Perceptions of PTSD and Alcoholism in One of Our Own

BY PAUL J. ANTONELLIS JR. AND CAROL STABEN-BURROUGHS

THE FIRE SERVICE HAS A GREAT DEGREE OF PRIDE in the service it provides. This pride tends to bond firefighters regardless of the size or makeup of the firefighter's department. The pride firefighters have for the history and the future of the service can at times cloud the issues they or coworkers may be facing. The perception of mental health issues in one of our own still carries a significant stigma in many departments. The sidebar "Battling Alcohol Abuse: One Firefighter's Story" is just one example of a firefighter who has had a long and colorful history dealing with the struggles of alcoholism and post-traumatic stress disorder (PTSD). As you read his story, you may be able to change his name to your name or that of a coworker and you may be able to change the name of the department to your department. The story is presented to share openly one firefighter's struggle with PTSD and alcoholism that eventually led to a forced retirement. The objective of this article is to explore some of what firefighters experience when facing substance abuse and mental health issues. The article links some of the points made in this story with common reactions to these types of issues.

The fire service has made great strides in identifying, treating, and accepting mental health issues over the past 10 years. However, this momentum must continue if the fire service culture is going to evolve. Alcoholism and mental health illness remain social issues in the United States, and many in the fire service have been or may be impacted by their physical or emotional toll. Individuals in the fire service need to develop a deeper understanding and acceptance of firefighters suffering from mental health issues such as alcoholism, PTSD, depression, and anxiety and come to understand that these issues can have devastating impacts on the individual firefighters, family members, coworkers, and fire department.[1] We have witnessed firsthand line firefighters, company officers, and chiefs who have had shortened careers in the fire service based on mental health- or alcohol-related issues. The daily blogs and news stories reporting firefighters who have been involved in alcohol-related incidents that impacted their jobs are common today. The fire service collectively has an obligation to openly, honestly, and respectfully discuss how alcoholism and mental health illness can impact the individual firefighter. The fire service must also understand that the firefighter who has struggled with alcoholism or mental health issues can still return to work in most cases and be a productive employee. How the department, individual, and coworkers respond to a firefighter's suffering from PTSD or alcoholism can determine whether those involved will experience a successful or a devastating outcome.

PERCEPTION AND REALITY

The research is clear that emergency service providers are exposed to traumatic events at a much higher rate than the general population and that this high rate of exposure to traumatic events makes the emergency service provider vulnerable to developing PTSD.[2,3] No training, education, or program can totally remove the effects of the stress firefighters experience in performing their duties even though some steps can be taken to reduce stress levels in firefighters who have been exposed to traumatic events and to improve the perception of firefighters who struggle with the effects of occupational stress. Firefighters will continue to be exposed to traumatic events that leave them vulnerable to developing mental health issues; however, the perception of a firefighter struggling with the effects of occupational stress needs to change to provide additional support for the firefighter in a recovery program. In many cases, firefighters who notice firefighters struggling with alcoholism or a mental health issue may look the other way so as not to get the firefighter in trouble (code of silence), or the coworkers may distance themselves from the struggling firefighter because they see that individual as "damaged goods."

According to the National Institute on Alcohol Abuse and Alcoholism, nearly 14 million Americans are alcoholics or abuse alcohol, and more than 700,000 Americans seek treatment for alcoholism on any given day.[4] Most people know someone who is abusing alcohol or is an alcoholic. Look closely; the firefighter sitting next to you may be silently struggling with alcohol abuse. The perception is that every-

● PTSD AND ALCOHOLISM

Battling Alcohol Abuse: One Firefighter's Story

BY CHARLES TALBOTT

As long as I can remember, I wanted to be a firefighter. My grandfather worked for Taunton (MA) Fire Alarm as a lineman, so I was exposed to the fire service at an early age. I was always amazed by the teamwork, the camaraderie, and the challenges these people faced. As soon as I turned 18, I joined the local fire department where I lived in Vermont. Shortly thereafter, I moved to Brewster, Cape Cod.

I learned that the town had a paid on-call fire department. On July 1, 1987, I joined the Brewster Fire Department. I spent almost the next five years there. The department provided me with fire training and sent me to emergency medical technician school and eventually to paramedic school. Those early years were some of the best years of my life.

In early 1992, I took the entrance exam to become a full-time firefighter with the Yarmouth (MA) Fire Department. There was a lot of competition for jobs back then, and I was fortunate to do well enough to be offered a job. On May 14, 1992, I started my full-time career with the Yarmouth Fire Department. I was excited and didn't quite know what to expect. It was a different department then, smaller and close knit with a lot of very experienced older guys on the job. I was told to keep my mouth shut, eyes and ears open, and maybe, just maybe, I might learn something. At the time, I had no idea of what post-traumatic stress disorder (PTSD) was, and critical incident stress debriefing (CISD) consisted of getting together with guys from the shift and discussing bad calls over a few beers, sometimes many beers.

My department is the busiest on Cape Cod, now running more than 6,000 calls annually. Early on in my career, I was exposed to significant and very unpleasant calls. At first, these calls didn't seem to bother me. I worked hard and "played" hard. Drinking was a big part of the culture back then, and I certainly did my share. At the time, it didn't seem to affect my work at all; showing up with the occasional hangover was the norm, but I was always able to perform my job to my superiors' expectations.

Inside, however, I was feeling more and more empty and depressed. I didn't feel like I could talk to anyone about how I was feeling. I was drinking more and more to escape from myself and what I was feeling. In 1998, I attempted suicide for the first time. I wanted to escape from everything going on in my life. The police found me in my car with a hose connected to the exhaust. I was taken to the hospital and then to a psychiatric facility for evaluation. I was diagnosed with depression, placed on medication, and cleared to return to duty. I actually stopped drinking for a while and completely immersed myself in my work. On the outside, it looked like I had turned the corner. I bought a house and a nice car, and I was in a good relationship.

On the inside, however, I was still lonely, anxious, and depressed. It seemed the only thing I truly enjoyed was work. I really felt that I was making a positive contribution to my community. When promotional exams came up, I studied hard and always did well. I was fortunate to get promoted to senior private and then lieutenant. My professional successes, however, didn't change the feelings I had inside. It seemed like the more success I had at work, the worse I felt about myself. Bad calls were still happening, and I just kept bottling up the unpleasant thoughts and images inside. I also started drinking again.

In 2004, I attempted suicide again. I was sent to another psychiatric facility and given the same diagnosis: depression. I was again given permission to return to duty; however, I was demoted to the rank of firefighter. This was devastating to me. However, I looked at it as a positive motivator and became determined to get my rank back. I curtailed my drinking, worked, and studied hard. When promotions were given, I was again promoted to the rank of lieutenant by the same chief who had demoted me. I had proven myself.

Again, on the outside, things looked good, but on the inside, things were still the same. My relationship ended because of my drinking, even though at the time I just wrote it off as our being incompatible. I still felt empty and lonely, and it seemed the only thing that gave me purpose in life was my job. I stopped going out with the guys and began spending more and more time alone. I spent a lot of time fishing by myself and drinking by myself. When people would ask how I was, I would always say I was fine and did my best to present myself as happy and enjoying life. I thought I was so smart that I was able to fool everyone. That didn't last long.

In July 2011, I was promoted to captain/shift commander. I was responsible for three stations and 14 personnel. I had

one would like to think that your firefighters would not come to work under the influence of a substance. The reality is that some of the firefighters working next to you may be abusing alcohol on or off the job, which can have a negative impact on how satisfied the firefighter is with the job.[5] The firefighter who once found the job rewarding and positive may now exhibit a negative attitude toward the work and those around him. Stress and substance abuse can play a central role in the firefighters sitting in silence with their struggles, who have developed a negative attitude toward the work they once enjoyed.

There is no easy way to ensure that everyone on the job is clean and sober all the time, but the process can begin with a commitment from the administration and the employees that they all want a safe work environment. As a coworker, your goal should be not only to discuss openly the fact that some in the fire service struggle with abusing alcohol but also to ensure that coworkers know that they have a responsibility to report an individual they think is at risk and that they have multiple options for reporting an incident/issue. The reporting process must include multiple reporting options, to allow the reporting party to file a report with a person other than a direct supervisor. The firefighter must be allowed to step outside the normal chain of command to report a mental health concern or an alcohol-related issue in the workplace. The options should include reporting an incident to someone outside the fire department—for example, the community's human resource department.

As Talbott says in his story, his firefighters feared saying anything to him or reporting his unacceptable on-duty

Battling Alcohol Abuse: One Firefighter's Story

finally achieved my professional goal. I always tried to better myself to prepare for this role. I went to the National Fire Academy for at least a week every year to better myself and prepare for this position. I was not prepared for the added stress and wear that came with this position. I found myself becoming more and more irritable with my shift and other people. It seemed I felt angry all the time, and I began to isolate myself more and more. I stopped doing the things I enjoyed and started using more and more vacation and sick time. I also began to drink heavily. Guys on my shift knew that something was up with me, but I made it very difficult for them to approach me. I spent more and more time in my office with the door shut. My world was becoming very small, and I didn't have any idea why.

In October 2012, I hit bottom again and ended up seeking treatment at a facility that had a program for firefighters, police, and military personnel. It was at this facility that I was first diagnosed with PTSD. Prior to that, all I knew about PTSD was that it was something combat soldiers experienced. I was resistant to the fact that I could be experiencing this. I couldn't accept the fact that I had somehow been damaged and wasn't coping well with the things I had experienced during my career—that I was somehow weaker than everyone else. I had failed to see or chose to ignore all the warning signs. I completed the program and was once again allowed to go back to work.

During this entire period, the department and my local union were very supportive, but the department was in uncharted waters. No one really was sure of what to do, including me. Unfortunately, the fire service tends to be reactive to issues rather than proactive. I did my very best to show that things were better. Inside, things weren't. I continued to drink heavily off duty; by this time, I only drank alone in my house. I was embarrassed by how much I was drinking and lied to everyone about my drinking. My off days were spent home alone drinking and being miserable and increasingly angry at everything. When I was on duty, people were afraid to confront me about my off-duty drinking. I was the boss, and I am sure they feared some type of retaliation if they brought it up. Things were just getting worse.

Finally, I crossed the line. While off duty and drunk, I texted a couple of members of my shift. I was critical of their performance and threatened them with a loss of overtime and shift transfers. I have no recollection of even sending these texts. They, rightfully, took these texts first to the union president and then to the deputy chief. I was placed on administrative leave.

At the urging of my union president, our union lawyer, and a good friend from the Boston Fire Department, I went to a 30-day inpatient facility in Pennsylvania that specializes in dual diagnosis for public safety personnel. There, I got a better understanding of what PTSD is and how it was affecting me. I completed this program and came home knowing I was facing disciplinary action for what I had done prior to going to the facility.

The situation was worse than I had thought. More members came forward about how I was acting when I was at work. I thought everything was fine when clearly it wasn't. I wasn't fooling anyone. This put the department and the union in a difficult position. They had to protect the members, but they also had an obligation to help me. After many discussions. I decided I had lost the ability to lead. I needed to put the needs of the department and my shift ahead of my own.

On September 11, 2013, I officially retired from the Yarmouth Fire Department. That had to be the saddest day of my life. I didn't notice or chose to ignore all the warning signs. By doing this, I was eventually consumed by them. I filed for a disability retirement and continued to drink heavily. I went to a few more inpatient facilities, but I was lost. Finally came the day when I had to just give in and accept what I was and get some help. My only other alternative was to drink myself to death. I chose to get help.

I am still battling with my PTSD and my drinking, although I have been sober for a while now. I am on a new medication that helps with the nightmares and the other symptoms of PTSD. I also am an advocate of early recognition of the signs and symptoms of PTSD. I urge all departments and personnel to take a proactive approach to this increasing problem. Hopefully, by sharing my story, I can help at least one member to avoid going through what I went through.

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behavior to the administration. Line firefighters struggle with the possibility that if they make a complaint about a supervisor or a coworker and the complaint is determined to be unfounded, they will pay a "price" for reporting the problem to the administration. Retaliation often comes in the form of intimidation, retaliatory actions, and other methods of bullying by the officer or other members in the department, such as peer pressure. This fear and intimidation perpetuate the code of silence that is often deeply rooted in the department culture.

Today, all fire departments should have a zero-tolerance policy pertaining to the use, possession, distribution, and sale of alcohol and other drugs at work. A zero-tolerance policy does not automatically mean that the employee who violated the policy is terminated; the policy is the starting point for identifying unacceptable behavior and outlining the actions that might be taken if a violation occurs. Labor and management must be willing to strike a balance for the member in need of services and the safe operation of the department.[6] One goal of a zero-tolerance policy is early detection so that the member can be removed from service to allow for a safe work environment and create a pathway for recovery. Because relapse is part of the recovery process, it can be predicted that the firefighter may have a later event that revolves around the same issue.[7,8] The zero-tolerance policy should fall under the workplace safety umbrella, in which labor and management work in partnership to create, maintain, and enforce a safe environment for the entire department.

The zero-tolerance policy must have a process that allows members of the department to report an issue to a super-

visor or human resource manager without fear of reprisal from others in the department (administration, supervisors, coworkers). Labor and management should work together to ensure that the zero-tolerance policy is disseminated to all employees annually and that specialized training is conducted on the different aspects of the policy with an emphasis on reporting unacceptable behavior.[9] The reporting process will often require a change in the fire service culture to alter this code of silence that prevents us from reporting our own. Reporting our coworkers will enable the firefighters to seek professional help early and will set the stage for the greatest results in the firefighter's recovery process. This may save the person from a protracted process and possibly the loss of a career, coworkers, friends, and family. The new culture should be based on the concept that by reporting alcohol or mental health issues, we are preventing further harm to the firefighter, therefore protecting our own. If the motto of protecting our own rings true, why are we not helping our fellow firefighters to seek professional help early? Why are we waiting until the situation becomes a forced retirement issue, demotion, loss of life, or loss of marriage?

As in Talbott's story, toward the end of his career he spent a great deal of energy protecting himself, hiding out in his office with the door closed, and creating a toxic work environment for those around him. It is important to point out that he is the first to admit that he created this negative work environment himself (granted, the captain did not see it as a problem at the time he was isolating himself) and wants others in the fire service to learn from his mistakes. Creating a negative environment prevented his firefighters from teaching and learning new firefighter skills and allowed the firefighters to see and be part of this toxic work culture. Thankfully, the department administration sent the message that Talbott's unacceptable behavior would not be tolerated. Credit must also be given to the department for providing an opportunity for the abusing firefighter to seek professional help and allowing a pathway back to work once the employee was in a recovery program. As he indicated in the story, Talbott had made several attempts to deal with his alcohol abuse; however, he chose to take the path that resulted in the end of his career. Regrettably, many others in the fire service are repeating this story with the same tragic results—a career ended too soon.

CULTURE OF CHANGE

Open communication would help change the perception that the person struggling with alcohol abuse is just a "drunk" and a "lost cause." Some have devoted their entire life to the fire service, and the service should view mental health issues and substance abuse as illnesses from which the person may need time to recover. One researcher argued, "Drinking was usually considered the sole business of the individual. Any questions or intrusions were viewed as an invasion of the person's privacy, much like asking another person about his sex life or religion. This taboo meant that employers felt as though they could not talk to an employee about what he was doing, even if it were affecting his job performance."[10] Today, if the behavior or actions have a negative impact on the job performance, the employer has every right to speak to the employee about the issue. As a supervisor, it is key for you to make note of the facts and not suggest or imply that the person has a drinking problem or is suffering from a mental health issue. The supervisor's job is not to determine what is bothering or impacting the firefighter; that is the responsibility of medical professionals. This is an error far too many supervisors make: They tell the person he has a drinking problem or PTSD. The supervisor's job is to document the facts that demonstrate an unacceptable behavior and refer the individual to the department employee assistance program (EAP) or the department medical office for assessment and diagnosis and treatment.

The emphasis on culture and its elements should encourage and support the long road in the recovery process for the firefighter struggling with a mental health issue or a substance abuse problem. Other researchers argue, "Drinking as part of the workplace culture or environment poses a special set of challenges for a significant subset of employees: recovered alcoholics. Recovered alcoholics are generally invisible in society; they are faced with social stigma and workplace barriers that are largely unintentionally constructed."[11] The fire service needs to take a proactive approach in creating a culture that minimizes the challenges that returning firefighters may face during the recovery process. If a firefighter had any other type of injury or illness, we all would be working hard to help the firefighter return and have a successful career; however the stigma, lack of understanding, and invisible nature of mental health issues, substance use/abuse, and alcoholism remain significant issues for many firefighters today.

RECOVERY PROCESS AND CHALLENGES

The recovery process is difficult in a situation like Talbott's because two or more issues must be dealt with concurrently: the alcoholism, the PTSD, and the depression. Dealing with only one issue will not work for very long. Another aspect of these types of situations is that they take years to develop, and they cannot be solved in a matter of a couple of office visits to a mental health professional.[12,13] Many firefighters function well on the job even as their mental illness or chemical disease is progressing. It is not until the situation reaches blatant critical proportions that coworkers, family, or friends take action. So much of that trajectory into alcohol abuse is that it is not seen as a problem in the early years. It is one of the ways of "being one of the guys." We tend to assume individuals will know their limits and monitor their own levels of alcohol intake. It is frequently only after control is gone that it begins to affect job performance, relationships, and personality; by then the damage is done.

The effects of PTSD can also take years to develop. Often, after a critical incident, we see an immediate drop in functioning in one or more of these areas: behavioral, cognitive, emotional, or physical. Frequent reaction to a critical incident is to deny that anything has changed [for example, "something is wrong (with me)"] and to work harder to avoid thinking about, talking about, or otherwise dealing with that

PTSD AND ALCOHOLISM

event. This starts a buildup of trauma. Firefighters, by the nature of their jobs, are exposed to life-threatening events, violent death, and the pain and loss of others. The things firefighters see, hear, smell, and touch are more critical and aversive than in most other careers. Sometimes, no matter how well-trained and prepared a firefighter is, things are going to get through the protective barrier.

Often, by the time one can be diagnosed with either PTSD or alcoholism, depression is fully developed; the brain has chemically changed. The symptoms of depression are obvious: sadness or irritability, isolation, loss of interest in daily activities, appetite or weight changes, sleep changes, loss of energy, self-loathing, reckless behavior, and feelings of helplessness and hopelessness (which are the precursors to suicidal thinking and behavior). (13) Appropriate treatment for the impaired firefighter may require concurrent treatment for all three issues: medication for the depression, cessation of alcohol use, and talk therapy for the underlying chemical dependency issues and talking about the events that led to the PTSD.

Fear of being labeled "crazy" or "weak" often creates a barrier to treatment. The fear of being placed on medication or labeled as having a mental health issue could result in a negative manner on career advancement or obtaining life insurance. Individuals refuse recommended medications, think they can stop drinking on their own (or maintain a moderate use), and deny that they were affected by critical incidents in their career. Oftentimes, firefighters do not get the help they need until they have endangered their job or their life and are forced to seek treatment, just like in Talbott's story. Paradoxically, it is the qualities that create a good firefighter—independence, confidence, courage, and strength—that often become the greatest obstacles to effective, early healing. Hence, the very traits that make the best firefighters are the very ones that can also hamper the firefighter from seeking and receiving the professional help needed to deal with a mental health issue or alcoholism.

Though some individuals will develop alcoholism, PTSD, and depression issues no matter what their department does, there are some steps departments can take to reduce the incidence in their firefighters. The first is to educate firefighters about trauma—what it looks like and what it can do to the individual and that it is normal to experience it; it is not a weakness. Departments can offer critical incident stress debriefings for those "over-the-top" events, especially being mindful of those firefighters who are early in their careers or young in age, for they haven't developed some of the coping mechanisms and may be more susceptible to the effects of the traumatic event than more seasoned firefighters. All department members should have annual training/education on the EAP and how it can benefit employees and their families. Follow-up after those incidents is also important, to allow the firefighter to continue to talk and "get it out." Departments can create a culture of openness and acceptance. The

veteran firefighters who are vocal about their own effects of trauma and their own ways of dealing with it, such as where they go for help and who they talk to when they see personal changes, are gifts to the younger, less-seasoned firefighters. The veteran firefighter can also be open about some of the steps taken in the past that did not prove helpful and resulted in compounding the traumatic incident, such as binge drinking. In a culture where there is open, honest, and respectful communication, members are less likely to hide symptoms and deny problems.

GUIDELINES AND RECOMMENDATIONS

The topics of substance abuse, alcoholism, and mental health are very sensitive. Many people hold strong beliefs and values on them. The strongly held beliefs and values can make the open, honest, and respectful communication process between labor and management challenging at best. The argument needs to be made that, collectively, the fire service needs to review these issues and create alternative approaches that will allow for supporting the firefighter in recovery. This will help stop the view that the recovery firefighter is "damaged goods" and no longer deserves a place in the fire service.[14] The following are some recommendations that departments may find helpful when considering a process for dealing with these topics. The recommendations may be helpful to some departments and may stimulate productive discussions around the topics.

Immediate Plan

- Review and update the department's zero-tolerance policy.
- Train all members in this policy; emphasize reporting methods for employees.
- Support a zero-tolerance policy for intimidation or harassment for employees reporting unacceptable behaviors to the department.
- Ensure workplace and employee safety.
- Clearly articulate the confidentiality policy to all members.
- Train department administration and officers on how to conduct an intervention of a troubled employee.
- Make all members aware of the administration's reasonable suspicion-testing process. For example, the officer in charge who suspects a member is not fit for duty will immediately relieve the member from duty and shall have the member medically evaluated. No member shall be allowed to drive himself home or to the hospital; no members shall be left alone. The officer in charge will prepare a detailed written report identifying the observed behavior and immediately notify the chief of department and consult with the Human Resources Department.

Secondary Plan

- Review and update the employee assistance and wellness programs; conduct educational sessions.
- Clearly identify and make all employees aware of the

PTSD AND ALCOHOLISM

department's mental health and medical treatment plans.
- Define and explain to all employees the long-term workplace mental health and medical issues.
- Review the current culture, if needed, and adjust it to create and maintain a supportive work environment for returning firefighters.
- Review and update the management of chronic and mental health conditions impacting firefighters.
- Have administration and officers complete mental health sensitivity training.
- Develop/review a comprehensive mental health provider reference list.
- Disseminate to all members referral (self-referral, employer referral, and family referral) and follow-up protocols.
- Tie in a drug-free workplace program to the department's safety plan.
- Establish/review the department's process for transferring medical information.

Employment Separation Plan

- Review the employment separation process with the individual *before* beginning the process (retirement, benefits, paid time, return of department equipment).
- Review common symptoms/reactions to employment separation with the firefighter and family members. For example, the employee may become depressed or angry after the separation; family members may notice that the employee may have uncontrolled outbursts. These symptoms/reactions may decrease in time. People respond in different ways and at their own pace.
- Continually evaluate and make modifications to the separation plan that supports the individual employee and the department.

The goal for labor and management is to work in partnership to develop clear lines of communication as to how and when medical records for the impacted firefighter should be released. Many firefighters have different opinions on what medical records the fire department is entitled to in the event of an injury; a firefighter who is abusing/using alcohol or drugs may feel that the department is not entitled to the medical records. The release of medical records can also extend to the department's random drug testing. It is common that firefighters released from duty as a result of a drug/alcohol issue are allowed back to work pending participation in a treatment program developed by the medical staff, who must show that the firefighter is attending the treatment and rehabilitation program. In the case *Men of Color Helping All Society, et al., v. City of Buffalo*, et al., No. 12-3067, 2nd Cir., 2013, the courts looked at the health and safety concerns and weighed them against the employer's concern for the firefighters working in a high-risk job. The court said that the request for medical records was to demonstrate that treatment for drug or alcohol abuse outweighed the rights of the firefighter's privacy. The recommendation is that labor and management seek a local legal opinion on the handling of medical records in

advance of an incident and disseminate the information to all members prior to an incident to ensure that employees have prior knowledge of the medical records requirements. Leaving this topic to the last minute will often create unfavorable results and additional disagreements between labor and management.

In several cases, the recovering firefighter was at home and received a certified letter from the department ordering him to produce the medical records. The certified letter comes as a surprise and can exacerbate symptoms for the firefighter, especially if the letter is delivered late Friday or Saturday and the firefighter cannot gain access to the administration to answer questions. Again, if the firefighter has prior knowledge that the department will be sending out a request for medical records, the firefighter will view the request differently. The department must balance the legal rights and responsibilities with personnel management.

Forced Retirement

Who or what situation terminates the employment determines whether or not the retirement is a forced retirement. A normal retirement is when the individual firefighter decides to retire on his own terms in his own time. Talbott is a great example of a forced retirement; he had a choice to retire early or face disciplinary action (which may have included demotion in rank and up to termination). He decided to retire early. Like so many others, Talbott did not plan to retire when he did; the byproduct of his alcoholism and PTSD resulted in an unacceptable behavior that ended a very productive career way too soon. Though some may say he chose his path, his retirement was the result of an on-the-job injury called PTSD; the retirement board also agreed. Just because Talbott has been granted a work-related disability retirement does not mean he can just sit back and enjoy his retirement. He must deal with the daily events that can exacerbate his symptoms. People with PTSD and alcoholism are engaged in a process to help them keep control of their symptoms so they can perform daily living skills (eating, clothing, bathing, social interactions). Keep in mind that relapse is part of the recovery process for people dealing with alcoholism. The forced retirement can be the answer for some fire service administrations, but the retirement system is not a means for dealing with personnel matters. The administration must make every effort to address the personnel matters internally and not just shift the matter to the retirement system.

Labor and management should develop an educational program for the members who might face an early retirement because of a career-ending injury or illness. A forced retirement can create additional strain on the firefighter and his family. Some of the common stressors faced in forced retirement are financial, emotional, loss of identity for the firefighter, the challenges of being home all the time, relationship conflicts, and how other firefighters may now view the firefighter. The

PTSD AND ALCOHOLISM

firefighter being forced to retire will struggle with the loss of his career on top of the struggles with the alcoholism or mental health issues. Depending on how the forced retirement is handled, it can have a positive result on the firefighter and allow for recovery, or it can produce the negative result of having the firefighter feel that he was disowned by the department.

The firefighter facing a forced retirement may experience some of the same symptoms experienced with the sudden death of a loved one. Elisabeth Kubler-Ross has written extensively on the process that people generally experience with a death of a loved one.[15] We have adopted her common symptoms of death and dying to the forced retirement process and the death of a career. What the firefighter is experiencing is the sudden death of his career. The firefighter may experience some of the following symptoms with a forced retirement:

Denial and Isolation. The firefighter may isolate himself from others or may have trouble accepting the reality that the firefighter career is over.

Anger. The firefighter may be angry at others for forcing the early retirement or at himself for making poor choices that resulted in the death of his career. The anger stage is often exemplified by the firefighter's filing a wrongful termination suit in the court system.

Bargaining. The firefighter may attempt to bargain with the department for another chance.

Depression. The firefighter who experiences one of the above symptoms or becomes stuck in one of the areas may become depressed. Depression left unmonitored can lead to a complicated recovery process or result in a relapse. One problem is, socially, people view retirement with positive thoughts, so the signs of depression may be hard to understand in the forced retirement individual. This, then, might lead to more separation from others who could be supportive.

Acceptance. The final stage is reached when the firefighter comes to terms with the forced retirement and accepts that his career is over and that he must start moving forward. To achieve the acceptance stage, the firefighter must not still be in one of the prior stages of the grieving process.

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The impact of alcoholism and mental health issues remains a social issue in the United States and has taken a toll on the fire service across the country. Regardless of the type or size of your department, you stand the chance of having an alcohol- or mental health-related personnel issue that, if not addressed, could result in someone's being hurt or killed. The sooner we can identify the firefighter struggling with an alcohol or mental health issue, the sooner the firefighter can seek professional help, offering the best chance of his returning to work. Allowing the code of silence to take control provides a

disservice to the affected firefighter. Waiting only decreases the chance that the firefighter can obtain the needed professional help and return to work to a rewarding career. Fire departments that create a culture of open, honest, and respectful communication on these issues provide a means for their members to understand the illness, become knowledgeable on reporting steps, have a respect for zero tolerance for substance abuse, and support firefighters seeking the professional help they need to perform in their position.

In many cases, how the administration handles the employment separation process can have a direct and significant impact on how the firefighter processes the death of his career. In the case of Talbott, he was in the acceptance stage of grieving the loss of his career. He is at peace with the poor decisions he made in his life, which were his and only his, that resulted in his forced retirement. However, keep in mind that Talbott every day must work to control his symptoms and that recovery is a process. He deserves a high degree of credit for telling his story so others can learn from his experience.

Many firefighters will be facing the same challenges, but we have not affixed a name or department to those who are suffering. More names and departments will be attached to incidents in the future if we do not take a proactive approach to the risk of alcoholism and mental health issues in the fire service. Keep in mind that there are many firefighters who have faced a forced retirement, have been labeled as a drunk or a "nut case," who to this very day struggle with the symptoms. Many more will continue to follow this path unless the fire service takes the needed steps to minimize the impact, help the troubled firefighter obtain professional help, and support a path to recovery.

The code of silence is a short-term action. We need to work on finding a long-term solution to the challenges of alcoholism and mental health issues in the fire service. We will only cause more harm by waiting and hoping that the problem goes away. ●

REFERENCES

1. Antonellis, P & Mitchell, S. (2005). *Post-Traumatic Stress Disorder in Firefighters: the Calls that Stick with You.* Ellicott, MD: Chevron Publishing.

2. Fullerton, CS, McCarroll, JE, Ursano, RJ, and Wright, KM. (1992) "Psychological Responses of Rescue Workers: Firefighters and Trauma," *Am J Orthopsychiatry, 62*(3), 371–378.

3. McCarroll, JE, Ursano, RJ, Fullerton, CS, Liu, X, and Lundy, A. (2002). "Somatic Symptoms in Gulf War Mortuary Workers," *Psychosomatic Medicine*, 2002, 64(1), 29–33.

4. National Institute on Alcohol Abuse and Alcoholism (2011). Alcohol Facts and Statistics. Retrieved: http://www.niaaa.nih.gov/publications/brochures-and-fact-sheets.

5. Kohan, A & O'Connor, BP. (2002). "Police Officer Job Satisfaction in Relation to Mood, Well-Being, and Alcohol Consumption," *J of Psychology*, 136(3), 307.

6. Lucero, MA & Allen, RE. (2006). "Implementing Zero Tolerance Policies: Balancing Strict Enforcement with Fair Treatment," *SAM Advanced Management Journal* (07497075), 71(1), 35-41.

7. Johnsen, E & Herringer, LG. (1993). "A note on the utilization of common support activities and relapse following substance abuse." *J of Psychology*, 127(1), 73.

8. Witkiewitz, K & Marlatt, G. (2004). "Relapse Prevention for Alcohol and Drug Problems: That Was Zen, This Is Tao," *Am Psychologist*, 59(4), 224-235. doi:10.1037/0003-066X.59.4.224.

9. Mehay, S & Webb, NJ. (2007). "Workplace drug prevention programs: does zero tolerance work?" *Applied Economics*, 39(21), 2743-2751. doi:10.1080/00036840600749532.

10. Goff, J. (1990). "Corporate Responsibilities to the Addicted Employee: A Look at Practical, Legal, and Ethical Issues," *Labor Law Journal*, 41(4), 214-221.

11. Gedro, J, Mercer, F, & Iodice, JD. (2012). "Recovered alcoholics and career development: Implications for human resource development." *Human Resource Development Quarterly, 23*(1), 129-132. doi:10.1002/hrdq.21118

12. Lehavot, K, Stappenbeck, CA, Luterek, JA, Kaysen, D, & Simpson, TL. (2014). "Gender differences in relationships among PTSD severity, drinking motives, and alcohol use in a comorbid alcohol dependence and PTSD sample." *Psychology of Addictive Behaviors*, 28(1), 42-52. doi:10.1037/a0032266.

13. Simpson, TL, Stappenbeck, CA, Luterek, JA, Lehavot, K, & Kaysen, DL. (2014). "Drinking motives moderate daily relationships between PTSD symptoms and alcohol use," *J Abnormal Psychology*, 123(1), 237-247. doi:10.1037/a0035193.

14. Ménard, KS & Arter, ML. (2013). "Police officer alcohol use and trauma symptoms: Associations with critical incidents, coping, and social stressors," *Intl J Stress Management*, 20(1), 37-56. doi:10.1037/a0031434.

15. *Men of Color Helping All Soc'y, Inc. v. City of Buffalo*, No. 12-3067-cv 20 (2013) (United States Court of Appeals for the Second Circuit.)

16. Kubler-Ross, Elisabeth (1997). *On Death and Dying.* New York, NY: Touchstone.

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