

Appendix A
Sample



Placer County Law Enforcement Chaplaincy
APPLICATION

Application For

Community Chaplain (CC) _____ **Chaplaincy Support** _____

Law Enforcement Chaplain (*1 year as CC completed or prior LE Chaplain*) _____

Name: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Email Address: _____

Member of what church? _____ How long? _____

Name of Pastor: _____

Address: _____

Describe your *Call* to law enforcement chaplain or caregiver ministry:

Referred by: _____

References: (Other than pastor or ecclesiastical supervisor)

1. Name: _____ Phone Number: _____
Address: _____
Relationship: _____

2. Name: _____ Phone Number: _____
Address: _____
Relationship: _____

3. Name: _____ Phone Number: _____
Address: _____
Relationship: _____

Ministry Education: _____

Ministry Experience: _____



Appendix B
Sample

Placer County Law Enforcement Chaplaincy
Commitment Letter

Thank you for prayerfully committing to work with the Placer County Law Enforcement Chaplaincy (PCLEC) for the fiscal year 2007-2008 (July to June). We are pleased to have you as a member of our outstanding team. PCLEC is a field service ministry to the members of law enforcement, their families, all first responders, and the citizens of Placer County. In order to have a positive impact on PCLEC, Law Enforcement and the Community in which we serve, your signature below indicates your agreement and support of the following:

1. I will regularly pray for the Placer County Law Enforcement Chaplaincy, my fellow Chaplains, and the support staff. I will regularly pray for the leadership of the Chaplaincy program, and seek God's best for the entire Chaplaincy.
2. I will maintain a personal walk with God, and refrain from such activities in my personal life that would damage or sully my reputation and/or that of the Placer County Law Enforcement Chaplaincy.
3. I agree that it is vital that my skills and training be kept sharp and up to date, in order to respond to emergency dispatches. I will maintain my skills by attending the mandatory monthly training meetings except when excused, in advance, by the Senior Chaplain, or Deputy Senior Chaplain. I understand that missing three meetings in a 12 month period or two consecutive meetings may require me to fulfill additional Shadow Training Hours under the direct supervision of another Chaplain before I can return to an Active Status.
4. I will submit a monthly activity report to the Chaplaincy office by the 7th day of the month so that my hours can be duly recorded and counted.
5. I will maintain reliable communication including a cell phone and/or a pager on a 7/24 basis so that I may be contacted when needed and will respond to pages and phone calls promptly whether or not I am available.
6. I will sign up each month as the primary responding (On-Call) Chaplain for the following:

On-Call Hours (Pick One)

- One 24-hour period
- Three 12-hour periods (Total of 36 hours)
- Five 8-hour periods (Total of 40 hours)

Weekday or Weekend On-Call Service (Pick One)

- Weekday On-Call
- Weekend On-Call
- Available Anytime

Appendix C
Sample



Placer County Law Enforcement Chaplaincy
Emergency Call Out Form

**Chaplain Name &
Badge No:**

Date	Start Time	End Time	Total Time	Agency	Event Code

Event Address:	
On Scene Contact:	

Primary Victims (Deceased / Injured)

Name	Address	B-Date / Notes

Secondary Victims

Name	Relationship	Address	Phone

Brief Summary

Follow-Up suggested	Yes	No
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Appendix D
Sample



Placer County Law Enforcement Chaplaincy
Monthly Report

Month: <u>June</u> Chaplain: <u>Sample</u>														CHAPLAIN MONTHLY REPORT				
OC	YR	DAY	EV#	ECO X	TIME IN	TIME OUT	AGENCY			ACTIVITY			1C DISP	CA	Std by	ADDRESS / INSTRUCTIONS	HRS	
	07	03			6:00	12:30	01	05	02	03	123						APD Motorcycle Event/Manual	6.5
	07	03					04	07	08	11								
	07	03					00											
	07	08			18:15	23:30	00				110						Monthly Training - Rocklin PD	5.3
	07	08			23:30	6:30	00				153				7.0		On Call	
	07	09			6:30	13:30	05				110						SAR Training	7.0
	07	09			13:30	19:22	00				153				6.8		On Call	
1C3	07	09	3	x	19:22	21:15	05	11	12	07	123		1C3		15		House Fire	1.9
	07	09			21:15	0:00	00				153				2.8		On Call	
1C3	07	10	1	x	8:22	12:45	05	00			115		1C3				1144 - Lincoln, CA	4.4
	07	10			14:00	16:08	00				111						ECO Reports, correspondence w/PCLEC	2.1
	07	13			8:00	11:30	03				110						Weapons Training	3.5
	07	14			19:22	22:30	00				110	111					Last night of Basic @ Bayside	3.0
	07	16			8:00	11:30	00				110						Chaplain Communication Workshop	3.5
1C2	07	16	3	x	20:46	0:05	05	11	12		115		1C2		10		1144 - Roseville, CA	3.3

AGENCY TOTALS					CODES				
	1	2	3	4	100	Self Generated Response		130	Officer Down-Injury/Death
00 PCLEC	8	1			101	Home/Hospital Visit		131	Hazardous Material/Spill
01 Auburn	1				102	Agency Visit/Briefing		132	Crime Or Crime Scene [Spec]
02 Rocklin			1		103	Ride Along		187	Homicide
03 Roseville	1			1	104	Counseling		211	Robbery
04 Lincoln	1				105	Wedding		245	Assult W/Deadly weapon
05 PCSO	4	1			106	Funeral		261	Rape
06 Tahoe					107	DUI Checkpoint		273	Child Neglect
07 CHP		1		1	108	Chaplaincy Presentation		273.5	Domestic Violence
08 Pks/Rec			1		109	Official Function		288	Sex Crimes Against Children
09 DA/Prob					110	Training	5	415	Disturbance
10 SIU					111	Administration	2	417	Threat With Weapons
11 Allide Assist		2		1	112	OCS Duties		459	Burglary
12 Citizen Assist			2		113	Ref.From/To Other Chaplains		C10	Bomb Threat
13 Jail					114	CISM		5150	Disturbed Person/Mental
14 Animal Control					115	Coronors Case - 1144	2		
15 Newcastle Fire					116	Death Notification			
16 Penryn Fire					117	1146T			
17 Lincoln Fire					118	1146A			
					119	1146C			
					120	Major Injury Accident			
					121	Major Injury Accident/W/Fatality			
TOTAL EVENTS	15	5	4	3	122	Officer Assist			
TOTAL HOURS	40.4				123	Agency Assist	2		
ECO TOTALS	3				124	Citizen's Assist			
STAND BY HOURS	15				125	Fire Assist			
TOTAL CHAPLAINS DISPTACHED	3				126	Hospital Assist			
Citizens Assisted	28				127	SET/SWAT			
					128	SAR			
					129	Officer Involved Shooting			

Appendix E
Handouts on Stress

Handout 1: *How does STRESS affect us?*

ALARM

This first stage is the mobilization of the body's defenses.

Messages from the Nervous System reach the hypothalamus gland which notifies the pituitary gland and adrenal glands.



The pituitary-adrenal system pumps hormones into the bloodstream. These hormones have the effect of speeding the heart rate, increasing respiration, and stopping digestive activity.

THE BODY IS READY FOR A FIGHT!

In animals or primitive man this alarm system triggers physical action (fight) or running away (flight) thus tension is released.

If there is neither fight, then there is NO RELEASE for all the preparedness. Such a situation can lead to ulcers, headaches, backaches, palpitations, rashes, and various other ailments.

RESISTANCE & ADAPTATION

In this stage the invader is fought off or some adjustment is made.

If tired, one sleeps. If hungry, one eats. If a large number of microbes are in a wound, inflammation seals off the site from the rest of the body.

The defense system works so well that most of the time, we are not even aware of it. We are all bombarded by hostile forces – but we are not all sick.

IT IS ONLY WHEN DEFENSE SYSTEMS HAVE BROKEN DOWN THAT ILLNESS RESULTS.

EXHAUSTION

A body cannot be under stress all the time. **RELEASE MUST OCCUR!**

Some people believe that illness is the result of STRESS. The interaction of a hostile condition with STRESS could be the cause of colds, allergies, asthma, headaches, ulcers, colitis, heart disease, arthritis, and other illnesses.

Appendix E
Handouts on Stress

Handout 2: How Vulnerable Are You To Stress?

The following test was developed by psychiatrists Lyle H. Miller and Alma Dell Smith of Boston University Medical Center. Score each item from 1 (almost always) to 5 (never) according to how much of the time each statement applies to you.

1	I eat at least one hot, balanced meal a day.
2	I get 7 to 8 hours of sleep at least 4 nights a week.
3	I give and receive affection regularly.
4	I have at least one relative within 50 miles on whom I can rely.
5	I exercise to the point of perspiration at least twice a week.
6	I smoke.
7	I take fewer than 5 alcoholic drinks a week.
8	I am the appropriate weight for my height.
9	I have an income adequate to meet basic expenses.
10	I get strength from my religious beliefs.
11	I regularly attend club or social activities.
12	I have a network of friends and acquaintances.
13	I have one or more friends to confide in about personal matters.
14	I am in good health (including eyesight, hearing, and teeth).
15	I am able to speak openly about my feelings when angry or worried.
16	I have regular conversations with the people I live with about domestic problems; e.g. chores, money, and daily living issues.
17	I do something for fun at least once a week.
18	I am able to organize my time effectively.
19	I drink fewer than 3 cups of coffee (or tea) a day.
20	I take quiet time for myself during the day.
	Total

To get your score, add up the figures and subtract 20. Any number over 30 indicates current vulnerability to stress. If your score is between 50 and 75, you are seriously vulnerable. If you total is over 75, you are extremely vulnerable.

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Appendix E
Handouts on Stress

Handout 3: *Murphy's Laws of Police Work*

1. If the bad guys are in range, so are you.
2. Incoming fire has the right of way.
3. Don't look conspicuous, it draws fire.
4. There is always a way.
5. The easy way is a trap.
6. Try to look unimportant, the bad guys may be low on ammo.
7. Professional criminals are predictable – it's the amateurs that are dangerous.
8. Criminals provoked into attacking on two occasions:
 - a. When you're ready for them.
 - b. When you're not ready for them.
9. Teamwork is essential – it gives them someone else to shoot at.
10. The small criminal element you have been ignoring is the big drug drop.
11. If your sting is going well, you have walked into an ambush.
12. Never draw fire – it irritates everyone around you.
13. Anything you do can get you shot, including nothing.
14. Never share a squad car with anyone braver than yourself.
15. When you have secured an area, don't forget to tell the criminals.
16. Never forget your weapon is made by the lowest bidder.

Dan Tyler included this as a handout in the workshop, "Keys to Successful Chaplaincy" which he led at the Florida Regional Seminar.

Article ~

WHAT YOU SHOULD EXPECT FROM A CHAPLAIN

by Chaplain David DeRevere

(Military Chaplains Review, month/year unknown)

Chaplains serving law enforcement come in all sizes, shapes, ages and religious persuasions. Most are male, but some are female. No matter, for there are common traits that should be shared by all.

Some of these common traits are listed below and explained:

ACCEPTANCE

A police chaplain cares about all members of a department because they are people. Members don't have to fit any particular mold or measure up to any special standard to be important. They don't even have to go to a church or to a synagogue. They don't have to know the Bible. A chaplain accepts them as they are, just because they are one of God's children. A chaplain doesn't have to agree with or condone whatever an officer does or says, he accepts a person without judgment for they are an important being.

AVAILABILITY

A chaplain should be willing to come whenever he or she is needed--this includes getting out of bed in the middle of the night. Chaplains are committed to responding when needed. Of course there will be times when a chaplain cannot respond immediately, but the complaint most often heard from chaplains is that the department doesn't call them enough.

If someone needs to talk personally with a chaplain, they should be able to get a prompt response. However, don't expect the chaplain to be a mind-reader. He may not realize that when you propose, "why don't you ride with me sometime, chaplain," that what you really want is to talk with him privately. Expect a quick response, however, when you say, "I've got something I would like to talk about with you."

CONFIDENTIALITY

An absolute must for chaplains is to keep what is told to them confidential. A person must be able to discuss almost anything with a chaplain and know that it will never go any further. The only exception is when there is a threat of danger; to either the person being counseled or someone else. A chaplain should make these ground rules known in advance.

Officers are a suspicious group but charges that a chaplain is a snitch for the chief are rarely true. An officer who makes a claim that he told something to the chaplain and now everyone knows about it, usually has overlooked the three or four other officers he also told.

CREDIBILITY

A chaplain must have integrity. A department can expect correct ethical behavior from their chaplain. They can expect a chaplain to stand up for what is right and just, even when it pertains to prisoners. Members of a department should be able to count on the chaplain to do what he says he will do. A chaplain's actions should square with his words. He should not only talk a good game, but live one.

FAITH

A chaplain must be a person of faith. This does not mean that a chaplain will always be preaching or quoting the Bible, but it does mean that his belief shines through in the kind of life that he lives and the things he says.

INTEREST IN YOU

A chaplain is genuinely interested in all the members of a department and their families. What they and their families do, and their successes or failures are important to the chaplain. He will be pleased to share both the joys and sorrows of their lives.

LAW ENFORCEMENT KNOWLEDGE

A chaplain should know what the world of a police officer is like. He should understand the pressures and keep abreast of the developments impacting on such a life. If the chaplain is new, it will take time for him to learn this.

A good chaplain strives to be conversant with everything pertaining to law enforcement--from use of deadly force policies, to union negotiations. He will recognize this is a different world.

A chaplain will not "play cop," for he does not function as a sworn peace officer. While many chaplains feel it is an obligation on their part to be able to defend themselves and not be a liability if they are riding with someone, their function is not to be another officer.

These are some of the basic ingredients of a chaplain. Most chaplains have them, but chaplains do have faults and some will make mistakes. After all, they are human too.

Chaplain David DeRevere is Executive Secretary of the International Conference of Police Chaplains. He was a volunteer chaplain for 19 years.

Article ~

A CHAPLAIN'S CALL

By Chaplain Walton J. Tully

Lucky thing for chaplains that Father Mulcahey of the TV series MASH had a good reputation among his medical unit - he didn't preach at them and he never supposed he was "one of the boys," yet he was always present to them and quietly served whenever and wherever they needed him.

"Chaplain, this is the dispatcher. We have a Code 44 (police officer down) and Unit 31 is in the emergency room.

This type of call sends an immediate chill up the spine. No one is quite sure what had happened or just how badly hurt the officer is. And this type of call usually comes in the middle of the night, rarely during the daylight hours. The chaplain dresses quickly and responds to the hospital to check on the officer, and on the officer's family who also have been called, and to work with the officer's friends who have gathered there as well. The chaplain is the comforting presence, the stabilizing influence in a time of uncertainty and fear.

Thankfully, this type of call is NOT the norm. More often it is the chaplain who regularly visits the station and becomes well acquainted with the department personnel will be approached by an officer who says, "Chaplain, do you have a few minutes? I need to talk about something that has been bothering me."

In many cases it will be a personal problem involving a family matter. It may be that they have received a reprimand from a superior officer and feels it was unjust or unwarranted. Rarely does the officer stop the chaplain to talk "church talk."

Introduction to the Chaplain

Today, more than ever in the history of law enforcement agencies, the need for religious guidance and assistance to law enforcement officers is great and demanding. Each day the police officer is faced with potentially dangerous situations as they come into contact with the baser elements of society. They must make split-second decisions that are just and right, knowing that someone with a lot of time will be analyzing what was done, and how it should have been handled differently- all with the expertise of an armchair quarterback. After careful deliberation of the facts that person will tell the officer whether or not the split-second decision was the right one. Many times after such a situation the officer has the feeling they are coming apart at the seams and need someone trustworthy to "dump on." That person has to be one who fully understands the circumstances surrounding the decisions that were made.

There is a great need to be able to "let it all hang out" with someone who will not be judgmental, but understanding. Someone needs to be there to hear what the officer is up against, yet is detached enough not to become personally involved in the situation.

Often an officer does not feel comfortable taking with the supervisor or even other officers about a problem they are experiencing. They do not want to take the problem home to the spouse or parents as they do not want to alarm them. Where can they go?

The police chaplain needs to be the one who can listen with empathy, advise calmly, and offer assistance when such assistance is appropriate. On call 24 hours a day the chaplain stands ready to respond. The key words are "service" and "presence." The chaplain knows they need to be with the officer whenever and wherever their service is needed.

The Chaplaincy is no place for a person who does not like to have his sleep interrupted. It is not a vocation or avocation for the person who is enamored of a uniform and wishes only to be used on "state occasions." The Chaplaincy must be filled by a person whose primary desire is to be of help to law enforcement personnel wherever and whenever the call may come.

The Chaplain's Qualifications

To be a chaplain, the person should:

- Be an ordained or licensed clergy person in good standing
- Show a God-like compassion, understanding, and a love for others
- Be able to relate easily to all kinds of people
- Maintain high spiritual and moral standards
- Manifest maturity in judgment, emotional stability, and personal flexibility
- Be tactful and considerate with people of every race, creed and religion
- Be willing to become involved in training (such as the basic academy, "in-house" training, seminars, etc.) that will enhance effectiveness in dealing with people and crises.
- Be familiar with the various helping agencies in the community to which referrals can be made.
- Be willing to respond to any and all situations where his presence as a chaplain is indicated
- Never have been convicted of a criminal offense, nor of offenses involving moral turpitude. (Minor traffic offenses are excluded).
- The police chaplain needs to be a person who has a deep concern for the spiritual and emotional well-being of law enforcement personnel. The chaplain may or may not have received the basic law enforcement training given to new officers, although some chaplains have become sworn officers usually serving as reserve or auxiliary officers, and some may carry weapons.

When I started my work as a volunteer police chaplain I found that the personnel were friendly, but would not openly talk about the problems of police work which were the root of their concerns. When I asked the sheriff how I could get closer to them, to get them to respond to me as their chaplain, he said, "Become one of them." After completing the 300 hours of training I began riding with them on patrol, and they did begin to talk. Once they know you are willing to face the street scene with them you will be accepted.

One thing the chaplain must not do is to preach to them when riding with them, or when speaking with them in the office. The chaplain should just be there accepting the officer as he or she is, but not trying to be "one of the guys," using inappropriate language or sharing stories that are "colorful." The chaplain must remember that he is God's representative to a hurting people and act accordingly.

Ways A Chaplain Can Help

There are many areas in which the chaplain can help officers in doing their duty. They include, but are not limited, to:

- Assistance in making notifications to families when there has been a death in the family due to homicide, suicide, accidental or natural causes.
- Help comfort persons seriously injured in an auto or other type accident, or comforting their family members.
- Assists in dealing with attempted or potential suicide victims and their families.
- Helping officers deal with confused and/or emotionally distressed persons.
- Aiding in cases of domestic disputes where families indicate a willingness to accept counseling (on a short-term, emergency basis only). Long term counseling should be referred to the person's own pastor or some other agency.
- Responding when an officer is killed or injured in the line of duty.
- Respond to scenes of major disasters in which law enforcement officers are involved, i.e., bombings, train or plane accidents, explosions, industrial accidents, toxic spills, etc. Be there in the field with the officers.
- Promote and conduct memorial services when appropriate. Observe National Law Enforcement Memorial Day on or about May 15th or each year.
- Attend such occasions as academy graduations, award or promotion ceremonies, dinners, social events, and other public functions as a representative of the department.
- Work in the area of public relations as liaison with other religious leaders in the community.

If there is an officer or a department whose primary concerns are child or spouse abuse or sex crimes, the chaplain can often be the soft shoulder for the officer who is feeling overwhelmed by it all. The department should never overlook the chaplain when it comes to dealing with juvenile delinquents because he may be a guiding influence.

Confidentiality

This becomes one of the touchiest areas in dealing with law enforcement personnel. There has to be an understanding with the chief or sheriff or other head officers of the department, that some things discussed will be highly confidential. Without this agreement there will be no possibility that an officer will completely unburden him/herself to the chaplain. The personnel have to know that this confidence will be maintained.

What happens if what the officer tells you has a direct bearing upon the individual's emotional stability and/or ability to do the job effectively? Now comes the question: Does the officer trust you implicitly? If so, then the two of you can probably work out some sort of an arrangement where he will be willing to talk with another professional counselor if it is out of your area of expertise.

If there is hesitation, a showing of a lack of trust in you, it will be up to you whether or not withholding information from the officer's supervisor will cause harm to the officer, to another officer, or to the general public. It becomes a judgment call, but one which will affect your relationship not only with that officer, but with the other officers in the department as well. Will your actions cause them to distrust you in the future? Will your actions cause "the brass" to lose confidence in you?

There is no easy answer to disclosing something told you in confidence.

The Police Family

The chaplain stands ready to assist the officers and family in the times of distress, crises involving the possibility of separation and divorce and problems in which children are involved.

No one understands the stress, the pressures, the problems, the discouragements that are a part of the officer's daily life except the person who has walked with that officer in good days as well as bad days. There are situations which the officer may not be able to discuss with an outsider due to department regulations, but for which the chaplain has been cleared and is available to respond. The chaplain may even have faced that or a similar problem previously.

Generally the chaplain can be called upon at any time, day or night, seven days a week. However, we do want to state that the chaplain will not, and does not wish to take the place of the officer's own pastor. The chaplain is there to help until the family's pastor can arrive, or to be the pastor if the family has no church affiliation.

The Authority Of The Chaplain

As stated before, the chaplain may or may not be a sworn officer, but he is a person of God with the responsibility to assist all officers on matters that fall within the realm of the Chaplaincy.

The chaplain should report directly to the chief law enforcement officer. It is to be understood, however, that any information of a privileged nature shall not be included in any report made by the chaplain to such head officer.

To be effective in his role as a helper, the chaplain shall be authorized to ride with officers on all shifts, shall be given permission to visit all offices of the department, and be welcomed at the various scenes at which the officers are working. This requires that the chaplain be issued a department identification card and possibly, a uniform so as to readily identify. If possible, the chaplain should have access to radio communications of some sort, and/or a pager in order to be in constant contact with the dispatcher in case of emergencies.

The chaplain shall not release any information to the news media except as authorized by the chief or the sheriff.

Learning In Retrospect

One department with which I became affiliated had an officer killed and one wounded in a shooting in the station parking lot ten months prior to my arrival in the city. I heard much about it and we held a memorial service one year after the death. That all seemed to go well and seemed to be comforting to the family.

A while later the second officer, the one who had been wounded, invited me to have a cup of coffee with him, I sensed that he wanted to talk about what had happened - post-shooting trauma had set in. I sat and listened, but I was too unsure of my relationship with him at the time to press him to reveal just how he felt. The right question probably would have opened the flood gate and healing might have taken place. But I sat there on my hands, doing nothing. And he did nothing and said nothing. A missed opportunity!

Was I wrong in not insisting on talking it out? In retrospect I would have to say, yes, I was wrong. This was a learning experience for me. Now, I would much rather err in pushing the officer to talk about the experience than in allowing him to suffer in silence. If you sense there is something bothering an officer let him know you know something is wrong, and that you want to help. We, as chaplains, must be willing to be vulnerable if we are going to be able to help others. And you officers, if you want to talk and the chaplain seems unsure of what to do - for heavens sake tell him or her.

The Police Chaplain needs to stay in touch with other chaplains, not only locally, but throughout the nation. There is an organization dedicated to keeping chaplains in touch with each other and also to provide continuing education in their specialized field. The International Conference of Police Chaplains (ICPC) exists for the purpose of fellowship, assistance on an international basis, and for providing seminars to help further the knowledge of police chaplains. Seminar leaders are provided by our own people as well as those from the FBI, local and state police agencies.

For more information on the International Conference of Police Chaplains, contact: ICPC, PO Box 5590, Destin, FL, 32540. (850) 654-9736, Fax (850) 654-9742. Website <http://www.icpc4cops.org>.

Article ~

A DAY IN THE LIFE OF A SENIOR CHAPLAIN

“Meeting the Need” Newsletter, Spring 2006

Have you ever wanted to know just how a Senior Chaplain spends their day? I mean, what do they do in between the occasional graduation, promotion or retirement dinners? We see the Chaplain on special occasions when he is asked to do an invocation, or say a few encouraging words to the troops. But just how does Chaplain Terry Morgan, Placer County’s Senior Chaplain, spend his days?

When Chaplain Morgan was asked, “What is a typical day for you?” He kind of smiled and laughed. “I don’t think there is ever a typical day in this job.” He said. “Some days are filled with administration type work. I might spend the whole day pushing paper, compiling information for reports, and typing up data. Other days, I don’t see the inside of the office all day.”

So, we decided to be “very scientific” about this. We asked Chaplain Morgan to open his planner, close his eyes and point to a day. Then we asked him to tell us about that day.

The particular day he pointed out was a long one. His day actually started in the wee hours of the morning. At 0300 (or 3 A.M.) Chaplain Terry’s pager went off. He called his answering service, and got bad news. Someone had lost their loved one unexpectedly during the night, and the Sheriff’s department was asking for the assistance of a Chaplain. Someone had to go and tell the family. There are currently 30 volunteer Chaplains that work for the Placer County Law Enforcement Chaplaincy and are available around the clock. He called a volunteer Chaplain who lived close by the scene to respond. The Chaplain told him he would go. Then, Chaplain Terry tried to get some rest as he waited for his volunteer Chaplain to call him back. He would not rest easy until he knew the task was finished, and the volunteer Chaplain was back home and safe. A couple of hours later his cell phone rang. The notification was done. The Chaplain had delivered the news, and comforted the family as best he could.

At 0645 (or 6:45 A.M.) the pager went off again. Another person had passed away, and a Chaplain was needed to respond. Chaplain Terry jumped up, and got dressed. So as not to wake the rest of the house, he quietly slipped out to his car.

It seemed, an elderly mother had died in the night, and her daughter found her dead the next morning. Chaplain Morgan worked with the grieving family for the next several hours. At first the family wasn’t even sure they needed a Chaplain. They felt like they were “imposing” on his time. He assured them that he was there for them, and it was no imposition. He helped the family contact other family members; contacted their minister; and made sure they understood what was going to happen next. He walked them through each step of the coroner process. When the coroner released the body, he helped them with funeral arrangements, and getting their mother’s body to a funeral home. It was emotionally draining, but by the end of the call, they were very thankful a Chaplain had come to help them.

“Most often, we are offering a ministry of presence. We are there for the families to talk to. We are non-judgmental, and often tell them they have our permission to cry in front of us,” says Chaplain Morgan. “We hold the victim’s hands, and sit with them while the coroner does their work. Sometimes we pray with them if they want us to, other times we just let them weep.”

By 10:00 A.M. Chaplain Morgan was on the road to the office. He grabbed a quick breakfast and a hot cup of coffee. By the time he got to the office, he had several phone calls to return, along with a stack of mail to go through, and a dozen or so emails.

Around 11:30 a.m., Chaplain Morgan visited the Roseville Police Department, one of the many law enforcement agencies in his jurisdiction. He did a walk through, greeting volunteers and officers alike. One of the officers it seemed had lost a loved one, and needed “just a couple of minutes to let his guard down with the Chaplain.”

“It must have been about 2:00 in the afternoon when I realized I didn’t have lunch yet. There was still a lot of work to do, so I ordered a big salad and an iced tea from the local pizza parlor. I remember eating lunch at my desk while still trying to catch up on paperwork.” Then the phone rang. An officer was having a difficult time dealing with a particularly difficult call he was on some time back, and just needed to talk.” He spent about an hour on the phone. “Officers are human too.” Chaplain Morgan said. “Sometimes they just need someone to talk to, to validate their feelings, and tell them they are doing a good job.”

“I once heard it said by a police chief from another jurisdiction, that when a community member needs help they call 911. But when an officer needs help, and they call 911, they are calling the Chaplain,” said Chaplain Morgan.

Another couple of hours of administrative work was still waiting on the desk. Chaplain Morgan was trying to find some alternative fundraising ideas. “The Chaplaincy works on a tight budget so money seems to always be an issue. People don’t always realize that we are a non-profit agency, so we are not totally funded by any one agency.”

Finally, the clock said 5:00 P.M. Chaplain Morgan had just enough time to change into his dress uniform and get to his next appointment. He was asked to attend an officer’s retirement dinner. He would go in, say a few encouraging words, and do an invocation at the start of the dinner. “The officers are always so grateful when ever we come out.”

Chaplain Morgan would sit and eat with them and swap stories for a while over dinner. He would try to make sure he got around to as many officers and their families as he could. Finally, he would wrap up about 10:00 that night, and be home by 10:30 or 11:00 p.m. Hopefully, it would be a quiet night.

~Article

SPECIAL ARTICLE
The Chaplaincy

**Chaplains see 'best and worst' in New Orleans recovery -
Placer officials spend weeks aiding emergency responders**

by [Penne Usher](#)

Journal Staff Writer, November 11, 2005



Terry Morgan



Jim Milne

Placer County Law Enforcement chaplains Terry Morgan and Jim Milne recently returned from a trip to New Orleans to counsel emergency personnel dealing with storm devastation. Photos by Penne Usher/Auburn Journal

NEWCASTLE - A rescue team in New Orleans came upon a rest home that appeared abandoned, but they felt the need to investigate.

[As they arrived] They heard bells ringing. The elderly bed-ridden patients rang the bells to get the attention of staff. The bells rang, but no one came. The staff had fled and left the 40 patients for dead.

[Meanwhile] At a children's hospital in New Orleans the staff didn't leave. They stayed with their patients. They all drowned together.

Chaplain Jim Milne of the Placer County Law Enforcement Chaplaincy program said Thursday that catastrophe and devastation brings out "the best and worst in people."

For weeks Milne and Chaplain Terry Morgan calmed and counseled law enforcement officers, rescue workers and firefighters in hurricane-ravaged New Orleans.

Their job as chaplains for the Placer County Law Enforcement Chaplaincy program is to comfort victims, their families and the law enforcement officers who protect and serve the community.

Morgan first flew to Baton Rouge three weeks after Hurricane Katrina hit the Gulf Coast. The 42-year-old from Orangevale has been to hundreds of car crashes and multiple murder scenes in his years with the county. But what he saw in New Orleans was horrific. "Twisted steel girders looked like pretzels and the sides of five- and six-story buildings were gone," Morgan said. "It reminded me of the

Oklahoma City bombing."

Morgan was sent to Louisiana to counsel and debrief the officers and firefighters that had been working 18- to 20-hour shifts for days on end, rescuing survivors and locating the dead.

"Its ventilation and validation," Morgan said. "You could call it counseling first aid."

He said the look on the officers' faces was that of dread and defeat.

"Eighty percent of the officers lost everything. Their homes were destroyed and families relocated," Morgan said. "Being only one person I couldn't get to so many officers."

He too worked 18 to 20 hours a day and was exhausted. Milne, 52, of Newcastle, arrived Oct. 26 and by then the water had receded in the area of the levee break.

"Nothing remained," Milne said. "You'd drive down the streets and all of a sudden you'd see a house in the middle of the road. "It was like somebody dropped the Monopoly board."

He took a three-hour helicopter trip above New Orleans with Federal Emergency Management Agency workers.

"After a while I couldn't watch any more," he said.

Milne said one Louisiana officer had been on vacation when the hurricane hit. He came back to work and one of the bodies he uncovered was that of his own mother.

Some officers have had enough. Milne said they've seen too much to stay in law enforcement. Others will form a bond with co-workers and move forward.

By the end of October law enforcement officers were recovering, as was the city.

"I tried to get them to see there is now a unique opportunity to create a new city," Milne said. "It's not what happens but what you do with what has happened."

The Journal's Penne Usher can be reached at penneu@goldcountrymedia.com.

Article ~

BREACHING THE BLUE WALL

By Lowell F. Lawson

This article originally appeared
as a Paul Harvey commentary.

I will never forget the sense of frustration that edged his voice as he spoke. "I go to the precinct and I stand and no one ever comes up to talk to me. He was a young police chaplain candidate. He had come to the end of his training period and had decided that he would not seek appointment as a police chaplain. A quiet individual who found it difficult to initiate relationships he had struggled through the most frustrating experience of his life. As a priest he was welcomed by his congregation and strangers smiled at him as he walked the streets. Not so when he went to the precinct as a police chaplain. He had met the BLUE WALL. And the BLUE WALL won.

The BLUE WALL. It is not a physical structure. It is the invisible social and psychological barrier that separates police officers from others. It is not the existence of such a barrier that is unique. Many groups erect such obstacles to relationships, doctors, lawyers, ministers, politicians, housewives, cheerleaders, bag ladies and winos - every distinctive group tends to segregate itself from others at some point. There is something which draws us together with others who share a commonality with us. All of us tend to withdraw behind a wall that keeps out others who lack that commonality.

Although there are many walled groups in society, there is something about the BLUE WALL that sets it apart from all other walls. That something is the intention of the wall. Police officers build the wall and they maintain it. No one breaches it without the approval of the officers.

Why is the BLUE WALL particularly impenetrable? Why is it, of all walls, the most difficult to breach? The answers are found in the nature of law enforcement. Police deal with the negatives of our culture. Their task is to restore a positive balance to situations and circumstances that are biased toward and/or un-inclined to accomplish. They restore domestic peace, recover stolen property, arrest those who commit crimes against citizens – to deal with the unpleasantness of life. It is a difficult job carried out under the bright lights of public scrutiny. Police officers inhabit a world little understood by those outside its boundaries. Little wonder they withdraw into an enclave surrounded by the BLUE WALL.

Police officers place the clergy at the far right end of the bad-good spectrum. Like many persons, police officers view others from a stereotypical frame of reference. They see the minister as naive; incapable of accepting the fact that there are bad people in the world. The minister is seen as one who has never heard the "four-letter words" and would be uncomfortable at a murder scene. The police officer thinks that ministers should seek the safe and quiet places, insulated from the real world of the streets.

An impenetrable wall. A closed society. That is the arena in which the police officer lives and moves and has his being. It is also the place where the chaplain must go if he is to be the chaplain. And so the obvious questions. Can you get there from here? How do you get there? The answer to the first question is "YES". The second answer is a bit more complex.

You can get behind the wall- unless you do you will be a police chaplain in name only. Yours will never be more than an appointed position. Certainly it will not be a ministry.

How do you get there from here? The route is not a short one nor is the journey brief. Rather it is long and winding.

When the chaplain enters the world of the police officer the initial reception may vary from acceptance to rejection. If the chaplain is known to the officers and a relationship has been built based upon previous contacts then entry may be eased somewhat. If the chaplain is unknown he may experience feelings ranging from indifference to ostracism. Hopefully there will be at least passive acceptance and toleration for his presence.

The chaplain must know who he or she is. His or her sense of calling must be clear. If it is then they will be willing to spend the time that it will take to establish their role as chaplain. Otherwise, he may soon become discouraged.

The chaplain must make a serious time commitment. They must visit the officers frequently enough to become a familiar face. They must go to the station often enough that the officers can identify them as a "regular".

The chaplain must assume responsibility for building relationships. They will need to initiate conversations, ask about how things are going, and speak a good word about something positive he has observed.

The chaplain must be a listener. What is happening in the lives of the officers? Who is buying a new home? Whose son is graduating from high school? Was the weekend hunting trip successful? How is the daughter who just had surgery? When is the new baby due...and how many kids will that make at home? The bits and pieces of news that are picked up while riding in the patrol car or waiting for roll call are the basis for conversations. Conversations are the basis on which relationships are built.

The chaplain should be an affirmer. Generally we live in a non-affirming society. Criticism is easy to come by and it is a frequent visitor in the lives of most people. Affirmation comes calling much more infrequently. Criticism is a constant companion of the police officer. The officer seldom arrives as quickly as needed. He uses too little tact and too much force in making an arrest. He forgets to put on his hat when making a traffic stop. The counseling register lists far more disciplinary actions than accolades.

Affirmation helps close the distance between officers and chaplains. When an officer maintains his composure in the face of an irate citizen venting his anger about some matter over which the officer had no control, the chaplain may say,

"You handled that very well." A simple comment. Yet for the officer who seldom hears much approbation it is better than a raise in pay (almost).

The chaplain should acknowledge special events. Birthdays, weddings anniversaries, completion of a college semester, and other significant milestones should be acknowledged. The death of a family member is a time when a visit to the funeral home will communicate boldly that the chaplain cares about the officer and be long remembered. These special remembrances become the foundation on which the chaplain achieves acceptance.

If the chaplain demonstrates sensitivity to the officers as individuals he will need not worry about acceptance. Gradually the word will be shared from officer to officer: "The chaplain is okay"...

No. Acceptance will not come overnight. But it will come. The route behind the BLUE WALL is not short nor is the journey brief. But it is well worth the taking.

WHAT IS A POLICEMAN?

He is a composite of what all men are, a mingling of saint and sinner, dust and deity.

Culled statistics wave the fan over the stinkers, underscore instances of dishonesty and brutality because they are news. What that really means is that they are exceptional, unusual, and not commonplace.

Buried under the froth are the facts. Less than one-half of one percent of police officers misfit the uniform. That's a better average than you will find among clergy.

What is a police officer made of? They, of all people, are at once the most needed and the most unwanted.

They are a strangely nameless creature who is "Sir" or "Ma'am" to their face and "fuzz" behind their back. They must be such a diplomat that they can settle differences between individuals so that each will think he won.

But...if they are neat, they're conceited; if they're careless, they're a bum.

If they are pleasant, they are a flirt; if not, they're a grouch. They must make, in an instant, decisions which would require months for an attorney.

But...if they hurry, they're careless; if they are deliberate, they're lazy.

They must be first to an accident and infallible with their diagnosis.

They must be able to start breathing, stop bleeding, tie splints and, above all, be sure the victim goes home without a limp, or expect to be sued.

The police officer must know every gun, draw on the run and hit where it doesn't hurt. They must be able to whip two men twice their size and half their age without damaging their uniform and without being "brutal".

If you hit an officer, they're a coward; If they hit you, they're a bully. They must know everything and not tell; Know where the sin is and not partake.

They must, from a single human hair, be able to describe the crime, the weapon, and the criminal and tell you where the criminal is hiding.

But... if they catch the criminal, their lucky; if they don't, they're a dunce.

If they get promoted, they have pull; if not they're a dullard.

They must chase bum leads to a dead-end, stakeout ten nights to tag one witness who saw "it" happen, but refuses to remember.

They run files and write reports until they ache in order to build a case against a felon who will get "dealt out".

They must be a minister, a social worker, a diplomat, a tough guy, and a gentleman/lady, and, of course, they will have to be a genius since they will have to feed a family on a policeman's salary.

Article ~

POLICE CHAPLAIN PROGRAMS AND THE CONSTITUTION

Source Unknown

The first amendment to the constitution of the United States provides the following protection: Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

One court summarized the protection of the first amendment thusly: "The amendment protects freedom of (religious) speech and expression of view. It protects the free exercise of religion. And it insures freedom of religious worship by prohibiting the government from any establishment of religion."

The supreme court articulated a three prong test in 1971 to determine whether a statute or government policy will offend the establishment clause of the first amendment. In *Lemon vs. Kurtzman*, (403 U.S. 602, (1971), the court said that: "First, the statute must have a secular legislative purpose; second, it's principal or primary effect must be one that neither advances nor inhibits religion; and finally, the statute must not foster an excessive government entanglement with religion."

SECULAR PURPOSE

The government act in question must not have a religious purpose. The supreme court has explained that there can be no "Animus of Religion" in the design or goal of the program. Religious tests for public employment are unconstitutional, per se. But, the court has also made clear that the presence of religious purposes would not doom a law or practice, as long as there was also a secular purpose. "The court has invalidated legislation or governmental action on the ground that a secular purpose was lacking, but only when it has concluded there was no question that the statute or activity was motivated wholly by religious considerations. Even where the benefits to religion were substantial we saw a secular purpose and no conflict with the establishment clause." *Id.* at p680. accord, *Wallace V. Jaffree*, *Van Zandt V. Thompson*, where the 7th Cir. Ct. of appeals held that the prayer room in the state capitol has the secular purpose of promoting meditation: "The resolution (Authorizing the Prayer Room) suggests that (The Legislators) may legislate better for having taken some time to thing quietly";

In *Carter V. Broadlawns Medical Center*, A case challenging a hospital Chaplaincy program, the 8th Cir. held that the district court plainly erred by focusing almost exclusively on the religious purpose in isolation from the larger context, which reveals a valid secular purpose (To Help The Patients Get Well). Thus, as long as there is a valid overall SECULAR PURPOSE, there may be religious benefits to the program without violating the first prong of the lemon test.

PRIMARY EFFECT TEST

The second prong of the lemon test states that the principal or primary effect of a law or program must be one that neither advances nor inhibits the practice of religion. Just because a program has a "primary" effect to promote some legitimate secular end, nevertheless the program may be further examined to ascertain whether it also has the direct and immediate effect of advancing religion. "Secular objectives no matter how desirable and irrespective of whether judges might possess sufficient sensitive calipers to ascertain whether the secular benefits outweigh the sectarian benefits, cannot serve... to justify... a direct and substantial advancement of religion."

However, the impact on religion must be direct and substantial. Where government action does not directly endorse religion or a particular religious practice, its primary secular effect is not rendered unconstitutional merely because it happens to harmonize with the tenants of religions. The mere fact that a religious organization receives an incidental benefit under a government policy does not violate the privacy effect prong. In *Lynch vs. Donnelly*, the supreme court stated that their precedents plainly contemplate that on occasion some advancement of religion will result from government action, but not every law that confers an "indirect", "remote", or incidental benefit upon religion is, for that reason alone, constitutionally invalid. However, the court said focus exclusively on the religious component of any activity would inevitably lead to its invalidation under the establishment clause.

In *Carter vs. Broadlawns*, the hospital Chaplaincy program was challenged on the grounds that it violated the effect test by providing financial aid to enable persons in its care to practice their religions. While the district court concluded that paying a chaplain to provide religious care is an advancement of religion, the 8th Cir. noted that some financial benefit to religion can be tolerated in applying the lemon test. It distinguished the neutrality of employing a counselor with the versatility and training to help persons all along the continuum of religious dispositions from cases where the effect was more direct and selective.

As the court stated in *Voswinkel vs. City of Charlotte*, supra, "The agreement here (between the city and Providence Baptist Church) necessarily has several obvious, direct, and constitutionally impermissible effects:

1. It provides for a publicly funded position that must, under the terms of the agreement, be filled by a "Minister". To the extent that one's status as a minister depends on some degree of adherence to the creed of, and is subject to control by, the denomination one serves, the agreement necessarily imposes a religious test for eligibility to a publicly funded office.

EXCESSIVE ENTANGLEMENT TEST

The final question under the lemon test is whether the challenged practice gives rise to an excessive government entanglement with religion. Government oversight - determining what material is religious and what is not, inquiries into religious doctrine, detailed monitoring or close administrative contact - is likely to violate the undue entanglement prong of the test. For instance, in 1981 the

supreme court said that a university would risk greater entanglement by attempting to enforce its exclusion of "Religious Worship" and "Religious Speech" than by opening its forum to religious as well as non religious speakers.

Oversight of the chaplains themselves risks undue entanglement. The district court in the Voswinkel case in North Carolina held there was undue entanglement because it was not clear to whom the chaplain must answer, in the last analysis, in the performance of his duties. Supra. thus giving chaplains as much independence as possible in performing their duties is desirable.

AVOIDING FIRST AMENDMENT PROBLEMS

It is evident we must be careful to avoid running afoul of the first amendment's establishment clause. The court in the Voswinkel case, though only a U.S. District Court, has given some guidance that should withstand the scrutiny of the U.S. Supreme Court: "The creation of a counseling position to which any counselor could apply and be considered on religiously neutral grounds in not a government action that could reasonably be said to threaten "An establishment of religion". "The city may, of course, spend money to provide its police officers with the purely secular services described in the agreement (between the city and the church). There is nothing ;unconstitutional in hiring a clergyman to perform those services, so long as the clergyman is selected as the result of a religiously neutral process rather than, as here, pursuant to a contract with a specific church that restricts eligibility to ministers. Indeed, to reject a job applicant because he is a minister would violate the first amendment prohibition against government interference with the "Free Exercise of Religion", as well as statutory prohibitions against religious discrimination in employment. Neutrality in religious matters, not hostility toward religion, is what the constitution requires. The court does on believe that a public employee, hired as a counselor through some neutral selection process, is constitutionally required to refrain from discussing "spiritual" or "moral" matters in the course of his counseling duties. There is nothing unconstitutional, per se, in a church's donating money or property to a governmental entity or in the passage of money from a government entity to a church for some purpose that does not threaten to assist religion or to entangle govt. excessively in religious affairs.

Any Chaplaincy program should have no constitution problems if:

1. The program has a "secular" purpose,
2. Is religiously neutral, and
3. Avoids excessive religious entanglement.
4. It is a long standing program (History)

A GUIDE TO GRIEF

By National Hospice and Palliative Care Organization

Grief is a normal response to loss. It can be the loss of a home, job, marriage or a love one. Often the most painful loss is the death of a person you love, whether from a long illness or from an accident or an act of violence.

This guide will help you understand the grief you and others may feel after a death, whether sudden or anticipated. We hope this guide will help you realize that these feelings are not unusual and things can get better. You are not alone.

The Grieving Process

Grief is painful and at times the pain seems unbearable. It is a combination of many emotions that come and go, sometimes without warning. Grieving is the period during which we actively experience these emotions. How long and how difficult the grieving period is depends on the relationship with the person who dies, the circumstances of the death, and the situation of the survivors. The length of time people grieve can be weeks, months, and even years. One thing is certain: grief does not follow a timetable, but it does ease over time.

Because grief is so painful, some people try to “get over” a loss by denying the pain. Studies show that when people don’t deal with the emotions of grief, the pain does not go away. It remains with them, and can turn up in unrecognizable and sometimes destructive ways. Understanding the emotions of grief and its feeling and symptoms are important steps in healing and in helping others who may be grieving.

The Feelings and Symptoms of Grief

Experts describe the process of grieving and the emotions of grief in various ways. The most commonly described reactions are: Shock, Denial, Anger, Guilt, Depression, Acceptance, and Growth. Some people experience the grieving process in this order. Most often, a person feels several of these emotions at the same time, perhaps in different degrees.

Shock

If the death comes suddenly, as in an accident or murder, shock is often the first response people feel. Even if the death is anticipated, there may be disbelief at its finality. A person may be numb, or, like a robot, be able to go through the motions of life while actually feeling little. At the same time, physical symptoms such as confusion and loss of appetite are common.

Denial

Shock and denial are nature’s way of softening the immediate blow of death. Denial can follow soon after the initial shock. People may know their loved one has died, but some part of them can’t yet accept the reality of the death. It is not uncommon to fantasize that the deceased will walk through the door, as if nothing has happened. Some people leave bedrooms unchanged or make future plans as if the loved one will participate, just as in the past.

Anger

Anger is normal. It may be directed at the deceased for leaving and causing a sense of abandonment, or at the doctors and nurses who did not do enough, or at a murderer who killed without remorse. People of faith may feel anger at God, for allowing so much pain and anguish. Anger may also be directed at oneself for not saving the life of the loved one. It can be a mild feeling or a raging irrational emotion. It can test one's faith in religion or even in the goodness of life.

Guilt

Few survivors escape some feeling of guilt and regret. "I should have done more" are words that haunt many people. Were angry words exchanged? Most people are very creative in finding reasons for guilt. So many things could have been done differently "if only I had known."

Sadness

Sadness is the most inevitable emotion of grief. It is normal to feel abandoned, alone and afraid. After the shock and denial have passed and the anger has been exhausted, sadness and even hopelessness may set in. A person may have little energy to do even the simplest daily chores. Crying episodes may seem endless.

Acceptance

Time alone will not heal grief. Acknowledging the loss and experiencing the pain may free the survivor from a yearning to return to the past. Accepting life without the lost loved one may give way to a new perspective about the future. Acceptance does not mean forgetting, but rather using the memories to create a new life without the loved one. Hoping for things to be as they were may be replaced by a search for new relationships and new activities.

Growth

Grief is a chance for personal growth. For many people, it may eventually lead to renewed energy to invest in new activities and new relationships. Some people seek meaning in their loss and get involved in causes or projects that help others.

Some people find a new compassion in themselves as a result of the pain they have suffered. They may become more sensitive to others, thus enabling richer relationships. Others find new strength and independence they never knew they had. After the loss, they find new emotional resources that had not been apparent before.

The Experience of Grief

Grieving people have two choices: they can avoid the pain and all the other emotions associated with their loss and continue on, hoping to forget. This is a risky choice, since experience shows that grief, when ignored, continues to cause pain. The other choice is to recognize grieving and seek healing and growth. Getting over a loss is slow, hard work. In order for growth to be possible, it is essential to allow oneself to feel all the emotions that arise, as painful as they may be, and to treat oneself with patience and kindness.

Feel the Pain

Give into it - even give it precedence over other emotions and activities, because

grief is a pain that will get in the way later if it is ignored. Realize that grief has no timetable; it is cyclical, so expect the emotions to come and go for weeks, months or even years. While a show of strength is admirable, it does not serve the need to express sadness, even when it comes out at unexpected times and places.

Talk About Your Sorrow

Take the time to seek comfort from friends who will listen. Let them know you need to talk about your loss. People will understand, although they may not know how to respond. If they change the subject, explain that you need to share your memories and express your sorrow.

Forgive Yourself

Forgive yourself for all the things you believe you should have said or done. Also forgive yourself for the anger and guilt and embarrassment you may have felt while grieving.

Eat Well and Exercise

Grief is exhausting. To sustain your energy, be sure to maintain a balanced diet. Exercise is also important in sustaining energy. Find a routine that suits you - perhaps walks or bike rides with friends, or in solitude. Clear your mind and refresh your body.

Indulge Yourself

Take naps, read a good book, listen to your favorite music, get a manicure, go to a ball game, rent a movie. Do something that is frivolous, distracting and that you personally find comforting

Prepare for Holidays and Anniversaries

Many people feel especially “blue” during these periods, and the anniversary date of the death can be especially painful. Even if you think you’ve progressed, these dates may bring back some of your painful emotions. Make arrangements to be with friends and family members with whom you are comfortable. Plan activities that give you an opportunity to mark the anniversary.

Get Help

Bereavement groups can help you recognize your feelings and put them in perspective. They can also help alleviate the feeling that you are alone. The experience of sharing with others who are in a similar situation can be comforting and reassuring. Sometimes, new friendships group through these groups – even a whole new social network that you did not have before.

There are specialized groups for widowed persons, for parents who have lost a child, for victims of drunken drivers, etc. There are also groups that do not specialize. Check with your local hospice or other bereavement support groups for more information.

If you find that you are in great distress or in long-term depression, individual or group therapy from a counselor who specializes in grief may be advisable. You can ask your doctor for a referral.

Take Active Steps to Create a New Life for Yourself

Give yourself as much time to grieve as you need. Once you find new energy, begin to look for interesting things to do. Take courses, donate time to a cause you support, meet new people, or even find a new job

It is often tempting to try to replace the person who has been lost. Whether through adoption, remarriage, or other means; this form of reconciliation often does not work.

Many people discover that there is hope after death. Death takes away, but grief can give back. It is possible to recover from grief with new strengths and a new direction. By acting on our grief, we may eventually find peace and purpose.

Helping Those in Grief

You may know someone who has experienced a loss. Many of us feel awkward when someone dies, and don't know what to say or do. The suggestions below are designed to help your friends, family, and coworkers who are grieving.

Reach Out to the Grieving Person

Show your interest and share your caring feelings. Saying the wrong thing is better than saying nothing at all. At the same time, avoid clichés like, "It was God's will", or "God never give us more than we can bear", or "At least she isn't suffering". Do not say you know how it feels. Do say you are sorry and that you are available to listen. Be prepared for emotional feelings yourself. A death generates questions and fears about our own mortality.

Listen

Your greatest gift to a grieving person can be your willingness to listen. Ask about the deceased. Allowing the person to talk freely without fear of disapproval helps to create healthy memories. It is an important part of healing. While you can't resolve the grief, listening can help.

Ask How You Can Help

Taking over a simple task at home or at work is not only helpful, it also offers reassurance that you care. Be specific in your offer to do something and then follow up with action.

Remember Holidays and Anniversaries

These can be a very difficult time for those who are in grief. Do not allow the person to be isolated. Remember to share your home, yourself, or anything that may be of comfort.

Suggest Activities That You Can Do Together

Walking, biking, or other exercises can be an opportunity to talk, and a good source of energy for a tired body and mind. Help the grieving person find new activities and friends. Include grieving persons in your life. Grieving people may require some encouragement to get back into social situations. Be persistent, but try not to press them to participate before they are ready.

Pay Attention To Danger Signs

Signs that the grieving person is in distress might include weight loss, substance abuse, depression, prolonged sleep disorders, physical problems, talk about suicide, and lack of personal hygiene.

Observing these signs may mean the grieving person needs professional help. If you feel this is the case, a suggestion from you (if you feel close enough to the person), or from a trusted friend or family member may be appropriate. You might also want to point out community resources that may be helpful.

Death can be a painful and permanent loss experience, and one of the hardest from which to recover. Death takes away, but facing it and grieving can result in peace, new strengths and purpose.

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Article ~

DEATH NOTIFICATION: SOME RECOMMENDATIONS

By Hubert Looney and Jerry L. Winsor

Without a doubt death is a most unpleasant, yet ever-present, reality for law enforcement officers. Law enforcement is a high-stress occupation for a variety of reasons, and the ubiquitous necessity of dealing with situations surrounding pre-mature death are significant contributing factors to the occupational stress. "Frequently," writes Friedrich Wenz. "line of duty/crisis situations include incidents in which the office must face tragic duties." Such duties he notes:

"...Include situations like telling a mother of her child's death, having to take a dead person to the morgue, or having, to clean up a body after an accident. The police observe death frequently and in a variety of situations, and exposure to death of others must register deeply on the mind of the law officer."

Doubtless the term "death" to a law enforcement officer brings to mind much more than the subtle, yet pervasive, fear of his or her own physical vulnerability. Unfortunately, in our society, few officers are encouraged to discuss death rationally, let alone develop a philosophy useful in facing tragic situations that are job-related. The purpose of this article is to deal practically with one aspect of this law enforcement stressor - death notification.

SOCIAL SERVICE FUNCTION

Many police officers have found death notification to be the hardest thing that they have done. It falls into the department's responsibility when no one else is available to do it. Perhaps the hardest task in all of law enforcement is that of telling a father and mother that their young son or daughter has been killed. Officers are affected most by this kind of death.

Because of its social services nature, death notification training has taken a back burner to other police services. Police organizations traditionally structure their training to contain approximately 80% police-related material and 20% services or social service material. In actual practice, the work turns out to be 80% social service in nature and 20% police related. Communication activities with citizens comprise the bulk of the modern officer's time.

SUGGESTIONS

Some suggestions we believe are helpful in accomplishing the task of death notification. There are no easy answers to a difficult job. We offer following:

1. Never take death information over the police radio. If the radio operator starts to do this, ask him to stop. Have him/her call you on the telephone or vice versa.
2. Obtain as much information as possible: what, when, where, and sometimes if possible, how. Disregard the why of the incident, you should not get into that during the notification (a simple answer to why is "I don't know").

3. Before you break off contact with your source of information make sure you have positive identification of the victim. Nothing is more inept than to be making the notification and have the supposed victim walk into the room, call on the phone, or later contact the grief stricken party. They may be elated at the moment, but later their elation will turn into bitterness for you and your department because of the trauma that you have caused.
4. Operating patrol vehicle emergency lights and flashers is inappropriate if department rules permit, keep a low profile when you park in front of the residence.
5. Never, if possible, carry a personal item of the victim with you. Leave all those items at the hospital or morgue. A simple note pad with the name or description written down will suffice.
6. Try by all means to get inside the residence before you deliver the message. If a medical emergency develops behind a closed door, you'll never know about it.
7. Never make the notification by telephone; the consequences could be too great.
8. Never go alone--a friend (of the victim), preferably a relative, can help break the news more easily. If your agency is fortunate to have an auxiliary chaplain available,, he or she may be of great help. Most people would rather hear the news from a relative than a policeman. Failing this, one officer in civilian clothes can be a help. Where possible, a female and male team of officers may function well in this capacity.
9. Try to assess the stability of the individual to whom the news must be broken. If in the officer's judgment, the person may be so shocked by the death notice that hospital treatment would be required, the officer should attempt to make some arrangement (i.e., one officer recalled an accident in which the child of a pregnant mother had just been killed. The mother was taken to the hospital on the pretext of making an identification of the child, so that the hospital personnel would be able to treat her when she reacted to the news.)
10. Relate the message straight out using a direct approach; i.e., "Your son had been involved in an accident. He has been killed." There is no way to soften the initial blow of this reality. Avoid jargon such as "your daughter was injured fatally." The message should be very clear at first hearing leaving no room for false hope as the word "injured" may allow.
11. If the family breaks down, you try to console the best you can. Almost any behavior is possible---anger, denial, questions, etc.- Physical violence is always a possibility. This possibility underscores the need for two people going on such calls.
12. Beware of the variety of reactions---some pass out, some become hysterical. Assess the situation. Read the non-verbal cues and try to anticipate needs e.g., a place to sit...some water. A "quick read" of the living environment may give you valuable hints to possible reactions.
13. If the person is alone, ask if there is a friend they could call or you could call that could come and be with them for a while. Men are just as emotional sometimes as women and; need the comfort of an understanding friend. If at all possible, stay until someone arrives.
14. It is usually better to be empathetic than sympathetic. The grieving person usually does not want sympathy from strangers. Feeling sorry for, is not as effective as feeling with the person. Some shared feelings may be most

meaningful. In no case should an officer's behavior give cause for false hope.

15. Be specific but tactful and try to avoid police jargon when explaining the situation; i.e., words like "fatality," "vehicular flow," and codes 11-44," etc. are out of place. Use plain language. Do not obscure the message and do not pass the buck. Center on meeting immediate needs. Do not get involved in a discussion of possible future actions.
16. Be prepared to spend a few minutes there. Don't drop the bomb and turn and walk out. Try to assess the situation. The family may have a question or two as soon as the initial shock can be handled. If questioned, be as honest about the situation as you can. They will let you know verbally or emotionally that they are handling it and will most of the time cue you in some way that they wish to be alone.

CONCLUSION

This is by no means a complete guide on the subject. Every call will be different. We believe that the subject of death notification needs to be included in academy training and in-service workshops, and even then it will still be a difficult job.

Article ~

I'M SORRY TO INFORM YOU . . .

Rev. Randy Sly
Riley County Police Department
Manhattan, KS.

"I don't want to be here," the officer mutters to himself. he stands under the porch light, waiting for the door to open, knowing the news he has will drastically alter the world of those inside.

As the door swings open, a woman stands apprehensively holding her toddler close. The officer swallows hard, for Daddy won't be coming home tonight. Or ever...

Of all the tasks in police work, death notification ranks as one of the most difficult.

Many police departments enlist the help of volunteer chaplains as a part of their notification procedures. Most police chaplains, members of the local clergy, have training or expertise that orients them toward the "people side" of problems. They can form a strong alliance with the assigned officer to become a complementary team who can present the news of a death, deal with the necessary details that need to be exchanged, and still provide person-centered support in the process.

A request for a death notification is a simple, standardized procedure in most departments. Usually the procedure is to order an officer or other representative to make contact with the party and inform them of the situation. Notices are received at all times of the day or night and for a variety of reasons. However, what seems to be a routine assignment may end up more complicated when the officer arrives at the person's residence. The outcome of the assignment may affect the party's ability to deal with the news effectively. This emotional jeopardy may seem overstated, yet the first moments of any tragedy stay with individuals for a long time. In addition, wrongful handling can also provide an opportunity for a negative experience in community relations. The following 10 action points are offered in order to maximize the ability of a department to carry out the task of notification effectively and efficiently.

1. ASSIGN A CHAPLAIN OR CLERGY PERSON WITH THE OFFICER.

While many departments use chaplains, they are oftentimes overlooked in their usefulness. A hectic shift might cause a supervisor to just give the assignment to a patrol officer. Contacting the chaplain is seen as an option rather than a necessity and is viewed as a nuisance when everyone is busy.

Utilizing a chaplain frees police officers, many of whom are fully capable to handle such a task, but who may be unprepared, untrained, or unable to handle what can follow. Responses to such news can be as varied as the people being notified. The problem is not so much one of carrying out the task, but in doing it well.

Hospital chaplains are taught to understand the "ministry of presence," meaning that they provide a needed function to an individual just by being there. They are a human extension of care and concern. The same principle holds true for the area

of death notification, where the police chaplain or local clergyman becomes the "presence of compassion" during an extremely stressful time. This does not discredit the officer as a compassionate person, but softens the impact made by the image of someone in uniform.

2. VERIFY THAT CORRECT INFORMATION HAS BEEN RECEIVED.

Very early one morning, an officer and I knocked on a door and proceeded to convey the information as it had been communicated to the department. The woman became extremely distraught because we told her that her father had died, but gave the name of her brother. She wasn't sure who was dead and who was alive. It took several phone calls to clear everything up.

Informing a person of the death of someone close is serious enough without confusion. While difficult to guarantee absolute accuracy, all those assigned to the task, chaplain, officer, supervisor, and dispatcher, should double-check all information for notification. This includes the name of the deceased, the name of the person to be notified, their addresses, the relationship to the deceased, and as much detail as possible surrounding the death. A follow-up call to the reporting agency may be necessary to re-confirm any ambiguous information.

3. TAKE SEPARATE VEHICLES.

When a chaplain and officer team make a notification call, each should travel in their own vehicle. This allows the chaplain to remain with the person while freeing the officer to return to patrol, etc. This is advantageous in most cases, except out-of-town calls, unusual circumstances or more dangerous settings.

When the team arrives at the location, they have no idea what they will encounter. Sometimes the person will become overly distraught and in need of longer term attention. Other times, he or she will become so disoriented that someone will need to make phone calls to bring friends or family for support. By arriving separately, each is able to stay as long as necessary without encumbering the officer in the process.

4. PLAN THE NOTIFICATION PROCEDURE.

The process should be outlined before the team leaves the station: who is going to do the talking, what is going to be said, how much can be said, etc. A death notification is usually better handled by the chaplain rather than the officer. The reason has less to do with ability than it does with position. A chaplain is traditionally viewed as the one charged with such responsibilities. He brings a sense of comfort into the process. I recommend that officers initiate contact with the person. The conversation might go something like this: "Good evening, are you Joe Taylor? I'm Officer Smith and this is Chaplain Jones from the police department. May we come in?"

The chaplain takes the lead in getting the people comfortable and giving the news. By proceeding this way, the officer provides authority and endorsement for the chaplain to do his work. He can add details and provide whatever support the chaplain may need.

This cooperative effort works to the advantage of the person being informed. One notification involved the tragic death of a little boy. I accompanied a female officer to notify his mother. After the news was given, the woman melted into the arms of the officer who provided exceptional emotional support at a critical time. We had already decided, before entering, that this would be the best way to handle the situation.

Chaplains, especially if they are new or infrequently used might not initiate the planning needed. As a volunteer, they feel somewhat awkward since this is not their domain. Officers should feel free to offer this opportunity to them, and invite them to take the lead.

5. THE TEAM'S PRESENCE ALREADY INDICATES SOMETHING HAS HAPPENED.

Those bearing bad news are tempted to hedge, to begin with small talk and avoid the real reason. The family would be better served by telling them up front what happened. The presence of an officer and chaplain has already alerted them of a problem. They have braced themselves and are not interested in idle chatter.

The actual notification procedure is quite simple. First establish the relationship between the party and the deceased. Next, inform the person of the death, slowly and carefully giving any details available. Then, calmly answer any questions they may have. If you don't know the answer, assure them that one may be found.

6. TRY TO GET PEOPLE INTO A COMFORTABLE SETTING.

We already mentioned giving the information first thing, but a moment will be needed to move into the privacy of the home (or other more secure setting). This will place the person to be in a better position to receive bad news. Since you have no idea how the party will react, ask to go inside rather than give the notification on the doorstep.

Ask the person(s) to be seated, or, at least, find a comfortable position. If other family members are present, they will naturally move to a supportive position, so give them a moment to do that.

When the notification must be made at a place of business, the person's supervisor should be contacted first and asked for assistance in getting the person to a place of privacy. Request that the supervisor remain with the person and have another close friend at the business (if possible) be present as well.

7. BE SENSITIVE TO SURROUNDINGS.

This point is closely related to the previous one. Notifying someone of a death can result in extreme emotional behavior. Often, we forget that there may be little children around or others nearby who may not understand what is taking place. When approaching the location, try to determine the dynamics that must be taken into account.

I once had to notify a mother that her son had been killed in a school bus accident. Upon arrival in the dentist's office where she worked, we found she was the receptionist. We had no opportunity to talk to the supervisor first. We asked the woman to take us to a private room and proceeded to share the news. The officer remained with the woman, while I sought out the woman's supervisor - one of the dentists. He was able to come in and provide additional comfort and support. He also had to deal with another sensitive problem--the woman's cries were very disquieting to the waiting patients.

8. PROVIDE A POLICE DEPARTMENT CONTACT.

Many questions arise in the mind of the person after the officer leaves. Be sure to leave a card with the name and number of the officer, the chaplain, or someone with the police department (victim assistance, community relations, etc.) who can be of further assistance.

Also, people are often in shock after receiving the news of a death and can confuse the facts. This phone number will give them an opportunity to clarify any blurred information and lessen the possibility of a misunderstanding, which later could be blamed on the department.

9. INITIATE A FOLLOW-UP.

Some people might feel abandoned after the initial notification. Some want clarification, others are unsure how they need to respond, still others didn't know what arrangements are necessary. The work of a chaplain can continue until such time as the party has made contact with their own clergyman, counselor, or other appropriate person who can go through the details with them.

One of my hardest assignments involved the murder of a teenager. After notifying his parents, I checked back with them later and even met with the father at the funeral home when he identified the body. Through these contacts, I was able to put the family in touch with the correct people at the police department, victim assistance, etc.

10. ASK IF THERE IS A RELATIVE, FRIEND, OR CLERGY PERSON THE WOULD LIKE TO HAVE CONTACTED.

The officer and/or chaplain provide the first line of support. In order for that care to continue, inquire if there is anyone you can contact for them, thus removing the burden of making a call at a very emotional time. Those I have called really appreciated the call. I then try to remain there until they arrive.

No one likes to deliver death notices, yet departments are regularly called upon to render this service. Communicating this information is a common occurrence, but it must not be treated commonly. The impact of notification can make a big difference in the ability of the informed party to handle the news appropriately. By implementing a person-centered and person-sensitive approach to death notification, departments can serve their communities in a vital and meaningful way.

You may not see your work in this area praised by the press but, be assured, it is acknowledged and appreciated by the people you touch.

Article ~

PROTECT YOURSELF FROM THE DEAD

Chaplain Harold Elliott, Arlington, TX PD

Police officers are constantly being taught street survival, and most of us shudder at the behavior of an unthinking officer who fails to protect himself. There is the ongoing discussion of how large a weapon should be carried and how many spare bullets should be at the officer's immediate disposal. All this is important, but no less important is that the dead will kill you too. It just takes the dead a bit longer to do the job. The living will shoot you, knife you, club you, or run over you. The dead will blow your mind apart and vandalize your emotions until you become a shell of a human being. These are the trappings of death.

Ask any officer to describe the first death scene he worked and he will remember almost every detail. He can recall the position of the body, facial expression, open or closed eyes, location of wounds, and type of clothing worn. No matter how many years ago, he'll still remember... of all the things we forget, it never seems to be a death scene. That being the case, it only stands to reason that an accumulation of such sights eventually takes its toll on an officer, unless he safeguards himself.

There is a social norm among many police officers which says, "Thou shalt have no unexplained reactions to the things which thou hast seen" So, they spend a bulk of their lives trying to convince themselves and others that they are totally unaffected by dealing with the dead.

Lectures on the subject can help, but they don't eliminate the impact of direct, prolonged experience; that can be a killer. I remember an old man who used to stroll the streets of my hometown with a sad face, bland personality, and a walk that resembled a funeral march. I never knew his name, but my mother always referred to him as "that old man who's dead and doesn't know it." The dead may not physically kill you but they can sap your emotional resourcefulness until you are about as useful as they.

How you receive death will make a considerable difference in the effect a corpse will have on you:

Those who equate human and animal death will likely become cynical, and persuade themselves that no scene is too bloody for them to view and remain unaffected. This illusion is generally exposed when the officer loses someone he loves.

Those who view death as the doorway into eternity will normally feel a sense of tender emotion. they may feel stress because of man's inhumanity to man or man's inhumanity to himself.

The job demands that an officer view death scenes. However, it does not demand that each officer view them in the same manner. Whenever I see a body, regardless of the circumstances surrounding the death, I view it as a wax figure in a museum. Some officers see the dead as mannequins. Others may view them as

evidence in the overall investigation. Still another may see the victim as only an object that once was alive and is now only a shell. Whatever image one may concoct, the result is the same: dehumanization of the victim. This isn't wrong, in fact, it is a natural part of our built-in survival kit.

Some officers would rather not show their real emotions at a death scene. Certain feelings are simply natural to human beings, and should not be construed as signs of weakness. For example, when alone in a room with a body, experiencing an eerie feeling; if the victim is child, female, or helpless individual, feeling intense grief; if sexual deviation is involved, feeling repulsion.

Officers also feel angry if death and mutilation are related to drugs or alcohol; if the victim was viewed by a family member, especially children, the officer may be moved to sympathy; and he will feel shock, the same as any other individual, if the victim is known to him personally.

Though most officers will contain themselves at the scene, if the victim reminds him of a loved one, he will probably cry when alone. It isn't uncommon for sickness to affect those who must work an exceedingly violent scene. Nausea is common if the odor is overpowering and the body of the victim is decomposed.

The dead person troubles us, disturbs our peace, gives us the creeps, stirs our fears, and gives us nightmares. Even the policeman's badge isn't thick enough to prevent it, and there isn't enough authority in the book to ward it off.

But we aren't defenseless. Take a look at some safeguards against being overcome:

Talk it out. Talk is good therapy. Some officers choose to talk to other officers. However, there is always the fear of appearing weak in the eyes of a comrade if true emotions are revealed. In departments where a chaplain is present, the officer may feel a freedom to bare his soul with the assurance of strict confidentiality. The officer who shares with his spouse is utilizing a good source of understanding. Every blood and guts detail need not be divulged to relate the story and get relief.

Crying is OK. Obviously there is a time and place for everything, but it should not be forgotten that crying makes us no less professional. Tears are terrific for washing away hurt. Some officers have wept at the scene and there is certainly no reason for apology, but whenever possible the officer will normally do this when alone.

Humor. Although humor should never be crude, and great precaution must be taken to avoid its use in the presence of family members or persons outside the police department, it should be recognized that well-placed humor is great release. It isn't necessarily disrespectful to use some humor at a death scene. Humor is a real salvation to those who use it wisely and at the appropriate place and time.

Take a break. Though it is necessary to view the victim, photograph the entire scene, and sometimes handle the body, it isn't necessary to stare at it over a prolonged period of time without a break. Take time out to regroup your thoughts,

get a breath of fresh air, and let your mind remove itself from the ugly sight of death.

Be prepared for, and understand something about, post-traumatic stress disorders. Two types of disorders are prevalent. First, the acute disorder has symptoms which occur immediately after or sometime during the event. They are things such as frequent urination, or an uncontrollable desire to just break away and run from it all. After a particularly difficult experience with a tragic death situation one officer said to me, "I hate this fob, I just want to get out of the whole mess." It had only been a few days before that he had sat in my office and related how much he loved police work.

Second, the delayed disorders are those which may occur two days, two weeks, or two years after an event or series of events. They include things such as sleep disorders, flashbacks, isolation and depression. I know one officer, who after working homicide in a major city, requested a transfer to any division in the department which didn't deal with death. Death had stacked up on him until he felt he could not stand it if he had to see another body. The number of gruesome death scenes the officer has experienced in a short time will obviously make him more prone toward post-traumatic stress disorders, especially the inexperienced officer.

The officer who is honest with himself will accept the fact that he is only human, and it is natural for humans to hurt at the sight of needless death, injury and mutilation. Wise is the officer who takes off his superman suit, and allows himself to be just plain Clark Kent.

Officers can't avoid blood in the alley and brains on the ceiling, but they can learn to deal with it in a manner which will preserve their own mental and physical health. If professional help is needed, get it. It is a weak person who thinks of himself as too strong to need support.

How strongly a person reacts to a situation depends on that person as an individual. The officer who continually holds in painful emotions or does not react at all, is a likely candidate for severe emotional problems. The wise officer takes the precaution of watching the living, avoiding needless danger, and not living in a mental graveyard.

Remember, the living can kill you physically, while the dead can kill you emotionally.

Protect Yourself From The Dead originally appeared in the April 1985 issue of Police Product News. Used here by permission.

Article ~

**APNEA, SUDDEN INFANT DEATH SYNDROME,
AND HOME MONITORS: PSYCHO-SOCIAL ISSUES**

Judy A. Duncan, Ma., MSW.

Since the Sudden Infant Death Syndrome (SIDS) is the most common cause of death during the first year of life in both term and premature infants, the use of home monitoring is rapidly increasing. The psycho-social issues surrounding apnea and SIDS and the impact of home monitoring on the family are discussed.

The most common cause of death in normal infants and graduates of Neonatal Intensive Care units during the first year of life is the Sudden Infant Death Syndrome (SIDS). One of the fastest growing industries in the health care field is providing home monitoring. Subsequent siblings of SIDS victims are at increased risk for SIDS themselves, or are they? What should we do for the child with an apparent life-threatening event? How does all of this relate and how does it apply to perinatal health professionals?

SUDDEN INFANT DEATH SYNDROME

Is not possible to discuss home monitoring and apnea without talking about SIDS. They are regularly linked in the minds of the general public and the health care community as well. It is important to clarify that the relationship of SIDS to apnea is only circumstantial. There is also no conclusive evidence demonstrating that monitors can prevent SIDS.

By definition, SIDS is "the sudden death of any infant that is unexpected by history and in which a thorough postmortem exam fails to demonstrate an adequate cause of death." Therefore, SIDS can only be declared a cause of death after an autopsy. What the pathologist is really saying is that he does not know why the child died.

SIDS is the number one cause of death for all infants between the ages of 1 month and 1 year. The rate is about 2/1000 in the United States and kills about 6000 babies a year. The peak ages for death are from 2 to 4 months, with a sharp decline after 6 months of age. More deaths occur in the winter months. We do not know why there is an age or seasonal variation.

The parent needs to know that SIDS cannot be predicted. The parents are blameless. The first real indication of increased risk for SIDS comes when the parents find the baby already dead. The fear of SIDS exists for all families. We need to be extremely cautious about adding to that fear by exaggerating the incidence of SIDS. We also need to be cautious about leading families to believe that we know what SIDS is and how to prevent it. We clearly do not.

ISSUES OF SIDS IN THE PREMATURE INFANT

In some ways SIDS following a premature birth causes even more anguish for the parents, and certainly hospital staff, than the death of a normal child. This is due to the fact that a premature baby may struggle to survive for weeks and sometimes for months, finally leaving the hospital and going home. For the perinatal health

professional there has been more time to build a relationship with the family during the premature baby's hospitalization. The infant's death comes as a cruel blow to all who have provided care. Sometimes hospital staff members question their clinical judgments regarding discharge. They wonder if they missed something, or left something undone. Sometimes the family places blame on hospital staff. More often, though they share the tragedy.

Prior to discharging a premature infant, the basic work with the family may center on the resolution of acute distress and fear. All families need support and information about the child's condition and likely clinical course. They need the opportunity to explore their feelings about grieving for the healthy, full-term baby they expected, but did not get, and to learn to accept and appreciate the baby they really have.

Throughout the infant's hospitalization, the time is available to assess the family member's strengths, weaknesses, and interpersonal styles, as individuals and as a unit. We can help the family use or build networks. We can assess their ability to problem solve by watching which coping mechanisms they choose, and how well they use them.

Particular areas need special attention. By the time discharge draws near, the parents have usually become familiar with monitors and may be uncomfortable about going home without one. The majority of infants who have not had significant apnea or bradycardia for the week prior to discharge are not in need of home monitors. Infants must be carefully selected for monitoring and the advantages and disadvantages of this option clearly delineated. Once decided, staff should teach the family how to use the home equipment while in the hospital and use it for the remainder of the infant's stay. This plan helps establish an easier transition from hospital to home. It also allows the staff to tailor the learning process to the individual family's needs and gives the family a chance to practice in a safe environment. It also enables the hospital staff to reinforce the concept of competency of the parents as the primary caregivers. It is vital that the apnea program coordinator and nurse work as a team. It is also important that the parents become part of the team caring for the infant and responsibility for the child's well-being can be shifted gradually from staff to parents. Apneic events can be simulated so that parents gain additional experience with problem solving.

SIDS AND THE SUBSEQUENT PREGNANCY

The process of building a relationship with the family following a SIDS death can begin during the subsequent pregnancy, sometimes even during the period between the SIDS death and the next pregnancy. The sooner the process begins the better. The pregnancy following a SIDS death primarily will deal with two basic issues, the SIDS death and safeguarding the expected child. The first step is to confirm that the baby died from SIDS by reviewing the autopsy. We have found several cases where the previous sibling had not died from SIDS. Revealing this to a family and helping them deal with such information requires sensitivity and time. The second step in the counseling process is to determine what needs the family has. There is often much unfinished business related to the grief process, especially if the child has recently died. For some parents this is the first time they have ever talked about the death of their child and the impact of that death on

them separately, as a couple, and as a family. It may also be the first time the parents have openly discussed their feelings, fears, and sense of loss with each other. I feel strongly that the initial session should be with both parents. A separate session can include siblings, grandparents, and other as appropriate.

Sessions can be done jointly by a nurse or a worker, and the physician. Families are more inclined to believe the facts about SIDS from a physician. They usually direct medical questions to him or her. It is helpful to have a health team composed of one male and one female interview a couple to decrease issues of power, control, and transference, and enhance modeling and support. Any team member can provide legitimacy and offer generalized statements about grief reactions or SIDS misconceptions.

It is important to assess how other siblings in the family (if any) are dealing with their own sense of loss and their reactions to the subsequent child. Parents may need encouragement or reinforcement to approach such topics with their children. They also may need education about what is age appropriate. Parents and children alike may have been trying to protect one another by not sharing feelings of grief, anger, fear and guilt.

Equally important as the meaning of the loss is the meaning and place of the new child in the family. Is the child thought of as replacement for the dead infant? Or is the child thought of as a child in his or her own right?

Families may have the idea that the subsequent sibling is somehow sick or different than other newborn infants. Parents may experience strong tendencies to be overprotective. Others may find it difficult to approach the baby and begin the process of bonding and attachment. The vast majority of families can successfully accomplish the task of incorporating the new infant into their family structure in constructive ways. What they need is information and support over time. Meeting those needs is certainly not new to perinatal health professionals.

The family concerns for safeguarding the new infant present themselves in a wide variety of ways. Some families will not leave the hospital without a monitor; others will not use the monitor under any circumstances. Some wait to decide until the child is one month old, and some when the new baby reaches the age at which the previous child died. The decision to monitor or not belongs to the family.

Currently there is no testing available, whether simple impedance or full scale sleep studies, that can identify infants at risk for SIDS. Indeed, Southall's prospective study of over 9000 infants demonstrated that two channel impedance recordings were not predictive. Finally, parents and health care professionals need to be clear that monitors cannot guarantee that an infant will not die from SIDS.

The perinatal staff needs to be sensitive to parental fears and anxieties. The usual nursery, postpartum and visitation arrangements may not be appropriate or adequate for these families. Mothers may be afraid to have rooming-in, or afraid to have the baby out of sight. Fathers may need to have longer and easier access to mothers and babies. Older siblings may need to actually see and touch the new baby. Mothers may have problems with breast feeding as a result of tension.

Infants might have to stay in the nursery for observation and testing. Some may have to be transferred to hospitals equipped for such testing.

There is a special category of SIDS sibling, when one infant of a multiple birth dies from crib death. The survivor is at increased risk. Most programs will then automatically evaluate and monitor the survivor. The impact of the death is compounded by the problems associated with home monitoring. These families need especially intense and prolonged support.

INFANTS PRESENTING THROUGH EMERGENCY DEPARTMENTS

Parents are routinely seen in emergency departments with infants who have stopped breathing, turned blue or are limp or unresponsive. All of these complaints need to be taken seriously. If the infant arrives in poor condition, or if paramedic reports confirm the parent's story, then the child is seen and evaluated, even admitted for observation or workup. If the infant arrives in good condition with nothing abnormal on exam and there is no corroboration of the event, many facilities send the family home. Most parents get a clear message that they overreacted.

It may be that the infant experienced "normal" (very brief) apnea, or a physiologic event during sleep. Perhaps the child choked on secretions and could have spontaneously resolved the spell with time. Providing the parents with these explanations for physiologic apnea is a component of quality care. However, the worst scenario would be to send the family home because the baby looked fine, only to have the child return dead because of an undetected etiology.

The burden of proof to document the etiology of the spells resets with the medical staff. The reported event should not be taken lightly regardless of the child's apparent good condition.

If the parents work and the child is brought in by a caregiver, or if one parent saw the episode and the other did not, a more complex situation exists. Those who did not see the episode may not believe it really happened, or that it was as severe as reported. Or there may be anger and blame directed toward the caregiver for not really watching the baby or not responding in an adequate manner to the medical emergency. At the same time the caregiver may be feeling totally responsible for the event and need support for the quality of care he or she provided.

Each family member or caregiver will assign meaning and significance to the event. Most people equate any cessation of breathing, whether awake or asleep, with crib death in the making. Most people fear that there would have been brain damage or death if then had not intervened. Most will still have questions and fears about the possibility of brain damage. Most believe that the spells will recur.

It is important to know if this is the child's first episode, a repeat episode or an episode that has happened during home monitoring. The concerns of the parents may vary. If it is one of many episodes, the family may feel the child is not making progress. They may be angry with the medical staff for not identifying and better managing the child's condition. They may be resigned and feel defeated in their efforts to care for their child, or they may be relieved to have the child hospitalized

and the burden of care removed from them, at least for a while. They may feel vindicated with a repeat episode when the initial episode was not taken seriously.

One of the most frightening things we can do to a family is to label these episodes as "near-miss SIDS" or an "aborted crib death." Can you imagine what you would think if you were the parent? You would fear or expect a real crib death at some future time. What does that notion do to feelings of security, family structure, and the continuation of attachment to the infant?

HOME MONITORING: IMPACT ON FAMILIES

It is not possible to introduce the element of home monitoring in to a family without creating change and the need to accommodate. Not all the changes are negative, not all are positive, but all families change.

There is always the possibility that the monitored child will be seen as ill or different from other newborns or other children in the family. At times the issue of home monitoring is seen as the cause of problems that actually predate the monitor and the child.

The basic explanation for many of the medical problems that result in home monitoring relates to developmental tasks the child must accomplish. Seen in this way, most families can begin to see their child as more normal than sick. This is a key concern for families and has to be addressed. Most often the social worker is the first to appreciate this.

Child abuse potentials exist for parents of monitored children just as they do for any set of parents. There are high levels of fear, frustration, anger, and isolation. Parents may be overwhelmed by the incorporation of the child into the family unit, let alone a child attached to a monitor. Assessing levels of parental expectations and realities is essential.

Practical issues of everyday life are also affected. The caregiver must always be physically close to the child to answer an alarm, as well as being able to hear the alarm. Simple chores like washing dishes or running a lawn mower have to be considered from the standpoint of alarm response time. None of these are impossible to do, but the parents need help altering their perspectives and learning to deal with such issues on their own.

There are many concerns about home monitoring. These notions may be held by the family, friends, relatives, or neighbors. We can provide anticipatory counseling so parents can go home knowing what to expect. Common misconceptions are 1) that the monitor can electrocute the child, 2) the child will be developmentally delayed by reasons of being confined and having movement restricted, 3) the child's condition is contagious, especially if the cause of the apnea is unknown, or if this is a SIDS sibling, and 4) the monitor will prevent death.

In the face of such enormous responsibility, stress, and fear, it is possible that the mother will become totally absorbed in the baby. This preoccupation can be to the exclusion of self-interest, involvement with other siblings, career goals, personal relationships, social activities, and marital relationships. Discord and dysfunction

can occur in any or all of these areas. Sometimes the mother is burdened with the entire responsibility for the care of the infant. This may evolve from a lack of resources for respite. It may be self imposed, imposed on her by other family members (often the father), or because she believe the infant is vulnerable despite the monitor.

Parents can be overwhelmed emotionally by the impact of monitoring. It can be frightening to assume such responsibility. Strong negative feelings toward the child are not uncommon. The parent may feel anger and resentment toward the child. Just as quickly they may feel strong urges to protect and shelter the child. Having a chance to explore the variations in feelings prior to discharge is important. It is also vital to assess those feelings after discharged by phone, home visit, and use of public health nurses and or parent aides.

Parents need help to sort out their feelings related to home monitoring. They need to look at their expectations and make adjustment to their real situation. The implications of CPR need to be addressed. What does it mean to assess you child as lifeless?

It would be ideal for parent s to have time away form their monitored child. This is not always possible for much reason. The parents may be too fearful to leave the child. Family and friends may be unwilling to assume the responsibility. Day care regulations may prohibit accepting children using medical devices. Home care nurses may not be familiar with home monitoring. Costs to the parents may be too high to pay for such care.

In the face of so may negative elements it might be expected that parents would strongly resist monitor, or quickly abandon it once they got home. Yet many studies and my own experience say just the opposite. What seems to make it easier for them is strong psycho-social support, good education, cease explanations of the need for monitoring, continuous access to service people and medical care, established criteria for discontinuation of home monitoring, and help during the process of weaning from the monitor. For the great majority of families at hospital, the levels of stress and anxiety were greatly reduced. Babies were returned to the family structure as safely and as soon as possible. Parents again gained a sense of control and mastery over their lives.

Training for home monitoring can be done by a variety of health care professionals - nurses, respiratory therapists, health care educators, social workers, or physicians. The professional level is not as important as the quality of the educational process in combination with identifying and meeting psycho-social needs.

Article ~

INFORMING THE FAMILY OF SUDDEN DEATH

Mark A. Robinson, M.S.W., U.C. Davis

Physicians are neither trained nor prepared for delivering the news of sudden death. The unique stresses which tax a physician during the medical or surgical emergency can affect the way he delivers the news. There are distinct strategies for preparing and delivering the news of death. An informative, chronologically ordered account of events up to and including the death, delivered after taking time to review all the facts, makes the task less stressful and is less likely to elicit unnecessary confusion and anger in survivors.

In dealing with medical emergencies, the physician is prepared to act quickly and efficiently to sustain life. Despite every effort, some of the patients in serious condition will die, and the physician will have to inform the relatives of the death. Since most physicians have had little formal preparation or training for this difficult task, they may experience anxiety before and during the encounter, and may be troubled by doubts about their style of delivery.

This article discusses the transition from dealing with medical trauma to approaching the family, and suggests ways of delivering the news of death.

PERIOD OF EMERGENCY TREATMENT

Medical emergencies are intense, action-oriented situations posing life-and-death problems that demand immediate identification and rapid attempts toward resolution. Diagnosis and treatment must occur almost simultaneously. This requires a high-quality combination of concentration, manual dexterity under pressure and leadership in applied medical-technical skill. Strong emotional reactions may be elicited by severely injured patients who are very young, who resemble one of the physician's family members or who are victims of criminal acts. These emotions can detract from the clear, objective concentration that is needed for effective performance. Setting aside these normal responses to maintain objectivity cannot be done without great effort and further energy drain.

When a patient dies after intensive efforts to save him, there is sometimes a dramatic change in atmosphere as activity comes to a halt and technicians, aides and nurses walk out to the treatment room. At this point, the physician is likely to be at a mental and emotional low point. When several hours of work and risks have been compressed into one, a person can be left temporarily exhausted. Unfortunately, it is at this time that the physician has to face family members and inform them of their loss. He cannot be certain how they will react to hearing such news; each family is capable of a wide range of feelings and expressions. This adds an immense surprise potential to the situation and may contribute greatly to the physician's anxiety.

The transition from dealing with medical trauma to dealing with family trauma is quick and dramatic. Objectivity must now be tempered by empathic sensitivity; role responses are replaced by interactional responses, and mechanical manipulation must give way to concerned involvement. It is not surprising that many physicians

develop a defensive maneuver to protect themselves from the stress of their situation. One common maneuver is to avoid thinking about, preparing for as long as possible after the death has re-involving oneself with another patient. Another way the physician may minimize stress and discomfort is to proceed from the medical trauma to the family trauma without hesitation. This decreases the time available for experiencing anxiety about the task to come.

While at first glance these tactics appear to be effective ways for physicians to reduce stress, they may have the opposite effect. By delaying the news, the physician may increase the relatives' anxiety and thus decrease their ability to assimilate, acknowledge and deal with grief. On the other hand, rushing in unprepared increases the likelihood of presenting the news in an awkward manner.

TRANSITION: MEDICAL TO FAMILY TRAUMA

There are other, more effective ways a physician can prepare himself to deal with the patient's family. Some helpful suggestions follow.

Acknowledge Feelings and Limitations

When treatment is finished, identify any strong feelings you are left with. An unusually hectic trauma case that results in death may generate a mood of frustration and resentment. Such feelings should be set aside for later resolution rather than carried into the family situation. Relatives may interpret these residual feelings as being directed to ward them. One family remarked that the physician must have been angry because they had not called the ambulance soon enough.

Remember that your limitations are related to your particular level of capability on any given day. If you are at the end of a particularly busy day, you may be less than able to deliver an objective, reasonable and calm presentation of death to a family. If this should occur, you might ask another physician who was involved in the case to assist you or take over the task entirely.

Review the Case

Before facing the relatives, review and, if necessary, make notes of the major points, symptoms, treatment procedures and patient's responses as they occurred. This will order your thoughts and help identify or anticipate areas which might be difficult to explain. One or two minutes of preparation can prevent unexpected verbal stumbling blocks during an unavoidably stressful situation.

Enlist an Aide – Call the Chaplain

Have someone accompany you, if possible. Choose a person who is willing and able to provide additional support, because it is helpful to share the emotional demands of the encounter with someone.

Obtain Data on the Family

Find out as much as possible about the relatives to be confronted. The main points are who is present, what their relationship is, what they have been told about the onset or treatment and how they have reacted to the situation thus far. Obtaining this kind of basic information lessens the surprise potential and can better enable you to prepare for special problems. These facts may be gathered from any person who has had contact or been involved with the family, such as a registration staff member, a social worker, a nurse, a volunteer, the ambulance driver or a member of the pastoral care staff.

The Rational Approach

The rational approach to informing a family of a death is nothing unique or extraordinary; in fact, it is probably the way most physicians inform relatives of illness or injury situations which do not result in death. Common sense and simple terminology are used to tell the family what problems occurred, what actions were taken and what the patient's response was. This information is given in chronological order. Consider the following example:

"Mr. Smith arrived here at 7:10 p.m. He had collapsed at the grocery store. The ambulance crew found that his breathing was extremely shallow and that his pulse was very weak and irregular, so they began giving him cardiopulmonary resuscitation. That means pushing down on his chest in regular forceful rhythm while forcing in air to breathe for him. When he arrived here, we continued CPR and obtained an ECG tracing of his heart activity. We found that his heart had stopped beating altogether, so we immediately gave him several heart medications. Next, we tried to get his heart to copy the rhythm of a temporary pacemaker we inserted, but the heart didn't pick up the device's rhythm. After using the paddles and mild electric shock, we had no other ways available to us. I'm very sorry to tell you that we pronounced him dead as of 7:50 p.m.

Discussion

When presenting this material to physicians, I am often asked two questions. One is: Why describe treatment and response when relatives are in a crisis state and are not likely to hear or understand much of what is said? This assumption is not valid. In a family of five, there are usually at least one or two who will accurately hear, perceive and retain what is said. These people will be able to repeat the facts to those who did not hear and to other relatives who will need an explanation in subsequent hours. Even those who do not fully comprehend the specifics of what is being said will be able to recognize the amount of effort expended on the treatment attempt. When given this information, many families are amazed at the actual amount of work involved, much more so than after hearing the more common and vague cliché "We did all we could."

The other common question I am asked is: What should the physician do if he approaches the family and they immediately demand to know whether the patient is alive or dead? When this happens, it indicates that the family has already considered the possibility of death and that they are going to be told. Relatives are more likely to confront the physician with this question when they have been well prepared with accurate updates on the patient's lack of response to treatment or when the patient has had previous severe exacerbations of some chronic disease,

such as a previous heart attack. One physician responds to this question by saying he would like to explain briefly how things went; he then proceeds if the family finds this acceptable. Most family members will focus intently on every word of the physician's account. Frequently, they will add up the facts as presented, and one will utter the conclusion of death before the physician does.

The gentle and gradual yet factually informative approach facilitates an intellectual acknowledgment of death and a more solid cognitive basis from which to react with normal grief. It is also helpful in providing more accurate data with which to prepare and inform others of the death.

Some physicians add certain information that is not actually necessary to an understanding of how the death came about. Such information may include the likelihood that the ambulance crew's resuscitative efforts were more than adequate and that the patient was oblivious to pain or unaware of his predicament. Without this information, many relatives envision the patient's last minutes as being filled with intense pain amid strange surroundings and with feelings of being abandoned by the family. Some of these notions spring from the survivors' own fears about death, and their impact can be minimized by factual information to the contrary. The following case shows that the importance of these subtle points cannot be overstated.

After a head-on car collision, a three-year-old child was brought to an emergency room. The child's mother, who had not been in the accident, arrived at the hospital an hour or so later and was informed of the death. She was well supported by nursing personnel and physicians until her relatives arrived. During the following year, she had a recurring nightmare of helplessly watching her son screaming for help and suffering from pain while he was pinned in twisted wreckage. After consulting a therapist, she returned to the same emergency room and was fortunate enough to find a physician who had been involved in the case and recalled it vividly. He informed her that the child's particular head injury indicated that he had been rendered totally unconscious immediately on impact. The woman's nightmares ceased.

If only a few people can be spared months of unnecessary anguish, the extra time involved in delivering the news of death in this way is justified.

TECHNIQUES TO AVOID

The Blunt Approach

The physician walks in, shakes his head and says, "I'm not going to pull any punches - he's dead." His blunt, curt announcement increases the likelihood that the patient's relatives will react with anger and confusion. The anger that this delivery elicits probably relates to its basically rude, insensitive tone at such an emotionally vulnerable time.

The Apologetic Approach

The physician walks in, sinks into a chair and sighs heavily. Hesitantly, he says, "This is one of the most difficult things I have to do as a physician..." or "I really hate having to be the one to tell you this but..."

This approach appears to be a sensitive way to approach the family. It may be an honest way to begin, because informing the family of a death probably is one of the most difficult tasks that a physician has to perform. The apologetic approach can be called a plea for mercy because it implies a need for forgiveness and thus may elicit pity and support from the relatives. That, in itself, is not objectionable because the physician has just provided a great deal of intensive work on behalf of the patient, and some expression of gratitude and empathy can be appropriate. The problem is that often a physician will elicit this response, accept the family's supportive attempt and then excuse himself to return to other patients. He is essentially getting more nurturing and support than he is providing, and thus is an additional drain on the family's already taxed resources.

Article ~

**COMMONLY ASKED QUESTIONS ABOUT SIDS:
A DOCTOR'S RESPONSE**

by J. Bruce Beckwith, MD

It is difficult to deal with the conflicting, confusing body of information and misinformation about SIDS that we're all confronted with in the daily and scientific press. We may be disappointed in our physicians because they give us information that conflicts with our own intuition or experience about SIDS, or because they don't seem to know much about it. My assigned topic is "Using Accurate Information." The definition of "accurate information" for each of us who work in this field is information which agrees with our own ideas! The following are my answers to some commonly asked questions.

WHAT IS THE CAUSE OF SIDS?

It is common to read in newspapers that the "cause" for SIDS has been discovered. Some recent examples are elevated T-3, maternal smoking, prematurity, poverty or viral infection. I believe that SIDS is not a disease, but a way of dying. It's an episode which occurs over a very brief span of moments that results in the death of a baby. Things which preceded that episode may or may not be relevant to SIDS. There are lots of so-called predisposing factors such as prematurity, but being a preemie is not the "cause" of SIDS. So many of the "causes" that we read about are really factors which describe a population of SIDS victims, but do not explain the cause of death.

In approaching SIDS, the thing that happened last is most important, namely how did the baby die? In other words, what was the mechanism of death? Perhaps the most significant original observation I've made on SIDS bears on that specific point - how they die. It is my belief, based upon many research findings, that at the end of a breath, as a baby lets out air and is ready to take a new breath during sleep, the airway closes off in the back of the throat. That closure makes it impossible for the baby to take a next breath. As a result, the baby may change position. The face may come to be straight down into the bedding, or might get wedged in a corner of the crib, or a blanket may be pulled over the head. These conditions may suggest the baby suffocated, but in fact, specific research has been done proving that even tucking the blankets on all four sides of the crib mattress does not cause blood oxygen levels to drop. So even when appearances may suggest the baby might have suffocated in its bedding, these appearances are misleading, and are the result of the way they die, not the cause of death.

If there is evidence of airway obstruction, how can we so confidently rule out suffocation? I emphasized earlier that the obstruction occurred at the end of a breath. One of the findings in the examinations of the SIDS babies are little pinpoint hemorrhages (petechiae) found in the chest organs of 87% of the cases. These hemorrhages result from instantaneous and complete closure of the upper respiratory tract at the end of a breath. If I were to go out and attempt to strangle somebody or put a plastic bag over their head, it would be almost impossible to produce the hemorrhages. The findings differ in SIDS and suffocations, with approximately 95% confidence levels.

So what causes SIDS? Again, I believe that SIDS is not a disease, but a way of dying. The mechanism appears to be sudden obstruction of the airway during sleep.

WHY CAN A HEALTHY BABY DIE SO SUDDENLY?

Why would the airway become obstructed during sleep in a healthy and thriving baby? Nobody knows for sure. If one accepts that we understand how they die, the next question is why do they die? A concept that I have found appealing for many years is that this stoppage, or obstruction of the airway is not due to a disease process or an abnormality of the baby, but is a reflection of the fact that babies at this time of life are undergoing an incredibly rapid state of growth and maturation.

Many important changes are occurring at the age when most SIDS occur. The infant is, among other things, coming into an age where he is beginning to sleep through the night. That's not just a simple change in habit pattern, but a change that is very fundamental and has to do with control mechanisms in the brain. Centers that are beginning to be active in the baby's brain didn't even exist when that infant was born. Virtually all of brain growth occurs in the first two years of life and the growth rate in the first six months is the most rapid of any time in life. During the time when these important control centers are in a period of transition, abnormal messages might come down to the organs of respiration, one of which is to "close off" rather than "open up." Normally, at the end of a breath, the throat collapses or closes, then opens up prior to a new breath being taken. But if the wrong message comes down from the brain, the throat may stay closed instead of opening. That wrong message isn't necessarily a result of this baby being abnormal, but occurs in a normal baby whose brain is growing at a tremendously rapid pace.

This view of SIDS is certainly one person's view; it's not shared by everybody who works in SIDS. It's a view which I find very reasonable and helpful; the concept is that the baby was normal when it dies, not abnormal. There is no way for anyone to predict that a normal baby is going to have this kind of abnormal event. Many factors may contribute to that event. Minor irritation of the airway may, by increasing the sensory input coming up the nerves from the throat to the brain, increase the likelihood of abnormal messages to come down. Thus, perhaps we have a connection with the minor respiratory infections which are present in many cases.

HOW IS THE SIDS DIAGNOSIS MADE?

In doing a post-mortem examination, we don't see the lethal mechanism directly. After death, muscles relax, so the pathologists don't find the throat muscles clamped shut. There are little things that we find consistently, such as the pinpoint hemorrhages I mentioned earlier, but none of those things account directly for death. They are only clues to the way they die, and helpful to the pathologist in diagnosing the case as SIDS.

The SIDS victim did not die of nothing. The baby died of a very distinctive entity. Any of you who are familiar with sudden infant death will know that the typical case falls into a narrow age range, and seemed to be okay except maybe for a cold, ate his last meal normally, was put to bed and was later found dead. You know when you hear that story what the pathologist is going to say. But when the story is different, then you really want to know what the pathologist found. When there are some unusual features to the case, the post-mortem becomes especially important, as there are many conditions other than SIDS which can kill infants and young children suddenly.

If we take all babies under one year, who have 1) died unexpectedly, 2) during sleep, with 3) no history of alarming symptoms, such as seizures, temperature over 105 degrees, and 4) no external findings to allow one to suspect a cause of death (like a fractured skull or a skin rash), 92% of cases will be diagnosed as SIDS after-autopsy. If the infant is 2 or 3 months old, it would be more like a 95% certainty. In some communities it is not possible to get an autopsy, but one can usually do an x-ray examination to add to these four criteria. With the presence of a normal full body x-ray, the chance the death was due to SIDS goes from 92% to 98.2%.

My baby wasn't a typical SIDS case.

Each of you who have personally experienced SIDS probably feels that your baby in some ways doesn't fit the classical profile. You read about "high risk" babies and it's very easy to confuse the concept of "high risk" with "typical." For example, a "high risk" baby might be born weighing less than three pounds to a disadvantaged family in the winter months. The risk to that baby is perhaps one in 50. If your baby was a full-term, 8-lb. baby who died in the summertime, and was a girl, it doesn't sound typical of the "high risk" baby that you hear about. But, in fact, most SIDS babies are not drawn from the "high risk" population. There are many more babies in our society who are in the "low risk" population, and the majority of SIDS babies are from this "low risk" population. Thus, the 8-lb. baby is a more "typical" SIDS victim than is a 3-lb. preemie. even though that preemie had a higher individual risk of dying. Because there are so many full-term babies, they constitute the majority of SIDS babies. The same principal applies to the other so-called "high risk" factors. Therefore, these things you read about "high risk" SIDS babies often lead to confusion and it is important to understand that "high risk" and "typical" are very different concepts.

Any one case is a single dot on the bell-shaped curve and it could fall anywhere on that curve. The description of a population as a whole does not describe each individual member of that population. That's an idea that's often difficult to get across. I don't know if the totally typical case of SIDS ever has occurred. Every baby that ever died was an individual, and every person who has lost a baby identifies SIDS with that particular individual - the hair color, behavioral patterns, and the medical history of the baby is the profile of SIDS to that parent and family. It's important for families to be able to appreciate that because that baby seemed different than the other children in that family, it doesn't mean that difference was in any way related to the death. My experience has made it very clear that there is no typical pattern of behavior, for example, in babies who later die of SIDS.

My baby cried out during the night he died and I feel so guilty because I didn't respond.

This was a death caused by airway obstruction and babies can't cry when their airway is obstructed. So when that baby was crying, he could not have been dying. He cried, went to sleep, and then died later. Not responding to that cry had nothing to do with the fact that the baby died. Babies do not die from crying.

Since SIDS only occurs during sleep, if I had awakened my baby, would he have died?

My answer has to be "no, he wouldn't have died then." But how in the world could anybody know at what moment it was going to happen? The way to prevent SIDS would be never to let a baby sleep, and that's obviously impossible.

IS SIDS CONTAGIOUS?

Again, the answer is "no." My personal experience with over 1,200 cases includes not one example where a SIDS victim was closely in contact with another SIDS victim (except for three cases of twin SIDS cases). There are times in every community when there are more SIDS than other times. When viral diseases of certain kinds are sweeping through the community, the incidents of SIDS will climb. But there is no "crib death virus."

Will it happen again in my family?

SIDS is not a hereditary disease. There are two widely quoted articles in the research literature that say that it may be familial. Each of those came up with a risk figure that scares everybody - of 1 in 50. Each of those two papers contains some important errors, so that the true figure is more like 1 in 125. Even these figures exaggerate the risk to siblings. There are two reasons for this.

One reason is the familial aggregation of risk factors, such as prematurity. For some mothers prematurity tends to occur repeatedly because of a relaxed cervix or other factors that make it difficult for her body to retain a baby in utero for nine months. Since 20% - 30% of any SIDS series will be preemies, any large SIDS series is going to include lots of subsequent preemies. Therefore, we would expect risk figures somewhat higher risk figures are not shared by the entire population of subsequent siblings, but only by the subsequent preemies.

The other reason is that there are some hereditary diseases that can kill babies suddenly and unexpectedly: heart disease, brain disease and a variety of biochemical disease that require some special studies to diagnose. If you take a large population of SIDS cases, it is likely to be contaminated by a few rare examples of these diseases. One of the most common that we know about is something that we now call familial infantile apnea, and that's a strongly hereditary disorder. If in the family background there are a lot of infant deaths, then a genetic disease mimicking SIDS could be a factor of concern. A few families will have genetic disease - most of these will have multiple sudden infant deaths in the family background as a clue to this fact. These few families do have a high recurrence

risk the others do not. In summary, there is no reason to believe that most families who experience the loss of a baby to SIDS are at any increased risk of recurrence.

Article ~

FACT SHEET: SIDS INFORMATION OF THE EMT

Prepared by: Paula Pachon,
Information Specialist National SIDS Clearinghouse

Sudden Infant Death Syndrome (SIDS), the sudden and unexpected death of apparently healthy babies, is the major cause of death of infants between the ages of 1 month and 1 year. In the United States, SIDS, sometimes referred to as crib or cot death, is responsible for the death of approximately 6,500 infants each year. It has been estimated that annually up to two deaths per 1,000 live births will be the result of SIDS.

SIDS deaths produce intense and traumatic reactions among surviving family members, as well as health care providers. Lifelong feelings of guilt, sibling emotional problems, divorce, and even, suicide are all too often the result of this tragic event. It is clear that there are multiple victims of this disease - the dead infant and the surviving family members.

SOME BASIC FACTS ABOUT SIDS

- SIDS is a definite medical entity and is the major cause of death in infants after the first month of life.
- The cause or causes for SIDS are not known.
- Approximately 90% of all SIDS deaths occur annually in the United States.
- Approximately 6,000 to 7,000 SIDS deaths occur annually in the United States.
- SIDS occurs in all socio-economic levels.
- SIDS is at least as old as the old Testament and seems to have occurred at least as frequently in the 16th and 19th centuries as it does now.
- Victims appear to be healthy prior to death.
- At this time, SIDS cannot be predicted or prevented, even by a physician.
- There appears to be no suffering; death occurs very rapidly, usually during periods of sleep.

WHAT SIDS IS NOT

- SIDS is not cause by external suffocation.
- SIDS is not caused by the type of feeding method used.
- SIDS is not caused by vomiting and choking.
- SIDS is not caused by immunizations.
- SIDS is not caused by child abuse or neglect.
- SIDS is not cause by overheating.
- SIDS is not contagious, it is not an infectious disease process.
- SIDS does not cause pain or suffering to the infant.
- SIDS cannot be predicted.
- SIDS is not caused by a lack of love.
- SIDS is not caused by a sleeping parent rolling over onto the baby.

SIDS AND THE ROLE OF THE EMERGENCY MEDICAL TECHNICIAN

The Emergency Medical Technician (EMT) is often the first official person on the scene following the discovery of the infant. The parents or other caretaker of the infant - e.g. grandparents, baby-sitter - cling to the hope that the EMT can do something to save the infant even though the child may be obviously dead. The role of the EMT in this situation is difficult. He should begin immediate emergency resuscitation efforts and comfort the parents whose reactions may range from numb silence to violent hysteria. By offering sensitive support to the family and gathering accurate information in a non-threatening manner, the EMT helps to alleviate the future emotional burden of the surviving family members.

How the EMT can tell if the infant is a SIDS victim

Only an autopsy can conclusively determine if an infant's death is due to SIDS. The EMT should make no assumptions about the cause of death. The death of an apparently healthy infant, and the general appearance of the infant in his crib may be misleading. There have been cases where SIDS has been mistaken for child abuse. Therefore, it is necessary that the EMT, as the first responder, know some of the identifying features characteristic of the SIDS victim as opposed to the abused child. The table on the reverse of this sheet provides a list of the general physical characteristics of each. This table will help the EMT in observing evidence useful to the medical examiner or coroner in identifying the possible SIDS victim as well as distinguishing this infant from a battered child.

Article ~

CHAPLAIN'S CORNER

By Chaplain Jack Poe

Law enforcement officers are a brave breed of unique men and women. They know up-front the risks that are involved in their line of work, yet they choose to place their lives on the line every single time they put on their uniforms and walk out the door to go to work. Their journey through life often places them in situations seldom seen by the majority of the members of the communities in which they serve. More often than not they encounter the rude and the crude who make their living by taking from others.

Most of the time, what they take are material things that for the most part can be replaced. Sometimes they take that which can never be replaced. Sometimes they take that which can never be replaced, human life. Every 57 hours in the United States, a law enforcement officer's life is taken in the line of duty. Law enforcement officers take an oath of office in which they promise to protect and serve. Providing that protection and service to the community means they live "in the valley of the shadow of death." Chief McBride has often described the world that needs police as being made up of two types of people. The Takers and the Givers.

On the evening of September 29th, one of the Takers took one of the Givers. Our community will never be the same. Officer Delmar Warren Tooman gave his life in the line of duty, faithful to his promise to protect and serve. Warren was a living witness to what he believed. The poem, *The Living Sermon*, sums up Warren's life nicely. Part of it reads, "I'd rather see a sermon than hear one any day. I'd rather one would walk with men than merely tell the way. The best of all the preachers are the ones who live their creeds. For to see good put in action is what every body needs. I may not understand the high advice you give, but there's no misunderstanding how you act and how you live.

Warren had attached to his rear view mirror this verse of scripture. "And the Lord shall deliver me from every evil work, and will preserve me unto his heavenly kingdom: to whom be glory forever and ever Amen." (II Timothy 4:18)

Even though Delmar Warren Tooman, "lived and walked in the valley of the shadow of death" for him, death had no grip on him.. for he had decided a long time ago who was going to shepherd his life. And if death were to come as we know it, he knew he would be ushered into God's heavenly kingdom.

Delmar Warren Tooman has left behind for us a great legacy of service to his community. In the changing world in which we find ourselves today, two things remain constant: A commitment to service, and: a willingness to do whatever is necessary to keep the peace. Sometimes the price is high. We commit ourselves to upholding the same high tradition. Those famous lines from the poem, "In Flanders Fields" reads, "To you from failing hands we throw the torch: be yours to hold it high". That is our pledge to our brothers who have fallen and the generations that are yet to come. We can do nothing less.

Post-Script:

Do not grudge your brother his rest, he has at last become free, safe, and immortal, and ranges joyous through boundless heavens: He has left this low-lying region and has soared upwards to that place which receives in its happy bosom the souls set free from the chains of matter.

Your brother has not lost the light of day, but has obtained a more enduring light. He has not left us, but has gone on before. -Seneca-

Article ~

MEN AND GRIEVING
By Charles Collenberger

FOR MALES...After a Death

You, a man, recently learned of the death of someone YOU loved. You may have been told by a police officer, doctor, or other spokesperson... or possibly you discovered it yourself. It really doesn't matter much whether it was murder, a drunk driving homicide, an accident, suicide, or a catastrophic illness. You are starting down a traumatic road which can, if you allow it, destroy your life.

At first, the sudden shock left you numb. You may even have cried a little. But then the little voice inside said, "Men don't cry." You then talked about what needed to be done, called the rest of the family, arranged the funeral, carried on with life.

You may have looked at the women in the family and found them incapacitated with outward displays of grief. Therefore, you decided to pull yourself together even more taking the pain like a "little soldier."

You kept busy so you wouldn't have time to cry. You met people at the door as well as in the funeral home. You supported your family. You might have remembered for a fleeting moment the last argument you had with the dead person, but it was quickly smothered. You couldn't lose a day of work. You had to pay for all of this.

You cram down the all-consuming anger over the way the death happened but have fleeting thoughts that you would rather be hunting down and killing the person who did this than working so hard to maintain control.

You get through the funeral, and then it's back to normal living, back to associating with people who don't know or don't understand. If you show too much emotion - or any at all - you are looked at with suspicion and run the risk of losing your job. You notice that after one "I'm sorry," colleagues look at the other way, seeming to hope you'll go away. They act like what happened to you is catching. So you bury yourself in your job, even though your loved one is in your thoughts nearly all the time. You try to push them aside and work. So, further down go the feelings, deep into the mind to fester.

Just about the time you think you'll survive, if it was a murder or other homicide, the trial starts. Each minute detail comes out. Your loved one is attacked by the defense attorney. You realize that the killing is considered a crime against the State rather than against your loved one, and you don't count except as evidence. It takes days for the trauma of a few minutes to be relived. Even if the case is "won" emptiness accompanies it. There can be no true justice. And, of course, appeals and other efforts to reverse the decision begin immediately and can continue for years.

You may begin to notice that some of the women in the family seem to have cried themselves into a semblance of recovery. They have cried together. They may

have joined a therapy or self-help group. Because they seem to be doing a little better, you can't talk to them for fear of appearing weak and maybe sending them back into grief. So you draw away...and feel guilty about it.

You may begin to accept overtime or take on more than you can possibly get done. Extra jobs, which at first helped with burial expenses, continue to be an escape from facing up. You spend less time at home facing the guilt from which you must escape.

Sleeping may have become a problem, and during the day you experience wide mood swings. A well-meaning but foolish doctor may give you some sleeping pills. They help outwardly. They help you forget, so you become dependent on them for day-to-day existence. Perhaps you try more and different kinds.

Evenings are a real problem. You can't talk with your wife anymore, and just sitting watching television doesn't keep the memories from returning. A few drinks might help. Maybe going out with the boys can get rid of the guilt you feel while being with your wife. Maybe your wife is the one who died. You just can't stay home anymore.

WHO CARES?

Everybody does! But they are standing outside the barrier you have thrown up around yourself. Their hearts are broken as they watch you destroy the man they love so dearly. But they can't break down the wall. Only you can break down this impassable, invisible wall.

HERE'S WHAT YOU MUST DO:

FORGET that "men don't cry."
FORGET the silent little soldier.
FORGET to hide your feelings.
FORGET it's not manly to ask for help.

BUT MOST IMPORTANT OF ALL, allow yourself to cry long and loud until you begin to recover. It won't be easy. Years of crippling training have to be undone. It takes tremendous courage to cry...almost as much courage as it did not to cry all these days.

Your life will never again be the same. You will not have your loved one back physically. Your relationship with him or her is changed, and now it is memories that you hold in your heart. No one can take those away. But you can only cherish the good memories if you are healing. And you will only heal when you allow the tears to flow.

Charles Collenberger has survived the murder of a loved one. He says, "I can cry. I am healing. I am surviving."

BRIEF HISTORY OF DEVELOPMENT OF CRISIS INTERVENTION

Post traumatic stress disorder has been around for as long as there has been human conflict. However, crisis intervention is a relatively new field and has been around in a variety of forms since the early part of the 20th century. One of the early support organizations was created in 1906, the National Save-A-Life League, which focused on suicide prevention.

Beginning with World War I and World War II evidence came to light that with early intervention chronic psychiatric morbidity was greatly reduced. Furthermore, it was also noted that the processes of immediacy, proximity and expectancy were identified as important “active ingredients” in effective emergency psychological response.

In 1944 Erick Lindemann’s observations of grief reactions to the Coconut Grove fire started the “modern era” of what we now recognize as crisis intervention. In the late 1950s community based suicide prevention programs began to grow.

From the early 1960s to the early 1970s crisis intervention continued to grow and expand. Crisis intervention was defined by Gerald Caplan as having three tiers of preventive psychiatry implemented within the newly created community mental health system (i.e. primary prevention, secondary prevention and tertiary prevention). It was proven that crisis intervention principles, when applied, reduced the need for hospitalizations of potentially “chronic” populations. This was a time when early work on crisis and stress in first responders began.

The 1980s brought about rapid growth in the crisis intervention field due to the DSM-II recognizing Post Traumatic Stress Disorder (“PTSD”) as threats to long-term mental health and called for examination of crisis and traumatic events. Also, the Air Florida 90 air disaster in Washington D.C. prompted re-examination of psychological impact on emergency personnel. In fact, this was the first time that small group Critical Incident Stress Debriefings (“CISD”), which was originally formulated in 1974, were utilized in a large scale disaster.

The 1980s also began the era of “Violence in the Workplace” when 13 postal employees were killed on the job in 1986. Since that incident, in 1989, the International Critical Incident Stress Foundation (“ICISF”) was formalized. It offers a standardized and comprehensive crisis intervention model which is utilized world wide. Since its formation there are now over 1,000 CISM teams and the ICISF has grown to over 7,000 members in 28 nations.

During the 1990s there have been a number of mass disasters world wide which have impacted CISM and PTSD. In 1992 there was Hurricane Andrew which tested the nationwide disaster mental health capability and the new mental health function of ICISF in the United States. In 1993 there was also the implementation of a nationwide crisis intervention system due to the Kuwait University for post-war Kuwait. Then America experienced one of the first modern-day terrorist attacks in the form of the first World Trade Center bombing. Once again, the DSM-IV

recognized Acute Stress Disorder as a legitimate after-effect of crisis and traumatic events.

In 1996, the Oklahoma City bombing emphasized the need for crisis services for first responders, as well as civilians. The TWA 800 air disaster further emphasized the need for emergency mental health services for families of the victims of traumas and disasters. Out of these tragedies came the OSHA 3148, which recommends comprehensive violence/crisis intervention programs in healthcare and social service agencies, and the Aviation Disaster Family Assistance Act.

Further recognition for the need of crisis intervention came about in the form of AFI 44-153 which mandates the establishment for crisis programs for the United States Air Force bases worldwide. Also, the Gore Commission recommended crisis services for the airline industry. ICISF gained United Nations affiliation. OSHA 33153 established the recommendation for crisis intervention programs for late-night retail stores. COMDINST 1754.3 required the United States Coast Guard to establish a CISM team for each of their regions. The Department of Defense DIRECTIVE 6490.5 established policy and responsibilities for developing Combat Stress Control ("CSC") programs throughout the United States military.

1999 brought in the advent of mass shootings with the Columbine High School in Colorado. This forced ICISF to re-examine the increase in issues of youth and school violence. As a result, ICISF established protocols, procedures in dealing with school crisis response and created a special program for just that purpose.

In 2000 there was an increase in international concern regarding the potential use of nuclear, biological and/or chemical terrorism. This concern also included the planning for mental health consequences which would follow in such an aftermath.

Then on September 11, 2001 the United States was again attacked by terrorist measures from a non-American enemy. Attacks against the World Trade Center in New York City, The Pentagon in Washington, D.C. and United Airlines Flight #93 showed the value of immediate response to crisis events. The mass disaster of the terrorist attacks showed how the enormous and prolonged intervention (approximately 1 ½ years) to victims, families, businesses, communities and first responders mitigated the need for long term counseling and the development of full blown PTSD was significantly reduced.

2002 was a year of growth and challenge. The NIMH published guidelines on Mental Health and Mass Violence, National Institute of Mental Health (2002). Mental Health and Mass Violence, Washington, DC: U.S. Government Printing Office. The EAPA also released guidelines on Disaster Mental Health. Employee Assistance Professionals' Association ("EAPA"), (2002). Report of the disaster preparedness task force, Boston, November, 2002. This was also the start of the liberation of Afghanistan and Iraq. The military struggles with the challenges of CSC among its various branches.

In 2004 mass disasters were seen world wide. First there was the tsunami which hit Indonesia causing massive damage and numerous deaths. Again, Critical Incident Stress Management Foundation of Australia ("CISMFA"), an affiliate of

ICISF, under took the rapid training of crisis responder for South Pacific relief agencies to work with both victims and first responders. Again, the United States was targeted by mother nature in the form of four major hurricanes hitting Florida and the southern United States. Crisis intervention services were challenged by the back-to-back storm and the mass devastation of entire communities throughout Florida and the southern United States.

In 2005 NVOAD released recommendations for disaster mental health intervention and training. Olson, J. (2005). "National Volunteer Organizations Active in Disaster: Successful Strategies for Collaboration During the Historic 204 Hurricane Season." *The Dialogue: A Quarterly Technical Assistance Bulletin on Disaster Behavioral Health (SAMHSA)*, Summer, 16-17. Also, that year was the year of Hurricane Katrina and Hurricane Rita. The southern United States and Florida again suffered massive devastation. Approximately 1,300 dead, many thousands of sick and injured, 33,000 aerial evacuations, and 96,000 square miles of severe damage all causing these storms to become the most devastating and costly natural disasters in United States history. They also provided significant challenges for all response organizations, including those dedicated to crisis intervention services.

As of 2006, fears of pandemic influenza arise and many states and local agencies begin preparations and simulations for the unforeseen. Crisis intervention services are tapped for guidance on dealing with widespread psychological distress.

The above-referenced milestones in the historical development of the field of crisis intervention have served to shape its nature and provide insight into its current status and to look to for growth and development in the future..