICISF standard of care."

The background and experiences of those responding to questions and comments posted in the LinkedIn discussion groups are diverse and represent mental health, EAP providers, and uniformed services (both first response and military). One recent question posted asked of the value of CISD which lead to a debate with several people chiming in regarding their experiences with CISM and the value of the program. Dr. Gist was an aggressive contributor within the discussion. Participants in the discussion referred to his contributions as "having a bullying tone" and "condescending." Knowing of his bias, which was clearly present several years before the Bisson et al article, I viewed his responses with a healthy dose of skepticism. I find it difficult to give credibility to someone who has a bias and is comfortable citing negative outcomes from studies with non-rescuers (the majority of the time from his own published works) to support that bias. I cannot, in the limited space of this article, go into much detail, but if you want to see this in action go to the LinkedIn site, search groups for the "Critical Incident Stress Caregivers" group and join. You will see two specific discussions under the questions: 1.)"Another person question the CISM and the group crisis intervention following death of staff- does it work? does it make difference to individual? what's the risk management? Any opinions?" and 2.)"How long can we wait to respond to the critical incident? 24-72 hours? (TRiM, CISM recommendations etc.) Should we act immediately or give it at least 24 hours?"

Then, just for the sake of contrast, go to the EAP Critical Incident Response discussion group, and look for that second question again. Absent Gist's tone, the discussion is civil, non-confrontational, and informative.

I do not (as my father would have said) have a dog in this hunt. This is an exciting time for critical incident response and we will continue expand our knowledge as long as critical incidents occur. As a farm girl from Wisconsin, I can recognize the smell from the barnyard when it hits my nose. Seriously, would CISM continue to be utilized, after this many years, if uniformed services personnel were being harmed by the process? I look forward to thoughtful, cordial, professional discussions on social media, but commentary needs to pass a smell test of sorts and indeed be thoughtful, cordial, and professional.

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CISM in the Humanitarian Aid Context

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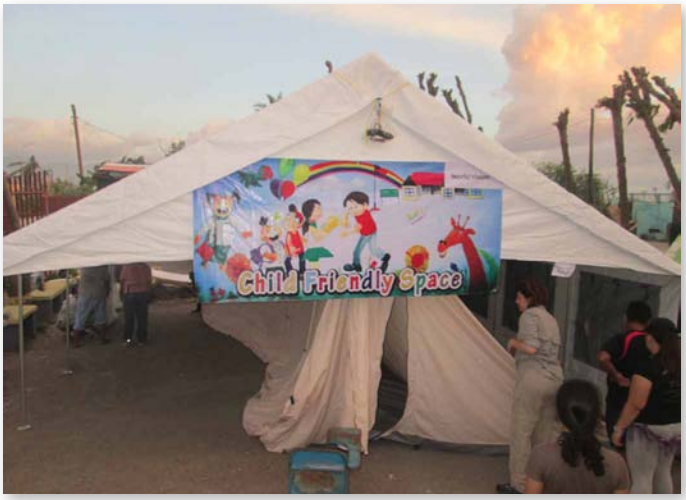
by three people—has a full-time dedication to the well-being of WVI staff worldwide. Our main tasks are training, coordination of large staff care interventions, collecting and reporting on critical incident data, strategic development of staff care strategies on a global, regional and country level, supporting the peer supporters and keeping ourselves up to date on new developments in the mental health crisis intervention field.

The WVI's staff care department has taken a holistic approach in developing a strategy that can be implemented across countries, cultures and religions. The three factors that make up our approach are: physical well-being, occupational well-being and emotional and spiritual well-being.

In any type of crisis, whether it be personal or related to a large disaster, we assess those three components. Physical needs may be related to personal security or physical integrity, but also to deployed staff's housing or staff health insurance. Occupational well-being refers to how staff feel within the organization, including its culture, and how engaged they feel with their work. Every year a survey is send out to all 45,000 staff to measure organizational well-being. In



2013 81% of all staff responded; their engagement index was 77% and the culture index was 75%. A good three-quarters of our staff are satisfied with our organizational culture and are happy working for WVI. The last part, emotional and spiritual well-being, is where CISM comes into place.

CISM Program in WVI

WVI has offices in 96 countries, and our goal is to have a minimum of two peer supporters in each country office, with the exception of a number of highly unstable countries. In those countries, the amount of critical incidents is typically higher and more volatile, and thus a higher number of staff will be affected. The desired number of peer supporters in countries like Afghanistan, Democratic Republic of Congo, Somalia, and Sudan, are a minimum of four.

Because our geographical work area is the world, our Staff Care Unit typically (budget depending) gathers in four locations across the globe to provide training. There are a number of issues that need to be taken into account when choosing a location: safety and security, accessibility, visa requirements, regional office preferences, and costs. Cyprus is generally the desired location to train staff from the Middle East and Eastern European projects, whereas Bangkok, Manila or Singapore are preferred for Asia; San José, Costa Rica is normally the venue for Latin America and the Caribbean and Nairobi, Kenya, Johannesburg, South Africa or Dakar, Senegal for our African training events.

Our training program consists of six courses. In year 1, our peer support students gather for a week to receive a two-day training in our in-house developed stress management course. On day 3, they are trained to become trainers in the same course, with the expectancy that they will run stress management trainings in their home offices / countries. On days 4, 5 and 6, participants are educated in GRIN – the combination course for Group and Individual Crisis Intervention.

The year following, the same students are invited back for another week of more advanced training. They will be trained in the ICISF courses Suicide Awareness and Pastoral Crisis intervention. Since 2012 World Vision has had the unique opportunity for its peer supporters to be trained in

Eye Movement Desensitization Reprocessing (EMDR) for paraprofessionals. This three-day course is a pilot project, taught by Dr. Ignacio Jarero, who teaches peer supporters to apply basic EMDR strategies for individuals and groups. With a total of six course certificates we feel confident that our peer supporters are well-equipped to support their colleagues in the aftermath of critical incidents.

CISM Interventions in WVI

At the time of this writing, WVI has trained about 550 people in CISM, of which there are around 400 peer supporters remaining due to attrition. Those 400 are based in 77 countries. We are well on our way to reaching our goal, but still have a few steps to take. In some countries, like the Philippines or China, there are more than 20 peer supporters because the country office invested in in-country training. But still, when a large disaster strikes, we may have to gather forces from around the globe to support the peer supporters as they themselves are affected or run the risk of being overwhelmed by the sheer magnitude of the event. Examples are the earthquake of 2010 in Haiti and last year's mega-typhoon in the Philippines.

As the financial year has come to a close, we can report that, last year, 471 incidents have been reported into WVI's incident management system. With 171 car/motor accidents reported, road safety is the largest threat to our staff, as it has been for a number of years. This is closely followed by 166 reports of violence, which can be anything from a house burglary to a street robbery at gun- or knifepoint. Most used interventions are the SAFER-R model for individual crisis intervention, followed by other interventions such as family and human resources support.

About 50% of all incidents were responded to by peer supporters and/or the staff care unit. While there is room for improvement here, our challenge lies in underreporting, communication between departments and a newly rolled-out system this year. We should considered adding a reporting component to our training modules, so our peer supporters will become more aware of the need to report incidents and more conversant in the process of reporting.

In the last ten years WVI's staff care unit has come an incredibly long way under the leadership of Dr. Michael Hegenauer and the never-ceasing advocacy efforts of Suzanne

CISM in the Humanitarian Aid Context (Cont'd)

Wavre and her predecessor Tony Culnane. CISM has become the major component in our staff care interventions, and every year we manage four or five training events worldwide. But we are far from sitting back and relaxing. With three full-time staff members in our Staff Care Unit, it takes great effort to provide the proper support and guidance to our large number of peer supporters stationed across the globe in the World Vision Partnership. Having an integrated incident management system is extremely helpful, yet a lot of work is needed to make sure our peer supporters make the best use of it. Another challenge is to keep our peer supporters up to date on developments in the crisis intervention field and ensuring that ICISF standards are upheld. And all this within a very tight budget.

Nevertheless, our combined passion for the well-being of our staff and with the wonderful support of CISM friends from the USA, Australia, Singapore, Hong Kong, Mexico, Germany, England, Ireland, Italy, Spain, Austria and so on….. we are ready for the next

The Impact of Psychological Trauma

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threatened death, serious injury, or a threat to the physical integrity of one's self or others. The first responder's response must also include feelings of intense fear or helplessness. Depending on the critical incident, PTSD can occur in first responders in a range from 8% to 32% of those responding.

Traumatic events disrupt the three domains of good physical and mental health: reasonable mastery over our daily activities, caring attachments to loved ones and friends, and a meaningful purpose in life that motivates us to become involved in the world each day and is a reason to live. Traumatic events are beyond our control by definition, disrupt our caring attachments through death or displacement, and shatter our sense of what makes life worthwhile.

Psychological trauma also has three sets of signs or symptoms that indicate traumatic stress. Frist are the physical symptoms of exaggerated startle response, hypervigilance, and irritability. Next are the intrusive symptoms which are memories of the event and include nightmares, daydreams, and sudden recall of events that are known as "flashbacks." The third set of symptoms are the avoidant symptoms and may include later post-incident avoidance of the critical incident site, avoiding talking about it, a diminished interest in daily events, and the sense of a foreshortened future.

A first responder may be said to be traumatized if he or she experiences disruptions in any of the three domains of good health and/or any of the three sets of symptoms. Psychological trauma may last thirty days. On the thirty-first day, if the responder is still experiencing disruptions in any of the six categories, the responder has moved from trauma to posttraumatic stress disorder (PTSD). Without adequate treatment, these disruptions will likely last until death.

Traumatic events raise at least four questions: Are some responders more at risk to develop trauma and PTSD? Are there certain incident risk factors? What are common negative physical and psychological health outcomes? And, finally, how is this problem treated?

Personal Risk Factors

There are some life events that increase the risk for anyone to become traumatized by a critical incident, and first responders are not exempt from these factors. Past untreated personal victimization in childhood increases the probability of developing trauma during a subsequent critical incident. Depression is a second risk factor. Depressed persons are more likely to experience anger, sadness, and futility during critical incidents. Social isolation is another important and often overlooked factor. Strong social support helps all of us to navigate difficult times, and its absence during critical incidents is keenly felt. A last common risk factor is substance abuse that complicates feeling and thinking during the incident.

Critical Incident Risk Factors

In addition to the personal risk factors, there are also risk factors in the critical incident itself that may increase the probability of developing trauma. These factors are specific to the roles of first responders and are present in both natural disasters and human-perpetrated violence.

Both arriving first onsite and prolonged exposure onsite increase the probability of psychological trauma. In these two situations responders may encounter the most horrific and grisly acts of destruction to persons and property. Losing caring attachments through the death of a family member, neighbor, or line –of-duty death are another incident risk factor. Inadequate training and/or organizational stress are also potential risk factors. Not feeling safe and not having a supportive and understanding network of colleagues and friends compounds coping post-incident, as does the absence of onsite debriefing during the incident.

Common Negative Physical/ Mental Health Outcomes

From a physical health perspective, personal injury, medical conditions related to the incident (e.g., respiratory issues after prolonged exposure to chemicals or smoke), and intense fatigue are common negative outcomes. Negative mental health outcomes may include anger, panic attacks, depression, and psychological trauma/PTSD with increasingly impaired functioning at home and at work. Substance abuse to self-medicate and lessen the impact of the incident begins, continues, and/or escalates post-incident. Anger over the incident may lead to domestic violence. Repeated exposure in subsequent critical incidents will further aggravate these wounds.

It doesn't have to be this way.

Treatments for Psychological Trauma and PTSD

First responders are worthy of the same compassionate care that they provide to critical incident victims. As we have seen, trauma may affect responders in a variety of ways and there are many helpful interventions to resolve these matters. The goal is to match any treatment(s) to the responder's needs. Providing crisis intervention counseling onsite post-incident is one way to begin to address responder needs. The CISM approach developed by Drs. Jeffrey Mitchell and George Everly, Jr. or my Assaulted Staff Action Program (ASAP) are helpful places to start.

Additional assistance with any lingering or late-onset issues can then be addressed. For any of these interventions to work, the responder must be safe and not abusing substances. These issues need to be addressed first. Below is a listing of the various treatments for each domain of good health and for each symptom group.

Health Domains: Reasonable Mastery: The first responder mindset of take charge, make decisions quickly, and remain detached is paradoxically not what responders need to adopt for post-incident self-care. Post-incident growth requires the mastery skills of empathy, having a good support network, and relying on others. A good way to increase or enhance one's overall mastery skills is to learn the skills of resiliency that Dr. Everly has outlined or the skills of stress-resistant persons that I have written about. In addition to these general mastery skills, specific first responder skills for safety, team approaches, implementing chain-of-command decisions, and the like can be provided in-house. Mastery of organizational issues, such as work overload, unclear job descriptions, and role conflicts also need to be addressed in-house.

Caring Attachments: All responders need social support networks from colleagues, supervisors, and agency directors. These attachments can occur one-on-one, in small groups, or include all agency personnel. More socially retiring responders will likely do better in one-on-one encounters. Meaningful Purpose in Life: Understanding and making sense of critical incidents is often difficult. In natural disasters, one can reflect on the laws of Nature, but in seemingly wanton human-perpetrated violence, making sense of what has happened is more difficult. Incorporating these terrible events into a first responder value system that emphasizes caring for others can be difficult. Group discussions as to cause can be helpful, as can more formal counseling. This may be indicated in cases of prior personal victimization and repeated exposures to critical incidents over the years.

Symptoms: Physical symptoms: The symptoms of hyperarousal and exaggerated startle from the adrenalin rush can be addressed through aerobic exercise, walking, relaxation exercises, mindfulness, and prayer. Other alternatives could include music, dance, or photography. Short-term use of anti-anxiety medications may also be helpful.

As for Intrusive Symptoms, unwanted memories of incidents have been responsive to Cognitive Behavior Therapy (CBT) and Rapid Eye Movement Desensitization (EMDR) as well as ongoing discussions with colleagues. Anti-depressant medications have proven helpful to some responders in controlling flashbacks. Lastly, avoidant symptoms are best addressed by discussing what one wants to avoid and then gradually re-experiencing the incident in small measured steps, so as to desensitize any unwanted fears, depression, or behavioral avoidance of the situation (*in vivo* desensitization).

Personal Growth: As painful as these incidents may be, some responders grow in these crises and become aware of personal strengths, a deeper appreciation of life, and spiritual enrichment. Pastoral counseling may enhance this growth.

There is a great deal of information in this column. Hopefully, it will help you to consider any possible negative impacts that you or others may be experiencing. You are not expected to know what treatments to select. However, there are senior managers in your agency and on the faculty and staff of ICISF who can help you locate the resources that you need. Good luck in your work and, as they used to say on *Hill Street Blues*: "Let's be careful out there."

Dr. Flannery is Director of the Assaulted Staff Action Program (ASAP) and is on the faculties of Harvard Medical School and the University of Massachusetts Medical School.

Deadly Force Encounters

Continued from page 3

traumatized. No one remains unscathed in the face of the taking of a life in the line of duty. Far too many law enforcement officers never return to duty in the aftermath of the deadly apprehension of suspects, as their ability to function on the job may be compromised by critical incident stress or post-traumatic stress, in addition to survivor guilt that remains unresolved. For many law enforcement officers, the taking of a life, regardless of circumstances or the numbers of lives spared in the process of shooting incidents, is of little consequence. This is readily made more injurious by the absence of peer support or CISM services that should be made available through their respective departments. Even if outpatient mental health services are recommended by peers or supervisors, a departmental stigma may pose obstacles that result in the decision not to seek mental health intervention. Regardless of all else, deadly force encounters comprise an assault upon the psyche and the soma and a host of predictable physical, emotional, and perceptual alterations that are unique to both law enforcement and military circles. In either case, the need for the provision of CISM and peer support services that lead to readjustment and reintegration is an essential aspect of psychological survival, whether electing to return to duty or making the ultimate decision to leave the force.

Fortunately, within more progressive police departments, peer support programs and widespread knowledge of the solid principles of crisis management and CISM are well-honed and routinely employed. Frequently, officers involved in deadly-force encounters are mandated and/or referred for participation in peer support activities in the hours or days following these critical incidents. An important caveat is that if debriefings are made mandatory, the stigma of seeking mental health services is removed. Of course, CISM and peer support are never to be considered a replacement for mental health intervention. Neither should they ever be considered forms of psychological treatment. Family members may also be offered support in the form of debriefings, but separately from officers as needed or upon request. As is always the case, peer support must be conducted by officers trained in CISM and peer support models. Credentialing in CISM is fundamental to the provision of any debriefing. When possible and ideally, debriefings should be conducted within 72 hours. Oftentimes, real life does not conform to these recommendations, particularly as physical injuries and departmental demands may delay service provision of any type. Most importantly, debriefings comprise a significant aspect of recovery from exposure to traumatic and tragic events, which are ordinarily in no short supply in the course of law enforcement duties.

With respect to assessing the ability of law enforcement officers to return to duty in the aftermath of deadly force encounters, it is deemed necessary and in the best interests of those officers involved to receive a secondary debriefing in the context of permitting them to have a voice, to put such a catastrophic experience into a healthier context and in some type of logical order, and to assist them in the process of respecting and honoring their actions on scene. It has been my experience that regardless of peer support and CISM interventions, it is a necessary and invaluable portion of the recovery process to conduct an individual debriefing as part of the return to duty evaluation process, utilizing well-established CISM principles and the seven step Mitchell Model as a guidelines (Introduction, Fact, Thought, Reaction, Symptom, Teaching, and Reentry Phases). The goals of this process, which are identical to those of the group debriefing model, are as follows, as this very well-established practice is based upon decades of rigorous study that have the potential to be extremely effective within law enforcement populations:

- Enable law enforcement officers to seek catharsis by relieving the likely tremendous emotional burdens carried in the aftermath of deadly force encounters.
- Acknowledge a wide range of uncomfortable emotions in regard to loss of life, injuries and fatalities on the job. Being able to emote or to express emotions normalizes reactions to traumatic events and is essential to the recovery process.Assess post-traumatic stress reactions, to include physical, emotional, behavioral, and spiritual responses to critical incidents.
- Provide comprehensive educational interventions involving what to expect subsequent to officer-involved shootings physically, psychologically, behaviorally, spiritually, and legally, in addition to provision of comprehensive information on most effective coping strategies.
- Assess mental status and psychological wellbeing and provide specific recommendations for additional follow-up treatment/ongoing psychological interventions.
- Evaluate complicating factors such as attempts to self-anesthetize with alcohol, prescription medications, or recreational substances.
- Evaluate the need to advocate

for further time off from duty for officers.

- Assess risks for self-harm and other-harm (suicidal ideation and homicidal ideation).
- Create treatment plans with specific recommendations for promotion of the recovery process.
- Celebrate the accomplishments and courageous actions of the law enforcement officer in the line of duty as a guardian of the public safety.
- Establish an action plan involving support personnel to contact for additional assistance as needed (family member, close friend, peer support staff, department chaplain or clergy selected by officer).
- Attempt to assure that no "secondary" injuries have occurred as a result of maltreatment by the officer's department following traumatic exposure (this may be unintentional, but is nevertheless considerably injurious (Digliani, 2012).

Communication with the referring police department remains privileged. If the referring department requests completion of any specific documentation concerning the referred officer's psychological status and ability to return to duty, for recommendations regarding continued psychological services, or for feedback regarding the officer's fitness for duty/ability to return to duty or light duty, formal releases of information must be obtained from the officer. The only information that may be revealed to the department is confirmation of attendance of the debriefing session. None of the services described above constitute a formal fitness for duty evaluation, which is a separate and distinct evaluation procedure conducted by psychologists contracted or employed by local police departments expressly for this purpose. If the agency or police department has legitimate concerns about fitness for duty, the officer should be referred to a mental health professional other than the "treating" mental health professional.

Treatment should be provided on a voluntary basis, subsequent to the initial evaluative debriefing session, based upon the recommendations of the treating clinician and, sadly, the availability of insurance benefits that will cover costs of treatment. Many departments are only able or willing to assume responsibility for payment of the initial mandatory debriefing session, and, in best case scenarios, to cover the costs of one to three additional sessions.

Individual debriefings become increasingly important in the case of officers who may feel uncomfortable in revealing issues that they cannot or should not in the presence of other officers, contingent upon investigative status of the deadly-force encounter and legal ramifications. This is regardless of the recognized and accepted effectiveness or value of the group debriefing process.

At the conclusion of individual debriefings and associated treatment provided in the aftermath of deadly force encounters, the hallmark of readiness is for officers to be

equipped to face the real possibility of having to rush headlong into another officer-involved shooting incident and to step directly back into the kill zone.

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