



SWPAG NEWSLETTER

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News letter created by
Communications
Committee:

LCDR Booker
LCDR Peglowski



Suicide: Aftermath for Providers

By

LT Robert E. Van Meir, MSW, LCSW, BCD

Suicide is, in fact, a rare event. How rare do you ask? Well it occurs about 16 times out of a population of 100,000 individuals. That equals out to .00016 of deaths a person willingly takes their own life. The number is a little higher when you start to look at the rates based upon gender, race, and age. An example of that is for America Indians and Alaska Native men the rate is .000276. In terms of numbers that is a small percentage, but it only takes one suicide to cause a person to be rattled to their core.

I have attended numerous suicidal trainings and workshops. I have also taught suicide assessment for over 16 years. I personally have assessed thousands of clients for potential suicidal ideations. One of my main duties at my current duty assignment is assessing suicide. I recently attended one of the best suicidal workshops that I have ever attended in February of this year, but nothing I have ever learned, taught, or experienced in a 22 year career in mental health prepared me for a phone call I recently received.

While watching a television show I saw that an old friend from South Carolina (I am currently in Washington State) was calling me. I pressed the ignore button so that it went to my voicemail because I only had about 20 minutes left to watch, and I figured it was my good buddy calling to complain about his wife. I assumed I would call him back after the show, but about 10 minutes later he called again. This time I realized that it might be important (well at least more important than the show I was watching).

I answered the phone. This led to him telling me one gut-wrenching sentence. That his brother, my best friend since Junior High School, the guy who was going to be my college roommate, the one friend that no matter how much time would pass we could always pick up right up where we had left off, had killed himself earlier that day.

We were both children of old Chief Master Sergeants. We enjoyed so many of the same things. We understood each other in a very deep and profound way. We could have intense conversations while never saying a word. This guy was the life of the party, he understood history with such passion that you felt it when he talked about all the reenactments that he would (Continued page 14)



from the *SWPAG Chair*

A Grieving City and Front Line Leadership:

Upon returning to my hometown of St. Louis, Missouri on August 20, 2014 to give back to my community and to support outstanding leaders like Capt. Ron Johnson, I experienced mixed emotions. On one hand, I felt proud, grateful and excited about being in a position to provide psycho-education to mourning individuals. On the other hand, I felt troubled, worried and disheartened.

On 21 August 2014, I spent three hours educating a group of individuals about healthy mourning, anger management and conflict resolution. As we dialogued about why we mourn Michael Brown and the way ahead, my pride, gratefulness and excitement begin to dwindle. As I attempted to educate individuals about some of the psychological challenges experienced by African Americans throughout history, I was filled with a spirit of concern. During our conversation, I realized that a larger percentage of attendees were truly in need of psycho-education, direction and guidance. Individuals expressed a great deal of compassionate and felt good about experiencing unity as a people, but many expressed that they did not have proper coping skills and could benefit from receiving guidance regarding how to communicate their grief, compassionate, anger and overall emotional synergy in a healthy, progressive and productive manner.

At the conclusion of my psycho-educational event, I decided to head to Ferguson to support individuals on the front-line. As I walked a mile and a half down West Florissant, my emotional ambivalence intensified. I saw hundreds of police, a few armored vehicles and protestors talking in small groups. As I approached one of the groups, Capt. Ron Johnson was standing in the center. He was politely answering questions from media reporters who attempted to put a negative spin on comments he made about the crisis at hand.



CDR Buckingham and Capt. Ron Johnson

Despite receiving emotionally arousing and provocative questions from media, Capt. Johnson remained calm and responded without apparent anger or distress. As I observed his demeanor, I felt proud and excited about being a Black man. After Capt. Johnson finished speaking, he thanked reporters for their time and departed the small group. As he walked away, the reporters turned their cameras toward another African American male who was very emotional, dramatic and loud. The young man began to rant and rave about injustice. As I listened to the young man, Capt. Johnson approached me and said, "Brother, this is the challenge that we are facing on the front-line. Cameras are everywhere and emotions are high. Everyone should be afforded an opportunity to speak and should definitely exercise their freedom of speech; however one's demeanor and delivery is vital to being heard. Without calmness, the struggle continues. This is why I stand guard." I thanked Capt. Johnson for his leadership and replied, "People like you and I must provide leadership and guidance because the nation is witnessing a perfect storm:"
(continue page 2)

Emotionally aroused, compassionate and angry people who have access to media reporters who are willing to interview anyone who will speak despite their emotional disposition demeanor or delivery. This is a recipe for disaster. We need you on the front-line. Thank you for being a voice that can be heard.”

Before we could finish our conversation, media reporters re-engaged Capt. Johnson and I walked off. In reflecting on my brief conversation with Capt. Johnson, I felt refreshed, yet troubled. Refreshed because I walked away knowing that we have calm and rational leaders on the front-line. Troubled because I felt sad for the foot soldiers who need and deserve to be heard. My sadness nearly brought me to tears because I know that their messages will be misunderstood, downplayed and even criticized because mainstream society will focus on their demeanor and delivery instead of their pain and suffering.

The emotional ambivalence that I am experienced was a result of being in St. Louis for just one day. Image how you would feel and express yourself if you witnessed the drama from day one (August 9, 2014)? As a psychotherapist and motivational speaker, I understand that proper delivery is crucial to being heard; unfortunately everyone does not have “excellent” communication skills. With this in mind, I plead with you to withhold the judgment and to not get caught up with the media hype. Matthew 7 instructs us to not to judge others or we too will be judged. For the same way we judge others, we will be judged, and with the same measure we use.

My challenge to mainstream society is to demonstrate empathy, to listen with a compassionate heart and to strive to instill hope in people who have and continue to mourn. Hope provides a means and desire to move forward. A person, who lacks hope, lacks the desire to progress and/or live. It is time to turn anger into awareness; marching into movements, protesting into polling, looting into love and rioting into righteousness. I have been told that actions speak louder than words. So, I am asking each of you to continue to lead with action. This is my charge and I am grateful for the opportunity to serve with fellow social workers and other PHS officers who understand the importance of what it means to serve on the front-line.

CDR Dwayne Buckingham

REMINDER!!!
SWPAG Meetings

**LAST MEETING OF THE
YEAR.**

**3 Dec 2014 – 1430-1530
EST**

**For more information
about our PAG, visit the
SWPAG website at
[http://usphs-hso.org/?
q=pags/swpag](http://usphs-hso.org/?q=pags/swpag)**

September is National Preparedness Month

September is 'National Preparedness Month'. As PHS officers, we have an obligation to be READY. In the spirit of the month, we would like to remind everyone of the importance of a few readiness issues. PHS Officers rotate their on-call every 5 months. The recent Unaccompanied Children Humanitarian Crisis served as a good reminder that we must communicate our roster rotations. Remember to inform your supervisors in advance of your on call month. Don't forget to communicate with fellow officers and civilian colleagues within your agency as deployment potentials arise and develop. Ensure that your skill sets are captured on CCMIS; this section of officer information was relied upon heavily recently to help locate Spanish speaking officers.

Readiness not only applies to your 'Basic Ready Status' as an officer; but also to yourselves, family and community. Utilize this site as a primer or refresher for your overall 'Preparedness': www.ready.gov

Your SWPAG Readiness Sub-Committee hopes you are all *PREPARED* to enjoy a wonderful Fall season!



Managing Your Social Work Career in the United States Public Health Service

Authored by: SWPAG Mentorship Subcommittee

As many of us have learned over the years, being responsible for guiding your own career throughout your tenure in the United States Public Health Service (USPHS) has its advantages and challenges. Many times, as mentors and leaders we are privy to feedback from officers surrounding the difficulties they have navigating the USPHS system in regards to moving their careers forward.

In an effort to respond to this very real concern, the SWPAG Mentorship Subcommittee, in considering feedback from multiple USPHS leaders and mentors, put together the "SWPAG Career Map & Mentoring Guide". The purpose of this guide is to be used as a tool for the officer and in conjunction with your mentor to begin to map your professional career as a Social Worker in the United States Public Health Service. There are a multitude of career growth and advancement opportunities throughout the agencies and divisions in which commissioned corps officers serve. As you review this tool, you will find sample breakouts that identify potential career paths as well as positions in which Social Workers can fill throughout their career.

Take time to review this tool and begin to dialogue with yourself and your mentor. Consider the following types of questions to incorporate into your career planning:

What do I enjoy doing?

What agencies would I like to work for?

Where do I see myself in the next five years?

What do I want to be when I grow up!!!

This tool can be found on the HSO SWPAG website under SWPAG Presentations and Trainings:

[http://usphs-hso.org/sites/default/files/hso_docs/pags/swpag/Presentations/SWPAG%20-%20Social%20Work%20Career%20Guidance%20Mentoring%20Tool%20-%20FINAL%202014%20\(rev%204%20\).pdf](http://usphs-hso.org/sites/default/files/hso_docs/pags/swpag/Presentations/SWPAG%20-%20Social%20Work%20Career%20Guidance%20Mentoring%20Tool%20-%20FINAL%202014%20(rev%204%20).pdf)

Helpful Readiness Websites

Readiness-Down to Basics	http://www.usphs.gov/corpslinks/pharmacy/documents/Readiness-DownToBasics.pdf
Readiness Guide and Checklist	http://ccrf.hhs.gov/ccrf/Readiness/Basic_Readiness_Checklist.pdf
PACE program	https://sites.google.com/site/usphspharmacyreadiness/home/pace
APFT Fitness Resources	https://sites.google.com/site/usphspharmacyreadiness/home/apft-fitness-resources
APFT Events and Proctors	https://sites.google.com/site/usphspharmacyreadiness/home/apft-events-and-proctors
APFT instructions	http://ccrf.hhs.gov/ccrf/physical.htm
APFT form PHS-7044 (Fillable)	http://ccrf.hhs.gov/ccrf/Forms/Fillable_PHS-7044.pdf
Medical Waivers FAQ	http://usphs.gov/corpslinks/pharmacy/documents/Medical_Waiver_FAQ.pdf
MAB Coversheet	http://ccrf.hhs.gov/ccrf/MAB_Fax_Coversheet.pdf
CCMIS	http://dcp.psc.gov
USPHS	http://www.usphs.gov
OFRD	http://ccrf.hhs.gov/ccrf/
Direct Access	https://portal.direct-access.us/psp/EPPRD/?cmd=login&languageCd=ENG& <div style="background-color: yellow; padding: 10px; text-align: center;"> <p>Check the SWPAG FACEBOOK Page to download the deployment check list :https://www.facebook.com/groups/292892854222444/#!/groups/292892854222444/files/</p> </div>

Understanding Personality Disorders

Part II Personality

Authored by LT Robert E. Van Meir, MSW, LCSW, BCD

Submitted on behalf of SWPAG R & R Subcommittee

In the first article we looked at Personality Disorders. How personality disordered individuals lack flexibility, and how they lack the ability to make use of feedback in constructive ways. Now we will turn our attention to the main types or “presentation styles” of the major personality disorders. We will include the common countertransference reaction that a provider often “feels” while working with these types of patients. These reactions can cause a provider to discount the individuals suffering and often times the provider dreads to see these patients in their schedule.

A very important step to working with this population is understand that their distress is very real to them. Attempts to use logic or cognitive reframing interventions usually fail. They fail because the individual does not feel listened too or understood. Framing interventions that emphasize their core conflict allows the individual to feel that you understand them.

The Paranoid Style:

These patients spend a large amount of their time worried that other people are out to get them. They mistrust people, and have a lot of fear. They are experts at finding details no matter how small or trivial that supports their belief system. They are so convince that they are right often times they try to trap or trick people into supporting there paranoid beliefs. They get mad and madder and often scare the people they are working with. This can create a cycle where they increase their anger and the other person gets more and more defensive.

When working with this group be sure to emphasize the role of fear in their statements, realize that logic and evidence will get you nowhere. Avoid the cycle of escalation and acknowledge the danger. Common reactions in providers include feeling anxious or even hostile with this group. The tendency to try and straight-out the patient is a very common trap that providers can fall into.

The Antisocial Style:

This individual sees the world as “dog-eat-dog”. It is every man for him or herself and you should do whatever you can so that you can “get-over” on others before they “get-over” on you. They make promises that they will not keep. Take advantage of every situation that they can, and they justify they actions. They don’t feel bad, they project blame onto everyone else, and they never I mean never take responsibility for their actions. They are usually pretty good con men and convince others that they will change their ways but only after people are “sick of them”. Once you have figured out their con game they will move on to another mark.

Emphasize with them their pattern of not honoring their agreements, the emptiness of their promises. The therapist will often feel hostility and maybe even “hate” the patient. Hopelessness is another common feeling when working with this population. Being able to tolerant these sometime intense emotions is key to being able to be present with the patient.

The Borderline Style:

Individuals who have a borderline condition react in ways that are often impossible to understand. One second you are the most loved person in their world, the next they will be screaming about how terrible of a person you are. Then they can act like it never happened. Because of this emotional dysregulation they seem unpredictable

and unstable. People often fall into the trap of trying to help then with their self-esteem. At times they seem “perfectly normal” and sometimes can never manage to be successful for a time.

These patients have the ability to “split” staff right down the middle. With half thinking they need strong limits and the other thinking they need lots of support. They can drain a person dry and often times the provider dreads working with this group of individuals. The provider needs to empathize that strong internal feelings are at the core of their patterns with people. It is important to point out how they often “create crises in their live”. This disorder requires time and outside help to truly provide any long-term relief from their suffering.

The Narcissistic Style:

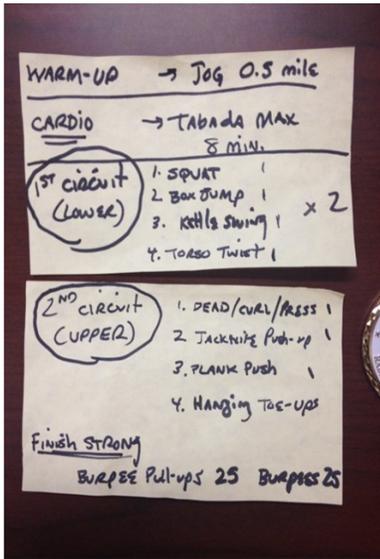
The common theme here is that this individual makes other people angry because they think that they are better than everyone else. They tend to focus only on themselves in communication with others, and they have a huge case of having to outdo other people. This person is invested in looking good and looking the part. They have a very inflated view of themselves and can be very touchy and easily wounded by others. They will often “size-up” everyone in a room and see how they “compare”. They have the ability to tear-down others so that they can boost up their fragile sense of self. They like to be the center of attention and feel like they deserve “special treatment”. They will lie to themselves in an attempt to make themselves even more important. They might have attend a class at Harvard but tell everyone that they graduated from Harvard.

These patients have a difficult time forming a treatment relationship and often time lack empathy for others. The provider can feel boredom, irritability and like nothing is happening in treatment. Paying close attention to the ways their self-image is easily wounded and how they have the need to inflate their own accomplishments. Realize that they can react with rage at the wounding no matter how small or unintended the slight may have been. Addressing their sense of “entitlement” and “specialness” are corner stones of working with this challenging group.

These of some of the major personality disorder individuals with whom we work with. By trying to understand some of their core conflicts or maladaptive ways of dealing with the world the provider can provide some empathy and maybe form a “better working relationship” with the patient. Emphasizing their internal fears and avoiding the strong reaction that they provoke in us can help us provide quality treatment to this very challenging and difficult patient population.



Siphoning a Lesson from Every Moment in Life LCDR LaMar Henderson



On Thursday, June 12, 2014 in front of all Health Service Officers who attended category day during the 2014 US Public Health Service Training Symposium, Rear Admiral Scott Giberson jokingly stated to the cadre that he would “break me” during a planned workout... As I write today, I am proud to say--I am not broken, but a stronger man and officer. This is not to say that he didn’t work me till I thought I was going to need an oxygen mask, but I walked out of the gym proud and ready to plan for the next time his schedule permits for me to work out with him.

Leading up to, during, and after the workout I gained some valuable insight that I wanted to share with my fellow officers. I hope you find it valuable.

Persistence—What the Admiral didn’t have time to explain during that day at COA, is that I had requested to do one of his workouts for some months. I had emailed and scheduled a time, but due to his demanding schedule he had to cancel and remarked that we would reschedule at a later date. With that said, every time I saw Admiral Giberson, I reminded him that he owed me a workout, and he would always remark..., “Anytime, just email me!” After the challenge at COA category day, I emailed him as soon as I returned to my desk and he accepted. I find this lesson appropriate for the current time when some officers are feeling ‘some type of way’ because they were not promoted. Remain steadfast and persistent to show that you are the best of the best of the Commissioned Corps!

Flexibility—When anyone attempts to meet and/or work with an Admiral, they should know that they have to be flexible. As it is easy to infer, their schedules are amazingly demanding and unpredictable. As mentioned above, this opportunity took months of persistence and the ability to accommodate his schedule. For example, I live 44 miles away from the Tower building, and had to be there for the workout by 6am. This may seem fine to those of you who are morning people, but I am a night owl and despise mornings. Thus, I implore you to set a goal and find malleable ways of achieving it (Continued page 9)

Preparation & Research—As a person who keeps an active workout schedule, I felt I was prepared to take on much of what the Admiral was going to throw at me. In preparation, I had hit the gym several times in the past week and done some intense cardio and weight training. While I was able to keep up and not be “broken”, I must say that I walked out of the gym tired as H-E-(double hockey sticks). It was the longest 42 minutes I have had in a while (please note he was pushing to complete the interval workout in 30 minutes!! I must have slowed him down). What I didn’t know was that Admiral Giberson was a former mixed martial artist and his wife is a personal trainer who works out harder than him! Since my brother is a “Jar Head”(BKA-Marine), I have first-hand knowledge of how insane workouts can be and how certain people have a passion for punishing people. Also, I didn’t know what type of workout we were going to do. Had I known, I could have tried to be better prepared. You can best believe, I will ask for the workout beforehand, when we work out again. In everything that you do, prepare and research the dynamics so that you can be well equipped to handle anything that comes your way!

Challenge—Accept challenges that come your way, where you see that they can help you grow. There are some challenges that are not worth the energy; logically each officer will have to assess the value of each challenge and/or opportunity. But those that are... go at it full force and never back down! During the workout, I was determined to not be “broken”, but I must say there were many moments I thought about tapping out! But I couldn’t, whether it was for all the Social Workers I was representing, all of the people who told me they put their money on me (Thank You all!)—I couldn’t let them or myself down. Basically, my actions are sometimes bigger than me; and the test and trials that come my way are mere growth lessons. For requesting, being persistent, flexible, and accepting the challenge, I was coined by the Admiral—in which he made it very clear that he doesn’t do very often.

I would like to thank and express my sincere appreciation to *Acting Deputy Surgeon General Rear Admiral Scott F. Giberson* for giving me the opportunity to grow through his guidance and example.



The 2014 Annual Continuing Education Meeting will be held December 2–5 in Washington, D.C. A preliminary schedule of the event is available.

The AMSUS Social Work Session is currently scheduled for 1100-1200 on Thursday 04 DEC

For more information, see website at:
amsusmeetings.org



Social Work Mentorship Meet and Greet Events Going National

LCDR Holly Berilla and LT Israel Garcia

Last year, the Social Work Professional Advisory Group's Mentorship Subcommittee launched the Meet and Greet Initiative as an effort to promote mentoring and networking opportunities for Public Health Service Social Workers.

Thus far, three very successful meet and greet events have been held in the DC Metro area and were attended by PHS and civilian social workers. The first took place at the Walter Reed National Military Medical Center in Bethesda, M.D., in conjunction with the annual medical ethics training. The second was held in a local restaurant in Rockville, M.D., with the participation of special guest RADM Sarah Linde, Chief Public Health Officer, Health Resources and Services Administration. The most recent meet and greet event took place in Rockville, M.D., in conjunction with the Trauma Informed Care conference sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The featured speaker was RADM Peter Delany, SAMHSA's Senior Officer and Director of SAMHSA's Center for Behavioral Health Statistics and Quality.

We are looking forward to many more meet and greet events to be held nationwide with a focus on social work officers located across the ten DHHS regions. The Region-based points of contact for the initiative include the following officers:

Region One: CDR Coons and LCDR Baez

Region Two: Vacant

Region Three (by agency):

- DoD (Army SG) - CDR Watkins

- HHS/OS/ASPR - CDR Hastings

- HHS/HRSA - CDR Pace and LT Houghton-Antonucci

- HHS/NIH - CAPT Aizvera

- HHS/SAMHSA – LCDR Berilla

- HHS/ACF – CDR White

- BOP – CAPT Jay Seligman

Region Four: CDR Baptiste and CDR Garcia

Region Five: N/A (I did not note any SW officers assigned in this region)

Region Six: LCDR Hearod

Region Seven: LCDR Jones

Region Eight: LCDR Stanson

Region Nine: CDR Burke and LCDR Pleasanton

Region Ten: CDR Combs and LT Van-Meir

If you would like to serve as a point of contact or would like to sponsor a meet and greet event please contact the meet and greet workgroup chairs: LCDR Holly Berilla (Holly.Berilla@samhsa.hhs.gov) or LT Israel Garcia (igarcia@hrsa.gov).

LCDR Mark Durham

According to Ginsberg (2008) management is dependent upon specific qualities such as the audience or the agency and these at times are in conflict with each other during the managing process. There are two theories of management, theory X and theory Y. Theory X approaches management from the perspective that workers are inherently lazy and desire to do the least amount of work for their pay (Ginsberg, 2008). Thus, it takes a great deal of work on the part of the manager to coerce the workers to perform. In opposition, theory Y takes the perspective that work is enjoyable as much as leisure or play to the worker and they take pride in what they do; in a sense that their personhood is positively defined through their work (Ginsberg, 2008). Management would be described as connecting workers to their tools or machines in order to that productivity occurs (Ginsberg, 2008).

In difference to management, leadership involves followers within a group focused on accomplishing a common goal (Northouse, 2013). There are two separate perspectives of the origin of leadership. One is that leaders have traits that people want to follow, their height or the extraversion are examples (Northouse, 2013). The other origin view is in the interaction or relationship between the leader and follower (Northouse, 2013). Some lead due to their title or position in an organization and others lead leaders because of their interaction with others, who follow the emergent leader (Northouse, 2013).

Management is about structure and consistency and dissimilarly leadership is about sparking movement for the purpose of change (Northouse, 2013). It seems that management is more external and obtuse and leadership is more internal to the individuals and to the group with specific goals and direction for the organization. Effective leadership is found in the leader communicating the ideas for the direction or the new purpose for the organization (Northouse, 2013). Effective leadership is also evident in integrity whereby followers believe their leader is believable and trustworthy for leadership (Northouse, 2013).

Authentic leadership focuses on the leader and what is going on within the leader; this intrapersonal perspective considers the self-concept, self-regulation, and self-knowledge of the leader (Northouse, 2013). A description of authentic leadership is where the leader is genuine, not a copy, and leads from conviction from past experiences that developed the leader into an authentic leader (Northouse, 2013). One criticism of authentic leadership is whether an immoral or irreligious person can be an authentic leader (Northouse, 2013). A second critique of authentic leadership is if an authentic leader is unorganized, unproductive and nontechnical can they be an effective leader (Northouse, 2013). One aspect where authentic leadership can apply to Social Work is that an authentic leader is heavily influenced by ethics, knowing the difference between good and bad or right and wrong (Northouse, 2013). This ability enables authentic leaders to be selfless, making decisions for justice that improves the good of an individual or community (Northouse, 2013).

The definition of the paradox of servant leadership is that the leader is the servant of the followers (Northouse, 2013). Putting their followers first the servant leader is concerned and empathic toward the needs and development of the followers, empowering them in their development to be their best is the description of servant leadership (Northouse, 2013). The criticism of servant leadership is the paradoxical name that implies that it is whimsy and contradictory to leading followers (Northouse, 2013). The attributes of servant leadership have yet to be established as specific and identified, more research is required to establish these components (Northouse, 2013). One way that servant leadership can be applied to Social Work is that these leaders tend to not be dominating or controlling. Followers will be strengthened and empowered through a leader that serves the followers (Northouse, 2013). A servant leader will be focused on service to the followers, patients, and the community (Northouse, 2013).

References

- Ginsberg, L. H. (2008). *Management and Leadership in Social Work Practice and Education*. Alexandria, Virginia, USA: Counsel on Social Work Education Press.
- Northouse, P. G. (2013). *Leadership: Theory and Practice*. Los Angeles, CA, USA: Sage Publications.

SW Officer Leads Running Team LCDR Jennifer Borneman

While Saturday's race expo was rainy and chilly, race day could not have been more perfect. Beautiful sunny skies and cooler than normal temperatures greeted the Annapolis Ten Mile runners which for the first time ever included the small but strong Team USPHS, led by Social Work PAG member LCDR Jennifer Bornemann

The weekend began with the race expo where Team USPHS hosted a booth complete with an USPHS flag, marketing materials and a group of energetic commissioned corps officers ready to tell our story. We shared our space with other organizations where we educated folks - especially a lot of Navy colleagues - and built some friendships along the way. LT Benbassat attracted many curious runners as he dazzled them in his Summer Whites. We even had a mascot - CAPT Shapiro's precious pup who welcomed everyone visiting our table.

On Sunday, we not only had runners racing but we also had a couple of diehard officers who volunteered and kept the race safe for all of the participants. LCDR Perdue and LT Tarlton helped to direct the participants and with their medical professional backgrounds, made sure everyone finished healthy and strong! All of the USPHS runners represented well as I had friends approach me after the race telling me about the USPHS runners who passed them along the course in their awesome shirts, with their speedy legs and friendly attitudes. CAPT Dando (joined us from NC), CDR Shukan (PHS Athletics Co-Executive Director), LCDR Nguyen (ten miler first-timer), LCDR Steffen (rock star), LT Pesce (JOAG MVP) and Team USPHS race organizer LCDR Jennifer Bornemann ran hard up every hill and across each bridge - while smiling along the way.

For those who might be interested in participating next year, the Annapolis Ten Mile Run is one of the premiere 10-milers in the country. It is a challenging but fun course that is organized by runners for runners. It also has the best race premium for the money! So... next spring keep your eyes open for a registration announcement as we hope to at least double and perhaps triple our USPHS presence in this Navy town!!

USPHS Race and Volunteer Team for the 2014 Annapolis Ten Mile Run

CAPT Jonathan Dando

CAPT Rita Shapiro
 CDR Evan Shukan
 LCDR Jennifer Bornemann
 LCDR Thuy Nguyen
 LCDR Christopher Perdue
 LCDR Scott Steffen
 LT Danny Benbassat
 LT John Pesce
 LT Gail Tarlton



SWPAG has started at FACEBOOK Page. Please go and request to join. The plan is to keep it updated with information that pertains to our SWPAG. We want to know all the good stuff that happens to you or if you have something important to share with the group.

If you want to post something, please send to:

tricia.h.booker.mil@mail.mil or justin.pegowski@ihs.gov

As usual, keep the articles coming for the newsletter!!

LIKE US ON FACEBOOK !!
Under USPHS SWPAG



NASW - NEW YORK CITY CHAPTER
National Association of Social Workers

I am a

basic agent for positive change - a client
advocating, injustice fighting, therapy
providing, systems testing, family
preserving, social conscious raising,
datacollecting, rights protecting, child
defending, staff developing, human
assisting, strengths focused, social
rights championing, ego lending, and
crisis intervening teacher, facilitator,
listener, encourager, supporter, and
leader with professionalism, integrity,
concern, empathy, values, love, trust,
honesty, and warmth -

Social Worker

Thanks to the Arkansas Chapter of NASW for inspiring this affirmation.



Continued from page 1

participate in. He had gotten into his truck and went to an empty field and shot himself. No note, no warnings, nothing to give hint to those close to him. He was not mentally ill. He was simply living. Working on getting back with his estranged wife and he had a job that he loved. We had just messaged back and forth a few weeks ago.

I was (still) in shock. The messages and phone calls from his left behind friends all asked the same question: “Why?”

This brought me to a cold hard reality... As mental health professional we have to admit as Bryan and Rudd (2006) stated in their article about suicide that predicting low base-rate phenomena such as suicide with any degree of reliability is not possible. We can learn about the areas that have been empirically demonstrated to be essential to *risk assessment*.

We learn about all the risk factors associated with suicidal thoughts and behaviors, how to practice safety planning, but one area that usually gets largely neglected is the effect that suicide can have on providers. Suicide is a dreaded potential outcome of mental health treatment. The word itself elicits powerful emotions, both at the conscious and unconscious level.

Common reactions to suicide are shock, denial, grief, guilt, anxiety, shame, feelings of betrayal, and feelings of inadequacy. These emotions can be intense. Providers may often neglect their own emotional needs as they work to meet professional responsibilities after a patient commits suicide.

The provider may need to lean on family, friends, and peers. These groups of people have been reported to be the most helpful support when coping with a patients’ suicide. The emphasis needs to be on emotional effects of the death rather than the details of treatment. If available, the provider can attend group meetings with other providers who have experienced a similar loss.

Supervisors can be a great source of support, too. Both past and present mentors can be supportive. The provider may consider precipitating in the rituals of death. These actions may include attending the funeral and the memorial service, or sending a sympathy message for the family. The provider may also need personal psychotherapy to work through the complex emotions.

Finally, the provider can participate in a psychological autopsy. Review the case, develop recommendations based upon the specific case, and then find ways to improve procedures when dealing with suicidal patients. Suicide may be a rare event, but when completed it has a far-reaching effect on many people, including the provider.

