TRANSITIONS CONNECTS

News & Resources for Mental Health in Arizona
Brought to You By Transitions Counseling and Consulting

Sneak peek inside this issue:

A FULL SPECTRUM OF CARE FOR THE FAMILY

TRANSITIONS COUNSELING IS NOW FULLY EMPANELED WITH TRICARE TO OFFER IOP AND PHP LEVELS OF CARE TO ADOLESCENTS & ADULTS

2021 was an incredible year for the Transitions Counseling and Consulting Family!

- We opened our East Valley South Mountain location
- Began offering Partial Hospitalization (PHP) for Adolescents
- Earned Accreditation with The Joint Commission
- Became fully empaneled with Tricare to offer the complete continuum of care to Tricare patients

As we start 2022, we plan to keep growing, providing much needed services in the community, while continuing to uphold our high standard of care. **We will begin this year by starting to offer the PHP level of care for adult patients (in Glendale and South Mountain) as well as opening an additional PHP for Adolescents in the East Valley.**

WORKING WITH FIRST RESPONDERS & MILITARY PATIENTS: POLICY MATTERS

WRITTEN BY: DR. STACEY KRAUSS, PSY.D., ABPP - CEO OF TRANSITIONS COUNSELING AND CONSULTING AND 10-YEAR U.S. ARMY COMBAT VETERAN

A quick examination of the literature on cultural competence in working with First Responders, Service Members, and Veterans reveals extent commentary on the values, customs, and beliefs of these communities. Rightfully so, given the unique characteristics and traditions that differentiate this group of people from those who have never served in such roles. However, an understanding of the health requirements for continued service in these positions is just as critical an element of cultural competence when working with members of this community – and unfortunately, it's often overlooked.

The armed forces and many first responder units require those serving to meet certain health-related criteria, commonly called "fitness for duty" standards. The goal of these regulations is to ensure that those working in harm's way (or in remote settings in which access to medical care is limited) are healthy enough to perform their jobs – which often include exposure to significant physical and psychological stressors.

While it's generally not the role or responsibility of healthcare providers to determine ultimate fitness for continued services (unless employed in a setting explicitly responsible for that professional service), we can help our patients by educating them about the implications of the diagnoses we've made, by answering questions to the extent we are able to about long-term prognoses, and can recognize when to encourage patients to seek clarification from medical staff affiliated with their service organization specific to their healthcare needs.

As but one example of the impact of these regulations, behavioral health clinicians often elect to diagnose adjustment disorder while refining the most appropriate diagnosis over the course of the first weeks of treatment. However, if that diagnosis remains in place for an extended period (greater than 6 months) the mere presence of it may trigger a formal review for separation from service - even for a Service Member who is functioning quite well. This is not to suggest that clinicians should alter diagnoses to support a particular outcome. As clinicians, we diagnose and offer treatment recommendations based solely on evidence and scientific support for all patients. Rather, this example serves as encouragement to be aware of how our diagnoses can impact the current or potential service of our patients so that we can have meaningful conversations with them when needed – just as we do in discussing the general risks and benefits of treatment during routine informed consent processes.

In closing, below you will find links for the current major policies on behavioral health and learning conditions that might impact military service:

1.) For those seeking initial enlistment: https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/613003v1p.PDF (Section 5.28, pages 46-48, specifically refers to behavioral disorders that are disqualifying for enlistment)

2.) For those currently serving: https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/613003v2p.pdf (Section 5.28, pages 35-36, specifically refer to behavioral disorders that will prevent retention in the service)

FIRST RESPONDERS WITH TRAUMA & STRESS RELATED DISORDERS: TREATMENT CONSIDERATIONS & APPROACHES

WRITTEN BY: TROY TANGEMAN, LPC, SUPERVISORY CLINICIAN
TRANSITIONS COUNSELING AND CONSULTING

Firefighters, Police, and paramedics/EMTs experience significantly elevated rates of posttraumatic stress disorder (PTSD) (Richard, 2021). First responders tend to experience PTSD and trauma-related symptoms at much higher rates than the general population. First responders often face distinctive organizational expectations, and other comorbidities, which may complicate trauma treatment. The need for careful assessment, coordination of care, and comprehensive treatment is paramount to successful treatment with this population. Providers should also consider current and relevant evidence-based approaches to treatment to provide the best care possible for our first responders challenged with PTSD or other trauma and stress-related disorders.

Considerations in Treating PTSD in First Responders:
Diagnosing trauma and stress-related disorders (e.g., PTSD, Acute Stress Disorder, etc.) can be a complex process and must meet specific criteria for diagnosis according to the DSM-5 (American Psychiatric Association, 2013). For example, the symptom patterns of acute stress disorder occur in the 3 days to the 1-month range, and the symptoms for PTSD must have occurred for at least 1 month. For PTSD, first responders must either have directly experienced the traumatic event, witnessed it, or heard about it. Direct experience might be an event where a firefighter has the roof of a burning building collapsed down on them causing injuries, a police officer is involved in a shooting incident, or an ER/Trauma Medical Professional experiencing a patient coding under their care.

Other criteria might be emergency responders witnessing a suicide jumper in person or hearing about a disturbing incident by proxy from another person in their organization or field, such as a paramedic talking to another paramedic about a horrible accident scene they responded to on a previous shift. In my experiences treating police officers and firefighters, they will sometimes describe aversive details of the traumatic events and how they cannot get the image of deceased individuals or severely injured persons out of their minds.

This may result in spontaneous and repeated intrusive recollections of the event (e.g., flashbacks, dreams) and in some extreme cases, a person may lose awareness of the present moment making it very difficult to function in the here and now. Firefighters, paramedics, police officers, and other first responders with PTSD may avoid any psychological cues that symbolize any aspect of trauma events. First responders might avoid conversations about traumatic events or anything that might arouse feelings or thoughts of traumatic events. This may include avoiding talking about trauma with their mental health or health care providers or avoidance with family members or members of their organizations outside of work.

First responders are often expected to stay at a scene until the job is finished, and to be able to, “handle it.” Many individuals resort to drinking and drugs to numb their trauma symptoms and then go back to work the next day only to be re-exposed to disturbing and traumatic situations all over again.

First responders experiencing trauma and stress-related disorders may experience negative and distorted beliefs. For example, a police officer with PTSD may believe, “I am a failure,” due to not engaging a shooter that wounded their partner.

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They may feel estranged or detached from their family members or members of their organization and experience persistent negative emotions (i.e., depression, guilt, anger, fear, horror, terror, or shame, etc.) First responders with PTSD may not be able to experience positive feelings of love, joy, and happiness. Many of those afflicted with symptoms report an exaggerated startle response, hypervigilance, trouble focusing or concentrating, sleep problems, feeling irritability, and angry behaviors. Some individuals with PTSD will engage in reckless behaviors such as driving extremely fast on a motorcycle on a weekend ride. Providers should also assess clients for dissociative symptoms such as depersonalization (feeling detached) and derealization where the first responder may report that their world feels dream-like or distorted in some manner.

Lastly, first responders with trauma and stress-related disorders may live in a culture of perceived self-reliance or be in denial that they are suffering at all. Some individuals fear being fired, losing their friends, and losing support from their organization. Others fear being looked upon as being weak or unreliable because they believe they should be able to cope with trauma and stress.

Evidence-based Treatments for First Responders:
The American Psychological Association's guidelines for treating posttraumatic stress disorder recommend several psychotherapies that are empirically supported for treating PTSD (Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (2017). (2021). https://www.apa.org/ptsd-guideline).

These therapies and interventions include cognitive behavioral therapy, cognitive processing therapy, cognitive therapy, prolonged exposure therapy, brief eclectic psychotherapy, eye movement desensitization and reprocessing therapy, and narrative exposure therapy (American Psychological Association, 2021).

Current clinical research on how EMDR can be effective shows the benefit of this treatment approach with first responders, which is the treatment approach of choice this writer uses with many of his clients (EMDRIA, 2021). EMDR is an information processing therapy (i.e., change happens internally) that uses saccadic eye movements, various forms of tapping, and auditory tones to encourage the processing, desensitization, of disturbing material, and the assimilation of healthy thought processes.

EMDR can be used to target not only disturbing memories from the past, but current symptoms, and future traumatic experiences a first responder may encounter. One of the benefits of EDMR is that it can take fewer sessions, and it does not require the confrontation of challenging negative thoughts which can damage the therapeutic alliance with patients disoriented from their PTSD symptoms (EMDRIA, 2021).

EMDR therapy does not require first responders to endure prolonged exposure to their traumatic experiences and EMDR is a kinder way of processing trauma by removing the need to be re-exposed to "old wounds" repeatedly. A patient participating in EMDR comes to new helpful insights on their own during the EMDR protocol, as the traumatic images, memories, thoughts, and feelings are cleared and replaced with a sense of calm, peace, and a better understanding of what was experienced.

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WRITTEN BY: TROY TANGEMAN, LPC COUNSELOR, TRANSITIONS COUNSELING AND CONSULTING

Conclusions of Treating First Responders:

In conclusion, first responders owe it to themselves to get the help they need, and it is the responsibility of those of us in the helping professions to encourage them to do so. These are the men and women who serve the community and help to keep people safe. These individuals deserve to receive the gold standard care they need to get back on the job or to have a peaceful retirement free of trauma symptoms. First responders who seek care are more likely to feel better, perform better, and be at their best for their communities. As a counseling professional who specializes in working with this population, it would be my recommendation that we continue to educate the public and mental health professionals about the specific needs of first responders so that we may be culturally competent and provide the best care possible.

References:

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

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Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (2017). (2021). https://www.apa.org/ptsd-guideline

EMDRIA.(2021). About EMDR Therapy. https://www.emdria.org/about-emdr-therapy/

FIRE FIGHTERS MENTAL WELLNESS: REALITIES OF THE PROFESSION AND STRIVING FOR WORK-LIFE BALANCE

WRITTEN BY: BRIAN FRENCH, LAC
PSCS WELLNESS AND PHOENIX FIRE DEPARTMENT

Brian French is a Licensed Associate Counselor, specializing in working with First Responders and their families, and has been a Phoenix Firefighter for over 15 years. He also serves and leads the Departments Peer Support Organization, being instrumental in connecting First Responders to the resources they need.

I've seen a shift in the Fire Service culture over the past 15 years...As a Firefighter, Peer Support Team member, and a licensed counselor, many firefighters have reached out to me for help. I've seen a common theme amongst them and I'm definitely not immune to the problem myself. It's the issue of work-life balance. This is easily a universal issue for many who work and have families. However, an in depth look at the job of a firefighter and the toll the long shifts and fluctuation of hyperarousal can take add a new depth to the issue.

I had a friend reach out the other week. He said, "I need some help". My friend, looking to find the right way to express himself, says to me "my wife says I'm an a------". I smirk, only because his statement is so similar to the countless other firefighters I've helped along the years. My reply is always the same, "I get it friend, that's kinda what happens to a lot of us". I mean it when I say that, normalizing the experience for the individual coming to me for help. We build up a type of callous resilience to the world in order to survive and thrive in our careers. We see so many on their worst day that if we don't build up that professional guard to wall off some of those emotions, our shifts would get real tough, real fast. It's about creating emotional distance to survive.

Another factor of the job that exacerbates the effects of stress over time is the schedule. Most firefighters work for at least 24 hours in a row. Then they are off for two days and then back to the firehouse for another 24 hour shift. After 24 hours of having one's parasympathetic nervous system taxed from calls - and being prepared for the calls that might occur - that first day off becomes a rest and recovery day. The second day off, after the recovery day, we can start to assimilate back into home life a little easier. Then, that evening we prepare for the next day's shift. Hydrate, do laundry, pack up, get good rest, and mentally prepare for what the next shift might bring. This type of schedule leaves little left for building closeness with those at home; husbands and wives, sons and daughters. Repeat this pattern for 25 years. Our families learn to embrace, or maybe tolerate, this version of life. Perhaps they see it as the sacrifice they make so that we can serve the community. Needless to say, they are along with us on the ride as we struggle to balance this type of life. It is not easy for the firefighter or their family and definitely can have an impact on their relationships and life at home.

A short time ago I had a conversation with a few firefighters on shift around the dinner table about the struggle of giving everything we can to our job. Even when we are not at the station, we spend our two days off recovering from the last shift and preparing to give 100 percent of ourselves the next shift to our job and our Fire Family. The job gets all of our attention, focus and energy, whether we are on shift or not. And in turn, our family at home receives the tired, cranky, overworked, hardened version of ourselves. At the dinner table the question proposed was, should our priorities be reversed, or at least balanced, and should we be striving more to give that 100 percent effort to our loved ones at home.

FIREFIGHTERS MENTAL WELLNESS (CONT'D)

WRITTEN BY: BRIAN FRENCH, LAC
PSCS WELLNESS AND PHOENIX FIRE DEPARTMENT

As Firefighters, we work very hard and sacrifice a large amount of time to ensure financial stability for our family. However, some firefighters are starting to see that we might fall short when it comes to the emotional needs at home. Many have reached out to me to start to "fix themselves" because they "don't want to be such a grump" to their family. I think many take notice that the transition from the person we are at the fire house, that makes us successful firefighters, is often not the version needed at home. The high expectations of the person we need and need others around us to be at the firehouse; routined, controlled, prepared, and vigilant at all times, does not translate well at home. Those same expectations when walking in the door at home can cause hostility and conflict. I see this time and time again in my office, as a counselor working with first responders and their spouses.

In the end, there isn't an easy solution, and it's not fair to weigh our responsibilities to either of our families (our fire family or family at home) in such black and white terms. Where one family is getting all and the other none. It comes down to balance. It's important to challenge our work life balance skills. It is crucial that we reevaluate the expectations we have for ourselves, our Families, and our Fire Family. It is necessary to have and stick to a solid plan of self-care and reach out for help when we need it. It's beneficial to have realistic expectations. Lastly, when coming home, it's important that as we exit the firehouse, we step out of work mode. We take off the hats of the fixer and safety monitor, we temporarily turn off the "dark humor" mindset and learn to relax and enjoy the time we have with our families so that they in turn can enjoy us.

TCC Now Offering PHP for Both Adolescents and Adults!

Transitions Counseling is expanding our Partial Hospitalization Program (PHP), which will begin serving adolescents and adults in January 2022 in new locations.

We've gotten feedback on the need for a level of care in between intensive outpatient programs and inpatient treatment. In an effort to meet those needs, our team has built a program that addresses specific treatment concerns at the PHP level and provides exceptional care in the least restrictive environment. There are times when hospitalization will be necessary, however, when clinically appropriate we hope to provide effective treatment in a manner that allows adolescents and adults the opportunity to receive the services that they need without being displaced from their homes and communities.

Our team specializes in group-based therapy, and we're thrilled to extend our existing PHP services to more convenient locations and to adult patients! We will be providing the same evidence-based care (DBT and CBT groups) that you've come to trust at our Joint Commission accredited facilities. We've hand-picked caring, highly skilled clinicians to ensure quality and efficacy. In addition, we offer a weekly family group to ensure support and effective communication.

Our program offers the following:

*Cognitive Behavioral Therapy *Dialectical Behavioral Therapy
*Expressive Arts Therapies Led by a Professional Counselor
*Mindfulness Based Approaches *Family Groups and Workshops
*Parent Support and Education
*Weekly Aftercare Groups - Including Weekend Options

PHP is offered at our North Phoenix, Glendale, & South Mountain Locations.

Refer a Patient:
Email: admissions@transitionscounselingandconsult.com | **Call Us:** (602) 363-0629

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Programs At Transitions Counseling

Transitions Counseling has five valley locations throughout North Phoenix, Glendale, Chandler and Ahwatukee. We offer Intensive Outpatient Programs, Partial Hospitalization Programs, Individual and Group Counseling for adolescents, emerging adults, and adults with depression, anxiety, PTSD/trauma, suicidal ideation and self harm.

Individual and Group Counseling

Transitions Counseling is proud to offer individual and group therapy options for adolescents and adults. Every patient participates in a comprehensive assessment and works with their therapist to create a treatment plan addressing their specific needs. Patients, with the guidance of their therapist, will identify the best treatment option(s) to provide appropriate support and assist them in meeting their goals.

Mental Health IOP

Our Mental Health IOP programs are divided into four age groups: Younger Adolescent (ages 10-13), Adolescent (ages 14-17), Emerging Adult (ages 18-26), and Adult (ages 27 plus). Curriculum has been developed to address the developmental needs in each specified age group. Our programs are focused on addressing core issues contributing to symptoms as well as supporting participants in developing and practicing distress tolerance and emotional regulation skills. Curriculum is based on dialectical behavioral and cognitive behavioral therapies, as well as the integration of expressive arts therapy. Each treatment plan is individualized to meet your patient's unique needs.

Mental Health PHP

Partial Hospitalization is an option for adolescents and adults who need a higher level of care than general outpatient therapy or intensive outpatient and are not in need of inpatient stabilization. The PHP program is overseen by a medical director to ensure the appropriate level of care for each participant. PHP meets 5 days per week for four hours per day. Our clinicians use a combination of DBT, CBT, and expressive arts therapy, customized to meet each patient's needs.

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