
FIREFIGHTER Support Information

Reference and Resource Handbook



“Supporting each other”

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Firefighter Support Information

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Introduction

Firefighters have supported one another since the inception of fire protection services. In the early years, when firefighters experienced emotional difficulties or troubling stressors, whether or not they were work related, they could always rely on each other. This tradition, previously known as the *firefighter brotherhood*, continues today. In the modern firefighting service, the brotherhood tradition has grown into the idea of a *firefighter family* and now includes men and women firefighters.

The firefighter family has been a strong psychological supportive resource for individual firefighters and remains so today. In addition, firefighters now have several alternatives for assistance when dealing with emotional and psychological difficulties. In several contemporary fire departments one of these alternatives is working with the department's peer support team...JAD

The Concept of Stress

Stress is a multifaceted and complex phenomenon. It appears to be a factor for all living organisms. The concept of stress has its origin in ancient writings and has developed significantly over the past several decades.

Stress: Hans Selye (1907-1982), an endocrinologist and researcher, defined stress as “the nonspecific response of the body to any demand, whether it is caused by, or results in, pleasant or unpleasant conditions.” A more contemporary and alternative view of stress maintains that the idea of stress “should be restricted to conditions where an environmental demand exceeds the natural regulatory capacity of an organism” (Koolhass, J., et al. 2011). Simply restated, in Selye’s view the intensity of the stress response is positively correlated with the combined intensity of *all* current demands. Therefore, as the totality of demands increase, the magnitude of the stress response increases. In the latter view, stress is hypothesized to occur only when the demands exceed those of everyday living. Included in these demands are the biological processes necessary to sustain life.

The concept of stress differs from that of *stressor* and *challenge*. *Stressor* is the term used for the demands that cause stress. Therefore, stressors cause stress. *Challenges* are a particular type of stressor. Stressors that are perceived as challenges do not appear to produce the negative effects associated with stress. Instead, challenges are frequently experienced as re-energizing and motivating. Whether a stressor is perceived as a challenge or a difficulty is influenced by many factors. Among these are: type and intensity of the stressor, stressor appraisal, perceived capability to cope with the stressor, available support and resources, individual personality characteristics, and likely assessed outcomes. This is why a stressor that represents a challenge for one person may cause significant stress in another.

Stressor: a demand that initiates the stress response. Stressors can be psychological or physical, low to high intensity, short to long duration, vary in frequency, and originate in the environment or internally.

Fight or flight: a phrase coined by Walter B. Cannon (1871-1945) to emphasize the preparation-for-action and survival value of the physiological changes that occur upon being confronted with a stressor. The fight or flight response later became associated with the Alarm phase of the *General Adaptation Syndrome*.

General Adaptation Syndrome (GAS): (Selye, H.) the GAS is comprised of three stages: alarm, resistance, and exhaustion. *Alarm* is the body's initial response to a perceived threat and the first stage of general adaptation syndrome. During this stage, the body begins the production and release of several hormones that affect the functioning of the body and brain. During the *resistance* stage of GAS, the internal stress response continues but external symptoms of arousal disappear as the individual attempts to cope with stressful conditions. In the final stage of the GAS, *exhaustion*, the prolonged activation of the stress response depletes the body's resources, resulting in permanent physical damage or death (http://www.ehow.com/facts_6118452_general-adaptation-syndrome.html).

Homeostasis: “steady state” - an organism’s coping efforts to maintain physiological, emotional, and psychological balance.

Overload stress: stress which is the result of a high intensity stressor, too many lesser intensity stressors, or a combination of both that exceeds normal coping abilities.

Deprivational stress: stress experienced due to lack of stimulation, activity, and/or interaction. An example of an environment likely to produce deprivational stress is solitary confinement. Deprivational stress is also the principle underlying the child discipline intervention know as *time out*.

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

Stress Management - Insights into the transactional nature of stress

Epictetus: (A.D. 55 -135) (1) “Men are disturbed not by things, but by the view which they take of them.” (2) “It’s not what happens to you, but how you react to it that matters.” Epictetus was one of the first early writers to recognize the intimate and inextricable relationship that exists between individuals and their environment.

Hans Selye: (1) “Man should not try to avoid stress any more than he would shun food, love or exercise” (2) “It’s not stress that kills us, it is our reaction to it.” (3) “Mental tensions, frustrations, insecurity, aimlessness are among the most damaging stressors, and psychosomatic studies have shown how often they cause migraine headache, peptic ulcers, heart attacks, hypertension, mental disease, suicide, or just hopeless unhappiness.” (4) “Adopting the right attitude can convert a negative stress into a positive one.” Selye is recognized by many researchers as the first person to specify the processes of biological stress. He is sometimes referred to as “father of stress research.”

R.S. Lazarus (1922-2002) (1) “Stress is not a property of the person, or of the environment, but arises when there is conjunction between a particular kind of environment and a particular kind of person that leads to a threat appraisal.” Lazarus maintained that the experience of stress has less to do with a person’s actual situation than with how the person perceived the strength of his own resources: *the person’s cognitive appraisal and personal assessment of coping abilities*.

Koolhaas, J., et al. "Stress revisited: A critical evaluation of the stress concept." *Neuroscience and Biobehavioral Reviews* 35, 1291-1301, (2011).

The Firefighter Culture

“Being a firefighter is the greatest job in the world”

With few exceptions, mainly police and military, there are few careers in this world that can compare to the fire service. When you enter the world of firefighting you become a member of a culture that very few outside of firefighting can understand.

What is the mystery of the firefighter culture? What drives men and women towards one of the most dangerous, exciting, and emotional jobs on earth? What are the stressors and additional psychological dangers present in firefighting?

Firefighter culture

As firefighters, the drive to help others is deeply engrained. This drive is so much a part of the fire service culture that firefighters willingly risk their lives to serve and save others. Sometimes this risk results in tragedy. Sadly, many firefighters have died during their performance of duty while attempting to save or otherwise help others.

The risk of firefighters dying in the line of duty is real and greater than in many other occupations. However, in addition to the primary dangers of firefighting, there is less observable, secondary danger for firefighters. This danger is seldom acknowledged and even less frequently addressed.

The secondary danger: “show no weakness”

For firefighters, what is worse; the fear of dying in the service to others or the fear of showing others, especially other firefighters, a perceived weakness? This question seems easy to answer for those outside of firefighting, yet firefighters know the real answer.

Weakness is a complex concept. To better understand this complexity, imagine a professional golfer. If the golfer struggles chronically or occasionally with stress as a result of the demands of the game would people believe that he is not worthy as a person? Would other golfers view him as weak? Not likely. Instead, they would say that he should be offered help or seek assistance for improved stress management. It appears, at least for golfers, that it is ok to be offered, ask for, and receive help.

Now imagine a firefighter. Firefighters, like everyone else, may struggle chronically or occasionally with the demands of the job. These demands comprise the stressors of firefighting and may be cumulative or incident-specific.

If a firefighter were to make a personal struggle known to others, would he or she be viewed as weak? Would he or she be offered assistance or be encouraged to seek help? Is there any rationale that would justify treating a firefighter different than a golfer?

The fear of showing weakness

The fear of showing weakness relates to the fear of being seen as defective, unable to take it, and not measuring up. It is founded upon the idea that “if you can’t take the

heat, get out of the kitchen”. Ultimately, it involves the fear of being rejected. It is associated with the need to appear strong, capable, and *indestructible*. This is why some firefighters will simply not ask for help...no matter how much they need it.

No one is indestructible

The myth of being indestructible has some psychological utility. It is a form of denial that helps firefighters to better confront dangerous circumstances by suppressing normal fear and anxiety. However, when taken to extremes, the idea of being indestructible creates numerous problems. It impedes the development of healthy self-insight and causes firefighters to deny serious difficulties. This can occur even as their lives are falling apart.

Questions to consider

Is it weak for firefighters to ask for help? Why do so many firefighters feel that by asking for help they will prove to others that they can't do the job? When, in fire service history, did the belief develop that showing human emotions and asking for help to cope with job stressors become proof of firefighter weakness? Why do some firefighters turn away from their own when problems become known. Why have some firefighters taken their own lives instead of reaching out for help?

The answer to these questions can be reduced to this: The fire service culture has not and does not generally support or encourage troubled firefighters to seek help. This remains true despite the fact that some fire departments have made valiant efforts to improve this situation.

There is some good news. The good news for the fire service is that if firefighters are willing to make some minor changes in their perspective, they can reduce or eliminate any perceived stigma for firefighters asking for help.

Two positive changes

There are at least two positive changes that can positively affect the fire service culture: behavioral health training and peer support programs. These two, in conjunction, function to educate firefighters on how to (1) communicate effectively, (2) recognize signs and symptoms of stress and traumatization, (3) recognize the warning signs of firefighter suicide risk, and (4) trust one another so that it is easier to speak about troubling emotional responses.

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

- 2) *Peer Support Program:* Appropriately trained firefighters can play a vital role in a fire department's effort to positively change the fire service culture. This is especially true when the desired change involves making it acceptable for firefighters to seek assistance with job or personal stressors. The "peer support" firefighter is not a trained counselor but has received specialized training in the principles of peer support. Peer support firefighters are trained to recognize signs of emotional distress and take appropriate action. This can range from a single peer support interaction to making recommendations for resources to further assist and support the firefighter.

When added by fire departments, these key components will address the negative attributes of the firefighter culture.

Being a firefighter is a dangerous but highly rewarding career. The honor, pride, and dedication to service of firefighters have earned them the respect of the communities they serve. Traditionally, it has been a job well done. This tradition should be continued but must now incorporate an improved firefighter self-care culture change.

Firefighters must release some of the past. This includes the belief that if firefighters ask for help they are showing weakness. Firefighters need to support and take care of one another.

The effort to improve

The effort to improve the fire service culture begins with every firefighter in America. Whether firefighter or chief, paid or volunteer, experienced or intern, all firefighters must work to make and maintain positive changes. Firefighters must stop ridiculing or teasing department members that are struggling with personal and job stressors. They must demonstrate, communicate, encourage, and support efforts of firefighters to seek appropriate peer and professional assistance when needed.

Conclusion

Taking an oath, pinning on a badge and becoming a firefighter will not protect firefighters from experiencing the responses that accompany the stressors inherent in firefighting. At times, these stressors can be overwhelming. When this happens, firefighters should seek assistance.

Some of the stressors involved in firefighting are dangerous and unavoidable. Some are dangerous but avoidable. Making it difficult for firefighters to ask for help when stressed is an avoidable stressor. The job is difficult enough. Does it really need to be made more difficult by maintaining a culture that views asking for help as a weakness?

Collectively, firefighters can alter the fire service culture to significantly diminish the "secondary danger" present in most fire departments.

Jeff Dill, LPC, Founder of Firefighter Behavioral Health Alliance, Assistant Chief, Palatine Rural Fire Protection District, Palatine, IL. and Jack A. Digliani

Firefighter Stressors and Stress Management

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

Some firefighter stressors:

Department politics

Stress from the firefighter culture: *show no weakness*

Inadequate equipment and/or training

Inadequate salary or compensation

Station house relationships and team personality conflicts

Perceived lack of support from chain of command

Working on traditional holidays

Shift hours: absence from family for long shift hours

Lack of sleep during long shift hours - Startle awakenings

Heat, smoke, deadly environments and other dangers inherent in firefighting

Exposure to dead bodies - death imprint

Near death experiences - high probability of on-the-job injury

Exposure to injured persons, blood, and gore

Search, rescue, and recovery activities

Failed rescues

Medical emergencies - Seeing and dealing with human suffering

Uncooperative, threatening, or violent citizens

Exposure to others grief responses

Family issues including those that arise out of "department vs. family" loyalty

Stress Management

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

1. Watch for the next instance in which you find yourself becoming annoyed or angry at something trivial or unimportant. Then practice letting go, making a conscious choice not to become angry or upset. Do not allow yourself to waste thought and energy where it isn't deserved. Effective anger management is a tried-and-true stress reducer.
2. Breathe slowly and deeply. Before reacting to the next stressful occurrence, take three deep breaths and release them slowly. If you have a few minutes, try out a relaxation technique such as meditation or guided imagery.
3. Whenever you feel overwhelmed by stress, practice speaking more slowly than usual. You'll find that you think more clearly and react more reasonably to stressful situations. Stressed people tend to speak fast and breathlessly; by slowing down your speech you'll also appear less anxious and more in control of any situation.

4. Jump-start an effective time management strategy. Choose one simple thing you have been putting off (e.g., returning a phone call, making a doctor's appointment), and do it immediately. Just taking care of one nagging responsibility can be energizing and can improve your attitude.
5. Get outdoors for a brief break. Our grandparents were right about the healing power of fresh air. Don't be deterred by foul weather or a full schedule. Even five minutes on a balcony or terrace can be rejuvenating.
6. Drink plenty of water and eat small, nutritious snacks. Hunger and dehydration, even before you're aware of them, can provoke aggressiveness and exacerbate feelings of anxiety and stress.
7. Do a quick posture check. Hold your head and shoulders upright and avoid stooping or slumping. Bad posture can lead to muscle tension, pain, and increased stress. If you're stuck at a desk most of the day, avoid repetitive strain injuries and sore muscles by making sure your workstation reflects good ergonomic design principles. There is information about ergonomics and healthy workstations to assure your station is more ergonomically safe.
8. Plan something rewarding for the end of your stressful day, even if only a relaxing bath or half an hour with a good book. Put aside work, housekeeping or family concerns for a brief period before bedtime and allow yourself to fully relax. Don't spend this time planning tomorrow's schedule or doing chores you didn't get around to during the day. Remember that you need time to recharge and energize yourself. You'll be much better prepared to face another stressful day.

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

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

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

Signs of Excessive Stress

Impaired judgment and mental confusion
Uncharacteristic indecisiveness
Aggression - temper tantrums and “short fuse”
Continually argumentative - increased family discord
Increased irritability and anxiety
Increased apathy or denial of problems
Loss of interest in family, friends, and activities
Increased feelings of insecurity with lowered self esteem
Feelings of inadequacy

Warning Signs

1. Sudden changes in behavior, usually uncharacteristic of the person
2. Gradual change in behavior indicative of gradual deterioration
3. Erratic work habits and poor work attitude
4. Increased sick time due to minor problems and frequent colds
5. Inability to concentrate, impaired memory, or impaired reading comprehension
6. Excessive worrying and feelings of inadequacy
7. Excessive use of tobacco, alcohol, or drugs
8. Peers, family, & others begin to avoid the person because of attitude/behavior
9. Excessive complaints (negative citizen contact or family member complaints)
10. Not responsive to corrective or supportive feedback
11. Excessive accidents or injuries due to carelessness or preoccupation
12. Energy extremes: no energy or hyperactivity
13. Sexual promiscuity or sexual disinterest
14. Grandiose or paranoid behavior
15. Increased use of sick leave for “mental health days”

Excessive stress can be expressed in physical or psychological symptoms, including:

Muscle tightness/migraine or tension headache
Clenching jaws/grinding teeth or related dental problems
Chronic fatigue/feeling down or experiencing depression
Rapid heartbeat/hypertension
Indigestion/nausea/ulcers/constipation or diarrhea
Unintended weight loss or gain - changes in appetite
Abnormally cold or sweaty palms
Nervousness and increased feelings of being jittery
Insomnia or sleeping excessively - strange dreams or nightmares
In extreme cases - psychotic reactions/mental disorder

Examples -

1. From cheerful and optimistic to gloomy and pessimistic.
2. Gradually becoming slow and lethargic, increasing depression.
3. Coming to work late, leaving early, sick time abuse.
4. Rambling conversation, difficulty in sticking to a specific subject.
5. Lack of participation in normally enjoyed activities.

Critical Incident Information

Critical incidents:

are often sudden and unexpected
disrupt ideas of control and how the world works (core beliefs)
feel emotionally and psychologically overwhelming
can strip psychological defense mechanisms
frequently involve perceptions of death, threat to life, or involve bodily injury

Perceptual distortions possible during the incident:

slow motion	visual illusion
fast motion	heightened visual clarity
muted/diminished sound	automatic pilot
amplified sound	memory loss for part of the event
slowing of time	memory loss for part of your actions
accelerated time	false memory
dissociation	temporary paralysis
tunnel vision	vivid images

Possible responses following a critical incident:

heightened sense of danger
anger, frustration, and blaming
isolation and withdrawal
sleep difficulties
intrusive thoughts
emotional numbing
depression and feelings of guilt
no depression and feelings of having done well
sexual or appetite changes
second guessing and endless rethinking of the incident
interpersonal difficulties
increased alcohol or drug use
grief and mourning

Factors affecting the magnitude of traumatic response:

Person variables - personality, view of reality, personal history, beliefs and aforethought, assessment of self performance, perception of alternative options, coping abilities, degree and result of stress management and stress inoculation training.

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

Traumatic Stress: Shock, Impact, and Recovery

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

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

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

Recovery—recovery does not follow impact as a discreet event. Instead, with proper support and individual processing, impact slowly diminishes. As impact diminishes, recovery begins. A person can experience any degree of recovery. No or little recovery can result in lifetime disability. Full recovery involves becoming stronger and smarter, disconnecting the memory of the incident from any enduring disabling emotional responses, and placing the incident into psychological history. Without recovery, persons remain *victims* of trauma. With recovery, they become *survivors*.

Posttraumatic Stress (PTS) - expected and predictable responses to a traumatic event. PTS normally resolves within one month of the incident through the person’s self-management and personal psychological resources. External psychological and emotional support systems are also of great value for the resolution of PTS. Clinically significant impairment is absent in PTS.

Posttraumatic Stress Disorder (PTSD) - a constellation of clinical symptoms which meet the specific criteria for the PTSD diagnosis (including clinically significant impairment). PTSD requires professional treatment to produce the most positive possible outcome. PTSD is often accompanied by a degree of *depression*.

Trauma: Chronological History and Psychological History

Firefighters who have experienced traumatic events want to place the incident behind them and move on. The difficulty for many firefighters is that the incident continues to impact their lives in less than desirable ways. This is because the incident, while in *chronological history*, is not yet in *psychological history*. The incident is in chronological history the instant that it is over. However, this is not the case with psychological history. When thoughts and other stimuli associated with the incident evoke powerful distressing responses following the incident, the incident is not in psychological history.

Placing the incident into psychological history involves disconnecting the memory of the incident from the gut-wrenching or negative emotional responses experienced during or immediately following the incident. When an incident is in psychological history, conditioned responses are minimized. Thoughts of the incident may produce emotional responses, but they will not be disabling. The person will be able to move forward, no longer being psychologically stuck in the incident.

A major component of traumatic incident recovery is placing the event into psychological history.

The ability to place experiences into psychological history is also important in everyday life. This is especially true of functional interpersonal relationships. In functional interpersonal relationships persons are able to emotionally move beyond the memory of minor transgressions and prevent such memories from continually exerting an undesirable influence on the relationship.

According to psychologist Albert Ellis, PhD (1913-2007), author of *Rational-Emotive Behavioral Therapy* (REBT) there are 12 primary irrational ideas that cause and sustain psychological difficulty. Irrational idea number 9 is presented here because of its relevance to “placing the event into psychological history” and as a reminder of what can be accomplished:

REBT Irrational Idea Number 9: *The idea that because something once strongly affected our life, it should indefinitely affect it* - Instead of the idea that we can learn from our past experiences but not be overly-attached to or prejudiced by them.

Ellis, A. (2004). *Rational Emotive Behavior Therapy: It Works for Me--It Can Work for You*. Amherst, NY: Prometheus Books.

How to Recover from Traumatic Stress

1. Accept your emotions as normal and part of the recovery/survival process.
2. Talk about the event and your feelings.
3. Accept that you may have experienced fear and confronted your vulnerability.
4. Use your fear or anxiousness as a cue to utilize your stress recovery skills.
5. Realize that your survival instinct was an asset at the time of the incident and that it remains intact to assist you again if needed.
6. Accept that you cannot always control events, but you can control your response.
7. If you are troubled by a perceived lack of control, focus on the fact that you had *some* control during the event. You used your strength to respond in a certain way.
8. Do not second-guess your actions. Evaluate your actions based on your perceptions at the time of the event, not afterwards.
9. Understand that your actions were based on the need to make a critical decision for action. The decision likely had to be made within seconds.
10. Accept that your behavior was appropriate to your perceptions and feelings at the time of the incident. Accept that no one is perfect. You may like/dislike some actions.
11. Focus on the things you did that you feel good about. Positive outcomes are often produced by less than perfect actions.
12. Do not take personally the response of the system. Keep the needs of the various systems (police, administrative investigation, the press, etc) in perspective.

Remember, fireground critical incidents happen because you are a firefighter and there are circumstances beyond your control, not because of who you are as a person.

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

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

Getting Help

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

This page adapts and includes information from the Colorado Law Enforcement Academy Handbook and *Reflections of a Police Psychologist* (Digliani, J.A., 2010).

Suggestions for Supporting Firefighters Involved in Critical Incidents

1. Initiate contact in the form of a phone call, text, email, or note. *Do not fall into the trap that “others will do it, so I don’t have to.” Your expression of support will be appreciated. Avoid becoming overly persistent or intrusive.*
2. Offer to stay with a traumatized firefighter for the first day or two after the event if you know they live alone (or help find a mutual friend who can). Alternatively, you could offer the firefighter to stay with you and your family. *This type of support for a firefighter living alone can be quite beneficial for the first few days following a traumatic incident.*
3. Let the traumatized firefighter decide how much contact he/she wants to have with you. They may be overwhelmed with phone calls and it may take a while for them to return your call. Also, they and their family may want some “down time” with minimal interruptions. *Avoid being intrusive, even if your actions are well-intentioned.*
4. Don’t ask for an account of the incident, but let the traumatized firefighter know you are willing to listen to whatever he or she wants to talk about. Be mindful that there is usually no legally privileged confidentiality for peer discussions. *A privileged communication relationship does exist between firefighters and certain others including psychologists, attorneys, licensed or ordained clergy members, spouses, physicians, and other licensed or supervised mental health professionals. In Colorado, members of a fire department peer support team (PST) are protected from testifying without consent under the provisions of C.R.S. 13-90-107(m), however this protection is limited and does not apply to “information indicative of any criminal conduct.” PST member confidentiality under C.R.S. 13-90-107(m) does not include protection against being compelled to testify in federal courts. PST members are ethically responsible for specifying the limits of confidentiality protections prior to engaging in any peer support interactions.*
5. Ask questions that show support and acceptance such as, “Is there anything I can do to help you or your family?” *In some cases where the pre-existing relationship will support it, just doing instead of asking is appropriate.*
6. Accept their reaction as normal for them and avoid suggesting how they “should” be feeling. Persons have a wide range of reactions to traumatic events. *If part of their reaction includes thoughts or feelings of homicide or suicide, or should you observe behaviors consistent with serious mental illness, you should immediately contact the PST or take other appropriate action.*
7. Remember that the key to helping a traumatized firefighter is nonjudgmental listening. *Just listening without trying to solve a problem or imposing your views can go a long way to support traumatized firefighters.*
8. Don’t say, “I understand how you feel” unless you have been through the same experience. Do feel free to offer a BRIEF sharing of a similar experience you might have had to help them know they are not alone in how they feel. However, this is not the time to work on your own trauma issues with this person. If your friend’s event

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

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

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

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

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

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

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

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

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

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

Adapted from "Suggestions for Supporting Officers Involved in Shootings and Other Trauma" written by Alexis Artwohl and published in her book, *DEADLY FORCE ENCOUNTERS*, co-authored by Loren Christensen (1997) (Alterations in original text made with permission). The thoughts and comments of Jack A. Digliani are represented in italics (added with permission).

Issues of Behavior, Change, and Communication

Remain mindful of your body language and what you communicate nonverbally. Nonverbal behaviors speak loudly, forcefully, and continuously.

Work on *your* issues – trust others (family members, peers, etc) to work on theirs.

Mindfulness vs Obsession. Remind yourself of the changes that you wish to make and maintain. You do not need to obsess about desired change but you must remain mindful. Take yourself seriously when attempting to implement change. Change is unlikely if your effort to change is too casual.

When dealing with others, decide what is negotiable. Where is your flexibility? Consider couples and group goals. If you agree to participate in a goal or activity that is not your personal preference, you accept the responsibility to support it, or at the very least not gripe about it. Once you agree, be a good sport-try to have a good time.

Positive sentiment - Negative sentiment. Previous experience and existing emotion can influence current perceptions. Try to evaluate the communication of others in context and as it occurs. Do not get stalled by historical negative sentiment. Give others a second chance. *Look* for the positive in order to *experience* the positive.

You *can* change, you *can* do things differently. It may feel a bit strange at first but don't quit. Persistence and adaptation are skills to be learned.

When attempting behavior change, you are looking to influence one part of your brain (the automatic thinking and behavior part) with another part of your brain (the intentional thinking and behavior part). You can influence your brain in positive ways.

Communicate to Motivate

Communicating to motivate another person involves finding something positive to say or to do. It provides realistic acknowledgement and encouragement. You may still complain, provide feedback, and offer guidance, however communicating to motivate avoids the personal criticism which often decreases the effort of others.

Self-communication (self-talk). You can *communicate to motivate* with yourself! Talk to yourself in ways that avoid self-criticism. Find something positive in your effort.

Exemplary or good communication takes more effort than “short-cut” or poor communication. Moderated humor can be useful. Good communication is not always “all business”...it can be fun and enjoyable.

Ask appropriate questions to clarify confusion. Appropriate: *Can you help me to better understand your point of view?* Inappropriate: *Do you have anything sensible to add?* (This implies previous comments have not been sensible and is personally invalidating)

Listen without bias. Discuss differences. Accept influence. Negotiate. Compromise. Make choices and take responsibility. Decide. Decisions can be tentative and “experimental”. Assess and reevaluate. Adjust if and when necessary.

Considerations for Change

- People can change.
- People do not change easily.
- Behavior is often related to reinforcement schedules.
- Behavior can be functional or dysfunctional.
- What is considered functional and dysfunctional behavior is dependent upon a system of values and specific cognitive conceptualizations.
- Thoughts that drive some behaviors may be considered functional or dysfunctional, and rational or irrational (with gradients of these variables).
- Many dysfunctional behaviors are learned and can be unlearned.
- In the change process, if the change is functional, ethical, and desired, it should be maintained. If the change is dysfunctional, it should be abandoned.
- Dysfunctional behavior is normally reinforced in some way (it meets some need). If you meet the need being met by dysfunctional behavior with more functional or acceptable behavior, the dysfunctional behavior will likely decrease or stop.
- The probability of change increases when there is a positive role model. Change is more likely to occur when the role model is respected or significant in some meaningful way.
- Support, peer support, and positive reinforcement aid the change process.
- The probability of change is enhanced with the enhancement of a person's self-esteem.
- Change is more likely as a person's competence and confidence increases.
- Change is complicated by untreated underlying mental disorders and/or substance addiction. Such conditions themselves can be a focus for change.
- When seeking to implement change, *self-acceptance* is important. The change process is enhanced when a person accepts who he or she is, while *simultaneously* targeting specific thoughts or behaviors for change.
- Do not underestimate the *potential* for change, the *possibility* of change, or the sometimes *difficulty* of change. However, keep in mind:

The difficult is not the impossible.

Anger: Get Educated

Got a problem? Everyone gets mad sometimes. So how does one tell the difference between a bad day and chronic anger? Ask yourself or someone you are trying to help these questions:

1. Do you often find yourself irritable and annoyed?
2. Do you find that certain people or situations make you furious?
3. Are you often irritable and don't know why?
4. Do you often use obscenities in your speech or mind?
5. Do you often think of people who upset you in terms of "a-hole", "jerk" etc.?
6. Do you have trouble giving someone a genuine compliment?
7. When something goes wrong, do you generally blame someone else?

If you answered "yes" to any of these questions, you may have a chronic anger problem.

Steps to alleviate Chronic Anger Syndrome

- Awareness is the first step. You may or may not be angry for a good reason. Anger can be 90% history and memories.
- Disrupt anger. Count to 10, write a letter, go for a walk, etc. Channel anger into something positive. Do not allow anger to control you or cause you to engage in bad or negative behaviors.
- Relaxation. Learn to disrupt or alter your anger response. Practice deep breathing. If answering telephones makes you mad and you must answer telephones, use relaxation strategies to interrupt and terminate your anger response.
- Change your environment. If you find yourself getting angry when you do X, find some reasonable and acceptable alternatives to X.
- Try silly humor. Looking at things from a humorous point of view diffuses anger and keeps things in perspective.
- Solve problems. If certain events, circumstances, or people irritate you, deal directly with the situation in an *appropriately* assertive manner. If necessary, ask for the help of others to address or resolve the issue.
- Learn skills. In order to resolve a situation wherein you find yourself chronically angry you may need to learn new skills. If you cannot swim and you get angry every time your child asks you to take her swimming, you can deal with your anger by learning to swim. This would create a mutual activity that could prove enjoyable for both of you.

Jerry L. Deffenbacher, PhD. Colorado State University-Department of Psychology

Warning Signs of Alcoholism - Information

1. Do you ever drink after telling yourself you won't?
2. Does your drinking worry your family?
3. Have you ever been told that you drink too much?
4. Do you drink alone when you feel angry or sad?
5. Have you ever felt you should cut down on your drinking?
6. Do you get headaches or have hangovers after drinking?
7. Does your drinking ever make you late for work?
8. Have you ever been arrested because of your drinking?
9. Have people annoyed you by criticizing your drinking?
10. Have you ever felt bad or guilty about your drinking?
11. Have you ever substituted drinking for a meal?
12. Have you tried to stop drinking or to drink less and failed?
13. Have you ever felt embarrassed or remorseful about your behavior due to drinking?
14. Do you drink secretly to avoid the concerns of others?
15. Do you ever forget what you did while you were drinking?
16. For women - Have you continued drinking while pregnant? (even small amounts)
17. For women - Have you continued drinking while breastfeeding? (even if only between feedings or in small amounts)
18. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
19. Have you ever had to take a drink while at work to feel better?
20. Do you feel shaky, unsettled, or sick if you do not have a drink for a few days?

Some Information About Alcohol

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

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

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

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

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

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

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

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

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

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

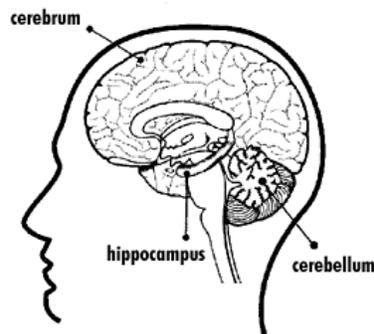
Biological (genetic) and psychosocial factors combine with environmental factors, such as the availability of alcohol, to increase the risk for developing drinking problems.

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

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

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

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



Regions of the brain affected by alcohol

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

Some Things to Remember

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

Some Things to Remember

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

Suicide Risk and Protective Factors

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

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

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

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

Some Types of Suicide

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

Firefighter Suicide Risk Factors

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

Suicide risk factors:

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

Firefighters should not avoid other firefighters they think might be suicidal.

PST: If you observe any of the behavior associated with suicide risk in another firefighter, contact should be initiated. Discuss your observations. Show you care. Introduce the subject of suicide. *Do not hesitate to bring the subject of suicide into the open.*

Conduct a field assessment and follow through on your observations. If you feel that the person is imminently suicidal, do not leave the person alone. Contact your clinical supervisor immediately. Together you arrange for the appropriate intervention.

If the person is not imminently suicidal, spend some time with him/her. Listen closely and provide emotional support. Contact your clinical supervisor. Provide information about available resources, including staff psychologist, department chaplains, the Employee Assistance Program, and community resources. Engage in appropriate follow-up. *The point is, do not hesitate to do something. You may save a life.*

Helping a Person that is Suicidal

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

- Take all suicidal comments and behaviors seriously.
- Initiate a conversation. Express your concern. Inform the person that you are there to help. Express caring. Establish rapport. Be yourself. Your support is demonstrated through a genuine caring relationship.
- Listen closely without being judgmental. Be mindful of what you say because the person may be overly sensitive to your remarks. *Be prepared:* the person may become quite emotional when communicating with you. *Remain calm:* strong emotion dissipates naturally and can provide a sense of relief.
- Bring the issue of suicide into the open. Ask about the person's current circumstances, thoughts, and feelings. Acknowledge the person's difficulties.
- Ask about past and recent self-harm thoughts and behavior.
- Ask about the availability of lethal means for suicide - many persons in the United States have ready access to firearms, which are the leading means of suicide in the U.S. Remove firearms and other lethal means if necessary.
- Determine if there is a suicidal plan - the more detailed and complete the plan, the greater the suicidal risk.
- It is ok to talk to the person about their suicidal thoughts. Let him or her know that such thoughts are often the result of depression and that depression can be effectively treated. Assure the person that with appropriate treatment suicidal thoughts and the feeling of wanting to die will diminish. Help to provide *realistic hope*.
- Do not hesitate to ask for help from the suicidal person and others. (1) Ask the person to help you to help him/her. (2) Others: interacting with a suicidal person is stressful. Professional assessment and intervention is often required.
- If you feel that the person is imminently suicidal do not leave him or her alone. If you are a peer support team member contact your clinical supervisor immediately. Together arrange for appropriate intervention. If you are not a member of a peer support team, contact a peer support team member or other appropriate resource person immediately. *Keep in mind that emergency intervention may be necessary, including involuntary hospitalization.*
- If the person is not imminently suicidal, spend some time with him or her, "provide an ear" and other emotional support. (See *Level of Suicide Risk*, p.67)
- Avoid providing problem solutions. Instead, (1) focus on listening and supporting the person. Let the person know that he or she is important to you. (2) Work to have the person contact or become involved with professional counseling services. Provide information about available support services.
- *If you are unsure about whether the person is or is not imminently suicidal or you do not feel competent to assess his or her level of self-danger, do not leave the person alone. Contact an available assessment and support resource immediately. The resource will make the assessment. Do this even if the person objects. This is the best way to keep the person safe.*
- Do not keep a "suicidal secret". Gently explain that you must contact others.
- Arrange for the person to be with others 24/7 for continued support and to add an additional level of safety if needed.
- Follow up as appropriate.

Common Misconceptions about Suicide

FALSE: People who talk about suicide won't really do it.

Almost everyone who commits or attempts suicide has given some clue or warning. Do not ignore suicide threats. Statements like "you'll be sorry when I'm dead," "I can't see any way out," – no matter how casually or jokingly said may indicate serious suicidal feelings.

FALSE: Anyone who tries to kill him/herself must be crazy.

Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

FALSE: If a person is determined to kill him/herself, nothing is going to stop them.

Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

FALSE: People who commit suicide are people who were unwilling to seek help.

Studies of suicide victims have shown that more than half had sought medical help in the six months prior to their deaths.

FALSE: Talking about suicide may give someone the idea.

You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true – bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

Source: *SAVE - Suicide Awareness Voices of Education*

Level of Suicide Risk

Low – Some suicidal thoughts. No suicide plan. Says he or she won't commit suicide.

Moderate – Suicidal thoughts. Vague plan that isn't very lethal. Says he or she won't commit suicide.

High – Suicidal thoughts. Specific plan that is highly lethal. Says he or she won't commit suicide.

Severe – Suicidal thoughts. Specific plan that is highly lethal. Says he or she will commit suicide.

Source: http://www.helpguide.org/mental/suicide_prevention.htm

National 24/7 Suicide Hotlines

1-800-SUICIDE (1-800-784-2433) 1-800-273-TALK (1-800-273-8255)
Military suicide hotline: 1-800-273-8255, www.firestrong.com

Death, Loss, and Survivorship

The following is a summary of issues involved in death, loss, and survivorship.

1. *Learning of the death.* Shock and denial are common initial responses to death, especially if the death is sudden and unexpected. Disbelief and confusion are frequently experienced.

2. *Reactions to death.* Many factors influence how intensely we feel the loss. Among these are the nature of attachment, spiritual views, the age of the deceased, how the person died, the similarity of the deceased to those we love, and the extent of the void that the person's absence leaves in our life. The death of another can also trigger our own fears of death and memories of previous traumatic events or losses.

3. *Grief and mourning.* Grieving takes time. This is important to remember because American culture is not readily accepting of lengthy grieving or mourning periods. Instead, there is the idea that a person needs to put the loss behind them and get on with life. There is no correct way to grieve. People deal with loss in different ways for different periods of time. The public expression of grief is *mourning*.

4. *Coping with loss.* It is common to experience powerful emotions. Confront emotions openly. Strong emotion may feel overwhelming. Breathe through it.

5. *Specific reactions to loss.* There are many possible reactions to loss. Common and normal reactions include sadness, crying, numbness, loss of appetite, inability to sleep, fatigue, anger and frustration, finding it difficult to be alone, or wanting to be alone. Utilizing your support system is the best way to deal with the pain of grieving.

6. *Stages of grief.* Many clinicians have identified what they refer to as stages of grief. Although such stages differ in terminology, the basic structure of the stages involve (1) an initial shock and denial, (2) a subsequent impact and suffering period, followed by (3) some adjustment and degree of recovery (similar to exposure to any traumatic event). However, grieving is a complex process; it does not progress clearly from one stage to another. It is normal to once again have feelings long thought to have disappeared.

7. *Healing.* Acknowledge and accept your feelings. You may experience seemingly contradictory feelings such as relief and sadness (for example, relief that a burden of care or the person's suffering has ended, and sadness due to the loss). This is normal. Keep in mind that your emotional attachment does not end upon the death of someone you care about. Remember, bereavement is the normal process by which human beings heal from loss.

8. *Surviving the loss.* Surviving the death of someone you care about involves honoring the memory of the person by acknowledging what the person contributed to your life. From here, you can further honor the person by reengaging life. It is important to remember that similar feelings can follow the death or loss of pets, non pet animals, and even plants and inanimate objects that have acquired some special meaning (like losing a family heirloom). Brain studies show that the same neural pathways of grief are activated regardless of the loss.

The Effects of Exposure to Death - Death Imprint

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

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

For firefighters, death is a more-than-usual topic for thought. For one thing, firefighter training encourages thinking about death; their own as well as others. This is present in fireground training, fire safety training, rescue training, self protection training, fire tactics training, and first aid.

Firefighters are also encouraged to think about death by the very nature of their work. Fighting fires and related first-responder duties expose firefighters to death in various ways, including crimes against persons, natural deaths, and deadly traffic accidents.

Firefighters must always be prepared to protect themselves. When performing job duties, firefighters must cope with the *assumption of possible danger*. This is very different from those in most other occupations, who live in a world of *assumption of safety*. It is the possible danger to their personal safety that has given rise to the often stated mantra of firefighters, "Everyone goes home."

Issues for Peer Support

Peer support team members recognize that differential fire assignments expose firefighters to various probabilities of death exposure.

First-responder firefighters are the most likely to be exposed to death. This is because of the *funnel effect*, wherein the cases involving death get funneled to first-responder firefighters. Some firefighters learn to effectively manage death exposure; they must do so if they are to continue in their work. To others, these firefighters can sometimes appear "cold" or "callous."

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

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

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

Death Imprint

When firefighters experience anxiety about death, it often involves thoughts about their death, the death of loved ones, the inevitability of death, the identification of a deceased person with still living loved ones, the future loss of loved ones, and memories of those that have already died. The actual degree of experienced distress varies and is dependent upon the intensity, frequency, and duration of anxiety.

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

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

Death Imprint and Peer Support

Peer support team members must remember that there does not have to be an actual death for a person to be effected by death imprint. Near death or serious injury that might have resulted in death is enough to trigger death imprint.

Coping with death imprint may require assistance beyond the scope of peer support. Although peer support can be a valuable asset to those experiencing death imprint, peer support team members that suspect serious reactions involving death imprint should notify their clinical supervisor, and make appropriate referrals or support the person to seek professional help.

Foundation Building Blocks of Functional Relationships

1. **Emotional Connection:** all relationships are characterized by feelings or the emotional connections that exist between or among relationship members. Love is one such feeling. Feelings and the emotional connection frequently alter or influence perceptions and behaviors.
2. **Trust:** is a fundamental building block of all functional relationships. Trust is related to many other components of functional relationships including fidelity, dependability, honesty, etc.
3. **Honesty:** functional relationships are characterized by a high degree of caring honesty. There is a place for “not hurting others feelings”. However, consistent misrepresentation to avoid short-term conflict often results in the establishment of dysfunctional patterns such as long-term resentment, invalidation, etc.
4. **Assumption of honesty:** with trust, we can assume honesty in others. A relationship in which honesty cannot be assumed is plagued with distrust and prone to suspicion. Such relationships are characterized by persons trying to mind read and second guess the “real” meaning of various interactions.
5. **Respect:** respect is demonstrated in all areas of functional relationships - verbal communication, non-verbal behaviors, openness for discussion, conflict resolution, etc. Without respect, relationships cannot remain functional because problem-resolution communication is not possible.
6. **Tolerance:** the acceptance of personal differences and individual *preferences* are vital to keeping relationships working well. A degree of mutual tolerance makes relationships more pleasant & less stressful.
7. **Responsiveness:** your responsiveness to others helps to validate their importance to you and reflects your sense of meaningfulness of the relationship. This is especially important in hierarchical relationships.
8. **Flexibility:** personal rigidity frequently strains relationships and limits potential functional boundaries. Highly functional relationships are characterized by reasonable flexibility so that when stressed, they bend without breaking. Many things are not as serious as they first seem. Develop and maintain a sense of humor.
9. **Communication:** make it safe for communication. Safe communication means that others can come to you with any issue and expect to be heard. Listen in a calm, attentive manner. Allow the person to express thoughts and feelings without interruption. Communication factors: *content-message-delivery* (Content - the words you choose in the attempt to send your message, Message - the meaning of what you are trying to communicate, Delivery - how you say what you are saying. Delivery includes nonverbal behavior and defines the content message). Remember: Protect less - communicate more. *Confrontation guidelines:* a caring manner, appropriate timing and setting, present your thoughts tentatively, move from facts to opinion.

10. **Commitment:** long-term functional relationships are characterized by *willingness* to work on problems, acceptance of personal responsibility, attempts to see things from other perspectives, conflict resolution, and the ability of members to move beyond common transgressions. Life is complex. People are not perfect. You must decide what is forgivable. If forgivable, put it in the past and move on. *Psychological history* and *chronological history*.

Remember: All of us have *special status* people. Spouses, significant others, etc. are special status people. It is ok to do some things differently for those with special status. For instance, comply with their wishes at times even though it's not your preference. They will return this courtesy, resulting in an improved relationship. Do you really need to assert dominance in every circumstance? Do you need to win every argument? Can you see things from viewpoints other than your own? These are important issues in functional relationships and *Life by Default - Life by Design*.

(See *Trauma: Chronological History and Psychological History* and *Life management: Life by Default - Life by Design*)

When talking or otherwise interacting with special status people (especially your spouse), *do not forget with whom you are interacting*. Remaining mindful that you talking to or interacting with a special person in your life will help you to moderate your behavior and maintain a MOB (Mindful of Blocks) mentality. This will help you to remain calm, respectful, and measured in potentially emotionally charged interactions. As a result, you will avoid behavior that you may later regret. For example, have you ever found yourself apologizing following a conversation with someone you care about by saying something like “I’m sorry, I shouldn’t have spoken to you that way”? If so, you did not maintain a MOB mentality during the conversation.

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

Issues in Interpersonal Relationships and Family Systems

- Rules
- Myths
- Generational boundaries
- Alliances and coalitions
- Function and dysfunction
- Homeostasis
- Underflow

In combination with *Some Things to Remember* and *Gottman’s Marriage Tips* the *Foundation Building Blocks of Functional Relationships* provide an excellent framework for those wishing to improve their marriage and other personal relationships.

Gottman's Marriage Tips

Couples researcher, psychologist John Gottman identified seven tips for keeping marriages healthy. In combination with the *Foundation Building Blocks of Functional Relationships* and *Some Things to Remember* they provide an excellent framework for those wishing to enhance or improve their marriage.

- *Seek help early.* The average couple waits six years before seeking help for marital problems (and keep in mind, half of all marriages that end do so in the first seven years). This means the average couple lives with unhappiness for far too long.
- *Edit yourself.* Couples who avoid saying every critical thought when discussing touchy topics are consistently the happiest.
- *Soften your "start up."* Arguments first "start up" because a spouse sometimes escalates the conflict from the get-go by making a critical or contemptuous remark in a confrontational tone. Bring up problems gently and without blame.
- *Accept influence.* A marriage succeeds to the extent that the husband can accept influence from his wife. If a woman says, "Do you have to work Thursday night? My mother is coming that weekend, and I need your help getting ready," and her husband replies, "My plans are set, and I'm not changing them". This guy is in a shaky marriage. A husband's ability to be influenced by his wife (rather than vice-versa) is crucial because research shows women are already well practiced at accepting influence from men, and a true partnership only occurs when a husband can do so as well.
- *Have high standards.* Happy couples have high standards for each other even as newlyweds. The most successful couples are those who, even as newlyweds, refused to accept hurtful behavior from one another. The lower the level of tolerance for bad behavior in the beginning of a relationship, the happier the couple is down the road.
- *Learn to repair and exit the argument.* Successful couples know how to exit an argument. Happy couples know how to repair the situation before an argument gets completely out of control. Successful repair attempts include: changing the topic to something completely unrelated; using humor; stroking your partner with a caring remark ("I understand that this is hard for you"); making it clear you're on common ground ("This is our problem"); backing down (in marriage, as in the martial art Aikido, you have to yield to win); and, in general, offering signs of appreciation for your partner and his or her feelings along the way ("I really appreciate and want to thank you for . . ."). If an argument gets too heated, take a 20-minute break, and agree to approach the topic again when you are both calm.
- *Focus on the bright side.* In a happy marriage, while discussing problems, couples make at least five times as many positive statements to and about each other and their relationship as negative ones. For example, "We laugh a lot;" not, "We never have any fun". A good marriage must have a rich climate of positivity. Make deposits to your emotional bank account.

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Communication, Occupational, and Relationship Imperatives

The Communication Imperative

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

The Relationship Imperative

Make it safe!

The Occupational Imperative

Never forget *why* you do *what* you do.

Digliani, J.A. (2010) *Reflections of a Police Psychologist*, page 256.

About the Author

Jack A. Digliani, PhD, EdD is a licensed psychologist and a former deputy sheriff, police officer, and detective. He served as a law enforcement officer for the Laramie County, Wyoming Sheriff's Office, the Cheyenne, Wyoming Police Department, and the Fort Collins, Colorado Police Services (FCPS). He was the FCPS Director of Human Services and police psychologist for the last 11 years of his FCPS police career. While in this position he provided psychological services to employees and their family, and clinically supervised the FCPS Peer Support Team. He received the FCPS Medal of Merit for his work in police psychology.

Dr. Digliani has served as the police psychologist for the Loveland Police Department and Larimer County Sheriff's Office (Colorado) for the past several years. During this period, he provided psychological counseling services to department members and their families. He was also the clinical supervisor of the agencies' Peer Support Teams. He has worked with numerous municipal, county, state, and federal law enforcement agencies. He specializes in police and trauma psychology, group interventions, and the development of police, fire, and other emergency worker peer support teams.

Dr. Digliani is the author of *Reflections of a Police Psychologist*, *Police and Sheriff Peer Support Team Manual*, *Firefighter Peer Support Team Manual*, *Law Enforcement Critical Incident Handbook*, *Law Enforcement Marriage and Relationship Guidebook*, and *Stress Inoculation Training: The Police*. He is a contributor-writer of Colorado Revised Statute 13-90-107(m) *Who may not testify without consent*, the statute and paragraph which grants law enforcement, firefighter, and medical/rescue peer support team members specified confidentiality protection during peer support interactions. He is also the primary author of the peer support section of the *Officer-Involved Incident Protocol* of the 8th Judicial District of Colorado.

In 1990, Dr. Digliani created the *Psychologist And Training/Recruit Officer Liaison* (PATROL) program, a program designed to support police officer recruits and their families during academy and field training. This concept was later extended to the fire service. The *Firefighter Recruit Support* (FIRST) program supports firefighters and their families during recruit training. Through his work, he developed the Freeze-frame method of critical incident debriefing, Option funnel versus Threat funnel, Level I and Level II peer support, the *Comprehensive Model for Police Advanced Strategic Support* for police officers, and the *Comprehensive Model for Peer Advanced Strategic Support* for firefighters (COMPASS). COMPASS is a career-long psychological health and wellness strategy for police officers and firefighters. In 2013, Dr. Digliani developed the conceptions of primary and secondary danger. He then created the "Make it Safe" Police Officer Initiative, a 12-element strategy designed to reduce the secondary danger of policing

To learn more about the Make it Safe Firefighter Initiative and the work of Dr. Digliani visit www.jackdigliani.com