TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

Truckee Meadows Peer Support Team mission is to promote the emotional and psychological health of our peers and public safety family. The Peer Support Team will engage as an understanding peer, focused on preserving dignity through one-on-one confidential communication, and support to peers and their families. Peer Support Members will offer emotional assistance, listen with a nonjudgmental ear, and provide direction to resources.

TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

SECTION 1

PURPOSE:

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INTENT

The Truckee Meadows Fire Protection District recognizes that its employees are the most valuable resource. As a result, the Truckee Meadows Fire Protection District has acknowledged the value of providing a way for their employees to deal with personal and/or professional problems. A successful approach to this problem is to provide a non-professional Peer Support Program in addition to the current Public Safety Employee Assistance Program (EAP) and the Chaplaincy Program. The Peer Support Program is composed of a group of peers who have been selected by the Peer Support selection process and have volunteered to be available to any employee of the department. This program will provide a way for Truckee Meadows Fire employees to work out personal and\or professional problems confidentially. The Peer Support Team will consist of members that not only care, but also understand the resources available to Truckee Meadows Fire employees. The purpose of the program is as follows:

A. Develop Peer Support Members who can identify personal conflicts and provide guidance or referrals to professional resources as needed.

B. Provide emotional support during and after times of personal and/or professional crisis to employees who express a need for assistance.

C. Support employees and their families during tragedies or critical incidents and make proper referrals to professional resources.

D. Check on employees who are off work due to extended illness, injury or administrative leave and provide support for those who express a need.

DEFINITIONS:

PEER:
Any member of the public safety family to include all on-line and off-line, active, retired person and their families. Volunteer staff would be considered an extension to the professional paid staff.

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PEER SUPPORT MEMBER (PSM)
A person who has basic peer support training and makes themselves available to other members of the public safety family. These members will be noted as PSM on Telestaff.

PEER SUPPORT COORDINATOR:
A Peer Support Member designated to lead the Peer Support Team.

PEER SUPPORT TRAINING COORDINATOR
A Peer Support Member designated to coordinate all aspects of training.

PEER SUPPORT SHIFT LEAD (PSL)
A Peer Support Member designated to coordinate activities and communications on each shift. Shall be noted as PSML on Telestaff

CRITICAL INCIDENT
A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a participant.

SECTION 2

DUTIES AND RESPONSIBILITIES

The Peer Support Coordinator acts as the primary liaison between the Peer Support Members, resource persons, Fire Chief and the Department. The Peer Support Coordinator serves as the link to ensure that the Peer Support Program is being managed by the Peer Support Members in accordance with the goals and objectives established for the program. The Peer Support Coordinator can be of any rank, line or non-line personnel.

A. The Peer Support Coordinator responsibilities are as follows:

1. Supervise the program daily.
2. Coordinate response of Peer Support Members to critical incidents.
3. Ensure compliance with department policy and direct the programs operation.
4. Coordinate the screening and recruitment of the Peer Support Team applicants.
5. Ensure Peer Support Members are following up on any outside referrals that have been made.

6. Offer guidance to and develop resources for Peer Support Members.
7. Coordinate initial and ongoing training of Peer Support Members.
8. Responsible for seeking and maintaining the program's budget and statistical data.
9. Ensure that the Peer Support Program and its Members are following federal, state, and local laws, as well as Best Practices, Policies, and Procedures of the department.
10. Coordinating Peer Support Team meetings.
11. Research ongoing training for members of the Peer Support Program.

B. The Peer Support Shift Liaison responsibilities are as follows:

1. On-duty Point of Contact for Dispatch and Chiefs.
2. Responsible for communicating and coordinating peer support members within each shift.
3. Shift ambassador for educating and promoting the peer support team.
4. Notify the Chaplain of all Critical Incidents.

C. The Peer Support Training Coordinator responsibilities are as follows:

1. Coordinate quarterly trainings.
2. Inform team members of any available training.
3. Coordinate, line, academy, and retiree training.

D. The Peer Support Member's responsibilities are as follows:

1. Convey trust, anonymity, and assure confidentiality within policy guidelines to employees who seek assistance from the Peer Support Team.
2. Provide assistance and support to peers on a voluntary basis.
3. Assist Peers by referring them to the appropriate resources when necessary.
4. Be available to the individual for follow-up support.
5. Submit Monthly Statistics Report via email to the Secretary or designee.

6. The Peer Support Member will agree to be contacted and, if practical, respond at any hour.

7. Applicable activities for a Peer Support Member include, but are not limited to:

   a. Hospital visitation

   b. Career issues support

   c. Critical incident support

   d. Death notification

   e. Provide information on the Department's Employee Assistance Program (EAP), Alcoholics Anonymous, credit counseling, etc.

   f. Relationship issues support

   g. Support for families of injured or ill employees

   h. On-scene support for personnel immediately following critical incidents

   i. Conduct critical incident stress management debriefings (CISM)

   j. Provide peer support information to current and new employees

   k. Introduce new employees to the Peer Support Program

   l. Assist supervisors in defusing personnel issues

The Peer Support Member will comply with federal, state, local laws, Best Practices, Policies, and Procedures of the Department. When necessary, contact the Peer Support Team Coordinator for assistance and guidance.

E. The Peer Support Secretary responsibilities are as follows:

1. Compile statistics from Monthly Statistics Report and submit to Coordinator.

2. Maintain list of resources used by the Peer Support Team.

3. Chair meetings in absence of the Coordinator.

4. Record minutes during meetings.

5. Maintain training records.

SECTION 3

PEER SUPPORT SELECTION PROCESS

When the Peer Support Team determines a need for new Members, the Peer Support Coordinator will be responsible for notifying the department members of the open position(s). The selection process will follow procedures established in the following:

A. Prospective Peer Support Members must be willing to meet the following criteria:

1. Agree to maintain strict confidentiality and sign the confidentiality agreement.
2. Be empathetic and possess interpersonal and communication skills.
3. Be motivated and willing to manage time effectively.
4. Must successfully complete the selection process.
5. Must attend and successfully complete the training program (IAFF Behavior Health Awareness on-line course, IAFF peer support training, 2 day program or equivalent).
6. Must remain in good standing with the Peer Support Team.
7. Complete 8 hours of continuing education per calendar year.
8. Attend minimum 2 of 4 meetings per calendar year.

B. Peer Support Team Membership and Removal:

1. Peer Support Members are recognized by the Fire Chief upon recommendation from the Peer Support Coordinator.
2. Peer Support Members may withdraw from participation at any time after notifying the Peer Support Coordinator.
3. Peer Support Members may take a sabbatical at any time after notifying the Peer Support Coordinator.
4. Peer Support Members may be removed from the program by the Coordinator for conduct inconsistent with policy and procedure.
5. Participation in the Peer Support Program must not detract from or interfere with primary Fire Department responsibilities.

C. Peer Support Member Conduct Evaluation Process:

1. A committee made up of 3 Peer Support Team members will evaluate the team member's conduct based on the following criteria:

   a. Breach of Confidentiality Agreement

   b. Not Meeting Annual Training requirements

   c. Minimum qualifications not met

   d. Conduct unbecoming of a Peer Support Member

   e. Violation of TMFPD Policy 1.3.3 (Code of Conduct)

2. A Remediation Plan will be developed up to and including removal from the team.

SECTION 4

SHIFT LIAISON NOTIFICATION GUIDELINE

A. Incidents that require a Peer Support Shift Liaison notification by a Peer Support Member:

1. Another employee's death or serious injury
2. Suicide
3. A violent death
4. Infant/child death or serious injury
5. Involved in an incident involving multiple deaths
6. Any incident that is likely to affect the employee's ability to interact with the public and carry out their job functions
7. Any other traumatic incident deemed appropriate

SECTION 5

RESOURCES

The following guidelines provide the Peer Support Member(s) formal authority to obtain certain organizational resources and support he\she needs to assist Peers:

A. The Peer Support Member is authorized to use department facilities to meet with employees.

B. The Peer Support Member is permitted to consult with employees on duty. Every effort will be taken to not conflict with training or company operations.

C. Participation in the program is voluntary.

D. The Department will accommodate training, workshop attendance, and assignment referrals to work locations outside the peer supporter's currently assigned location as resources allow at the Fire Chief's discretion.

E. The Department will provide basic Peer Support Member materials.

SECTION 6

CONFIDENTIALIY

A. The acceptance and success of the Truckee Meadows Fire Protection District's Peer Support Team will be determined, in part, by observance of strict confidentiality. It is imperative that each Peer Support Team member maintain confidentiality of all information gleaned about an individual within the guidelines of this program. Confidentially statement in Appendices of this manual.

B. Communication between the Peer Support Team Member and Peer being assisted is considered confidential except for matters which involve the following:

1. Danger to self.
2. Danger to others.
3. Suspected child abuse.
4. Domestic violence.
5. Where divulgence is requested by the peer.
6. Drug and/or alcohol misuse that may be life threatening.

7. There is evidence of serious mental illness.

8. When otherwise required by law.

C. Peer Support Members acknowledge that during the course of performing their assigned duties as a Truckee Meadows Fire Peer Support Team Member, everything said to them in their role as a peer supporter should be kept to themselves as confidential unless one of the above exclusions applies.

D. As a general principle, Peer Support Members will inform the Peer, prior to discussion, what the limitations and exceptions are regarding the information revealed. In those cases where a question regarding confidentiality arises, Peer Support Members will immediately contact the Peer Support Team Coordinator.

E. In Peer Support Team settings, Peer Support Members will speak about issues raised in general terms being careful not to disclose information that would identify individuals.

F. Peer Support Members will diligently consider their surroundings when having confidential conversations, noting who may be able to hear confidential dialog.

G. Peer Support Members will consider the security of records and take reasonable care to properly secure confidential information on personal computers and will take steps to ensure that others cannot view or access such information.

H. Peer Support Members are required to acknowledge that they have read and understand the requirements set forth in the Peer Support Team Confidentiality Agreement.

I. As a Peer Support Team Member, we understand and agree that our failure to fulfill any of the obligations set forth in the Confidentiality Agreement and/or a Peer Support Members violation of any terms of the Confidentiality Agreement shall result in the Peer Support Member being subject to appropriate conduct evaluation, up to and including, termination of service on the Peer Support Team.

J. If Peer gives consent for divulgence of confidential information:

1. A general principle for Peer Support Members to follow is to inform the person, prior to discussion, what the limitations and exceptions are regarding the information revealed. In those cases where a concern or a question regarding confidentiality arises, the Peer Support Member must immediately contact the Peer Support Coordinator, who will take appropriate action.

2. Should a peer request confidential information to be shared then the Peer Support Member shall obtain a signed Consent of Divulgence form. The completed and signed Consent of Divulgence form shall be maintained by the original Peer Support Member.

SECTION 7

DISCIPLINE AND INTERNAL INVESTIGATIONS

A. It may occur that a Peer Support Member is assisting an individual who is or becomes the subject of a disciplinary investigation. The Peer Support Member should be guided by the confidentiality policy of the Peer Support Program. Members will not volunteer any information received in confidence; however, Members may not hamper or impede the actual investigation, nor may they attempt to shelter the individual from the department's investigation. (AB 301, NRS 190)

B. The Peer Support Member(s) role in disciplinary situations is one of support and assistance to the Peer during the stress they may face during the disciplinary process, but Peer Support Members have no right to participate in or be present during the Truckee Meadows Fire corrective action process. If Peer Support Members have any questions or concerns regarding these situations, they should consult with the Peer Support Coordinator for guidance and assistance. The Peer Support Member is strictly guided by the confidentiality policy. The department investigators and supervisors shall respect the confidential conversations between Members and Peers.

SECTION 8

REFERRAL PROGRAM

The Referral Program is established to assist employees in dealing with problems. Problems may include domestic, financial, health, other personal or job-related difficulties. Support is voluntary and an employee cannot be ordered to participate. The employee shall be assured that the consultation is or has been arranged solely for his/her benefit and will be confidential.

A. Referrals may occur as follows:

1. An employee may personally contact any Peer Support Member, or the Peer Support Coordinator for referral to either professional counseling or a Peer Support Member.

2. An employee aware of another employee who may need assistance can initiate a referral by contacting any Peer Support Team Member. The referred employee will be contacted to assess their receptiveness to Peer Support assistance; however the employee's participation is voluntary.

3. Supervisory personnel have the authority and responsibility to recommend Peer Support to employees when appropriate; however the employee's participation is voluntary.

4. A family member or associate of the employee may make a referral; however, the employee's participation is voluntary.

5. Dispatch personnel may make a referral through an on duty Battalion Chief.

SECTION 9

PEER SUPPORT TRAINING PROGRAM

A. Peer Support Team Members should receive training in the following areas:

1. Active listening.
2. Critical incident stress.
3. Debriefing and defusing techniques.
4. Post-traumatic stress.
5. Problem solving skills.
6. General assessment skills.
7. Referral and follow-up.
8. Self-Care training.

B. The suggested minimum training is:

1. Basic Peer Support Course (Usually 2 day course).
2. Basic Critical Incident Stress Management (CISM) class.
3. Advanced Critical Incident Stress Management (CISM) class.
4. Suicide Identification and Assessment
5. Self-Care

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REFERENCE AND RESOURCE

TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

The Truckee Meadows Firefighter Peer Support Team Manual is an extrapolation and modification of the Police and Sheriff Peer Support Team Manual.

Firefighter Peer Support Team Manual
Reference and Resources manual Edition 3.2

Also by Jack A. Digliani:

Contemporary Issues in Police Psychology
Reflections of a Police Psychologist (2nd ed)
Stress Inoculation: The Police
Police and Sheriff Peer Support Team Manual
Law Enforcement Critical Incident Handbook
Law Enforcement Marriage and Relationship Guidebook
EMS Peer Support Team Manual
Civilian Peer Support Team Manual

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Peer Support: Stage Model of Peer Support

Peer support interactions often involve contacts wherein a fundamental peer support relationship provides supportive assistance to persons confronting a relatively transient stressful or traumatic period in their lives. However, peer support has the potential to help others who are confronting more comprehensive and enduring difficulties.

Peer support can assist persons to initiate and maintain long-term positive life change. Such change involves many factors, including personal effort – effort for change and a secondary effort for consistency to maintain change. The Stage Model of Peer Support is an excellent framework for providing peer support in all situations, including those situations involving comprehensive life change.

Stage Model of Peer Support

Stage I Exploration (the current picture: What's going on?)

Stage II Person Objective Understanding (preferred picture: What do I need or want?)

Stage III Action Programs (the way forward: How do I get what I need or want?)

Stage I: Exploration

1. Attending
2. Engaged (active) listening
3. Genuineness
4. Empathy
5. Concreteness
6. Non-judgmental
7. Transparency
8. Reflection and paraphrasing
9. Respect
10. Trust
11. Supportive summary
12. Field assessment

Stage II: Person Objective Understanding

- Self-disclosure

- Advanced accurate empathy
- Immediacy
- Confrontation

Guidelines for Supportive Confrontation

Confrontation does not have to be dramatic. “I don’t understand how what you’re doing is helping. In fact, it may be making things worse” is a useful low-key confrontation:

1. The first rule of confrontation is - do not confront another person if you do not intend to increase your involvement with him/her.
2. Do not confront when angry.
3. Confront only if you experience feelings of caring or some sense of connection.
4. Confront only if the relationship has gone beyond the initial stages of development or if basic trust has been clearly established.

If all of the above conditions are present but you feel that the person would not benefit from confrontation, you should:

1. Avoid confrontation
2. keep exploring
3. Strengthen the relationship
4. Help the person become ready for the challenges inherent in confrontation

How to Confront Constructively

1. Distinguish between observations and inferences. Communicate the distinction clearly.
2. Present the data on which the inferences are based before stating the inference.
3. Use “I messages” throughout the confrontation.

Stage III: Action Programs

1. Concrete workable goals
2. Set priorities
3. Check behaviors
4. Make it effective

5. Move from less serious to more serious when possible
6. Consider the person's values
7. Develop relapse-prevention strategies

To provide the highest quality peer support: Remember –

1. A common mistake is trying to move from Stage I to Stage III too fast.
2. Help the person reframe, reinterpret, and re-conceptualize dysfunctional thoughts and behavior.
3. Remain mindful of the transactional nature of the person-environment relationship.
4. Frame the problem so that it has a resolution (discuss the idea that some things cannot be changed, therefore the difficulty must be addressed in ways other than effecting it directly).
5. Do not become the client of the person you are trying to help.
6. Avoid imposing your world view.
7. Use care when working with people that you dislike or with whom you have a troublesome history.
8. If you are not able to work comfortably with a person for any reason, refer to another peer support team member or appropriate supportive resource.
9. Refer to professionals when appropriate. This includes specialists outside of the counseling profession, such as attorneys, financial advisors, and so on.
10. Remain within the parameters of your departmental PST policy, your PST operational guidelines, and your PST training.
11. Avoid creating or encouraging dependency.
12. Peer support team members are committed to enhancing a person's independence and self-determination.
13. Utilize appropriate follow up.
14. Contact your team coordinator or clinical supervisor as appropriate.

If you have unfinished psychological or emotional business, seek appropriate counseling. Do not work out your issues in your peer support interactions.

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Action Plan Steps

Step 1: Have I clearly identified the problem?
Step 2: How am I thinking about the problem?
Step 3: Are my thoughts rational or irrational?
Step 4: Is there a better way for me to re-think or conceptualize the problem?
Step 5: What do I want to change?
Step 6: How should I specify and prioritize my desired changes?
Step 7: What are the possible obstacles to my desired changes?
Step 8: How will I overcome these obstacles?
Step 9: How and when will I implement my plan?
Step 10: How will I evaluate the outcome and maintain positive change?
Step 11: How will I prevent a relapse to dysfunction?

Action plans are most helpful when they are written. As a peer support team member you can use the Peer Support Team Action Plan Worksheet, design a specific action plan format to meet the specific needs of the person, or assist the person design an action plan. Any of these will improve the action plan's effectiveness.

When it comes to action plans, be creative. Assist in creating something that works for the person you are trying to help.

TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

Peer Support Team Action Plan Worksheet Summary

The Peer Support Team Action Plan Worksheet may be used in conjunction with peer support and the information included in the Peer Support Team 10-Step Action Plan.

Step 1	What is the issue? What am I **WORRIED** about? Have I clearly identified the problem?	IDENTIFY THE ISSUES, WORRIES, AND PROBLEMS TO BE ADDRESSED.
Step 2-4	Are my thoughts rational or irrational? Do I need help to understand the difference? Is there a better way to think about or conceptualize the problem? What are my **OPTIONS**?	IDENTIFY OPTIONS. RECONSIDER IRRATIONAL CONCEPTUALIZATIONS. CONSIDER: choices, decisions, AND likely consequences. Think of options as opportunities to move forward.
Step 5	What do I want to **CHANGE**?	DO I NEED TO CHANGE MYSELF OR MY ENVIRONMENT? MAYBE SOME OF MYSELF AND SOME OF MY ENVIRONMENT. CONSIDER: *development of coping skills.*
Step 6	**SPECIFY** and **PRIORITIZE** desired changes and goals.	MAY INVOLVE CHANGING THOUGHTS, FEELINGS, BEHAVIORS, AND ELEMENTS OF THE ENVIRONMENT.
Step 7	What are the **ROADBLOCKS?** What obstacles are in the way of change?	ANTICIPATE THE DIFFICULTIES OF POSITIVE CHANGE.
Step 8	**PLAN** to address or overcome the obstacles.	IT IS EASY TO THINK ABOUT OBSTACLES AS OVERWHELMING. DEVELOP A CREATIVE ACTION PLAN THAT INCLUDES OVERCOMING OBSTACLES.
Step 9	**IDENTIFY** how and when you will **IMPLEMENT** your action plan.	IMPLEMENT THE ACTION PLAN.
Step 10	How will I **EVALUATE** the outcome and **MAINTAIN** positive change?	EVALUATE THE OUTCOME OF THE ACTION PLAN. REVISE AS NEEDED. PLAN TO PREVENT RELAPSE TO DYSFUNCTION.

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Peer Support Team: Helpful Phrases

The following sentences and phrases may be helpful during peer support interactions.

Supportive:

- It's good to see you…
- I'm glad you're ok (here, uninjured, to see you, etc)…
- You have been through a lot…
- That was one heck of a call…

Exploratory:

- What happened…
- Did something stressful happen to you recently?
- Bring me up to date on…
- Tell me more.
- Let's take some time to go over this…
- Can you help me understand…
- How would X help you Y…
- What would happen if you did (did not) do…
- What are the likely consequences of…
- Do you see any alternatives (options, implications, etc) to…
- What I think you're saying is…is this accurate?
- You feel…because…?
- If I'm following you, you feel… because…
- Have you thought about how this could be different?
- I'm not clear on…can you help me to better understand?
- What are your thoughts/feelings on this (making it better, coping, etc)?
- What are your greatest fears about…
- Can you talk more about your thoughts/feelings about…
- What will the next few days be like for you?
- What are your plans for the next few days?

- It's been __ days since __. How are you doing? What has been happening?
- What is happening now for you?
- How will you deal with this experience (anger, pain, incident, loss, etc)?

Combination of Supportive and Exploratory:

- That's a lot to deal with. This sounds like a difficult time for you. Let's see if we can come up with a plan to manage things over the next few days…do you have any ideas?

Assessment:

- How would you describe your feelings (thoughts) right now?
- Have you had any thoughts or feelings which are strange or unusual for you?
- Have you had thoughts of suicide or hurting yourself?
- Are you thinking about harming someone else in any way?

These suggestions for peer support do not represent an exhaustive list. In this regard, you are limited only by your imagination, training, perceptions, and appropriate boundaries. In peer support communication there is no substitute for **common sense**.

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Support Tips

Useful things to remember when providing peer support:

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

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BEHAVIOR HEALTH

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

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: 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.

Resistance Stage of GAS, the internal stress response continues but external symptoms of arousal disappear as the individual attempts to cope with stressful conditions.

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.

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.

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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
4. Trust one another so that it is easier to speak about troubling emotional responses.

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.

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.

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.

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

1. Impaired judgment and mental confusion
2. Uncharacteristic indecisiveness
3. Aggression – temper tantrums and “short fuse”
4. Continually argumentative

5. Increased irritability and anxiety – feeling like a "time bomb"
6. Increased apathy or denial of problems
7. Loss of interest in family, friends, and activities
8. Increased feelings of insecurity with lowered self-esteem
9. 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:

1. Muscle tightness/migraine or tension headache
2. Clenching jaws/grinding teeth or related dental problems
3. Chronic fatigue/feeling down or experiencing depression
4. Rapid heartbeat/hypertension
5. Indigestion/nausea/ulcers/constipation or diarrhea
6. Unintended weight loss or gain - changes in appetite
7. Cold and sweaty palms which is not normal for the person
8. Nervousness and increased feelings of being jittery Insomnia or sleeping excessively – strange dreams or nightmares

9. In extreme cases – psychotic reactions/mental disorder

Stress Management

There are various effective stress management strategies. Stress management strategies can be as simple as making minor adjustments in your diet, and as complex as implementing major life changes.

Stress management includes:

Renegotiating your life:

There is no substitute for renegotiating and changing a stressful lifestyle. Renegotiating lifestyle frequently requires reassessing personal values, resetting personal boundaries, disputing irrational thoughts, discontinuing dysfunctional behavior, and increasing healthy activities (such as physical exercise).

Breathing exercises:

Controlled, intentional, diaphragmatic, and rhythmic breathing have been used as a means to manage stress for as long as there has been recorded history. The utility of controlled breathing has been well-demonstrated across many personal and occupational environments, including marriage and family relationships, policing, firefighting, and the military. Relaxation breathing is likely the most effective low-effort/high-benefit relaxation strategy available.

Meditation:

Meditation has been used since antiquity to train the mind, alter consciousness, and to induce relaxation. There are many forms of meditation.

Relaxation training:

Relaxation training involves learning how to induce physical and psychological relaxation. There are many variations of relaxation training including progressive muscle relaxation, tense-release muscle relaxation, and whole-body relaxation. Mental imagery, directed scenarios, cognitive coping statements, and other-sense imaginations are frequently a component of relaxation training.

Massage and "bodywork":

Manipulation of muscles and nerves for relaxation.

Body scan:

Body scanning is a relaxation technique wherein a person mentally scans his or her body and learns to identify tension areas within the body. Once the area of tension is identified, relaxation skills are applied so that the tension is reduced and a greater degree of overall relaxation is achieved.

Biofeedback:

In biofeedback, instruments are used to measure specific physiological activity known to be associated with stress. These measurements comprise the "feedback" that is then used to direct relaxation efforts or other desired physiological changes. The physiological measures of biofeedback include brain wave activity, muscle tension, heart rate, heart beat interval, respiration rate, blood pressure, blood flow, extremity temperature, and electrodermal conductivity. By learning to appropriately influence one or more of these physiological measures, overall stress levels can be reduced. Biofeedback may be applied in the treatment of several medical conditions as well as to induce relaxation.

Hypnosis: Hypnosis is a trance-like state in which you have heightened focus and concentration (Mayoclinic.com). The hypnotic state can be induced in another person by a therapist (hypnotherapy) or it can be self-induced (self-hypnosis). Many persons find hypnosis useful as a stress management tool. This is due to the focused and relaxed state inherent in the hypnotic induction and process. Hypnosis also has a show business history. When used for entertainment, hypnosis it is called "stage hypnosis".

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Critical Incident Information

Critical incidents:

- Are often sudden and unexpected
- Disrupt ideas of control and how the world works (core beliefs)F
- 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

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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 discernible 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.

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.

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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, fire ground 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.

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.
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." Critical 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 critical 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 firefighters often need to make 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.
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 critical 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.

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Critical Incident Management and

Return to Duty Protocol

Preparation and Stress Inoculation Training:

Firefighters should receive instruction in department critical incident procedure and critical incident stress inoculation as part of their basic fire academy training.

Concept of **second injury -** second injury occurs when a firefighter is treated poorly following a critical incident, even if unintentionally. Second injury is especially likely if the poor treatment comes from his or her department. Remember, you don't have to intend harm to do harm.

1. Remove from scene/place in controlled environment

    a. Firefighter notification of spouse, family/notification by Truckee Meadows Chaplain, Honor Guard, and or Peer Support member if firefighter is incapacitated
    b. On-scene support (peer support team, psychologist)/confidentiality
    c. Contact top administrator (chief) or designee. Ongoing admin/staff support
    d. Administrative leave pending processing of incident/press releases/telephone, email screening if warranted
    e. Trauma Intervention Program – initiation into mental health councilor/psychologist support program

2. Recognition of personal risk – recognition of firefighter's perceptions, conceptions, emotions, effort, and actions. Appoint contact firefighter

3. Family involvement: spouse/children (immediate support, nature of incident, issues of vulnerability, peer reactions, work, school, released press information, extended family responses, etc)

    a. Prepare for possible negativity: press, segments of community, family members of victims, other sources

4. Debriefing if appropriate, other support interventions if debriefing is unwarranted.

a. Debriefing: voluntary, invitation of participants – consider support persons, dispatch personnel, other department personnel/individual follow-up/peer support team member reach-out, timeframe.

b. Preferred Debriefing group – Sierra Nevada Critical Incident Stress Management Services (775)352-4103 /(775)858-6004.

5. Expedite any necessary investigations: criminal and/or administrative investigations, district attorney, review boards, etc - expedite closure (especially if firefighter actions are being investigated)

6. Consider scheduled assigned or voluntary off-duty work/evaluated on an individual case basis – Consider any other incident-specific factors

RETURN TO DUTY

1. **Return to scene** – experiential perspective. Firefighter is accompanied by staff psychologist or peer support team member and experience is processed. Consider spouse or others if requested by the firefighter.

   a. **Caution considerations:** Issues of retraumatization or vicarious traumatization.
2. **Re-introduction to equipment** – process the re-exposure to equipment experience. Check for anxiety triggers associated with previously neutral objects, locations, or perceptions. Range of experience psychologically and emotionally processed immediately or in later meeting with staff psychologist.

3. **Firefighter Wellness Assessment (FWA) -** conducted as part of the Trauma Intervention Program by the staff counselor/psychologist.

4. **Graded re-entry** – traumatized firefighter not "thrown" into full duty assignment.

   a. Specifically designed graded re-entry:

      i. modified duty (uniform/non-uniform)
      ii. buddy firefighter
      iii. where within the department

iv. designed to meet specific assessed needs and actual circumstances
v. alteration if needed as program progresses.

b. Important that firefighter completes the re-entry on his or her normally assigned shift, but this may be altered if deemed necessary. Upon successful completion the firefighter is returned to full duty the following will be considered:

i. mechanism of safety net
ii. periodic contact with psychologist and additional psychological support if necessary
iii. Peer support

5. **Follow-up** - scheduled appointment(s) subsequent to completion of graded re-entry.

a. Timing and number of follow up appointments vary as deemed appropriate.
b. Year of firsts, peer support team and departmental reach-out.
c. Peer support team member assigned (selected by involved firefighter) for one year.

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.

Burnout and Boreout: Signs and Symptoms

The concept of burnout has been in existence for many years. It was first conceptualized and named by psychologist Herbert Freudenberger in 1974. Burnout is used to describe "someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (Freudenberger, H.J.& Richelson, G.,1980, 13. Burn out: the high cost of high achievement. New York: Bantam Books). Burnout can occur in all areas of life, including work, marriage, family, sports, avocations, and hobbies.

Some Signs and Symptoms of Occupational Burnout

- A sense of dread, "nervous" stomach before shift
- Fatigue – feeling tired most of the time, no energy
- Easy to anger, irritability, lack of tolerance, lack of interest
- Low self-esteem, feelings of low mood and depression
- Negative outlook on life, life meaninglessness, job meaninglessness
- A sense of being trapped, without options, "boxed in"
- Tension headaches, increased migraines, muscle aches
- Nervous stomach, eating and digestive disturbances
- Increased use of alcohol, nicotine, or other drugs
- Sleep disturbances , anxiety dreams or nightmares
- Sexual dysfunction: no desire, inability to perform, or hypersexuality
- Uncharacteristic negative behavior or "acting out"
- Lack of concern for behavior consequences
- Carelessness on the job, poor firefighter safety
- Increased citizen and family complaints
- Increased problems with coworkers and supervisors

Some Signs and Symptoms of Occupational Boreout

Boreout is a term first used by Swiss management consultants Peter Werder and Philippe Rothlin to describe the feeling of being understretched at work. **Boreout is the opposite of burnout**. Persons that are bored out have lost interest in what they do and lack a sense of identification with their work. For firefighters, boreout can occur after the challenge of learning how to be a firefighter diminishes, when they feel underemployed or

underutilized, or upon being reassigned, transferred, or promoted (some firefighters will be overwhelmed by the demands of being reassigned, etc, others will not be challenged or have enough to do).

To address boreout firefighters need to reevaluate their position, rewrite job descriptions, initiate new tasks and job functions, take on rewarding challenges, talk to supervisors to address assignment parameters, and expand job responsibilities. **The answer to boreout is creativity.**

Considerations for Coping with Occupational Burnout and Boreout

1. Withdraw – for a short time, take a break from the job
2. Rediscover – the values that first brought you to firefighting
3. Reengage – the job with rediscovered values and recreated parameters
4. Reclaim – your career, your marriage, and your life

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.

Summary of De-escalation Strategies

1. Remain calm, try to stay in the "adult". Speak in a clear, concise manner. Remember you are trying to engage the adult in the other person. Avoid trigger words and profanity. Your goal is to increase your influence and voluntary compliance.

2. Assess initial and ongoing level of threat. Utilize the interview stance unless more protective positioning is warranted. Maintain the appropriate personal distance for the interaction. Arrange for assistance and backup if necessary.

3. Remain aware of your surroundings and options. This includes formulating an escape route to a cover position should it become necessary.

4. Communication: content-message-delivery. Delivery influences the message communicated via the content. Communication occurs within an environment or context. Practice engaged listening. Ask for the person's help to accomplish what you want. Use words like "we", "our", and "together". Follow-up with information about what you can do. Remain mindful of nonverbal behavior.

5. Provide acceptable options and alternatives within the present context. If possible, permit the person a face-saving way to resolve the issue, especially in the presence of family or friends. Keep cultural and ethnic differences in mind. Monitor your stereotypical preconceptions and feelings.

6. Unless intended, as in the use of the short order, try using an educational or informative approach in the place of an authoritative approach. Unless duty-bound to act immediately, you can use the educational or informative approach. Remain professional. Communicate with respect. Be helpful and friendly to the degree possible. Be responsive. Avoid dishonesty. Follow through on what you say. Remember, you can always move to an authoritative approach if needed or if other strategies fail.

7. Acknowledge the emotional state of the person. Ask for their cooperation in allowing you to assist them. This increases the probability of successful problem resolution. A sense of humor can also go a long way but don't overdo It. Apologize if you're wrong or you make a mistake. Start over.

8. Proximics. Remain attentive to your personal spacing. Think: attention and psychological availability vs. apathy and intimidation.

9. Know yourself: what thoughts and beliefs are you bringing to the transaction? Perceptions, conceptualizations, core beliefs, and world views effect our interactions.

10. Tolerance within boundaries. Allow for psychological differences and various behaviors within acceptable boundaries. It's ok to tolerate some "blowing off steam".

11. Stay alert. You must be prepared to protect yourself or otherwise act immediately should circumstances warrant. In duty-bound circumstances, tactical options become the priority.

TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

Warning Signs of Alcoholism – Information

1. Do you ever drink after telling yourself you won't?
2. Does your drinking worry your family?
3. Do you drink alone when you feel angry or sad?
4. Have you ever felt you should cut down on your drinking?
5. Does your drinking ever make you late for work?
6. Have you ever been arrested because of your drinking?
7. Have people annoyed you by criticizing your drinking?
8. Have you ever felt bad or guilty about your drinking?
9. Have you tried to stop drinking or to drink less and failed?
10. Have you ever felt embarrassed or remorseful about your behavior due to drinking?
11. Do you drink secretly to avoid the concerns of others?
12. Do you ever forget what you did while you were drinking?
13. For women - Have you continued drinking while pregnant? (even small amounts)
14. For women - Have you continued drinking while breastfeeding? (even if only between feedings or in small amounts)
15. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
16. Have you ever had to take a drink while at work to feel better?
17. Do you feel shaky, unsettled, or sick if you do not have a drink for a few days?
18. Have you ever stockpiled alcohol to avoid anxiety about not having it available?
19. Do you hide alcohol to avoid the concerns of family or friends?
20. Do you plan activities to insure that alcohol is available?
21. Do you look for happy or sad occasions to justify drinking alcohol?
22. Has the availability and consumption of alcohol become an overriding concern?

Some Information About Alcohol

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

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.

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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.

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.

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

TRUCKEE MEADOWS FIREFIGHTER PEER SUPPORT

- 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
- Apply thought stopping/blocking to negative thoughts
- Identify and confront internal and external false messages
- Confront negative thinking with positive counter-thoughts
- Break stressors into manageable units; deal with one at a time
- Relax, then engage in a graded confrontation of what you fear
- A managed experience will lessen the intensity of what you fear
- Only experience changes experience, look for the positive
- Reclaim your marriage; reclaim your career; reclaim your life
- Stressor strategies: confrontation, withdrawal, compromise (combination)
- Match coping strategy with stressor – the strategy must address the stressor
- Remember: transactions and choice points = different outcomes
- Work: do not forget why you do what you do (Occupational Imperative)
- Utilize your physical and psychological buffers
- Healing involves changes in intensity, frequency, and duration
- Use your shield when appropriate (psychological shield against negativity)
- Things do not have to be perfect to be ok
- Create positive micro-environments within stressful macro-environments
- Think of strong emotion as an ocean wave- let it in, let it fade
- Trigger anxiety— I know what this is; I know what to do about it
- Goal to become stronger and smarter (with the above = the 2 and 2)
- Walk off and talk out your anxiety, fears, and problems (walk and talk)
- Being vulnerable does not equal being helpless
- Enhance resiliency – develop and focus your innate coping abilities
- Develop and practice relapse prevention strategies
- Develop and utilize a sense of humor, learn how to smile
- Time perspective: past, present, future (positive – negative)
- Things are never so bad that they can't get worse
- Do not forget that life often involves selecting from imperfect options

- Access your power: the power of confidence, coping, and management
- Stay grounded in what you know to be true
- Keep things in perspective: keep little things little, manage the big things
- Become aware, tactical pause, breath, feel, decide what action you need to do.

Suicide Prone Individuals

Suicide prone individuals may demonstrate some or all of the following features in response to problems everyone faces:

1. Particular disposition to overestimate the magnitude and insolubility of problems. Little problems seem big, big problems seem overwhelming.
2. Incredible lack of confidence in their own resources for solving problems.
3. Tend to project a resulting picture of doom into the future.
4. The suicide-prone person has somehow incorporated the notion of the acceptability or desirability of solving problems through death.
5. Death is viewed as relief.
6. Either/Or thinking. Either X or suicide (death).The person does not give credence to in- between options. This kind of thinking creates a false dilemma.
7. Hopeless and helpless perspective, meaninglessness. “There’s no point to living.”

HELPFUL THOUGHTS:

Motivation

Suicide, suicide attempts, and suicide threats can be representative of a person’s perceived need to escape, manipulate others, punish him/herself or others, or a combination of these. A sense of humiliation or embarrassment, or an undesired environmental event (prison sentence, illness, divorce, exposure of secret activity, etc.) frequently increases thoughts and probability of suicide.

Statement

“Even though you may be thinking of suicide, it is worthwhile to talk to others about options or alternatives.” (The longer the person talks to you, the less likely it is that they will follow through on their suicidal threat)

Remember

Suicidal persons are often depressed and see no positive prospects for the future. They often think or say things like, “The world would be better off without me”, “I have nothing to live for”, and “There’s no hope”.

The best thing that you can do for a suicidal person is to help provide realistic hope. If a person is experiencing intense suicidal impulses, hospitalization will likely become necessary. The strength of such suicidal impulses can vary in intensity over time.

Suicide Potential

There are many life events and experiences that increase the potential for suicide. These are some of the more common.

Stressful life situations:

- Divorce or relationship break-up – includes divorce of family member or friend
- Loss of job or position – loss of perceived status in society
- Death of a loved one or acquaintance
- Unwanted pregnancy or feeling pressured to have an abortion
- Undesired change of environment
- Perceived failure in any life area

Signs of depression:

- Changes in appetite – changes in eating habits
- Loss of interest in sex
- Sleep difficulties
- Isolation from friends and family
- Self-medicating with alcohol and other drugs
- Low mood and mood swings
- Poor performance at work
- Feelings of hopelessness
- Loss of meaningfulness

Greater risk of suicide if:

- History of suicide attempts
- A family history of depression and suicide
- Public trend of suicide
- Little or no support system
- Harsh criticizing family
- Behavior that never seems to be good enough for significant others

Immediate danger signs:

- Talking about suicide – direct or veiled. Saying "goodbye" in unusual manner
- Giving away treasured items – arranging for permanent care of pets or livestock
- Sudden peace within difficult circumstances with no obvious change of circumstances
- Formulation of a suicide plan – the more thought out and detailed, the more risk
- Obsession with the notion or idea of death – purchasing lethal items (guns, drugs, etc)

If you believe someone is suicidal:

- Trust your suspicions – treat all suicidal perceptions seriously. Express your concerns.
- Do not leave the person alone if you feel the person is imminently suicidal.
- Be supportive. Contact or refer to appropriate resources. Follow up as appropriate.

Even if "sworn to secrecy", do not keep a deadly secret.

SIG-E-CAPSS

SIG-E-CAPSS is a mnemonic used to identify and assess the most common symptoms of depression. In SIG-E-CAPSS, there is the presence of or impairment in one, more, or all of the following areas.

- S – Sleep
- I – Interest
- G – Guilt
- E – Energy
- C – Concentration
- A – Appetite

- P - Psychomotor retardation
- S - Sexual dysfunction
- S - Suicidal ideation

BATHE

BATHE is another mnemonic that can be useful when attempting to assist others. BATHE can be applied in general supportive settings as well as screening for depression and suicidal thinking. BATHE helps to structure the peer support interaction so that potentially vital pieces of information are not missed.

B	Bother/Background	What is bothering you the most?	Helps to determine current circumstances.
A	Affect	How is that Affecting you?	Helps to determine how the person is responding to current circumstances.
T	Trouble	What is it about this that Troubles you the most?	Helps to prioritize the difficulties of the current circumstances.
H	Handle	How are you Handling that?	Helps to assess the coping abilities and coping strategies of the person.
E	Empathy	Express: Empathy/understanding of the person's concerns	Helps to establish supportive rapport between you and the person.

BATHE as represented here is the work D.L. Powell, MD.

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.

Firefighter suicide risk factors:

- Diagnosis of depression, anxiety, or other mood disorder 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 an 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:

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 or crisis call center 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 useful when trying to help a person that is suicidal.

1. Take all suicidal comments and behaviors seriously.
2. Initiate a conversation. Express your concern and willingness to help. Listen closely without being judgmental.
3. If the person is intoxicated, arrange for detoxification. If the person is known to have an ongoing alcohol or substance use problem, support and encourage the person to seek and engage appropriate treatment.
4. Be mindful of what you say because the person may be overly sensitive to your remarks, but you do not have to "walk on eggshells". Be yourself.
5. Remain calm: the person may express strong emotion. This will normally dissipate naturally. You may also be emotionally affected. Accept your emotions as a natural and normal part of your caring interaction.

6. Acknowledge the person's difficulties without minimization or overstatement. Do not joke about what is serious to the person.
7. Avoid trying to "cheer up" the person. Instead, focus on listening and supporting.
8. Avoid providing problem solutions or recommendations unless asked. Encourage the person to seek professional assistance if necessary.
9. Bring the issue of suicide into the open. Ask about the person's current thoughts and feelings about suicide.
10. Ask about past suicidal thoughts, feelings, and attempts.
11. Ask about the availability of lethal means for suicide. Easy access to firearms is especially dangerous.
12. Remove firearms and other lethal means if necessary. Control potentially lethal prescribed medications or street drugs if warranted.
13. Determine if there is a suicidal plan – the more detailed and complete the plan, the greater the suicidal risk.
14. Suicidal thoughts are often the result of depression. Talk to the person about depression and that depression can be effectively treated. Assure the person that with appropriate treatment for depression, suicidal thoughts and the feeling of wanting to die will diminish. Help to provide realistic hope.
15. Do not hesitate to ask for help from the suicidal person. Ask the person to cooperate with you and your efforts to help.
16. If the person is not imminently suicidal, spend some time with him or her, "provide an ear" and other emotional support. Depending on the circumstances and your relationship, encourage, assist, or insist that he or she engage professional services. If warranted, arrange for the person to be with others 24/7 for continued support and to add an additional level of safety.
17. If you feel that the person is imminently suicidal do not leave him or her alone. Contact the police or other emergency resource. Do this even if the person objects. Keep in mind that if the person refuses voluntary intervention, emergency involuntary evaluation and treatment may be necessary.
18. If you feel that the person is somewhat suicidal but you do not feel competent to assess the level of suicidality, do not leave him or her alone. Contact the police or other available assessment and support resource. Do this even if the person objects. This is the best way to keep the person safe.
19. Do not keep a suicidal secret. If necessary, gently explain that you must share the information provided to you and that you must contact others.
9. Follow up as appropriate. Factors influencing appropriate follow up include your history with the person, your current relationship with the person, the current circumstances, how much future involvement you are willing to have with the person, and anticipated future circumstances.

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.

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:

    a. An initial shock and denial
    b. A subsequent impact and suffering period, followed by
    c. 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 fire ground 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 due to the circumstances of a particular case.
2. 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.

Recognizing Mental Disorders – Field Assessment

Recognizing a person suffering from a mental disorder can be difficult. Serious mental disorders such as schizophrenia, depression, and bipolar disorder, when severe, are easily recognized. It is the more moderate degrees of these and similar conditions that represent the most challenging assessment and resolution problems.

Firefighters should be skilled in making mental illness field assessments. At minimum, mental illness field assessments must determine if there is reasonable cause to believe that a person is mentally ill, and, if yes, (2)

due to the mental illness, is the person a danger to him/herself or others, or gravely disabled. Simply stated, gravely disabled is a condition wherein persons are so seriously mentally ill that they are unable to care for themselves, are endangered by this incapability, and require immediate intervention to avoid unintentional self-harm.

Signs (behaviors and other things observable) and symptoms (information reported to you by the person) are the primary components of mental illness field assessments. Observations of reliable other persons can be used in field assessments.

When conducting a field assessment, a person's behavior must be evaluated within context. Many behaviors and emotional responses which might indicate mental illness in one context might not in another.

During field assessments, look for:

1. Odd, bizarre, or otherwise unusual behavior.
2. Sudden changes in behavior (including verbal communication).
3. Major changes in mood: depression or mania (also: bipolar disorder).
4. Pressured speech – inability to moderate speech production
5. Inability to "track" conversation or to stay on topic.
6. Extreme anxiety, panic, or fright.
7. Delusions: disorder of thought (formal thought disorder).
8. Hallucinations: disorder of perception (auditory common in schizophrenia).
9. Dementia: impairment in memory and executive function.
10. Delirium: impairment of consciousness (also: drug induced excited delirium).

Keep in mind that mental illness is symptomatic and differs from intellectual developmental disorder (formerly called mental retardation).

Suggestions for Interacting with Persons that are Mentally Ill or Suicidal

1. Always be cautious and remain alert.
    a. Human behavior is ultimately unpredictable.
    b. Assessment of threat level is complicated by drugs/alcohol/mental illness.

2. Take time to consider the situation. Unless duty bound, proceed thoughtfully.

a. Obtain information from others if possible.
b. Do not hesitate to call for assistance. A team approach is often successful.
c. Talk to the person. State your purpose: "I am here to help."

3. Communication: Avoid abusive language and threatening behavior.
    a. Many disturbed persons are already frightened.
    b. The person may become frightened upon arrival of emergency personnel.
    c. Communicate to develop rapport and trust: use first names if appropriate.
    d. If applicable, bring the issue of suicide into the open: "How long have you thought about killing yourself?"
    e. Avoid challenges - "You don't have the guts to kill yourself."
    f. If appropriate, explain what you are going to do before you do it. This normally decreases anxiety and lessens the probability of acting out.
    g. De-emphasize authority when appropriate.
    h. Most mentally ill persons will respond to firefighters who display a caring attitude. Ask for the person's help to accomplish your goals. Appropriate supportive touch can be useful in some cases (use with caution and only when indicated).
    i. Consider the "short order" if necessary or if rapport fails.
    j. Never assume that the person cannot understand you.
    k. Contact relatives or friends of the person if necessary for disposition.
    l. Use physical force only as the situation demands.
    m. Never de-emphasize personal safety.

4. Do not allow yourself to be angered.
    a. The person may be very adept at provoking anger (name calling, threats, etc.).
    b. Anger directed at emergency personnel is often displaced.
    c. The person's anger responses are frequently the result of frustration or fear.
    d. If you remain calm, you lower the probability of the person acting out.
    e. Many persons will resist to a point, then voluntarily comply with your directions.

5. Avoid excitement.
    a. As a general rule, keep outside stimulation to a minimum.
    b. A calmer, more stable environment increases the probability of compliance.

6. Avoid deception.
    a. It is sometimes tempting to lie to bring about a resolution, however deception is often unnecessary and may be harmful. Exception: when life is at risk any strategy or technique that you reasonably think might accomplish your goal is justified.

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.

Conceptually, the relationship is supported by the foundation blocks, while the foundation blocks can be damaged or repaired by the relationship they support.

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

Issues in Interpersonal Relationships and Family Systems

- Rules and 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 "startup" 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.

Marriage: Extramarital Affairs

"There is a true test of marital fidelity. The test has three components:

1. You are attracted to a person not your spouse, who is also attracted to you, (yes, it is possible to be attracted to a person who is not your spouse)
2. The person makes it known to you that he or she is available and willing to engage in romantic or sexual activities.
3. You believe that you can engage in such activities and not be discovered. You pass the test if you walk away and redirect your emotional energies to your spouse and into your marriage" (Digliani, J.A., 2015. Reflections of a Police Psychologist 2nd ed, 166).

There are three general categories of extramarital affairs:

1. Emotional affair (little or no physical contact – can last days to years)
2. The infamous "one night stand"
3. Ongoing sexual affair (may also be emotional and can last days to years)

A person may also engage in multiple affairs of various types and combinations.

Discussion

Some rationales and motivations for extramarital affairs:

1. "To save my marriage" - (the marriage is not meeting various needs and so the person goes outside the marriage to fulfill what is perceived to be lacking. In this way, the person can stay in a marriage that might otherwise need to be ended)
2. "If I can get it, why not take it?" - (this perspective comes from a "me first" and hedonistic approach to marriage and life. It completely disregards marriage commitment and the emotional well-being of the spouse)
3. "It just happened" "We didn't plan it" - (this rationale denies personal responsibility, decision making, and marriage commitment)
4. "It's your fault, not mine. If you treated me better…" – (this position denies personal responsibility and attempts to shift the responsibility for personal behavior to the spouse)

Can an affair be good for a marriage? Although an affair may focus a couple on improving their marriage, affairs are seldom "good" for a marriage.

Can an affair be overcome in a marriage? Yes, to varying degrees, in some marriages.

Affairs and addiction to sex: current diagnostic information – DSM

Nymphomania and satyriasis (excessive sexual drive) ICD-10-CM

Process addictions - Soft addictions

Peer Support: How would you as a peer support team member assist a person who comes to you with information that (s)he is having an affair or that they have just discovered that their spouse has had or is having an affair?

Considerations for Successful Retirement

Retirement Issues

Retiring from the fire department after many years of service represents a major life transition. Many firefighters look forward to retirement and the opportunities it presents, however, major life changes, even when desired, can be stressful and potentially overwhelming.

For successful retirement from the fire service, firefighters need to prepare. Although having sufficient funds is important, this preparation should go beyond financial considerations. Firefighters need to prepare psychologically. This is best accomplished by life-by-design considerations and should begin years before actual departure.

To help firefighters better decide when they should retire and to help them psychologically prepare for the transition out of firefighting, peer support team members can assist those considering retirement by discussing or providing them with a copy of the Retirement Checklist.

Retirement Checklist

1. Have you planned your financial circumstances to meet your retirement needs?

2. Have you discussed your retirement with your family? How will it affect their lives?

3. Have you arranged for medical insurance benefits?

4. Is it time for a change? Have you given all that you reasonably can to firefighting?

5. Are you still connected to firefighting or have you checked out years ago? If you are still connected and it is not time for a change, continue your career. If you have checked out and it is not time for a change, reclaim your career. If it is time for a change, pursue retirement. **Do not end your successful firefighting career as a ROD (Retired on Duty) firefighter.**

6. Are you prepared to lose the prestige associated with being a firefighter?

7. Have you thought about who you are without the badge? What will be your personal identification after retirement? Will "retiree" or "retired firefighter" work for you? What will you put in its place? For some firefighters, being a retired firefighter is enough. For others, it is not. For the latter, the identity of functioning in new role can be helpful, such as business owner, volunteer, sports enthusiast, grandparent, hiker, and so on. It can be just about anything, as long as it feels right. When considering retirement it's best to remember the old adage, "It is better to retire to something than to retire from something".
8. How will you occupy the time previously spent at work? Hopefully, not with food, alcohol, or computer video games. Many firefighters that have never had a serious problem with overeating, drinking too much, and spending unproductive days in front of a computer when working, develop these problems after retirement.

9. Following retirement, there is frequently some measure of boredom. Most firefighters will deny this. They say things like "I'm busier now than when I was working." It is seldom true. I am uncertain why it is so difficult for retired workers to admit that their lives have slowed down. After all, isn't that part of the reason for retirement? Of course, this may not be true for all former firefighters. It is likely that some retired firefighters are busier retired than when working. But for most of them, things slow down. Newly retired firefighters frequently report feeling as if a great weight has been removed from their shoulders (even if they are busier, what is keeping them busy is often less stressful than the duties of firefighting). The stress reduction experienced by most firefighters upon retirement is often remarkable.

10. Time structuring and time management is important in retirement. Even the pleasure of travel, sports, and coffee with friends eventually wears thin. This is especially true if many of your firefighter friends are still working and you find yourself alone much of the time. Managing time and making it meaningful is a primary challenge of retirement.

11. How will you continue to contribute to your community? After a career of public service, many firefighters enjoy continuing some form of community service.

12. How have you prepared for your retirement? Help yourself by writing out a retirement action plan. Consider including support counseling for you and your family.

Responding to these questions and thinking about these issues will better prepare you for retirement.

As mentioned, retirement is a transition. Transitions take time. Once retired, be patient. It may take some time to find your retirement rhythm.

Fire Department Retirement and Emotional Abandonment

Upon retirement, some firefighters talk about feeling emotionally abandoned by the department and former coworkers. To address this issue, some fire departments have developed programs which actively involve retired firefighters. These programs include volunteer services and assignments, social events, and ongoing access to the fire department (which encourages ongoing transaction with working firefighters). As desirable as these programs have proven to be, it seems that most departments lack them.

Retired firefighters that feel emotionally abandoned and have a desire to stay connected or reconnect with their department and former coworkers have at least two options, (1) wait for someone to reach out to them (a low probability event) or (2) initiate contact and reestablish the supportive relationships which once existed (much more likely to produce positive results).

Working firefighters that have had close ties with a now retired firefighter can reach out. The reach out does not have to be anything elaborate…an occasional telephone call or invitation for coffee will do. Even if a retired firefighter does not feel emotionally abandoned, such efforts will almost certainly be appreciated.

Keeping Yourself Healthy

Supporting others in stressful circumstances can in itself be stressful. Peer support team members can be vicariously traumatized, retraumatized, or otherwise emotionally overwhelmed in their attempt to help others. Peer support team members will be able to better support others if they remember one of the most basic principles of peer support – even supporters need support.

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You're important. Take care of yourself. Take care of your family. Allow them to take care of you. Positive family bonds are excellent buffers against stress.

To feel better and to remain a functional family and peer support team member do what you can to keep yourself healthy. To maintain a healthy lifestyle consider the following:

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

Stay connected to your clinical supervisor or advisor. This relationship establishes direct support for the peer supporters. As a natural consequence of this relationship, your clinical supervisor or advisor is supported by you and other peer support team members.

Peer support team members endorse the support principle. They avoid the idea that "I'm a peer support team member. I help others. I don't need or ask for support."

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