Critical Incident Stress Management and Peer-Support For Law Enforcement Personnel: An Objective Review of Data and Practice for Administrators
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ABSTRACT
This report is designed to highlight the current trends in Critical Incident Stress Management (CISM) and applicability to law enforcement organizations. Some discrepancies are noted in current research specifically concerning the legitimacy of Critical Incident Stress Debriefing (CISD) as a viable intervention. It should be noted that strengths and weaknesses of debriefings are discussed, however, it is more important to understand that CISDs are just one tool in the cache of resources of CISM. This report was developed with the intent to facilitate a higher level of understanding about CISM, with the objectivity to aid organizations with the development of support programs relevant to their individual needs. CISM is a perpetually evolving field of study, and on-going research is continuously conducted in an attempt to improve the efficacy of the interventions. Consequently, program development at the agency level should commence with due regard for all current research and scientific development.

Author Note:
While there is no intent to legitimize or disprove any of the current practices in Critical Incident Stress Management (CISM), this report is intended to highlight strengths and weaknesses of said contemporary practices. Moreover, this report focuses on the application of CISM in law enforcement settings and scenarios where it is determined to be effective, essential, and comprehensive. This report, by no means, attempts to conceptualize a completeness of standard practices, nor should it serve as a definitive guideline for establishing CISM policies and procedures for any specific jurisdiction or entity. CISM is an evolving intervention methodology, and any recommendations should be considered to be subject to a similar scale of evolution.
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“Post-traumatic stress is ‘...the development of characteristic symptoms following a psychologically distressing event ... outside the range of human experience.’” Symptoms can be characterized by: intrusive recollections, excessive stress arousal, withdrawal, numbing, and depression” (Kureczka, 1996, p.3). It is important to note that the “... signs and symptoms must last more than 30 days for an individual to be diagnosed with Post-Traumatic Stress Disorder (PTSD)” (Kureczka, 1996, p.3). An estimated 4 - 10 percent of individuals in the general population who experience a critical incident will develop a full-fledged post-traumatic stress disorder (Kureczka, 1996). That finding does not include the effects of post-traumatic stress or cumulative effect experienced or carried by emergency services personnel.

Research has indicated that critical incident stress affects upwards of 87 percent of all emergency service workers at some point in their careers (Kureczka, 1996, p1). In many cases, the stress from one incident is compounded by two or more factors. For example, an officer involved in an armed confrontation exchanges gunfire with a suspect. The officer is wounded, the suspect dies, and the incident becomes a major media event. The injury to the officer, the use of deadly force, and the media scrutiny—conceivably three separate critical incidents—compound the effects of the stress from the initial event. This bears witness to the aforementioned cumulative effect. As emergency service personnel are repetitively and perpetually exposed to critical incidents, the likelihood of carrying excessive stresses increases proportionately.

Critical incident stress manifests itself physically, cognitively, and emotionally. Everyone has a unique reaction to stress, and each incident poses its own particular challenges. An officer may experience some, all, or none of the reactions. The reactions may occur immediately or may be delayed. Mapping a perceived reaction to stress is virtually impossible, due to many unique challenges, thus mitigating the overall negative effects stress actually poses a significant challenge. In most instances these symptoms will subside in a matter of weeks. However, many of those affected by such stress will suffer permanent, emotional trauma that will adversely affect their personal and professional lives. Therefore, having immediately deployable resources at hand can assist employees in need and can greatly benefit the recovery of those employees.

Maintaining appropriate perspective is paramount when dealing with a critical incident. It is also beneficial to the success of peer-support programs. While it is essential to understand post-traumatic stress and Critical Incident Stress Management (CISM) practices, peer-support in and of itself is not designed as a definitive intervention tool. Peer-support programs should be developed as a resource to aid afflicted individuals, and should not to be mistaken as an intervention to cure ailments. Professional psychological and psychiatric care is required as an oversight for peer-support entities. They should also be included as the standard of care for underlying conditions that could lead to long-term detriments if left untreated. Peer-support teams should have trained individuals with the ability to relate to traumatized individuals. Peers are used because of the commonalities within the profession.
Peer-support providers can be, and should be, trained to facilitate appropriate levels of communication to aid traumatized individuals in the development of personal coping skills. These coping skills should assist sufferers in moving toward establishing a “new normal” in the wake of traumatic encounters.

**Critical Incident Stress Management (CISM)**

The term “critical incident” is often referred to during “... traumatic events that involve the potential for severe injury, death, and/or devastation” (Clair, 2006, as cited in Garrison, 1991, p.45). A critical incident is more widely recognized as any incident likely to have a debilitating, emotional consequence for anyone involved in it and are likely to create adverse consequences for engagement in future stress-inducing circumstances (Bogaerts, Daalder, Van Der Knapp, Kunst & Buschman, 2008). This definition is broad and presents a challenge concerning the distinction of the description of an incident. With consideration for contemporary trends in public safety, it may be impossible to differentiate incidents having impact on responders from those that may have been referred to as routine in past reference. Furthermore, the ideology of “routine encounters” is arguably abstract and antiquated as well. The prevalence of terroristic activities and increasing severity and consequence of natural disasters perpetually redefines the sense of normalcy throughout the world. Lest we fail to mention these events are occurring in higher frequency. For these reasons, the categorical definition of Carlier, Voerman, and Gersons (1994) is preferred. Calier, Voerman, and Gersons (1994) separated critical incidents into two categories. The first category includes incidents in which the individual is an active participant (e.g., shootings, hostage situations, and riots). The second category includes incidents in which the individual is not present for the actual event, but arrives to encounter the aftermath of the event (p.90). Public safety and security workers often experience both types of critical incidents throughout their careers. Often, the demands of public safety require responders to potentially encounter more than one of these events or varying combinations of these incidents in a single tour-of-duty.

CISM is widely utilized and respected in law enforcement contemporary practices. Not unlike many aspects of modern law enforcement, CISM can be traced to roots from military practice. There are some distinct differences between military practice and application in civilian law enforcement. Military application has three primary pillars of crisis intervention: proximity (field support), immediacy (rapid support), and expectancy (tendency to normalize reactions to adverse scenarios). More commonly referred to as the P.I.E. Principle, this is the historical foundation of crisis intervention for the military and law enforcement (Sheehan, Everly & Langlieb, 2004, pp. 1-2). While the P.I.E. Principle lends significant contributions to the framework of civilian CISM, it is also noted that military debriefings aim to promote continuity of operations and the urgency of “pressing forward” in battle. Whereas, in civilian application, the continuity of operations is a long-term goal and personnel maintenance is the primary focus. Historical reference is indicative that success of peer-support is founded in a peer-support entities’ ability to operate with diversity and flexibility, paying attention to the complexity of evolving situations or scenarios that may have already occurred. Furthermore, crisis intervention is based on the premise of perpetually evolving dynamics. When a scenario evolves, so must the interventions. Therefore, a battle coming to a conclusion in terms of the force-on-force encounter does not constitute any level of finality on the impact of personnel involved. Traumatic stress may manifest in an undetermined time frame, based on individual interpretation of the event.
Critical Incident Stress Management (CISM) strategies for law enforcement are geared to assist traumatized personnel from the tendency to gravitate toward dissociation. According to Marmar (1996), dissociation is a method of compartmentalizing experiences that often cause fragmentation in the memory recall. Subjects prone to dissociate themselves from an event may believe they are dealing with the crisis adequately, but typically this is not the case. The likelihood of confounding the problem is exponential, and a cumulative effect of the stress becomes more apparent. In other words, dissociation manifests itself in a much more negative manner than dealing with the crisis head-on. People are more likely to experience a variety of adverse side effects when permitted to dissociate from the original stress reaction. Common cumulative side effects include: hyper-emotional response to terror, helplessness, or grief, despite a false euphoric interpretation of stability (Marmar, 1996). In essence, dissociation is avoidance. By avoiding the stress reaction, individuals are more likely to create additional problems because the original stress reaction may be unaddressed.

A primary goal of peer-support entities is to facilitate verbal communication in an attempt to promote an open atmosphere. This atmosphere should provide personal interaction and assist sufferers in developing coping skills. Therefore, dissociation is likely minimized, while normalcy is more immediately redefined.

Education of peer support members is imperative to the success of the program and the processes. There is a necessity for a salesmanship process where trained individuals explain the peer-support process, establish confidence in the usefulness of a CISM program, and define the commitment of those devoted to peer-support. In an effort to maintain an objective overview, educational efforts should also highlight potential detriments. These detriments may include an unwillingness of those who are afflicted to participate. Team members must understand the effects of cumulative stress in an individual’s willingness to participate. However, participation in a peer support program is voluntary and should never be deemed a mandatory process since demanding participation is likely to prompt adverse reactions and results.

Critical Incident Stress Management (CISM) is a difficult theoretical perspective for which to establish an operational framework. Due to the nature and diversity of traumatic experiences, it is nearly impossible to produce a stand-alone protocol that can be applied in a unilateral manner. According to Solomon (2006), everyone interprets the intensity and severity of critical incidents at varying paces and by differing means and levels of coping. It is imperative to have a sound foundation from which to initiate interventions. However, be mindful that any tactic employed must be interchangeable with other tools in the CISM cache. Evolution of the mitigation process is based on the needs of the group or individual, and established operational timelines will likely be counterproductive. Remember, the ability to develop coping skills varies from individual to individual. Earmarks in the intervention process such as stabilization, coping and resource identification, and recovery support are mentioned with a vague timeline. However, the pace of the intervention is still based on the response of those participating in the process. Any timeline should be utilized merely to earmark the order of occurrence for various interventions, not to dictate the pace of the interventions.

Critical Incident Stress Management (CISM) is the generalized, theoretical framework behind all of the interventions available in a peer-support or clinical aid toolbox. CISM embodies numerous tactics and is divided into categories and sub-categories in the application of interventions. One keynote in the tactical assortment for CISM is Critical Incident Stress Debriefing (CISD), and it is perhaps the most complex to understand and utilize.
Critical Incident Stress Debriefing (CISD)

Critical Incident Stress Debriefings (CISDs) have been under a great deal of scrutiny in the past decade. Studies have been conducted in an attempt to examine the efficacy of this tactic as a traumatic stress intervention. Several studies concluded that CISDs might actually be harmful, citing various reasons for this belief. For instance, some professionals believe group debriefings may foster negative consequences in terms of distorting one’s perception of the event through disclosure of another’s interpretation (Arendt & Elklit, 2001). Reviews of other studies (Campfield & Hills, 2001) alluded to problematic outcomes of debriefings if not facilitated in a timely manner. However, research is inconclusive due to the nature of individual (victim) interpretation of any event, type of event, and lack of definitive standard for timeliness of interventions. Conversely, it is believed that debriefing is a naturally occurring social phenomenon, where trained facilitators aid in the healing processes of afflicted individuals (Fullerton, Ursano, Vance, & Wang, 2000). The strength of this theory is implicit in the result (i.e., those who engage most actively in social support groups typically manifest fewer long-term consequences). It is important to consider that a CISD is one aspect of the CISM process. The CISD is merely a tool utilized when attempting to mitigate stress reactions invoked by exposure to a critical incident or a traumatic experience. CISDs are often confused in discussion with CISM and vice versa. In an attempt to understand the validity of CISM, it is necessary to understand where the CISD aligns with the entire process.

As previously mentioned the debriefing process is credited to roots in military history. Debriefings were utilized originally as battlefield interventions for military soldiers, and were effective in naturally occurring groups. For example, soldiers exposed to similar battlefield circumstances, or those who fought in the same battles were noted to seek support from one another. A portion of this phenomenon was due to proximity and availability, and another portion to commonplace in the experiences endured by similarly trained personnel. There is a bond between military soldiers within their respective units, which closely resembles the bonds of law enforcement officers within respective units and/or agencies. From a command perspective, military debriefings have been deemed useful for soldiers returning from combat in acute amounts of time following exposure to adverse conditions. Military commanders focus more on intelligence-gathering aspects of debriefings, in order to assess perceived stressors on soldiers. Consequently, commanding officers operate with informed calculation for subsequent deployments of personnel. Commanders may be more effectively in planning tactics and increasing the efficacy of subordinates carrying out the ordered tactics, by gathering such useful data (Fullerton, Ursano, Vance, & Wang, 2000). Debriefings for military members have been shown to be useful, but were not intended to be a psychological intervention.

Birthed from the same footprint as military debriefing, CISDs have many similarities yet they focus more on psychological well being. Unlike the military’s primary use for debriefings as intelligence gathering, civilian applications of debriefings are geared more at developing a sense of normalcy as a result of exposure to abnormal circumstances. In particular with law enforcement, CISDs in civilian application are designed to minimize the effects of event-related stress, while preventing additional stress when possible. There are many phases to the application of debriefings in law enforcement, but training is paramount. Debriefings are typically done in single sessions; however, the complexity of conducting a debriefing requires clinical oversight to professional standards of psychological care (Chemtob, Tomas, Law, Cremniter et al., 1997). Also defined by Regel (2010), a psychological debriefing is one aspect of critical incident stress management commonly utilized by the military, public safety, and mental health professionals.
A psychological debriefing is a post-traumatic stress intervention, which involves group discussion and review of the traumatic experience. This debriefing is designed to facilitate a process of normalization for abnormal circumstances. Originally implemented by Jeffrey T. Mitchell, Ph.D. in the early 1980s, CISDs were designed to promote healing while implementing positive coping mechanisms. Original target audiences were emergency service personnel. Debriefings were designed to facilitate an educational process about common reactions to traumatic incidents. Participants were familiarized with common physiological reactions that may be interpreted as abnormalities in bodily functions. The perception of abnormality is converted to a standard of normalcy through education. Each individual will process stress in a unique way, and there is no way to predict what will occur physiologically as a result of stress-induced trauma. Historical commonalities in physiological response to trauma are explained in this process. The idea is to facilitate participant movement toward developing normalcy by directing them toward personal recovery at their own pace, and establishing resiliency while moving toward other potentially stressful environments and circumstances (Regel, 2010).

Properly trained helpers, including peer-support personnel and licensed clinicians have observed a great deal of success in debriefings. However, CISDs have been scrutinized for many reasons. Timing of a CISD is critical. A CISD conducted too soon or delayed too long may cause harm (Hawker, D.M., Durkin, J & Hawker, D.S.J., 2011). The long-standing practice of utilizing a single-session debriefing has also received scrutiny, citing that too brief or a misguided session may imprint negative associations to the event on attendees (van Emmerik, A.A.P., Kamphuis, J.H., Hulsbosch, A.M. & Emmelkamp, P.M.G., 2002). The possibility exists that listening to the recollection of events from another’s perspective could manifest a negative imprint on one’s memory of an event, thus defying the objective for each individual to establish coping tactics for the trauma. In addition, ordering mandatory debriefings may have adverse reactions. Much of the research notes indicate the importance of voluntary participation.

While there exists a diverse assortment of reasons to scrutinize CISDs, definitive research in support or against CISDs is lacking. Remembering that CISDs are only one tactic under the umbrella of CISM, it is important to note that clinical oversight is critical to the use of debriefings and may help reduce many of the adversities associated with CISDs. It is suggested that debriefings performed by untrained, unqualified personnel may be damaging. However, research is lacking in stating that CISDs are a hazardous intervention technique when conducted by qualified professionals. Much research is aimed at testing the validity of a CISD as a tool to reduce the traumatic experience in terms of preventing the long-term affliction of Post-Traumatic Stress Disorder (PTSD). Since PTSD is a clinical diagnosis, it should be noted that this does not influence the usefulness of a CISD in peer-support applications, nor as a post-traumatic stress mitigation tool.

Peer-support personnel are not clinicians and are not trained nor licensed to make diagnoses. Peer-support personnel exist to assist traumatized peers. Properly trained peer-support members are better equipped to not only deal with traumatized personnel, but to know when more definitive care is needed. Debriefings do not “... prevent psychiatric disorders or mitigate the effects of traumatic stress, even though people generally find the intervention helpful in the process of recovering from traumatic stress” (Arendt & Elklit, 2001, p.423).

International Critical Incident Stress Foundation (ICISF)
**Individual Crisis Intervention, Peer Support, & Group Crisis Intervention.** This three-day course combines all of the content of the International Critical Incident Stress Foundation’s (ICISF) Individual Crisis Intervention and Peer Support & Group Crisis Intervention courses. All of the ICISF offerings are instruction-based training sessions designed to facilitate a general understanding of CISM for peer-support facilitators. Some of the coursework offers a detailed understanding of CISM and how the CISD aligns with the entire process. The ICISF is an internationally accredited body of professionals with psychological backgrounds and formalized educations. The Individual Crisis Intervention, Peer Support, and Group Crisis Intervention are basic, educational level courses recommended for anyone participating as a peer-support provider. However, ICISF encourages all providers to attend the array of course offerings. Continuing education is further encouraged. CISM requires a great deal of attention to education and training. All of ICISF course offerings include practical and tactical training as well. (International Critical Incident Stress Foundation, Inc., n.d.)

**Advanced Group Crisis Intervention.** This part of the course is designed to provide participants with the latest information on CISM techniques and post-trauma syndromes. Advanced Group Crisis Intervention builds on the knowledge base obtained through the Group Crisis Intervention course and/or reference materials/publications. At the conclusion of this course, participants will have been exposed to specific, proven strategies to intervene with those suffering from the exposure to trauma. Emphasis will be placed on advanced defusing and de-briefing procedures in complex situations while noting that not any one specific strategy applies to every scenario.

This course was designed for Employee Assistance Personnel (EAP), human resources and public safety personnel, mental health professionals, chaplains, emergency medical services providers, firefighters, physicians, police officers, nurses, dispatchers, airline personnel, and disaster workers already trained in the CISD format. This course is also useful for anyone working extensively with trauma victims. This course requires previous training and experience at the Individual Crisis Intervention level. The ICISFs “Group Crisis Intervention” should be viewed as a prerequisite. (International Critical Incident Stress Foundation, Inc., 2010)

**Course Highlights**
* Relevant research findings
* Managing complex group oriented crisis interventions
* Nature and importance of incident assessment
* Strategic intervention planning
* Comprehensive, integrated, systematic and multi-component CISM
* Concepts of enhanced group processes
* Significantly delayed interventions
* Multiple incident CISDs
* Suicide of a colleague

**Small group crisis support sessions after a disaster**

**Suicide Prevention, Intervention, and Postvention.** This course provides clarity and direction for difficult questions like: “Why do people kill themselves?” “How do I ask someone if they are feeling suicidal?” “What do I do if someone says they are suicidal?” And, “How do I deal with the strong emotions suicide generates?” Participants will gain basic information about suicide, while developing practical skills for prevention, intervention, and postvention. Small group role-playing allows participants to apply suggested techniques as they are learned. This course is open to anyone wanting to learn more about suicide intervention.

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There is typically no prerequisite for attending this level of training, however, it is encouraged to utilize this training in collaboration with other ICISF course offerings. Professionals from the fields of Business & Industry Crisis Intervention, Disaster Response, Education, Emergency Services, Employee Assistance, Healthcare, Homeland Security, Mental Health, Military, Spiritual Care, and Traumatic Stress may benefit and are encouraged to attend. (International Critical Incident Stress Foundation, Inc., 2010)

**Course Highlights**

* Common myths about suicide
* Risk factors for suicidal behavior
* Frequent motivations for suicide
* Problem solving methods
* Effective intervention strategies
* Elements of effective postvention
* Elements of survivor grief
* Community referral sources
* “Mini-lecture” on suicide
* Feelings and reactions of suicide survivors

**Concerns of Police Survivors (C.O.P.S.) - Traumas of Law Enforcement.** This three-day course assists officers and agencies in developing general orders to address traumatic issues affecting officers. In addition, this class prepares them to better understand the emotional support needs of the fallen officers’ families. Officers will learn: appropriate death notification procedures, funeral protocol, the necessity for emotional debriefings following a critical incident, law enforcement suicide awareness, officer disability, issues faced by traumatized officers, the effects of an officer death on coworkers, appropriate methods for dealing with survivors after the funeral, and the importance of peer-support for officers that continue on the job. (Concerns of Police Survivors, n.d.)

**Trauma Resource Institute (TRI) - Trauma Resiliency Model Training.** Trauma Resiliency Model (TRM) Training is a three-day course designed to assist clinicians with the necessary skills to work with children and adults with traumatic stress reactions. The TRM is an integrative mind and body approach that focuses on the elegant design of the human nervous system and how to expand resiliency. The TRM also focuses on the biological basis of trauma and the automatic, defensive ways the human body responds to threats and fear, including the responses of “tend & befriend,” fight, flight, and freeze.

The TRM explains the common responses following stressful and/or traumatic events from a biological perspective, which reframes the human experience from one of shame and mental weakness, to one of hope and biology. The TRM is a comprehensive treatment that offers concrete, practical skills, coupled with education about the biology of trauma. The TRMs goal is to reduce or eliminate symptoms of traumatic stress by returning the body and mind back to balance. It can be used to treat anyone who has experienced or witnessed an event perceived as life threatening or an event posing a serious injury to self or others. This training is also helpful to other front line workers in an attempt to reduce or diminish vicarious traumatic reactions, while promoting self-care (Miller-Karas & Cross, 2013).

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Much of the contemporary research supports the use of resiliency tactics in conjunction with the traditional aspects of CISM. As previously noted, there is no singular tactic, which should be considered more favorable than others in the CISM perspective. Durkin (2012) noted, “... that when using these techniques, crisis resolution within hours is possible where protocols are followed and the sessions are allowed to conclude at their optimal time.” Durkin’s philosophy is to utilize all available tools while working toward resiliency, in essence helping individuals become self-supportive.

Further affirming a humanistic approach, it is important to adhere to a hierarchy of needs when addressing one’s interpretation of traumatic events. First, the safety and security of the stress-affected personnel is paramount in this approach. People are going to be more readily encouraged to participate in a healing program and seek support more willingly if their needs are met. For instance, many critical incidents lead to an administrative leave for personnel involved, whether by company policy or by physical or physiological necessity. As a result, personnel are likely to have concerns regarding loss of pay, disconnect from the rewards of their work and/or job performance, or even social withdrawal. While this does not exhaust the list of possibilities, it sheds light on some of the common concerns. If these concerns and necessities are not respected, the likelihood of assisting those affected by the circumstances is conversely exponential. There is also a liaison role to be understood when performing the task of peer-support. Personnel needing assistance are likely to have a host of questions regarding the event. They may have questions concerning administrations opinion of the event, about the impact of the event on others, or otherwise. Peer-supporters must be capable of seeking answers to difficult questions.

Next, in keeping format with training and standard practices, it is necessary to begin facilitating a positive reframing of the circumstances and assisting those involved with developing the “new normal.” In this phase, it may be useful to elicit the strengths of the group (if a group setting has developed) and pull upon the positive perceptions of those who are willing to share on that level of disclosure.

Survival stories or the likeness of life-affirming, personal testimony is highly effective in reframing of personal interpretations. Finally, in the essence of establishing self-resiliency for participants in the peer-support process, it may be necessary to continuously monitor the interactions of all involved parties. Some participants may have more difficulty dealing with the circumstances than others. These individuals are often more likely to begin to compartmentalize the effects of the stress. Anyone perceived to be withdrawing from the process, or during any stage of the process, should be discretely offered a one-on-one session with qualified peer-support personnel or clinicians. A referral to more definitive care may be required (Seely, 2007). Note the trend toward self-resiliency (i.e., reframing) and the focus on assessment and necessary referral for professional care. This is the level of operations that peer-supporters are capable of providing, and these are widely recognized as a highly effective skill set.

Post-Traumatic Growth

Similarly, and directly in support of TRM, the concept of Post-Traumatic Growth (PTG) is a way to describe positive outcomes that may result from trauma or a traumatic experience. Any perceivable positive, personal growth, which results from a stress reaction to a traumatic experience, is the essence of Post-Traumatic Growth. PTG effectively measures the process of creating a “new normal” in the aftermath of a traumatic experience. The greater the measure of personal growth one experiences, the greater the perceivable efficacy of PTG (Tedeschi & Calhoun, 2004). PTG embodies a cognitive processing of the traumatic experience. Illustration of
the individual’s ability to redefine, reframe, and heal from the traumatic experience is observable. A traumatized individual will tangibly begin to restructure their world view (Chopko & Schwartz, 2009). PTG is certainly a complimentary theoretical approach to the TRM. Operating in a similar manner as the TRM, whereas PTG focuses on promoting a “new normal” for traumatized individuals. Incorporating traumatic experiences into one’s perception of life is an underlying focus of resiliency, and promoting resiliency is an underlying goal of CISM.

**Peer Support Teams**

Contemporary research and scholarly review of the topic of peer-support demonstrates a high level of credibility for utilizing such a program. Peer-support programs are a cost-effective way to insure human resource assets are functioning at optimal levels. It is not uncommon to find research indicating that certain aspects of peer support programs may be harmful. This research tends to focus on singular causality for adversity in peer-support. The most common re-occurring theme for peer support criticism remains a lack of training and qualified support providers.

Traditional CISM teams offer crisis intervention services spanning three stages of the traumatic event and interpretation thereof: pre-crisis, acute crisis, and post-crisis phases. Everly & Mitchell (2000) defined seven core services: pre-incident preparation; education, demobilization, and group informational briefing; defusing; CISD; individual and family intervention; follow-up; and referral services (Bendersky, Clements & Fay-Hillier, p.134). Considered to be subject matter experts in the field of CISM; Everly & Mitchell established a widely used framework in peer-support settings. Much of the aforementioned ICISF course offerings are based on the work of Everly & Mitchell. CISM teams are typically comprised of individuals from varying professional backgrounds (i.e., clinicians, mental health providers, or even members of the clergy) (Everly & Mitchell, 1998). Common existence of peer-support teams may also be prevalent with doctors, nurses, police officers, firefighters, emergency medical providers, or the like (Bendersky, Clements & Fay-Hillier, 2001). Mitchell & Everly have long-standing credibility in the field of CISM and the development of peer-support hypotheses and are widely respected as pioneers in the field.

According to McNally & Solomon (1999), establishing a qualified selection process and maintaining confidentiality are critical to the success of any peer-support program. Noting CISM and peer-support team development within the FBI, a discreet selection process for qualified professionals has been credited with success in the program. Professional involvement from those educated in the areas of confidentiality and mandatory reporting is necessary. Merely understanding these concerns requires a great deal of education, training, and tactical proficiency. Reverend Dennis Hayes (2013) has worked extensively with the FBI on numerous critical incidents including, but not limited to the terror attacks of September 11, 2001. With formal education from the Roman Catholic Church, as well as master’s level accreditation in helping professions and CISM, Hayes noted the complexity of operating within all guidelines of health codes, confidentiality principles, and local, state and federal laws. Additional factors may come into play, such as the complexity of maintaining a peer-support entity in law enforcement once the factor of national security is applied.

The FBI is considered a widely respected organization. Subject matter experts are handpicked by trained members and clinical professionals involved in the process. It should also be noted, as is seen in much of the other research, that the operational capabilities of peer-support teams are not mutually exclusive to the law enforcement (sworn) community. A great deal of www.jghcs.info (ONLINE) JOURNAL OF LAW ENFORCEMENT/VOLUME 3, NUMBER 2
attention is afforded to families, survivors of traumatic occurrences with fatalities, and community outreach programs.

Additional complexities in establishing and maintaining a peer-support team are limitless. With the endorsement of the NYPD and Police Unions, POPPA (2005) was created as a confidential, voluntary, independent, non-departmental assistance program for the NYPD that used trained, volunteer NYPD officers as peer support members. POPPA volunteers have been recruited and trained from all ranks and backgrounds of the NYPD. Note the internal selection process for qualified individuals as previously illustrated by the FBI. Since 1996, POPPA has run a 24-hour help line, which allows officers in need to speak to a trained peer support member. Calls are self-referred and all assistance is voluntary. Within 24 hours (the same day if necessary), a peer support member will meet face-to-face with an officer in need. A majority of calls into the help line result in a face-to-face peer meeting. To protect privacy, these face-to-face meetings take place outside departmental facilities, and no records are maintained.

The peer support member provides an empathic ear and screens for major safety issues, such as suicidal or homicidal ideation, alcohol abuse, and risk of violence. This is in accordance with meeting the needs of the individual before further support can commence. Understanding the sign of strength in seeking assistance versus the perception of weakness for doing the same, asking for help is discussed as a sign of strength. Resiliency is promoted and trained on when necessary. Personal resourcing is discussed and implemented. When necessary, the officer is provided with a referral to a trained mental health professional experienced in working with police officers. Programs such as POPPA have an advantage over other programs because of the resource pool is much larger. Peer support officers do not provide ongoing counseling. Their role is to screen, support, and act as a bridge toward professional assistance. Clients needing further assistance are advised to seek professional care (NYPD POPPA, 2005).

A critical review of the NYPD Police Organization Providing Peer Assistance (POPPA) program (2005) illustrated some of these complexities. Post-traumatic stress seems like an understandable side effect of police work. Despite stereotypes that portray police officers as heroic and invincible, a significant number of police officers that are exposed to diverse work-related traumatic events develop significant post-traumatic stress symptoms. Although not exclusive to the law enforcement community, many suffer from additional complications, including high rates of alcohol abuse, marital and family problems, domestic violence, and suicide. Police officers with psychological or personal problems are often reluctant to seek assistance from internal departmental services. Fears of stigmatization, adverse job consequences (e.g., modified work assignments, altered career paths, or loss of one's weapon), and perceptions of personal weakness or failure prevent police officers from seeking help. While the perception of weakness is represented herein, this must not be overshadowed. Police officers are expected to solve problems, and that is a persona many adopt as a lifestyle. Not understood in a relative, proper state of humility, this persona may contribute adversely to any officer’s ability or willingness to seek assistance when struggling with life’s challenges. As a closed group, police officers are often unwilling to share their problems with mental health professionals. Mental health professionals are seen as outsiders and officers often believe these professionals cannot understand the inner workings of police culture.

NYPD personnel have conducted additional research in particular to address stress reactions of personnel in the wake of the 9/11 terror attacks. While the data is not definitive in its conclusions, it noted a cumulative effective of stress-induced trauma was likely to create an increased risk for PTSD and other long-term, related ailments. Furthermore, these studies noted
that, despite inconclusive diagnoses for the likeness of PTSD, many officers have suffered long-term afflictions in social contexts and work-related impairments. Of notable consideration is the commonality of inappropriate reactions to ongoing stress-inducing exposures. For instance, officers may be either hyper-vigilant in more “routine” encounters or not moved by highly stressful encounters. These irregularities are attributed primarily to a lack of involvement in support programs, an inability to cope with past circumstances, compartmentalization of experiences, or similar coping deficiencies (Dowling, Moynihan, Genet, & Lewis, 2006). The authors noted that attempting to reduce the impact of cumulative stress reactions is a key function of peer-support teams. Providing resources to educate and console traumatized personnel, while being mindful of the need to refer to professionals increases the efficacy of the human resources. Peers caring for peers can only benefit the deployment of the most valuable and experienced human resources. It has no perceived negative impact on the roles they are trained or suited to perform.

**Recommendations**

It is difficult to establish a centralized framework from all peer support teams to function universally. However, industry standards and best practices have established some internationally recognized guidelines that may serve as a foundation for any entity establishing a peer-support team. In a collaborative study, Creamer et al. (2012) found a strong consensus on the following points. First, peer support teams should be able to provide a level of initial intervention and be available to assist peers in need. Peer supporters must be able to listen and empathize. They must have the ability to identify with the peer group, and should represent that peer group. When necessary, peer supporters must be able to determine a need for professional and/or definitive care. Peer supporters must understand that they are not required, able, or justified by education or training to make definitive diagnoses. It is further deemed useful to maintain peer support as an ongoing, daily function of the provider duties. Peer supporters are able to hone their skills by routinely assisting peers in the course their normal, professional functions. These skills are perishable and require continuous devotion to education and training. Peer-support should not be utilized to arbitrate labor disputes or disputes between rank and file. However, stress reactions from such disputes are important to address.

A general consensus exists that to become a peer supporter, one must be a member of the target population. In addition, these individuals should have considerable field experience and be respected by his or her peers. Creamer et al. (2012) agreed that potential peer supporters should undergo a formal application and selection process. There was strong support for the notion that peer supporters should receive training in the basic skills required to fulfill their role (i.e., listening skills, psychological first aid, and information about referral options). Psychological first aid is an important tenet of the peer-support process. It involves active listening by the supporter followed by direction to the affected peer to assist in coping and restructuring of the stressful event. Psychological first aid is focused on helping those affected by stressful events to minimizing the potential from a crisis reaction. Equally, it was agreed that peer supporters should not receive training in higher-level interventions such as prolonged exposure or cognitive restructuring. There was consensus that potential peer supporters should meet specific training standards before commencing their role (Creamer et al., 2012). Additional suggestions made include peer supporters participating in ongoing training, supervision, review, and accreditation to ensure maintenance of skills.

A consensus was reached in that mental health professionals should occupy the position of clinical director and should be involved in supervision and training (Creamer et al., 2012). www.jghcs.info (ONLINE) JOURNAL OF LAW ENFORCEMENT/VOLUME 3, NUMBER 2
Furthermore, appropriate clinical oversight should be established through protocols governing confidentiality long before it becomes an administrative stumbling block. Common practice dictates that clinical support should be available when required. However, there was no expectation that mental health professionals would necessarily have to be consulted on every case.

An analysis of all contemporary practice illustrates that peer supporters should not limit their activities to high-risk incidents, but rather should be part of routine employee health and welfare. Informal peer support as a routine part of a day’s work was seen as integral to a successful program. It is believed that establishing permanence in support services rendered on an ongoing basis is not a healthy relationship to establish; instead support providers should seek specialist advice and offer referral pathways for more complex cases. Equally, it was recognized that, in some cases, support would be required for extended periods, thus also illuminating the necessity of permitting one to heal at their own pace. The fine line in the dynamic of the relationship is drawn with adherence to training and seeking the warning signs that may require referral to definitive care. It was agreed that peer supporters should maintain confidentiality (except in circumstances where a threat to self or others is verbalized, etc.) whatever the case, however, rules of confidentiality must be clearly defined from the perspective of clinical oversight.

Creamer et al. (2012) agreed that peer supporters should normally be offered as the initial point-of-contact after exposure to a high-risk incident, unless the officer requests otherwise. In other situations, employees should be able to self-select peer supporters from a pool of accredited supporters. Maintaining an active list of qualified personnel who can be reached on a moment’s notice is imperative.

With an international consortium of professionals serving the human services field of CISM and peer support, it is notable to have such a high level of collaboration on key points. These recommendations serve as a contemporary, collaborative example of the most widely recognized, best practices around the globe. Collaborations of witness testimony, professional development, and recognized standards permit a comprehensive development of a peer-support team.

Author End Notes

This document is intended to increase understanding of the importance of CISM, peer support teams, and professional services associated with psychological distress, particularly in law enforcement application. Thus, these contemporary considerations and recommendations must be understood to be evolutionary and dynamically divergent. There is no exact science in the establishment and implementation of any of these programs. However, a lack of professional guidance is universally observed to contribute some level of negligence on the part of administrators seeking to implement such programs.

It is impossible to incorporate all facets of contemporary best practices when seeking to implement peer-support teams into law enforcement social norms. However, a lack of proper education is no excuse for shortcomings in planning and preparation. Certain ideologies cannot be overlooked: adherence to the prescriptions of CISM is a must; clinical oversight is a must; and scrutiny in the selection process is critical to success of any peer-support team. Many further correlations can be drawn. A great deal of development and scientific integration is possible. Adhering to the evolution of concepts and practices in accordance with contemporary challenges is critical to future success of peer-support teams.

Developers of peer-support teams are likely to find any of the aforementioned tools useful in the conceptualization process while establishing a foundation for respective team mem-
bers. This review of contemporary ideologies is not an exhaustive list of all possible practices. It has been the objective of this review to merely expose some of the contemporary framework to assist in the development and implementation of peer-support teams according to particular agency needs and necessities.

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